

Persistent Earache Due to Tonsillolith

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Tonsilloliths are rare dystrophic calcification formed as a result of chronic inflammation of the tonsils. Tonsilloliths tend to occur more commonly with increasing age and are relatively rare in children. We report a case of unilateral tonsilloliths in an eight-year-old boy, who presented with earaches and history of regurgitating tiny yellowish-white foul smelling pellets. The tonsilloliths were successfully removed under local anaesthesia following which the symptoms subsided.

Key words: *Earache, Tonsillolith, Myiasis.*

Small areas of calcification in tonsils are a common clinical finding in adults but, large well-formed concretions are very rare [1]. Tonsilloliths are due to a rare form of dystrophic calcifications that are formed as a result of chronic inflammation of the tonsils [2]. Tonsilloliths usually occur in adults and are relatively rare in children [3]. We report an 8 year old boy who presented with recurrent bilateral earaches, paroxysms of coughing and regurgitating tiny yellowish-white foul smelling pellets. This case posed a diagnostic difficulty before the simple diagnosis of tonsilloliths was made.

CASE REPORT

An eight-year-old boy was referred to us by his family physician for recurrent bilateral earaches and self-limiting paroxysms of coughing and grunting for the last three months. He was apparently normal between the episodes. There was no fever, ear discharge, dysphagia or a history suggestive of asthma. His past medical history was uneventful except for having received two courses of empirical antibiotics for suspected otitis media. Immunization, developmental history, and anthropometry were appropriate for his age. Oral examination, systemic examination, indirect laryngoscopy and otoscopic examinations were normal. The differential diagnoses considered at this point were convalescent pertussis and gastroesophageal reflux disease. His baseline investigations were normal and he did not respond to anti-reflux medications.

The boy was brought again by the mother who complained that he was regurgitating tiny yellowish-white foul smelling 'worm eggs' for the last few days and was

having bad breath. Examination of oral cavity was normal except for halitosis. Stool microscopy was normal. We advised them to maintain good oral hygiene and an anthelmintic drug was prescribed. They returned in a week's time with the regurgitant sample. The specimen was hard in consistency, oval in shape and yellowish-white in colour measuring around 5×2 mm. The panoramic radiograph showed radio-opaque masses overlapping the ramus of the right mandible. A detailed oral examination was undertaken under local anaesthesia. When gentle pressure was applied on the anterior pillar of the right tonsil, few small white hard structures popped out from the tonsillar crypts. These pellets were confirmed as tonsilloliths (tonsil stones) and were successfully removed under local anaesthesia. The post-operative period was uneventful and the symptoms subsided.

DISCUSSION

Tonsilloliths are calcareous concretions in the crypts of tonsils which are usually asymptomatic and may incidentally be found on radiographs [4]. Small concretions may be asymptomatic, while more severe forms may present with pain and foreign body sensation in the throat, swelling in the tonsillar fossa, odynophagia, otalgia, peritonsillar abscess and halitosis [1]. These are rarely seen in children [4]. Since tonsils are supplied by glossopharyngeal nerve, any irritation or pain can be referred to the ear along the tympanic branch of the glossopharyngeal (Jacobson's) nerve.

In our case, though the child presented with earache and halitosis, we initially did not suspect tonsillolith owing to the rarity of this condition in children and absence of abnormal findings on oral examination. The history of

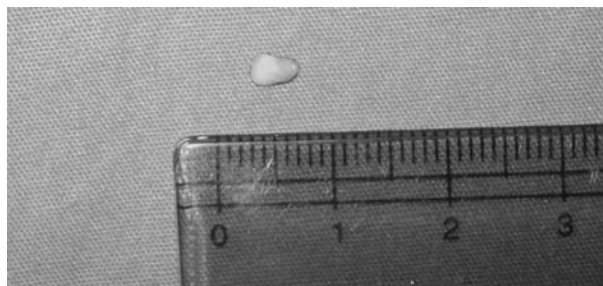


FIG.1 Tonsil Stone.

extrusion of egg-like structures was misleading and was responsible for the delay in diagnosis. Although some worms infecting lungs during their life cycle can present with regurgitation of eggs, the helminthic eggs are too small to be seen with naked eye [5]. However, larval stages of housefly can be seen in cases of oral myiasis. But they are photophobic and often tend to hide deep into tissues for a suitable niche to develop into pupa [6].

Tonsilloliths frequently consist of carbonates and phosphates of calcium and magnesium [1]. The exact pathogenesis is not known, but is believed to be associated with chronic or recurrent oral infections [3,4]. Fibrosis near the openings of the tonsillar crypts due to repeated inflammation may result in accumulation of bacterial and epithelial debris and formation of retention cysts which can subsequently calcify [2]. Unlike most reported cases,

there were no features suggestive of tonsillitis in our case. This condition may be diagnosed by simple inspection of both tonsillar crypts and can be confirmed by a panoramic radiograph or computed tomography without contrast [1, 2]. Most tonsilloliths are small and asymptomatic and require no treatment [2]. Small, symptomatic tonsilloliths can be removed manually under local anesthesia, while large, symptomatic tonsilloliths associated with pain, swelling and dysphagia should be removed surgically [1].

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Corrosive Tracheo-esophageal Fistula Following Button Battery Ingestion

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We describe a case of corrosive tracheo-esophageal fistula following button battery ingestion in a 1-year old nonverbal pediatric patient. The delay in diagnosis was caused by failure to obtain correct history and failure to detect opacity of the battery in the neck at the first visit. The large fistula was successfully treated with division and repair with non absorbable sutures, with interposition of strap muscles between separated trachea and esophagus.

Key words: Button battery, Corrosive ingestion, Ingestion, Tracheo-esophageal fistula.

Tracheo-esophageal fistula following a foreign body impaction in the esophagus is a rare and serious complication. We report consequences of an unrecognized button battery impaction in

the esophagus, which resulted in tracheo-esophageal fistula formation and was not diagnosed for more than 18 days due to masquerading of button battery shadow by haziness of associated pneumonia.