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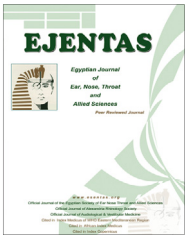

CASE REPORT

Nasopharyngeal carcinoma with metastases to colon

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KEYWORDS

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Abstract Squamous cell carcinoma (SCC) of the nasopharynx is amongst the most common head and neck cancers. The most common distant metastases are to the bone, liver and lung. Herein, we are reporting a rare case of a 61-year-old man with nasopharyngeal carcinoma (NPC) who presented with 3 weeks history of blood streaked sputum, post nasal drip and blocked nose with no history of epistaxis, tinnitus and unilateral hearing loss. Almost 2 years upon completion of his concurrent chemotherapy and radiotherapy, he developed a right hypochondrium mass and underwent colonoscopy which revealed a mass in ascending colon and which was then subsequently resected via right hemicolectomy. Histological analyses from the resected specimen confirmed its nasopharyngeal origin.

1. Introduction

Nasopharyngeal carcinoma (NPC) is a tumour arising from the epithelial cells of nasopharynx. It is the commonest epithelial cancer in adult.[1] It is a unique tumour which is endemic to Southern China specifically amongst Cantonese origin and Southeast Asia affecting 10–50 per 100,000 populations per year.[2] Intermediate incidences are seen in the Mediterranean Basin and the Artic.[3] In Malaysia, NPC is a prevalent cancer. Based on the National Cancer Registry 2003, there were 1125 incident cases of NPC in Peninsular Malaysia. Amongst the diagnosed patients, 57% were Chinese, 19% Malay, 1% were Indians and the remaining 23% were from other ethnic groups.[4] The tumour can extend within or out of the nasopharynx to the other lateral wall and or posterior superiorly to the base of skull, or the palate, nasal cavity or oropharynx. It then typically metastasizes to cervical lymph nodes.[1] World Health Organisation (WHO) classified NPC into 3 sub types: (1) squamous cell carcinoma, typically found in older adult population; (2) non keratinizing carcinoma; (3) undifferentiated carcinoma.[1] Commonly reported distant metastases of NPC are to the bone 70–80%, viscera (liver 30%, lung 18%) and at lower rate extra cervical lymph nodes (axillary, mediastinal, pelvic, inguinal).[5] For the past few years there are also reports on distant metastasis in NPC to other rare sites of such as pericardium,[6] small bowel,[7] sternum,[8] rectum[9] and intra

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thoracic endotracheal[10] metastases. However, metastases to colon are extremely rare and to our knowledge this is the first reported case of NPC with histologically confirmed metastases to colon.

2. Case report

A 61-year-old Chinese man presented with 3 weeks history of blood streaked sputum, post nasal drip and blocked nose with no history of epistaxis, tinnitus and unilateral hearing loss. He has no cervical lymphadenopathy. Anterior rhinoscopy showed hypertrophic inferior turbinates bilaterally with clear mucous secretions and otoscopic examination showed no abnormality. Endoscopic examination of the nasopharynx revealed a nasopharyngeal mass covered with slough over the left Fossa of Rosenmuller. The mass is obliterating the left Eustachian tube opening. Histopathology finding of the biopsied mass reported as non-keratinizing NPC (WHO type III) (see Fig. 1).

Computed tomography (CT) of the head and neck showed soft tissue mass obliterating the left Fossa of Rosenmuller and multiple small bilateral cervical lymph nodes less of subcentimeter dimension. Chest radiograph and Ultrasonography of abdomen showed no significant abnormalities. The patient was diagnosed to have NPC stage **T1N0M0** and was treated with concurrent chemo radiation with weekly cisplatin. A complete tumour response was achieved and he was in clinical remission after completing his treatment until he presented again with right hypochondriac mass 19 months later. Subsequent CT of the abdomen and pelvis revealed a heterogenous lobulated mass in the region of caecum measuring 4.7 cm × 6.2 cm × 5.8 cm with loss of plane with abdominal wall muscle and surrounding mesentery fat streakiness. There is also a heterogenous hypodense nodule in the right adrenal gland measuring 3.6 cm × 3.0 cm × 4.9 cm with surrounding fat streakiness which suggestive of right adrenal gland metastasis.

