

CASE REPORT

Olgu Sunumu

Yazışma adresi

Correspondence address

Cengiz TEKİN

Department of Plastic,
Reconstructive and Aesthetic Surgery,
Istinye University Faculty of Medicine,
İstanbul, Türkiye

cengiz.tekin.1005@gmail.com

Geliş Tarihi / Received : April 06, 2025

Kabul Tarihi / Accepted : February 14, 2026

Bu makalede yapılacak atıf

Cite this article as

Yıldırım C, Datlı A, Yazar S, Tekin C.

A Rare Case That Causes Dyspnea, Dysphagia
and Snoring: A Giant Antrochoanal Polyp

Akd Med J 2026;12: 1-4

— Cem YILDIRIM

Department of Plastic,
Reconstructive and Aesthetic Surgery,
Nisantasi University Faculty of Medicine,
İstanbul, Türkiye

— Aslı DATLI

Department of Plastic,
Reconstructive and Aesthetic Surgery,
Istinye University Faculty of Medicine,
İstanbul, Türkiye

— Serhat YARAR

Department of Plastic,
Reconstructive and Aesthetic Surgery,
Private Practice of Op. Dr. Serhat Yazar,
İstanbul, Türkiye

— Cengiz TEKİN

Department of Plastic,
Reconstructive and Aesthetic Surgery,
Istinye University Faculty of Medicine,
İstanbul, Türkiye

A Rare Case That Causes Dyspnea, Dysphagia and Snoring: A Giant Antrochoanal Polyp

Dispne, Disfaji ve Horlamaya Neden Olan Nadir Bir Vaka: Dev Antrokoanal Polip

ABSTRACT

In this case report, we present a case of a giant choanal polyp case extending to the oropharynx along with our surgical approach. A 75-year-old male patient was referred to us with complaints of left nasal obstruction, dyspnea, dysphagia, snoring and foreign body sensation in the throat, which had been increasing over the last 2 years. The mass was observed to prolapse to the posterior side of the uvula. At this point, we decided to use surgical suction. Using the negative pressure of a surgical suction, the mass was grasped and delivered through the left nasal orifice and could then be manipulated. We gently continued the dissection using a clamp and elevator. We cauterized the pedicle, and en bloc resection of the antrochoanal polyp was achieved. Functional Endoscopic Sinus Surgery (FESS) is considered as the gold standard technique. In addition to FESS, the use of a microdebrider may also be suggested. In our case, without using endoscopy and microdebrider, the polyp was manipulated with the negative pressure effect of surgical suction and released with the help of an elevator. In the absence of endoscopy, complete removal is still possible using gentle dissection aided by surgical suction.

Key Words

Antrochoanal Polyp, Dyspnea, Dysphagia, Snoring, Nasal Obstruction

ÖZ

Bu olgu sunumunda, dev birantrokoanal polip vakasını ve uyguladığımız cerrahi yaklaşımı sunuyoruz. Yetmiş beş yaşında erkek bir hasta, son iki yılda giderek artan sol burun tıkanıklığı, nefes darlığı, yutma güçlüğü, horlama ve boğazda yabancı cisim hissi şikayetleri ile kliniğimize yönlendirildi. Yapılan muayenede, kitlenin küçük dilin arkasına doğru prolabe olduğu görüldü. Bu aşamada cerrahi aspirasyon kullanılmasına karar verildi. Cerrahi aspirasyonun oluşturduğu negatif basınç ile kitle sol burun deliğinden çekilerek mobilize edildi. Diseksiyon, bir klemp ve elevatör yardımıyla dikkatlice devam ettirildi. Pedikül koterize edilerek antrokoanal polip en blok olarak çıkarıldı. Fonksiyonel endoskopik sinüs cerrahisi, koanal poliplerin tedavisinde altın standart teknik olarak kabul edilmektedir. Buna ek olarak, mikrobebrider kullanımı da önerilmektedir. Olgumuzda endoskop veya mikrobebrider kullanılmadan polip, cerrahi aspirasyonun negatif basınç etkisiyle manipüle edilmiş ve bir elevatör yardımıyla serbestleştirilmiştir. Bu teknik, endoskopik ekipman bulunmadığında bile, dikkatli diseksiyon ve negatif basınç yardımıyla polipin tamamen çıkarılabileceğini göstermektedir.

