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## **Intracranial Development of the Transient Form of Nasal-Pharyngeal Cavity Structures Carcinoma**

Wewnątrzmożgowe następstwa naciekania nowotworowego z nosogardzieli

Almost all the malignant tumours of the nasal-pharyngeal cavity are primary tumours, which develop from the tissues creating the frame of this anatomic space. Much more seldom they are secondary tumours infiltrating the walls of the nasal-pharyngeal cavity; some of them are the metastases of a distant primary tumour: clear-cell renal carcinoma, bronchial carcinoma (1).

In Neurology Clinic we observed a patient with a picture of nasal-pharyngeal cavity carcinoma with the penetration to the cranial fossa, which was revealed in the late stage of the disease.

### **CASE DESCRIPTION**

The patient S. W., aged 62, retired (no. of case history 8917/93), was admitted to Neurology Clinic due to a gradually increasing diplopia, hyperaesthesia of the left half of the face, and hearing impairment within the left ear. These ailments had occurred for the first time 5 months earlier, then difficulties with swallowing of food supervened on the ailments. He was healthy so far and in the history data he only mentioned the otitis of the left ear he had suffered from 1 year earlier.

General medical examination did not show any perceptible deviations from the normal state. On the basis of neurological examination the damage of the left cranial nerves V, VI, VIII, IX, X, XII was found. OB: 8/21, RR: 120/80. Laboratory examinations of the blood and urine did not reveal deviations from the norm. X-ray chest examination and usg of the abdominal cavity were normal. The routine laryngological examination of the head carried out in a typical way was normal, whereas in the osseous fenestra lack of pneumatization of the left mastoid process cells was found. In this situation the guided laryngological examination was rerequested. On the basis of the examination in the posterior

rhinoscopy slightly bleeding exophytic proliferations visible on the left side were shown, passing onto the left pharyngeal-tympanic capsula.

The CT assessment of the head was carried out with regard to the pterygopalatine fossa and superior pharynx, from the cranial basis to the level of fundus.

In this examination the presence of abnormal pathologic structure of tumour appearance on the left side was revealed. The tumour fills the left pterygopalatine fossa, parapharyngeal space, it damages the osseous structures of the cranial basis and the pyramid apex. The lesion partially fills the sphenoid sinus on the left side and partially damages the lamellae of the pterygopalatine bone. The infiltration also covers the soft parts, i.e. the muscles of the parapharyngeal space. The diameter of the tumour is about 5 cm.

In further diagnostic procedures a segment from the afore-mentioned tumour was collected for anatomico-pathologic evaluation. Histopathologic examination no. 992273 from the nasopharynx: *carcinoma transitionale*.

In this situation surgery treatment was abandoned, whereas treatment with radiation energy was proposed. Therefore, the patient was sent to the Voivodeship Oncological Hospital.

The nasal-pharyngeal cavity neoplasms initially develop cryptically, due to favourable anatomic conditions in this region. Many authors emphasize difficulties with the early recognition of the nasal-pharyngeal cavity neoplasms. Wang quotes the definition "blind spot" for the diagnostics of that region. Approximately 70% of patients on the average notify of the ailments already in the advanced stage of the disease, with the symptoms of expansion to the region or, with the symptoms of metastases to the lymph nodes (5).

The clinical symptoms of the nasal-pharyngeal cavity neoplasm can be divided into local symptoms connected with the presence of the primary tumour and the symptoms which are induced by the metastases. The local symptoms are those related to the nose, throat, ears as well as neurological symptoms. The ailments on the side of the nose and throat may at first consist in very unobtrusive, gradually increasing symptoms of the chronic rhinitis, impairment of patency of the nose, change in the tone of the voice. Bleeding from the nose or throat may also occur, which is, however, an inconstant symptom, and occurring late in general. The auricular symptoms may appear relatively early in the form of unilateral impairment of hearing, being the result of the closure of the internal opening of the auditive tube due to either infiltration or oedema in this region (3).

Neurological symptoms are the result of the pressure of the cranial basis nerves induced either by the diffusing neoplastic infiltration or neoplastically changed lymph nodes of the retropharyngeal space. Therefore, these symptoms always prove the advanced stage of the neoplasm. Neurological symptoms mostly refer to several nerves at the same time.

Depending on which nerves are damaged several neurological symptoms complexes can be distinguished. The cranial nerves II, III, IV, V and VI are the most frequently damaged ones. A complete syndrome of these symptoms is defined as Jakob's syndrome.

The damage of the cranial nerves IX, X, XI and XIII is defined as Villaret's syndrome. In the far-advanced tumours the symptoms of the damage of all the cranial nerves may occur (2, 3).

The diagnosis of the nasal-pharyngeal cavity malignant tumour should be established at the earliest possible stage of the disease because the immediate entering upon the treatment is essential for the further course of the disease.

The local symptoms in the initial stage of the disease are often poorly pronounced and that is why the patients do not look for the help of the specialist in laryngology.

Scrupulous examination of the nasal-pharyngeal cavity allows to state the cause of the ailments in most of the cases.

The establishment of the diagnosis of the nasal-pharyngeal cavity malignant tumour in the stage of its medium progression is not difficult after the right assessment of the anamnestic data and carrying out vision control of all the walls of the nasal-pharyngeal cavity.

Posterior rhinoscopy should be carried out at scrupulous anaesthetization of the soft palate and nasal-pharyngeal cavity walls (1, 5).

Despite the distinct radiosensitivity, characteristic of most of the neoplasms of the nasal-pharyngeal cavity, the radiocurability of this group of tumours is relatively low. 5 years' survival is obtainable in 25—30% of patients on the average, and part of therapeutists report much lower percentage of recovery, amounting to only several per cent.

The prognosis depends largely on the degree of progression of the neoplasm. In the cases with no clinical symptoms of metastases to the lymph nodes 50% recovery was obtained. The presence of metastases in the lymph nodes greatly worsens the prognosis but does not prejudice the incurability, whereas with the metastases to the cranial nerves on the obtained results are palliative as a rule. The complete cure is observed only in individual cases (4).

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#### STRESZCZENIE

Przedstawiono sytuację pacjenta hospitalizowanego w Klinice Neurologii z powodu raka jamy nosowo-gardłowej z penetracją do jamy czaszki i zajęciem nerwów czaszkowych, co ujawniło się w późnym okresie choroby.