Head and neck tuberculosis: The great mimic

Mohamad I, Nik Hassan NFH, Nik Othman NA

Mohamad I, Nik Hassan NFH, Nik Othman NA. Head and neck tuberculosis: The great mimicry. *Malays Fam Physician.* 2016;11(2 & 3);38.

Keywords:
Tuberculosis; Otolaryngology; Tuberculosis vaccines

Authors:

Irfan Mohamad
(Corresponding author)
MD, M.Med (ORL-HNS)
School of Medical Sciences, Universiti Sains Malaysia Health Campus, Kelantan, Malaysia
email:irfankb@usm.my

Nik Fariza Husna Nik Hassan
MD, M.Med (ORL-HNS)
School of Health Sciences, Universiti Sains Malaysia Health Campus, Kelantan, Malaysia

Nik Adilah Nik Othman
MBChB, M.Med (ORL-HNS)
School of Health Sciences, Universiti Sains Malaysia Health Campus, Kelantan, Malaysia

Dear Editor,

We read the article published in the past issue of MFP entitled 'Primary tuberculosis of the hard palate' with great interest.[1] Indeed, it is a common pathology occurring at a rare site. In the reported case, the sign of having palatal mass was not provisionally suspected as tuberculosis (TB), leading to investigation along the line of a malignant lesion, which included MRI. We have encountered a number of extrapulmonary TB cases manifested as lesions along the upper aerodigestive tract, with negative findings on chest evaluation. Extrapulmonary TB is more frequently encountered nowadays.

In the head and neck region, the presenting symptoms of TB might be the same with other pathologies. Mimicry of other diseases causing delayed diagnosis is common. For example, TB of the middle ear presents as a chronic, painless ear discharge – one of the most common otological complaints. This symptom sometimes does not bother the patient enough to seek early treatment until new sequelae or complications, such as vertigo or facial asymmetry develops.[2] TB otitis should be suspected in a chronic discharging ear that fails to respond to the usual anti-bacterial therapy. A high level of clinical suspicion is needed for early diagnosis and commencement of anti-tubercular treatment.

Likewise in laryngeal TB, the presenting symptoms are voice changes, sore throat with or without haemoptysis, dysphagia and odynophagia.[3] The symptoms mimic laryngeal reflux disease, chronic pharyngitis or even carcinoma of the larynx. The diagnosis can be confirmed only with a tissue diagnosis taken for biopsy. With an index of suspicion, the additional request for mycobacterial culture will help to consolidate the diagnosis of TB.

Among the common differential diagnoses of a painless growing neck mass, especially in an adult male, is a cold abscess or scrofula.[4] This term refers to TB of the cervical neck lymph nodes. It is more common in immunocompromised patients; especially in users of illicit intravenous drugs.[5] Clinical suspicion is important, leading to prompt accurate investigation and treatment.

Direct communications between the lungs and other parts of head and neck regions, namely the oral cavity, pharynx and larynx, have been reported in the literature. In a clinically suspected case, screening starts from history. Important predisposing factors include a previous history of TB, contact with TB patients, lack of vaccination with Bacillus Calmette–Guérin or living in a community where herd immunity is suspected to be breached (vaccine-hesitant community[6]). After the screening workup and confirmatory investigations, the commencement of anti-tuberculous treatment is quite standard and straightforward. The paramount importance in the management of these head and neck TB is the awareness of its existence among the primary health care workers, leading to high clinical suspicion of the disease.

References

1. Chen IHK, Jamal S, Pua KC. Primary tuberculosis of palate. *Malays Fam Physician*. 2015;10(3);32–4.
2. Puvan Arul, Nik Othman NA, Mohamad I. Disseminated tuberculosis of middle ear mimicking cholesteatoma. *Int Med J*. 2015;22(1): 47–9.
3. Khan R, Harris SH, Verma AK, et al. Cervical lymphadenopathy: Scrofula revisited. *J Laryngol Otol*. 2009;123(7):764–7.
4. Hermani B, Sawitra D. Laryngeal tuberculosis: an important issue. *Acta Med Indones*. 2006;38(1):29–32.
5. Mohamad I, Jaafar R. An intravenous drug abuser with painless neck masses. *Malays Fam Physician*. 2014;9(3);49–50.
6. Dube E, Laberge C, Guay M, et al. Vaccine hesitancy: an overview. *Hum Vaccin Immunother*. 2013;9(8):1763–73.