Case report

A 26-year-old woman presented with complaints of swelling over the right parotid area since 5 months and discharge from the right ear since 3 months. Clinical examination of the parotid region revealed a nontender, soft, fluctuant parotid swelling of 4×2 cm, with right level 1b lymphadenopathy and granulations at annulus and dull, lustureless retracted TM with discharge. FNAC of parotid and granulation biopsy revealed epithelioid and giant cells with no caseation. Z-N stain for AFB, chest radiograph, serum ACE levels were unremarkable. Montoux test was positive (20*20mm) and ESR was 42 mm/hr. A CT scan showed isodense mass with hypodense centre and rim enhancement in the right parotid gland and MRI on T2W images had mastoiditis and middle ear mucosal disease. The patient was advised ATT and had remarkable improvement.

Conclusion
Parotid gland and middle ear tuberculosis is rare. FNAC and Z-N staining of the aspirate, should be routinely done. Further an AFB negative presumptive diagnosis by this method may prompt a trial of ATT which can be rewarding.

Keywords:
middle ear, Mantoux test, parotid, tuberculosis

Introduction
Tuberculosis in the parotid gland is an infectious disease, which manifests by an increase in the gland volume, making it lobulated and ultimately causing lymphadenitis. Only few cases of tuberculosis of the parotid gland with middle ear affliction have been reported in the literature. Parotid tuberculosis must be part of the differential diagnosis of tumors that increase parotid volume. It is difficult to assess its true incidence, as the large series of patients reported has been selected from hospitalized subgroups with established tuberculosis [1]. These patients usually have the initial symptom of painless otorrhoea. The possibility of tuberculosis is considered only when there are extensive pale granulations in the middle ear, with sensory neural deafness or facial palsy. Early diagnosis and prompt treatment is of paramount importance in preventing otological and the possible intracranial extension.

We report a case of a young woman who had parotid swelling initially, followed by mastoiditis, which was provisionally diagnosed to be of tubercular origin [acid fast bacilli (AFB) –ve, Mantoux test +ve] without lung involvement and had excellent response to antitubercular treatment (ATT).
at the angle of the jaw, 25–30 ml of thick, cheesy pus was drained. It was negative for AFB staining, and the culture did not yield any mycobacteria. The patient was treated with ATT regime of rifampicin, isoniazid, pyrazinamide and ethambutol for 2 months and of isoniazid and rifampicin for 4 months. The patient was observed for signs of healing regularly, and upon noticing the improvement after 2 weeks, it was decided to complete the regime of 6 months (Fig. 3).

Discussion
The Southeast Asian regions, which account for about 25% of the world’s population, alone carry a disproportionate rate (38%) of the world’s burden of tuberculosis [2]. In India, about 30% of the population has tuberculosis, and one million people develop a highly infectious variety of tuberculosis every year. Although tubercular otitis media is believed to present with profuse ear discharge, profound hearing loss, facial paralysis and multiple perforations, it is observed by many authors that these features do not always present in all cases. Multiple perforations are hardly ever seen, which may have been present during the earlier phase of the disease. Severe or permanent hearing loss is a frequent occurrence, and pale granulations are the most significant feature reported by numerous authors, as evident in the present case. Pulmonary focus is usually present when the parotid gland is affected, with blood and lymphatic spread being the most probable routes of spread [3]. Holmes et al. [4] reported that the primary disease is rather rare due to the inhibiting effect saliva has over the mycobacterium. In the present case, there was neither a prior history of tuberculosis nor was it the primary focus; in addition, fine needle aspiration cytology was inconclusive and culture results were negative. There was delay and dilemma in the diagnosis of the case.

In the present case, presumptive diagnosis of parotid and middle ear tuberculosis was made based on the high prevalence of tuberculosis in India and positive Mantoux test. Hence, a trial of ATT was started. At the end of 3 months of treatment, patient had resolution of middle ear disease and parotid swelling, along with well-healed scar at incision and drainage site.

The cases treated with antituberculosis drugs recover well; therefore, recently, the role of surgery has been revised. The need for surgical management arises in case of frank abscess formation in the parotid as seen in our case and when there is neoplasm. However, in tuberculosis of the middle ear and mastoid, ear surgery
should be reserved for decompression of the facial nerve and for removal of necrotic material, whose treatment might not be effective with antitubercular drugs [5].

**Conclusion**

Tubercular otitis media and parotid tuberculosis are uncommon diseases and if left untreated can result in facial palsy, sensorineural hearing loss, ossicle erosions, damage to the surrounding structures, postaural fistula and parotid sinuses. As the diagnosis at times is extremely challenging, the clinician must maintain a high index of suspicion that even AFB negative and Mantoux positive disease can still be tuberculosis. Early presumptive ATT offers every prospect of eventless healing.

**References**

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