probably indicates that the tumour is not a para-
ganglioma but represents one of the classes of
neuroendocrine carcinomas. Attention to the clinical
behaviour as well as the light microscopic features
and immunohistochemical antigenic profile should
prevent incorrect diagnosis and classification.

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Laryngeal paraganglioma. A review and report of a single

Polymorphous low-grade adenocarcinoma (PLGA)
of the tongue

Dear Sir,

We read with interest the case report entitled ‘Polymorphous low-grade adenocarcinoma of the
tongue’ by de Diego *et al.* (July 1996). We would like
to share our experience with a case of PLGA arising
from the glossotonsillar sulcus.

A 50-year-old female presented with history of
foreign body sensation the right side of her throat for

the past six months. There was no history of
difficulty in swallowing or change in voice. On
examination there was a $1.5 \times 1.5$ cm mucosa
covered, firm mass on the right glossotonsillar sulcus with
induration extending on to the right tonsil and
adjacent base of the tongue. Biopsy under local
anaesthesia was reported as low-grade adenocarci-
noma. Chest X-ray, ultrasonography of the abdo-
men, thyroid scan (radioactive iodine$^{131}$ uptake) and
bone scan were normal. CT showed well demarcated
mass on the right glossotonsillar sulcus with exten-
sion to the base of the tongue and the right tonsil.
Subsequently the patient underwent wide excision of
the tumour including partial mandibulectomy, neck
dissection and reconstruction with pectoralis major
myocutaneous flap. Post-operative recovery was
uneventful. On gross examination there was a
$3 \times 2 \times 2$ cm greyish-tan mass. The final histopatho-
logical report was PLGA. Areas of prominent
papillary pattern were noted. All the lymph nodes
examined histopathologically were free of metaста-
sis. No post-operative radiotherapy was given. Two
years since her operation she remains asymptomatic
and free of any evidence of recurrence.

The authors’ comment on the role of prophylactic
neck dissection in PLGA seems to be very much
valid. Retrospectively we feel that in our case neck
dissection could have been avoided. We are keeping
our patient under regular close follow-up in view of
worse clinical behaviour of PLGA with papillary
elements.

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*Erratum*

Arytenoidopexy for bilateral vocal fold paralysis in
and Methods section read ‘in a few cases there was
intermittent abduction movement’ this should have
read ‘in a few cases there was intermittent adduction
movement’. We apologise for any inconvenience
causd. Ed.