A nine year old female presented with a chief complaint of recurrent left-sided nasal obstruction, rhinorrhea, and occasional epistaxis. She had undergone two endoscopic resections in the prior 1.5 years, both at outside hospitals; pathology had revealed squamous papilloma with mild dysplasia. In-office nasal endoscopy, limited by patient cooperation, showed a fleshy, polypoid mass traversing the floor of the left nasal cavity, abutting the septum and inferior turbinate. The remainder of the examination was unremarkable.

A computed tomography (CT) scan revealed an opacification along the left inferior turbinate and nasal floor, and minimal soft tissue thickening of the medial left maxillary sinus (Figure 1A). Magnetic resonance imaging (MRI) showed a 3.3 x 0.4 x 1.5cm T1 and T2 hypointense mass with minimal heterogeneous and punctuate enhancement, filling the left inferior nasal cavity and extending into the nasopharynx. There was no evidence of mass effect or bony erosion (Figure 1B, 1C).

The patient subsequently underwent endoscopic resection. Intraoperatively, the lesion filled the nasopharynx and extended through the right posterior choana, and fragmented easily with suctioning. Frozen sections revealed papilloma. Removal of the bulk of the mass revealed a polypoid mass that could fill the entire nasal cavity, often involving more than one sinus, making the point of attachment difficult to identify in awake patients. CT imaging may delineate the origin at a point of bony sclerosis or deformation of the nasal wall, whereas MRI helps distinguish the mass from inspissated secretions or inflammatory changes, and allows evaluation of the extent of tumor growth. Pathologic examination is necessary to distinguish IP from other polypoid lesions of the sinonasal tract. It is histologically characterized by hyperplastic ribbons of squamous or ciliated columnar multilayered epithelium mixed with mucocytes that grows endophytically into the underlying stroma.

IP has rarely been described in the pediatric sinonasal population, with less than 20 confirmed cases in the English language literature. Hayman’s landmark study of 149 patients with sinonasal IP included no pediatric cases. Schramm’s series of 376 pediatric sinonasal masses did not include a single case of IP.

REFERENCES