Intratonsillar Mass in a Teenager

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A previously healthy 17-year-old male presented to the emergency room for evaluation of subacute left-sided throat pain. On routine evaluation by his pediatrician, he was noted to have a significantly enlarged, asymmetric left tonsil. He was otherwise asymptomatic but treated with a 10 day course of clindamycin. He was subsequently re-evaluated by his pediatrician and transferred to the emergency room with concern for a tonsillar mass, given no improvement in size or appearance of his enlarged left tonsil. In the emergency room, the patient was afebrile with negative strep test and normal white blood cell count. He denied any fevers, dysphagia, odynophagia, voice changes, or difficulty tolerating secretions. Examination revealed an asymmetric, left-sided tonsillar mass without overlying mucosal ulceration or changes (Figure 1). On closer inspection, an approximately 6.5 x 2 x 1 cm firm, white mass was seen emanating from within the left tonsil, suggestive of a large tonsillar stone (tonsillolith). Attempts to remove the stone at the bedside were unsuccessful given the size. He was taken to the operating room, and excision and endoscopic-assisted extraction of the tonsillolith (Figures 2-4) was performed prior to tonsillectomy.

Tonsilloliths are products of calcified accumulates of food, cellular debris, and microorganism aggregates in the crypts of palatine tonsils.1 In contrast to small tonsilloliths, which are frequently found bilaterally within cryptic tonsils, large or “giant” tonsilloliths are rarely seen. Clinically, they appear as unilateral white or yellow masses within the tonsillar region. On clinical examination, they can be concerning for malignancy or peritonsillar abscess, especially if there is significant mucosal coverage of the stone and warrant further evaluation. Diagnosis can be made in most cases on clinical examination, with visualization and direct palpation of the tonsil and surrounding soft palate. A lateral neck X-ray will normally...

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confirm a tonsillolith by demonstrating a radio-opaque shadow; however, given the wide differential of calcified lesions in this region, that is not sufficient in itself to make a diagnosis.2,3 Tonsilloliths should be differentiated from other radio-opaque structures and lesions that occur in nearby soft tissues such as foreign bodies, calcified granulomas, sialoliths, calcified stylohyoid ligament, cysticercosis, calcified lymph nodes, and carotid artery arteriosclerosis.4

Removal of these large tonsillar concretions can usually be achieved via curettage or local excision in the operating room under general anesthesia. Removal under local anesthesia at bedside is dependent upon size of the stone and patient tolerability. Despite no prior history of chronic tonsillitis, our patient underwent subsequent bilateral tonsillectomy to prevent tonsillolith reformation given the large cavitary defect in the tonsil space which would likely result in tonsillolith recurrence over time or trapping of food matter and foreign bodies. Our patient tolerated the procedure well without complication, and had a fully healed tonsillar fossae at follow-up.

In conclusion, tonsilloliths are commonly seen as small, white, hard calcifications within cryptic tonsils. Giant tonsilloliths are rarely seen and can be concerning on presentation for malignancy or oropharyngeal infection. Management of these lesions includes removal from the oropharynx with or without tonsillectomy.

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