Adenotonsillar Granuloma: Histopathological Correlation

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Introduction

Granulomatous inflammation of the tonsils and adenoids is rare, but when present, a systemic or local disorder has to be ruled out. Cases of tonsillar enlargement due to sarcoidosis [1–4], Crohn’s disease [1], tuberculosis [5, 6], fungal infection and histoplasmosis [7] have been reported. In most of the few reports of granulomatous disease, an obvious local or systemic disorder was the cause of the granulomatous reaction in the tonsil and adenoids.

Materials and Methods

This study is a retrospective clinico-pathological review; 21,410 specimens of tonsil and adenoid tissue were subjected to histological examination during the period from 1995 to 2003. Twenty-three cases of tonsillar and adenoid granuloma (12 males and 11 females) were identified. Haemotoxylin and eosin stains were reviewed and clinical features noted. Results: Of 23 cases, 11 were adenotonsillectomies, 10 tonsillectomies, 1 adenoidectomy and 1 excision biopsy of the right tonsil. Histologically, the slides reviewed showed 4 types of granulomatous inflammation that can affect the adenotonsillar tissues. The most common type was non-caseating epithelioid granulomas. Clinically, 22 cases presented with symptoms of chronic tonsillitis, nasal obstruction and obstructive sleep apnoea. None had any systemic granulomatous disorders. Only 1 case had tuberculosis. Conclusion: In all the cases but one there was no obvious systemic aetiology for the granulomatous changes in the adenotonsillar tissues. Hence, the cost effectiveness of clinico-pathological examination of the resected adenoid and tonsil is still questionable.
Results

Between 1995 and 2003, out of a total of 21,410 specimens, 23 cases of adenotonsillar granulomas were detected affecting 12 males (aged 3–65 years) and 11 females (3–33 years). Males were older, averaging 18 years compared to females, averaging 12.5 years, with no specific explanation for this difference. Most patients presented pre-operatively with a history of chronic or repeated attacks of tonsillitis (n = 12), followed by nasal obstruction (n = 9) with obstructive sleep apnoea in 7 cases; 2 patients presented with unilateral palatine tonsil hypertrophy. The pre-operative diagnostic impression of the treating physician was chronic tonsillitis in 13 cases, obstructive sleep apnoea in 7 patients, and tuberculosis or malignancy in 1 patient. Fourteen cases of the granulomatous lesions involved a palatine tonsil alone (6 bilateral, 8 unilateral); 8 cases involved adenoids and palatine tonsils, and 1 case involved an adenoid only.

Routine laboratory investigations including complete blood count were performed pre-operatively. Of interest, lymphocytosis of more than 50% of the differential white cell count was noticed in 19 patients (82.6%). Chest X-rays were performed in all patients, with no abnormality reported. Intra-operatively, 13 patients (56.5%) had extensive fibrosis of the tonsillar tissues with more bleeding than usual. Two patients had primary postoperative haemorrhage. The tuberculin test was done postoperatively with only 1 positive result (65-year-old male), who presented with right unilateral tonsillar hypertrophy for which he had undergone tonsillectomy to rule out malignancy. Histopathological study confirmed the diagnosis of tuberculosis. All patients had been followed up for a period ranging from 2 to 8 years. To date, except for 1 patient with tuberculosis, none have had a specific diagnosis. Systemic disorders such as sarcoidosis, brucellosis and lymphomas have been ruled out.

Pathology

A total of 8 patients had granulomas in both tonsils and adenoids, 6 in both tonsils only, 8 in unilateral tonsils (4 in the right and 4 in the left tonsils) and 1 had granuloma in the adenoid only. The lesions were categorized according to type (morphology), distribution (discrete or coalescent) and location (follicular and parafollicular, parafollicular alone, peritonsillar). Four types of lesions were detected with 23 cases of adenotonsillar granulomas (table 1). The majority were non-caseating epithelioid granuloma (n = 20). Other types included caseating epithelioid (n = 1), foreign-body (n = 1) and miscellaneous granuloma (n = 2). Non-caseating epithelioid granulomas alone were found in 20 patients and coexisted with a miscellaneous form of granuloma in 1 case. Subjectively, they varied from few to moderate, or extensive in numbers. They were discrete (12 cases) or coalescent (8 cases). The location ranged from follicular and parafollicular ar-

Fig. 1. Non-caseating granuloma is seen within a follicle. HE.
In 14 cases (fig. 1), the parafollicular zone alone in 4 cases to the peritonsillar area in 1 case. Caseating granulomas were identified in 1 patient with right tonsillar biopsy. They were coalescent and had a central caseation. Miscellaneous granulomas were composed mostly of foamy macrophages mixed with lymphocytes, multinucleated giant cells, cholesterol crystals and occasional vacuoles (fig. 2). In 1 patient, the granuloma was solitary; in another it co-existed with multiple discrete non-caseating granulomas and was located adjacent to a ruptured crypt (table 1). The Ziehl-Neelsen stain for acid-fast bacteria was positive in 1 patient who had a caseating epithelioid granuloma in the histopathological examination of the tonsil. Fungal stains were negative in all cases.

### Discussion

Granulomatous inflammation involving the palatine tonsils occurs in numerous settings, including tuberculosis, fungal infection, Hodgkin’s disease [8–10], keratinizing squamous cell carcinoma [11, 12] and tonsillar malakoplakia [13, 14]. It is seen most commonly in tuberculosis and less frequently in fungal and unusual bacterial infections.

Our series showed patients with no known systemic diseases and in whom postoperative adenotonsillar tissues showed non-specific granulomatous inflammatory changes. Only 1 of the patients had had a diagnosis of tuberculosis. No other systemic disorder was noted in any of the other patients.

Primary tonsillar tuberculosis is rare and seen in countries with a high incidence of tuberculosis. Diagnosis is made by histopathological picture and culture results. The clinical picture could resemble sarcoidosis with pulmonary disease, cervical lymphadenopathy and granulomatous inflammation. This necessitates a proper diagnosis since the treatment modalities of both differ vastly. This is difficult especially if no acid-fast bacilli are present in the tissue.
seen. Our single adult male patient was initially diagnosed as having a non-specific granulomatous tonsillitis, with negative Ziehl-Neelsen staining of sputum and negative culture for acid-fast bacilli. However, he was clinically diagnosed after tonsillectomy and histopathological examination of the specimen. He was successfully treated with antituberculosis medications.

Routine histological examination of the tonsil and adenoid remains controversial. Missing unsuspected diagnosis such as malignancy and granulomatous disease and the medicolegal consequences are the main reasons [15, 16]. Although there is no consensus regarding routine microscopic examination of the tonsils and adenoids, several studies considered that the histological examination of the tonsils and adenoids results in unnecessary cost and consumption of resources and time. Nevertheless, examination should be reserved for selected cases, such as older patients and patients with gross asymmetry and a history of malignancy [15–17]. Our series demonstrates the prevalence of granulomatous affections of the tonsils and adenoids in otherwise healthy individuals. The fate of this non-specific granulomatous disease is unknown. Of clinical interest, 19 patients (82%) showed lymphocytosis in the pre-operative evaluation. In addition, 2 patients (8%) developed posttonsillectomy bleeding in which the granuloma might have played a role.

**Conclusion**

Since the clinical significance of granulomatous reactions is still obscure and the rate of occurrence of the idiopathic granulomatous reaction (0.001%) is low, the validity of the histopathological examination of all surgical specimens of tonsils and adenoids remains questionable.

**References**