

Case Report

Bilateral synchronous tonsillar carcinoma with bilateral neck disease

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ABSTRACT

We report a 60 year old man diagnosed to have bilateral tonsillar carcinoma. He presented with bilateral neck swelling with suspicious looking tonsils. Bilateral wide excision tonsillectomy was done. Histopathology showed localized bilateral squamous cell

carcinoma. We proceeded with bilateral modified neck dissection and patient underwent Radiation therapy. (Rawal Med J 2013;38:79-80).

Key words: Bilateral tonsillar carcinoma, bilateral neck disease.

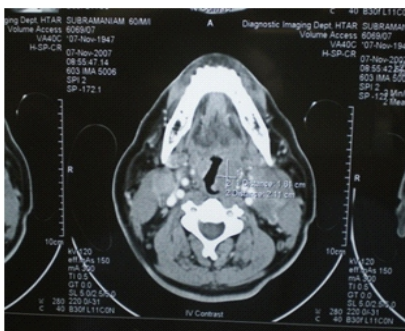
INTRODUCTION

Bilateral synchronous tonsillar carcinoma is very rare. There are very few cases reported in English Literature to the knowledge of the authors. Carcinoma of tonsil is the third commonest malignancy of the head and neck after thyroid and laryngeal cancers.¹ Out of this, synchronous cancers occur in four per cent of head and neck cancer patients. We report a case of bilateral synchronous tonsillar carcinoma with bilateral neck disease.

CASE REPORT

A 60 years old, Indian male presented with bilateral neck swelling for two to three months duration. The initial swelling was on the right side of the neck, followed by the left. It was associated with odynophagia for one and half month duration. He denied weight loss, dysphagia or hoarsness. He was previously diagnosed to have diabetes and hypertension and was on medication. He also gave a history of smoking and alcohol intake for past 30 years.

Fig 1: CT showing mass arising from both tonsils.



On examination, he had bilateral neck swelling, which measured 1-2 cm, hard, fixed and non tender on the right. Left neck swelling measured 3-4 cm, with similar features. Throat examination showed bilateral tonsillar enlargement with irregular growth, left larger than right. Flexible Naso Pharyngo Laryngoscopy (FNPLS) showed growth extending from left tonsil to the post nasal space. Biopsy of the lesion was done in clinic and was reported as bilateral squamous cell carcinoma of tonsils. FNAC of neck nodes showed features suspicious of carcinoma. Computed tomography was reported as oropharyngeal carcinoma (Fig 1) with metastasis to regional lymph node.

Fig 2: Lymph nodes enlargement.



On table, zero degree scope showed the mass in nasopharynx to be lymphoid tissue. Direct laryngoscopy showed irregular mass over both tonsils left larger than right. Neither of tonsils were fixed. Anterior pillar, soft palate, uvula, posterior pharyngeal wall, tongue and base of tongue were normal. Wide excision tonsillectomy done with muscle excision. Each tonsils was histologically sliced and reviewed separately. Histopathology report of right tonsil came back as squamous cell carcinoma and left tonsil was poorly differentiated and both margins were clear.

Bilateral Modified Neck dissection type 3 was performed for bilateral synchronous tonsillar squamous cell carcinoma with bilateral neck metastasis. On table, staging was right - T2N2b, left-T2N3. Cervical nodes from levels 1-5 were removed and could be easily excised (Fig 2). The nerves, muscles and vessels were not involved. Histopathology of left neck nodes level 2, 3 and 4 showed metastatic squamous cell carcinoma. He completed radiation therapy and had been free of any tumor recurrence one year post operation follow up. However, patient developed severe pneumonia and succumbed to it.

DISCUSSION

The risk for patients with head and neck cancers is high for development of a second primary head and neck malignancy. If the second malignancy is identified simultaneously within six months of the primary lesion, it is called synchronous cancer. If it develops after a period of six months, it is called metachronous cancer.² In the esophagus, it is usually synchronous while in the lung it is usually metachronous.³

There are two main theories to explain the predisposition to multiple head and neck cancers. The first is HPV and the other is field

carcinogenesis. In our patient, we attribute the cancer to the history of prolonged exposure to cigarette smoke. A careful search for second malignancy must be made to detect the rare case of bilateral disease.

Bilateral tonsillectomy should be advocated in all cases irrelevant for unilateral or bilateral as studies reports show that 18% of a study population with an unknown primary were found to have a tonsillar primary by doing ipsilateral tonsillectomy.³ Leaving one tonsil behind can confound future examination as this can appear suspicious for a pathologic asymmetry rather than an iatrogenic one.⁴

In summary, synchronous cancers in the head and neck region should never be over looked as even though it is a rare presentation. Therefore, a complete search for a second head and neck primary should be done as chances of missing one is high and eventually the outcome of may be compromised.

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Collection and assembly of data: Shashi Gopalan
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