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Huge Cervical Mass Hiding A UCNT from the Cavum: About A Case

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Abstract Case Report

An enormous cervical mass by adjacency in nasopharynx cancer is exceptional. This impairment poses difficulties at all stages of care from diagnosis to treatment. It is the consequence of significant tumor aggressiveness. We report the case of a 52-year-old patient presenting to the emergency room with a picture of a huge cervical mass that has been evolving for a week. Several biopsies were performed objectifying a UCNT of the cavum. The patient died before the start of treatment.

Keywords: enormous cervical mass, nasopharynx cancer, UCNT, huge cervical mass.

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INTRODUCTION

Due to its deep basal cranial topography not very accessible to examination, and despite a rich but misleading borrowing symptomatology, caval cancer remains a late diagnosis and a formidable prognosis.

Objective: To Think Of A UCNT of the Cavum with Atypical Cervical Extension

CASE REPORT

This is a 52-year-old patient, a chronic alcoholic and tobacco user who is homeless and is being treated in psychiatry for severe depression. Presenting to the emergency room with a cervical abscess picture that has been evolving for 1 week.

The onset of symptoms goes back 2 years with the installation of a nasal obstruction with epistaxisand rhinorrhea and cervical lymphadenopathy, all progressing with deterioration of general condition.

On admission to the emergency room, the clinical examination revealed a conscious, eupneic patient with an immense nauseating ulcerative-budding mass infiltrating the sternocleidomastoid muscle, the skin with areas of superinfected tissue necrosis. A CT scan was done showing several collections of right laterocervical abscesses fusing at the level of the ipsilateral cervical deep spaces complicated by right jugular thrombosis.

Several skin biopsies were taken and sent to the returning anapath for lymph node metastases from a UCNT of the cavum. Before starting treatment, the patient died.

Fig-1: Patient's cervical image

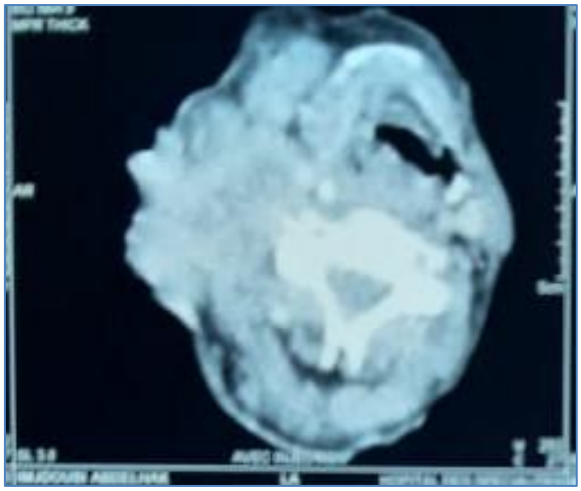

Fig-2: Axial CT of the neck after injection of the contrast product injecting an enormous cervical mass

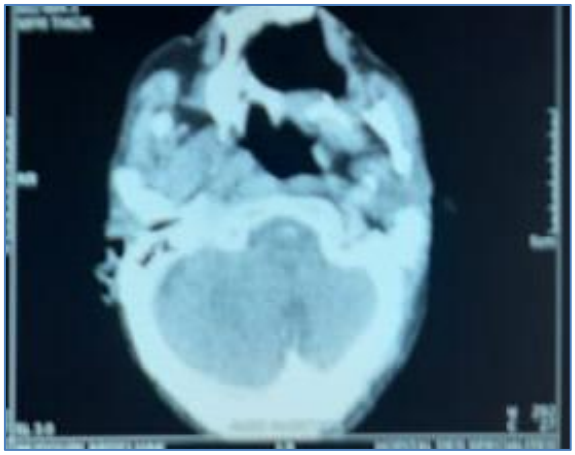

Fig-3: Facial CT in axial section after injection of the contrast product showing an irregular thickening of the cavum with effacement of the rosen-muller fossa

DISCUSSION

Nasopharyngeal carcinoma most often starts in the Rosen Muller fossa. The tumor spreads gradually and can invade the mucosa or grow there in the submucosa invading adjacent structures such as the nasal cavities, the side walls of the oropharynx, the parapharyngeal space [1]. Clinically, the diagnosis of caval cancer can be confused by cervical involvement of the type of abscessed collections flowing into deep spaces, as is the case with our patient.

Indeed, lymph node metastases are almost the rule (75%). They are cervical, mobile and staggered along the path of the internal jugular or in the retro-pharyngeal space. They can be unilateral or bilateral [2, 3, 4].

The diagnosis of caval cancer was corrected by imaging. In addition, nowadays, the PET-scan has revolutionized the exploration of head and neck cancers. It is done, for some teams, as a first line instead of CT or MRI, especially in cases of nasopharyngeal cancer with significant metastatic potential [5]. Only multiple biopsies allow the diagnosis. Endoscopy can be used to assess tumor extension to neighboring structures [2, 3]. Only biopsies can make the diagnosis by having the histological type of the tumor [6]

Among the classifications that have been proposed for the study of this neoplasia, the most used is that of the AJC / UICC proposed in 1997 [7]. This last version seems superior to those of Ho and AJC 1986, with a better definition of prognostic groups for both T and N, and it incorporates data provided by imagery.

- T1: tumor confined to the nasopharynx.
- T2: extension to the soft tissues of the oropharynx and / or nasal cavity
  - T2a: without parapharyngeal extension
  - T2b: with parapharyngeal extension
- T3: tumor with invasion of bone structures and / or paranasal sinuses
- T4: intracranial extension and / or cranial nerves and / or the infratemporal fossa and / or the hypopharynx and / or the orbit.
- N0: absence of ganglion
- N1: unilateral lymph node less than 6 cm above the clavicles
- N2: bilateral lymph nodes less than 6 cm above the clavicles
- N3:
  - N3a lymph node greater than 6 cm
  - N3b extension in the supraclavicular hollow

From an anatomopathological point of view, malignant epithelial tumors represent more than 90% of cancers occurring in the cavum [4, 6]. The classification used is that of the WHO, based on the degree of differentiation:

- WHO 1: keratinizing squamous cell carcinoma.
- WHO 2: non-keratinizing squamous cell carcinoma.
- WHO 3: Undifferentiated nasopharyngeal carcinoma (UCNT). As is the case with our patient

The other types are rarer, whether glandular tumors, lymphomas or even connective tumors.

CNP is both radiosensitive and chemosensitive. Conventional radiotherapy and associated treatments have improved her prognosis. The proximity of several critical organs and the topography of the nasopharynx constitute the technical difficulty of irradiation. (20, 21) Our patient died before the start of treatment.

CONCLUSION

An enormous cervical mass by adjacency in caval cancer is exceptional. This impairment poses

difficulties at all stages of care from diagnosis to treatment. It is the consequence of significant tumor aggressiveness. Caval cancer is usually diagnosed at a late stage because of its deep location. The prognosis depends on the stage of development, the earlier the stage the better the prognosis.

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