

CERVICAL METASTASIS FROM OCCULT NEOPLASM

13 Year survival after treatment

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Summary

In about 8% of cases presenting with metastatic disease in cervical lymph nodes, there is initial failure to find the primary lesion.

Whatever the stage at which the metastatic disease is recognized, and whatever the treatment employed, the prognosis for most of these patients is poor. Long survival is rare. (Comess, Beahrs and Dockerty, 1959; France and Lucas, 1963; Greenberg, 1966; Jesse and Neff, 1966; Marchetta, Murphy and Kovari, 1966; and Shaw 1970).

A case is here reported of metastatic carcinoma in cervical nodes in a patient who is alive and well 13 years after treatment, the site of the primary tumour remaining unknown.

Case Report

The patient, a woman aged 30, presented on 27/5/57 with a non-tender, right-sided neck swelling, the size of a golf ball, of about two months duration. On examination the swelling was noted to lie under the upper half of the right sternomastoid muscle, and was not attached to superficial or deep structures. Examination of the mouth, tongue, throat, nasopharynx, oropharynx, laryngopharynx and larynx revealed no abnormalities. A W.B.C. and differential W.B.C. were within normal limits, and the lungs, on X-Ray, were clear.

The site of the swelling was explored and an enlarged lymph node was excised. Biopsy showed carcinomatous metastasis of the 'lymphoepithelioma' type. Another E.N.T. examination was performed; again no evidence of a primary lesion could be found.

On 5/9/57 more nodes were palpable at the site of the previous excision. The

patient was referred to the Royal Marsden Hospital. The histology of the excised node was there labelled as undifferentiated polygonal cell carcinoma. She was fully investigated, including a biopsy from the nasopharynx, but no evidence of the primary neoplasm could be found. A large lower abdominal mass was noted; laparotomy revealed a massive fibromyoma of the uterus and a sub-total hysterectomy and right salpingo-oophorectomy were carried out. Following this operation, a hard nodule was found in the right lobe of the thyroid gland. It was decided to continue with the Telecobalt 60 treatment to the neck and to explore the thyroid after completion of the irradiation. Exploration revealed a normal-looking thyroid gland and biopsy confirmed this. The response to irradiation was excellent.

A period of 13 years has now elapsed. The patient still shows no evidence of malignant disease. The site of the primary lesion has never been determined.

Discussion

A recent, progressive, painless swelling in the neck of an adult is a very significant symptom. If the swelling, whether unilateral or bilateral, is thought clinically to be an enlarged lymph node (or nodes), the condition should be regarded as malignant, unless proved otherwise.

Correct management of such a case consists in searching for a primary lesion in the head and neck and, if unsuccessful, elsewhere. In about one in ten of cases a primary tumour may not be evident initially. A thorough E.N.T. examination will be indicated, bearing in mind that the nasopharynx is the commonest site of occult primary neoplasms. The subsequent frequency of primary site involved is variable but an accepted order is: naso-

pharynx, tonsil, tongue base, thyroid, larynx (not cordal) floor of mouth, palate, laryngopharynx, (Shaw 1970). Other primary sites are the bronchus, oesophagus, breast, stomach, kidney, large intestine, rectum and prostate.

It is useful to note the location of the involved node, or nodes, in the neck, as this may give a clue as to the site of the primary lesion. Node enlargement high in the deep cervical chain suggests a primary in the nasopharynx, tonsil, or tongue base. If bilateral, or along the spinal accessory chain, one should suspect the nasopharynx. Lesions of the tongue and floor of the mouth usually metastasize to the submaxillary group. Single node enlargement in the mid or lower zones of the jugular chain should lead one to suspect the larynx, pharynx, cervical oesophagus, or thyroid. Supraclavicular node involvement may be metastatic from almost any site in the body, but most commonly bronchi, breast, stomach or lower oesophagus, the latter two chiefly to the left side. (Shaw, 1970).

Excision biopsy of cervical nodes should not be used as a short cut to diagnosis. It should certainly not precede an E.N.T. examination. It is no credit to arrive at a diagnosis by node biopsy when an obvious head and neck primary tumour had been present and could easily have been found had an E.N.T. examination been carried out.

Nevertheless, it is accepted that lymph node excision is often necessary. Histology of enlarged cervical nodes will in most cases distinguish between disorders arising in the lymph node itself — such as Hodgkin's disease, lymphosarcoma, reticulosarcoma, etc. — and metastasis in a node. However, histology of cervical metastases is often inconclusive as regards the determination of the primary site, unfortunately; the picture is in most cases that of squamous or anaplastic carcinoma. Nodal histology can at times, however, provide direct evidence for suspecting the true site of the primary carcinoma — metastases from a papillary thyroid carcinoma is the best example.

Perusal of the relevant literature reveals that the prognosis for these cases of cervical metastases from occult tumour is not good. A neoplasm that has metastasized when first seen is less amenable to control than one that has remained localized. The great majority of cervical metastases are squamous or undifferentiated carcinoma, and the ultimate prognosis is poor regardless of type of therapy. There is almost universal agreement that treatment of any kind can only be effective if the primary lesion is detected early and treated. However, Jesse and Neff claim a higher cure ratio where the primary site was never found. This sounds paradoxical to other authors. It could be explained though, by the possible inclusion of the primary tumour in the field of irradiation, or by its spontaneous regression.

Similar cases of long survival after treatment for cervical metastases from an unknown primary tumour have been reported in the literature, but they are few in number. Long survival is definitely uncommon, and the 13-year survival in this case is a rare occurrence.

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