CASE REPORT

Spontaneous Bilateral Septal Hematoma in Adult: An Unusual Case Presentation

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ABSTRACT

Septal hematoma is an uncommon complication that is usually seen in a case of traumatic nasal bone fracture. However, it is very rare to have a spontaneuous septal hematoma. We report case of 44 years old Malay lady presented to us with complain of epistaxis, with worsening blockage, nasal pain and sneezing for past 5 days. However, she had no history of trauma. Rigid 0 degree nasoendoscopy done and noted septal swelling and felt bogginess upon palpation. Aspiration done noted 5cc blood seen. Incision and drainage done and bilateral nasal packing inserted. Patient was admitted in ward for observation and eventually discharged well. This case is important to highlight the clinical features and diagnostic challenges associated with septal hematoma, particularly when there is no history of trauma. This case report highlights the importance of early recognition and prompt management regardless unidentifiable cause in order to prevent from complications such as septal abscess, cartilage necrosis and saddle nose deformity. Above all, this is to raise awareness among clinicians about rare but potentially serious condition.

Keywords: Spontaneous septal hematoma, epistaxis, incision and drainage, nasal packing

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INTRODUCTION

Nasal septum hematoma is defined as presence of blood in between septal cartilage and mucoperichondrium. It is uncommon, but frequently seen in nasal trauma. Spontaneous septal hematoma (SSH) is very rare. Some possible etiologies would be vascular fragility, hypertension, infection or even coagulopathies.[1] Bilateral invovement further adds to its rarity and may increase risk of complications due to more extensive compromise of septal vascular injury. Even though it is rare, it is important to clinicians to detect septal hematoma in order to prevent complications. This case is important to report a rare presentation of spontaneous bilateral nasal septal hematoma. It is also to highlight the possible cause, clinical features and diagnostic approach associated with septal hematoma particularly when it does not involve trauma. This case report helps in emphasize as well regarding importance of early recognition and prompt management regardless unidentifiable cause in order to prevent from complications such as septal abscess, cartilage necrosis and saddle nose deformity. All in all, this is to raise awareness among clinicians about rare but potentially serious condition.

CASE PRESENTATION

A 44 years old lady, with no known comorbidities, no known drug and food allergy. Patient presented to the otorhinolaryngology (ORL) clinic with the complaint of epistaxis for past 5 days. It was sudden

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onset and she noticed to have epistaxis (unsure which side) when waking up from bed around 2am. Subsequently having on and off epistaxis and resolved spontaneously. Patient also complained of worsening nasal blockage, nasal pain and sneezing. She mentioned that feeling feverish one day prior visit to ORL clinic. Otherwise, no cough, denies history of fall/trauma, no history of nasal prick, no other rhinitis symptoms, no ear/throat symptoms, no history of taking traditional medication, no family history of malignancy/bleeding disorders, denied high risk behaviour and no history of taking traditional medication or blood thinners. On examination, patient was alert, concious and not tachypneic. Blood pressure was 170/108 (patient was in pain as well), pulse rate was 100 beats per minute, Oxygen saturation was 98% under room air and temperature. Anterior rhinoscopy revealed bilateral inferior tubinate hypertrophied and mucosa was pale. Cold spatula test noted reduce misting over left nostril. Other examinations were unremarkable.

Rigid 0-degree nasoendoscopy revealed septal swelling. Left septal swelling (Figure 1) was bigger than right septal swelling (Figure 2). A bogginess was felt upon palpation, bilateral hypertrophied inferior turbinate, mucosa pale, bilateral osteomeatal complex clear and bilateral fossa of rossenmuller and eustachian tube clear. We decided to aspirate over bilateral septal swelling and turned out to be 5cc blood. Thus, we proceeded with incision and drainage over bilateral septal region and Merocel size 8 (nasal packing) inserted over bilateral nostril. Hemostasis secured. All procedure done were consented by patient. Later, the patient was admitted for intravenous antibiotics, intravenous tranexamic acid, analgesia, vital signs monitoring and bolster charting. Blood investigations were normal. Patient was well in ward and vital sign stable. We removed merocel on the 2nd day of admission. We repeated nasoendoscopy prior to her discharge which showed no more swelling over septum and normal findings. She was discharged well and was given appointment for follow-up. She came for subsequent follow-up. Nasoendoscopy was done and showed normal findings. Then she was discharged from the ORL clinic well.

