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CARCINOMA OF UNKNOWN PRIMARY: DIAGNOSTIC AND THERAPEUTIC DILEMMA: A CASE REPORT

Oncology

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ABSTRACT

Introduction: Neck lymph node metastasis with an unknown primary in the head and neck region is a common problem in the surgical oncology unit. The optimal management strategy for such patients is still not very well defined which in turn gives rise to ample confusion in the mind of the clinician. We are presenting one such interesting case where lymph node metastasis had been variously diagnosed as originating from salivary gland, thyroid and finally found to be squamous cell carcinoma with unknown primary.

Case Report: A 37 year old female presented with bilateral swelling in the cervical region. Initial FNAC from both side was suggestive of mucoepidermoid carcinoma probably originating from parotid. Further workup with USG neck suggested infective pathology in the cervical swelling and also revealed lesion in the right lobe of the thyroid and isthmus. An array of investigations followed which only added to the confusion and finally b/l biopsy was done which confirmed squamous cell carcinoma in the b/l cervical swelling. B/l neck dissection followed by radiotherapy was done after histopathology confirmed it to be metastatic carcinoma.

Discussion: Carcinoma of unknown primary is defined as the histological diagnosis of metastasis without the detection of a primary tumour. Cervical node metastasis with unknown primary is a common problem with incidence upto 7%. There are various treatment protocols but primary modality of choice is surgery followed by postoperative radiotherapy. The intent of treatment is curative as the lymph node metastasis represents regional spread.

Conclusion: We present this unique case because of the interesting mode of presentation, the diagnostic and therapeutic dilemma it created among the various speciality clinicians involved in this patient's care and the eventual successful intervention.

KEYWORDS

INTRODUCTION

Carcinoma of cervical lymph node with unknown primary with no optimal management guidelines has for a long time kept clinicians at their wits end with regard to the diagnostic and therapeutic modality that they can offer to their patients. Carcinoma with unknown primary in the head and neck region is fairly common in surgical oncology practice and its incidence is approximately 7%[1]. We are presenting one such interesting case where lymph node metastasis had been variously diagnosed as originating from salivary gland, thyroid and finally found to be squamous cell carcinoma with unknown primary giving rise to ample confusion in the mind of the clinicians treating the patient and anxiety and fear in the patient and her relative.

CASE REPORT

A 37 year old female presented to the OPD of the Department of Surgical Oncology with bilateral cervical swellings from 5 years duration for which she had taken medication from a local practitioner without any improvement. The size of the swelling on the left side was 3x3 cm and on the right was 2x1 cm and was mobile and firm to palpate.

Workup included USG neck which indicated an infective pathology of the neck swellings and also picked up 1.5 cm lesion in the right lobe of thyroid. FNAC was done which concluded the lesion in the thyroid to be colloid goiter and b/l cervical swellings were reported to be of infective etiology. Second FNAC of the cervical swelling showed metastatic mucoepidermoid carcinoma arising from the parotid. Since there was a discordance in the FNAC reports CT scan of the Oral Cavity, Neck and Thorax were ordered which concluded only cervical lymphadenopathy in b/l neck with tiny cystic lesion in the thyroid with no other lesion any where else including the parotid. Hence a third FNAC was ordered which only added to the confusion in the mind of the clinician as it reported the cervical swellings to be metastatic squamous cell carcinoma. An extensive and exhaustive array of investigations followed to search for the primary such as panendoscopy, PET CT etc but failed to locate the primary.

Lack of a definitive diagnosis with multiple FNAC reports led to confusion in the mind of the clinicians treating the patient and also struck fear in the patient. This led to the final decision of conducting an open biopsy which was reported to be squamous cell carcinoma. Based on this report bilateral neck dissection was done followed by radiotherapy. Patient is doing well with three months of follow up.

DISCUSSION

Carcinoma of unknown primary is defined as the histological diagnosis of metastasis without the detection of a primary tumour. Cervical node metastasis with unknown primary is a common problem with incidence upto 7%[1]. The evaluation, diagnosis and treatment modality remains controversial for such cases and many a times even after a exhaustive workup diagnosis and therapeutic approach remains uncertain.

Of note among the risk factors is the recent discovery HPV positivity amongst patients of cervical lymph node metastasis with unknown primary especially arising from oropharynx[2]. Whether HPV positivity has any prognostic effect is unknown.

The emerging newer techniques such as CT Scan, MRI and PET Scan have all been added to the diagnostic armamentarium of the carcinoma of the unknown primary in search of the occult primary. At present, the standard initial evaluation includes complete head and neck examination, flexible nasolaryngoscopy, cross-sectional mucosal imaging by contrasted computed tomography, magnetic resonance imaging. Recently flourodeoxyglucose F 18– labeled positron emission tomography (PET) has been added in the work-up of patients with an unknown primary carcinoma in the head and neck region[1]. PET scan in particular can detect one third of the occult primary [3,4]. In case the primary lesion remains undiscovered, patient is traditionally taken to the operating room for bilateral tonsillectomy and blind biopsies. This approach can detect 17%- 50% of the occult primary tumour[5].

The management of hncup remains a therapeutic dilemma. The objective is to treat the mucosal surface harboring cancer, deal with nodal involvement and prevent distant metastasis. The treatment options consists of surgery alone, radiotherapy alone or combined modality treatment [6]. Most studies advocate neck dissection followed by radiotherapy [7]. Combined modality of treatment though leads to better treatment outcomes[8] however also comes with the risk of increased toxicity.

CONCLUSION:

This is a fascinating case as such kind discordance in the histopathology report is not usually seen. We present this unique case because of the interesting mode of presentation, the diagnostic and therapeutic dilemma it created among the various speciality clinicians

involved in this patient's care and the eventual successful intervention.

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