Otolaryngology Case Reports 6 (2018) 56–60

Contents lists available at ScienceDirect

Otolaryngology Case Reports

journal homepage: www.elsevier.com/locate/xocr

Isolated tubercular parapharyngeal abscess masquerading as peritonsillar abscess: A case report

Shikharani Patel*, Rajiv Kumar, Prem Sagar, Rakesh Kumar

Department of Otorhinolaryngology—Head & Neck Surgery, All India Institute of Medical Sciences, New Delhi, India

ARTICLE INFO

Keywords:
Mycobacterium
Tuberculosis
Neck abscess
Parapharyngeal space
Gene xpert

ABSTRACT

Introduction: Tubercular abscess of parapharyngeal space without caries spine is a rare entity. This case report presents a immunocompetent adult female with parapharyngeal tuberculosis masquerading as peritonsillar abscess and could only be diagnosed by gene xpert.

Case presentation: We report a rare case of an isolated parapharyngeal space tubercular abscess in a 22 years immunocompetent female who was evaluated for throat pain and swallowing difficulties for 2 months. In clinical examination there was a bulge in left tonsillar fossa with congested tonsil pushed medially. Computed tomography scan showed localized abscess in left parapharyngeal space. USG guided aspiration was done and sent for bacterial and tubercular cause to be ruled out. All other reports were inconclusive except gene Xpert for TB was positive.

Management and outcome: Based on this we started ATT and patient was completely symptoms free in 3 months. Repeat scans done which did not show any residual abscess.

Discussion: Although tuberculosis is one of the most common infectious disease in India, tubercular abscess only localized to parapharyngeal space is not a common entity.

Introduction

Tuberculosis is a common problem in Indian sub-continent mainly affecting the lungs. The common sites for extra-pulmonary tuberculosis are lymph nodes, pleura, genito-urinary tract, abdomen, skeletal and central nervous system. The reported incidence of head and neck tuberculosis is 10%–15% within the extra-pulmonary sites [1]. Tuberculosis of spine leading to caries spine and later retropharyngeal and parapharyngeal space (PPS) abscess is reported entity in this group. However, tubercular PPS abscess is a very rarely encountered condition in isolation. We are reporting this case in an immunocompetent adult female who presented in our OPD with complains of swallowing difficulties and throat pain. This case report highlights atypical clinical presentation of tubercular abscess at an uncommon site. Radiological work-up, laboratory investigations and probable differential diagnosis of such a lesion has been discussed along with brief review of literature.

Case report

A 22 years old female presented to our outpatient department with complaints of swallowing difficulties and change in voice since the last 2 months. Patient was being treated in a private hospital as a case of peritonsillar abscess and advised incision and drainage based upon CECT neck which was showing abscess in left PPS, but she refused treatment. On presentation patient was afebrile and well nourished. Oral cavity and oropharyngeal examination showed a bulge in left tonsillar fossa with tonsil pushed medially and mild congestion over tonsil and anterior pillar There was no bulge in posterior pharyngeal wall (Fig. 1). Fibreoptic laryngoscopy (FOL) showed vocal cords were normal and mobile. Rest of the ENT examination was within normal limit. On admission, repeat scan (CECT Neck) was done to see progression of the abscess (Fig. 2a, b, 2c). CECT Neck showed non-progressive well localized abscess in left PPS. Further work-up was done to establish the diagnosis which is summarized in Table 1. USG guided aspirate showed acute inflammatory exudates only. A differential diagnosis of peritonsillar abscess, tubercular abscess and pseudo - aneurysm of ICA were kept. Pseudoaneurysm of ICA was suspected because there was peripheral calcification in CECT scan (Fig. 2a). CT angiography was performed to rule out pseudo-aneurysm which showed an abscess with no vessels involvement (Fig. 3). The diagnosis of peritonsillar abscess was ruled out based on normal TLC count (6200cumm) and absence of clinical features i.e. fever, hot potato voice, drooling of saliva etc. The diagnosis of tubercular aetiology was difficult to establish in the setting of absent caries spine or

* Corresponding author.
E-mail address: shikha.vss@gmail.com (S. Patel).

https://doi.org/10.1016/j.xocr.2018.02.003
Received 23 November 2017; Accepted 11 February 2018
Available online 19 February 2018

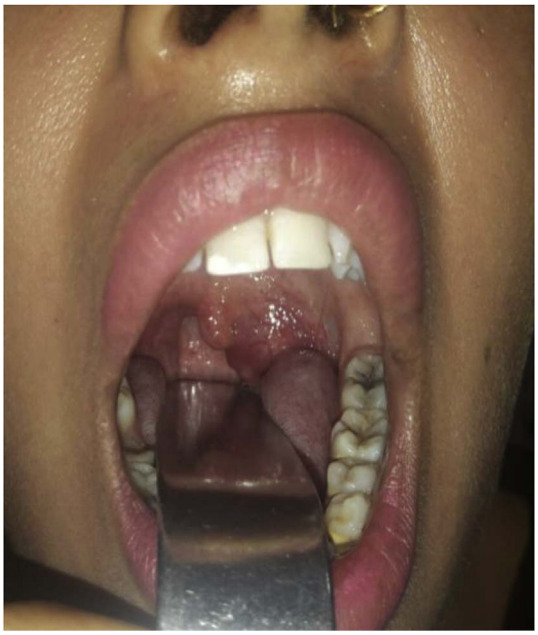

Fig. 1. Left tonsil pushed medially.

