A 14-year-old male complaining of a congenital mass on the nasal dorsum presenting to Shaheed Sadoghi Hospital of Yazd University of Medical Sciences, Yazd, Iran. The mass was dark purplish in color. There was no change in its size till the age of six years when it gradually began growing so that within a period of six months it reached its current size.

In the period of growing there was no pain, discharge, bleeding. He had no history of trauma, rhinosinusitis, or loss of smell.

On physical examination, there was a mass, 4.4 cm in diameter, on the right upper third of the lateral side-wall of the nose. The skin covering the lesion was hyperpigmented and sensitive to stimulation. It was compressible with positive transillumination. Telecanthus was evident. No sign of bleeding or scar was obvious on the mass (Figure 1). On the anterior rhinoscopic examination, the nasal mucosa was normal. There was no bleeding or rhinorrhea; the septum was deviated to the left side. A T2 weighted MRI was obtained (Figure 2).

**What is Your Diagnosis?**

See the page 550 – 551 for the diagnosis
Anterior encephaloceles are a group of rare congenital malformations of the brain. Only a few large series have been published to date. For unknown reasons, the condition is more frequently reported in South-east Asia.

The encephaloceles are divided into two groups: anterior and posterior. The sites of anterior encephalocele include frontoethmoidal, nasofrontal, nasoethmoidal, nasoorbital, transethmoidal, nasopharyngeal, orbital, transsellar, transsphenoidal, and interfrontal. In our case, the subtype of encephalocele was nasofrontal.

There are two methods for excision of the anterior encephalocele: craniofacial and extracranial approach.

We feel that craniofacial surgery is rarely indicated in the majority of patients and an extracranial approach is sufficient to remove the encephalocele and to repair the dural defect. In this patient, we used the extracranial approach. A circumferential incision was made around the mass and the skin was carefully dissected from the lesion. The lesion was elevated by a periosteum elevator from maxilla, cheek, and lateral nasal wall. The mass was finally separated from the inferior orbital rim. Dissection was carried out from lateral to medial until reaching the stalk where the lesion communicated with brain. The lesion was thoroughly released from the orbit and its surroundings. It was then detached from the anterior cranial fossa. It contained brain and dura, which excised by a knife. Dural defect was sutured by a 3/0 silk suture. The reconstruction was performed in three layers of autologous fascia lata, septal bone, and fascia lata. The dura was sutured to fascia lata and the septal bone was secured by a screw followed by a layer of fascia lata again (Figure 3). To achieve a complete homeostasis, surgical was kept in place in multiple layers and skin was closed in two layers. The pigmented skin over the mass was excised too.

The extracranial approach is rather than the intracranial procedure is emphasized because excellent cosmetic results may be achieved in the majority of patients with minimal morbidity and mortality (Figure 4).

References


