RELEVANT ANATOMY

ARTERIOVENOUS ANOMALY

ESTHESIONEUROBLASTOMA

NEUROFIBROMATOSIS TYPE 1

GLOMANGIOPERICYTOMA

SINONASAL MELANOMA

VARIOUS NEOPLASMS

ARTERIOVENOUS FISTULA

POSTTRAUMATIC PSEUDANEURYSM

ARTERIOVENOUS MALFORMATION

BACTERIAL SINUSITIS

FUNGAL SINUSITIS (aceto-invasive type)

c-ANCA + GRANULOMATOSIS WITH POLYANGITIS

REFERENCES

3. Pulmonary and cerebral AVM’s are common. They can be symptomatic or asymptomatic and may require treatment.

The eruption of blood from the nasal cavity is usually a self-limited condition, requiring little to no significant clinical consequence. Most cases are associated with irritation or injury to a rich vascular plexus within the anterior nasal septum, and rarely associated with tapetum. Treatment of posterior epistaxis can be attempted with tamponade, but often requires more invasive interventions, such as clipping or embolization.

The nasal cavity receives blood supply from both the internal carotid (via branches of the ophthalmic artery) and external carotid arteries (via branches of the sphenopalatine and facial arteries). The territories of these arterial branches demonstrate a high degree of overlap, which carries two important consequences: 1) provides a robust network of collateral flow to preserve the viability of delicate soft tissues throughout the nasal cavity, and 2) it allows for anastomotic routes between the internal and external arterial circulation. Both scenarios can complicate the management of epistaxis, which can be refractory in some cases or associated with unintentional embolization of the retina or brain in others.

In the posterior nasal cavity, anastomotic connections exist between the branches of the sphenopalatine artery and ethmoid branches of the ophthalmic artery, as well as with the greater palatine artery. The territories of these arterial branches demonstrate a high degree of overlap, which carries two important consequences: 1) it provides a robust network of collateral flow to preserve the viability of delicate soft tissues throughout the nasal cavity, and 2) it allows for anastomotic routes between the internal and external arterial circulation. Both scenarios can complicate the management of epistaxis, which can be refractory in some cases or associated with unintentional embolization of the retina or brain in others.

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INTRODUCTION

Epistaxis is a commonly encountered, albeit nonspecific, clinical presentation, which can on occasion indicate the presence of a serious underlying pathology. In particular, high volume and recurrent epistaxis are more likely to be caused by any number of worrisome medical conditions, including benign and malignant neoplasms, accidental andiatrogenic injury, as well as other vascular malformations (both acquired and hereditary), and various infections. These conditions can be associated with high morbidity or mortality, so effective and appropriate treatment relies upon timely diagnosis.

Epistaxis can be caused by any process that leads to injury or dissection of the normal vascular supply. Therefore, the differential for intranasal bleeding is broad. In general, epistaxis can be categorized by location anterior vs. posterior, lateral vs. septal, and internal vs. external carotid supply.

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