

## CASE REPORT

### A RARE CASE REPORT OF SYNCHRONOUS MALIGNANCY – SQUAMOUS CELL CARCINOMA OF BASE OF TONGUE AND ADENO CARCINOMA OF STOMACH

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**ABSTRACT:** The synchronous occurrence of primary squamous cell carcinoma of base of tongue with gastric adenocarcinoma is very rare. We report a case of 50 year old male patient presented to ENT OPD with complaints of throat pain, painful swallowing since 1month. Indirect laryngoscopy showed ulceroproliferative growth in Base of tongue, vallecula and epiglottis. Upper GI endoscopy showed ulceroproloferative lesion involving base of tongue, left epiglottis and vallecula. Endoscopic Biopsy from the growth revealed squamous cell carcinoma of the base of the tongue and adeno carcinoma of the stomach. We report this case to highlight a rare occurrence of synchronous malignancy of posterior tongue and stomach.

**KEYWORDS:** Multiple primary tumors, panendoscopy, head and neck, squamous cell carcinoma.

**INTRODUCTION:** Approximately 70% of oropharyngeal cancers are squamous cell carcinoma. Oropharyngeal squamous cell carcinoma is said to represent 10-15% of all head and neck tumor. There is an increasing prevalence of oral cavity and oropharyngeal carcinoma in last decade, particularly in men aged 35-64 year. More common in men with sex ratio 4:1, in 6<sup>th</sup> n 7<sup>th</sup> decades.<sup>1,3</sup> Tumor at tongue base rarely produce any symptoms and are not easy to detect. Consequently, the overwhelming majority of such patients have locally advanced tumors when they present.

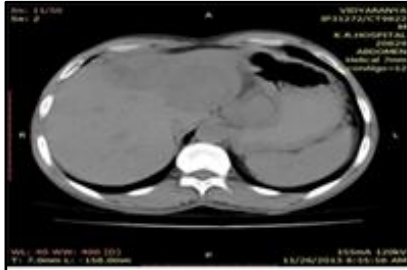
**CASE REPORT:** A 50 year old male patient presented with complaints of throat pain, difficulty in swallowing of 1 month duration. Patient is smoker and alcoholic since 30 years. He also gave history of loss of appetite and weight loss. On ENT examination there is presence of nicotine stain in buccal mucosa. Indirect laryngoscopy showed ulceroproliferative growth in base of tongue, left vallecula and left supraglottis. Vocal cords were not visible. There was no significant lymphadenopathy.

Biochemical Investigations reports of blood and urine were within normal limits.

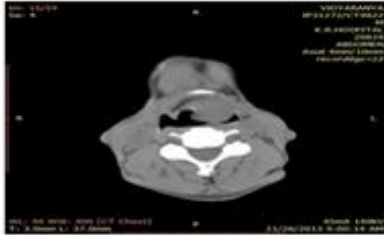
#### Upper GI endoscopy Shows:

1. Ulceroproliferative growth involving base of tongue, left epiglottis and vallecula.
2. Chronic gastric ulcer in the gastric antrum.
3. Biopsy was taken from both lesions.

## CASE REPORT



CT Abdomen showing lesion in the liver



CT Neck Showing lesion from base of tongue



CT showing aortocaval lymphnode with pancreatic lesion.

### Biopsy revealed:

1. 1st Specimen showed tumor tissue with features of an infiltrating moderately differentiated squamous cell carcinoma.
2. 2nd specimen showed bits of gastric mucosa and tumor tissue with features of moderately differentiated adeno carcinoma.

In a view of evaluating clinically missed neck nodes CT scan neck (plain and contrast) was done which revealed enhancing isodense mass lesion measuring 34x30x26mm arising from base of tongue with extending inferior to involve the left vallecula and epiglottis. Lesion is seen to involve the left aryepiglottic fold and left pyriform sinus. There was no neck node metastasis.

In view of evaluating metastasis from gastric carcinoma CT abdomen (plain, IV & oral contrast) revealed stomach thickness of 12mm, Liver showed 2 hypodense lesion in left lobe of segment II,III measuring 43x53x53mm and in segment IV measuring 45x57x43mm. Body of pancreas showed hypodense lesion measuring 72x55x45mm. Aortocaval lymph node measuring about 11x6mm was seen.

## CASE REPORT

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### Endoscopic pictures:



An ulceroproliferative Supraglottic growth



Gastric Antrum- Lesion

TNM staging of above growths is T4ANoMX Stage 4A of Oropharyngeal carcinoma. T4N1M1 Stage 4A of gastric antral adenocarcinoma.

