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Unilateral Pedunculated Lymphangiectatic Fibrolipomatous Polyp of the Palatine Tonsil: A Rare Case

Case Report

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Abstract

Lymphangiomatous polyps are rare benign hamartomatous tumors of the palatine tonsils that can cause significant distress to the patients such as sore throat, foreign body sensation, a lumpy feeling in the throat region, dysphagia, and eventual suffocation. In this paper, the case of a 17-year-old male who came to the outpatient clinic with a complaint of difficulty in swallowing, eventual vomiting, and occasions of hematemesis is presented. On physical examination, the patient had a smooth-surface, polypoid, pedunculated tumoral lesion originating from the middle pole of the left palatine tonsil and protruding into the oropharyngeal isthmus. The patient underwent left tonsillectomy. Histopathological examination of the surgical specimen showed typical features of a lymphangiectatic fibrolipomatous polyp. The case reported herein with the brief literature review points out the clinical and the benign, non-neoplastic characteristics of the lymphangiectatic fibrolipomatous polyp, which can be cured by surgical excision along with tonsillectomy.

Keywords: Dysphagia, hamartoma, palatine tonsil, polyp, tonsillectomy

Introduction

Squamous papillomas are the common benign tumors of the tonsils. Lymphangiomatous neoplasms are the next most common lesions followed by epidermal inclusion cysts (1). They sometimes carry different names such as lymphangioma, hamartomatous tonsillar polyp, lymphangiomatous polyp, lymphangiectatic fibrous polyp, lymphangiectatic fibrolipomatous polyp, and so on according to their stromal components (2). Lymphangiomatous polyps generally present as a pale or pink pedunculated lesion attached to the palatine tonsil. They consist of dilated amorphous lymphatics with fibrous, lymphoid, and/or adipose stroma, and they are considered to be a hamartoma or, to some authors, an acquired lymphangiectatic malformation (3-7). Because of the eccentric histopathological features of these polyps, there is still difficulty in describing them with a common terminology and in classifying them correctly. Therefore, in light of our case, the clinical, surgical, and histopathological features of a lymphangiectatic fibrolipomatous polyp are described so as to contribute to the literature pool of these uncommon benign lesions of the palatine tonsil.

Case Presentation

A 17-year-old male came to the Ear Nose and Throat Diseases outpatient clinics of Silopi State Hospital with the chief complaint of a difficulty in swallowing, plus some occasions of vomiting and bloody saliva for the past few months. On inspection, an approximately 3×2×1 cm pale polypoid lesion with its stalk attached to the left tonsil was observed (Figure 1). On palpation, the mass was soft to firm, smooth-surfaced, mobile, and non-pulsatile. It had an attachment to the left tonsil with a ~1 cm thick pedicle. Other physical examinations, including fiber optic endoscopic work for dysphagia and hematemesis, revealed no evidence of trismus, cervical lymphadenopathy, or accompanying head and neck pathology. Systemic examination did not disclose any significant abnormalities.

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All routine hematological and other biochemical investigations were normal. Computed tomography of the neck showed a 26×14 mm hypodense polypoid soft tissue lesion protruding from the oropharyngeal inlet and extending from the uvular level to the epiglottal tip (Figure 2) but no pathological lymph nodes or additional lesions.

The patient underwent left tonsillectomy with the excision of the polyp by preserving its attachment to the tonsil. The operation was performed under general anesthesia and was uncomplicated. The tonsil was removed using the conventional cold dissection method, and bipolar cautery was used for hemostasis. Blood loss was minimal. The surgical specimen is shown in Figure 3. Dimensions of the polypoid mass was 3×2×1.5 cm postoperatively.

