

LYMPHOEPITHELIAL CARCINOMA OF NASAL CAVITY-A RARE CASE IN A RARE SITE**Dr. K. Anbukkarasi*¹, Dr. Hemalatha Ganapathy², Dr. P. Karkuzhali³**Postgraduate¹, Professor², Professor and H.O.D³
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ABSTRACT

We report a case of a 39-year-old man who presented with history of bleeding from left nasal cavity on and off for 2 weeks. Examination of the nose revealed a fleshy mass arising between the nasal septum and middle turbinate of left nasal cavity. Diagnostic nasal endoscopy was done which showed a fleshy mass arising from the middle turbinate of the left nasal cavity. Excision biopsy was done and sent for histopathological examination. CT head and neck was done which showed no evidence of tumor in the pharynx or any metastatic spread to adjacent structures. So the tumor was of pure nasal origin. Based on the CT findings and histopathological report the diagnosis of LEC NC was made.

KEYWORDS: Lymphoepithelial carcinoma, nasal cavity, pathology.**INTRODUCTION**

Lymphoepithelial carcinoma of the nasal cavity (LEC NC) is an extremely rare tumor, with most cases identified in patients from Southeast Asian countries.^[1] Similar to its morphological analogue of the nasopharynx, LEC NC has a strong association with EBV.^[2] We report and discuss the diagnosis of this rare case in a rare site.

CASE REPORT

A 39 yrs old male farmer, a chronic smoker and alcoholic presented with history of bleeding from left nasal cavity, on and off for 2 weeks. No complaints of hearing difficulty or difficulty in opening the mouth or fullness in the ear or blurring of vision or headache. Examination of the nose revealed a fleshy mass arising between the nasal septum and middle turbinate of left nasal cavity. Diagnostic nasal endoscopy was done which showed a fleshy mass arising from the middle turbinate of the left nasal cavity. Excision biopsy was done and sent for HPE. CT head and neck was done which showed no evidence of tumor in the pharynx or any metastatic spread to adjacent structure. So the tumour is of pure nasal origin. Histological examination of the biopsy demonstrated a tumor proliferation that was made of irregular sheets, islands and single neoplastic cells richly infiltrated by lymphocytes and plasma cells. Epithelial component consisted of large cells with indistinct cell borders resulting in syncytial appearance, vesicular nuclei and moderate mitotic activity. Necrosis

and keratinization were absent. There was no involvement of cervical lymph nodes.

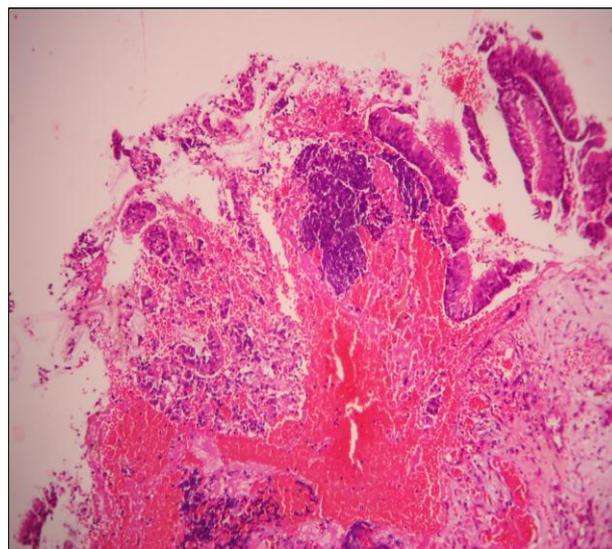


Fig. 1: Scanner view showing respiratory epithelium overlying haemorrhagic and fibrous stroma enclosing islands of tumour cells admixed with lymphocytes.

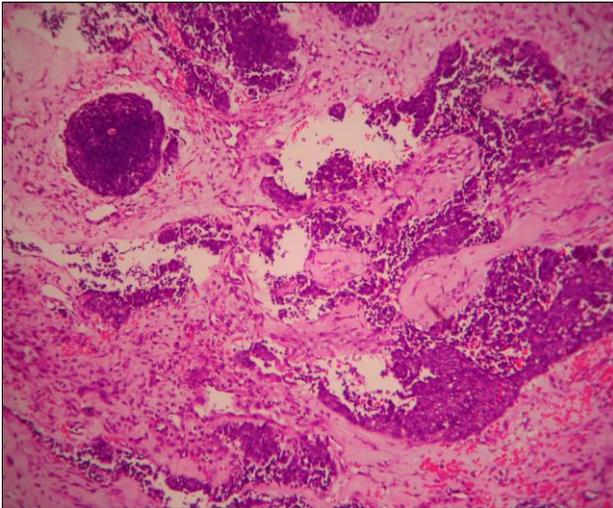


Fig. 2: Low power view showing sheets and islands of tumour cells surrounded by lymphocytes.

