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Nasopharyngeal tuberculosis: About 3 cases

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Abstract
The nasopharyngeal tuberculosis is a rare chronic infection representing less than 1% of the forms of this disease. Less than one hundred cases have been reported since 1936. It is most often associated with pseudo-tumoral forms associated with cervical lymphadenopathy and raises problems of differential diagnosis with nasopharyngeal tumors and only the biopsy allows slicing. Its prognosis is good under anti-bacillary treatment. We report the case of 3 patients who have nasopharyngeal tuberculosis whose clinical picture is made of cervical lymphadenopathy with nasal obstruction, and whose diagnosis is made by a nasal endoscopy with biopsy of the nasopharyngeal.

Keywords: tuberculosis, nasopharynx, histological diagnosis

Introduction
The tuberculosis is one of the most common infectious diseases in the world. The localizations at the level of the ENT sphere are often secondary or associated with pulmonary forms; the primitive forms although rare are not exceptional. Tuberculosis of the nasopharyngeal is a rare chronic infection. Less than one hundred cases have been reported since 1936. It is most often associated with pseudo-tumoral forms associated with cervical lymphadenopathy and raises problems of differential diagnosis with nasopharyngeal tumors and only biopsy allows slicing.

Observations
Case 1
A 35-year-old patient, without any notion of tuberculosis counting, consulted for unilateral deafness. The clinical examination found a right sero-mucous otitis without any notion of nasal obstruction, epistaxis or cervical lymphadenopathy. The sero-mucous otitis has been confirmed by the tonal audiogram and the impedancemetry. We completed the assessment by a rigid tube nasal endoscopy showing the presence of a budding process of the roof of the nasopharyngeal. Facial CT showed an irregular tissue process of the upper wall of the nasopharyngeal, suggesting first a malignant tumor (Fig. 1a). We undertook a first biopsy whose result was inconclusive. A second biopsy made the diagnosis of tuberculosis of the nasopharyngeal. An antibacillary treatment combining isoniazid (5 mg / kg / day), rifampicin (10 mg / kg / day) and pyrazinamide (30 mg / kg / day) for two months, followed by treatment with rifampicin and isoniazid for four months gave excellent results with normalization of the otoscopic and endoscopic appearance of the nasopharyngeal.

Case 2
A 15-year-old woman, who has a concept of tuberculous contagion (father treated for pulmonary tuberculosis), consulted for bilateral cervical lymphadenopathy that had been evolving for one year, without muco-purulent rhinorrhea, nasal obstruction or epistaxis. This symptomatology evolved in a context of fever, with night sweats, asthenia, anorexia and unquenchable slimming. The clinical examination revealed a right spinal lymphadenopathy, firm, mobile, and 3 cm in diameter, with small left digastric lymphadenopathy. Endoscopic examination of the nasopharynx, done with the rigid optics at 08, found an important mucosal hypertrophy of the posterior and superior walls of the nasopharyngeal. Nasopharyngeal computed tomography in coronal and axial sections confirmed the pseudotumoral appearance of the nasopharyngeal (Fig. 1b). A biopsy was then performed, the histopathological examination revealed numerous lymphoepithelioid and gigantocellular granulomas with caseous necrosis. The pulmonary X-ray was without abnormality. The patient was started on antituberculous treatment combining isoniazid (5 mg / kg / day), rifampicin (10 mg / kg / day) and pyrazinamide (30 mg / kg / day) for two months, followed by treatment. Rifampicin and isoniazid for four months. Clinical control noted the regression of cervical lymphadenopathy and the disappearance of endoscopic abnormalities in the nasopharyngeal

Case 3
A 14-year-old girl, without any notion of tuberculous contagion, consulted for bilateral cervical lymphadenopathy, evolving for 3 months, which are gradually increasing in volume, with notion of nasal obstruction and rhinorrhea muco-purulent without epistaxis, for whom the examination Clinical finds cervical jugulo-carotid cervical lymphadenopathy high bilateral, painless, mobile, firm, of varying sizes, the largest of which is 4 cm long axis. Cervico-facial CT showed a thickening of the posterior superior wall of the nasopharyngeal (Fig. 1c). Nasal endoscopy was performed on

the rigid tube showing a budding process at the posterior superior wall of the nasopharyngeal, which motivated the performance of a biopsy with histopathological examination revealing epithelioid and gigantocellular granulomas with caseous necrosis. The tuberculin intradermal reaction was 18 mm. The blood count and standard pulmonary X-ray returned without abnormalities. The child was put under the same antituberculous treatment of the two previous patients with a good improvement.

