

CARCINOMA OF NASOPHARYNX IN EARLY CHILDHOOD

Pages with reference to book, From 57 To 58

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Nasopharyngeal cancer constitutes about 0.6¹% of all cancers. Being the “blind spot” of head and neck, it is usually missed in its early stage if one is not aware of it . As a rule that biopsy of a lump in the neck must not be done unless a primary in the nasopharynx, hypopharynx, larynx or even oesophagus and stomach is first excluded. However, this rule is some times ignored as evident from the two cases being reported.

CASE 1

S.G. a seven year old girl, presented to the surgical OPD reporting a large lump of six months duration in the right side of her neck. There was history of dysphagia, trismus and change in voice. On physical examination, a large mass in the nasopharynx, pressing the soft palate down, was seen. Examination of the neck revealed a large node in the posterior triangle on the right side. Biopsy of cervical node was done by the general surgical unit as an outpatient case, probably by a junior doctor and reported as “acute or chronic nonspecific cervical lymphadenitis” - The child was put on antibiotics and sent home. A month later, the child returned to the same unit, and was then referred to us for further management. On examination the child had total nasal obstruction, total dysphagia because of the massive tumour of the nasopharynx extending to the oropharynx, and a malignant fistula resulting from the previous biopsy of her neck. She was toxic and dehydrated (Figures 1 and 2).

