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Unilateral fibroepithelial polyp of palatine tonsil- A rare case

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Abstract
Fibro-epithelial polyp are one of the common muco-cutaneous lesions but rarely seen in the oral cavity and from the palatine tonsil are extremely rare.[1] These benign polypoid lesions are of mesodermal origin. Symptoms are mostly nonspecific or mild. A large pedunculated polyp may lead to an airway emergency if dislodged in the laryngeal inlet.
An unusual presentation of pigmented pedunculated fibroepithelial polyp of palatine tonsil in a 14 yr old paediatric female patient is been discussed with the clinical and histopathological features of the lesion.

Keywords: fibroepithelial polyp; palatine tonsil; pedunculated polyp; pigmented polyp; tonsillar mass; tonsillar neoplasm; bacterial colonies

Introduction

A fibroepithelial polyp (FEP) is one of the most common benign cutaneous lesions of mesodermal origin [1]. Fibroepithelial polyps have a male predilection and estimated prevalence of 1.2%. The aetiology of fibroepithelial polyp is chronic inflammation. They can be of congenital, infectious or traumatic origin.
Commonly occurring sites for fibro-epithelial polyps are the genitourinary tract and skin. They are seen in the external auditory canal, nasal cavity, pharynx, epiglottis and tracheobronchial tree in head-and-neck region, but rarely in palatine tonsil [2, 3, 4, 5]. They may be sessile or pedunculated. In palatine tonsils, pedunculated polyps are rare [1].
Here, we discuss a rare case of pigmented pedunculated fibroepithelial polyp of right tonsil in a paediatric patient.

Case Presentation

14-year-old female came to our out-patient department with complaints of painful swallowing and foreign body sensation in throat for 1 month. Patient was apparently alright 1 month back when she started complaining of pain while swallowing, which was insidious in onset, gradually progressive in nature, pain was moderate in intensity and pricking type, it was relieved on taking medication, aggravated on taking spicy food. History of recurrent upper respiratory tract infections was present along with fever. There was no complaint of nausea, vomiting, regurgitation, difficulty breathing or cough.
On examination of oral cavity, patient had grade 1 palatine tonsil hypertrophy, non-inflamed with no cheesy material filled in crypts. A 2cm x 1cm brown black pedunculated, polypoidal mass was seen attached to the upper pole of right palatine tonsil (Figure 1). On palpation it was soft to firm in consistency, non-tender, with no oozing out of purulent material on pressure. It was mobile all around but fixed to underlying tonsil with a fibrous stalk. Indirect laryngoscopy was normal. All the routine pre-operative investigations were normal.
Patient was taken up for tonsillectomy under general anesthesia, using dissection and snare method. The polypoidal mass was also excised (Figure 2). The mass was sent for histopathological examination.
Microscopically, section showed a polyp covered with stratified squamous epithelium with focal ulceration. The stroma was composed of fibro-collagenous tissue with presence of thin walled blood vessels and minimal chronic inflammatory cell infiltrate (Figure 3).
The patient was stable postoperatively and discharged after 48 hrs. Patient is now asymptomatic and on regular follow up.

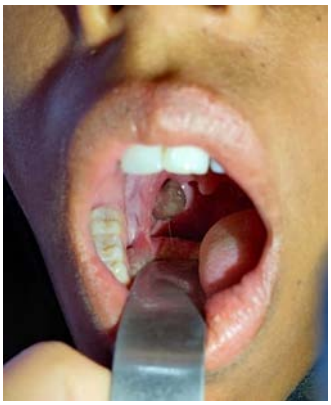

Fig 1: Preoperative clinical picture of oropharynx, showing mass attached to the right palatine tonsil

