



LYMPHANGIECTATIC FIBROLIPOMATOUS POLYP OF THE TONSIL: A RARE BENIGN TONSILLAR LESION

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ABSTRACT **Background:** Lymphangiectatic fibrolipomatous polyps of the palatine tonsil are exceedingly rare benign hamartomatous or reactive pseudotumorous lesions comprising variable proportions of fibrous stroma, mature adipose tissue, and dilated lymphatic channels. Because of their atypical macroscopic presentation, they often clinically mimic more sinister oropharyngeal neoplasms. **Case Presentation:** We report the case of a 19-year-old male presenting with a 3-month history of a slowly progressive, painless left oropharyngeal mass causing throat discomfort and mild dysphagia. Physical examination revealed a pale pink, lobulated, soft, pedunculated polyp measuring approximately 3 cm × 1 cm arising from the left tonsil. Computed tomography (CT) of the neck demonstrated a 28 mm × 10 mm well-defined, hypodense polypoid lesion extending from the uvular plane to just above the epiglottic tip, without significant cervical lymphadenopathy. Complete surgical excision of the polyp was performed under general anaesthesia. Histopathology confirmed stratified squamous epithelium overlying a stroma with numerous dilated, endothelial-lined lymphatic vascular channels and lobules of mature adipocytes set within a dense fibrous matrix, diagnostic of a lymphangiectatic fibrolipomatous polyp. The postoperative recovery was uneventful with no signs of recurrence on follow-up. **Conclusion:** Clinical and histopathological recognition of this rare entity is critical to avoid misdiagnosis as a malignant neoplasm and to ensure definitive surgical cure via complete excision or tonsillectomy.

KEYWORDS : Palatine Tonsil, Lymphangiectatic Polyp, Fibrolipoma, Hamartoma, Benign Oropharyngeal Tumor, Case Report.

INTRODUCTION

Benign non-epithelial neoplasms and polyps of the palatine tonsil are uncommon, accounting for a minor fraction of all tonsillar resections and oropharyngeal lesions. Among these, the lymphangiectatic fibrolipomatous polyp represents an exceedingly uncommon histological variant characterized by the concurrent proliferation of fibrous connective tissue, mature adipose lobules, and prominent, dilated lymphatic vessels.

Patients typically present in young adulthood with an insidiously growing, unilateral, pedunculated tonsillar mass causing foreign body sensation, dysphagia, muffled voice, or recurrent throat irritation. Due to its fleshy or lobulated appearance, clinicians must carefully distinguish it from malignant neoplasms such as lymphoma, squamous cell carcinoma, liposarcoma, or vascular malformations.

The pathogenesis remains a subject of ongoing debate. Two predominant hypotheses exist in the literature:

- **The Chronic Inflammatory/Reactive Theory [2]:** Recurrent tonsillar infections and chronic inflammation produce localized lymphoid hyperplasia, tissue edema, and secondary, irreversible obstruction of draining efferent lymphatic channels. This lymphatic stasis and tissue congestion subsequently trigger fibroblastic and lipomatous proliferation, eventuating in a polypoid protrusion.
- **The Hamartomatous Theory [3]:** The lesion represents a congenital or developmental hamartoma rather than a true neoplasm or reactive process, as fibrous, vascular, and adipose components are normal constituents of the tonsillar bed and tonsillopharyngeal space, arranged here in an aberrant architecture.

We present herein a well-documented case of a 19-year-old male with a symptomatic lymphangiectatic fibrolipomatous polyp of the left palatine tonsil successfully treated via surgical excision, along with clinicopathological correlation and review of relevant literature.

Case Presentation

Patient History

A 19-year-old male, resident of Bihar, India, presented to the Outpatient Department of Otorhinolaryngology with chief complaints of a painless mass on the left tonsil for 3 months. The mass had been gradually increasing in size, causing progressive throat discomfort, foreign body sensation, and mild difficulty in swallowing (dysphagia). There was no history of hemoptysis, dyspnea, stridor, otalgia, fever, chronic cough, altered voice, or unintentional weight loss. Past medical, surgical, and familial histories were unremarkable.

Clinical Examination

On general physical evaluation, the patient was alert, oriented, and

hemodynamically stable (blood pressure: 120/78 mmHg, pulse: 74 bpm, respiratory rate: 16/min, afebrile). Systemic examination of the cardiovascular, respiratory, gastrointestinal, and central nervous systems revealed normal findings, with all cranial nerves intact. Neck examination did not reveal any palpable cervical lymphadenopathy or thyroid swelling.

