An Unusual Oral Mass in an Immunocompromised Patient

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Background

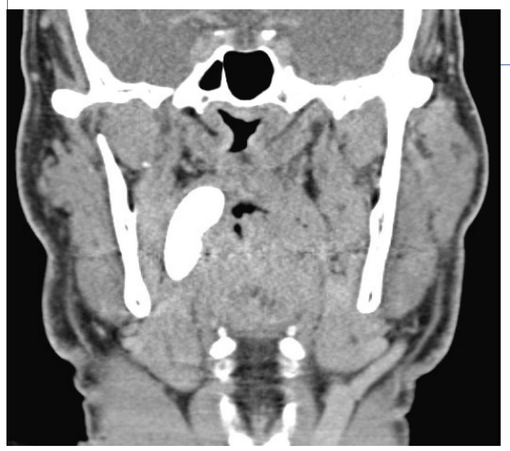
The findings of tonsillar asymmetry prompts a broad differential including carcinoma or lymphoma, however other common etiologies must not be excluded. This case report illustrates the importance of including benign pathology on the differential, such as tonsillolith, in an oropharyngeal mass. Characteristic findings on physical exam and radiological studies can possibly differentiate benign etiologies from cancer. This could potentially avoid unnecessary patient anxiety, testing and procedures.

Case Presentation

62-year-old male past medical history significant for HIV and Graves disease. He had a history of smoking <1ppd x 40 years). He was referred to the ENT clinic for imaging. Findings of a possible parapharyngeal mass was seen on dental x-rays. Patient was asymptomatic and denied dysphagia, odynophagia, SOB, voice changes, weight loss, otalgia. On examination, the right tonsil was significantly enlarged and firm to palpation compared to the left tonsil. There was no cervical lymphadenopathy.

Clinical Course

- CT of the neck revealed a solitary 2.7cm x 1.1cm x 3.4cm right tonsil mass with no surrounding edema or pathologically enlarged lymph nodes (Image 1).
- Due to concern for neoplasm, the patient underwent unilateral tonsillectomy.
- Intraoperatively, a firm intratonsillar calcified mass was revealed with a dimension of 3 cm x 3 cm x 1 cm (Image 3).
- Pathological examination of the mass in the tonsil revealed a tonsillolith (Image 4)
- Pathology report stated it was composed of 80% carbonate apatite and 20% struvite
- Microbiology showed actinomyces



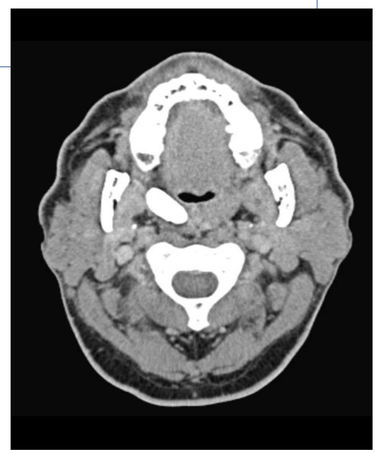


Image 1 and 2. CT Neck

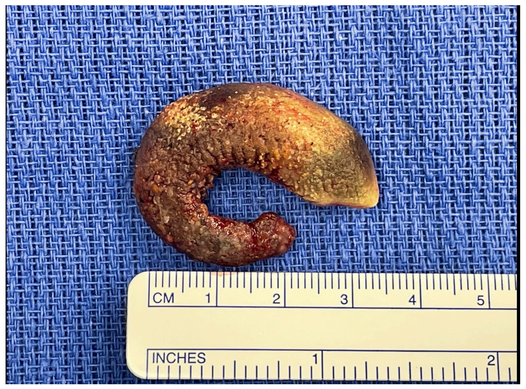


Image 4: Resected tonsillolith

Discussion

Preventative measures for the development of tonsillolith include antiseptic gargles, flushing of the tonsils with an oral irrigator, and drinking a generous amount of water with meals. Small tonsilloliths can be easily treated with oral hygiene such as mouthwash gargles and manual removal. Giant tonsilloliths are often difficult to remove at bedside and may need more extensive treatment such as manual removal under anesthesia, enucleation or curettage (8), or tonsillectomy (9).

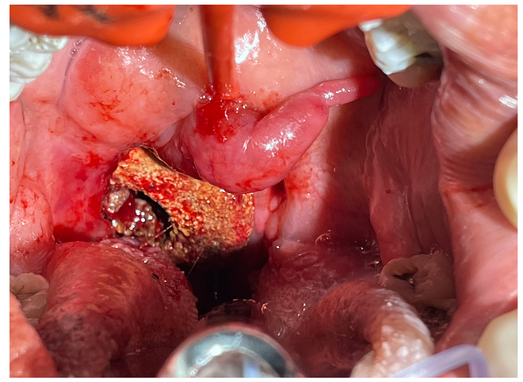


Image 3. Intraoperative finding of intratonsillar calcified mass

Conclusions

This case illustrates the importance of imaging and intraoral exam in patients with an oropharyngeal mass, especially in immunocompromised patients where there is a high degree of suspicion of neoplasm. On CT, a radiopaque mass in the tonsil region with no associated edema or cervical lymphadenopathy is more suggestive of a benign process rather than infection or malignancy. Tonsillectomy should be considered to confirm the diagnosis and symptomatically treat the patient.

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