

Metastatic Squamous Cell Carcinoma of Nasal Vestibule: A Rare Case

Smitha Gangaraj, Chandre Gowda

ABSTRACT

Metastases to the sinonasal region are very rare. They constitute to less than 1% of nasal malignancies. To our knowledge, this is the first case of metastatic squamous cell carcinoma of nasal vestibule with primary carcinoma of pyriform fossa to be reported. We present this case for its rarity. We have also reviewed literatures on squamous cell carcinoma of nasal vestibule.

Keywords: Metastasis, Nasal vestibule, Squamous cell carcinoma.

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INTRODUCTION

Metastatic tumors are rarely encountered in the nasal cavity. The most common site is the kidney followed by lung, breast, urogenital tract, gastrointestinal tract and thyroid gland.¹ To our knowledge, no case of metastatic squamous cell carcinoma of nasal vestibule is reported in literature. We report a case of the above with previous history of carcinoma of pyriform fossa.

CASE REPORT

A 60-year-old male patient presented with episodes of left-sided epistaxis and tenderness at the tip of the nose, since 1 month. He also complained of rapidly growing growth in the left nostril. There was a previous history of carcinoma of right pyriform fossa-stage 3, for which he had undergone wide field laryngectomy followed by radiotherapy and chemotherapy, a year back.

On examination, a firm, tender swelling was noted on the medial aspect of left nasal vestibule, measuring about 2 × 2 cm, obstructing the anterior nares and pushing the columella (Fig. 1).

MRI of PNS showed nodulo-proliferative space occupying lesion arising from left mucocutaneous junction, measuring 3.2 cm vertically and 2.7 × 2.4 cm in other dimensions projecting into anterior nares and posteriorly abutting on the anterior part of nasal septum. There was no evidence of any intranasal extension and the turbinates and PNS were normal (Fig. 2).



Fig. 1: Growth in the left nasal vestibule with post-laryngectomy tracheostomy

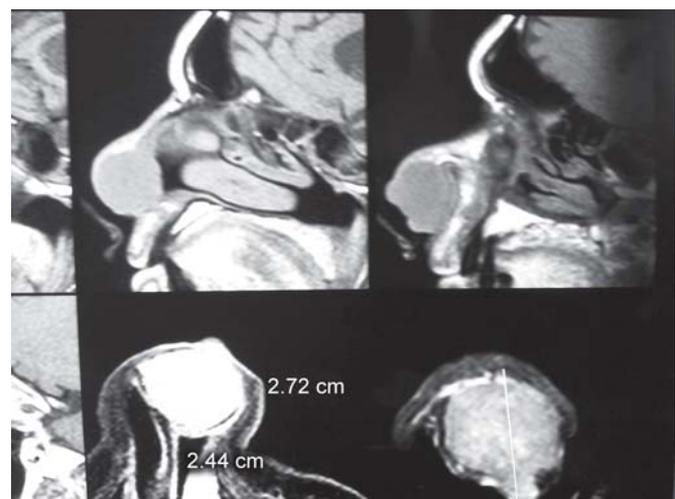


Fig. 2: MRI PNS showing nodulo-proliferative growth arising from mucocutaneous junction of anterior nares without intranasal extension

A biopsy was taken and on histopathological examination it was concluded to be a moderately differentiated invasive, large cell nonkeratinizing squamous cell carcinoma (Fig. 3). Patient is undergoing radiotherapy.

DISCUSSION

Metastases to the sinonasal region are very rare. They constitute to less than 1% of nasal malignancies. The reported cases of sinonasal metastasis are of hepatocellular carcinoma, renal cell carcinoma, pancreatic adenocarcinoma and follicular carcinoma of the thyroid.²⁻⁴ To our knowledge this is the first case of squamous cell metastatic carcinoma

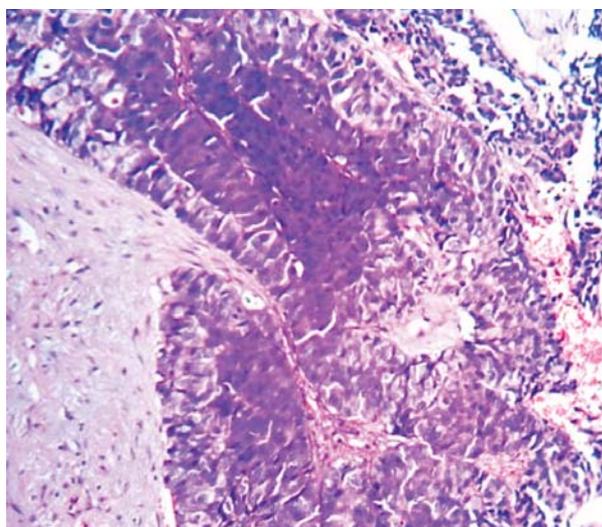


Fig. 3: Microscopic picture showing atypical cells arranged in sheets and clumps. The cells are pleomorphic with hyperchromatic nucleolus. Mitotic figures are also noted (H&E, $\times 10$)

of nasal vestibule. The typical symptoms of sinonasal metastatic tumor include nasal obstruction, epistaxis, pain, local swelling and exophthalmos, which are indistinguishable from those of primary nasal neoplasm.⁵ The only method that ultimately determines the diagnosis is biopsy.^{6,7}

There are several staging systems of squamous cell carcinoma of nasal vestibule. Wang's classification proposed in 19768 is as follows: T1—the lesion is limited to nasal vestibule, relatively superficial, involving one or more sites within. T2—the lesion has extended from nasal vestibule to its adjacent structures, such as the upper nasal septum, upper lip, philtrum, skin of the nose and/or nasolabial fold, but not fixed to the underlying bone. T3—the lesion has become massive with extension to the hard palate, buccogingival sulcus, large portion of the upper lip, upper nasal septum, turbinate and/or adjacent paranasal sinuses, fixed with deep muscle and bone involvement. 1997 AJCC staged it as follows: T1-tumor is 2 cm or less in maximum diameter. T2—tumor is greater than 2 cm but not more than 5 cm in greatest diameter. T3—tumor is greater than 5 cm in greatest diameter. T4—there is invasion of cartilage, bone or nerves. In UICC 2002, it is staged

together under the heading of nasal cavity tumors. Stage 1: Limited to site of origin. Stage 2: Extension to adjacent site (e.g. orbit, nasopharynx, paranasal sinuses, skin, pterygomaxillary fossa). Stage 3: Base of skull, pterygoid plate destruction, intracranial extension.

The choice of treatment modality depends upon the cosmetic result following the procedure. If significant deformity or mutilation will result following surgery, radiation treatment should be the treatment of choice (external beam combined with interstitial implant).⁸

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