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Tumour of palatine tonsil as a medical and social problem — a case report

Abstract

Hyperplastic lesions of oral cavity and throat, despite being relatively accessible in the objective examination, are often discovered accidentally, at the level of considerable clinical advances. The majority of hyperplastic lesions in this area has its source in palatal tonsils, and mostly applies to smokers or people abusing alcohol.

The authors present a clinical case of a patient who admitted extreme sanitary neglects and draw attention to the problems of prophylaxis, diagnosis, and treatment, as well as to widely understood social aspects. Worth emphasizing are: the role of a family physician, organization and efficiency of a general medical care, social care and the availability of palliative care.

Key words: tumour of palatine tonsil, social and medical problems

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Introduction

In recent years, the frequency of tumours of the middle — oral part of the throat increased by almost a half. The prevailing number of hyperplastic lesions in this area has its source in the palatine tonsils, and applies mostly to smokers and people abusing alcohol [1].

Eighty percent of those are malignant tumours — primary forms of endothelial and lymphatic origin and many secondary forms are present among those. The latter are mostly a consequence of distant metastasis of rectal cancer [2], pulmonary gigantocellular carcinoma [3] and malignant melanoma [4]. Benign lesions — with the histopathologic structure of lipoma or schwannoma — are obviously rare [5].

The relation between the neoplastic transformation in the human upper respiratory tract and infection with Epstein-Barr virus (EBV), and especially with the presence of highly oncogenic types of the human papillomavirus (HPV) was proved [6, 7]. The infection with HPV, transmitted during sexual intercourse, medical devices, and laser devices, is not enough for the malignant neoplasm to develop. The period from the infection and the development of pathologic lesion takes many years, during which the gene mutations induced by the HPV E6 and E7 oncoproteins, integration of genomes and DNA resources occur and finally the cell loses control on its proliferation [6, 7].

Clinical symptoms of initial phase of the disease — sore throat — are not characteristic [8, 9]. With

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time the sensation of mechanical obstruction, disturbances of swallowing and articulation and later pain, shortness of breath and trismus develop [8, 9].

Due to the significant percentage of detected malignant lesions, any asymmetry of the throat anatomy requires concern [10].

For the diagnostic purposes the majority of available imaging modalities with computed tomography (CT), nuclear magnetic resonance (NMR) and transcutaneous and endoscopic ultrasound (USG) is useful [11, 12].

The treatment is based on the combination of surgical techniques and chemotherapy and radiotherapy and depends on the histopathologic form of the tumour [8, 9, 12].

Case description

A male patient, 59-years-old, was admitted for treatment as a surgical emergency service due to advanced necrotic lesions of right lower leg and foot. The clinical condition did not allow for subjective examination — the patient responded only by moving his eyelids and nodding his head — with significant difficulties and pain.

Subjectively, the patient was in a moderately severe condition and very weakened due to dehydration and extreme wasting. Pale, dry and had exfoliating skin with anatomical contours of bones and joints showing due to muscular atrophy and subcutaneous tissue atrophy. The right lower leg and foot mummified due to the development of dry gangrene and palpable enlarged and painful lymphatic nodes in the inguinal area at the same side. Among the deviation from normal condition, special attention was drawn by the tumour located in the oral cavity of a purple red colour and diameter of approx. 4 cm. Its contours were irregular, the surface was dry, covered with a grey coating and its initial point was hard to determine. The presence of the tumour was connected with permanent blood oozing, shortness of breath, irritating odour and severe disturbances of swallowing and articulation.

According to the report of the ambulance service physician the general condition of the patient — scruffy and not using any medical care previously — in general quite poorly. Significant deterioration was observed within the last four months when the patient became unable to move on his own and the dyspnoea and problems with nutrition increased. During the admission the arterial blood pressure was 155/90 mm Hg, heart rate 86/min, and

body temperature 36.8°C. The performed laboratory tests showed anaemia and electrolytic disturbances.

