This 57 year-old woman presented with a seizure. She had a history of attending the ENT and neurosurgical departments for more than a decade. At the time of her initial presentation many years prior, her main complaint was of nasal congestion. A nasopharyngeal biopsy confirmed an olfactory neuroblastoma. (Figure 1)

Olfactory neuroblastoma is an uncommon slow growing tumour of the nasal cavity with no established etiological basis. With a neuroectodermal origin, it arises from the olfactory epithelium of the upper nasal cavity. Most cases arise from the cribiform plate, upper third of the nasal septum, superior turbinates or anterior ethmoidal air cells. However, it typically presents late when multiple structures are involved, which may include the orbits and intracranial compartments.

Accounting for approximately 2% of sinonasal tumors, although often late to present, ironically only a minority of patients experience anosmia. The commonest complaint at initial presentation is nasal blockage accounting for nearly a quarter of cases, with headache and epistaxis the next most frequent symptoms.

Multi-modality imaging is essential in that the most recognized management of this infrequent tumor is a combination of craniofacial surgery and radiotherapy. The imaging pathway in this case was typical, with CT and MRI complementing each other in maximizing tumor delineation. Computed Tomography has superior definition is reviewing bony involvement which is a typical finding, whereas MRI has superiority in evaluating the extent of soft tissue invasion and establishing tumor boundaries against post obstruction fluid in the paranasal sinuses. In this case the CT illustrates the gross destruction of the skull base, orbital and sinus margins. (Figures 2-5) The MRI outlines the extension of disease involving the pituitary fossa, brainstem and frontal sinus invasion. (Figures 6 and 7)
REFERENCES

