Rare Case of Tonsillar Lymphangiomatous Polyp with Supraglottic Extension.

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ABSTRACT

A 67-year-old male presented with airway compromise when supine. Nasolaryngoscopy revealed a bulky polypoid mass that extended from the tonsil to the ipsilateral aryepiglottic fold, pharyngeal wall, epiglottis, and arytenoid preventing visualization of the glottis. The patient was taken to the operating room for direct laryngoscopy and biopsy/debulking of the mass. Pathology revealed a lymphangiomatous polyp (LAP). LAP is almost always limited to the palatine tonsils without involvement of other subsites. This patient had significant extension into the pharyngeal wall and supraglottis resulting in airway compromise and representing an exceptional case not previously described.

REFERENCES


INTRODUCTION

Benign lymphatic lesions of the tonsil include lymphangiomas, cavernous lymphangiomas, hamartomas, and lymphangiomatous polyps. Lymphangiomatous polyps (LAP) are exceedingly rare benign masses that typically originate in the palatine tonsils¹. LAP of the tonsil are documented to be rare²-⁵. The authors present the first reported case of a tonsillar LAP with extension to the supraglottis.

CASE PRESENTATION

A 67-year-old male presented with right aural fullness, intermittent otalgia, dysphagia and new onset nocturnal apneic episodes and airway compromise when supine. He had no history of smoking, alcohol, or chemical exposure. Flexible nasolaryngoscopy revealed a bulky exophytic, polypoid mass that extended from the right tonsil to the ipsilateral aryepiglottic fold, pharyngeal wall, lingual surface of the epiglottis, and arytenoid mucosa preventing visualization of the true vocal cords.

The patient was taken to the operating room for direct laryngoscopy and biopsy/debulking of the mass. Conscious fiberoptic nasotracheal intubation was performed with difficulty due to the supraglottic bulk of the lesion. Excision of the lesion was performed with the use of suspended operative laryngoscopes and a Crowe-Davis mouth gag with extended tongue blades designed for transoral robotic surgery.

HISTOLOGY

Histologic examination revealed squamous epithelium-covered fronds with focal squamous hyperplasia and rare dyskeratotic cells. Variably-sized, dilated lymphatic channels and blood vessels were present within the submucosa of the fronds (Fig 3A). The stroma surrounding the lymphatic channels was composed of fibrous connective tissue with focal adipose tissue. At the base of the mass and extending to the tips of some of the fronds was tonsillar tissue with reactive changes (Fig 3B). A portion of the mass was submitted for flow cytometric studies which demonstrated no evidence of B-cell monoclonality or aberrant T-cell expression.

CONCLUSION

Lymphangiomas are common in the head and neck, however LAPs are rare lesions that develop in the upper aerodigestive tract of adult and pediatric patients²-⁵. Patients can be asymptomatic or present with a range of symptoms from dysphagia, pharyngodynia, and globus to, in this case, apneic events and airway obstruction. These previously were believed to be limited to the palatine tonsils- the supraglottic extension of the lesion in this patient is unique among previously reported cases. LAP should not be excluded from the differential diagnosis if the supraglottis is involved by a benign-appearing mass.