

An Unusual Presentation of Nasopharyngeal Carcinoma

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Abstract

Nasopharyngeal carcinoma may present with bewildering arrays of signs & symptoms. Diagnosis often becomes difficult and requires a high degree of clinical suspicion for the disease. Nasopharyngeal carcinomas have low incidence in western countries but are endemic in china. Due to the nasopharynx being a silent symptom area, they have an indolent course and diagnosis is usually made at an advanced stage. Aetiological factors have been linked to genetic , environmental ,dietary factors and Epstein Barr virus .We present a case of an unusual presentation of nasopharyngeal carcinoma with Isolated 3rd nerve partial palsy{ Presenting as exotropia & diplopia & pupil being normally reacting} and chronic suppurative otitis- media right side without any secondaries neck ..

Keywords : Nasopharyngeal carcinoma. clinical presentation.

Introduction

Nasopharyngeal carcinoma is a relatively rare malignancy of Indian subcontinent. Scalon and other describe nasopharyngeal carcinoma as always challenging problems from both as therapeutic and diagnostic stand point, malignant lesion of the nasopharynx are perhaps most commonly misdiagnosed, most poorly understood and most pessimistically regarded among all the tumours of upper respiratory tract.

Case Report

A 66 year male presented in eye out patient department. with outward deviation of right eye and diplopia . Vision was 6/18 in both eyes with both reacting pupils.Patient was diagnosed as having isolated 3rd nerve partial palsy.Subsequently patient was referred to medicine department . Patient had past history of antitubercular therapy two years back.Thereafter patient came to E.N.T out patient department.. with c/o ear discharge Rt . ear and decreased hearing from Rt ear for the last 3 years , blood stained sputum for 6 months and inability to close right eye properly for 2 months. There was pain in right ear, right eye and mastoid region. The pain was continuous ,deep seated, throbbing headache with otorrhoea . {Grdnigo like syndrome} Loss of appetite was present though no history of weight loss could be elicited. Patient was chronic smoker for the last 40 years. There was no history of neck lump, bony pains or seizures, There was history of blood stained cough and expectoration off and on for the last 6 months and patient had nasal blockage Rt. side for the last 1 month.

Examination revealed :

Right ear having a small perforation in posterosuperior area but there was no mass in external auditory canal although debris were present which were removed.

Left ear was normal.

On anterior rhinoscopic examination there was mild **deviation** of septum to left side and mucoid secretions were present in middle meatus. On posterior rhinoscopic examination there was mass filling whole nasopharynx.

On examination of oral cavity proper and oropharynx there was a smooth surfaced mass infiltrating soft palatae . Patient had poor orodental hygiene . Indirect laryngoscopy was normal. No lymph adenopathy was observed on neck examination.

Systemic examination showed no abnormality . Cranial nerve examination revealed isolated 3rd nerve partial involvement initially sparing the pupil but later on developed ptosis and involvement of VI nerve . All other cranial nerves were normal.CT scan showed malignant mass showing bony destruction of floor of right middle cranial fossa and having components in infratemporal space, suprahyoid neck as well as intracranial component{right temporal} . There was soft tissue component of mass present in EAC and middle ear cavity with associated mastoiditis. There was erosion of right carotid canal/ jugular bulb with associated thrombosis.As per radiologist findings are suggestive of nasopharyngeal carcinoma.

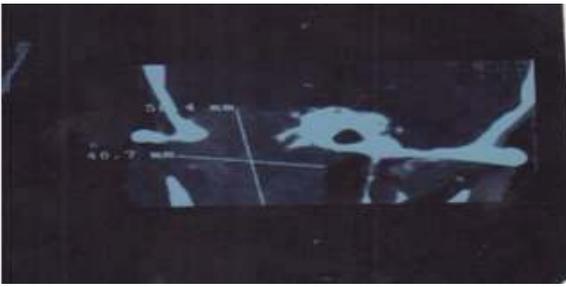


Figure(I)

Biopsy was taken from invaded area of soft palate and sent for histopathological examination. Biopsy showed nasopharyngeal carcinoma . Patient was evaluated and advised radiotherapy.



Figure(II)



Figure(III)

Figure(IV)



PHOTO GRAPHS OF NASOPHARYNGEAL GROWTH OF CHHAJU RAM



FIRST PHOTOGRAPHS OF CHHAJURAMION REPORTING ENT. O.P.D.

Figure(V)



Figure(VI)

Figure (VII)
LAST PHOTOGRAPHS OF CHHAJU RAM BEFORE SENT TO RADIOTHERAPY

Discussion

Nasopharyngeal carcinoma is frequent malignancy of nasopharynx. India has a low incidence {age standardized rate >1/100000 males}. Male to female ratio of 2-3:1. It presents as bimodal age peaks, first peak is at post adolescent age i.e., below 20 years and second later in life at 55-65 years. Many factors play role in aetiology of nasopharyngeal carcinoma. These include race, genetically determined susceptibility and environmental and chemical carcinogens. The precise role of each factor is unknown. Histologically world health organization has classified nasopharyngeal carcinoma in three types. Type I is squamous cell carcinoma, Type II is nonkeratinising carcinoma that is transitional cell carcinoma and Type III undifferentiated carcinoma that is lymphoepithelioma and anaplastic carcinoma.

In 95% of patients nasopharyngeal carcinoma presents with cervical lymphadenopathy, nasal, aural or neurological symptoms. Ophthalmic presentation as the initial presenting feature of nasopharyngeal carcinoma is uncommon. Most frequently involved cranial nerves are V, VI, IX, X accounting for 50% of all palsies. IX & X are invariably involved together and most common group to be affected. Isolated VI cranial nerve palsy is common. Sore throat or throat pain is a rare presentation and its incidence is not documented.

Biopsy in early stages can be taken with endoscopes even from suspicious areas from nasopharynx under direct vision. Further extent of deep infiltration may only be determined by CT or MRI in early stages. Nasopharyngeal carcinoma is radiosensitive, the primary treatment modality is external beam radiotherapy. The usual radiation dose delivered to nasopharynx ranges from 66 to 70 GY and approximately 60 GY to neck. This dose is usually given 1.8 to 2.0 GY daily fraction through two lateral opposing field with or without anterior field. Surgery is reserved for the treatment of recurrent or residual disease after external radiotherapy.

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