Choanal Polyps Originating from Unusual Sites: A Rural Tertiary Care Center Experience

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Abstract

Introduction  Choanal polyps are benign lesions arising from the sinonasal mucosa, extending through the choana into the nasopharynx. Though polyps arising from the maxillary sinus and extending to the choana are common, polyps arising from the sphenoid sinus ostium, posterior part of middle turbinate, and inferior and middle meatus are quite uncommon.

Objective  To document the site of origin of choanal polyps arising from unusual sites; their clinical, radiological, and histopathological characteristics, as well as diagnostic challenges and management.

Methods  This retrospective, single-center study included 14 patients aged 16 to 75 years-old with choanal polyps. After obtaining informed consent, their clinical, radiological and surgical details and histopathology reports were reviewed. Patients were followed for at least 6 months after surgery.

Results  The predominant symptoms were unilateral nasal obstruction (n = 9), snoring, rhinorrhea, and epistaxis. Though anterior rhinoscopy was unremarkable, a mass could be visualized during posterior rhinoscopy in 11 patients, and a mass could be directly visualized in the oropharynx in 2 patients. After diagnostic by nasal endoscopy, these polyps were noted to arise from the posterior aspect of the middle meatus (n = 6), middle turbinate (n = 3), posterior septum (n = 3), sphenoid sinus ostium (n = 1), and inferior meatus (n = 1). All patients were managed surgically. The histopathological examination revealed inflammatory polyp (n = 12), actinomycosis (n = 1), and rhinosporidiosis (n = 1). Patients were followed up for 6 to 22 months. We observed no complications or recurrence.

Conclusion  Diagnostic nasal endoscopy should be performed in all patients presenting with nasal obstruction, to rule out choanal polyps arising from unusual sites. Complete polyp removal and appropriate treatment based on histopathology prevents recurrence.

Keywords
- nasal polyp
- actinomycosis
- nasal septum
- sphenoid sinus
- rhinosporidiosis
- endoscopic excision

Introduction with Objectives

Choanal polyps are benign, soft tissue lesions which arise from nasal or paranasal sinus mucosa and extend through the choana into the nasopharynx.¹ Choanal polyps represent approximately 4 to 6% of all nasal polyps.² Although most choanal polyps are of inflammatory etiology, their exact pathogenesis is still not clear. Allergy, atopy, venous obstruction, and infections are thought to play a role in the etiopathogenesis of choanal polyps.

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Patients with choanal polyps often present with unilateral or bilateral nasal obstruction, snoring, nasal discharge, headache, and epistaxis. Though antrochoanal polyps, that is polyps arising from the maxillary sinus and extending to the choana, are more common, polyps arising from sphenoid sinus ostium, posterior part of middle turbinate, posterior nasal septum, and the most posterior part the of inferior and middle meatus are quite uncommon. Polyps arising from these uncommon sites are often missed in anterior rhinoscopy and pose a diagnostic challenge to clinicians. There are very few studies in literature that describe choanal polyps originating from these unusual sites, posteriorly in the nasal cavity.

We have encountered polyps originating from unusual areas in the posterior part of nasal cavity, which were missed on anterior rhinoscopy but could be visualized on posterior rhinoscopy. Furthermore, a detailed diagnostic nasal endoscopic examination could be used to identify the site of origin of these polyps. The aim of this study is to document the site of origin of choanal polyps arising from unusual sites in the posterior part of the nasal cavity, as well as to describe their clinical, radiological and histopathological characteristics, diagnostic challenges, and management.

**Method**

In this retrospective study conducted at the Sri Devaraj URS Medical College and Research Center, we enrolled 14 patients with an age range from 16 to 75-years-old, who were diagnosed to have choanal polyps and treated between 2016 and 2019. Patients with previous history of nasal trauma, and nasal or paranasal sinus surgeries were excluded. A written informed consent was obtained from the study participants to use their clinical data. The presenting symptoms, past history, clinical examination details, nasal endoscopy findings, and radiological details of these patients were retrospectively reviewed. Details of surgery, intraoperative findings, and histopathology reports of these patients were reviewed. Patients were followed for a minimum period of 6 months after the surgery. The study was approved by the Institutional Ethics Committee (Id: DMC/KLR/IEC/308/2020).

