A big solitary oropharyngeal papilloma in a child

Raman Wadhera *, Vijay Kalra, Sat Paul Gulati, Anju Ghai

Department of Otorhinolaryngology, Pt. BDS PGIMS Rohtak, Haryana, India
Department of Anesthesiology, Pt. BDS PGIMS Rohtak, Haryana, India

Received 30 September 2012; accepted 7 October 2012
Available online 29 October 2012

Abstract Malignant oropharyngeal tumors are far more common compared to benign tumors. Oropharyngeal papilloma is typically present in adults. We are reporting a case of a big solitary papilloma arising from uvula in a 7-year-old male child. It was excised under general anesthesia.

© 2012 Egyptian Society of Ear, Nose, Throat and Allied Sciences.
Production and hosting by Elsevier B.V. All rights reserved.

1. Introduction

Benign oropharyngeal tumors are far less common compared to malignant tumors. Oropharyngeal papilloma is typically present in adults. We present a very rare case of a big, solitary squamous papilloma in a child.

2. Case report

A 7-year-old male presented with a 2-month history of local irritation in the throat and frequent throat clearing. The patient developed difficulty in swallowing solid food since 2 weeks. There was no history of nasal symptoms, fever or throat pain. General physical and systemic examination was within normal limits. Throat examination revealed a pink colored, solitary pedunculated mass measuring 3 cm × 2 cm with numerous finger like projections at the surface (Fig 1). A provisional diagnosis of papilloma was made. X-ray of the soft tissue neck lateral view showed the mass attached to the uvula (Fig 2). Excisional biopsy was planned under general anesthesia. Direct laryngoscopy was performed to inspect the remainder of the respiratory tract. On palpation the mass was firm in consistency and was attached to the uvula. Lesion was sent for histopathological examination, which confirmed the diagnosis of a squamous papilloma. Follow up at 6 months revealed no recurrence. Our departmental board of postgraduate studies which is equivalent to the institutional review board approved the paper.

3. Discussion

A squamous papilloma is a benign epithelial neoplasm, diagnosed most often in adults. It predominates in males. The soft palate and the uvula are the usual oropharyngeal sites of origin. It is a soft, painless, usually pedunculated exophytic nodule with surface projections that impart a “cauliflower” or wart like appearance. Squamous papilloma has a white or pink color depending on the surface keratinization. The papilloma is usually solitary and enlarges to a maximum size of about 0.5 cm with little or no change thereafter.1,2

Examination of squamous cell papilloma by histopathology, electron microscopy, immunohistochemistry and by DNA analysis, using in situ hybridization (ISH) or southern
blotting supports a role of human papilloma virus (HPV) in the cause of these lesions. Squamous papillomas are most commonly associated with HPV-6 and HPV-11 virus subtypes. Not all squamous papillomas are virally induced, some may be the result of mechanical irritation and others (although possibly viral related) are genetically determined such as those occurring as a component of Cowden’s syndrome.

On histopathological examination, the papilloma is classically an exophytic lesion demonstrating a complex pattern of multiple finger-like projections of stratified squamous epithelium surrounding a central vascular connective tissue core.

The epithelium may be hyperkeratotic or acanthotic, and the supporting collagen usually contains inflammatory cells, especially if there has been a superficial ulceration of the lesion due to trauma.

The clinical differential diagnosis of a papilloma includes fibroma, verruca vulgaris, fibrous hyperplasia, condyloma acuminatum, pyogenic granuloma and verrucous carcinoma.

Oropharyngeal papilloma is less proliferative than the squamous papilloma of other sites of the head and neck such as larynx. Though sometimes the development of precancerous proliferative verrucous leukoplakia and squamous cell carcinoma, can occur within squamous papilloma. Treatment of these lesions involves surgical excision or ablation with the use of a CO2 laser, recurrence in the oropharynx is unlikely. A vaccine targeted against HPV types 6, 11, 16 and 18 has been introduced recently for the prevention of cervical cancers and genital warts. It is possible that this vaccine may prevent HPV-related lesions of the head and neck as well, such as squamous papilloma, laryngeal papillomatosis, and perhaps some cases of oral and oropharyngeal squamous cell carcinoma.

A medline search revealed that there has been no reported case of papilloma in a child arising from the uvula with such a good X-ray documentation.

Figure 1  Pink colored, solitary pedunculated mass measuring 3 cm × 2 cm with numerous finger like projections at the surface.

Figure 2  X-ray of the soft tissue neck lateral view showing the mass (arrow) attached to the uvula.

References


