Incidence of Occult Primary—Their Diagnosis and Non Surgical Management

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Twenty one (16.5%) cases of Occult primary (18 males and 3 females) were analysed out of 121 cases of secondaries in the neck regarding their diagnosis and non-surgical management over a period of six years, from March, 1990 to Feb., 1996 in the department of ENT and Radiotherapy of I.G.M.C. and Hospital Shimla. Majority of these cases were in the age group of 50-70 years and 95% of these cases had squamous cell carcinoma and in one case there was adenocarcinoma. 12 (57%) of these patients were in N3 stage. 13 patients were treated by radiotherapy, 3 by chemotherapy whereas remaining 5 cases absconded and therefore no treatment could be given to them.

INTRODUCTION

An Occult primary is one in which patient presents with a metastatic cervical malignancy from an unknown primary source. Metastasis of unknown origin accounts for approximately 5% of patients, inspite of detailed workup (De Braud et al, 1989). One third of such patients also have additional symptoms including pain, weight loss, malaise, fatigue but less than 20% of these patients present in the early stage of disease due to lack of significance given to these symptoms. According to Winegar and Griffen (1973) average time of presentation from first sign of mass appearance in the neck was 5.1 months. The size of swelling indicates the prognosis e.g. a metastatic node of more than 3 cm size carries a poor prognosis (Loren et al 1991). Various methods of treatment are surgery only (Marchetts et al, 1963, Berrie et al, 1970), Radiotherapy only (Greenberg, 1966; Probert, 1970), combination of both with Chemotherapy (De Braud et al, 1989) with varying success rate.

In this study we have retrospectively analysed the presentation and management of patients of metastasis of unknown origin in cervical nodes seen in E.N.T. and Radiotherapy departments of I.G. Medical College, Shimla, over a duration of six years.

MATERIAL AND METHODS

This study included twenty one patients of unknown primary cervical node seen in ENT and Radiotherapy departments of Indira Gandhi Medical College and Hospital, Shimla between March, 1990 to February, 1996 out of 121 cases of secondaries in the neck. There were 18 males and 3 females, with a male: female ratio of 6:1. The age of patients ranged from 36 to 75 years and about 75% of cases were seen in 5th to 7th decade of life. All the patients included in the study either refused for surgery or were unfit for surgery.

PATHOLOGY

Squamous cell carcinoma was the commonest seen in 20 patients. Poorly differentiated type seen in 15 patients, moderately differentiated type in 4 patients and well differentiated type in 1 patient only. One case presented with poorly differentiated Adeno-Carcinoma.

Histopathology

Squamous cell Carcinoma	20	(95.55%)
(a) Poorly differentiated	15	(71.4%)
(b) Well differentiated	01	(5.0%)
(c) Moderately differentiated	04	(20.0%)
Adenocarcinoma	01	(4.4%)

Workup—A complete physical examination,

history and otolaryngological examination was done.

Chest X-ray, soft tissue neck X-ray and routine laboratory investigations were done in all patients. Direct Laryngoscopy was done in 14% of patients, 14% underwent barium swallow, Ultrasonography in 9.5% for liver, Kidneys and Gall Bladder. 9.5% patients underwent Endoscopy/Oesophagoscopy.

Staging : Nodal status staged according to UICC 1987.

Nodal Staging (UICC 1987)

N 1	2	9.52%
N 2	7	33.33%
N 3	12	57.12%

57.12% patients were in the stage N3 i.e. 12 patients out of 21 presented with fixed nodes. 33.33% patients were in N2 stage, and only 9.52% had N1 stage i.e. only 2 patients out of 21 had mobile homolateral nodes.

NODES PRESENTATIONS

Single node involvement was seen in 14 patients (67%). Commonest site of involvement was jugulodiagastic node and upper deep cervical group of lymph nodes i.e. 67% (14/21) followed by Jugulo-omohyoid and Middle deep cervical 33.3% (7/21). 3 patients had multiple ipsilateral lymph nodes and bilateral involvement of the lymph nodes.

TREATMENT

Radiotherapy was given to 13 patients out of which 6 received radical Radiotherapy and an equal number of patients received palliative

radiation while one patient received single fraction of 10GY due to advanced disease and poor general condition. 3 patients received chemotherapy only because of advanced nature of disease 5 patients didn't turn up for treatment.

Radiotherapy was given to the cases with local nodal stage N1, N2 only. The cover area was from the nasopharynx upto clavicle, so that if any primary is present there, it can also get irradiated. Total area got upto 45 Gy and boost dose of about 10 to 15 Gy more than the total area was given to the local node. Palliative Radiotherapy in the form of major palliation was given to cases with N3 Nodal stage and a total dose of 35-40 Gy/3-4 wks. was given these cases. Minor palliation was given to cases whose general condition was poor and who presented with a big mass and/or fungation with skin involvement.

DISCUSSION AND CONCLUSION

Although cancer of Head and Neck region accounts for less than 5% in Western Countries but in India it accounts for more than 30% (Million et al 1989). According to De Braud et al (1989) Metastasis from unknown origin in cervical nodes especially of a squamous cell carcinoma has an occult primary in Head and Neck region. Therefore a detailed otolaryngological workup is very important to rule out primary in Head and Neck region. In the present series the incidence of occult primary was found to be 16.5% and only two patients of N1 Nodal stage were followed upto one year and they showed disease free period and the size of secondaries was also found to be reduced significantly. Rest of the cases were lost to follow up because of advanced nature of disease or lack of awareness.

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Congratulation !

Dr. K. Subramanyam, Professor and Head, ENT department, Gandhi Medical College, Hyderabad has received the "Vijayashree Award" on 6th June, 1997 by "India-International Friendship Society".