CASE REPORT

Oropharyngeal Tuberculosis: case report

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ABSTRACT

Tuberculosis involves most organs and tissues. However, oral cavity oropharynx is a rare occurrence. A 20 year old male student presented with of difficulty in swallowing of 4 weeks duration. Clinical presentation and investigations performed are discussed in detail. It is can be suggested that patients who present with distinct globular yellowish white oropharyngeal pustular lesion that fail to respond to antibiotic therapy may include tuberculous pharyngitis in the differential diagnosis, especially in countries where tuberculosis and immunodeficiency state are rampnat.

INTRODUCTION

Tuberculosis involvement of the oral cavity is rare. Mycobacterial pharyngio-tonsilitis can occur as an isolated occurrence or as a result of expectoration of infected sputum from pulmonary involvement especially in-patients in developing countries (1). Tuberculous pharyngitis is characterized by minute gray or yellow tubercle on the fauces or palate. These rapidly breakdown into shallow ulcers which spread widely in the mouth and pharynx to cause pain during swallowing. excessive salivation. a throaty voice and rapid emaciation (1). Where one is confronted with a presumed pharyngeal infectious process that is unresponsive to empiric antibiotic therapy. smears. culture and biopsy sampling of affected tissues are necessary to validate tuberculosis involvement (2).

The aim of the report is to try to put the rare tuberculous pharyngitis be considered in as a differential diagnosis in patients who failed the usual antibiotic therapy especially in developing countries like Ethiopia.

CASE REPORT

A 20 year-old student presented to Jimma referral hospital with an insidious onset of difficulty in swallowing. low-grade intermittent fever and anorexia of 1 week duration. The patient was examined and given antibiotics for a presumed pyogenic pharyngeo-tonsillitis. He took the drugs for 3 weeks but not relieved from his illness. Two months after the initial

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symptoms. the patient developed right side pleuritic chest pain and cough productive of whitish sputum. Then he underwent physical examination and investigations. Vital signs were within normal limits. The pertinent findings were solitary. discrete. yellowish-white circular oropharygial pustular lesion 1.5 cm in diameter located on the left side of the midline. Neibouring mucosa was normal. There were no palpable lymph nodes in the head and neck regions but the tonsils were moderately congested bilaterally. In the lungs. there was dullness and decreased air entry on the right basal areas.

Investigations revealed that ESR was 63mm/hr. WBC=7500/mm^3. N=61%; L=34%; E=5%. Chest x-ray showed right middle third alveolar infiltrate suggestive of pneumonia. Fine needle aspiration (FNA) biopsy of the oropharygeal lesion aspirated pus and was drained. Covering epithelium flapped out forming superficial pharyngeal ulcer. The FNA smear showed necrotic background consisting of lymphocytes. macrophages and neutrophils. The cytologic reading was consistent with an abscess. Bacteriological examination of sputum for acid bacilli (AFB) was performed twice and was positive in both occasions serology test for HIV was not done.

Considering the overall features of clinical. bacteriologic. radiographic and cytologic features. tuberculosis was diagnosed and rifampicin. ethambutol. Isoniazide. pyrazinamide and vitamin B6 were prescribed for the patient. After 1 month of anti-tuberculosis therapy. the patient showed improvement with decrease in the intensity of pain during swallowing. By the end of the second month of therapy the pharyngeal lesion healed completely.

DISCUSSION

Oropharyngeal tuberculosis is a rare presentation of the disease ever in the presence of extensive pulmonary tuberculosis (6). Tuberculous pharyngitis is characterized by minute gray or yellow tubercle on the fauces or palate. These rapidly breakdown into shallow ulcer which presents with undermined edges. minimal indurations and pseudo-membranious base underlying congested blood vessels and the ulcers spread widely in the mouth and pharynx to cause pain in swallowing. excessive salivation and rapid emaciation (2).

Tuberculosis develops in the submucosa especially of Peyer's patches and spread along the lymphatic vessels and recognized as sites of mucosal involvement in patients with pulmonary tuberculosis (3). Primary tuberculous lesions of the oral mucosa are exceedingly rare. and most lessons are secondary to pulmonary disease. The bacilli are carried in the sputum and enter the mucosa through a small break where they produce irregular painful lesions.

The diagnosis of oral cavity tuberculosis requires the identification of the causative agent. It may be isolated on sputum smears or tissue biopsy specimens (3-5). Once anti-tuberculous treatment is instituted. the pharyngeal lesion. which is secondary to pulmonary tuberculosis in this report. improves within 2-3 weeks and is completely healed by the third month.

REFERENCES

1. Baily-BJF. Head and neck surgery. Otolaryngeology. Philadelphia. J.B Lippincott Co: 1993; P 559
2. Turbines-S. Guinta-J. Maloney-PL. Orificial tuberculosis. J. Oral Surgery. 1975; 33: 443-53.
3. Rubin-E. Pathology. Philadelphia. J.B Lippincott Co. 1994; 2nd Ed. P 1242
4. Torres-HO. Ehrlich-A. Modern Dental assisting. W.B. Saunders Co. 1985; P 165.
5. Birrell-JF. Logan Turner's disease of the nose. throat and ear. Bristol. John Wright 1977 pp. 110.
6. Carrolin-Bain RJ. Tseung-MH. Edwards-RH. Tuberculous retropharyngeal abscess producing respiratory obstruction. Thorax. 1989; 44:599-600.