Fig 1a: endoscopic image of the nasopharyngeal showing a budding tumor suspected of malignancy;

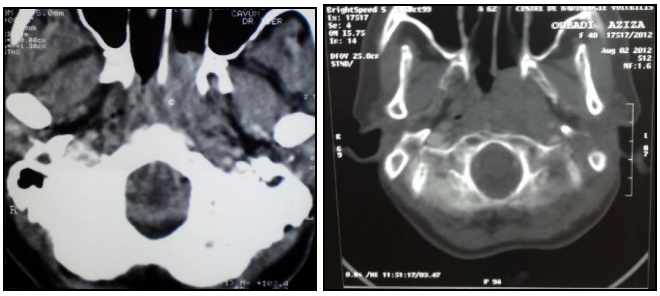

Fig b and c: CT images in axial section showing a tissue process of the nasopharyngeal.

Discussion

Tuberculosis remains a problem with, according to WHO estimates, nearly 9 million people with tuberculosis each year and 2 million deaths. The resurgence of TB is partly explained by the epidemic of HIV infection. Extra-ganglionic tuberculosis of the ENT sphere is a rare pathology, representing less than 1% of localizations. Nasopharyngeal tuberculosis affects mainly young people. It can be manifested by otological signs or more frequently by cervical lymphadenopathy that draws attention to the nasopharyngeal [1]. The mode of cavern contamination involves local inoculation by inhalation of bacilliferous dust, or dissemination by blood or lymphatic system from a mainly pulmonary focus. The involvement of the nasopharynx is essentially secondary. Tuberculosis of the nasopharyngeal is rarely manifested by rhinological symptoms. In its classical form it is manifested by unilateral seromucosal otitis, but is revealed by cervical or bilateral cervical lymphadenopathy in three quarters of cases. In 2003, Tse and Al published a series of 17 cases of nasopharyngeal tuberculosis, mainly pseudotumoral forms [2]. In all cases, the symptomatology is insidious. We note, however, that signs of tuberculous impregnation, neurosensory and respiratory signs have been reported in the literature. The differential diagnosis is of paramount importance, particularly in our context marked by the frequency of nasopharyngeal cancer. The radiological signs are not specific and are especially in favor of a tumor process; CT and MRI make it possible to affirm the absence of invasiveness of this tumor. Endoscopic examination of the nasopharyngeal is imperative, several aspects of cavern tuberculosis have been described in the literature: ulceration, irregular ulceroburging tumefaction, regular mucosal hypertrophy or even an enlarged appearance of adenoids, and all these aspects could very well correspond to a malignant pathology. The positive diagnosis can only be confirmed by histological examination with the presence of epithelio-giganto-cellular granulomas with caseous necrosis, all endoscopic and radiological clinical signs are especially in favor of a tumor etiology, hence the need to achieve several biopsies in different places to eliminate a nasopharyngeal carcinoma or an association that remains possible but exceptional [3]. The identification of the germ by direct examination or after culture on specific medium requires 4 to 6 weeks and can be unsuccessful. Modern techniques such as PCR allow earlier diagnosis and can sometimes resolve an epithelial-giant cell granuloma without caseous necrosis [4]. The treatment of cavum tuberculosis is medical based on an antibacillary multidrug therapy; the classic combination used is a triple therapy with rifampicin, isoniazid and pyrazinamide for 2 to 3 months and followed by a relay for 4 to 6 months by a dual therapy (isoniazid and rifampicin). The therapeutic efficacy is based on the regression of clinical and endoscopic signs. Any abnormal development should evoke resistance or a possibility of neoplastic disease coexisting, hence the need for iterative biopsies. The risk of relapse is estimated at 1%, mainly due to the appearance of multidrug-resistant BK strains.

Conclusion

Although it is a rare condition, primary tuberculosis of the cavum is worth recalling. The presence of many clinical, endoscopic and radiological similarities with nasopharyngeal malignancies is often a problem of differential diagnosis, its prognosis under antibacillary treatment is generally good, and the failures are mainly related to the emergence of multiresistant strains to the treatments.

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