CASE REPORT

Spontaneous nasal septal haematoma and abscess: a case report and literature review

Abstract

Background: Spontaneous nasal septal haematoma or abscess is a rare condition that can result in serious infective and cosmetic complications.

Methodology: We present a case of a delayed diagnosis of a spontaneous nasal septal haematoma in a healthy 53-year old male, as well as a comprehensive review of the literature on spontaneous nasal septal haematoma and abscess.

Results: Spontaneous nasal haematoma and abscess are rare entities with only 2 previous reports of spontaneous nasal septal abscess in immunocompetent adults and one paper reporting spontaneous nasal septal haematoma in a Nigerian population.

Conclusions: Nasal septal haematoma can occur spontaneously in healthy individuals with no predisposing factors or trauma. Prompt recognition and treatment is paramount to avoid potentially serious complications.

Key words: nasal septum, nose, nose deformities, acquired

Introduction

Nasal septal haematoma (NSH) is most frequently encountered as an uncommon complication of nasal trauma or surgery that can be complicated by superimposed abscess formation if left untreated. Nasal septal abscess (NSA) is a rare but serious condition. We present a case of a spontaneous NSH in a healthy 53-year-old man presenting with a nine-day history of septal swelling and nasal obstruction. We review the literature on NSH and nasal septal abscess (NSA), including reported spontaneous cases, rare causes, complications and principles of management.

Case report

A previously well and active 53-year-old man presented to the emergency department of a major urban teaching hospital with a nine-day history of sudden onset nasal obstruction, pain and swelling. The patient denied any minor or major facial trauma in the weeks prior to developing his symptoms, nor any history of sinusitis, septal furuncle, dental pain or symptoms suggestive of a dental infection. The nasal obstruction was initially accompanied by low grade fevers that resolved within the first 48-72 hours, moderate pain that had resolved prior to presentation, nasal dorsal swelling and clear rhinorrhoea. The patient denied any history of prolonged bleeding, easy bruising, recurrent infections, immunosuppression or a family history of the same. He had presented to his primary care physician within 72 hours of symptom onset and was prescribed a course of oral amoxicillin and clavulanic acid with minimal improvement.

On examination the patient was afebrile with marked tenderness and swelling of the nasal dorsum. There was mild erythema of the columella but no features of facial cellulitis. There was almost complete obstruction of the nasal vestibules bilaterally due to significant anterior nasal septal swelling that was cherry red, fluctuant and tender to palpation (Figure 1). Full blood count was significant for a leukocytosis of 15 x10⁹/L (normal range 4.0 -11.0 x10⁹/L), predominately due to a neutrophilia of 9.3 x10⁹/L (normal range 2.0-8.0 x10⁹/L) and a monocytosis of 1.95 x10⁹/L (normal range 0.2-1.00 x10⁹/L).

A diagnosis of seemingly spontaneous NSH/NSA was suspected, and the patient was placed on intravenous cephazolin and
Spontaneous NSH / NSA

consented for an incision and drainage that occurred within 24 hours of presentation. At surgery, a hemitransfixion incision was made; purulent material was evacuated from the submucoperichondrial plane and sent for culture and sensitivities. Examination of the septal cartilage remarkably revealed a predominately intact quadrilateral cartilage with only a small defect supraanteriorly and adjacent necrotic perichondrium that was debrided. A small drain was inserted and the mucoperichondrial flap closed with a transseptal quilting suture. Intravenous cephazolin was continued.

A mildly elevated INR of 1.3 (normal range 0.8-1.2) on admission had normalised by day 1 of the admission without intervention; specialist haematology opinion advised against further investigation. Culture of the purulent exudate grew Staphylococcus aureus resistant to penicillin but sensitive to cephalexin, clindamycin, erythromycin and flucloxacillin. The patient was discharged after removal of the drain 48 hours postoperatively and continued oral cephalexin. He remained systemically well and afebrile for the duration of his admission with normalisation of his leukocytosis prior to discharge.

At one week the patient remained well with moderate improvement in nasal obstruction but with residual septal swelling. At eight weeks the septal swelling had completely resolved with return to normal nasal function. A mild saddle deformity had developed which the patient had noted but at this stage was unconcerned with the change in cosmesis (Figure 2).

Literature review

A comprehensive review of the literature was performed in MEDLINE using the search terms (nasal sept*) and (hematoma or abscess*) as subject headings and keywords with no restriction on date but limited to English language. References from relevant articles were reviewed to identify any further articles.

