Objective:
We present a case of transient cranial nerve deficits secondary to benign lymphadenopathy of the parapharyngeal space.

Method:
The authors conducted a literature review and case report.

Results:
A 24 year old male presented to the otolaryngology clinic with a four week history of swelling behind the angle of the mandible, dysphagia, and hoarseness. Initial physical exam revealed decreased gag reflex, poor right sided palate elevation, and right vocal cord paresis by laryngoscopy. An MRI demonstrated a 2.5 cm x 3.0 cm x 4.4 cm multiloculated, cystic mass within the right parapharyngeal space. A CT-guided biopsy was non-diagnostic. The patient was managed conservatively. An MRI three months later revealed complete resolution of the parapharyngeal mass and the patient was asymptomatic.

Conclusions:
Rarely acute cranial nerve deficits caused by lymphadenopathy. Given that most parapharyngeal neoplasms are benign, a period of watchful waiting may be prudent in the management of these masses.

OBJECTIVE
We present a case of transient cranial nerve deficits secondary to benign lymphadenopathy of the parapharyngeal space.

DISCUSSION
Neoplasms of the parapharyngeal space account for only 0.5%-1.5% of head and neck neoplasms. In a recent review of 114 parapharyngeal neoplasms, 84% were benign and 16% were malignant. Salivary gland tumors accounted for two thirds of malignant cases.

The lymph nodes in the parapharyngeal space receive drainage from the sinonasal tract and the oropharynx. Lymphadenopathy is a common condition following infections of these areas. There are many examples in the literature of lymph node involvement in the parapharyngeal space conditions including nasopharyngeal cancer, papillary thyroid cancer, lymphoma, and Castleman’s disease. Common complaints associated with a mass in the parapharyngeal space include dysphagia, neck swelling, and dysarthria. However, a search of the online archives of the National Library of Medicine could not produce a reported case of lymphadenitis secondary to acute tonsillitis producing transient vocal cord dysfunction.

The parapharyngeal space is a difficult location to access for surgical resection of masses. Its proximity to vital structures increases the risk of significant morbidity following surgery. The subject of this case report presented with a suspicious mass which turned out to be an inflamed lymphoid tissue secondary to a acute tonsillitis. The resultant cranial nerve involvement was benign and transient. Given that most parapharyngeal neoplasms are benign, a period of watchful waiting may be prudent in the management of these masses.

REFERENCES