

Rare Tonsillar Papillomatosis Location

Mohamed Amine Mennouni*

CHU Ibn Rochd, Morocco

*Corresponding Author: Mohamed Amine Mennouni, CHU Ibn Rochd, Morocco.

Received: January 03, 2019; Published: February 11, 2020

Abstract

Oral papillomas are benign proliferative lesions whose pathophysiology remains open to several discussions. These lesions are painless slow-growing masses. As a tonsillar lesion, it raises concerns because of its clinical appearance and its evolving risks. These lesions usually occur between 30 and 50 years old, and sometimes before 10 years old. Squamous papilloma oropharynx accounts for 8% of all oral tumors. The tongue and the soft palate are the usual predilection locations for the lesion. It can occur on any other surface of the oral cavity, such as the uvula and vermillion of the lip, the tonsillitis localization is even rarer.

Keywords: Cauliflower Lesion; HPV Virus; Oropharyngeal Lesion; Amygdala; Squamous Papilloma

Introduction

Papilloma is a benign epithelial tumor, particularly recurrent and is considered as the most frequent benign tumors of the respiratory tract [1].

Tonsilleal localization is very rare compared to the upper aero-digestive tract [2]. Oropharyngeal papilloma is typically present in adults. Its physiopathology remains unknown, two etiologies have been proposed and remain synergistic: local irritation and Human Papillomavirus (HPV) infection [3].

Our main objectives are to discuss this potentially life-threatening clinical form and to highlight the difficulties of management.

Observation

We report the case of a 15-year-old child with no particular pathological history admitted to the ENT emergencies for moderate dyspnea. The onset of symptomatology was 2 years ago with the appearance of local irritation of the throat without other associated signs evolving in an apyretic context the symptomatology was complicated by progressive dysphagia predominant to solids and moderate dyspnea Oropharyngeal examination showed an oropharynx with tonsillar hypertrophy completely obstructing the oropharynx, the cauliflower-shaped lesion (Figure 1).

Cervical CT showed an expansive budding process of the two tonsils protruding into the pharyngolaryngeal lumen measuring 21 mm (Figure 2).

The endoscopic exploration under general anesthesia objectified a tumor process occupying the two tonsils obstructing the oropharyngeal light, the larynx is free.



Figure 1: Clinical appearance of the tumor.

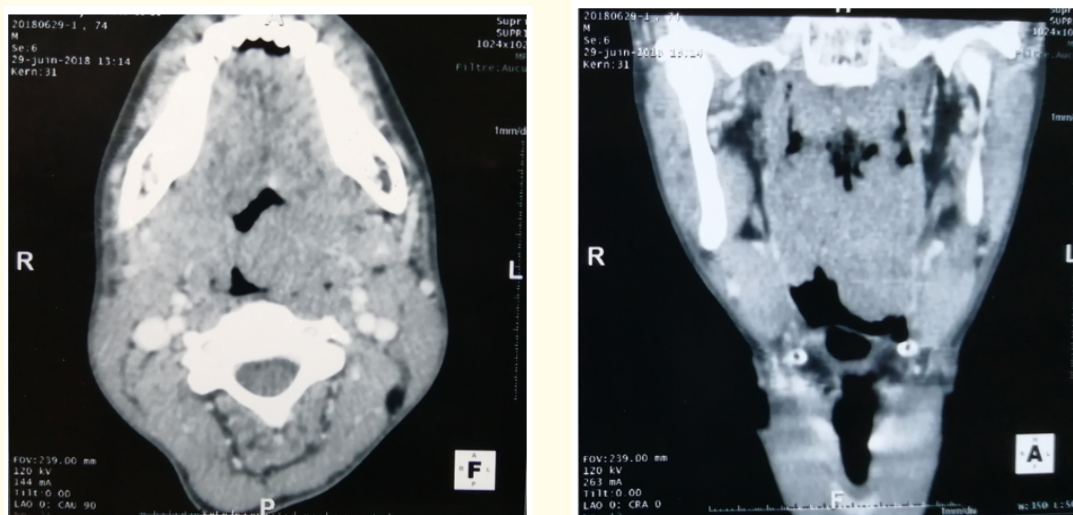


Figure 2: Cervical CT in axial section: Tissue process of the amygdala.

