Reader's Forum-15

Q. 1 What is your approach for Metastatic Cervical Nodes with occult primary Investigations and Management ?

A. Detail history of addictions and cytology give clues to diagnosis. Metastatic nodes are hard, but may be soft cystic, so should be considered in the D/D of any neck mass. If clinically apparent, primary is not seen on first look in the Head and Neck area, I proceed by performing an FNAC of the node (rarely an open biopsy is required) for confirming the histopathology of the node. If malignancy is proved, a meticulous search for primary is done in the head and neck area especially, searching for evidence of primary in the nasopharynx, base of tongue, Vallecula, tonsil, pyriform sinus, thyroid and paranasal sinuses, palpating for suspicious areas of induration and taking biopsy (punch or wedge) from these areas. X-ray of the chest. PNS, Ba swallow is followed by nasopharyngoscopy, hypo-pharyngoscopy, bronchoscopy and oesophagoscopy and biopsies from suspicious areas. In the absence of clinical or endoscopic suspicious areas, blind biopsies are taken from the fossa of Rosenmuller, base of the tongue, pyriform sinus and tonsil of the affected site, if the other sites i.e. breast, stomach, intestine and genitalia have been ruled out as probable site for primary by allied faculties. Most of the time, the primary can be detected and the treatment can be started. If the primary remains undetected, the treatment policy adopted is external beam radiation of the node by bilateral parallel portals, follow up if nodes do not regress completely. R N D is considered for residual disease. Follow up at 2-3 monthly intervals, if required biopsies from suspected sites.

Dr. Alok Bose Majumdar
Calcutta.

A. Investigations

CBC with ESR and X-ray chest PA view. Panendoscopy under GA with blind biopsy from nasopharynx, base tongue, pyriform fossa, carina, tonsil.

C.T. scan of nasopharynx and oropharynx (if patient is affording).

If all the above are negative and node is operable then radical neck dissection with sparing of spinal accessory followed by radio-therapy including nasopharynx. If N1 node-only radiotherapy including nasopharynx-repeat panendoscopy. If no primary is localised and node persists, proceed for RND with sparing of spinal accessory. N3 node, not fixed to carotid, do RND followed by radio-therapy. N3 node fixed to carotid, then palliative radio-therapy.

Dr. Farida Wadia.
Surat.

A. If the preliminary search for the primary is negative, then panendoscopy and biopsies including blind biopsy from the fossa of Rosenmuller, failing which RND should be done.

Dr. G. C. Sahoo
Annamalainagar.

A. We have studied 260 cases of metastatic cervical lymph-adenopathy with occult primary.

Our approach is as follows :

Routine Investigations

1. Thorough Head and Neck examination with Hopkin's telescope or fibreoptic scope and Nasopharyngoscopy with sinus endoscope.
2. Chest X-ray, Ba swallow-mandatory
3. Triple endoscopy and cytology-No blind biopsies except from suspicious areas.
4. CT Scan-in selected cases, more for deciding on operability than for finding primary.

Note :- Only 2% +ve detection of primary from these investigations.

Management

1. In every operable case, classical radical neck dissection first followed by 5000rads of telecobalt therapy as soon as healing is complete. 3 years. Survival rate : 72%
2. In inoperable case, Radiotherapy first, 4 cases out of 64 became operable. 3 year. Survival rate : 6%

3. No chemotherapy, On protocol studies of 40 patients, none benefitted significantly.

4. Palliation only in advanced cases.

**Dr. Jatin Mody
Rajkot**

A. Firstly all such patients undergo detailed clinical, relevant radiological (including barium swallow) and endoscopic (triple endoscopy if necessary) work up to exclude the presence of primary lesion in the upper aerodigestive tract. Blind biopsy from nasopharynx is usually done. If this is negative, FNAC is recommended to know whether it is due to squamous carcinoma or adeno carcinoma. In the case of the latter the search for the primary is usually localised below the clavicle including the breast, lungs, GIT and uterus (after excluding primary in the salivary glands). In case of squamous carcinoma however, in fit and young patients with N1 and N2 disease combination of pre-operative radiotherapy followed by RND is suggested. (in some instances, it is preferable that surgery precedes the postoperative radiation). However, N3 disease is usually recommended for palliation only.

**Dr. Sudhir Bahadur
New Delhi.**

A. In cases of Metastatic cervical nodes with occult primary, the evaluation begins with a complete history and physical examination, which should include indirect mirror exam of nasopharynx, oropharynx, hypopharynx and larynx. In addition, I would also inspect scalp, face and neck for suspicious lesion. Location of Lymph-adenopathy can give some idea of possible primary site of lesion.

Upper Neck Level I, II : Mouth, Anterior 2/3rd
tongue, tonsil, base of
tongue

Upper Post triangle: Nasopharynx
Level III & IV : Hypopharynx, Thyroid,
Oesophagus.

Supraclavicular triangle : Lung, Ovary, Breast,
Stomach.