retropharyngeal abscess. Chest X-ray and X ray cervical spine was done to look for primary site of tuberculosis, and both were normal. Repeat aspiration was performed for further laboratory investigations including culture for AFB, Gram staining and Gene-Xpert (Table 1). Gene-Xpert was reported to be positive and final diagnosis of tubercular parapharyngeal abscess was made. Medical consultation was taken and patient was started on ATT including injection streptomycin. Patient was reviewed in OPD after 20 days and there was significant improvement in signs, symptoms and gross reduction in size of the swelling. Patient was advised for repeat CECT neck after 3 months. Clinical examination showed complete resolution of swelling (Fig. 4) and scan showed complete resolution of parapharyngeal abscess (Fig. 5a and b).

Discussion

Differential diagnosis of a parapharyngeal space occupying lesions can be numerous. The common one are abscesses, branchial cyst, tumours of different origins and cystic hygroma [2]. Rare lesions can be metastatic deposits and ICA aneurysm in this location. Most of them can be diagnosed by either clinical presentation supplemented with radiological features. In very few cases complete blood work-up is helpful. Atypical presentations of some diseases can lead to confusion and requires detailed work-up for establishing the correct diagnosis. We dealt with one such case where tubercular abscess in an uncommon site

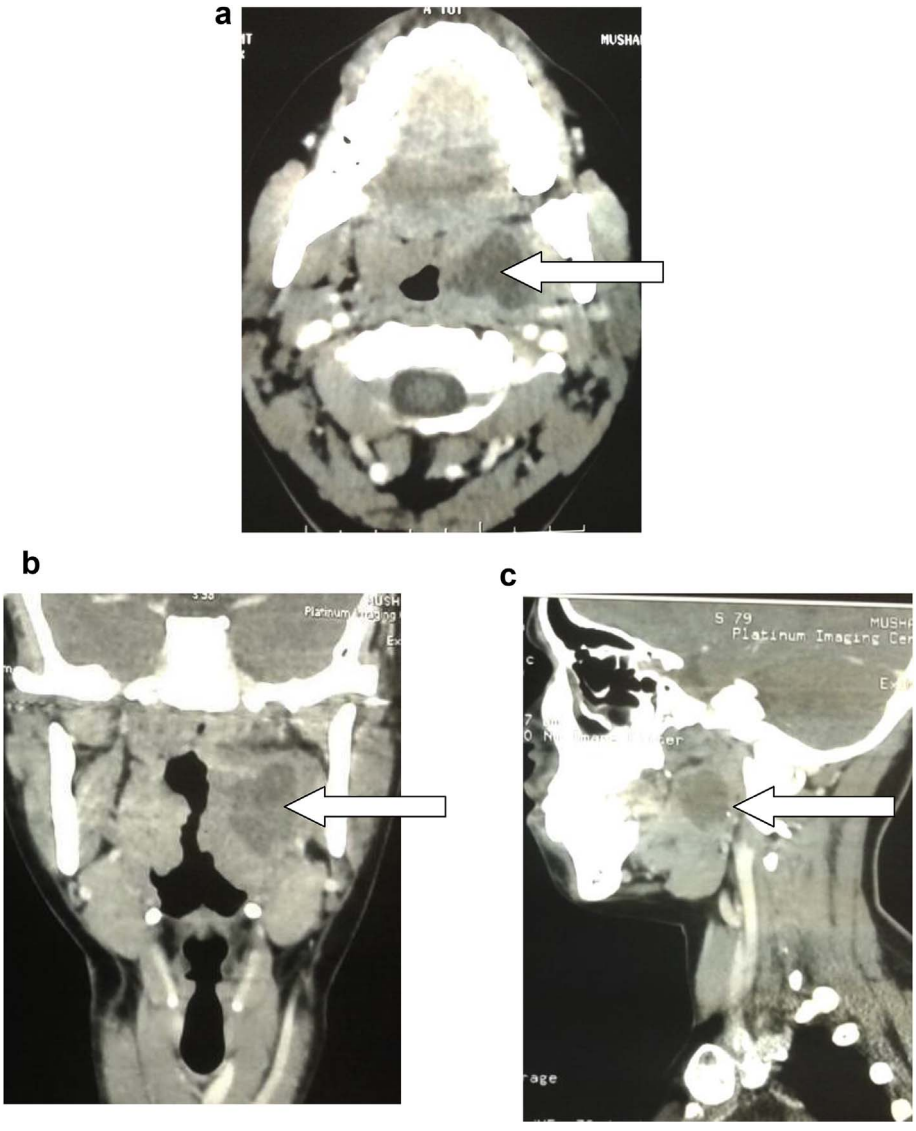

Fig. 2. a. Axial CECT showing left parapharyngeal abscess; b. Coronal section; c. Saggital section.