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Hairy Polyp in the Oropharynx of an Infant with Sudden Onset Respiratory Distress

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Abstract

Hairy polyps are rare non-neoplastic tumours that can occur anywhere in the body. When they present in the oropharynx they usually arise from the nasopharynx.

A hairy polyp originating from the left eustachian tube orifice was found in a 12-month-old boy with respiratory distress presenting with severe inspiratory stridor following an episode of vomiting. The patient was instantly intubated and the mass was successfully removed by transoral surgery under endoscopic visualization in second time. Although the diagnosis of a hairy polyp is very rare, it should be considered in the differential diagnosis of lifethreatening airway obstruction.

Introduction

Hairy polyps are rare non-neoplastic tumours that can occur anywhere in the body. They are especially rare in the pharynx, arising when there from the nasopharynx. They present at, or shortly after, birth with intermittent respiratory obstruction, stridor or feeding difficulties **[**1**]**

Our objective is to describe the sudden onset of symptoms and the late presentation of this potentially fatal lesion and to add this case to the limited cases reported in literature.

Case Report

A male infant, 12 months of age, presented at the Pediatric Emergency Department with dyspnea and alternating intensity inspiratory stridor following an episode of vomiting. The infant had taken " a respiratory position" probably in order to facilitate his difficult breathing. After the exposure of his thorax the infant presented insertion of the xyphoid process and the jugular notch and also use of the assertive respiratory muscles that indicated the severity of the respiratory difficulty.

During the simple tongue depression for the overview of the oropharynx, a large mobile and pendiculated mass was revealed, blocking the airway and causing intermittent obstruction. The condition seemed critical and there was concern about the autoambutation of the mass. The infant underwent an emergency intubation due to respiratory distress and was admitted into PICU.

After the condition of the patient was stabilized a rhinopharyngolaryngoscopy was performed demonstrating a pendiculated mass which originates from the nasopharynx close to the left eustachian tube orifice occupying almost entirely the oropharynx, obstructing the airway.

These findings were confirmed on a computed tomography with cross sections 1.25 and 2.5 mm thick before and after intravenous administration of contrast performed under general anaesthesia.

Subsequently under general anesthesia, a tonsillectomy tongue depressor was inserted. The attachment site of the lesion was easily defined by elevation of the soft palate with nelaton catheter and by the use of 30◦, 4-mm endoscope. The lesion was completely removed by using the bipolar diathermy bayonet forceps through transoral route under endoscopic visualization. The lesion was a 3.0cm 1.5 cm 0.7 cm-sized, pear-shaped, firm mass pendiculated on the medial surface of the left eustachian tube orifice.

The mass was subsequently excised endoscopically and the patient recovered uneventfully.

Immediately after operation, the patient's symptoms disappeared and no complications developed. The patient discharged at the second postoperative day with no problems.

The use of rigid angle endoscopies in this surgery can provide several advantages compared with mirror visualization.**(**4**)**

Histology showed a necrotic vascular stem that confirms the risk of impending autoamputation of the lesion and airway obstruction and justifies the implementation of immediate prophylactic intubation to protect the airway.

In summary the histological examination showed a polypoid epithelial/mesenchymal lesion with extensive ischaemic necrosis >80%**]** lined by necrotic non-keratinizing squamous epithelium **[**compatible with oral mucosa**]**.

The central part of the lesion is composed of mature adipose and connective tissue, while shadows of hair follicles and eccrine glands are recognized. The overall histological picture is compatible with a hairy polyp.