Anahtar Kelimeler

Antrokoanal Polip, Dispne, Disfaji, Horlama, Burun Tıkanıklığı

INTRODUCTION

Choanal polyps can be defined as benign, solitary and soft tissue masses that usually extend unilaterally into the nasopharynx and even the oropharynx. Most choanal polyps occur as an antrochoanal polyp originating from the lateral walls of the nasal cavity and particularly the maxillary sinus antrum (1). The choanal polyp was described first by Killian in 1906. Killian described them as an isolated, solitary paranasal sinus mass or cyst that protrudes into the boundaries between the nasal cavity and the nasopharynx, or even to the oropharynx (2). Choanal polyps are rare. In the general population, they constitute approximately 4% to 6% of all nasal polyps. The most common symptom of antrochoanal polyps is unilateral nasal congestion, as polyps are usually located unilaterally. A large antrochoanal polyp may extend into the oropharynx. Various symptoms such as snoring, sleep apnea, foreign body sensation in the throat, swallowing problems and bleeding can also be seen due to the mass effect of the polyp (2-4).

The gold standard surgical technique is Functional Endoscopic Sinus Surgery (FESS) (2). In the literature, there are several studies that proposed the FESS for antrochoanal polyps (5, 6). However, a simpler surgical method was performed in our case. With the help of surgical suction, the antrochoanal polyp was excised and removed through the nostril. There is no similar technical approach in the literature. In this case report, we present a case of a giant choanal polyp extending up to the oropharynx and our surgical approach.

Case Report

A 75-year-old male patient was referred to us with the complaints of left nasal obstruction, dyspnea, dysphagia, snoring and foreign body sensation in the throat, which had been increasing over the last 2 years. Anterior rhinoscopy was normal. On Computed Tomography (CT) evaluation, a right side deviated nasal septum and a polypoid mass was detected extending from the left maxillary sinus ostium to the choanae. The mass was observed to originate from the maxilla medial region with a thin pedicle. The right nasal passage was observed naturally. On CT scan, it was observed that this mass extends from the posterior of the inferior concha to the oropharynx and fills the nasopharynx (Figure 1).

There was left maxillary sinusitis. The patient had no comorbidities. Under general anesthesia, it was observed that this mass prolapsed to the posterior side of the uvula. At this point, we decided to use surgical suction (its vacuum power 400-600 mmHg). With the negative pressure of a surgical suction, the mass was caught through the left nasal orifice and could be manipulated. Then, we gently continued the dissection with a clamp and elevator. Finally, we cauterized the pedicle, and the en bloc resection of the antrochoanal polyp was achieved (Figure 2).

No complication occurred during surgery. A silicone nasal splint was placed. It was removed on the second postoperative day. The polyp was medium-hard with a regular surface,

and its dimensions were 6x2x2 cm. After two years of follow-up, the patient had no complaints of nasal obstruction, dyspnea, dysphagia or snoring. Written informed consent was obtained from the patient for publication of the case report and the accompanying images.



Figure 1. CT scanshowing a mass extending from the posterior of the inferior concha to the oropharynx and fills the nasopharynx.



Figure 2. Intraoperativeview of the antrochoanal polyp during removal through the nostril.

DISCUSSION

The etiology of choanal polyps remains uncertain. However, in the literature, allergic conditions and chronic inflammation have been implicated for the etiology of choanal polyps. In addition, some predisposing factors such as ostium obstruction and chronic sinusitis have also been proposed. Also, submucosal cysts that develop as a result of thrombosis in lymphatic vessels after sinus infections are thought to cause polyp formation (2, 3).

One of the main features of antrochoanal polyps is the rapid growth trend, which results in their large size. The reason for this feature may be that the fibroblast growth factor (FGF) and the transforming growth factor- β (TGF- β) are significantly higher in the choanal polyps than the normal nasal mucosa (7).

The most common symptom of the choanal polyps is ipsilateral nasal congestion. They can also cause snoring, foreign body sensation in the throat, epistaxis, respiratory distress, sleep apnea, anosmia, headache and swallowing problems due to oropharyngeal extension. Unexpected difficult intubation has been reported in a patient with a giant choanal polyp filling the oropharynx. Furthermore, in the literature, there were cases of hearing loss have also been reported that may develop due to occlusion of the eustachian tube by the polyp (2, 8).

On the anterior rhinoscopy and transnasal endoscopy of the patient with antrochoanal polyp, a polypoid mass obstructing the airway can be detected. In addition to these methods, the masses originating from the posterior can be detected by CT and Magnetic Resonance Imaging (MRI). A choanal polyp is observed as a uniform, homogeneous and hyperdense mass on the CT scan. On the CT scan, the features such as the size of the mass, bone destruction, and a contrast agent uptake can be distinguished. The MRI with its high soft tissue resolution provides important information in terms of the mass spread and its relationship with surrounding tissues. It is important that the evaluation with MRI and BT scan in terms of excluding a lower concha hypertrophy, nasopharyngeal angiofibroma, adenoid hypertrophy and other soft tissue tumors (9).