I would also perform Lab Investigations like CBC, LFT and X-ray Chest. Next step would be to do an FNAC followed by proper exam under anaesthesia of Nasopharynx, Oropharynx, Hypopharynx, Larynx. Direct visualisation and palpation, particularly base of Tongue, Tonsil and Nasopharynx.

I would also perform Oesophagoscopy and Bronchoscopy.

If no primary detected, then take selected Biopsy from Nasopharynx, base of Tongue & Tonsil.

If FNAC & endoscopy is-ve, then I would go for excision or incisional biopsy under GA and send for frozen section. If + ve in frozen section, then do radical neck dissection at the same sitting (if Dx if of Sq Cell Ca). If diagnosis if undifferentiated ca on frozen section, then wait for permanent section. If report is lymphoma, Adenoma-Ca or Lymphoepithelioma, then treat with RT & CT combination.

For Adeno-Ca, patient is evaluated for disease below clavicle and treated with RT + CT according to primary disease.

In cases of Metastatic Adenocarcinoma, I would rule out Adenocarcinoma of submandibular or parotid gland and treat accordingly by surgery and post-op RT.

Metastasis from Squamous Cell Ca :

Advanced Neck N2, N3 : Treat with surgery and post-op RT.

N2 : treatment with surgery alone.

RT should cover Neck & Pharyngeal areas.

**Dr. Grish Mishra
Karamsad.**

A. Management of MUC (Metastasis of Unknown Origin) :

The flow chart gives the work up and the treatment of a case of Neck metastasis from an unknown primary.

FNAC

Squamous Cell Ca
Panendoscopy
R/O primary in
Primary detected : treat
Primary
Chemotherapy
Not detected : RND +
Post operative RT

Adenocarcinoma
Thyroid Scan
R/O primary in
Breast, GIT, Lung
Primary detected-
Post operative
Not detected : RND
+ or -CT

Undifferentiated or
Poorly differentiated Ca
Nasopharynx, Lymphoma
If-ve, RND +
Radiotherapy

- a. Panendoscopy includes Nasopharyngoscopy, DL, Oesophagoscopy and Bronchoscopy.
- b. A routine CT of the Head & Neck is not necessary in the workup.
however it may be done in specific instances, e.g. to evaluate the Nasopharynx, when there is no mucosal disease.
- c. During DL & Nasopharyngoscopy, directed biopsies of suspicious areas is preferable to routine blind biopsies, as blind biopsies have a low + ve yield.
- d. When administering post-operative radiotherapy, all areas at risk of harbouring possible primary should be included in RT fields, i.e. from Nasopharynx to the Hypopharynx
- e. If FNAC is suggestive of undifferentiated Carcinoma, lymphoma has to be ruled out by special immunohist-chemical studies.

Dr. Umanath K. Nayak.
Hyderabad.

A. In the beginning, I make a complete and careful local examination. It means an examination of oral cavity. I, very carefully, look into the valleculle on either sides.

Also, I examine - base of tongue
- both pyriform fossae
- cricopharynx

Most of the times, I even use 4% Xylocaine spray for local anaesthesia. The examination of the nose and nasopharynx is another step. With the help of nasal endoscope, the nasopharynx is clearly visible to rule out any pathology in the Rosenmuller's fossa.

General systemic examination is also essential.

Routine blood counts and X-ray Chest, PA View is another investigation which I routinely do.

Management :- I divide it into two types :

- (a) Unilateral nodes (b) Bilateral nodes
- (a) Unilateral nodes - Again, no categories.

Mobile nodes - I prefer to do a block dissection and then Radiotherapy post op. Fixed nodes-I send them for radiotherapy and after 6 months, go for a toilet surgery.

(b) Bilateral nodes - Here, according to my experience, the prognosis with surgery and Radiotherapy is the same, Hence, I send patients for Radiotherapy.

Dr. V. N. Gajendragadkar
Jalna

A. In case of proved metastatic C nodes with occult primary on clinical exam

Investigations

Panendoscopy

MRI (if patient can afford)

Management

R N D -If glands are free, followed by RT C060

RT C060 - fixed glands.

Follow up : Regular periodic OPD check up i. e. Panendoscopy to detect and treat primary.

Dr. Hasmukh C. Shah
Nadiad.

A. In case of cervical metastases where the primary is occult, I would routinely do a X-ray Chest and a barium swallow. The newer imaging modalities invariably do not help. Thorough examination under anaesthesia palpation of the base of the tongue, a triple endoscopy which includes a bronchoscopy, oesophagoscopy, and naso-pharyngoscopy. Sometimes, blind biopsies from sites such as the nasopharynx, pyriforms etc. can be undertaken. Location of the node and histology also indicate the possible location of primary, e.g. nodes in the lower neck and a histology of adenocarcinoma invariably comes from a primary in the GI track or breast.

Dr. Pushkar Lele
Nashik.

New Questions

1. What is perilymph gush due to ? How will you manage the same ?
2. How do you proceed when you find a fistula over lateral semicircular canal while doing a mastoidectomy in a patient with fistula sign positive ?

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