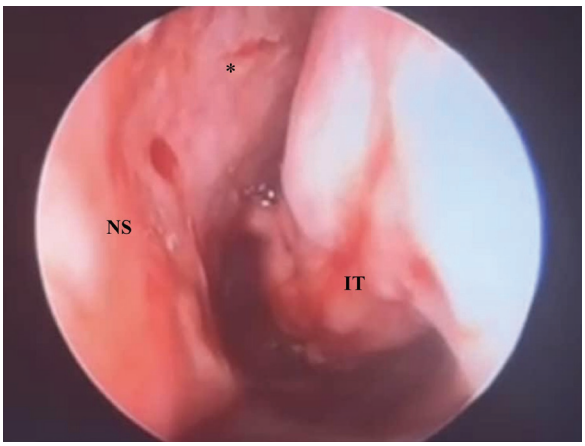

Figure 1: Left septal swelling (* marked) (NS: nasal septum, IT: inferior turbinate).

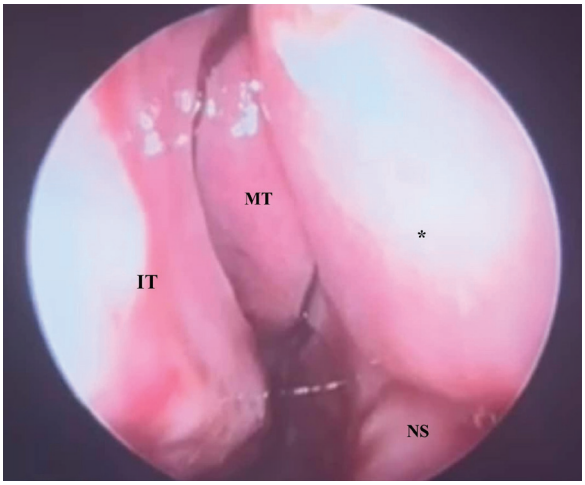

Figure 2: Right septal swelling (* marked) (NS: nasal septum, IT: inferior turbinate, MT: middle turbinate).

DISCUSSION

Spontaneous septal hematoma (SSH) of the nasal septum is an uncommon but potentially serious entity. While most cases follow nasal trauma or surgery, rare instances occur without any clear precipitating event.[1] The nasal septal cartilage receives its nourishment through diffusion from the overlying mucoperichondrium. Bleeding between this layer and the cartilage forms a hematoma, separating the cartilage from its blood supply, which can lead to ischemic necrosis and subsequent septal perforation or saddle-nose deformity if untreated.[2,3] Although trauma is the usual cause, spontaneous cases have been attributed to vascular fragility, hypertension, infection, or unrecognized micro-trauma.[4] Typical presentation includes nasal obstruction,

pain, and swelling of the septum. In spontaneous cases, symptoms may be subtle, leading to delayed diagnosis.[4,5] Prompt surgical drainage remains the cornerstone of treatment to prevent cartilage necrosis. Drainage involves incision and evacuation of the hematoma, placement of a small drain or nasal packing, and administration of broad-spectrum antibiotics to prevent secondary infection or abscess formation.[3-5]

Early otorhinolaryngology referral and follow-up are essential to prevent complications. Untreated septal hematoma may progress to septal abscess, cartilage necrosis, saddle-nose deformity, or even intracranial complications such as cavernous sinus thrombosis.[2] The favorable outcome in our patient emphasizes the importance of timely recognition and intervention. This case underlines that SSH can develop without trauma or coagulopathy. Emergency physicians and primary clinicians should maintain a high index of suspicion for SSH in any patient with unexplained nasal obstruction or septal swelling. Early diagnosis and management prevent disfigurement and systemic complications.

CONCLUSION

Spontaneous bilateral nasal septal hematoma is an extremely rare clinical entity that may present without the typical history of trauma, posing a diagnostic challenge. This case underscores the importance of maintaining a high index of suspicion in patients presenting with epistaxis, nasal obstruction and septal swelling. Early diagnosis through careful clinical examination and prompt management with drainage and appropriate antibiotic therapy are crucial to prevent serious complications. Increased awareness among clinicians is essential to ensure timely intervention and favorable outcome.

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