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Secondary Tonsillar Tuberculosis: Case Report

Sekonder Tonsil Tüberkülozu : Olgu Sunumu

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ABSTRACT

There has been a dramatic decrease in the incidence of tuberculosis during the last century. Due to this decrease, oral cavity involvement has diminished to a point at which it is now very rare. Tonsillar tuberculosis is a rare location among oral lesions. Secondary tuberculous lesions of the oral cavity are more common than primary lesions and are seen mostly in older persons. The rarity of oral tuberculous lesions has made the clinicians less sensitive to the disease as part of a differential diagnosis, which results in misdiagnosis of some patients. In this case report, we present a secondary tonsillar tuberculosis to draw attention to this rare location of tuberculous lesions, by which the primary lung tuberculosis of the cases could be diagnosed and treated as is in this case.

Keywords
Tonsil, tonsillar tuberculosis, oral tuberculosis, tuberculosis.

ÖZET

Son yüzyılda tüberküloz olgularında anlamlı bir azalma görülmektedir. Buna bağlı olarak tüberkulozun oral kavite tutulumu sıklığı da azalmıştır. Oral kavite lezyonları içinde tonsil tutulumu da nadir görülür. Sekonder tüberkülozda oral kavite lezyonları primer tüberküloza göre daha sıktır ve daha çok yaşlılarda görülür. Oral tüberküloz lezyonlarının nadir görülmesi klinisyenlerin hastalığın tanısını koymasında güçlüklere ve bazı hastalarda yanlış tanı konmasına neden olmaktadır. Bu vaka sunumunda sekonder tonsil tüberkulozunun nadir tutulum yerine dikkat çekilerek primer akciğer tüberkulozlu vakalarda kullanılan tanı ve tedavi yöntemlerinin bu durumda da kullanılabileceğini gösterdik .

Anahtar Kelimeler
Tonsil, tonsil tüberkülozu, oral tüberküloz, tüberkülozis

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INTRODUCTION

Tuberculosis is a systemic disease with worldwide distribution and has been a public health problem for many years. Primary tuberculosis, the childhood form of tuberculosis, often occurs in the lungs, the back of the throat or the skin. Secondary tuberculosis may be due to exogenous reinfection or to reactivation of a dormant endogenous infection (6,7). Relatively rare occurrence of oral tuberculosis is known (3). Oral lesions are either primary or secondary, and are seen as superficial ulcers indurated soft tissue lesions or even as lesions at the jaw (4,6,9). The primary lesion remains painless in the majority of the cases . The secondary lesions are more common and are seen mostly in older persons. With the advances in chemotherapy, improvement of public health, hygiene and the nutritional status of general population, there has been a dramatic decrease in the incidence of tuberculosis during the 20th century. Oral cavity involvement has diminished even more. Most of the primary cases have been reported from countries where the incidence of tuberculosis is relatively frequent (6).

We report here a case with secondary tonsillar tuberculosis confused with a carcinoma and want to draw attention to this very rare disease.

CASE REPORT

A 29 year-old male presented with two months history of hoarseness, sore throat, difficulty in swallowing and weight loss, fever and sweating at night. He had no cough, chills and hemopthysis. Oral examination revealed bilateral enlargement of the palatine tonsils, with a few white to yellowish plaques on the surface (Resim 1a). Videolaryngoscopic examination showed the presence of edema and enlargement of the bilateral aryepiglottic folds, arytenoid cartilages and pyriform fossas. Bilateral vocal cords were mobile and normal in appearance (Resim 1b). Examination of the neck did not show cervical lymphadenopathy. Laboratory tests revealed a total leucocyte count of 5200/mm3, with 80,9 % polymorphs, 7,9 % lymphocytes. The ESR was 60 mm/hr.

The result of bacteriological study for acid fast bacilli was positive. The patient showed tuberculin sensitivity to the purified protein derivative (PPD) (13 mm) . Chest X-ray showed micronodular infiltrates (Resim.2a). Human immunodeficiency virus (HIV) searched by ELISA was negative. Palatine tonsil and anterior plica biopsies were performed.

Gross inspection of the biopsy materials, the biggest measuring 5x3x2 mm, showed gray-white tissues. Microscopic examination of the formalin fixed specimens was done by hematoxylin and eosin (H-E) stained slides. The tissues showed partly an ulcerated surface and were partly covered by an atrophic epithelium. The areas underlying the mucosal and ulcerated surface were infiltrated by compact aggregates of inflammatory cells and occasional multinucleated cells . The basic microscopic lesion was granulomatous inflammation that was developed by macrophages with abundant eosinophilic cytoplasm, giving them a superficial resemblance to epithelial cells (epitheloid histiocytes) and occasional Langhans' giant cells having nuclei distributed around the periphery of the large eosinophilic cytoplasm. Some of these foci of epitheloid histiocytes were loosely rimmed by fibroblasts and lymphocytes containing central granular debris, created early caseating tubercles (Fig. 2b). There was no wide central caseous necrosis. Histochemical evaluation of the granulomatous lesions was done by Ziehl-Neelsen stain on paraffin-embedded tissue sections. The presence of some acid-fast bacilli (Mycobacterium tuberculosis) was observed by the meticulous screening of the slides.

