Fig. 2.17 **Keloid formation may be unpredictable:** a normal ear punctum from an earring puncture is adjacent to a large earring keloid.

Fig. 2.18 **“High” ear piercing shows** the unpredictable nature of keloids. (No keloid at lobule earring site.)

Fig. 2.19 **An infected granuloma** at the site of earring insertion.

Fig. 2.20 **Nickel sensitivity** limits the use of certain earrings and has caused eczema on the lobule (arrow).

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Fig. 2.22 Trauma. Traumatic “cutting-out” when the earring is pulled by a baby or adult in ill-humor. Infection at the time the sleepers are inserted is another hazard (see Fig. 2.19). Surgical repair requires a Z-plasty, for simple excision and suturing may cause “notching” of the lobule.

Fig. 2.21a–c “High” ear piercing (Fig. 2.20, arrow) complicated by infection (frequently pseudomonas) may lead to abscess formation. The puncture with high ear piercing (unlike the lobule) punctures cartilage and may lead to the additional problem of cartilage infection—perichondritis. Abscess incision with drainage, splinting, and antibiotic therapy (e.g., ciprofloxacin) is needed. Permanent deformity of the pinna may result, requiring a difficult plastic surgical repair (a). This involves taking a rib graft and modeling this to reconstruct the absent helix, antihelix, and scaphoid fossa of the pinna (b; c, post-op.).
Fig. 2.71 Serious complications may arise from spread of infection from chronic suppurative otitis media (CSOM) with or without cholesteatoma, but are uncommon. Labyrinthitis, facial nerve damage, and intracranial infection may all occur. The figure shows posterior fossa brain abscesses (lower arrows) (a ventriculoperitoneal shunt is in place; upper arrow).

Fig. 2.72 Aural granulation. In the same way that epithelium may migrate through a perforation into the middle ear, mucous membrane may extrude outwards to the meatus. Middle-ear mucous membrane extruding through a perforation (arrow) becomes infected and presents with a discharging ear. An aural granulation is seen in the deep meatus. Granulation may also form on the drum of the margin of the perforation, and rarely granulation tissue forms on an intact drum in otitis externa (granular myringitis) (see Fig. 2.49).
Fig. 2.73 Aural polyp. If the growth of granulation tissue is exuberant, a pedunculated polyp develops, which may present at the orifice of the meatus (arrow). Granulations and polyps commonly arise from the tympanic annulus posteriorly, but the originating site may also be the mucous membrane of the promontory, eustachian tube orifice, and antrum and aditus. Careful and thorough removal of polyps and granulation tissue to their site of origin is necessary. If the polyp is associated with cholesteatoma, removal by mastoid approach is required.

Fig. 2.74 Mastoid abscess. A red, acutely tender swelling filling the postauricular sulcus (arrow), and pushing the pinna conspicuously forwards and outwards, is characteristic of a mastoid abscess.

In the past, mastoidectomy was needed for an acute mastoid abscess complicating acute otitis media. This was extremely common in the preantibiotic era, and required exenteration of the mastoid air cells (cortical mastoidectomy). The operation is now rarely performed in countries where antibiotics are available.
Fig. 3.9 **Nasal papilloma.** Benign lesions on the nose such as a mole or papilloma are common. If large, however, the obvious site on the nose necessitates excision and biopsy.

![Nasal papilloma](image)

Fig. 3.10 **Nasal papilloma excision.** Excision is not straightforward. An elliptical excision with closure will produce an obvious nasal asymmetry, and more elaborate techniques are required to ensure a satisfactory result, e.g., an island sliding flap (a–c).
Fig. 3.11a, b Rhinophyma, in which the skin becomes thickened and vascular, may produce gross nasal deformity in which the skin epithelium becomes thickened and vascular. “Shaving” of the excess skin (without skin grafting) is the surgical treatment. Irregular areas of epithelium (arrow) should be sent for histology since basal or squamous cell carcinoma may occur within a rhinophyma.
Fig. 3.44a–c **External rhinoplasty.** A transverse incision across the columella (a, with a “notch” to give a minimally perceptible scar) enables the skin of the nose to be elevated superiorly with exposure of all the underlying structures (b).

This rhinoplasty approach is used for many nasal deformities. It also enables lesions on the dorsum of the nose to be excised without an obvious overlying scar. The lesion being removed here is a nasal sinus (c).

Fig. 3.45a, b **Mentoplasty.** The improvement with rhinoplasty in this case has been accentuated by mentoplasty (see Fig. 3.46).

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Fig. 3.46 A silastic implant has been inserted adjacent to the mandible. A receding chin is not to be overlooked in a patient seeking rhinoplasty, for it accentuates the nasal deformity, and mentoplasty gives a subtle but striking improvement in appearance.

This implant may be introduced either by an external submental incision or on intraoral incision via the mucosa of the buccal sulcus.

Fig. 3.47a–c Marked mandibular underdevelopment (a) in which a mandibular advancement to restore dental occlusion as well as the esthetics was combined with a rhinoplasty (b). The radiograph (c) shows the sliding advancement and wiring of the mandibular bone.
Fig. 4.10 A large torus palatinus may take on a curious, irregular appearance suspicious of a carcinoma. Similar bony swellings occur on the lingual surface of the lower alveolus opposite the premolars (torus mandibularis).

Fig. 4.11 Torus mandibularis. A white bony hard lesion arising from the inner aspect of the mandible may present as a swelling in the floor of the mouth (arrow). This is considerably less common than the torus palatinus.
**Fig. 4.12** A bilateral torus mandibularis (arrows).

**Fig. 4.13** **Ectopic pleomorphic adenoma.** A palatal swelling which is not bony and hard may be a fissural cyst if mid-line, but if placed to one side (as it is here), it is almost certainly a tumor of one of the minor salivary glands. Biopsy is necessary. It is frequently a pleomorphic adenoma, but may be an adenoid cystic carcinoma or other malignant salivary tumor. A tumor extension from the maxillary antrum must also be excluded.

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