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Clinical Image

Unilateral Tonsil Hypertrophy and Homolateral Adenopathy

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INTRODUCTION

The most common aetiology of unilateral palatine tonsil hypertrophy is a squamous cell carcinoma; in most case, there is an isolated, indurated and increased in size amygdala with or without ulceration of the mucosa. The second aetiology is lymphomas, characterized by a sub-mucosal mass, its growth leads to the asymmetrical size of the amygdala. In the first situation, a cervical node can be observed and in the second situation multiple nodes can be reported. We report the case of a young patient with a right cervical mass accompanied by pain and dysphagia, strongly evocative with a squamous cell carcinoma of the right tonsil associated with a node metastasis.

CASE REPORT

A 27-year-old man is referred to you for a right cervical mass accompanied by pain and dysphagia that have developed for 2 months. The patient reports asthenia and a weight loss of 3 kg. His history shows Hashimoto's thyroiditis with untreated hypothyroidism, asthma and active smoking, estimated at 11 packs a year. The clinical examination found a 6 cm firm and fixed mass at the right sub-digastric level, as well as a bulky painful and indurated tonsil (Figure 1,2). An injected cervico-facial and thoracic CT scan confirms the clinical examination with the presence of a 69 mm x 19 mm right cervical lymphadenopathy of level III and a homolateral tonsil enlargement(Figure 3). The rest of the examination is without particularity. The standard biological and serological assessments (HIV, toxoplasmosis, EBV, CMV and syphilis) are negative.

Clinical examination and CT scan made us suspect squamous cell carcinoma.

Tonsil biopsy performed in consultation reports a possible epithelioid granuloma with diffuse follicular lymphoid hyperplasia. Yet, asthenia and pain of the patient seems to be incompatible with a benign proliferation like tuberculosis or sarcoidosis. Because of the small sample size and uncertain diagnosis, we performed panendoscopy and adenectomy by cervical approach (Figure 4). Definitive results confirmed diffuse non-Hodgkin's large lymphoma B cells. To date, 2 years after the diagnosis of diffuse non-Hodgkin's large lymphoma B and 6 cycles of R CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone), the patient is still considered in clinical and radiological remission.

Figure 1: Profile photograph of the patient showing right a cervical mass at the right sub-digastric level.

Figure 2: Endobuccal photograph of the patient showing a right tonsil enlargement.

Figure 3: Axial Cervico-facial injected CT-scan showing a right cervical lymphadenopathy of level III (black arrow) and a homolateral tonsil enlargement (white arrow).

Figure 4: Per-operative photograph of cervical approach of the adenectomy.

DISCUSSION

The association of lymphadenopathy and an enlarged tonsil with dysphagia and deterioration of the general condition in an active smoking man raises at first a tumour process of type squamous cell carcinoma. Nevertheless, the age and the pathological results directed the diagnosis towards an infectious process or a sarcoidosis. These hypotheses are part of the causes of unilateral tonsillary hypertrophy with lymphoma and amyloidosis [1]. Due to the deterioration of the general condition, a panendoscopy with enlarged tonsil biopsies and a diagnostic adenectomy were performed and allowed the diagnosis of non-Hodgkin's malignant lymphoma B diffuse with large EBV-negative cells on the 2 sites. The majority of head and neck lymphomas are non-Hodgkin's lymphomas (67%). The main location concerns the cervical nodes. For extra-lymph node locations, the Waldeyer ring is the most affected (54%), with almost 40% of the cases concerning the palatine tonsils. Diffuse large malignant B lymphoma cells are the most common subtype, affecting mainly men over the age of 50 [2]. In the literature, no case is reported before the age of 30 [3,4].

Malignant lymphomas are characterized by great heterogeneity on the clinical, genetic and morphological levels. Although diffuse non-Hodgkin's large lymphoma B cells are one of the most common forms for the head and neck, it is not reported for the patient's age group. Large surgical pieces are important to define the lymphoma subtype because the classification is complex [5]. The rapidity and the accuracy of the pathology diagnosis has a real impact on thepatient's therapeutic management.

CONCLUSION

In young patients who havecervical adenopathy or tonsillar enlargement, we have to talk about the diagnosis of lymphoma. However, one should not forget the possibility of other diagnoses.

In all cases, samples of quality must be collected in sufficient quantity to confirm diagnosis.

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