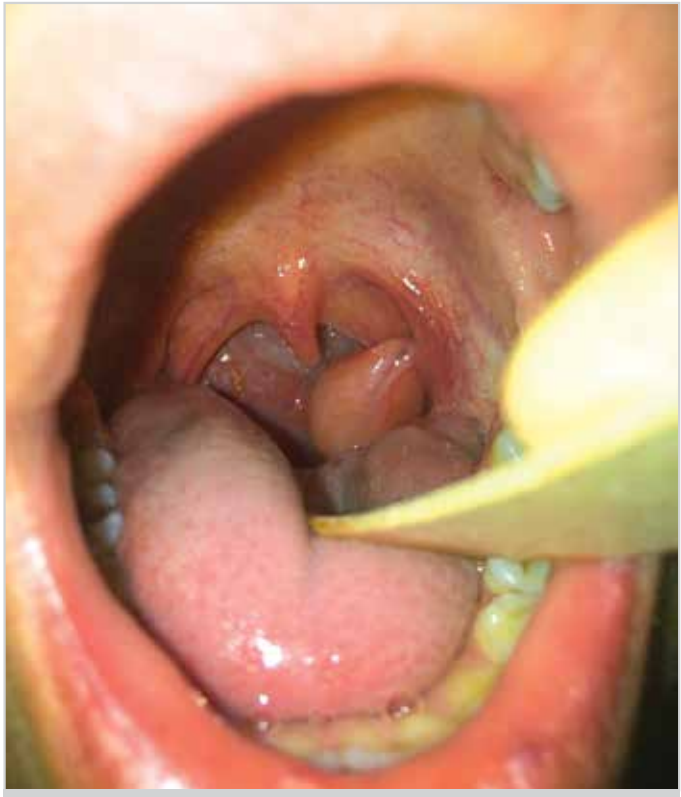

Figure 1. Oral cavity examination revealed a pale pink polypoid soft tissue originating from the left tonsillar fossa

The macroscopic pathology of the specimen was reported as a 2.5×1.8×1.2 cm polypoid lesion with a smooth white cut surface and an 0.8 cm peduncle through which it was attached to a 2.5×2.3×1.5 cm piece of left tonsillectomy material. Histologically, the overlying surface epithelium was squamous. There were dilated ductal structures and colonies of small lymphocytes packed into submucosal spaces as well as small groups of adipose tissue in the fibrous stroma. The tumor showed no stromal infiltration and extension into its peduncle or the tonsil. The overall histopathology of the lesion was reported as "lymphangiectatic fibrolipomatous polyp," and the left tonsillectomy material was reported as "chronic tonsillitis". The patient has been asymptomatic for a year since the surgery.

Informed consent was obtained from both the patient and his father as a written document.

Discussion

Most head and neck lymphangiomatous lesions are located in the skin and subcutaneous tissues, and the palatine tonsil is a relatively less common site. Pedunculated polypoid lesions of the tonsil, although presented under various types of nomenclature, are relatively rare tumors (7).

The pathogenesis and classification of lympangiomatous lesions is still unclear. Because they are composed of abnormal cells and tissue proliferations found in the location of their origin, here the tonsil, we agree that these tumors are reasonably hamartomatous (3-7). While chronic inflammation and obstruction of the lymphatics of the tonsillar surface are accused for development of these tumors, as seen in this case

