

잠복원발종양의 원발병소 진단시 내시경 유도하 생검 및 구개편도적출의 진단적 의의

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Diagnostic Significance of the Endoscopy-guided Biopsy with Tonsillectomy in Suspected Occult Primary Tumor

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ABSTRACT

Background and Objectives : An occult primary tumor is defined as histologic evidence of malignancy in the cervical lymph nodes with no apparent primary site of origin for the metastatic tumor. **Materials and Methods** : Twenty-three patients who have failed to detect primary tumor on their initial physical examinations, endoscopy and other imaging studies, underwent endoscopy-guided biopsy under the general anesthesia. The histologic examination of frozen sections was done in the operation room. For those failing to give results by the histologic study, we performed the ipsilateral tonsillectomy biopsy. **Results** : Nine primary lesions were identified : four cases of tonsillar fossa, one case each of nasopharynx, base of tongue, hypopharynx, supraglottis, and esophagus. In the three of the four tonsillar cancer cases, the primary foci were also identified by tonsillectomy biopsy. All the patients whose primary foci were tonsillar fossa showed metastasis of the jugulodigastric lymph node. **Conclusion** : Our results indicate that patients who are considered to have occult primary tumor should be evaluated by endoscopy-guided biopsy under the general anesthesia. Also, this study finds that if the histologic result of the frozen section were negative, ipsilateral tonsillectomy can be justified, especially for patients who show metastasis of jugulodigastric cervical lymph node. (**Korean J Otolaryngol 1998;41(3):371-376**)

KEY WORDS : Occult primary tumor · Endoscopy-guided biopsy · Tonsillectomy.

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¹⁾ 1944
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23 가 , level III 12 (40.0%), level IV 2 (6.7%), level V 3 (10.0%) (Ame-rican Joint Committee on Cancer, 1988) N2a 가 10 (43.5%) 가 , N3가 7 (30.4%), N2b 가 3 (13.1%), N2c가 2 (8.7%), N1가 1 (4.3%)

19 (82.6%), 3 (13.0%), 1 (4.4%)

7 (36.8%), 5 (26.4%), 7 (36.8%) 12

가 , 가 가 9 (39.1%) , 3 (13.1%) 가 가 가

12 가 5 (21.8%), 2 (8.7%), , 1

(Table 1).

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52.4 . 50 60 33 69 7 (30.4%) 가 20 (87.0%), 가 3 (13.0%) 6.7 : 1

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13 (43.3%) 가 , level III 12 (40.0%), level IV 2 (6.7%), level V 3 (10.0%) (Ame-rican Joint Committee on Cancer, 1988) N2a 가 10 (43.5%) 가 , N3가 7 (30.4%), N2b 가 3 (13.1%), N2c가 2 (8.7%), N1가 1 (4.3%)

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12 가 5 (21.8%), 2 (8.7%), , 1

(Table 1).

가 9 , 가 4 (44.4%) 가 (Fig. 1). 가 5 , 3 ,

Table 1. Primary site

Primary site	Numbers (%)
Nasopharynx	1 (4.3%)
Tonsil	5 (21.8%)
Post. pharyngeal wall	1 (4.3%)
Base of tongue	1 (4.3%)
Aryepiglottic fold	1 (4.3%)
Esophagus	1 (4.3%)
Lung	2 (8.7%)
Unknown	11 (48.0%)
Total	23

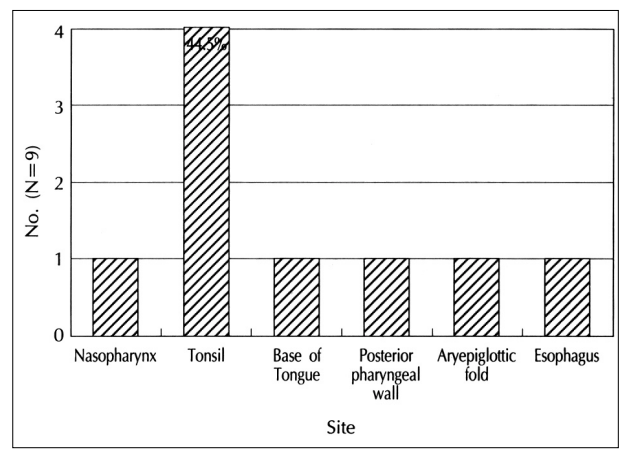


Fig. 1. Detection iste by endoscopy guided biopsy & tonsillectomy.

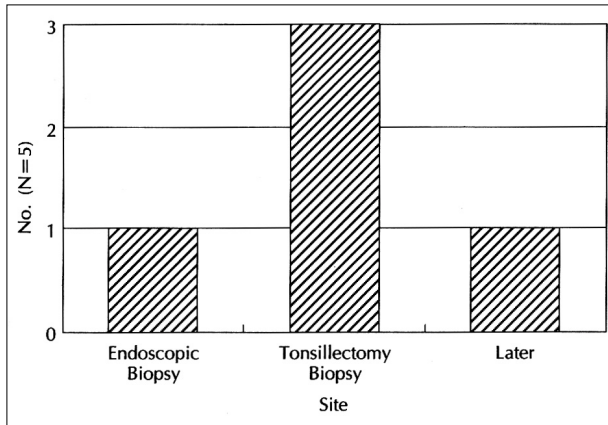


Fig. 2. How we detect the tonsillar cancer?

