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Letter to Editor

Ear, Nose and Throat Section

Epiglottic Chondroma: Diagnostic Challenges and Management Strategies

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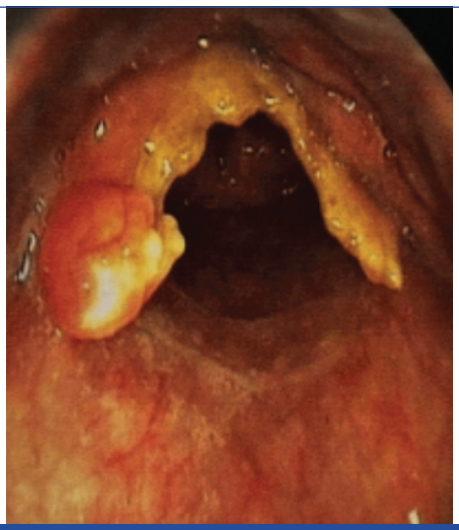
Dear Editor,

Chondromas are benign neoplasms arising from cartilaginous tissue, predominantly found in bones; with soft-tissue occurrences are rare [1]. Among the infrequent sites of occurrence, chondromas of the upper aerodigestive tract are exceptionally uncommon [2]. Diagnosing epiglottic chondroma presents a challenge due to its rarity and non specific clinical presentation. Limited cases in the literature highlight the importance of considering chondromas in the differential diagnosis, especially in patients with chronic symptoms such as dysphagia or globus sensation [3-5].

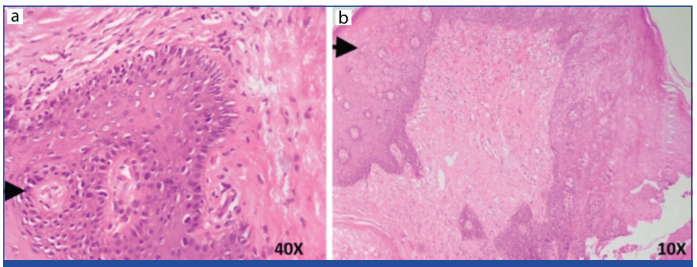
This letter contributes to the understanding of epiglottic chondromas and highlights the need for individualised treatment approaches. A 56-year-old woman presented to the hospital with a chief complaint of a one-month history of a foreign body sensation in her throat and odynophagia. Her past medical history included tuberculosis, treated 39 years previously. Physical examination was largely unremarkable, but video-direct laryngoscopy revealed a “nibbled” epiglottis [Table/Fig-1]. The patient reported no fever or weight loss and there were no palpable neck masses or other laryngeal abnormalities.



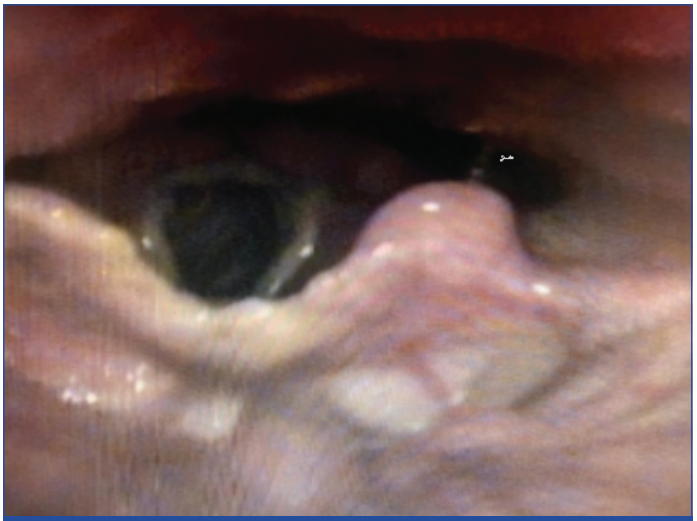
[Table/Fig-1]: Laryngoscopy image showing "nibbled" epiglottis.

A direct laryngoscopic biopsy was performed, and the sample was sent for histopathological examination. Histopathology revealed stratified squamous epithelium with a subepithelial lobulated lesion. The lesion consisted of cells embedded within lacunar spaces with small, round nuclei and condensed chromatin, consistent with chondroma [Table/Fig-2].

Given the benign nature of the lesion and the absence of significant symptoms, surgical excision was not pursued. Conservative management was initiated with methylprednisolone 16 mg Three Times Daily (TDS) for five days, then Twice Daily (BD) for five days, and finally Once Daily (OD) for five days. The patient is currently receiving antireflux medication and is under long-term follow-up every three months for surveillance [Table/Fig-3].



[Table/Fig-2]: Histopathological image of epiglottis lesion (H&E stain): a) Stratified squamous epithelium showing small, round nuclei with condensed chromatin (black arrowhead); b) Lobulated cartilaginous lesion with an abundant hyaline cartilage matrix beneath the epithelium (black arrowhead).



[Table/Fig-3]: Laryngoscopy image at six-month follow-up.

These tumours generally grow slowly and can present with symptoms such as hoarseness, dyspnoea, dysphagia, or a palpable neck mass [6,7]. In this case, the patient initially reported a foreign body sensation in the throat, leading to further diagnostic evaluation. Although the clinical presentation suggested laryngeal tuberculosis due to the “moth-eaten” appearance of the epiglottis, the diagnosis was ultimately epiglottic chondroma. This eroded and ulcerated appearance of the epiglottis is often seen in laryngeal tuberculosis [8].

This case highlights the need for increased awareness among clinicians regarding such rare entities and the importance of a thorough diagnostic approach to ensure accurate identification and appropriate management. While conservative management with regular surveillance is typically sufficient for asymptomatic cases, awareness of such rare neoplasms is crucial for clinicians to ensure proper diagnosis and management.

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