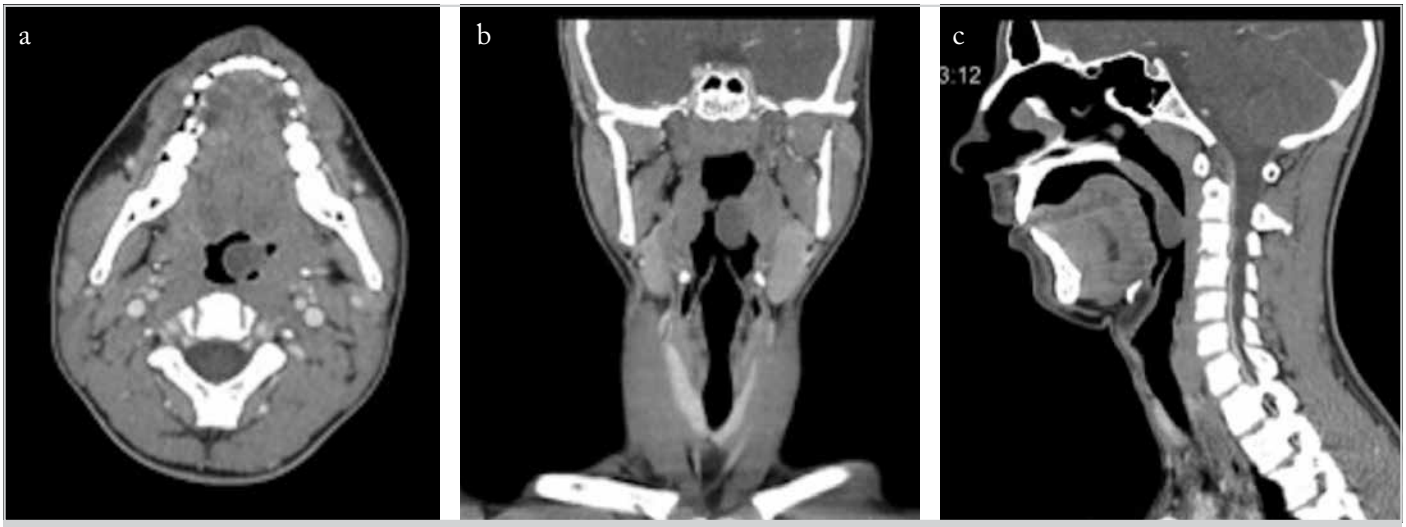

Figure 2. a-c. Axial (a), coronal (b), and sagittal (c) sections of computed tomography of the neck showed a hypodense polypoid lesion in the left tonsillar region extending to the level of the epiglottis just above the oropharyngeal inlet

Figure 3. Surgical specimen of left tonsillectomy, including the polypoid mass, just after fixation

there is not always associated chronic tonsillitis or any tonsillar pathology in the patient's history, which suggests that these are not the mechanisms of lymphomatous polypoid proliferation.

The clinical presentation varies, including simple sore throat, dysphagia, stepwise deglutition, and eventual suffocation or vomiting, especially if the patient is young (4, 8). These tumors occasionally become large, as was the case here, and cause obstructive symptoms and sometimes present as bilateral (4, 5, 9). The reported cases have mostly been in adults with only a few exceptions (2-8). The present case also expressed that he had experienced occasions of bloody saliva, especially after meals. Among the tissue components of the lymphangiomatous polyps, the stalk might be responsible for this symptom because it has vascular formations and loose fibrous tissues inside of it. In the stalk region from the specimen presented here, a thick-walled artery and smooth muscle hyperplasia appeared. It has been shown that the polyp itself has poor blood flow and chronic inflammatory features and thus is not expected to be responsible for hemorrhage (6).

These tumors generally look similar to any polypoid lesion attached to the surface of the tonsillar bed or to the lateral pharyngeal wall, including a pedicle, a smooth surface, and a pale or pink color (1, 2, 4, 6). The presented case was a good example of these definitions (Figure 1). Although a supplementary study is not crucial for diagnosis, immunocytochemical antibodies might have a role in differentiating the components of the ductal structures and the stroma so as to provide a specific pathologic diagnosis of the subtypes (2, 4). Nevertheless, immunohistochemical examination was not applicable for this case because of the medical and technical conditions of the local Pathology clinic. In addition to the other subtypes of lymphangiomatous polyps, differential diagnosis of such a lesion of the tonsil includes other benign tonsillar lesions like fibroma, fibroepithelial polyp, hairy polyp, hemangiomatous hamartoma, fibrovascular polyp, lipoma, neurofibroma, schwannoma, and plasma cell granuloma (2, 10).

Surgical removal of the lesion is claimed to be curative for lymphomatous polyps and other benign neoplastic or non-neoplastic lesions of the palatine tonsils (8). However, because lymphangiomatous polyps have their pedicles attached to the palatine tonsil, ipsilateral tonsillectomy which also includes the excision of the lesion would be preferable (4, 9). In the presented case, because there was no history of recurrent tonsillitis, only left tonsillectomy was chosen. The patient has been symptom and disease free for a year.

Conclusion

Lymphangiectatic fibrolipomatous polyps of the palatine tonsil are rare benign tumors that generally cause a lumpy feeling in the throat region but might also lead to obstructive symptoms. Histopathologically, they consist of dilated lymphatic channels with fibrous, lymphoid, and adipose stromal tissue. They can safely be cured by surgical excision with associated tonsillectomy.

Informed Consent: Written informed consent was obtained from patients' parents who participated in this study.

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