

'Medical rhinoplasty' in nasal sarcoidosis

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INTRODUCTION

Nasal involvement with sarcoidosis was first recognised by Boeck (1899) who noted mucosal changes in four of his nine original cases of systemic sarcoidosis. However, it was not until 1937 that nasal mucosal involvement was confirmed histologically (Kistner and Robertson, 1938). Estimates of the incidence of nasal sarcoidosis have ranged as high as 20%, although in a recent series it was found to be only 3% (Wilson et al., 1988). It may affect nasal skin, mucosa or bone and those with nasal manifestations will occasionally seek treatment for cosmetic reasons. We report the management of two such cases.

CASE REPORTS

Case 1 - A 38 year old Asian woman was referred for consideration for a rhinoplasty. She presented with a three year history of a swelling of the bridge of her nose, which she attributed to a previous injury. On examination there was a soft tissue swelling overlying the nasal bones and upper lateral cartilages. Anterior rhinoscopy revealed a granular mucous membrane. A small area of lupus pernio was present on the left cheek (Figure 1). There was no clinical evidence of involvement elsewhere. Her chest radiograph showed hilar lymphadenopathy and the Kveim test proved positive. A diagnosis of sarcoidosis was made. She was commenced on prednisolone 30 mg daily combined with chloroquine sulphate 400 mg daily. There was a very good initial response and the prednisolone was steadily reduced and the chloroquine cut to 200 mg daily. The nose had returned to normal within three months and she is at present on 5 mg prednisolone on alternate days. Since then the small area of lupus has likewise regressed.

Case 2 - A 39 year old woman with known sarcoidosis was referred with a four year history of a tender swelling over the bridge of her nose. She was on prednisolone 5 mg daily. She was also being treated for hypertension which had presented problems as far as increasing her steroid dosage in the past. On

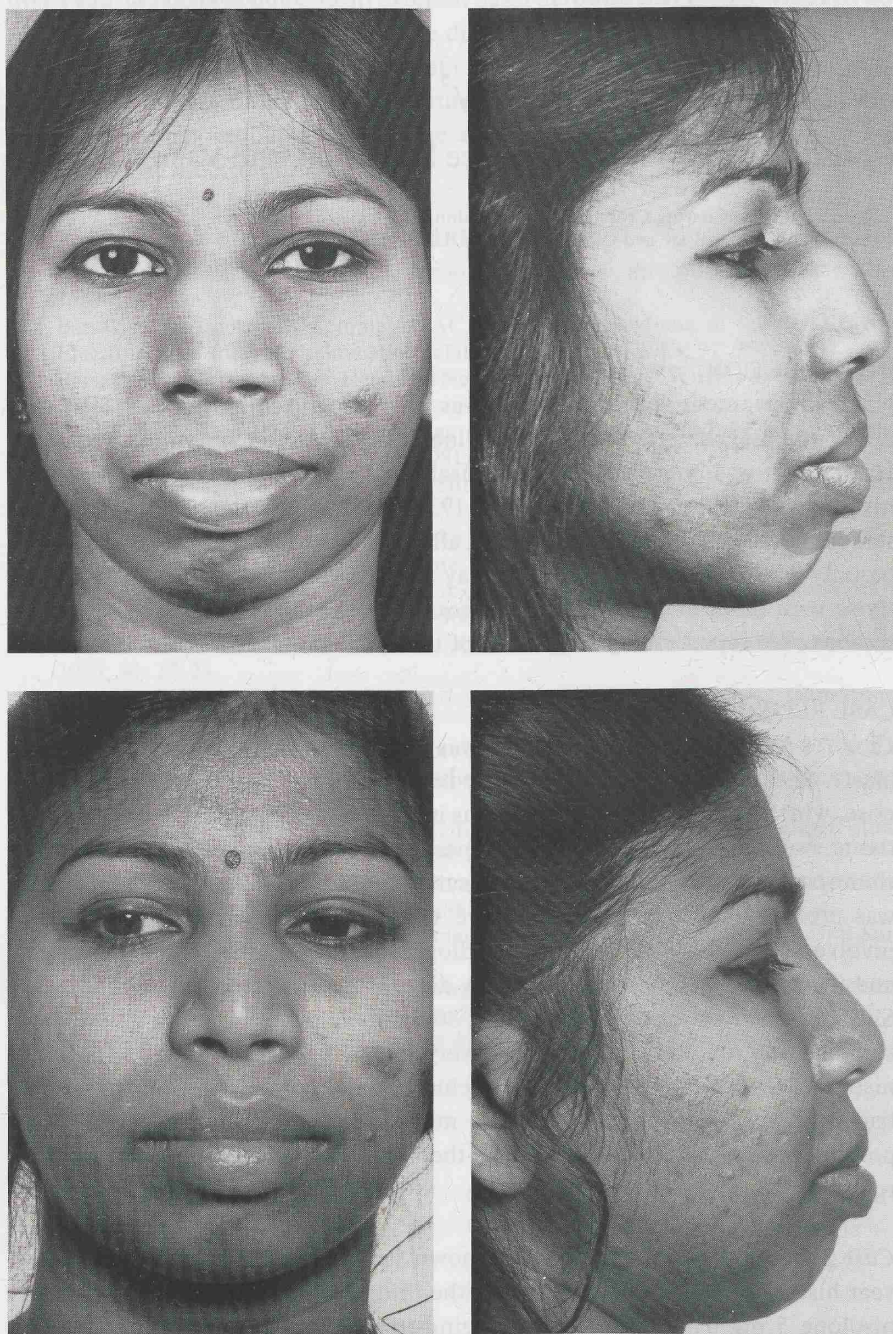


Figure 1. Above: before treatment. Below: three months after treatment.

examination she had a dorsal nasal hump and anterior rhinoscopy revealed granular nasal mucous membranes.

The prednisolone was stopped and she commenced dexamethasone 10 mg daily, while continuing her anti-hypertensive treatment. The nasal mucous membranes returned to normal within one month and the dorsal hump had improved dramatically within two months. The dexamethasone was reduced to 10 mg on alternate days following this and within four months of starting treatment the hump had disappeared. The patient is at present on no medication.

COMMENT

Nasal sarcoidosis may present with the following cosmetic problems:

1. Cutaneous involvement may lead to areas of lupus pernio or to a generalised swelling of the nasal tip (Munro Black, 1966).
2. Saddling may occur secondary to involvement of the nasal septum (Bull, 1983).
3. Involvement of the nasal bones and subcutaneous tissues may produce swelling of the nasal bridge as seen in these cases (Munro Black, 1966).

Topical steroids have been found useful in controlling symptoms from nasal mucosal involvement but there is no agreed treatment policy for involvement of the bones and subcutaneous tissues in nasal sarcoidosis. In general, nasal surgery (especially rhinoplasty) is avoided until the disease is quiescent. However, these cases illustrate that adequate medical treatment of the underlying condition may actually remove the necessity for subsequent surgery.

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