Tumours of the Nasopharynx:-

Anatomy:-

The sites in the nasopharynx are:

1. Posterosuperior wall: extending from the junction of the hard and soft palates to the skull base.
2. Lateral wall: including the fossa of Rosenmuller.
3. Inferior wall: consists of the superior surface of the soft palate
4. Anterior wall: posterior choana & posterior part of the septum.

Benign tumours:-

- ### Juvenile nasopharyngeal angiofibroma

The commonest of the rare benign tumours of the nasopharynx.

- usually present between the ages of 18 & 20 years.
- There is a predilection for males.

Pathology:-

- A firm tumour, consisting of fibrous tissue with varying degrees of vascularity. The blood channels may or may not have a muscle coat. Originates from the periosteum of one or other side of the roof of the Nasopharynx
- Extensions occur :
- Into the nose.
- Into the pterygoid fossa.
- Into the ethmoidal region.

Clinical feature:-

1. Progressive nasal obstruction.

2. Recurrent severe epistaxes.

3. 'Nasal' speech (rhinolalia clausa).

4. Conductive deafness occurs from pressure on the Eustachian tube, usually of one side.

5. A smooth, lobulated, rubbery tumour is found in the nasopharynx. It is reddish or grey in colour.

6. Late features due to extension. Include:

. Broadening of the nasal bridge ('frog-face' deformity).

. Unilateral prominence of the-cheek.

. Displacement of the globe of the eye.

Radiography:-

- The tumour may be shown in the nasopharynx.
- It may show displacement of lateral nasal wall into the antrum, and of the septum to the opposite side.
- There may also widening of the Space between the outer wall of the maxilla and the mandible, in the anteroposterior projection.
- Angiography demonstrates the size and vascular supply of the tumour and offers the radiologist the opportunity to embolize the feeding vessels.

Differential diagnosis:-

- an antrochoanal polyp undergoing fibrosis.

Treatment:-

- Conservative treatment.
- Irradiation.
- Cryosurgery.

- Surgery. The tumour may be approached by two routes:

(a) Transpalatal approach.

(b) Combined lateral rhinotomy and per-oral approach.

Squamous-cell carcinoma

- The commonest tumour of the nasopharynx.
- is especially common in

1. Chinese peoples.
2. HLA-A2, HLA-8Sin2 and HLA-A3 are usually found in the affected Chinese.
3. High titres of Epstein-Barr virus are usually found in association with the disease.

- The fossa of Rosenrruller is a common site.

Clinical types:-

- 1. Proliferative. giving rise to signs of obstruction in the nasopharynx.
- 2. Ulcerative. When epistaxis may be a prominent feature.
- 3. Infiltrative and non ulcerative. In which neuro-ophthalmological signs result.

Clinical features:-

1. Metastasis in the lymph nodes of the neck.
2. Symptoms of local invasion (Trotters triad)

- Conductive deafness.

- Elevation and immobility of the homolateral soft palate.
- Pain in the side of the head.

3. Other symptoms of invasion
   - Internal strabismus.
   - Exophthalmos.

4. Nasal obstruction. In the proliferative type of tumour.

5. Epistaxis. In the ulcerative type.

Diagnosis:-

- Postnasal mirror.
- Flexible fibrescope.
- Radiography.
- Biopsy.

UICC classification:-

UiCC classification

- Tis Carcinoma in situ.
- TO No evidence of primary tumour.
- Tl Tumour confined to one site (including tumour identified from positive biopsy).
- T2 Tumour involving two sites,
- T3 Tumour extension to nasal cavity and/or oropharynx.
- T4 Tumour with extension to base of skull and/or involving cranial nerves.
- TX The minimum requirements to assess the primary tumour cannot be met.

Tumour staging:-

- N: Nodes.
- Nx: lymph nodes cannot be assessed.
- N0: no regional nodes involved.
- N1: single ipsilateral lymph node less than 3 cm in diameter.
- N2a: single ipsilateral lymph node between 3 and 6 cm in diameter.

- N2b: multiple ipsilateral lymph nodes, none larger than 6 cm diameter.
- N2c: bilateral or contralateral lymph nodes, none larger than 6 cm diameter.
- N3: lymph node larger than 6 cm in diameter.

Tumour staging:-

- M:Metastasis.
- Mx: not assessed.
- M0: no distant metastases.
- M1: distant metastasis present.

Treatment:-

- Radiotherapy: The method of choice, because

1. surgical removal of the primary growth is rarely possible.
2. metastases are often present when the patient is first seen.
3. the tumours are usually anaplastic and highly radiosensitive.

- Treatment must include the whole lymphatic field.
- A central palatal fenestration-allows inspection and the destruction of any residual growth by diathermy. A permanent palatal obturator can be worn without great inconvenience.

Prognosis:-

- Factors that may influence prognosis include

1. Clinical stage.
2. Patient age.
3. Gender.
4. Presence of keratinization.
5. Lymph node metastasis.
6. Genetic factors.

Other malignant tumours:-

LYMPHOMA:-

- The lymphomas are usually seen in younger patients.
- TREATMENT

1. External irradiation
2. Cytotoxic drugs.