After the histopathological diagnosis, medical treatmentwas started to patient. Isoniazid 300 mg, rifampin 600 mg, ethambutol 1500 mg, morphazi-

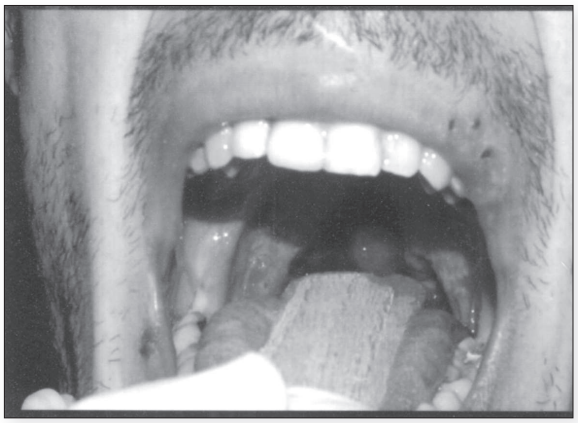

Figure 1a. Oral examination revealed bilateral enlargement of the palatine tonsils , with a few write to yellowish plaques on the surface

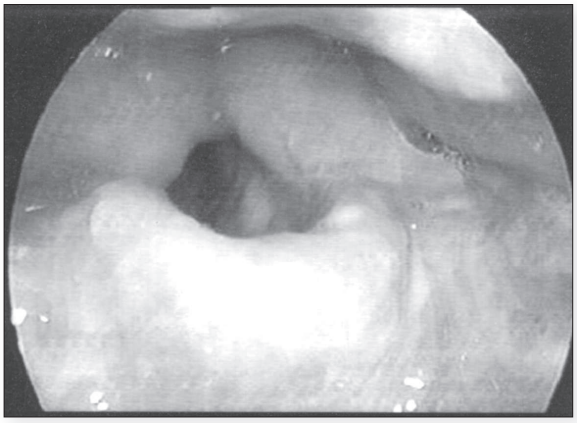

Figure 1b. Videolaryngoscopic examination showed the presence of edema and enlargement of the bilateral aryepiglottic folds, arytenoid cartilages and pyriform fossas.

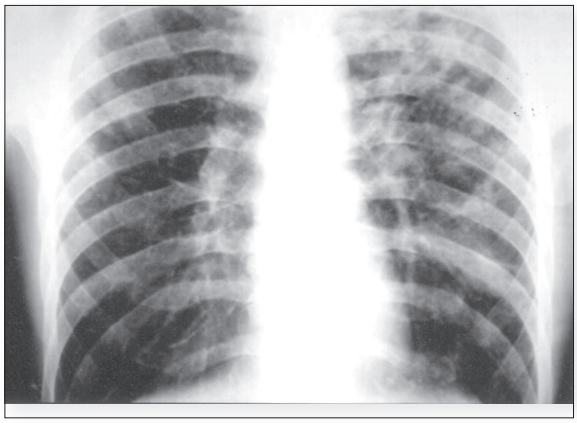

Figure 2a. Chest X-ray showed micronodular infiltrates

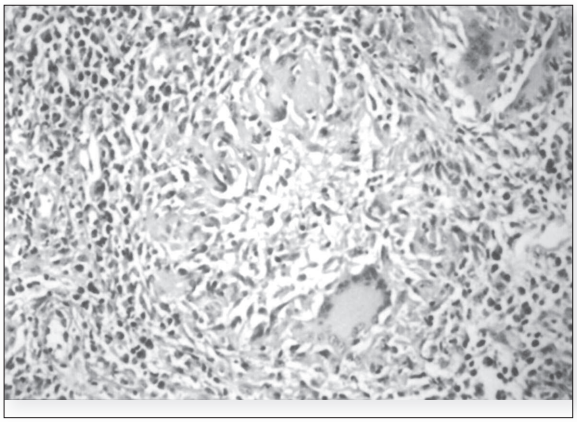

Figure 2a. A closer view of a composed of epiteloidhistiocytes and a Langhans' giant cell. H-E,X50

namide 2,5 g daily were given and 1 week after the begining of treatment owing to patient own reguest , he has been discharged and continued his treatment at home.

DISCUSSION

Even when tuberculosis was a common problem, involvement of the oral cavity was relatively rare. Tonsillar tuberculosis lesions are even rarer, and simultaneous involvement with oral lesions are not infrequent (1,2,8). Lesions of oral tuberculosis can be ulcer, nodule, plague forms (4). The most common form is the ulcerative form and ulcerative form was seen an our patient. Although saliva is thought to have an inhibitory effect on tubercle bacilli , tuberculosis of a tonsil can result from infection caused by contact with a material containing tubercle bacilli, such as unpasteurized milk (3,5,11). Small tears in the mucosa may be favorable sites for the localization of organisms. Differential diagnosis of tonsil tuberculosis includes inflammatory and neoplastic pathologies of the tonsil. With a marked decrease in general incidence of tuberculosis, oral cavity involvement has diminished to a point at which it is now very rare, and clinicians are not sensitized to the disease as part of a differential diagnosis, so that, there are patients in whom the diagnosis is missed entirely(6).Altough oral tuberculosis can be seen in all ages and in both sexs (4). It is usually seen in midage and olderly male patient but in our case young male patient was effected. Low socioeconomic status, history of smoking, and having contact with a case known to have active tuberculosis should alert the dentists and otolaryngologist, especially in countries where tuberculosis is seen frequently, to consider the confirmatory diagnostic studies (9,10). Diagnosis of tonsillar tuberculosis is based on PPD test, chest radiography and histopathological findings, as well as acid-fast stains and cultures for the organisms (3). In our case PPD test result was 13 mm. , micronoduler infiltrates were seen on chest X-ray, granulamatous inflammation was seen in microscopic examination and asidfast stains were positive . The occurrence of mycobacterial infection as a part of AIDS , is another concern in the tuberculosis lesions.

As a result , we have to remember the possibility of oral tuberculosis in patients with chronic painful oral ulcerative lesion.

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