He was then referred to surgical team for further investigation. Colonoscopy was performed by the surgical team which revealed a mass in the ascending colon. Biopsy taken from the mass in ascending colon reported as adenocarcinoma. Two weeks later he underwent right hemicolectomy and review of the histopathology finding from the right hemicolectomy specimen confirmed as metastatic NPC (see Fig. 2).

Microscopically the malignant cells are involving the serosa and some malignant cells are seen within the lamina propria. The tumour cells are negative for CK20 and CK7. Tumour margins were completely resected. A month following the surgery he developed right supraclavicular node and further investigation with Multi-slice CT head, neck and thorax revealed bilateral supraclavicular nodal metastasis and distant metastasis to liver, lungs and right adrenal. Upon recovering from surgery he was planned for 3 cycles of chemotherapy with 5-Flouracil and cisplatin. Unfortunately he developed episodes of intestinal obstruction and was unfit for continuation of treatment. His condition deteriorated and unfortunately he succumbed to death 2 months later at home before being able to undergo his treatment.

3. Discussion

Squamous cell carcinomas (SCC) of the head and neck are relatively common and usually associated with radical surgery and poor outcome.[9] Prognosis is poor in those with advanced or metastatic disease. NPC on the other hand offers good survival with non-surgical treatment. Aetiological factors include Epstein–Barr virus (EBV), genetic susceptibility, and consumption of food with possible carcinogen-volatile nitrosamines.[1] The incidence of metastases is often underestimated with clinical diagnosis, as shown by three- to fourfold increased rates of metastases of head and neck SCC, 26–57% in autopsy studies compared to 5.3–23.7% in clinical studies.[9] There are multiple factors influencing the incidence of distant metastases such as location of the primary tumour, initial T and N stage of the neoplasm, and the presence or absence of regional control above the clavicle. Incidence of distant metastases is higher in patients with advanced nodal disease, particularly in the presence of jugular vein invasion or extensive soft tissue disease in the neck.[11]

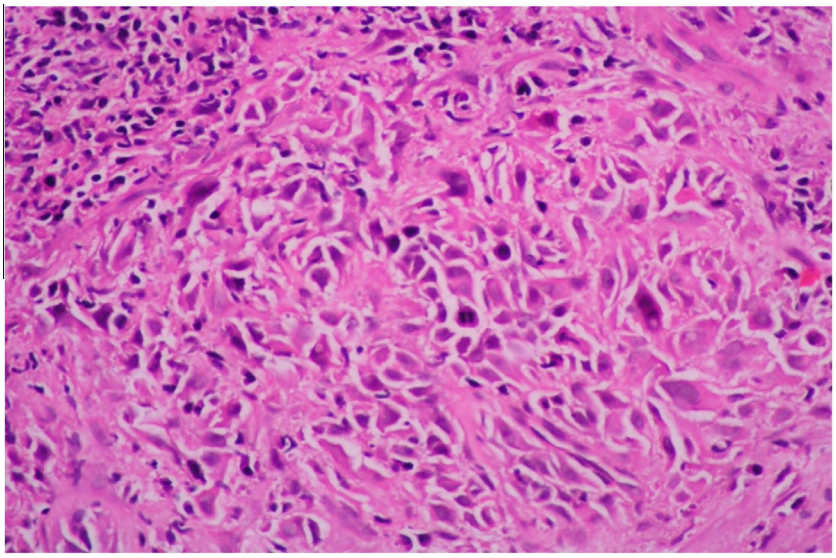

Figure 1 The picture of biopsy taken from left Fossa of Rosenmuller showed malignant cells exhibiting individual cell keratinization and intercellular bridges.