An endoscopic study on the prevalence of the accessory maxillary ostium in chronic sinusitis patients

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INTRODUCTION

The maxillary sinus is also known as the Antrum of the Highmore and is the largest of the paranasal sinuses and the most commonly affected in sinusitis. During evolution, the Homo sapiens changed to an upright posture and the maxillary sinus ostium also got rotated to a higher position and the sinus lost the advantage of a gravitational drainage. It has to depend upon the ciliary action and effective ventilation of the nasal cavity to clear the secretions.

Structures located on the lateral nasal wall especially the nasal septum, turbinates, bulla ethmoidalis and the uncinate process play an important role in directing the nasal airflow. During inspiration, due to the Bernoulli effect, the nasal airflow creates a negative pressure in the nasal cavity which helps in the sinus drainage. When there is a mucosal swelling, the cilia get paralysed, resulting in poor mucus clearance and mucus stasis in the sinus and secondary infection.

Infection increases the mucosal swelling further and blocks the natural sinus ostium. A vicious cycle is formed.
and the pressure inside the maxillary sinus builds up, which leads on to a rupture of the weaker membranous part of the medial wall, facilitating drainage and an accessory maxillary ostium (AMO) is thus created.² It has been compared to the perforation of the tympanic membrane in case of acute otitis media.³ The AMO development has also been postulated as due to a congenital dehiscence of the fontanels.

The objective of the study was to identify the presence of an AMO during nasal endoscopy in patients with symptoms of chronic sinusitis and to correlate it with the findings of their X-ray para nasal sinus and analyse the incidence of the AMO in chronic maxillary sinusitis patients.

**METHODS**

This clinical study was conducted at the Department of Otorhinolaryngology and Head and Neck Surgery of Aarupadai Veedu Medical College and Hospital located at Puduchery South India, from August to October 2019. This study was approved by the Institutional research committee. 52 adult patients aged between 18-70 years attending the ENT outpatient department with symptoms of nasal obstruction, nasal discharge, sneezing, and headache and post nasal drip for more than 4 weeks were selected for the study.

Any patient below the age of 18 years and all patients with a previous history of nasal trauma, nasal surgery or co morbidities like diabetes, hypertension or bleeding disorders were excluded from the study.

Routine blood investigations such as Hb%, total and differential white blood cell count, absolute eosinophil count and X-ray of the paranasal sinuses were done to identify any anatomical abnormalities and other factors that contribute the development of sinusitis. After obtaining an informed consent they were subjected to nasal endoscopy under local anaesthesia to identify any AMO. Local anaesthesia and decongestion of the nasal cavity was achieved by packing both the nasal cavities with ribbon gauze strips soaked in a mixture of 10 ml of 4% xylocaine topical solution and 10 drops of 0.1% Otrivin nasal drops for 10 minutes prior to nasal endoscopy.

With the patients in sitting position, nasal endoscopy was done on both sides using a 0° and 30° rigid nasal endoscopes of 4 mm diameter which were attached to a camera and a monitor. Classical 3 pass endoscopy was done and various abnormal findings like septal deviations, concha bullosa, polyps and abnormalities of the uncinate, bulla or middle turbinate were recorded. The presence of AMO, its location, numbers, and presence of any discharge through the AMO were meticulously recorded. Appropriate medical or surgical treatments were advised and carried out for these patients.

Statistical analysis was done with simple interactive statistical analysis and the results are presented.⁴

**RESULTS**

In the study group of 52 patients there were 28 male (53.9%) and 24 female (46.1%) patients. Many of the patients had multiple symptoms and the common presenting symptoms were nasal obstruction (92%) headache or facial pain (88%) nasal discharge (84%) and sneezing (54%) and shown in Figure 1.

![Patient symptomatology](image)

**Figure 1:** Patient symptomatology.

AMO was identified during endoscopy in a total of 20 patients (38.4%) of which there were 12 males and 8 females. The age wise prevalence is shown in Table 1.

**Table 1: Age wise prevalence of AMO.**

<table>
<thead>
<tr>
<th>Age group (in years)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-30</td>
<td>5</td>
<td>2</td>
<td>7 (13.4)</td>
</tr>
<tr>
<td>31-40</td>
<td>2</td>
<td>3</td>
<td>5 (9.6)</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
<td>3</td>
<td>5 (9.6)</td>
</tr>
<tr>
<td>51-70</td>
<td>3</td>
<td>0</td>
<td>3 (5.8)</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>8</td>
<td>20 (38.4)</td>
</tr>
</tbody>
</table>

AMO was unilaterally identified in 14 patients (26.9%) and bilaterally seen in 6 patients (11.5%). The location wise prevalence is shown in Table 2.

