# VERSATILITY OF MAXILLARY ANTRUM PATHOLOGY: CASE SERIES

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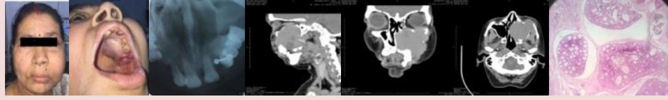
Knowledge about neighbour is essential to have peaceful existence- That's about antrum pathology. Maxillary sinus the abutting neighbour of oral region may be troubled by dental or sinogenic pathology.

**Aim:** Case series study done with an objective to emphasises history taking and examination of multifaceted maxillary sinus pathology.

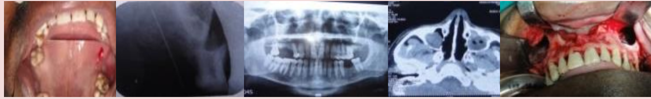
## ADENOID CYSTIC CARCINOMA

54/F reported with swelling on left side of face since 3 months after extraction of left upper teeth. Pre extraction occlusal X-ray showed bone destruction, but was unnoticed. *Key features- Gross swelling of left half of hard palate, enlargement of left nostril, I/O mass obliterating the occlusion. *CECT depicts 4.6x5.68x6.1 cm sized well defined, expansile, solid infiltrative mass, centred in left maxillary sinus. *Incisional biopsy showed Adenoid cystic carcinoma cribriform pattern type of hard palate. *T/t- subtotal maxillectomy under GA and an obturator for functional and aesthetic rehabilitation.



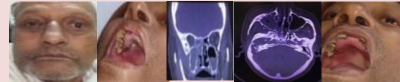
## KERATOCYSTIC ODONTOGENIC TUMOUR

34/M visited with of pain and discharge in the upper left vestibular region for the past 1 year. *H/O traumatic extraction of 26, 3 years back. *IOPA of 26 with 25 no. Gutta percha point showed it's 3\4 length inside the left maxillary sinus. *OPG reflected small 2 mm × 2 mm ovoid radiolucent area cupping bony defect with a radio opaque margin. *CECT displayed polypoidal soft tissue mass in the right and left maxillary sinus with a breach in the anterior wall of the sinus. *T/t- B/L Caldwell luc under GA was done and enucleated cystic wall with cheese content was sent for HPE which confirmed KCOT of Max. sinus.



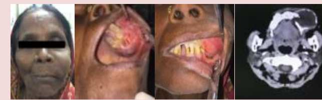
## MUCORMYCOSIS

65/ M, presented with swelling of right half of face, nasal blockage & nasal discharge for more than 20 days. *Key features- Patient had uncontrolled diabetes mellitus, foul smell, palatal fistula covered with necrotic slough present on right half of hard palate. * Nasal swab which was sent for C/S showed fungal growth. *Biopsy of palatal slough favoured mucormycosis. *CT PNS- showed soft tissue density lesion filling all sinuses along with erosion of Rt.Sup. lveolar ridge and post. Inferior wall of max. sinus. *T/t- palatal obturator for fistula and Inj.Amphoterecin B 50mg for 14 days followed by partial maxillectomy and rehablitation with an obturator



## MUCOCELE

58/F reported, with gross swelling on her left side of face since 6 months. * Key features- 3*5 cm intraoral swelling obstructing occlusion, medially displaced 24 & 25. *FNAC fluid which was clear brownish colour showed collections of acute and chronic inflammatory cells, and cystic macrophages. *CECT depicted expansile homogenous mass with scalloping and resorption of posteroinferior, medial and superiolateral walls of sinus. These findings favoured mucocele of maxillary sinus. *T/t- enucleation of cyst via Caldwell Luc sinusectomy. Operative specimen on HPE confirmed mucocele. Patient was followed up for regular 5 months : no recurrence.

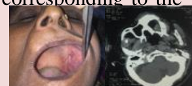


## RADICULAR CYST

20/M reported with pain at left upper half of face since 1 month. *H/O fall on ground 10 years back with pain in upper front teeth but no treatment received. *Key features- Lt. nasolabial fold obliterated, tenderness from 11-25. Vitality test negative for 21, 22,23,24. 8 ml of purulent fluid was extripated. *OPG- showed large cyst associated with 11-26 engulfing ¾ Lt. Max.sinus. * T/t- Extraction of 21 and RCT of 22, 23 & 24 done followed by enucleation of cyst via Caldwell Luc. Biopsy confirmed radicular cyst.

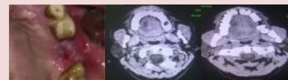
## RESIDUAL CYST

62/F reported with watery discharge from her left cheek since 6 months. * Key feature- I/O small depression present on buccal side of residual ridge of 16. *OPG showed radiolucent area in the right maxillary region corresponding to the previously extracted tooth. *5 ml fluid extirpated for FNAC showed inflammatory content. *CECT showed cystic lesion in maxillary antrum. *T/t- Caldwell Luc under GA. *HPE report of operative specimen confirmed diagnosis of residual cyst.



## ORO ANTRAL FISTULA

63/M presented with pain in upper jaw and nasal discharge since 5 days after traumatic extraction of left upper tooth. * Key feature- unhealed socket of 26 with Gutta percha point entering Lt. Max. Sinus and positive Valsalva test. *CT depicted opacity and discontinued floor of the Max. Sinus along with communication between the oral cavity and the sinus. *T/t- de epithelialization of fistulous tract and closure with double pedicle flap. Followed up for one month: symptom free.



**Conclusion:** Comprehensive history taking and examination is decisive for validating diagnosis, and when discussing maxillary sinus pathology it becomes imperative as one has to forfend it's dental or sinogenic origin. To stave off, specific investigation must be encouraged as it will endow successful treatment outcome.

**References**

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