Tonsillar Lymphangiomatous Polyp, A Case Report And Literature Review

Z A AL-Qudehy, Y AL-Nufaily, H Yagi

Citation

Z A AL-Qudehy, Y AL-Nufaily, H Yagi. *Tonsillar Lymphangiomatous Polyp, A Case Report And Literature Review*. The Internet Journal of Otorhinolaryngology. 2013 Volume 15 Number 1.

Abstract

We report a case of a 23 year old Indonesian female patient who presenteded with foreign body sensation and dysphagia. She was found to have a left tonsillar polypoidal mass and a tonsillectomy was performed. The histopathology result came back as lymphangiomatous polyp. Tonsillar lymphangiomatous polyp is an uncommon hamartomatous lesion that generally arises from the tonsillar surface and it has rarely been reported in the medical literature, with only five reported cases in children and six in adults.

INTRODUCTION

Hamartomas are simple and spontaneous growths composed exclusively of components derived from local tissue. The growths produce an excessive number of cells that reach maturity and cease to reproduce, so the growth is self limiting. Hamartomas often present many clinical features of a neoplasm, although they are basically malformation1. Tonsillar lymphangiomatous polyp is a kind of hamartomatous lesion and it has been described by different nomenclatures such as lymphangiectatic fibrous polyp, polypoid lymphangioma of the tonsil, hamartomatous tonsillar polyp and so on2-5. The purpose of this paper to present a tonsillar lymphangiomatous polyp in a 23 year-old patient who had her symptoms of foreign body sensation and dysphagia for the last three years and yet the condition was still not diagnosed.

CASE REPORT

A 23-year-old Indonesian lady was seen in our ENT OPD with chief complaint of foreign body sensation and difficulty of swallowing of three years duration. However she was otherwise asymptomatic. She was not a smoker and was healthy with no previous surgery or treatment. The local physical examination revealed a pedunclated mass extending from the left palatine tonsil. There was no evidence of cervical lymphadenopathy. She underwent tonsillectomy. Grossly, there was a 1.9 X 1.1 cm sized polypoid mass attached to the left tonsil (Fig. 1) with slender stalk (Fig. 2); it was firm in consistency and appeared fibrotic.

Figure 1

Gross photograph of left tonsil specimen. A Polypoid mass extending from tonsil, Showing smooth surface. (left: polyp, right: tonsil).

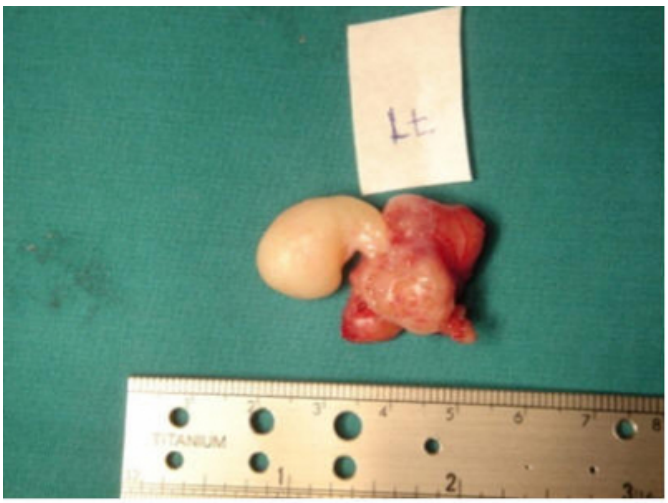
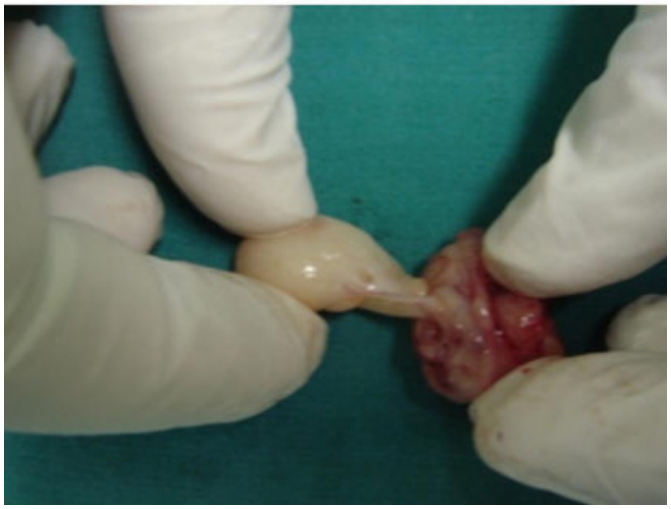


Figure 2

Left tonsillar polypoid mass with slender stalk showing the feeding blood vessel.