**Table 2: Location prevalence of the AMOs.**

<table>
<thead>
<tr>
<th>AMO</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral</td>
<td>10</td>
<td>4</td>
<td>14 (26.9)</td>
</tr>
<tr>
<td>Bilateral</td>
<td>2</td>
<td>4</td>
<td>6 (11.5)</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>8</td>
<td>20 (38.4)</td>
</tr>
</tbody>
</table>

In our study we found the AMOs to be located mostly in the posterior fontanel in 13 cases (65%) and located in the anterior fontanel in 9 cases (45%). The various anatomical location of the AMOs is shown in Table 3. One patient had bilateral AMOs located in the anterior fontanel on one side and posterior fontanel on the other side. Another patient had bilateral AMOs and both were located on the anterior fontanel in either side.
### Table 3: Anatomical location of the AMOs.

<table>
<thead>
<tr>
<th>AMO</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post. fontanel</td>
<td>6</td>
<td>7</td>
<td>13 (65%)</td>
</tr>
<tr>
<td>Antr. fontanel</td>
<td>7</td>
<td>2</td>
<td>9* (45%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13</td>
<td>9</td>
<td>22*</td>
</tr>
</tbody>
</table>

* One patient had a bilateral AMOs, located in the anterior fontanel on one side and posterior fontanel on the other side. Another patient had a bilateral AMOs and both were located on the anterior fontanel on either side.

### Table 4: Means value for the prevalence of the AMOs.

<table>
<thead>
<tr>
<th>Means</th>
<th>Label</th>
<th>Mean</th>
<th>SD</th>
<th>Std err</th>
<th>95% z-Cl</th>
<th>Frequency</th>
<th>%</th>
<th>++%</th>
</tr>
</thead>
<tbody>
<tr>
<td>r1:</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>r2:</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>r3:</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>r4:</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>4.25</td>
<td>2.061553</td>
<td>1.030776</td>
<td>2.229712</td>
<td>6.270288</td>
<td>4</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

### DISCUSSION

The maxillary sinus is located in the maxillary bone. The medial wall of the maxillary bone has a large opening known as the maxillary hiatus which is partly filled by bony structures such as the maxillary process of the inferior turbinates, perpendicular plate of the palatine bone, lacrimal bone, uncinate process and ethmoidal bulla. The remaining gap is filled by a membranous portion formed by the mucous membrane of the middle meatus and the maxillary sinus. This membranous portion lies anterior and posterior to the uncinate process and forms the anterior and posterior fontanels (Figure 4).

Sindel et al in their cadaveric study have identified that the posterior fontanel is closed by mucous membrane and periosteum and reported the AMO incidence to be 13.8%. Yenigun et al in 2016 have reported a 19.10% incidence of AMO. The natural ostium of the maxillary sinus drains in to the posterior inferior part of the infundibulum in most of the cases. The AMO is usually located in the posterior fontanel or in the anterior fontanel. In our study we found the AMO to be located mostly in the posterior fontanel in 13 patients (65%) and in 9 patients (45%) the AMO was located in the anterior fontanel.

The role of the AMO has not been clearly defined. The development of the AMO has been postulated as a congenital dehiscence found in the fontanels or an acquired dehiscence due to sinusitis.

In the acquired theory, due to infection and inflammation the natural ostium gets blocked and the pressure inside
the maxillary sinus builds up leading on to a rupture of the weaker membranous part of the medial wall and an AMO is created.

In our study also we identified that out of 43 patients who had NSD, 12 patients (27.9%) had an AMO on the same side of the septal deviation.

X-ray Water’s view of the paranasal sinuses is a simple and valuable screening tool for diagnosing sinusitis. According to the study by Gujrathi et al the conventional X-ray para nasal sinus has a sensitivity of 97.6% and specificity of 47.6%. In case of sinusitis haziness is seen in 97.6% of the X-rays. In our study the X-ray of the para nasal sinus showed maxillary sinus haziness or mucosal thickening in 32 patients (61.5%).

All these studies support the acquired theory that the AMO formation is secondary to sinus infection and blockage of the natural ostium.

CONCLUSION

The identification of an AMO through nasal endoscopy is a simple procedure. In patients presenting with symptoms of sinusitis, visualisation of an AMO during nasal endoscopy could be taken as an additional indicator of previous incidences of natural ostium obstruction. Coleman et al in their study have commented that mucus stasis due circular flow between the natural or surgical ostia and the accessory ostia could be a reason for chronic infections and have demonstrated an extended middle meatal antrostomy technique. Presence of an AMO could be considered as an indication for a wider middle meatal antrostomy which can be achieved by joining the natural ostium and the AMO for better results

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REFERENCES