In view of extensive lesion of base of the tongue, supraglottis, hypopharynx CRTT Chemotherapy and radiotherapy was advised. The surgical treatment could be hemiglossectomy, total laryngectomy and hypopharyngectomy with reconstruction and tracheostomy. However the patient was not fit for the surgery.

In view of extensive hepatic, pancreatic and aortocaval lymph node metastasis no surgical option was considered for ca stomach. Patient was advised chemoradiotherapy. Palliative treatment was advised.

**DISCUSSION:** In recent decades multiple primary cancers in one patient is not uncommon. Second neoplasm are classified as 'synchronous, defined as occurrence of index tumor and second malignancy within 6 months of each other.<sup>1</sup>

In conclusion our case highlights a rare occurrence of synchronous double malignancy consisting of oropharyngeal squamous carcinoma and gastric adeno carcinoma. The first incidence of multiple tumors in a patient was reported by Billroth in 1889.<sup>1</sup> However, it was not until 1932, after Warren and Gates presented a review on multiple primary tumors that more attention was drawn to the subject.<sup>1,2</sup>

## CASE REPORT

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A detailed history, including tobacco use and alcohol consumption, should be taken and a detailed examination with mirror and flexible fiberoptic endoscopy of the pharynx and larynx and a chest radiograph should be performed. For carcinoma of the oral cavity, oropharynx, hypopharynx, and larynx panendoscopy is mandatory (laryngoscopy, rigid bronchoscopy, esophagoscopy, and nasopharyngoscopic examination) at the time of evaluation and biopsy of the primary malignant lesion with the patient under general anesthesia.<sup>3</sup>

In addition, barium swallow examinations were performed for patients with symptoms suggestive of esophageal disease. CT, MRI, PET and SPECT should be done.

The tumor prompting specialist attention is termed as “index tumor,” and synchronous tumors are defined as all additional tumors found at the same time or discovered within 6 months of the diagnosis of the index tumor and second primary tumors met the criteria as defined by Warren and Gates<sup>1</sup>:

1. Each lesion was distinct, separated by normal tissue.
2. Each malignant lesion was confirmed by histologic examination.
3. The possibility of metastatic disease was excluded.
4. Lung lesions termed “second primary” were solitary and histologically distinct from the primary cancer examination.

Any second primary tumor found more than 6 months after the discovery of the index tumor was termed a metachronous tumor. Follow-up assessments should be performed monthly for 3 months and every 3 months afterward.

The concept of field cancerization or “condemned mucosa syndrome” is the most popular theory put forward to explain the development of multiple cancers.<sup>1</sup> This concept, used to explain the high local recurrence rate of oral cancer, also is applicable to the high rate of multiples synchronous primary lesions in the upper aerodigestive tract. Carcinoma of other distant sites and specifically those arising from the nasal cavity, salivary glands, orbit, lacrimal apparatus, skin of the lips, thyroid, and stomach should be ruled out.

These tumors are believed to have an etiology different from those oropharyngeal /laryngeal/esophageal tumors, which are mucosal in origin and exposed to similar irritants, e.g. tobacco 20 cigars<sup>1</sup> a day and alcohol 37g.<sup>1,3</sup> () Laryngeal cancer accounted for 38.4% of all head and neck. Patients who developed a second primary tumor tended to have a lower tumor stage (T1 and T2). The average age of patients with multiple versus single lesions is greater at the time of diagnosis by 3 to 4. The sex ratio of 4 to 1 for male to female is seen.<sup>3,4,5</sup>

For the above case the treatment option could be CTRT (Chemo therapy and radio therapy) for oropharyngeal carcinoma. As palliative treatment for adeno carcinoma of gastric antrum anterior Gastro jejunostomy with chemo therapy should be given.<sup>6</sup>

In conclusion, patients with head or neck squamous cell carcinomas shown that the esophagus, gastric carcinoma is the site with the highest risk of developing a synchronous second primary tumor in patients with head or neck carcinoma, particularly those with laryngeal carcinoma.

Lung second primary tumors are less common, and in contrast to Western experience, oral cavity and pharyngeal second primary tumors appear to be rare. This study emphasizes the importance of esophagoscopy in the initial assessment of a patient with head or neck malignant lesions.

## CASE REPORT

A diagnosis of metachronous malignancy calls for surgical intervention. In many instances, it is possible to perform radical surgery. The 5-year survival rate was 66.5% in patients with metachronous malignancy who had undergone curative surgery; this rate was similar to that obtained in patients with synchronous malignancy.

Based on these findings, we suggest that it is important to do Careful pre- and intraoperative examination which may make it possible to reduce the incidence of so-called metachronous malignancy.

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