Histologically, it was polypoidal lesion (Figure 3), lined by squamous epithelium (Figure 4), with underling inflamed core of fibrous tissue, with dilated lymphatic vessel (Figure 5).

Figure 3

The mass is polypoidal in shape

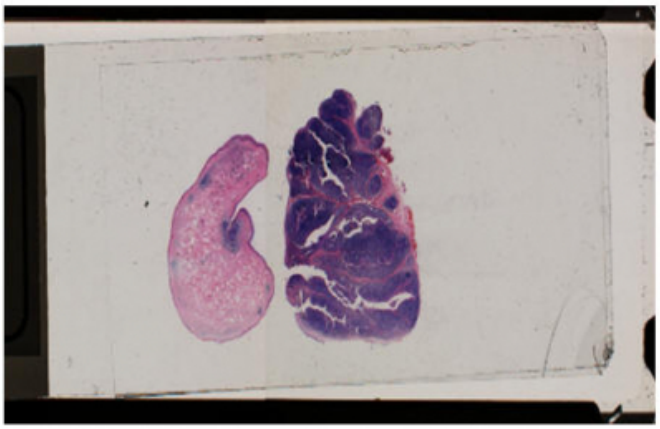


Figure 4

The lesion is lined with squamous epithelium.

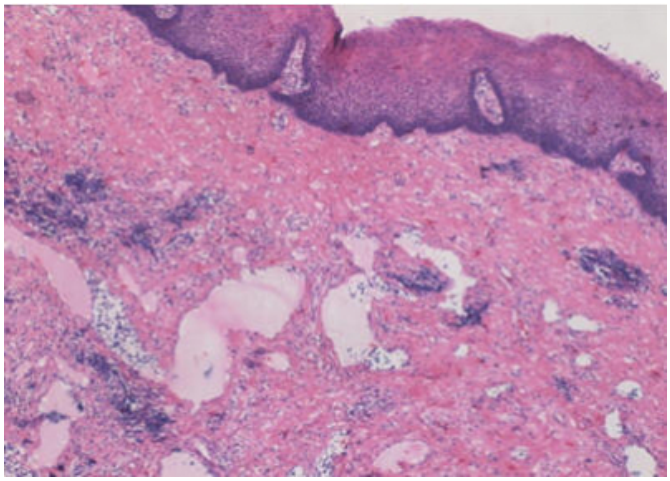
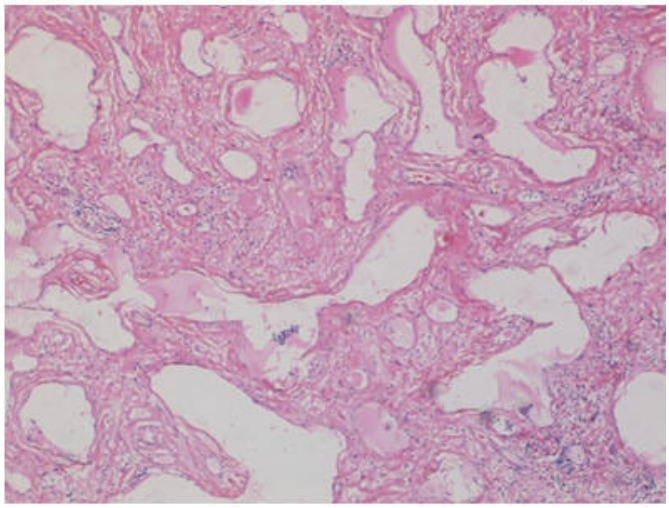


Figure 5

A core of inflamed stroma with dilated lymphatic vessels.



In the follow up period, the patient remained asymptomatic with no evidence of remnant or recurrence.

DISCUSSION

The head and neck is the most common anatomic region for lymphangiomatous lesions, accounting for over 90% of all lymphangiomas6. Most arise in the skin and subcutaneous tissues, but other sites include the larynx, parotid gland, mouth, and tongue7. The tonsil is less common site for the development of lymphangiomatous tumors. It contained the two basic tissue types of the tonsil-lymphoid and epithelial-in the characteristic close anatomical relationship of tonsillar tissue, this feature supports the hypothesis that benign tumors of the tonsil may be hamartomas of the tonsil or bronchiogenic remnant rather than true neoplasms8. The pathologists have had difficulties in specifically classifying

their cases and they have named them as fibrolipomas or have given them a more descriptive diagnosis, such as " polypoid tumor containing fibroadipose tissue."3 Clinical features are dysphagia, snoring, and the sensation of foreign body with insidious progression5. According to the size of the tumor, swallowing disorders, cough, aspiration and eructations can occur9.