Spontaneous NSH or NSA in adults and in the absence of immunosuppression or coagulopathy is extremely rare with only two previously reported cases of spontaneous NSA in the literature and one paper describing a series of spontaneous NSH in a Nigerian population. NSA in the immunocompromised has been reported secondary to a variety of underlying causes including insulin and non-insulin dependent diabetes, HIV, haematological malignancies and chemotherapy.

Bennett and Rapado reported a case of a 39 year old female with a three week history of nasal congestion and anterior septal nasal swelling with no precipitating event or underlying pathology. Incision and drainage of the collection revealed a NSA with loss of the central quadrilateral cartilage but preservation of caudal and dorsal struts. No follow up was reported.

Salam and Camilleri described the case of a 38 year old female with a 4 day history of a painful, swollen, congested and erythematous nose that did not improve with oral antibiotics. The patient was mildly febrile and anterior rhinoscopy revealed the typical swollen and tender anterior septum. The patient was commenced on intravenous amoxicillin/clavulanic acid. Incision and drainage under general anaesthesia revealed an intact septal cartilage and an abscess cavity that was evacuated. No cosmetic deformity was present at 2 weeks but longer follow up

Figure 1. Anterior bilateral nasal septal swelling causing bilateral nasal obstruction.

Figure 2. Appearance of nose at 8 weeks post incision and drainage. A. complete resolution of septal swelling and obstruction. B. Resultant dorsal nasal saddle deformity.
A higher number of spontaneous NSH and NSA are reported in the paediatric population (Table 1). This increased frequency could be due to a variety of factors that make identifying a precipitating event more difficult, rather than any true increased predisposition to spontaneous NSH or NSA. These include difficulties in self-reporting injuries as well as anatomical differences that make minor trauma more likely to result in NSH. For the same reasons NSA is more likely to develop due to delay in recognition and diagnosis of NSH.

### Discussion

NSH or NSA are defined as a collection of blood or pus respectively between the nasal septum and mucoperichondrium or periosteum. The first reported case of a NSH in the literature was in 1810 by Cloquet who also described the treatment principle of incision and drainage. NSH is most commonly seen as a complication of facial or nasal trauma or as a post-operative complication following septal surgery. NSA is thought to most frequently occur due to superimposed bacterial colonisation of a haematoma or as a complication of septal surgery. Other reported causes include nasal furuncle and infection from adjacent structures. Rare causes for NSA and NSH have also been reported in the literature (Table 2).

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Duration of symptoms (days)</th>
<th>Antibiotic treatment</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 months</td>
<td>Female</td>
<td>14</td>
<td>Cotrimoxazole</td>
<td>Complicated by intracerebral abscess and skull base osteomyelitis</td>
</tr>
<tr>
<td>21 months</td>
<td>Male</td>
<td>14</td>
<td>Not reported</td>
<td>Auto-discharged</td>
</tr>
<tr>
<td>7 years</td>
<td>Male</td>
<td>5</td>
<td>Vancomycin and piperacillin/tazobactam</td>
<td></td>
</tr>
<tr>
<td>11 years</td>
<td>Female</td>
<td>2</td>
<td>Ampicillin/Sulbactam</td>
<td></td>
</tr>
<tr>
<td>11 years</td>
<td>Male</td>
<td>3</td>
<td>Not reported</td>
<td>History of recurrent infections but no reported immunodeficiency investigation</td>
</tr>
</tbody>
</table>

Table 3. Reported complications of NSA.

<table>
<thead>
<tr>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naso-oral fistula</td>
</tr>
<tr>
<td>Meningitis</td>
</tr>
<tr>
<td>Subdural abscess</td>
</tr>
<tr>
<td>Septic arthritis</td>
</tr>
<tr>
<td>Sigmoid sinus thrombosis</td>
</tr>
<tr>
<td>Skull base osteomyelitis</td>
</tr>
</tbody>
</table>

Chukuezi et al. reported a consecutive series of 46 patients with NSH in a Nigerian general hospital. The age range was from 2 to 60 years and the aetiology of the haematoma was attributed to either trauma, in 14 cases, or spontaneous, 32 cases. No other potential contributing factors were reported, including bleeding diathesis, immunosuppression, previous surgery or recent infection. Eight of the spontaneous cases were reported in the discussion as users of intranasal tobacco snuff, but these cases were not re-assigned from the spontaneous group. Eight of the patients were found to have developed NSA at the time of incision and drainage with four having intracranial complications. The reported relative incidence of spontaneous to non-spontaneous NSH in this paper makes it an outlier within the literature. This raises the possibility that other contributing or local causative factors, such as tobacco snuff use, have not been assessed or reported in this paper with the effect of artificially raising the percentage of cases reported as spontaneous.