A mass biopsy was performed and the histological study showed a tonsillar papilloma with no signs of malignancy (Figure 3).

Bilateral tonsillectomy under general anesthesia was performed. Both anterior and posterior abutments were respected. During surgery, even minimal trauma to the oropharyngeal mucosa was avoided due to recurrent lesions (Figure 3).

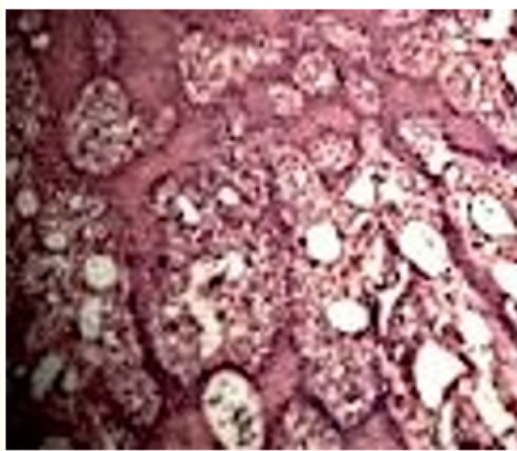


Figure 3: Histological section characteristic of a papilloma.

The postoperative suites were simple, without incident. The clinical evaluation at 2 years did not find any recurrence.



Figure 4: Postoperative aspect.

Discussion

Squamous papillomatosis of the oropharynx is a benign epithelial tumor, diagnosed most often in adults with a predominance in the male sex [3]. This lesion usually occurs between the ages of 30 and 50 and can sometimes occur before the age of 10 [4].

The soft palate and the uvula are the most common oropharyngeal sites [4], rarely affecting the tonsil alone. The physiopathology of oropharyngeal papilloma is unknown to date: two main hypotheses have been mentioned the most: The first hypothesis is hyper-

regeneration of the mucosa in response to chronic mechanical or chemical irritation or injury. The second hypothesis is a viral mechanism linked to HPV infection [3]. HPV is a DNA virus with a tropism for squamous epithelia; It groups together a hundred subtypes divided into two classes according to their tropism: HPV with cutaneous tropism and HPV with mucous tropism [4]. In mucosal tropic HPV, one distinguishes, according to their oncogenic power, the "high risk" genotypes, possessing carcinogenesis properties (mainly HPV-16 and HPV-18) and genotypes with "low risk" (mainly HPV-6 and HPV-11) [5,6].

The symptomatology of squamous papilloma depends on its location and size; often asymptomatic when it develops in the palate of the bones, on the other hand papilloma's pharyngolaryngeal localization, may be life-threatening causing an obstruction of the respiratory tract especially in children [1]. Its endoscopic appearance is characteristic but not pathognomonic. It has been described as a sessile polypoid formation most often or pedunculated, well defined with respect to the adjacent tissue [7]. It is usually small (5 mm), but giant forms (up to 5 cm) have been reported in the literature [4,8]. It is usually of a whitish or pinkish color and has a soft, smooth or slightly rough texture [8]. Imaging is not essential for the diagnosis of oropharyngeal papilloma; requested in case of diagnostic doubt or to assess the lesion's characteristics and its extent [9]. It is essentially based on computed tomography (CT). The tumor is often homogeneous, isodense and heterogeneously enhances after injection. Magnetic resonance imaging (MRI) is not required for first intention. The tumor appears in hypersignal T2, hyposignal T1 compared to the adjacent muscles. Histologically, papilloma develops from the squamous epithelium of the oropharyngeal mucosa. The histological features found are: hyper- papillomatosis, hyperacanthosis and hyperkeratosis [6]. The clinical differential diagnosis of papilloma includes fibroma, common warts, fibrous hyperplasia, condyloma acuminata, pyogenic granuloma and verrucous carcinoma [9].

