Case Report

Nasopharyngeal Lymphoid Hyperplasia of an HIV Carrier, Mimicking Nasopharyngeal Cancer

Lymphoid hyperplasia of cervical lymph nodes is a common head and neck presentation of human immunodeficiency virus (HIV) infection. Lymphoid hyperplasia of HIV carrier presenting as nasopharyngeal tumor and neck mass is rarely discussed. We reported a 30-year-old male patient who had left side neck mass for 3 months. Nasopharyngeal cancer with neck metastasis was suspected due to the huge nasopharyngeal tumor and neck mass. The patient was then transferred to our clinic for further evaluation. Physical examination revealed a 30 × 30 mm mass over the left jugulodigastric area and a 20 × 20 mm mass over the left posterior triangle of neck. Telescopic examination revealed a 20 × 20 mm bulging mass over the nasopharynx. Nasopharyngeal biopsy was done and histopathologic examination revealed lymphoid hyperplasia. Laboratory survey showed seropositive for HIV infection for both enzyme-linked immunosorbent assay (ELISA) and western blot tests.

CASE REPORT

The 30-year-old homosexual male patient stated a progressively enlarged left side neck mass, nasal obstruction and snoring for more than 3 months. There was no tenderness over the neck mass and there was no diplopia nor epistaxis. He went to a local hospital for diagnosis and treatment. Nasopharyngeal cancer with neck metastasis was suspected due to a large tumor in the nasopharynx and a left side neck mass. Then he was referred to our OPD for further evaluation. At our clinic, physical examination and CT scan showed a 30 × 30 mm mass over the left jugulodigastric area and a 20 × 20 mm mass over the left posterior triangle of neck. Telescopic examination and CT scan revealed a 20 × 20 mm bulging mass in the nasopharynx. Biopsy was done over the nasopharyngeal mass and histopathologic examination revealed nasopharyngeal tissue with prominent lymphoid tissue. Prominent germinal centers were also noted. There was no evidence of neoplasm. Laboratory survey showed seropositive for HIV infection for both enzyme-linked immunosorbent assay (ELISA) and western blot tests. There was no other evidence of neoplasm.
cept hyperuricemia with gouty arthritis.

Under the impression of HIV infection with nasopharyngeal lymphoid hyperplasia and cervical lymphadenopathy, the patient was referred to infection department for further management. He received HIV protease inhibitor therapy (Kaletra + Combivir) and the neck mass regressed one month later. The nasopharyngeal mass regressed too. The serum viral load decreased from 278143 copies/mL to 143 copies/mL.

**DISCUSSION**

Head and neck manifestations are quite common in acquired immune deficiency syndrome (AIDS) patients, including enlarged neck lymph nodes, nasopharyngeal lymphoid tissue hyperplasia, extranodal localization of non-Hodgkin’s lymphoma, Kaposi’s sarcoma, oral hairy leukoplakia and candidiasis. Initially 40% patients with AIDS were reported to have head and neck manifestations. With increased awareness, more lesions were recognized. Now it seems that nearly all patients with AIDS have head and neck manifestations.

Nasopharyngeal lymphoid tissue masses with or without cervical lymphadenopathy in HIV infection have been discussed before. Nasopharyngeal lymphatic hyperplasy can be found in up to 88 per cent of asymptomatic HIV infection. Shahab et al. reported 9 cases of HIV positive patients with nasopharyngeal lymphoid tissue masses in which five had moderate to marked cervical lymphadenopathy. Stern et al. have reported 7 cases of benign nasopharyngeal masses with HIV infection presenting symptoms of nasal obstruction and hearing loss. None of the patients had cervical lymphadenopathy known to be HIV infected. They suggested that nasal obstruction and hearing loss secondary to nasopharyngeal lymphoid proliferation in high-risk patients can be an early sign of HIV infection. Weig et al. reported 12 cases with lymphoid changes of nasopharyngeal and palatine tonsils. Eight of them were not found any risk or history of HIV in infection. HIV in infection was suspected on the basis of the histologic changes seen in the resected tonsillar and adenoidal tissue.

We did not find in this case any risk of HIV in infection.
Nor had he known to be infected with HIV in infection before the serology test. Since nasopharyngeal cancer had been ruled out by nasopharyngeal biopsy, cervical lymphadenopathy was most likely due to infection, which might come from homosexual activity and was confirmed by the serology test.

HIV infects human T lymphocytes and destroys the immune system progressively to become AIDS. The latent period usually takes several years. Mortality of AIDS is high, and the disease is infectious to other people before it is diagnosed. If we can diagnose HIV infection earlier, the prognosis would be better because the immune system is not destroyed yet. Combined chemotherapy reduces the virus number to a very low level that the patient can live a nearly normal life.

In epidemic areas of nasopharyngeal cancer such as Taiwan, Hong Kong, southern China and southeastern Asia, nasopharyngeal cancer will be first suspected if the patient has both nasopharyngeal mass and neck mass. Other differential diagnoses are ignored while efforts are made to prove the malignancy. Since almost all the patients with HIV infection have some kinds of manifestations in head and neck region, otolaryngologists should be familiar with these manifestations in order to diagnose and treat HIV infection as early as possible.

REFERENCES