A Case of Tonsillar Diffuse Large B Cell Lymphoma
Ray Min DO, Helaine Larsen DO
Department of Family Medicine
Good Samaritan Hospital Medical Center, West Islip, NY

Introduction
Diffuse Large B Cell Lymphoma (DLBCL) is the most common histologic subtype of non-Hodgkin’s lymphoma (NHL). Extranasal NHL within Waldeyer’s ring is a relatively uncommon entity, but when it occurs it can be seen in the palatine tonsils. This is case presentation of DLBCL that presented as peritonsillar hypertrophy in an outpatient setting. This case highlights how common symptoms should raise a primary care physician’s index of suspicion for a more serious disease process.

Case Presentation
A 56-year-old African American male presented to our emergency department for further evaluation and was peritonsillar abscess and patient was sent to the skin: Warm, dry, intact without rashes, abdomen: Soft, nontender, nondistended, no wheezes, lungs: Clear to auscultation bilaterally no wheezes, CV: Regular rate and rhythm, normal S1S2 anterior cervical chain and posterior auricular area, neck: Large nontender left submandibular lymph node with largest lymph node of 2.5cm in diameter, deviation of uvula to the right, HEENT: hoarse, muffled voice; large erythematous left throat pain with associated hoarseness of voice and tactile fevers, Symptoms included dysphagia with solids and odynophagia but denied cough or shortness of breath. Pertinent history included recent routine dental cleaning 3 weeks ago.

There was no significant past medical or surgical history. He was not on any medications. He had no significant social history.

Vital Signs:
Temp 98.0F, BP: 124/76, HR 75, RR 18, O2 97% on RA

Physical Exam:

Vital Signs: Temp 98.0F, BP: 124/76, HR 75, RR 18, O2 97% on RA

Physical Exam:

HEENT: hoarse, muffled voice; large erythematous left tonsil protruding beyond midline with white exudate and deviation of uvula to the right.

Neck: Large nontender left submandibular lymph node on palpation and scattered lymph nodes along left anterior cervical chain and posterior auricular area.

CV: Regular rate and rhythm, normal S1S2

Lungs: Clear to auscultation bilaterally no wheezes

Abdomen: Soft, nontender, nondistended, no hepatosplenomegaly, normal bowel sounds

Skin: Warm, dry, intact without rashes

A rapid strep test was negative. Our working diagnosis was peritonsillar abscess and patient was sent to the emergency department for further evaluation and treatment.

Inpatient Hospital Course
In the emergency room, an attempt was made to aspirate presumed abscess area but only 1 cc of serosanguineous fluid was expressed. A CT scan head and neck without contrast showed an enlarged left tonsil and peritonsillar mass that measured 4.8cm. There was left sided lymphadenopathy at levels II – V, with largest lymph node of 2.5cm in diameter.

Lab Results:

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDH 273</td>
<td>481/274</td>
</tr>
<tr>
<td>ESR 53</td>
<td>12.5</td>
</tr>
<tr>
<td>HIV 1/2 negative</td>
<td>1.2/107</td>
</tr>
<tr>
<td>CD20-positive, CD3-negative B lymphocytes</td>
<td>4.8</td>
</tr>
<tr>
<td>ESR 53</td>
<td>38.6</td>
</tr>
<tr>
<td>CD20-positive, CD3-negative B lymphocytes</td>
<td>1.2</td>
</tr>
<tr>
<td>CD20-positive, CD3-negative B lymphocytes</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Our differential diagnosis now included malignancy, so biopsy was performed. Final pathology confirmed CD20-positive, CD3-negative B lymphocytes, consistent with DLBCL.

Response to Treatment
PET scan after 4 cycles of R-CHOP revealed a response to therapy. PET scan after completion of 6 cycles showed no evidence of hypermetabolic malignancy. The patient has remained disease free for one year and continues to follow with us for health care maintenance.

Discussion
Primary tonsillar lymphomas usually occur within the fifth to seventh decades of life with a slight predominance in males. Most cases present with localized stage I or II disease. DLBCL is the most common histologic type of NHL, but extranasal tumors of Waldeyer’s ring are still relatively uncommon. Treatment guidelines have not been standardized, but prior studies have shown improved 5-year survival of up to 88-100% in patients with combination chemotherapy and radiation in early stage primary localized tonsillar DLBCL.1-3 Interestingly, our patient only received chemotherapy without radiation, and achieved remission in one-year follow up. Further studies can be done to observe survival rates in patients treated with chemotherapy alone.

Conclusions
This case represents a relatively uncommon presentation of Non-Hodgkin’s lymphoma that can mimic a common infectious etiology. In an outpatient family medicine practice, providers commonly see complaints of sore throat with low grade fever. However, when a patient presents with red flag symptoms, the provider should expand their differential to avoid missing potentially fatal diagnoses. Fortunately, this patient was treated and diagnosed promptly, and cured with chemotherapy alone.

References