

A Concerning Uvula Abnormality

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A 21-year-old woman with no significant medical history presented to our clinic with "something hanging" from her uvula. She had noticed it a few months prior to presentation when she felt a tickling sensation at the back of her throat. At presentation, she said it now felt like it grew, because it was causing her to gag at times when swallowing.

She denied any pain, difficulty swallowing, difficulty breathing, snoring, bleeding, or any changes in her voice. She is concerned because she believes her uvula is now connected to her tongue and is worried it may be cancerous.

On physical examination, her vital signs were stable with 100% oxygen saturation on room air. Results of a head, eyes, ears, nose, and throat examination were normal except for the uvula abnormality. An oropharynx examination revealed a thin strand of tissue connecting the tip of her uvula to the base of her tongue (**Figure**). No cervical lymphadenopathy was noted, and the rest of her examination was unremarkable.



Figure. A thin strand of tissue was noted connecting the tip of her uvula to the base of her tongue.

Based on the patient's history and physical examination, which one of the following is the most likely diagnosis?

- A. Cleft uvula
- B. Squamous papilloma of the uvula
- C. Uvulitis
- D. Isolate uvular angioedema

Correct answer: B. Squamous papilloma of the uvula

Given the patient's history and examination findings, the growth was consistent with squamous papilloma of the uvula, especially with the visual formation of the bridge of tissue.

Discussion

Papillomata are benign growths that occur mostly on the palate and tongue but can occur on the uvula as well.¹ They are usually asymptomatic, but symptoms can be present depending on the length of the lesion.² The peak occurrence is in adulthood, and patients usually present with continuous throat irritation.² However, oral squamous cell papillomata, like squamous papilloma of the larynx, are not associated with cancer.¹ The pathology of oral squamous papillomata shows stratified squamous epithelium with a fibrovascular core.² Squamous papilloma has been associated with human papillomavirus (HPV), but recent literature theorizes that it may be an unrelated incidental finding.² The treatment options include surgical or electrocautery excision, laser ablation, cryosurgery, or intralesional injections.² Recurrence is not common; individuals with HIV may have a higher risk of recurrence, but recurrence is rare among immunocompetent individuals.^{1,2}

Other differential diagnoses to consider are cleft uvula, uvulitis, or isolated uvular angioedema. Cleft uvula is one of the less-severe forms of cleft palate, which usually presents with cleft palate and rarely on its own.³ It can range from barely bifurcated to complete bifurcation with cleft palate and cranial nerve IX

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impairment.³

Uvulitis is inflammation and swelling of the uvula most commonly secondary to *Haemophilus influenzae* type b or streptococcal pharyngitis.⁴ It is different from allergic edema of the uvula in that uvulitis presents with fever, pain, and erythema.⁴

Isolated uvular angioedema (ie, Quincke disease) is caused by a type 1 hypersensitivity reaction.⁵ Treatment includes corticosteroids and antihistamines as well as airway protection.⁵

Patient outcome

Our patient was referred to an otolaryngologist for further evaluation. The specialist performed a biopsy, results of which showed benign squamous papilloma and no epithelial dysplasia. This confirmed the diagnosis of squamous papilloma of the uvula. The patient had completed the HPV vaccine series as a teenager. The pedunculated mass was surgically excised in the specialist's office. No further follow-up was needed after surgical resection and pathology report per the specialist.

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