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Quiz

A female with 'two uvulas'

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A 38-year-old female presented with foreign body sensation in the throat for one year. It was increasing in severity. There was no other associated symptom. Examination of the oral cavity showed an abnormal looking uvula (Fig. 1). The rest part of the oral cavity, oropharynx and larynx were unremarkable. What is your diagnosis?

Fig. 1 Oral examination showed an abnormal looking uvula.

(Answer and discussion on the next page)

Answer: A tonsillar cyst

Initially the clinical diagnosis of parauvular cyst was made. She was started on a course of amoxicillin/clavulanate for a week but no respond. She was taken into the theatre for excision of the mass under general anaesthesia. The mass was noted to be arising from the superior pole of the left tonsil. Left tonsillectomy was performed. The right tonsil was grade I and normal in appearance. Histopathological study of the excised mass showed the cyst measured 15x8x8 mm with dark-brown blood content and suppurative acute inflammatory exudates in a uniloculated cyst. The final diagnosis was reactive lymphoid hyperplasia with tonsillar cyst with abscess content. A 10-month follow up showed no recurrence of the lesion.

Discussion

Tonsillar cyst is a benign lesion in the oropharynx. It is usually found on routine examination for other pathology in the oral cavity. It is an incidental findings rather than a complaint, due to its small size. A relatively bigger cyst can compromise the upper airway as the location of the tonsil is in the oropharynx. A case of chronic ventilator failure secondary to a tonsillar cyst was reported (Loke *et al.*, 2010). The cyst was causing obstructive sleep apnea and hypoventilation, in which resolution of symptoms was gained following tonsillectomy. However in the reported case, the cyst was not apparent on routine clinical examination. It was a tonsillar hypertrophy appearance on clinical ground.

In this case, the location of the cyst had made it resembled a bifid uvula. The recognition of a true bifid uvula is very important to be established as it serves as the landmark of an underlying submucosal cleft. It is regarded as the earliest form of a cleft palate and any procedure especially adenoidectomy must be with great caution to avoid nasal reflux and hypernasality (Suryadevara and Tatum, 2007). In the present case however, on closer inspection, it was found that the surfaces of the adjacent masses were different. The left mass showed more tensed in appearance resembling a collection in a sac, evidenced by few small dilated capillaries on the surface. These features are not seen on the normal uvula, as in this case. Furthermore, even the mass slightly had pushed the uvula to the right; it was still relatively close to the left anterior pillar.

Even the described common locations for tonsillar cyst are in the vallecula and epiglottis, the occurrence of cyst in an uncommon site has been reported including down to the level of false cord (Kimura *et al.*, 2007). Imaging is not routinely indicated in the suspected small-sized tonsillar cyst. The diagnosis is based on clinical findings which can be safely managed with transoral excision. In cases whereby the location and the size matters, and the diagnosis are uncertain, a computed tomography can or magnetic resonance imaging is rewarding.

References

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