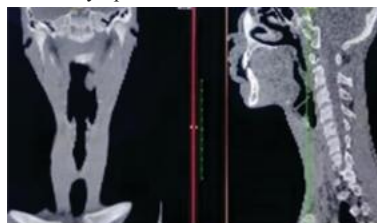
On intraoral and oropharyngeal examination, a soft, pedunculated, pale pink to fleshy mass measuring approximately 3 cm × 1 cm was visualized arising from the superior pole/medial surface of the left palatine tonsil. The lesion was slightly lobulated with a smooth, intact mucosal surface showing no evidence of ulceration, bleeding, or active purulent exudate. On palpation with a tongue depressor, the mass was non-tender, soft, pliable, and non-compressible. The right tonsil and posterior pharyngeal wall were unremarkable.



Laboratory & Radiological Investigations

Routine haematological and biochemical profiles—including complete blood count, erythrocyte sedimentation rate, coagulation profile, fasting blood glucose, renal function tests, and liver function tests—were all within normal limits.

Contrast-Enhanced Computed Tomography (CECT) of the neck (coronal and sagittal reformations) demonstrated a well-circumscribed, hypodense, polypoid soft tissue lesion measuring approximately 28 mm × 10 mm. The mass protruded into the oropharyngeal airway, extending from the level of the uvula inferiorly to just above the tip of the epiglottis. Surrounding tissue fat planes were well preserved, and no invasion into deeper muscular planes or pathological cervical lymph nodes were noted.



Operative Intervention

Following pre-anaesthetic clearance, the patient underwent complete surgical excision of the left tonsillar polyp under general anaesthesia with endotracheal intubation. The pedunculated base attaching the polyp to the tonsillar parenchyma was carefully defined, clamped, and excised with clear margins using bipolar cautery to ensure complete haemostasis. (Note: While complete surgical excision with concurrent ipsilateral tonsillectomy is considered the definitive preferred modality, selective complete base excision preserving remaining tonsillar bed was safely achieved in this instance).

Histopathological Examination

- **Gross Pathology:** The resected surgical specimen consisted of a tan-white, mucosa-covered polypoid mass measuring approximately 3.0 cm × 1.0 cm × 0.5 cm. On bisection, the cut surface was homogenous, yellow-white, with a soft, uniform consistency and no foci of hemorrhage or necrosis.
- **Microscopic Examination:** Hematoxylin and eosin (H&E) staining revealed a surface lined by mature non-keratinizing stratified squamous epithelium. The subepithelial stroma comprised prominent collections of markedly dilated, thin-walled, endothelial-lined lymphatic channels filled with proteinaceous lymph fluid, interspersed with discrete lobules of mature adipocytes devoid of nuclear atypia, all embedded within a moderately dense, vascularized collagenous fibrous stroma. No cellular pleomorphism, mitotic activity, or malignant features were observed, confirming the diagnosis of a Lymphangiectatic Fibrolipomatous Polyp of the Tonsil.



Postoperative Course and Follow-up

The postoperative recovery period was smooth and uneventful. The patient was started on soft oral diet on postoperative day 1 and discharged in stable condition. At subsequent follow-up visits up to 6 months post-surgery, complete mucosal healing was documented without signs of local recurrence or functional impairment.



DISCUSSION

Polyps of the tonsil are among the rarest benign lesions of the upper aerodigestive tract. Historically classified under diverse nomenclatures—such as lymphangiomatous polyps, fibrolipomatous hamartomas, fibroepithelial polyps, or lipomatous polyps—these entities share a benign prognosis but may present substantial diagnostic challenges [1].

Histologically, the present case displayed classic triad features:

1. Marked lymphangiectasia (dilated ectatic lymphatic channels),
2. Mature, uniform adipose lobules (lipomatous element),
3. Fibrous stromal support under normal stratified squamous epithelium.

Clinically, these polyps are usually unilateral, asymptomatic, or produce mild mechanical obstructive symptoms such as dysphagia, globus sensation, snoring, or airway compromise if large [4]. The differential diagnosis includes tonsillar hypertrophy, squamous papilloma, lipoma, hemangioma, schwannoma, pleomorphic adenoma of minor salivary glands, lymphoma, and squamous cell carcinoma.

CT and MRI are valuable diagnostic adjuncts that demarcate the exact anatomical extent, exclude invasion into the parapharyngeal space, and rule out regional lymph node involvement. Definitive management is surgical excision; recurrence is exceptionally rare provided the pedicle and underlying tonsillar attachment are completely removed, frequently in conjunction with tonsillectomy.

CONCLUSION

Lymphangiectatic fibrolipomatous polyp of the palatine tonsil is a rare, benign clinical entity with an excellent prognosis. Otolaryngologists, surgeons, and pathologists must remain cognizant of its clinical and histological features to avoid aggressive overtreatment and distinguish it from oropharyngeal malignancies. Complete surgical excision provides definitive histological confirmation and cure.

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