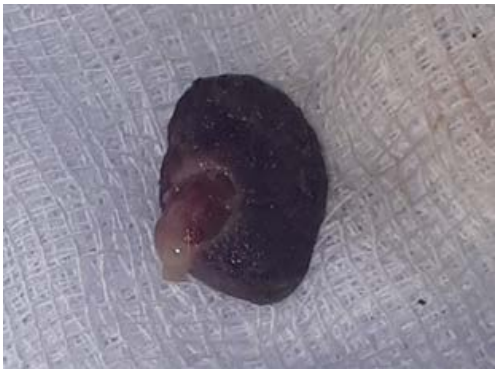

Fig 2: Picture showing gross polypoidal mass, post excision

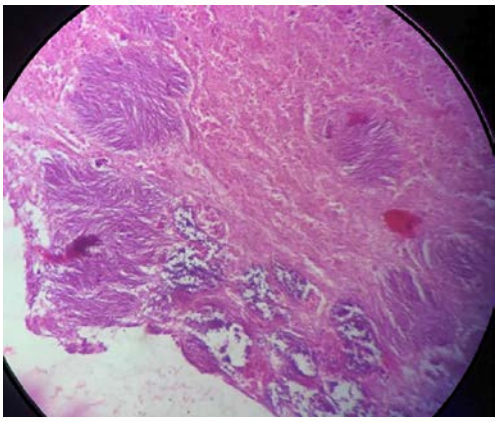

Fig 3: Microscopic image of histopathology slide, showing fibroepithelial polyp (H&E stain, 40X).

Discussion

FEP have been synonymously used with others terms such as acrochordons (pl. acrochorda), fibrovascular polyps, skin tags, soft wart, soft papilloma, soft fibroma or lipofibroma (if large in size). FEP are the small uncommon benign lesions having mesodermal origin. They are commonly unilateral [5, 6, 7]. Their etiology widely remains unclear [8]. Typically, FEP represents reactive hyperplasia of fibrous connective tissue which appear after mucosal trauma. The first theory explaining the cause is focal loss of elastic tissue [6]. According to other theory it is a mixture of different tissue elements which has close resemblance with hamartoma of the lamina propria enlarging gradually [7].

Skin of the neck, trunk and face are the common sites for FEP. Genitourinary system and bronchus may occasionally show such pathology. FEP in the head neck region is rare, which includes oropharynx, epiglottis, hypopharynx, nasal cavity and external auditory canal but rarely in palatine tonsil [2-5].

According to Bouquot and Gunlach study, FEP have a prevalence of approx 12 per 1000 population, with a male preponderance [9].

These are the benign neoplasms which have extremely less malignant potential. Only 5 among the 1335 specimens of fibroepithelial polyps were malignant in another study [8].

Clinically FEPs may be asymptomatic, or may present as foreign body sensation, painful swallowing, snoring, difficulty in breathing, or even sudden airway compromise due to dislodgement of polyp. Iron deficiency anaemia can be a consequence of chronic bleeding from the polyp. Cukic reported a case which had choking, respiratory distress and coughing of abnormal tissue mass due to a large polyp originating in the oropharynx [10].

Management involves securing the airway first. Surgical resection is the treatment of choice. Complete excision of the polyp along with the stalk avoids recurrence. Depending upon the involvement of the surrounding tonsillar tissue or the presence of recurrent episodes of tonsillitis, the surgical excision of the mass can be done along with tonsillectomy, as was done in our case [7].

The differential diagnosis for fibroepithelial polyp in oral cavity involving tonsil include fibroma, lipoma, mucocele, lymphoid polyp, giant cell fibroma, peripheral giant cell granulomas, lymphangiomatous polyps, lymphangiectatic fibro lipomatous polyp, lymphangioma, fibrovascular polyp, neurofibroma, schwannoma, or proteus syndrome [7].

All the above-mentioned lesions are difficult to diagnose just based on clinical findings, and to differentiate between them histopathological examination is required.

Conclusion

Fibroepithelial polyp is a rare benign lesion which may have potential of malignancy. Surgical excision is the treatment of choice. Histopathology is necessary to confirm the diagnosis.

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