The primary goal in the treatment of choanal polyps is complete excision of the polyps in the nasal and choanal parts. In addition to the excision of the polyp, the sinus mucosa from which the polyp originates must be cleaned and the sinus ostium must be expanded. In the literature, the postoperative recurrence rate of antrochoanal polyps has been reported as 25% (2, 10).

FESS is considered the gold standard technique. In addition to the FESS, the use of a microdebrider may also be recommended (11).

In another technique described in the literature, the authors combined the endoscopic middle meatal surgery and transcanine sinusoscopy (12). A microdebrider is placed in the sinus and the antral part of ACP. It is then excised by power instrumentation under the endoscopy.

In our case, without using endoscopy and microdebrider, the polyp was manipulated with the negative pressure effect of surgical suction and released with the help of an elevator. Then, the pedicle was cut with an electrocautery. It was completely removed from the nostril without disintegration. In the absence of endoscopy, we believe it can be effectively removed with the help of surgical suction. We believe that this approach represents a practical way.

ACP has characteristic features in the macroscopic evaluation. It has a respiratory epithelium on its surface, a central cystic component, and surrounding edematous stroma and with variable degrees of inflammatory cell infiltration (13).

CONCLUSION

Choanal polyps that cause unilateral nasal congestion, dyspnea and dysphagia are very rare in the literature. The posterior of the nasal cavity and nasopharynx should be examined in patients with these complaints. Choanal polyps should be considered in the differential diagnosis. In addition, in the absence of endoscopy, as we have done in our case, complete removal is possible with gentle dissection using the surgical suction. Written informed consent was obtained from the patient for the publication of this case report and the accompanying images.

Informed Consent

The participants' rights were protected and written informed consent was obtained before the procedures according to the Helsinki Declaration.

Conflict of Interest

The authors have no conflict of interest to declare.

Financial Disclosure

The authors declared that this study has received no financial support.

1. Kizil Y, Aydil U, Ceylan A, Uslu S, Baştürk V, İleri F. Analysis of choanal polyps. *J Craniofac Surg*. 2014;25(3):1082-4.
2. Frosini P, Picarella G, De Campora E. Antrochoanal polyp: analysis of 200 cases. *Acta Otorhinolaryngol Ital*. 2009; 29(1): 21-6.
3. Promsopa C. Septochoanal polyp with osseous metaplasia: a case report. *J Med Case Rep*. 2016;10:149.
4. Kodur S, Siddappa SM, Shivakumar AM. Giant Antrochoanal Polyp-A Rare Presentation. *J Clin Diagn Res*. 2017;11(1): MD01–MD02.
5. Mielcarek-Kuchta D, Simon K, Kondratowicz D, Lukomska Z, Rybak-Korytowska A. Functional endoscopic sinus surgery (FESS) in unilateral sinus disease. *Otolaryngol Pol*. 2017;71(5):29-35.
6. Pagella F, Emanuelli E, Pusateri A, Borsetto D, Cazzador D, Marangoni R, Maiorano E, Zanon A, Cogliandolo C, Ciorba A, Pelucchi S. Clinical features and management of antrochoanal polyps in children: Cues from a clinical series of 58 patients. *Int J Pediatr Otorhinolaryngol*. 2018;114:87-91.
7. Peric A, Jovanovski A, Durdevic BV. Giant angiomatous choanal polyp originating from the middle turbinate: a case report. *NT Updates* 2017;7(1):53–6.
8. Hori Y, Taniguchi K, Okabe T, Sakamoto A. A case of unexpectedly difficult intubation caused by a large asymptomatic choanal polyp. *JA Clinical Reports* 2016;2(1):2.
9. Kim YK, Kim HJ, Kim J, Chung SK, Kim E, Ko YH. Nasal polyps with metaplastic ossification: CT and MR imaging findings. *Neuroradiology*. 2010;52(12):1179–84.
10. Aktaş D, Yetişer S, Gerek M, Kurnaz A, Can C, Kahramanyol M. Anthrochoanal polyps: analysis of 16 cases. *Rhinology* 1998; 36(2): 81-5.
11. Vleming M, De Vries N. Endoscopic sinus surgery for antrochoanal polyps. *Rhinology* 1991;29:77-8.
12. El-Guindy A, Mansour MH. The role of transcanine surgery in antrochoanal polyps. *J Laryngol Otol* 1994;108:1055-7.
13. Mandal S, Bhandari A, Jalan S, Mondal RK. Osseous metaplasia of antrochoanal polyp: Case report and radiological-pathological correlation. *Indian J Radiol Imaging*. 2019;29(4):468-71.