A Non-Carcinomatous Nasopharyngeal Mass with Cervical Lymphadenopathy

Aishah Harizah Abdullah Alwi, Mimi Ezreena Esa, Khairul Azhar M. Rajet, Khairuddin Abdullah, Siti Zarqah Omar, Irfan Mohamad

1Department of Otorhinolaryngology, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu, Malaysia
2Department of Pathology, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu, Malaysia
3Department of Otorhinolaryngology-Head & Neck Surgery, School of Medical Sciences, Universiti Sains Malaysia Health Campus, Kota Bharu, Kelantan, Malaysia.

INTRODUCTION

Tuberculosis (TB) is caused by Mycobacterium tuberculosis that often affects the lungs, as TB is an airborne disease. TB occurs without any exceptions in terms of age, site, and geographical region. According to World Health Organization, in 2015, Asia had the largest number of new TB cases at 61% followed by Africa with 26%. It is uncommon for extra-pulmonary TB to involve the head and neck regions and this region accounts for about 20% of all reported cases [1].

CASE REPORT

A 14-year-old Malay woman presented with left neck swelling for the 2-week duration, which was initially painful. The patient was also noted to have a sore throat. She also had constitutional symptoms of loss of weight, loss of appetite and night sweats. Otherwise, she had no nasal or ear symptoms, fever or prolonged cough. The patient had strong contact with pulmonary TB among her relatives, including her grandmother and her schoolmate. The patient had previously visited private practitioners and had completed 2 courses of oral antibiotics. She was also admitted once for completion of intravenous cefuroxime. Her ESR was 44 mm/hour and Mantoux test was reported as chronic granulomatous inflammation suggestive of TB. Ziehl-Nielsen stain for acid-fast bacilli was positive. The patient was started on anti-tubercular drugs and 2-week follow up later showed significant mass regression.

DISCUSSION

Upper respiratory tract TB is found in 1.8% of all tuberculous cases and nasopharyngeal is the least common [1]. Its low incidence is attributed to
The diagnosis is based on a high index of suspicion. Nasopharyngeal TB can manifest neither in a healthy individual with no history of TB contact nor in an immunocompromised individual. However, to determine the primary site for TB can be challenging as patients may present without any pulmonary symptoms or with non-specific complaints such as weight loss, low-grade fever, malaise and night sweats. Nonetheless, nasopharyngeal symptoms would be a postnasal drip, epistaxis, nasal blocked, rhinorrhea and chronic cough.

TB of the nasopharynx is often underdiagnosed due to its atypical and less obvious symptoms and signs. There have been reports of diplopia and headache [3, 4]. Despite this, the most common presentation in nasopharyngeal TB is cervical lymph node enlargement. The pattern of lymph node involvement shows that multiple lymph node groups are affected in most cases and the commonest lymph node group involved is of the posterior triangle. The next common group of lymph nodes involved was the anterior triangle, middle third group. Axillary lymph nodes were involved in 12 cases [5].

However, the highlight of this case is the nasoendoscopic examination which showed fullness over right FOR with wide differential diagnoses namely nasopharyngeal carcinoma, lymphoma or granulomatous disease. To establish the diagnosis, biopsy and histopathology studies play an important role. A typical pathological report for diagnosing TB filtering action of vibrissae and bactericidal actions of nasal secretions [2].

Granulomatous formation composed of epithelioid histiocytes and Langhan-type multinucleated giant cells with rim of lymphocytes.
is caseating granulomatous inflammation with multinucleated giant cells of Langhans’ type and foreign body giant cells, with or without necrosis. A positive Ziehl-Nielsen staining for AFB or bacterial culture can also be demonstrated [6]. In our case, biopsy and histopathologic findings demonstrated granulomatous formation with positive Ziehl-Nielsen stain hence confirming the diagnosis of nasopharyngeal TB.

In conclusion, TB infection must be considered as one of the differential diagnoses for cervical lymphadenopathy. The necessary workup for TB should be performed to support the diagnosis. Biopsy and histopathology studies must be done in all cases in order to get the accurate diagnosis. Nasopharyngeal TB has a good prognosis with timely treatment, with a complete resolution of the disease can be expected.

REFERENCES