Introduction

Nasal dermal sinus is a very rare congenital anomaly that is frequently associated with inclusion cysts (dermoid or epidermoid). 1–3 At the end of the second month of gestation, the nasal and frontal bones are separated by the foniculus frontalis. In this period, the dura projects into the nasal area through the anterior skull base opening (foramen cecum), and lies in contact with the skin at the tip of the nose. Failure during ossification to obliterate this transcranial connection is the embryological pathway to nasal dermal sinus tract development. 1–4 In the present case, combined use of high resolution magnetic resonance imaging and computed tomography (CT) clearly demonstrated the detailed anatomical relationship of the dermal sinus associated with a dumbbell-shaped dermoid to the surrounding structures such as the foniculus frontalis and foramen cecum. 3,5

Case Report

History and Examination

The patient was a boy aged 1 year and 4 months who had had a small pit at his nasion from birth and had developed swelling of the forehead. The sagittal view of a T2-weighted image demonstrated a dumbbell-shaped, mixed intense dermoid at the foramen cecum. The sinus tract was depicted as a strand of isointensity between the dermoid and the nasion. Serial sagittal views of T1-weighted images revealed the capsule of the dermoid enhanced with contrast medium, and that the subcutaneous abscess was in continuity with the dermoid. On diffusion-weighted imaging, both the dermoid and subcutaneous abscess were demonstrated as a hyperintensity. Serial sections of the sagittal and coronal computed tomography scans clearly showed an enlarged foniculus frontalis and foramen cecum remnant and dehiscence of the crista galli. The purulent dermoid cyst including the capsule and the dermal sinus tract were removed completely. We describe our detailed anatomical relationship between the sinus tract with dumbbell-shaped dermoid and the surrounding structures, and emphasize the importance of these anatomy for operation.
mixed intense dermoid at the foramen cecum. The sinus tract was depicted as a strand of isointensity between the dermoid and the nasion. An abscess in the subcutaneous tissue of the forehead (black asterisk) was noted adjacent to the dermoid. The subcutaneous swelling of the forehead is demonstrated as hyperintensity (solid star). (C) Serial sagittal views of T1-weighted images revealed the capsule of the dermoid enhanced with contrast medium (Gd-DTPA). The subcutaneous abscess is in continuity with the dermoid (white arrow). The sinus tract is not apparent on this image. (D) Axial view of the Gd-enhanced T1-weighted image. The dermoid is dumbbell-shaped (white arrow indicates the neck of the dumbbell). The subcutaneous abscess (white asterisk) is noted adjacent to the dermoid. (E) Diffusion-weighted image at a level comparable to that of (Fig. 1D). Both the dermoid (white arrow) and subcutaneous abscess (black asterisk) are demonstrated as hyperintensity. (F, G, H) Serial sections of the sagittal (F, H) and coronal (G) computed tomography scan. The enlarged fonticulus frontalis remnant (white arrow), enlarged foramen cecum remnant (white dotted line), and dehiscence of the crista galli (white arrow heads) are clearly visible. Part of the falx is calcified (gray arrow). (I) Three-dimensional computed tomography. A bony defect is evident at the midline of the junction of the frontal bone and the anterior fossa with bifid crista galli (white arrow heads). (J) Schematic drawing demonstrating the anatomical relationship of the dermoid (D), subcutaneous abscess (A), and swelling (S) with surrounding structures.
dermoid and subcutaneous abscess were demonstrated as a hyperintensity (►Fig. 1E). Serial sections of the sagittal and coronal CT scans clearly showed an enlarged fonticulus frontalis and foramen cecum remnant and dehiscence of the crista galli (►Fig. 1F, G, H). Three-dimensional CT imaging showed a bony defect at the midline of the junction of the frontal bone and the anterior fossa, with a bifid and bulging crista galli (►Fig. 1I).

**Operation and Pathological Findings**
The subcutaneous abscess was evacuated through a coronal skin incision on the frontal region, and then the purulent dermoid cyst including the capsule was removed. The part of the dermoid capsule that was tightly adherent to the dura was carefully coagulated. There was a bony defect at the nasion (►Fig. 2A). The dermal sinus tract was also dissected through a tiny skin incision (►Fig. 2B).

Microscopically, the dermoid cyst wall was typically lined by a keratinizing squamous epithelium. Intraluminal keratin and hair shafts were also demonstrated (►Fig. 2C). The sinus tract was a ductal structure lined by stratified squamous epithelium (►Fig. 2D). The orifice of the sinus was opened.
Discussion

The schematic drawing in Fig. 1J demonstrates the detailed anatomical relationship between the sinus tract with dumbbell-shaped dermoid and the surrounding structures. The body of the dumbbell-shaped dermoid was located in the enlarged fonticulus frontalis and foramen cecum remnant; the head of the dumbbell was the intracranial extension of the dermoid with bulging dura. A bifid and bulging crista galli was also attributed to the intracranial extension of the dermoid. Although bacteriologic examination failed to reveal the causative agents, the microscopically opened sinus tract resulted in the formation of the subcutaneous abscess adjacent to the purulent dermoid.

References

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