

Late-presenting congenital polypoid lesion of the nasopharynx

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DESCRIPTION

A 3-year-old girl was referred to our department by her primary care doctor because of a polypoid lesion in her oropharynx that was clearly visible even with simple inspection with a headlight and a tongue depressor (**figure 1A**). Her parents reported a history of steadily worsening snoring in the past 12 months, and sleep apnea episodes, occurring almost every night during the past 3 months. Her previous medical history appeared, otherwise, unremarkable, and her parents denied the presence of any feeding or swallowing difficulties in her infancy or later on. Fiberoptic nasendoscopy revealed a pedunculated, whitish mass that seemed to derive from the left edge of the nasal surface of the soft palate, very close to the sidewall of the nasopharynx. This pear-shaped mass was rather opaque and lacked the characteristic translucency seen in typical inflammatory nasal polyps. In close-up observation, it also bared a scant few hair shafts. Otoscopy revealed secretory otitis media on the left side. A CT scan was requested, mostly to help us rule out communication with the intracranial space. The lesion appeared not to have any connections with the cranial cavity as the skull base across the whole neighbouring area was intact, showing no signs of focal defects. Furthermore, the fact that the lesion had a core that demonstrated fat density on CT imaging further narrowed our differential diagnosis to that of teratomas, hamartomas and fibrolipomas (**figure 1B**).

Subsequently, the patient underwent a transoral excision of the mass under general anaesthesia with the aid of a Boyle-Davis mouth gag, a retropalatal 120° rigid endoscope and bipolar diathermy (**figure 2A**). The polyp was excised en block and from its point of attachment. Histologically, the

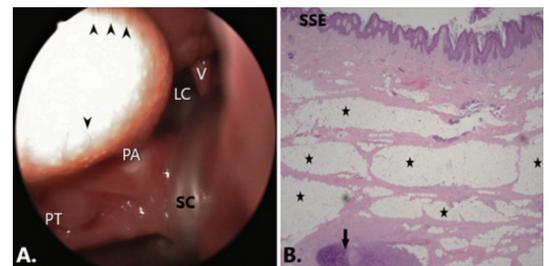


Figure 2 (A) Intraoperative view through the 120° rigid endoscope. A pedunculated, pear-shaped mass that bears scant hair shafts (arrowheads) hangs into the oropharynx. V, vomer; LC, left choana; SC, suction catheter, placed through the right nasal cavity, used to retract the soft palate; PT, palatine tonsil, superior pole; PA, point of attachment of the polypoid mass. (B) Histopathology slide of the hairy polyp. Stratified squamous epithelium with underlying skin adnexal structures envelops a central core with aggregates of adipocytes (stars) and isles of cartilage (arrow). SSE, stratified squamous epithelium.

lesion encompassed a core of fibroadipose tissue that also contained aggregations of cartilage and muscle. This core was enveloped by a layer of keratinising squamous epithelium that contained normal adnexal structures, like hair follicles, sebaceous glands and sweat glands (**figure 2B**). These findings were compatible with a hairy polyp of the nasopharynx. Postoperatively, her sleep-disordered breathing symptomatology showed immediate improvement. At present, the patient remains free of recurrence after almost 8 months of follow-up.

Hairy polyps are rare benign polypoid tumours that usually occur in neonates or infants. They affect chiefly the nasopharynx and oropharynx and are composed of mature mesodermal and ectodermal derivatives of normal histological composition.¹ However, these derivatives (skin and normal adnexa, adipose tissue, muscles and cartilage) are non-native to the area in which these tumours arise. Despite their extreme rarity, they represent the most common congenital, benign naso-oropharyngeal tumour.² Their size and location determine the severity of their clinical presentation, which may range from ordinary, non-specific symptoms to devastating situations presenting right from birth. Rarely, they present, as in our case, after the first year of life with generally less severe symptoms like nasal obstruction, secretory otitis media or simple snoring.³ Sporadic cases of presentation in adolescence

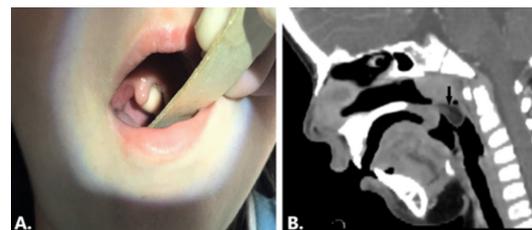


Figure 1 (A) Photograph of the patient. A whitish polypoid mass is seen behind the uvula, hanging into the oropharynx. (B) CT imaging, sagittal view demonstrating a pedunculated lesion (arrow) with a central core of a density similar to that of adipose tissue.



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or even adulthood have also been reported.¹⁻⁴ The aetiology and classification of these tumours are still ambiguous; some authors consider them dermoids, others choristomas and others bigeminal teratomas.¹⁻⁶ Histopathology is essential for a definitive diagnosis, and complete surgical excision is considered to be curative. Recurrences are extremely rare and are thought to result from incomplete excision.¹ Despite their rarity, hairy polyps should be included in the differential diagnosis of oropharyngeal and nasopharyngeal masses, especially in paediatric populations.

Learning points

- ▶ Hairy polyps are rare, benign polypoid tumours that usually occur in neonates or in infancy, and are very infrequent after the first year of life.
- ▶ When they present in childhood or adolescence, they usually do so with less severe symptoms like single-sided nasal blockage, secretory otitis media or sleep-disordered breathing.
- ▶ Despite their rarity, they should be included in the differential diagnosis of oropharyngeal and nasopharyngeal masses, especially in paediatric populations. Complete surgical excision is the recommended treatment.

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REFERENCES

- 1 Dutta M, Roy S, Ghatak S. Naso-oropharyngeal choristoma (hairy polyps): an overview and current update on presentation, management, origin and related controversies. *Eur Arch Otorhinolaryngol* 2015;272:1047–59.
- 2 Foxwell PB, Kelham BH. Teratoid tumours of the nasopharynx. *J Laryngol Otol* 1958;72:647–57.
- 3 Zakaria R, Drinnan NRT, Natt RS, et al. Hairy polyp of the nasopharynx causing chronic middle ear effusion. *BMJ Case Rep* 2011;2011. doi:10.1136/bcr.08.2010.3244. [Epub ahead of print: 03 Mar 2011].
- 4 Tariq MU, Din NU, Bashir MR. Hairy polyp, a clinicopathologic study of four cases. *Head Neck Pathol* 2013;7:232–5.
- 5 Delides A, Sharifi F, Karagianni E, et al. Multifocal bigeminal mature teratomas of the head and neck. *J Laryngol Otol* 2006;120:967–9.
- 6 Batsakis JG. Pathology consultation. Nomenclature of developmental tumors. *Ann Otol Rhinol Laryngol* 1984;93:98–9.

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