Large Fibroepithelial Polyp of the Palatine Tonsil

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Fibroepithelial polyp (FEP) is an uncommon benign lesion of the pharynx and polyps originating from the palatine tonsil are extremely rare. Symptoms are usually mild and nonspecific. However, larger pedunculated lesions may lead to an airway emergency if dislodged in the laryngeal inlet.¹

A 45-year-old female was referred to our department with a year-long history of foreign body sensation in her throat. She also reported the occasional feeling of something resting on the back of her tongue as well as episodes of snoring followed by a choking sensation and a lack of breath during the sleep. Initial examination of the oropharynx was normal, but mirror laryngoscopy revealed a smooth, finger-like elongated growth measuring 7.5 cm in length, originating from the inferior pole of the right palatine tonsil (Figure 1). It was hanging down the lateral aspect of the right piriform fossa and was hard to discern from the surrounding structures. The growth was more apparent when the patient was asked to forcefully cough or clear her throat, which would displace the lesion on the dorsal surface of the tongue, making it clearly visible during the oropharyngoscopy. The patient underwent complete removal of the lesion by cold steel right tonsillectomy under general anaesthesia (Figure 2). The right palatine tonsil with the lesion was sent for histopathologic evaluation that revealed an FEP (Figure 3). On subsequent follow-ups, there were no signs of recurrence or residual tumor tissue.

Fibroepithelial polyp is regarded as a pseudotumor consisted of variable amount of stroma covered by squamous epithelium. The only previous article reporting an FEP in an adult patient described a small, 2 × 1 cm polypoid mass from the superior pole of right tonsil.² Previous studies have documented fibroepithelial tonsillar polyp in a child,³ as well as other histologic subtypes.⁴

Unlike their counterparts in the oral cavity which are associated with chronic mechanic irritation caused by ill-fitting dentures,² the pathogenesis of tonsillar FEPs remains unclear. Other theories, such as chronic inflammation with obstruction and congestion of tonsillar lymphatic channels or isolated hamartomatous proliferation of tonsillar tissue elements, have been suggested in the pathogenesis of other histologic subtypes.⁴

The patients may be completely asymptomatic for extended periods of time, with only intermittent episodes of irritating cough or choking sensation due to spontaneous movement of polyp. The patients can describe intermittent regurgitation usually associated with an episode of coughing or eructation, accompanied by a choking sensation relieved by the swallowing of the polyp. In such cases, they may be misdiagnosed with a psychiatric disorder, and the tumor remains undetected. Often these are mistaken for a malignancy, causing unnecessary stress to the patient.

Clinical diagnosis can be challenging, as the polyp can be hard to discern from the normal pharyngeal mucosa. Occasionally, it is not possible to detect the precise point of the pedicle’s origin and assess its base. The pedunculated form of the polyp is probably due to the continuous movement of the oropharynx during breathing, swallowing, or speech.

Histologically, giant polyps represent a mixture of fibrous elements, adipose tissue, and vessels lined by normal squamous epithelium. The differential diagnosis for FEP includes fibroma, plasma cell granulomas, lymphangiomatous or fibrovascular polyps, lymphangioma, lipoma, neurogenic tumors and squamous papilloma.

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The management of tonsillar FEP is relatively straightforward and is achieved by tonsillectomy. Some authors have shown comparable results with excisional biopsy using monopolar diathermy under general anesthesia. Fibroepithelial polyp of the palatine tonsil with a long pedicle can produce an acute airway obstruction and potentially be life-threatening. Therefore, complete surgical removal is mandatory as soon as the polyp is recognized.

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