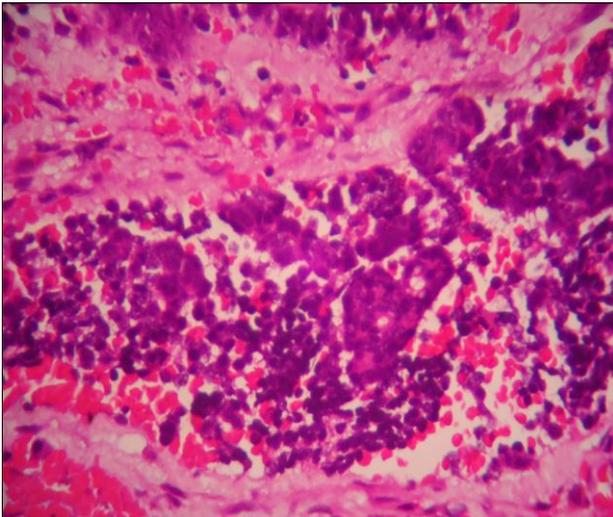


Fig. 3: High power view showing nests and islands of tumor cells arranged in syncytial pattern with enlarged nuclei and prominent nucleoli.

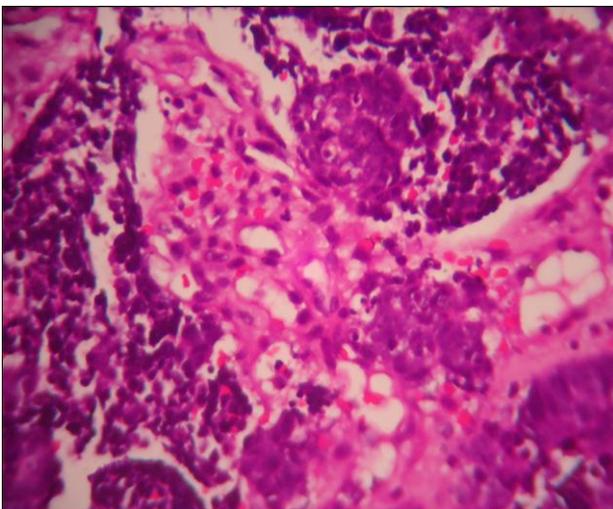


Fig. 4: High power view showing lymphocytic infiltrate around the tumor islands and fibrous stroma.

DISCUSSION

Lymphoepithelial carcinoma of the nasal cavity is extremely rare with the majority of the cases identified in Southeast Asian countries.^[1] It was recently accepted as a distinct entity separated from nasopharyngeal carcinoma by topography but still similar to this entity histologically.^[3,4] In the past, LEC and undifferentiated carcinoma of the sinonasal tract have been used as synonyms, but the latter is more aggressive.^[2]

Clinically, most patients presented with nasal obstruction and/or epistaxis. Occasionally, cervical lymph nodes' metastases may be the initial presenting symptom.^[1,3] The nasal cavity is affected most often, followed by the paranasal sinuses^[1]. Morphologically, LEC NC is similar to nasopharyngeal undifferentiated carcinoma. The tumor is arranged in irregular islands, solid sheets and single neoplastic cells with syncytial appearance. The nuclei are usually vesicular with prominent nucleoli. The lymphoid component tends to be less prominent as compared with its nasopharyngeal counterpart. Mitoses may be seen but necrosis and keratinization are usually absent.^[2]

Immunohistochemically, tumor cells show an immunoreactivity for pancytokeratin and EMA. The surrounding cellular infiltration is a mixture of CD20 and CD3 positive B and T lymphocytes. LEC NC must be distinguished from other malignant tumors particularly sinonasal undifferentiated carcinoma, lymphoma and malignant melanoma seeing that each lesion has a different treatment and outcome.^[3] Immunohistochemical stains allow distinction from lymphoma and melanoma.

Sinonasal undifferentiated carcinoma is EBV-negative and tends to be much more pleomorphic with central necrosis and high mitotic index.^[2] Similar to its nasopharyngeal counterpart, LEC NC has a strong association with EBV, detected by immunohistochemistry and in situ hybridization technique for EBV-encoded RNA (EBER). Because of the reduced number of the reported cases, it is difficult to determine the optimal treatment of LEC NC. This tumor is highly radiosensitive and radiotherapy should be considered as the main treatment even when there is lymph node metastasis.^[5] Chemotherapy may be added particularly when there are distant metastases.^[2] More recently, intensity modulated radiation therapy seems to provide low rates of radiation-induced toxicity with high local control and better survival.^[6,7] The prognosis of LEC NC is stage dependent, it declines when distant metastases are present.^[2]

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