**Result**

A total of 14 patients from 16 to 75-years-old, 12 of which were males and 2 females, with diagnosed choanal polyps were enrolled in our study. (Table 1) The majority of patients (n = 9) presented with unilateral nasal obstruction as the chief complaint. (Table 2) Anterior rhinoscopic examination was unremarkable in all the cases. On posterior rhinoscopy, a polypoidal mass could be visualized in the nasal cavity in most of the patients (n = 12) and a bulky mass could be directly visualized in the oral cavity in two patients. In 12 patients the polyp was unilateral and in 2 patients, bilateral polyposis was seen. Associated anatomical abnormalities, such as deviated nasal septum, were also noted in 10 patients with unilateral polyp. In all these patients, after meticulous nasal endoscopic examination, the polyp was found to be arising from unusual sites in the posterior part of the nasal cavity. (Table 3)

On detailed diagnostic nasal endoscopy, 6 polyps were found to be arising from the posterior part of the middle meatus, of which one polyp looked yellowish and bulky, protruding between the middle turbinate and the uncinate process, touching the floor of nose and the nasal septum, and extending posteriorly into the choana. (Fig. 1) These patients underwent functional endoscopic sinus surgery and the polypoidal mass was sent for histopathological examination. The suspicious yellowish mass had features suggestive of actinomycosis, for which the patient was started on doxycycline. All 6 patients were regularly followed up in our outpatient facility, and none of them had recurrence.

We encountered 3 septochoanal polyps attached to the posterior part of the nasal septum by a thick, long stalk which extended to the nasopharynx. (Fig. 2) Patients were taken to

**Table 1** Table showing the age distribution of patients who presented with choanal polyp

<table>
<thead>
<tr>
<th>Age group</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>16–30 years</td>
<td>2</td>
</tr>
<tr>
<td>31–45 years</td>
<td>7</td>
</tr>
<tr>
<td>46–60 years</td>
<td>4</td>
</tr>
<tr>
<td>60–75 years</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 2** Chief presenting complaints of patients who presented with choanal polyp

<table>
<thead>
<tr>
<th>Chief complaint</th>
<th>No. of patients</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral nasal obstruction</td>
<td>2</td>
<td>14.2</td>
</tr>
<tr>
<td>Unilateral nasal obstruction</td>
<td>9</td>
<td>64.2</td>
</tr>
<tr>
<td>Snoring</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>2</td>
<td>14.2</td>
</tr>
<tr>
<td>Hyposmia</td>
<td>7</td>
<td>50</td>
</tr>
</tbody>
</table>

**Table 3** Site of origin of choanal polyp in the nasal cavity

<table>
<thead>
<tr>
<th>Origin of the polyp</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posterior part of middle meatus</td>
<td>6</td>
</tr>
<tr>
<td>Posterosuperior part of nasal septum</td>
<td>2</td>
</tr>
<tr>
<td>Posteroinferior part of nasal septum</td>
<td>1</td>
</tr>
<tr>
<td>Postero medial aspect of middle turbinate</td>
<td>1</td>
</tr>
<tr>
<td>Posterolateral aspect of middle turbinate</td>
<td>1</td>
</tr>
<tr>
<td>Posteroinferior part of middle turbinate</td>
<td>1</td>
</tr>
<tr>
<td>Inferior meatus</td>
<td>1</td>
</tr>
<tr>
<td>Sphenoid sinus ostium</td>
<td>1</td>
</tr>
</tbody>
</table>
the operating room and the polyp was excised endoscopically. The base of the stalk was cauterized using bipolar cautery.

