INTRODUCTION
Inflammatory pseudotumor, which clinically mimics neoplasm, is a space occupying collection of inflammatory cells, histiocytes and fibroblasts. They are mostly found in lungs and orbits but rarely in head and neck region. Sometimes clinical presentation and imaging study shows aggressive appearance which causes difficulty in diagnosis and management. We present a case of nasal cavity inflammatory pseudotumor in a 32-year female involving right nostril and nasal tip. The clinical behavior of the lesion mimicked a malignant lesion.

CASE REPORT
The patient was a 32-year female presenting to the ENT OPD with history of progressively increasing right nasal blockage for one year. She had initially developed nasal pruritus which was attributed to allergic rhinitis. However, her symptoms did not improve following use of medication. She had also underwent surgery for a lesion obstructing her nasal cavity; however, no postoperative histopath was advised and the lesion recurred with greater intensity. Anterior rhinoscopy revealed an exophytic firm, reddish granular mass 3 x 2 cm in the right nostril and nasal tip causing erythema of overlying skin. The mass was pushing the septum to opposite side. Margins were ill defined. Extra ocular movements were normal with no nasolacrimal duct obstruction. The recurring lesion with short history and unusual location raised the possibility of malignancy. However, no neck nodes were palpable. Her cranial nerves were intact and the remainder of the head and neck examination was unremarkable. Punch biopsy of the lesion proved inconclusive. Laboratory data revealed normal hematology and ESR. CT scan demonstrated a 2 x 2 cm mass in the anterior part of nasal cavity involving the nasal tip and pushing the septum. There was no evidence of involvement of the paranasal sinuses or orbits and no cervical lymphadenopathy.

Patient's primary concern was to save her cosmetic appearance, if any surgical intervention was planned for the nasal tip. She was advised excision and repair with flaps. Mass excision was planned under GA through open rhinoplasty approach (Figure 1). Per operatively there was a clear plane between the mass and the skin. Dissection was carried out by preserving the overlying skin. Wound was closed in layers. Postoperative recovery was uneventful.

Specimen excised was sent for histopath which revealed a spindle cell lesion composed of extensive areas of fibrosis with mixed inflammation including eosinophils,

ABSTRACT
Inflammatory pseudotumor is a solid fibro-inflammatory tumor that clinically mimics a neoplastic lesion. Inflammatory pseudotumor is usually found in the orbits and lungs, but rarely in the sinonasal area. Presence of pseudotumor in nasal cavity is even scarce and there are only a few reports to date. We present a case of pseudotumor involving the nasal tip area in an adult female mimicking as a slowly enlarging mass.

Key Words: Inflammatory pseudotumor. Nasal mass. Female. Nasal tip.

Figure 1: Intraoperative photographs.

Figure 2: Postoperative photograph of excised mass and histopath report.
plasma cells, neutrophils, and lymphoid aggregate (Figure 2).

**DISCUSSION**

Inflammatory pseudotumor (IPT) is described as a solid fibro-inflammatory tumor that clinically mimics a neoplastic lesion. It represents a class of pathologic lesions that have a heterogeneous background of inflammatory cells, histiocytes, and fibroblasts in them commonly. These variable lesions carry numerous names: inflammatory pseudotumor, plasma cell granuloma, histiocytoma, postinflammatory pseudotumor, and inflammatory myofibrohistiocytic proliferation.1-3

Though IPT has been identified in all different regions of the body, they are most commonly identified in the lungs and orbits. Within the head and neck, extra orbital lesions have been reported, in rare instances, in the nasal cavity, paranasal sinuses, nasopharynx, pterygopalatine fossa, salivary glands, parapharyngeal space, larynx, oral cavity, and thyroid. Unlike non-head and neck lesions, sinonasal IPT affects a broad age range. Constitutional symptoms are often minimal or absent.4-6

The underlying etiology of inflammatory pseudotumor is unknown. The leading debated hypotheses are between infectious versus neoplastic causes.6 Infectious pseudotumors have been described as a result of Mycobacterium, EBV, Actinomyces, Nocardia, Mycoplasma, and Pseudomonas.6 There are reports of multiple recurrent lesions with sarcomatous transformation and metastasis. The majority of cases remain idiopathic as is the case described in this report.6,7

Treatment for IPT has historically been surgical resection, which is well documented in the literature. Coffin et al. found 69% of patients in his series had complete recovery without disease recurrence.7 This appears consistent with other reports. High-dose corticosteroid therapy, occasionally with chemotherapy, has generally been reserved for cases in which surgical excision was not feasible due to location or undesirable cosmeses. Cure rates with corticosteroids for head and neck inflammatory pseudotumor are difficult to determine, as there is no one study with enough statistical power to draw this conclusion confidently. If one can generalize from the literature on orbital pseudotumor, cure rates with high dose corticosteroids range from 31 to 37%,8,9

External beam radiation therapy has been described alone, and in combination with surgical resection and/or corticosteroids. Total radiation doses in these reports have ranged from 15 to 50 Gy to the tumor site. It is not clear what role radiation therapy has in the treatment of head and neck pseudotumors, but the current treatment paradigm relegates radiation therapy to a rarely used modality.8,9

Due to the scarcity of cases, no RCTs exist on the treatment of IPT. Treatment is, therefore, best left to the clinician’s judgment and local practice patterns. In brief, inflammatory pseudotumor is more frequent in the lung and orbit and arises uncommonly in the nasal cavity. We presented a case of nasal inflammatory pseudotumor. Due to the aesthetically sensitive area of disease, open rhinoplasty was planned with the consent of patient. Our patient achieved a dramatic response with restoration of normal cosmetic appearance post-treatment. She is currently without evidence of disease 12 months postsurgery.

**REFERENCES**