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# Supraglottic non-Hodgkin B-cell lymphoma – A case report

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**SUMMARY**

The head and neck are the second most common region for the extra-nodal lymphomas which accounts for 2.5% of total world population. Isolated presentation of laryngeal and hypopharyngeal lymphoma is rare, accounting for about 1% of all laryngeal tumours, predominantly the B-cell phenotype. The most common laryngeal neoplasm is squamous cell carcinoma which accounts for about more than 90% of all laryngeal tumours, hence making the laryngeal lymphoma a rare event. Extra-nodal Non-Hodgkin Lymphoma(NHL) in epiglottis is extremely rare, accounting for 0.7% of all NHL and 1% of laryngeal tumours. In Malaysia there is only 1 case reported in 2018. We are presenting a case of 72-year-old Malay lady with underlying Diabetes Mellitus, Hypertension, and Ischaemic Heart Disease with primary extra-nodal epiglottic lymphoma who presented with a history of foreign body sensation in the throat and throat pain for a month. No shortness of breath or noisy breathing. No history of loss of weight or appetite, and no history suggestive of B symptoms of lymphoma. Intraoral examination was normal, however on 70-degree endoscopic examination of the throat, revealed a mass over the right lingual surface of the epiglottis. Other laryngeal structures were normal, vocal cord were mobile and symmetrical. Biopsy from the mass was taken and reported as diffused large B-cell Non-Hodgkin Lymphoma. CT scan was done and revealed the epiglottic mass with scattered lung nodules suggestive of lung metastasis. She was referred to a Haematologist for further treatment. Due to the small number of cases, no proper treatment guidelines were available, however, there were treatment modalities such as concurrent chemotherapy or just radiotherapy. Patient had undergone 8 cycles of CHOP (cyclophosphamide, Doxorubicine, Vincristine, and Prednisolone) chemotherapy regime, and weekly Rituximab for 4weeks, followed by external radiotherapy. In this case, she started the same regime. Post treatment staging showed improvement over the epiglottic mass but the lung nodules persisted.

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# Nasopharyngeal tuberculosis

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**SUMMARY**

Nasopharyngeal tuberculosis usually presented as aconsequence of pulmonary tuberculosis and occurs in 1.9% of patients with pulmonary tuberculosis. However, isolated nasopharyngeal tuberculosis without the lung involvement is extremely rare. We report a recent case of isolated nasopharyngeal tuberculosis which illustrates a diagnostic difficulty.A 30-year-old female healthcare worker presented with one-month history of sore throat, which worsened for 2 weeks and was associated with odynophagia and dysphagia. She denied any fever but has loss of weight. At the presentation she had completed 2 courses of antibiotics. On examination, no cervical lymphadenopathy noted. Rigid nasoendoscopyrevealed thick sloughs at nasopharynx extending down to the oropharynx. Multiple tissue biopsiestaken for histology, mycobacterium PCR and fungal culture. Allwere negative as well as infective parameters and connective tissue screening. An empirical antifungal therapy together with antifungal nasal douching were commenced which showed a significant clinical improvement. After 4 weeks, repeated nasopharyngeal biopsy was done and reported as inflamed necrotic tissue with presence of abundant acid-fast bacilli. She was then commenced with anti-tubercular drugs and the symptoms were resolved.In conclusion,symptoms and signs of the nasopharyngeal tuberculosis are not typical, making the diagnosis often difficult and challenging. A proper repetitive tissue biopsy is mandatory in the presence of diagnosis dilemma. Mimicry improvement with antifungal treatment should not deter us from pursuing the diagnosis.