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Case Report: an Unusual Case of Secondries from Occult Primary

Medical Science

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ABSTRACT

Carcinoma of unknown primary site (CUP) represents a heterogeneous group of malignancies presenting with lymph node or distant metastases, for which diagnostic work-up fails to identify the site of origin 1. Squamous cell carcinoma (SCC) is the most common histotype, followed by adenocarcinoma, undifferentiated carcinoma and other malignancies (for example, lymphoma and melanoma) 2-5. Presenting a case of 24 year old female who was known case of Pulmonary Koch with bilateral swelling over sub mandibular reigon which was hard in consistency, non-tender, no discharge, local area temprature not raised.

Introduction

Metastatic squamous neck cancer with occult primary is a disease in which squamous cell cancer spreads to lymph nodes in the neck and it is not known where the cancer first formed in the body. Signs and symptoms of metastatic squamous neck cancer with occult primary include a lump or pain in the neck or throat. Tests that examine the tissues of the neck, respiratory tract, and upper part of the digestive tract are used to detect (find) and diagnose metastatic squamous neck cancer and the primary tumor.

Case Report

A 24 year old female referred by physician to our surgical OPD for swelling in upper 1/3rd of neck on both sides since three months. Patient had past history of pulmonary koch's 12 years back for which she received AKT. The patient had history of recurrent attacks of rhinitis, earache and tinnitus both ears,headache 6 months back, for which she was treated conservatively for rhinosinusitis by an ENT surgeon. and she got relieved of the symptoms. After some period the patient started developing bilateral neck swellings in upper third reigon on both sides which were initially small in size and gradually progressing in size. The Swellings were non tender, firm to hard in consistency for which she again consulted her physician and he advised AKT to the patient. Then the patient came for consultation and she was planned for of exision of swelling on both sides suspecting tubercular lymphadenitis. After doing work up and basic investigations patient was then taken to surgery and swellings on both sides were exised and sent for histopathology.

Grossly the lymph nodes seen were encapsulated,irregular and firm, cut section showed multiple matted lymph nodes (figure 1) .

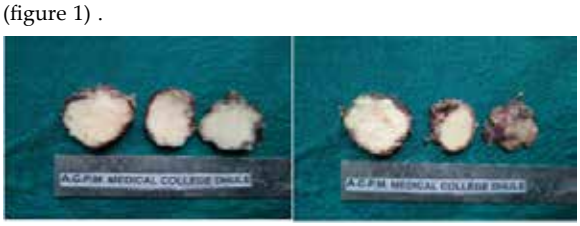
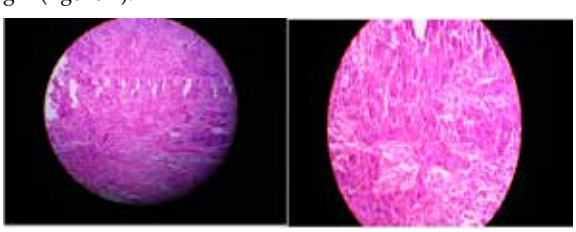


Figure 1 – Enlarged Lymph nodes.

Microscopically the impression was metastatic lymph nodes suggestive of poorly differentiated non keratinizing squamous cell carcinoma of ?upper aero-digestive tract origin (figure 2).



The histopathology report was surprising for the consultant and came to the conclusion that it may be secondaries in the neck with occult primary.

After that CT neck was done which revealed multiple small nodes in the neck on both sides. (Figure 3). Multiple Secondries seen around the extend into any direction, eroding the base of skull and passing via the Eustachian tube, foramen lacerum, foramen ovale or directly through bone into the clivus, cavernous sinus and temporal bone. In such cases the bone has irregular margins where it has been destroyed, characteristic of aggressive processes[9-12].

Figure 3 - CT Neck images

Then taking detail history from the patient and the relatives and co relating the series of events and reports Consultant referred the patient to ENT department.

When ENT surgeon, going through all her reports, did a thorough check up, could not come to any conclusion sug-

gestive of upper aero digestive tract malignancy from history as well as on clinical examination. Patient did not C/O blocking of nose, epistaxis, snoring. When on further questioning he got the history of earache and tinnitus in the past, he checked the nasopharynx by elevating the soft palate with his forceps (Figure 4,5).

To every one's surprise, a pinkish ulcerative peanut sized growth with slough on the surface was revealed in the nasopharynx. The growth was vascular and bled easily

Thus the diagnosis was confirmed as carcinoma of nasopharynx with secondaries in the neck. The patient was referred for radio and chemotherapy to the higher centre.

Figure 4 – Nodule seen

Discussion

Carcinoma of unknown primary site (CUP) associated with aero digestive tract of origin is often associated with Nasopharyngeal carcinoma of origin.

- Nasopharyngeal carcinomas are divided into three types [6-7]
- **Type I:** keratinizing squamous cell carcinoma
- **Type II:** non-keratinizing squamous cell carcinoma (aka lymphoepithelioma)
- **Type III:** undifferentiated carcinoma
- Risk factors are different depending on the histologic type of tumour present:
- Type I (keratinizing squamous cell carcinoma) can be thought of as a run-of-the-mill head and neck squamous cell carcinoma, which happens to be located in the nasopharynx. Its biological behaviour is similar and it shares the same risk factors, namely smoking and alcohol [2].
- Types II and III on the other hand (non-keratinizing squamous cell carcinoma and undifferentiated carcinoma respectively) are strongly associated with Epstein Barr virus (EBV) and are seen particularly in Asia [6-8].
- All three types express cytokeratin, and types II and III have incorporation of the EBV into their genome, and circulating IgA antibodies to EBV in peripheral blood .
- Recently, HPV infection showed an etiologic role in the development of non-endemic EBV-negative nasopharyngeal cancers. HPV-positive and EBV/HPV-negative tumours exhibited worse outcomes than EBV-positive tumours [8]

Conclusion

Early, but often ignored symptoms, include nasal obstruction, epistaxis or conductive hearing loss due to Eustachian tube obstruction and the development of a middle ear effusion. Actual presentation is often delayed until more sinister signs are evident including nodal masses in the neck (most common), cranial nerve palsies, tinnitus, headache or even diplopia and proptosis [10-11]. One study indicated the following symptoms. Nasal symptoms: including bleeding, obstruction, and discharge (78%). Ear symptoms: including infection, deafness, and tinnitus (73%), Headaches (61%), Neck swelling (63%). Literature says that Nasopharynx is the most common site for occult primary and the first presentation may be multiple bilateral lymph nodes swelling (60-90%) and also it is not uncommon to see in younger age group .

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