The polyp was found to be arising from mucosa over the posterior aspect of the middle turbinate in 3 patients. The mass could be probed all around except at its attachment to the middle turbinate. The polyp extended far posteriorly through the choana, obstructing bilateral choanae and extending into the nasopharynx.

In a 47-year-old male patient, a reddish bossellated mass was seen arising from the inferior meatus by a short, narrow pedicle, very close to the opening of the nasolacrimal duct, and extending posteriorly into the oropharynx. (Fig. 3) Functional endoscopic sinus surgery was done, and histopathology revealed rhinosporidiosis. The patient was treated using dapsone 100 mg once daily for a period of 6 months. On follow-up visits, there were no signs of recurrence.

In an elderly patient who came to our outpatient facility with complaints of snoring and throat irritation, the polyp was found to be arising from the mucosa near the sphenoid sinus ostium via a slender, long stalk extending to the nasopharynx and leading to a bulky polypoidal mass extending to the oropharynx. (Fig. 4) Endoscopic excision was done, followed by cauterization of the base of the stalk under general anesthesia.

Diagnostic imaging was performed in all these patients in the form of computed tomography (CT) with axial and coronal cuts to identify the site of origin of the polyp, to assess the extent of the polyp, and for surgical planning. The findings were remarkable, especially in patients with septochoanal and sphenoochoanal polyps where a thin long stalk could be identified arising from the posterior choana leading to a large homogenous opacity in the nasopharynx or oropharynx. (Fig. 5) Patients with sphenoochoanal polyps had minimal mucosal thickening in the sphenoid sinus, whereas the rest of the sinuses were free from pathology. In 9 of the patients with choanal polyps, mucosal thickening was
Choanal polyps often present in all 4 sinuses; however, there was no evidence of mass or polyps within the sinus of these patients.

Among the 14 patients in our study, 5 patients had history of allergic symptoms in the past, and 12 patients gave family history of nasal allergy. In 12 of the 14 patients, histopathology revealed inflammatory polyps, of which 7 patients had eosinophilic infiltration. All patients were followed up for 6 to 22 months after treatment (mean follow-up time of 18 months). None of the patients had any postoperative complications or recurrence.

**Discussion**

Choanal polyp was originally described by Killian in 1906. Patients with choanal polyps often present with nasal obstruction, nasal discharge, snoring, headache, epistaxis, and obstructive sleep apnea. Among choanal polyps, antrochoanal polyps are the most common. This may be due to the closely opposing mucosal surfaces and turbulent airflow in the ostiomeatal complex region. The Bernoulli phenomenon and gravity are likely related to nasopharyngeal extension of the choanal polyps. Local inflammation due to allergy or infection may be a predisposing factor for polyp formation in unusual sites. Many patients in our study gave a history of allergic symptoms in the past. Allergic rhinitis and previous recurrent respiratory tract infections might have caused local inflammatory changes over the nasal mucosa and made them more predisposed to polyp formation.

Most choanal polyps in our study exhibited smooth, well-defined, greyish-white appearance, which is consistent with simple nasal polyps in both gross and microscopic appearance. Eosinophils are usually more likely to be present in polyps arising from middle meatus, when compared to those found in antrochoanal polyps. In our study, eosinophilic infiltration of polyp was present in 5 patients, all cases with the polyp arising from the middle meatus.

Clinical symptoms for choanal polyps are often same as those caused by antrochoanal polyps. In our study most patients presented with bilateral nasal obstruction. A case of asymptomatic choanal polyp was reported in 2016, which was identified due to the problems it posed to intubation prior to an unrelated surgery. The polyp was arising from the posterior ethmoid sinus and was later removed by endoscopic polypectomy. In our patients, intubation could be performed with minimal difficulty.

