

CASE REPORT

Lingual tonsillitis post tonsillectomy: a rare cause of odynophagia

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Keywords

Lingual tonsil, tonsillitis.

Abstract Lingual tonsil is a part of Waldeyer's ring. It consists of lymphoid follicles and subject to proliferation and hypertrophy. Palatine tonsillitis, by far is the commonest cause of odynophagia originating from oropharyngeal region. Lingual tonsillitis is a rare occurrence. We reported a patient who presented with severe odynophagia after two months of palatine tonsillectomy. Examination revealed the lingual tonsils were inflamed and covered with exudates.

Introduction

Lingual tonsil is the most neglected member of Waldeyer's ring (Lewis *et al.*, 2000). Histologically, it comprises of collection of lymphoid follicles similar to the palatine tonsil. Thus, the structure is also subjected to similar pathology such as infection and hypertrophy.

Case summary

A 35 year old lady presented with history of recurrent sore throat associated with fever and odynophagia. Examination revealed signs of chronic inflammation of the palatine tonsils. Other adjacent structures including base of tongue, posterior pharyngeal wall, adenoids and larynx were unremarkable. She was diagnosed as chronic tonsillitis and planned for tonsillectomy. Bilateral palatine tonsillectomy was performed. There was no immediate complication related to the surgery. The patient was discharged well. The histopathological examination of the removed tonsils showed reactive lymphoid hyperplasia. She was symptom free for about two months.

Two months later she came again to

our clinic because of severe odynophagia which made her unable to take orally for two days duration. Examination revealed the palatine tonsillar fossae were clear with no residual tonsillar tissue. Posterior pharyngeal wall was not inflamed. Rigid 70° laryngoscopy was performed. The lingual tonsils were prominent with exudates filling the crypts (Figure 1). The diagnosis of acute lingual tonsillitis was established.

She was admitted and treated with intravenous antibiotics. After three days, the general condition improved. She managed to take orally well. Examination of base of tongue showed granular prominence at both sites of lingual tonsils. She was discharged and given appointment for reassessment.



Figure 1 Prominent lingual tonsils with inflammatory exudates.

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Discussion

Lingual tonsillitis is a rare differential diagnosis of odynophagia (Joseph *et al.*, 1984). As shown in our case, lingual tonsillitis is common in patient who had undergone palatine tonsillectomy (Pino Rivero *et al.*, 2004). The spectrum of symptoms in lingual tonsillar pathology is usually distinct between inflammation and infection compared to hyperplasia or hypertrophy (Lewis *et al.*, 2000). Inflammation, with symptoms like odynophagia and otalgia is more common pathology. Most of the time, the clinical features of lingual tonsillitis is more notorious than the palatine tonsillitis. This is mainly because of its location that is more central as compared to the palatine counterpart (Pino Rivero *et al.*, 2004). Being in the center, odynophagia will be a more prominent symptom.

Obstructive symptoms such as dysphagia, globus sensation and sleep related breathing disorders are known to occur because of the enlarged lingual tonsil will occupy the oropharyngeal space. Lewis *et al.* (2000) reported a 10-year-old boy with lingual tonsillar hypertrophy presenting with paroxysmal cough. After treatment with laser lingual tonsillectomy with ablation of all lingual tonsillar tissue, the patient was symptom free. Other complication of an enlarged lingual tonsil is upper airway obstruction. It can be one of the presenting symptoms (Dindzans *et al.*, 1984), or it can occur as an acute emergency in a previously undiagnosed lingual tonsillar hypertrophy (Arrica and Crawford, 2006).

Acute lingual tonsillitis usually resolves with antibiotics. However, chronic infection or symptoms attributed to lymphoid hyperplasia may require surgical intervention (Joseph *et al.*, 1984). Lingual tonsillectomy is a surgical treatment that is seldom performed because problems

attributable to chronic lingual tonsillar hypertrophy are infrequently diagnosed (Lewis *et al.*, 2000 and Golding-Wood and Whittet, 1989). However, if it indicated, several methods or surgical techniques have been reported. These include diathermy, carbon dioxide laser and microdebrider (Barakate and Havas, 2008).

In conclusion, lingual tonsillitis is a relatively uncommon diagnosis to be made. It is probably due to the location that may be missed in incomplete oropharyngeal examination, or the symptoms are masked during acute palatine tonsillitis. It is more common in post-tonsillectomy patient, and the features are more severe than palatine tonsillitis. Treatment is the same with palatine tonsillitis ie antibiotics during acute attack and excision of the lingual tonsil if it is recurrent.

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