Pathophysiology in laryngeal granulomatous disease

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A 35 year old male presented to our Pneumology Department with a one month history of persistent fever, moderate weight loss (7 kilograms in a week), night sweats, dysphagia, cough and a history of tobacco and alcohol use. Had notable hoarseness of voice and no history of recent tuberculosis contact. No cervical lymphadenopathy. Laboratory tests within normal range. By laryngoscopic biopsy, histopathological examination showed necrotising granulomatous inflammation without marks of malignancy. Ziehl Neelsen staining of the tissue and sputum sample revealed both acid fast bacilli and grew mycobacterium tuberculosis on culture. Based on national protocol[1], he started right away a 4 drug antituberculous therapy and had within a week a good clinical improvement.

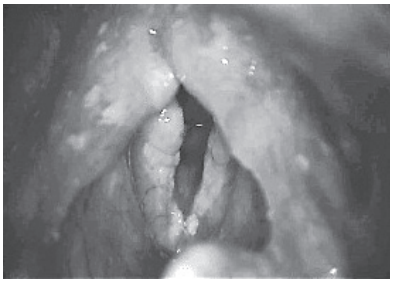

FIGURE 1. The Otorhinolaryngologist performed a fiberoptic laryngoscopy which unveiled oedema and diminished mobility of the right true vocal cord, enlargement of the arytenoids, along with predictable granulomatous harshness of true vocal cords bilaterally, upraising suspicions of laryngeal carcinoma.

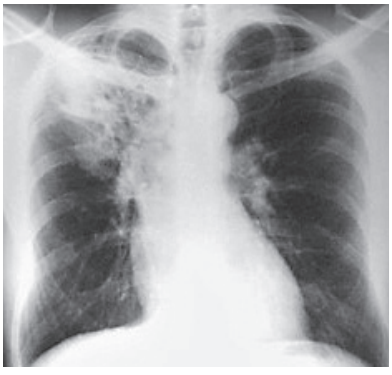

FIGURE 2. Chest radiography displayed granulomas in the left middle lung, consolidation of the right upper lung zone with numerous cavitary lesions in the right infrahilar region.

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1. http://old.ms.ro/documente/GHID%20Metodologic%20de%20implementare%20a%20Programului%20national%20de%20prevenire,%20supraveghere%20si%20control%20al%20tuberculozei%202015_15424_18333.pdf.