A higher number of spontaneous NSH and NSA are reported in the paediatric population (Table 1). This increased frequency could be due to a variety of factors that make identifying a precipitating event more difficult, rather than any true increased predisposition to spontaneous NSH or NSA. These include difficulties in self-reporting injuries as well as anatomical differences that make minor trauma more likely to result in NSH. For the same reasons NSA is more likely to develop due to delay in recognition and diagnosis of NSH.
identify any causative factors. Reported cases of late onset of NSH after trauma with a normal examination on presentation have been reported and illustrate the importance of appropriate patient counselling and clinician vigilance.

NSH is more prevalent in the paediatric population due to differences in structure and anatomy of the immature nasal septum. A softer and more flexible septal cartilage combined with a loosely adherent mucoperichondrium are thought to make NSH more common, particularly after minor trauma. Rates of subsequent NSH formation are also thought to be higher due to delay in recognition from minor injuries with often no external signs of injury and the difficulty often encountered in performing adequate examination in this population. Consideration of non-accidental injury in children with NSH or NOSH, particularly under the age of 2, has been suggested by several authors.

The mainstay of NSA and NOSH treatment is incision and drainage and intravenous or oral antibiotic therapy. The most common organisms isolated from NSH include Streptococcus species, Haemophilus influenzae and Staphylococcus aureus. Cases of methicillin resistant Staphylococcus aureus (MRSA) NSA and fungal NSA have also been described in immunocompromised patients illustrating the importance of maintaining a high index of suspicion for uncommon causative microbes in high risk patient groups including those not responding to appropriate treatment or in recurrent abscesses.

Nasal packing and/or septal quilting sutures are used to reduce the potential of re-accumulation of blood or pus but the possibility of recurrent NSH or subsequent NSA should always be considered. If marked destruction of the septal cartilage is identified at the time of surgery and cosmetic deformity is likely to result, a decision to perform early or delayed reconstruction can be made. Satisfactory long-term results of immediate septal reconstruction have been reported in the literature.

Untreated NSA or NOSH can result in nasal deformity due to destruction of the nasal septal cartilage from pressure necrosis or disruption of the blood supply from the overlying mucoperichondrium, and in the setting of NSA, direct effects of the infective organism. NSA can result in a variety of rare complications including potentially life threatening intracranial complications due to the rich lymphatic and valveless venous complex of the nasal septum (Table 3). At least one author has advocated for the judicious use of computed tomographic imaging with any suggestion of complication.

Despite purulent material being drained at the time of surgery, we believe this case represents a spontaneous NSH that subsequently developed into an abscess. We favour this diagnosis over a primary spontaneous NSA due to the long delay between initially developing symptoms and presentation as well as the absence of persistent fevers, facial cellulitis, systemic toxemia or other complication even in the context of treatment with oral antibiotics from the primary care physician. Delay in referral to a tertiary referral centre for otolaryngological opinion resulted in external nasal deformity even with minimal cartilaginous destruction identified at the time of incision and drainage.

Conclusion

NSH and NSA are rare clinical entities. NSH can occur in healthy individuals with no predisposing factors or history of trauma. Delay in presentation or diagnosis can result in serious life threatening infective sequelae as well as long term cosmetic and functional problems. Prompt recognition by medical professionals and early treatment is required to avoid long term and serious complications.

Consent to publish

Written informed consent for publication of the patient’s clinical details and images was obtained from the patient. A copy of the consent form is available for review by the Editor of this journal.

Authorship contribution

CM conducted the literature review, acquired the case history and completed initial drafting of the manuscript. JR proposed the concept and structure of the manuscript and critically revised the manuscript. All authors read and approved the final manuscript.

Conflict of interest

The authors have no conflicts of interest to declare.

References

29. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
30. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
31. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
32. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
33. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
34. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
35. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
36. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
37. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
38. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
39. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
40. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
41. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
42. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
43. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
44. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
45. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
46. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
47. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
48. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
49. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126
50. Mooney and Rimmer. Tel: +61-43-316 8316. E-mail: craig.mooney@monashhealth.org. 867 Centre Rd Bentleigh East Victoria 3165, Australia. Head and Neck Surgery Department of Otolaryngology. Monash Health. 126