Usually the morphological aspect of the tumor is similar to the one of a polypoid lesion attached to the tonsil, to the wall of the tonsillar bed, or to the lateral wall of the hypopharynx, pedunclated, with single or multiple lobulation, smooth surface and a bright red color or pink as the pharyngeal mucosa5. Kardon et al.4 reviewed 26 cases of lymphangiomatous polyps and they described the various histological features of the polyps. They were usually covered by squamous epithelium and showed variable degree of epithelial hyperplasia and proliferation of lympho-vascular channels, collagen, adipose tissue and lymphocytic infiltration were present in the stroma10.

Treatment is through surgical resection. Complete excision of the lesion including the stalk is usually successful. In adults, surgery can be performed under local anesthesia8. In the case of voluminous lesions of the pharynx or esophagus and/or in children, general anesthesia is preferred11. The tumor is grasped and tractioned to the oral cavity with a forceps for further clamping of its stalk and total excision12. Even for giant tumors, lateral pharyngotomy was hardly ever necessary13. In our case, because there was a history of recurrent episodes of tonsillitis, we choose to perform bilateral tonsillectomy.

CONCLUSION

Lymphangiomatous polyps of the tonsil are benign tumors that most frequently present as mass lesions and are composed dilated lymphatic channels and a fibrous, lymphoid and/or adipose stroma. They have varied histological features. Treatment is mainly by surgical excision of the mass alone or tonsillectomy, depending on the involvement of the surrounding tonsillar parenchyma or presence of recurrent episodes of tonsillitis. There is usually no recurrence according to the literature.

References

1. Batsakis JG. Tumors of Head and Neck. Clinical and Pathological Consideration, 2nd ed., The Williams & Wilkins Co. Baltimore, 1979, pp231
2. Hiraide F, Inouye T, Tanaka E. Lymphangiectatic fibrous polyp of the palatine tonsil. A report of three cases. J Laryngol Otol 1985; 99:403-9.
3. Al Samarrae SM, Amr SS, Hyams VJ. Polypoid Lymphangioma of the tonsil: report of two cases and review of the literature. J Laryngol Otol 1985; 99:819-23.
4. Kardon DE, Wenig BM, Heffner DK, Thompson LD. Tonsillar lymphangiomatous polyps: a clinicopathologic series of 26 cases. Mod Pathol 2000; 13: 1128-33.
5. Shara KA, al-Muhana AA, al-Shennawy M. Hamartomatous tonsillar polyp. J Laryngol Otol 1991; 105:1089-90.
6. Kennedy TL. Cystic hygroma-lymphangioma: a rare and still unclear entity. Laryngoscope 1989;99:1-10.
7. Stal S, Hamilton S, Spira M. Hemangiomas, lymphangiomas, and vascular malformations of the head and neck. Otolaryngol Clin North Am 1986; 19:769-96.
8. Lupovitch A, Salama D, Batmanghelichi O. Benign hamartomatous polyp of the palatine tonsil. J Laryngol Otol 1993; 107:1073-5.
9. Huttenbrink KB, Stoll W. Stridor in the neonatal period in heterotopic gastric mucosa of the hypopharynx. Laryngol Rhinol Otol (Stuttg), 1987; 66-2: 67-69.
10. Han Suk Ryu, Soo Young Jung, Jae-Soo Koh, Seung-Sook Lee. Tonsillar Lymphangiomatous Polyp- Report of Two Cases-. The Korean Jour. Of Pathol, 2006; 40: 381-4.
11. Meirelles RC, Neves-Pinto RC. Mesenchymal Hamartoma of the Tonsil in a Child: a Case Report. Arr. Otorrinolaringol., 2005; v.9, n.3, p. 239-241.
12. Santana-Hernendez DJ, Ell SR, Da-Costa P, Macklin CP, Hussain SS. Giant hamartoma of the oropharynx. J.Laryngol.Otol., 1996; 110-5: 480-2.
13. Patterson HC, Dickerson GR, Pilch BZ, Bentkover SH. Hamartoma of the hypopharynx. Arch Otolaryngol, 1981; 107-12: 767-72.

Author Information

Zeinab A. AL-Qudehy, Dr,
Dammam Central Hospital
Saudi Arabia
drzeinabent@yahoo.com

Yasser AL-Nufaily, Dr,
Dammam Central Hospital
Saudi Arabia

Hashim Yagi, Dr, Prof.
Faculty of Medicine, University of Khartoum
Soudan