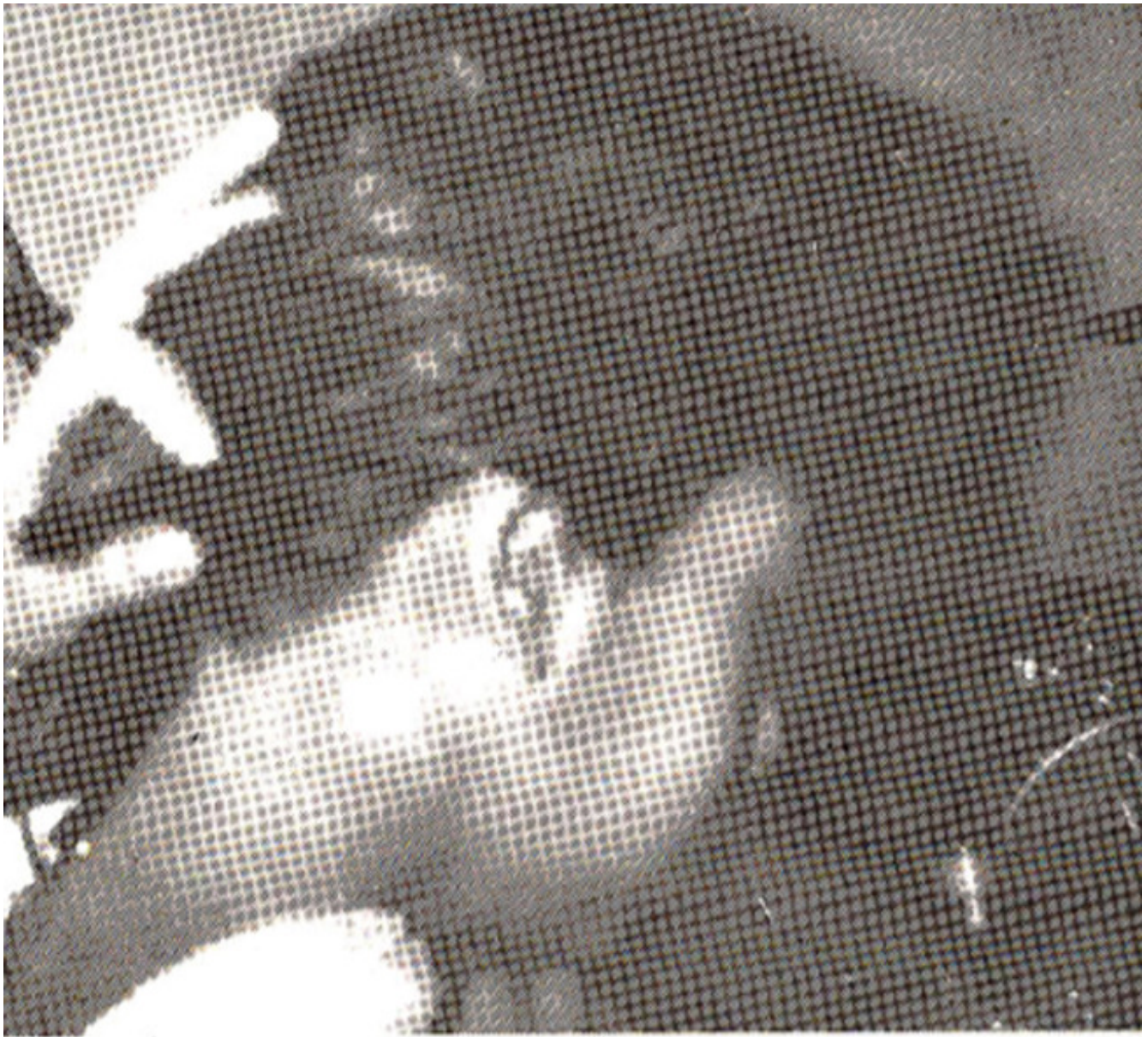


Figure 1. Secondary Malignant Nodes.



Figure 2. Post-Radiation Malignant Fistula.

Her ESR was 64mm and X-ray chest was clear. Examination under inhalation anaesthesia was carefully performed and a biopsy was taken from the mass in the nasopharynx. The mass was very hard but friable. The biopsy report came as "poorly differentiated carcinoma." The child was sent for radiotherapy but died soon after.

CASE -II

A.K. age 8 years, presented with left sided epistaxis of six months duration. Examination showed a large red mass in the nasopharynx and a small node on the left side of his neck just behind the left sub-mandibular gland which was mobile but rather firm. A clinical diagnosis of nasopharyngeal angiofibroma was, therefore, made. His Hb was 8g% and X-ray chest was normal. His anaemia was corrected and he was prepared for excision biopsy with the provisional diagnosis of angiofibroma. The mass was removed with no untoward post operative complications. Biopsy of cervical node was not done . A nasopharyngeal pack, left to control the bleeding was removed after 48 hours. The specimen removed was examined with the naked eye and appeared to be a fibroangioma. However, the biopsy report came as nasopharyngeal carcinoma “poorly differentiated”. Owing to the young age of the child, presenting clinical features and the naked eye appearance of the tumour removed, the histological diagnosis was doubted and radiotherapy not instituted. A biopsy of the neck gland was done two weeks after the first operation and it, too, was reported as metastatic carcinoma. By then the nasopharyngeal mass had considerably increased in size. Radiotherapy was then started but the child died soon after.

DISCUSSION

Nasopharynx is one of the most difficult areas for early diagnosis. Being the “Blind Spot” the disease is usually beyond its boundaries at the time of diagnosis. One of the early symptoms of disease in this area is earache, followed soon by lymph gland enlargement. Biopsy of a lymph gland in the neck should not be done unless a primary lesion in the nasopharynx, hypopharynx, larynx, posterior part of the tongue or even the oesophagus and bronchus is excluded. In our first case, diagnosis was made more difficult by the age and sex of the child. Sawai’ in his review of 1036 cases has reported only one child of 9 years age and the male/female ratio of 8:1. Both the cases being reported are, to our knowledge, so far the youngest with carcinoma of nasopharynx. We would like to reemphasize that biopsy of a cervical node whatever the age or sex of patient, should only be done after a thorough examination of the upper respiratory and digestive tract has been done to exclude carcinoma in the area.

REFERENCE

1. Sawai, M.M. Cancer of nasopharynx - A review of 1036 cases. Indian. J. Cancer, 1983;20: 89-96.