After the initial preparation the patient was qualified for emergency operation. Under subarachnoid anaesthesia (ASA IV E) the right lower leg was amputated at the height of 1/3 of the thigh. The vital signs were monitored in a typical manner. No significant deviations from the normal condition were observed. The course of anaesthesia and operation was not complicated. In the post-operative treatment the parenteral hydration, antibiotic therapy, and antithrombotic prophylaxis were introduced. The electrolytic deficits were supplemented as needed.

The clinical condition of the patient was relatively improved. The consulting laryngologist stated that the initial point of the tumour in the oral cavity is the left palatine tonsil. After the surgical treatment was finished it was decided to transfer the patient to the ward of laryngology for diagnostics and further treatment. During the fifth day after the surgery the general condition of the patient significantly deteriorated due to the intensified bleeding in the area of the palatine tonsil and increasing dyspnoea. The introduced symptomatic treatment — concentrate of red blood cells, antithrombotic agents, and oxygen therapy — was ineffective. The patient was transferred urgently to the laryngologic emergency service. Due to the large extent of dyspnoea the middle tracheotomy was performed immediately. In the post-operative period among others, the antibiotic therapy and nutritive preparations were used. In the following days of hospitalisation — despite intensive treatment — the incidents of intensified bleeding from the tumour repeated and symptoms of circulatory and respiratory insufficiency developed. In the sixth day sudden circulatory arrest occurred and the patient consequently died.

Discussion

Hyperplastic lesions of oral cavity and throat, despite being relatively accessible in the objective examination are often discovered accidentally at the level of considerable clinical advances. The growing tumour can cause dyspnoea and also problems with nutrition and articulation [13]. With time the oropharyngeal dysphagia, aphonia, respiratory insufficiency, and cachexia occur. Usually the correlation between the size of the tumour and the progression of the disease process and intensity of clinical symptoms is observed [13].

The domination of male patient in the patient population, the predisposition for addictions and

often low social and economical status together with neglects of prophylaxis and hygiene have decisive impact on the late diagnosis of the disease and incomplete or unsystematic treatment [6, 14]. Some of the patients do not give consent for any medical treatment and sporadically observed are cases of improbable neglect [15, 16].

The complex problems of diagnostics and treatment complicate the problems of the anaesthesiological nature. Most important of those apply to the selection of anaesthesia, difficulties in intratracheal intubation and are connected to the necessity of obtaining and maintaining the patency of the respiratory tracts [17, 18]. The picture is completed by the malnutrition causing problems with wound healing.

The primary localisation of the lesion in the oral cavity and throat supports the revealing mood disorders in the type of depression. It can have various forms from severe stimulation with anxiety and irritability to extreme bradyohrenia and autistic behaviour. The causes of depression can be chronic pain, suffering due to the insufficient body function, loss of social or professional position [19]. Aphonia, especially in man can cause the castration complex [20]. The overlapping of the health problems, social problems, mental problems and spiritual problems is the basis of the deadaptive syndrome. The syndrome is the reaction to losing features valuable for the patient and develops in people incapable of independent existence and who have no support from the society [19].

Thus the purpose of the therapy is not only the optimum surgical or oncologic effectiveness but also the best possible life quality [13]. The parameter must be constantly monitored, both during treatment and during rehabilitation. Anderson Dysphagia Inventory is a survey study that was the first research satisfactorily describing the psychosocial and emotional effect of dysphagia on the life quality of patients [13].

The authors presented a clinical case of a patient recognizing as important the fact that the neglects took place at present in the centre of large municipal agglomeration. Thus the authors point out not only the problems of prophylaxis, diagnosis, and treatment but widely understood social aspects. The ones worth emphasizing: the role of a family physician, organization, and efficiency of general medical care, social care and the availability of palliative care. The authors also ask about the borderline between freedom and autonomy of the patient and the situation when and of what reasons the patient resigns from searching for strategies giving chances for survival [21].

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