Tonsillar tuberculosis with coexisting lymphoma: A case report

Li Ping Teoh, MD[1], Chian Ling Tang, Doctor of ORL-HNS[3], Pek Ser Heng, MMed (ORL-HNS)[3], Li Yun Lim, MMed (ORL-HNS)[1,2]

[1]Department of ORL-HNS, Sarawak General Hospital, Kuching, Sarawak, Malaysia, [2]Department of ORL-HNS, Faculty of Medicine and Health Sciences, University Malaysia Sarawak (UNIMAS), Sarawak, Malaysia, [3]Department of ORL-HNS, Sibu Hospital, Sibu, Sarawak, Malaysia

SUMMARY

The co-existence of tuberculosis (TB) and lymphoma share similar presentations and both may masquerade each other leading to diagnostic dilemmas. Herein, we would like to report a case of an elderly man with existing TB in whom failing to respond to treatment led to investigations that unveiled the coexistence of a non-Hodgkin lymphoma. A 71-year-old man presented to our department with a one-month history of odynophagia and left submandibular swelling. He was treated with multiple courses of antibiotics but symptoms not resolving. Physical examination showed enlarged tonsils bilaterally with exudates. There was also a left cervical lymph node enlargement. Biopsy taken from both tonsils and histopathological examination (HPE) showed no malignancy. Biopsy was also sent for a Genexpert test for tuberculosis and the result was positive for *Mycobacterium tuberculosis*. A fine needle aspiration was taken from the neck mass and the result was non-diagnostic. As the result from the Genexpert test was positive, he was started on anti-TB treatment. After three months of treatment, the tonsils were still hypertrophied and the left neck nodes never resolved. Suspicion was raised and a second biopsy was done with an incisional biopsy taken from the left neck nodes. The tonsils biopsy still showed no malignancy but the HPE from the neck nodes showed diffuse large B-cell lymphoma. Patient was counselled for chemotherapy but refused. He succumbed to the disease three months after refusal of chemotherapy. The co-existence of extrapulmonary tuberculosis and lymphoma is rare, which leads to a diagnostic dilemma especially if one was not known to have underlying lymphoma. Tuberculosis will usually be suspected first due to our endemic nature and in this case, further investigations were only done when the symptoms were not resolving with anti-TB treatment. Therefore, suspicion of both conditions occurring concurrently should arise early if treatment was unsuccessful.

Giant pleomorphic adenoma of submandibular gland

Tan Shi Nee, MBBS, MS (ORL-HNS), RPSGT[1,4], Saravanan Gopalan, BDS, MClident (OMFS)[2], Marzuki Zainal Abidin, BDS, MClident (OMFS)[3], Rubinderan M, DDS, MFDS RCSed, FRACDS, MOMFsurg[1], Primuharsa Putra SHA, MD, MS (ORL-HNS)[4,5]

[1]Department of Otorhinolaryngology, Head and Neck Surgery Hospital Lahad Datu, Sabah, Malaysia, [2]Department of Oral Maxillofacial Surgery, Hospital Queen Elizabeth, Kota Kinabalu, Sabah, Malaysia, [3]Department of Oral Maxillofacial Surgery, Hospital Serdang, Selangor, [4]KPJ Healthcare University College, Nilai, Negeri Sembilan, Malaysia, [5]Ear, Nose and Throat-Head & Neck Consultant Clinic, KPJ Seremban Specialist Hospital, Malaysia

SUMMARY

Benign tumours of submandibular glands are rare, however pleomorphic adenoma (PA) is the most prevalent type among all of them. Although there are a lot of publications, giant pleomorphic adenoma is extremely rare. These tumours are usually painless and slow growing but when neglected on some occasions, they can be disfiguring and mandate surgical excision. This is a report of a rare and large, unusual case of a giant submandibular pleomorphic adenoma with the management process there after being discussed. A 46-year-old male non-Malaysian presented to Hospital Lahad Datu recently with complaint of a large mass on the left side of the neck for the past 12 years. There was no history of difficulty in breathing, odynophagia, dysphagia and facial disfigurement. Physical examination showed a lobulated mass, non-tender and firm over the left submandibular region. No skin changes noted. Movement of the tumour mass can be palpated bimanually. No palpable lymphadenopathy. Fine-needle aspiration cytology of the mass was inconclusive. Computed tomography (CT) of the neck revealed a large mass arising from left submandibular gland measuring 9.1cm x8.9cm x 9.1cm with clear margin near the carotid sheath and sternocleidomastoid muscle. The tumor was surgically excised. Intraoperatively, noted there were a lot of dilated vessels due to stretching of the capsule as a result of the enlargement of the mass. The patient recovered well and was discharged on day 5 post-operative. No recurrence was observed during the five months of post-surgery. Histopathological report came back as PA. It is a formidable challenge for a surgeon to manage a huge PA. Neglecting such tumors can cause disfiguring appearance due to the gigantic mass and in a worst case scenario may even cause airway obstruction and chronic neck pain if it continues to enlarge towards the neck.