Oropharyngeal papilloma is the least proliferating compared to other papillomas found in other sites of the cervicofacial region such as the larynx [4]. Sometimes, the development of precancerous, leukoplastic lesions and even squamous cell carcinomas develop in squamous papilloma. Its natural history remains poorly known, including its evolutionary potential and the risk of malignancy. A few cases of squamous cell carcinoma of the esophagus in the context of oesophageal papillomatosis have been reported [10]. Treatment of these lesions relies mainly on surgical excision externally or endoscopically with CO₂ laser; the choice depends mainly on the size and location [7,10]. For oral locations, removal is done by the endo-oral route regardless of size. For pharyngeal locations, the choice depends on the tumor size, the good endoscopic exposure and the risk of haemorrhage.

Despite the surgical treatment, the recurrence of papillomas is not negligible, hence the importance of good long-term follow-up [11].

Currently, no consensus is available for the management and endoscopic monitoring of papillomas [11].

HPV vaccine 6, 11, 16 and 18 has recently been introduced for the prevention of cervical cancer and genital warts; it is possible that this vaccine prevents the occurrence of HPV lesions in the head and neck, both squamous papilloma, laryngeal papillomatosis and some cases of oropharyngeal carcinoma [6,10].

Conclusion

Papilloma of the tonsil is a rare benign tumor of the oropharynx. Its natural history remains poorly known, including its evolutionary potential and the risk of malignancy. Currently, no consensus regarding endoscopic management and monitoring is validated.

Declaration of Links of Interest

The authors declare that they have no link of interest.

Bibliography

1. Larson DA and Derkay CS. "Epidemiology of recurrent respiratory papillomatosis". *APMIS* 118.6-7 (2010): 450-454.
2. Babaji P, *et al.* "Squamous papilloma of the hard palate". *Indian Journal of Dentistry* 5.4 (2014): 211-213.

3. Bohn OL, *et al.* "Identification of human papillomavirus in esophageal squamous papillomas". *World Journal of Gastroenterology* 14 (2008): 7107-7111.
4. Devi RS, *et al.* "Unusual Length of Pedicle: Pedunculated Squamous Papilloma of Uvula Causing Unusual Dysphagia of Long Duration in a Child of 10 Years". *Case Report of Dentistry* (2014): 313506.
5. Takeshita K, *et al.* "Clinicopathological characteristics of esophageal squamous papillomas in Japanese patients with comparison of findings from Western countries". *Acta Histochemica et Cytochemica* 39 (2006): 23-30.
6. Villiers EM, *et al.* "Classification of papillomaviruses". *Virology* 324.1 (2004): 17-27.
7. Bouvard V, *et al.* "WHO International Agency for Research on Cancer Monograph Working Group. A review of human carcinogens- Part B: biological agents". *Lancet Oncology* 10 (2009): 321-322.
8. Zribi S, *et al.* "Laser en laryngology". *J TUN ORL* 28 (2012): 37-41.
9. Park SH, *et al.* "A case of esophageal squamous papillomatosis". *Korean Journal of Internal Medicine* 27 (2012): 243.
10. Donnellan F, *et al.* "Esophageal papillomatosis complicated by squamous cell carcinoma". *Endoscopy* 44 (2012): E110-E111.
11. Lian TS, *et al.* "Benign tumors and tumor like lesions of the oral cavity". *Cumming's Otolaryngology, Head and Neck Surg.* 5th edition. Philadelphia: Mosby, Elsevier (2010): 1287-1292.

Volume 3 Issue 3 March 2020

©All rights reserved by Mohamed Amine Mennouni.