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Primary tuberculous parotitis

Sir,

Tuberculous parotitis is extremely rare, even in countries such as India, where the disease is rampant. Clinically, it presents as a slow-growing localized mass, indistinguishable from a neoplasm.[1] Imaging studies may be non-specific. In the salivary glands, where trucut and incisional diagnostic biopsies have never found favor, fine-needle aspiration cytology (FNAC) can provide a pre-operative diagnosis.[2] It is often the preliminary step in the workup of a patient with a parotid mass, and thus unnecessary surgery can be avoided in cases of inflammatory lesions. We present a case of parotid tuberculosis in a 16-year-old female that was diagnosed on cytology and managed medically.

The patient presented with a two-week history of painful swelling in the right infra-auricular region that was gradually progressive and did not resolve with antibiotic therapy. There was no history of fever, cough or weight loss. There was no past or family history of tuberculosis. She was not immunocompromised. Local examination revealed a 3 × 2-cm, soft, cystic mobile swelling in the right parotid region that was slightly tender [Figure 1a]. On pressing over the swelling, there was a pus-like discharge from the Stensen's duct opening. There was no lymphadenopathy. General examination was not significant. Result of routine lab investigations and chest radiograph were within normal limits. FNAC yielded pus-like material. Microscopic examination revealed satisfactory cell yield consisting of focal clusters of ductal epithelial cells, showing reactive changes. Multiple clusters of epithelioid cells with a few Langhans / "foreign body" type giant cells were seen [Figure 1b]. Background showed mixed inflammatory cells consisting of neutrophils, lymphocytes, histiocytes, a few erythrocytes and cellular debris. No lymphoid globules were seen. Smear stained with Ziehl-Neelsen stain showed acid-fast bacilli. Cytological diagnosis of tuberculous parotid abscess was considered, which was confirmed by culture. Patient was put on anti-tuberculous therapy which resulted in resolution of swelling with clinical improvement.

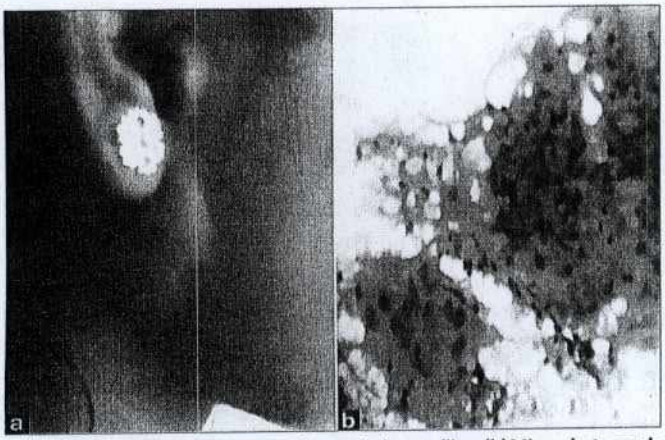

Figure 1: (a) Photograph showing infra-auricular swelling. (b) Microphotograph showing epithelioid cells in clusters with Langhans type giant cells (H and E, ×100)

Tuberculous parotitis accounts for 2.5% to 10% of parotid pathologies.[3] Till recently, fewer than 100 cases have been reported in the literature.[4] It may occur either as parotitis secondary to primary focus in the lung as a result of hematogenous/lymphatic spread or as primary disease due to autoinfection from the oral cavity.[5] There are two pathological forms of tuberculous parotitis, the common localized form is due to involvement of intraglandular/periglandular lymph nodes, while the rare diffuse form involving parenchyma may be secondary to the nodal infection.[4]

The two clinical forms of tuberculous parotitis are, acute tuberculous sialadenitis, which presents with diffuse glandular enlargement; and chronic sialadenitis, which manifests itself as an asymptomatic localized lesion within the parotid gland, slowly growing in size for many years.[5] In our case, the presentation was that of acute unilateral tuberculous parotitis.

To conclude, tuberculous parotitis is an overlooked entity in the evaluation of patients with a solitary mass in the parotid gland in the absence of history of tuberculosis. Early recognition of this disease entity and proper awareness of its potential existence can spare the patient from unnecessary surgical intervention.

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