A case of giant tonsils

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The aim of this case report is to present an adult male whose dysphagia, rhinolalia clausa, and neurological symptoms cleared following tonsillectomy.

Case history

Mr. D.M., aged 51 years, a crofter from the Isle of Barra, was admitted to the Orthopaedic Department of the Western Infirmary, Glasgow, on 26 June 1970. Eight days prior to admission he had developed pain in the back of the neck, radiating to both shoulders and down both arms, following trivial injury to the neck while lifting a dustbin. He was treated with cervical collar and analgesics. The pain disappeared after three days. On 24 June 1970 he developed slight weakness of the grip in both hands and paraesthesia of both hands. He also had slurring of speech and dysphagia. He was able to swallow only small bits at a time. About eighteen months previously he had had a prolapsed intervertebral disc in the lumbar region and this continued to trouble him intermittently.

X-ray of the cervical spine showed evidence of cervical spondylosis. He was seen by Mr. T. W. Howard, Orthopaedic Surgeon, who did not think that the radiological feature and trivial injury suffered by the patient explained the weakness and muscle wasting of small muscles of the hands and flexor muscles of the fingers.

Physical examination

This revealed gigantic tonsils with irregular surface, virtually blocking the oropharyngeal isthmus. The enlargement seemed unlikely to be inflammatory in nature. Apart from these giant tonsils, no other lymphadenopathy or splenomegaly was noted. The possibility of a reticulosis was considered which could have explained both the enlarged tonsils and the neurological signs. This was investigated by Professor A. Goldberg, whose findings were essentially negative.

As the haemostatic mechanism was within normal limits, tonsillectomy was carried out on 24 July 1970. At the operation, it was noted that the surface was irregular with irregular cysts giving a 'Papillomatous' appearance. The deep surface was well encapsulated. During the four weeks following the operation, power of the muscles of his hands returned; his dysphagia and rhinolalia disappeared. Before leaving hospital, he was able to manage a knife and fork with ease, although he was discharged with unexplained raised E.S.R. of 44 mm./hrs.

Investigation

Haematological: Hb. 104 per cent; W.B.C. 6400/cmm.; Blood group O Rh(D) positive; Thrombotest 58 per cent of normal coagulation activity. Bone marrow: Normal picture.
FIG. 1.
X-ray showing large mass occupying oropharyngeal isthmus.

FIG. 2.
Picture showing huge fleshy tonsils.
Clinical records

Biochemical: Studies were not informative.
Immuno electrophoresis: Increase in normal Ig.G. band.
Serum: Albumin 3.4 gm./100 ml.
Serum: Globulins 4.4 gm./100 ml.
Electrophoresis: Increased gamma globulins.
X-ray of the cervical spine: showed degenerative arthritic change affecting intervertebral joints of C.V.6/7. Disc space was slightly reduced. Soft tissue opacity in the hypopharynx and number of calcifications projected (Fig. 1). Tomography confirmed the soft tissue swelling.
Chest: Calcified tubercles were present in both apical lung fields.

Pathology report

The right tonsil weighed 40 gm. and measured 65×40×35 mm. The left weighed 30 gm. and measured 60×50×35 mm. The crypts were obvious, with pus in some areas (Fig. 2). The mass was moderately fleshy. Microscopy confirmed inflammatory change in the crypts. Squamous lined cysts had been formed. The lymphoid tissue shows reactive change with marked germinal centre formation. There was no evidence of reticulosis.

Unfortunately, three months later the patient was readmitted to the Western Infirmary. This time with right foot drop and hypoesthesia over the dorsum of the feet. While in the hospital, the condition steadily worsened, with increasing backache. The X-ray of the lumbar spine showed destruction of the body of the fifth lumbar vertebra and narrowing of the L4–5 intervertebral space. Lumbar spine was explored under general anaesthesia, but the patient died during the procedure due to cardiac arrest. Post-mortem was carried out which showed eosinophilic celled carcinoma of the kidney with secondary deposits in the lumbar spine.

Comments

This is an unusual case, as the enlarged tonsils of enormous size occurred in an adult male in the sixth decade, with dysphagia and rhinolalia clausa. The cause for the enlargement was revealed by histology as chronic inflammation. The various investigations have not yielded an explanation of the cause of bilateral neurological symptoms and signs which unexpectedly cleared after tonsillectomy.

Enlarged tonsils are a common feature in children and several cases have been reported where enlarged tonsils have caused respiratory obstruction leading to cor-pulmonale (Ainger, 1968) and dysphagia. The cause of the enlargement has usually been recurrent subclinical infection of the tonsils or in some cases a hypogamma-globulinaemia, where patients are unable to resist repeated infections. Neurological complications have not been reported.

Summary

A man of 51 years with gigantic tonsils causing dysphagia, rhinolalia and weakness of the hand; all symptoms cleared following tonsillectomy.

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REFERENCE