**Actinomycosis** is an infection caused by *Actinomyces israelii*, which is a gram-negative anaerobic bacteria. It commonly causes cervicofacial, thoracic, and abdominal infections. Actinomycosis affecting the nasal mucosa is relatively rare; literature says that it is more likely to occur in immunocompromised patients, in the presence of mucosal injury and copathogens. However, our patient was not immunocompromised. The antibiotics effective in treatment of actinomycosis are penicillin, tetracycline, cephalosporins, macrolides, imipenem. Treatment duration varies from 6 weeks to 1 year depending on the severity of the infection. Our patient was treated with doxycycline for 6 weeks.

Rhinosporidiosis is an infection caused by *Rhinosporidium seeberi*, grouped under the class mesomycetozoea. It is primarily a water borne disease. The characteristic appearance of whitish dots over a red mass was not prominent in our case. Another case of rhinosporidiosis being found incidentally in a patient with nasal polyposis was reported by Manickam et al. in 2015; it was diagnosed after postoperative histopathological examination, which helped in embarking on appropriate treatment postsurgery. When encountering a reddish fleshy mass in unusual sites of nasal cavity, which is insensitive and bleeds on touch, the possibility of sinonasal malignancy, papilloma, hemangioma, and tuberculosis should also be kept in mind. Diagnosis should be confirmed by histopathological examination. Dapsone may be administered to prevent recurrence. Our patient was treated with dapsone for a period of 6 months postoperatively, and there was no recurrence of infection.

Polyps arising from the middle turbinate are very rare. We encountered 3 such cases, one of which actually mimicked an antrochoanal polyp, but through detailed nasal endoscopy, it’s origin from the middle turbinate was confirmed. In all 3 cases, the bilateral ostiomeatal complex were clear and both maxillary sinuses were free from polyps, which was similar to the observations of Özcan et al. in 2004, and Gupta and Singh in 2013.

Sphenoid polyps refer to polyps arising from mucosa covering the anterior wall of the sphenoid sinus, near the sphenoid sinus ostium or from the sphenethmoidal recess, and extending into the choana. In their study on sphenochanal polyps, Lim and Sdralis concluded that sphenosomal polyps may be more common than believed, because most of them are small and asymptomatic, and some may regress spontaneously. A case of sphenochanal polyps reported by Kesawrani et al. mentioned the possibility of these polyps being missed on anterior rhinoscopy and misdiagnosed as nasal obstruction due to deviated nasal septum, especially in the presence of a septal spur. In our patient, as the stalk of the
polyph was slender and originated far posteriorly in the nasal cavity, close to the sphenoid sinus ostium, it was not visualized on anterior rhinoscopy and the site of origin became evident only after detailed nasal endoscopic examination. Hence, in all cases presenting with recent onset of nasal obstruction and snoring, a detailed nasal endoscopy is mandatory as the possibility of sphenochonal polyp cannot be excluded.

Septochoanal polyps are polyps arising from the posterior part of the nasal septum and extending posteriorly into the choana. Stammberger reported 3 cases of septochoanal polyps arising from the posterior nasal septum in 1990. A case of septochoanal polyph was reported by Birkent et al. in 2009. It is often found to be attached to the posterior part of the septum by a narrow pedicle, which was the case in our study. Endoscopic excision of the polyph, with cautery or removal of the mucosa over which the pedicle of septochoanal or sphenochonal polyph is attached are necessary to prevent recurrence. Histopathological examination should be done in all the patients, keeping in mind the possibility of inverted papilloma, actinomycosis, and rhinosporidiosis in these rare polyphs. In elderly patients, malignancy should be excluded.

Conclusion

Choanal polyphs can arise from anywhere in the nasal mucosa. Clinicians should remember that choanal polyphs can originate from unexpected sites in the nasal cavity. Detection of the site of origin of choanal polyphs by a thorough nasal endoscopy and imaging techniques is crucial for planning the surgery. Early diagnosis of etiology of choanal polyph by histopathological examination allows for appropriate treatment postoperatively, which has a bearing on treatment results and prognosis.

Conflict of Interests

The authors have no conflict of interests to declare.

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