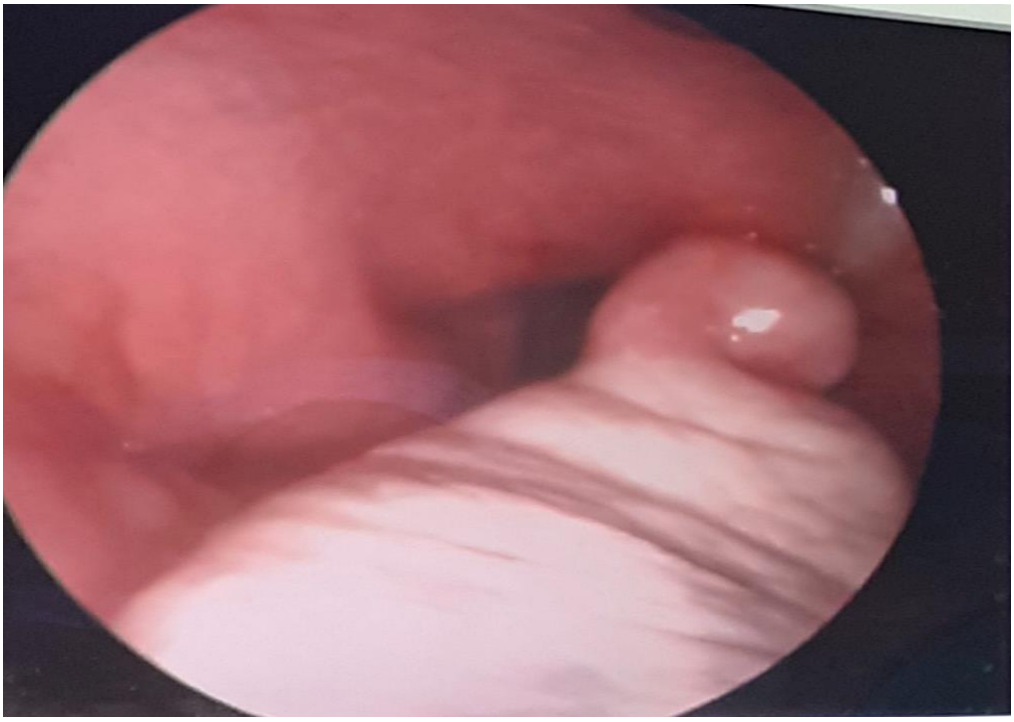

Figure 1. Endoscopical View

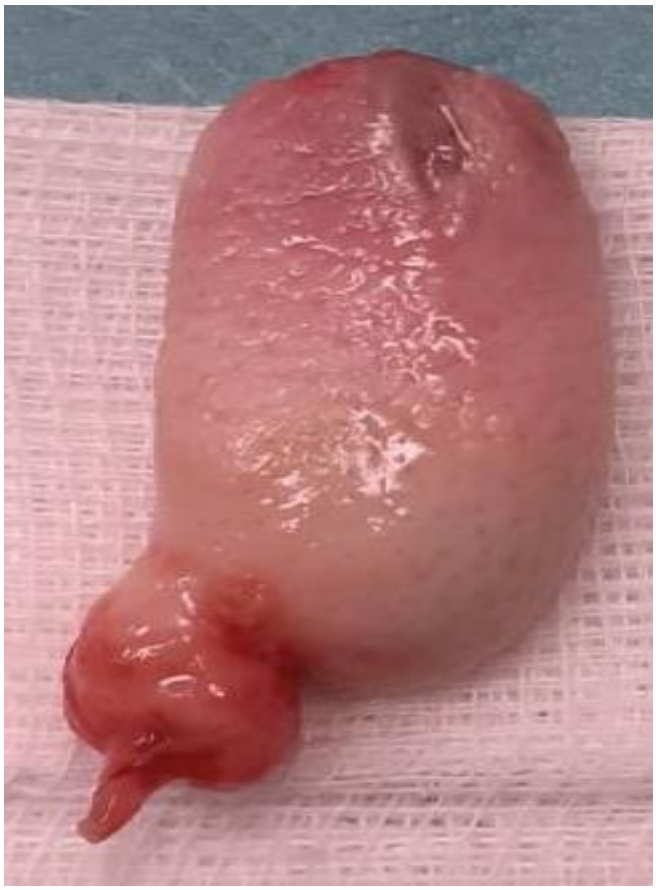

Figure 2 Anatomical Preparation

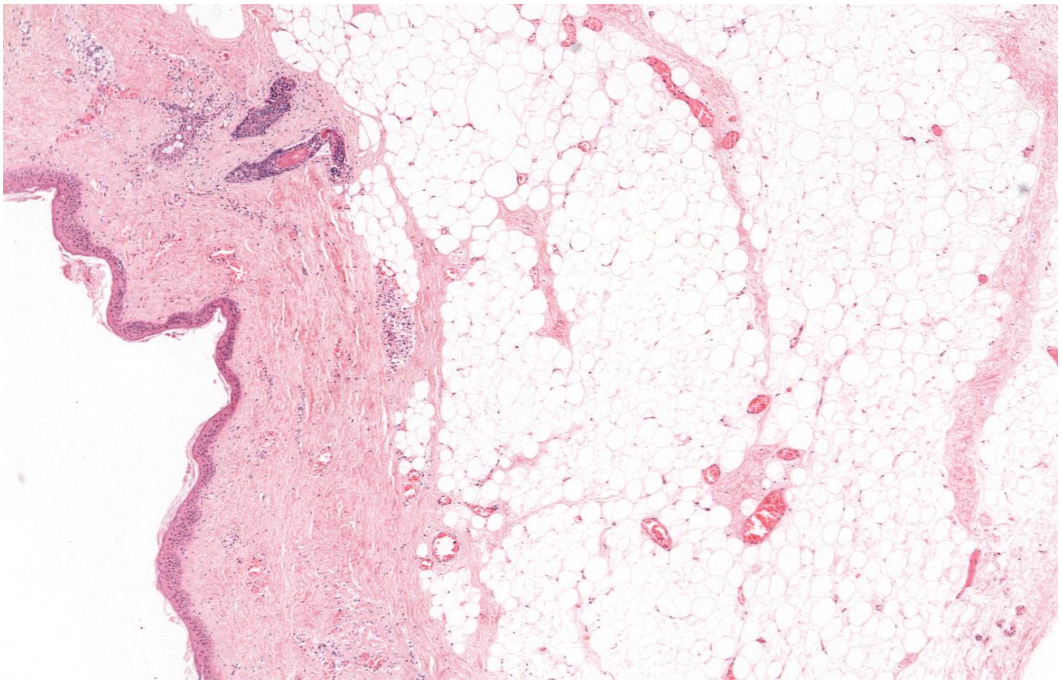

Figure 3 A Partly viable polypoid epithelial/mesenchymal lesion covered by squamous epithelium and composed of mature adipose tissue Hair follicles and eccrine glands are obvious

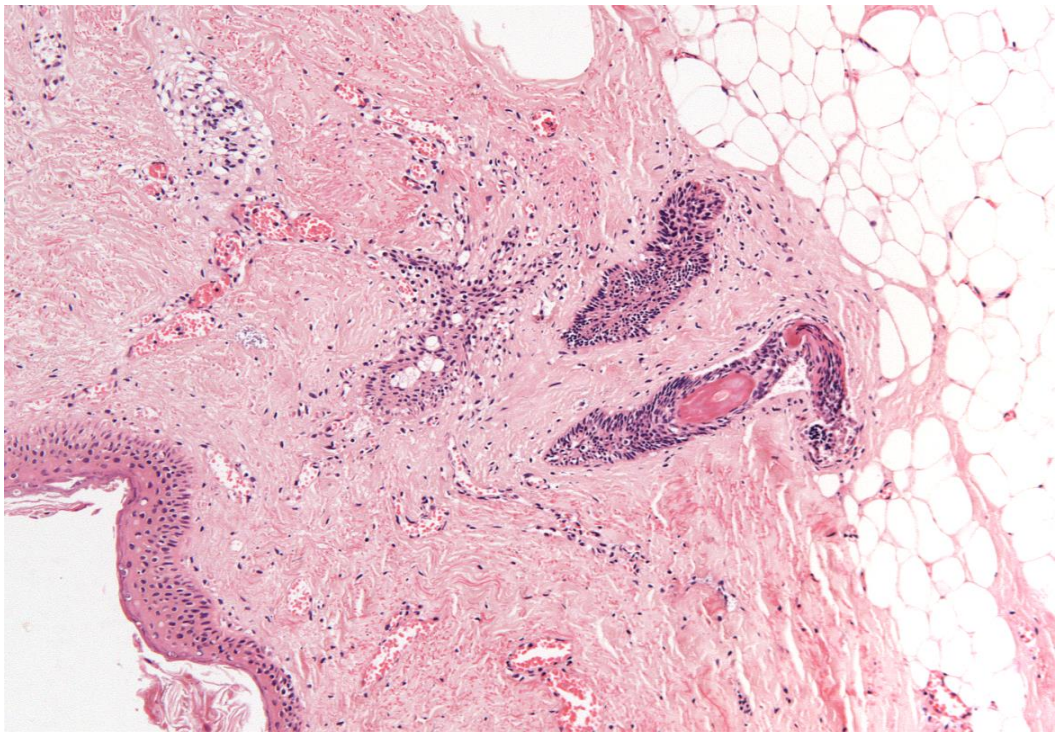

Figure 4 Higher magnification . Hair follicles with ischaemic degeneration

Discussion

Hairy polyps are rare. They are most commonly seen in neonates, although they have been reported in adults.

Female infants are six times more commonly affected than males. There is no evidence to indicate a familial incidence. **[**1**]**

Dermal or hairy polyps, described in the neonatal pharynx are part of embryonic disorders and consist of mature tissues derived from exoderm and mesoderm **(**bigerminal choristoma**) (**5**)**

Total removal of the lesion is the treatment of choice.

This case is a hairy polyp of the oronasopharynx that chiefly presented abruptly with dyspnea and inspiratory stridor following an episode of vomiting in a male infant, 12 months of age. This clinical presentation is not commonly reported in this entity.

Airway distress in young children must be managed with a broad differential diagnosis in mind and the oropharyngeal examination of all children in distress should be done by the pediatrician as the minimum and fast method of diagnosis, since this clinical entity is visible as a pendiculated lesion protruding into the oropharynx.

Although the diagnosis of a hairy polyp is very rare, it should be considered in the differential diagnosis of lifethreatening airway obstruction **(**3**)**

The etiology is still controversial and includes congenital malformations and activation of pluripotent stem cells.**(**6**)**

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