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CASE REPORT

Hepatic cystic metastatic tumors from a locally controlled nasopharyngeal carcinoma



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Summary Liver cystic neoplasms are uncommon and vary from benign to overtly malignant. Liver cystic metastases are rare and mostly come from colon, pancreas, ovary, kidney, neuroendocrine, and prostate cancer. Nasopharyngeal carcinoma (NPC) with liver cystic metastasis has only been reported once. Here, we report a 52-year-old man with liver cystic metastasis from locally cured NPC. The patient received concurrent chemoradiotherapy for NPC 4 years ago and presented with a 6-month history of upper abdominal fullness and pain. No evidence of local recurrence of NPC was found at his regular follow-up examinations after concurrent chemoradiotherapy. Abdominal magnetic resonance imaging showed a large, well-defined, lobulated cystic lesion with poor contrast enhancement occupying both lobes of the liver. Hepatic cystic metastasis was suspected. Ultrasound-guided liver tumor biopsy was performed. Histological examinations disclosed a pattern of poorly differentiated squamous cell carcinoma with focal sarcomatoid differentiation based on the P40 immunohistochemical stain. *In situ* hybridization for Epstein–Barr virus early RNAs confirmed the diagnosis of metastatic NPC. It is difficult to make a diagnosis in liver cystic neoplasms, especially from a rarely reported origin. In our case, we used clinical history and Epstein–Barr virus early RNAs as a specific marker to make an accurate diagnosis.

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Introduction

Nasopharyngeal carcinoma (NPC) is an epithelial cancer related to Epstein–Barr virus (EBV). NPC is endemic to certain well-defined populations. The highest incidence of NPC is found in a Cantonese region of Southern China. In Taiwan, there were 1579 new cases of NPC in 2007, and this condition ranked as the 10th most common cancer affecting the male population, with an annual incidence rate of 10.05 per 100,000 men [1]. NPC shows a rate as high as one-third for local or locoregional recurrence or metastasis. In various reports, the incidence of distant metastases from NPC ranges from 17% to 54%. Bone, lung, liver, and distant lymph nodes are the most common sites of distant metastases. Most liver metastases from NPC are solid, and cystic metastases are rarely reported [2].

Liver cystic lesions represent a heterogeneous group of disorders. Most liver cystic lesions tend to have a benign course. However, liver cystic neoplasms are rare and may vary from benign to overtly malignant [3]. The most commonly reported liver cystic neoplasm is cystadenoma. Other liver cystic neoplasms including primary neoplasms (cystadenocarcinoma and squamous cell carcinoma) or secondary from metastases (ovary, pancreas, and colon) are rarely reported. The origin of these liver cystic neoplasms may present a diagnostic challenge in daily practice. Here, we report a case of liver cystic metastatic neoplasms from NPC without evidence of local recurrence. EBV early RNAs (EBERs) are a valuable tool for accurate diagnosis of liver metastatic cystic neoplasms from NPC.

Case report

A 52-year-old man presented with abdominal fullness and pain and body weight loss of 5 kg in the past 6 months. He had a history of nonkeratinizing undifferentiated NPC, cT2aN2M0, Stage III and underwent concurrent chemoradiotherapy 4 years ago. There was no evidence of local recurrence in his recent regular follow-up examinations. He also had history of gastric ulcer bleeding and received subtotal gastrectomy 25 years ago. He had no known specific family history. He drank alcohol occasionally and was also a smoker for 25 years. Physical examinations revealed hepatomegaly (liver span of 15 cm in the right subclavian line and 9 cm in the sternum midline) with local tenderness over the epigastric region. Laboratory data showed anemia with hemoglobin 9.8 mg/dL (normal range: 13–17 mg/dL); normal serum total bilirubin 0.4 g/L (normal range: 0.5–1.5 g/L); normal aspartate aminotransferase 27 U/L (normal range: < 37 U/L); normal alanine aminotransferase 15 U/L (normal range: < 40 U/L); abnormal serum alkaline phosphatase 489 U/L (normal range: 40–129 U/L); abnormal r-glutamyl transpeptidase 302 U/L (normal range: 5–36 U/L); normal serum α -fetoprotein 2.05 ng/mL (normal range: < 5.0 ng/mL); normal carcinoembryonic antigen 2.83 ng/mL (normal range: < 5.0 ng/mL); abnormal serum carbohydrate antigen 19-9 53.4 ng/mL (normal range: 0–37 ng/mL); and abnormal anti-squamous cell carcinoma antigen 8.1 ng/mL (normal range: 0–2.1 ng/mL). Hepatitis B surface antigen and hepatitis C virus antibody were both negative. Blood EBV viral load was 82,801 copies/mL. Stool

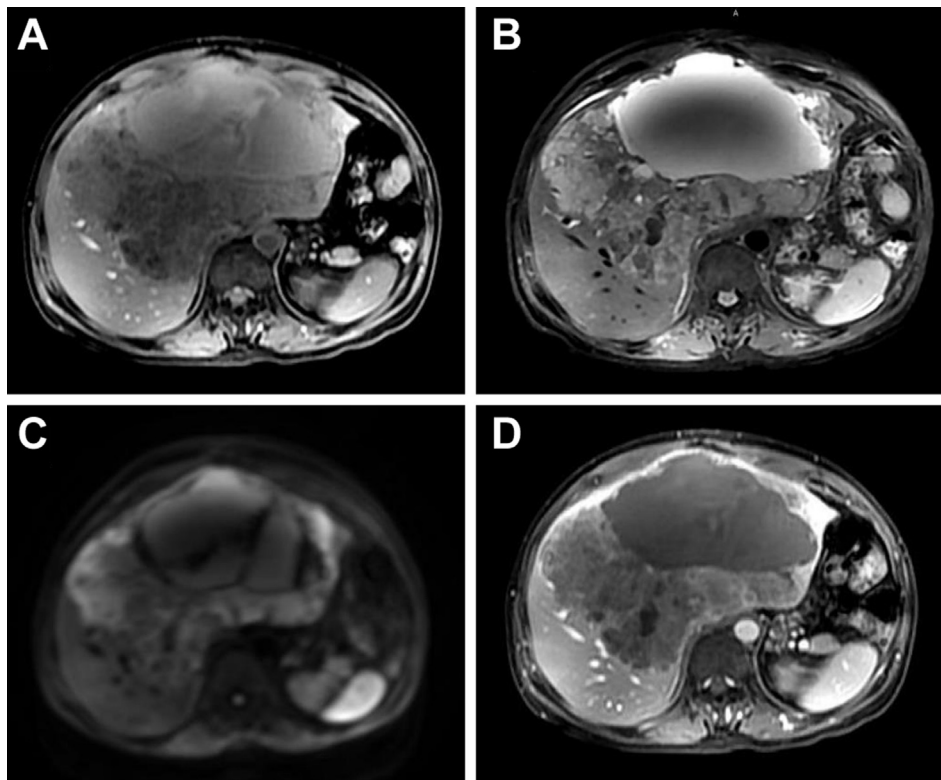


Figure 1 A large, well-defined, lobulated mixed cystic and solid lesion occupying both lobes of the liver showed hypointensity on T1-weighted imaging (A), hyperintensity on T2-weighted imaging (B), and diffusion-weighted imaging (C). During dynamic study, the lesion revealed poor contrast enhancement (D).

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