Table 2. Primary site vs. neck level

Confirmed primary site	Neck level		
	level II	level III	level IV, V
Nasopharynx	1	1	1
Tonsil	3	1	
Post. pharyngeal wall		1	
Base of tongue	1	1	
Aryepiglottic fold	1		
Esophagus		1	
Lung		1	1

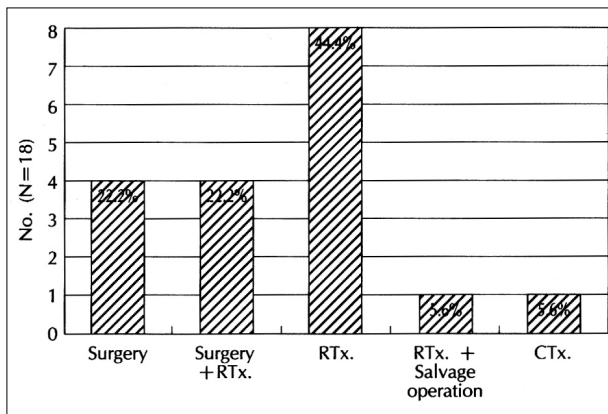


Fig. 3. Neck treatment modality.

RTx. : Radiation therapy, CTx. : Chemotherapy

1, 가 1 (Fig. 2). 가

level II, IV, V
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(Table 2).

9

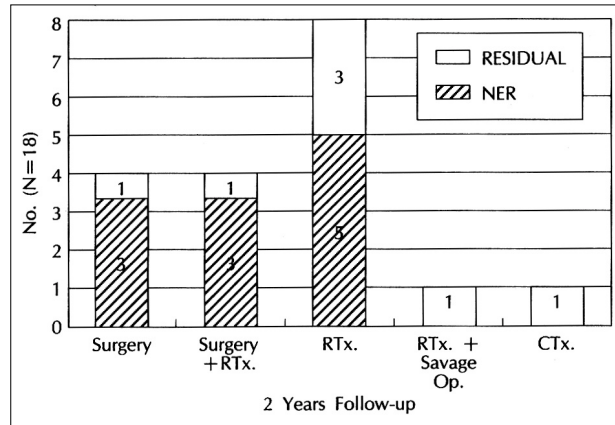


Fig. 4. Neck treatment results.

RTx. : Radiation therapy, CTx. : Chemotherapy

, 8, 1
(Fig. 3), 2
9 4,
8 2, 1
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Martin⁶⁾ 47.8%, McGuirt⁷⁾ 26.4%, Leipzig¹³⁾ 36.8%, Shaw¹⁴⁾ 36.8%,
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 TNM Stage(American Joint Co-
 mmittee on Cancer, 1988.) Wang⁹⁾ X-
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REFERENCES

- 1) Lucente FE. *Instructional courses. In: Shaha AR. The unknown primary. 8th ed. St. Louis: Mosby Press;1995. p.199-204.*
- 2) Martin H, Morfit HM. *Cervical lymph node metastasis as the first symptom of cancer. Sur Gynecol Obstet 1994;78:133-59.*
- 3) Basakis JG. *The Pathology of head and neck tumors: The occult primary and metastases to the head and neck, part 10. Head Neck 1981;3:409-23.*
- 4) Lee DJ, Rostock RA, Harris A, Kashima H, Johns M. *Clinical evaluation of patients with metastatic squamous carcinoma of the neck with occult primary tumor. Southern Medical Journal 1986; 79:979-83.*
- 5) Weingar LK, Griffin W. *The occult primary tumor. Arch Otolaryngol Head Neck Surg 1973;98:159-93.*
- 6) Martin HE. *Untimely lymph node biopsy. Am J Surg 1961;102:17-9.*
- 7) Mcguirt WF, Mccabe BF. *Significance of node biopsy before definitive treatment of cervical metastatic carcinoma. Laryngoscope 1978;88:594-97.*
- 8) Peter's BR, Schnadig VJ, Quinn FB Jr, Hokanson JA, Zaharopoulos P, McCracken MM, et al. *Interobserver variability in the interpretation of fine needle aspiration biopsy of head and neck masses. Arch Otolaryngol Head Neck Surg 1989;115:1438-42.*
- 9) Wang RC, Goepfert H, Barber AE, Wolf P. *Unknown primary squamous cell carcinoma metastatic to the neck. Arch Otolaryngol Head Neck Surg 1990;116:1338-93.*
- 10) Spiro RH, DeRose G, Strong EW. *Cervical node metastasis in occult origin. Am J Surg 1983;146:441-6.*
- 11) Damion J, Hybel RH. *The neck mass. Postgraduate Medicine 1987; 81:97-107.*
- 12) Shockley WW, Pillsbury III HC. *The neck diagnosis and surgery. In: Stiernberg CM, Mostert JF. Unknown primary lesion. 1st ed. St. Louis: Mosby Press;1994. p.431-7.*
- 13) Leipzig B, Winter ML, Hokanson JA, Galveston. *Cervical nodal metastases of unknown origin. Laryngoscope 1981;91:593-97.*
- 14) Shaw HJ. *Metastatic carcinoma in cervical lymph nodes with occult primary tumor-diagnosis and treatment. J Laryngol Otol 1970;84: 249-65.*
- 15) Talmi YP, Wolf GT, Hazuka M, Krause CJ. *Unknown primary of the head and neck. J Laryngol Otol 1996;110:353-6.*

- 16) Ord RA, Aisner S. *Accuracy of frozen sections in assessing margins in oral cancer resection. J Oral Maxillofac Surg* 1997;55:663-9.
- 17) Dillon WP, Harnsberger HR. *The impact of radiologic imaging on staging of cancer of the head and neck. Seminars in Oncol* 1991; 13:64-79.
- 18) Foust RJ, Duong RT. *Roles of computed tomography and magnetic resonance imaging diagnoses in the treatment of head and neck cancer. Hematol Oncol Clin North Am* 1991;5:657-65.
- 19) Muraki AS, Mancuso AA, Harnsberger HR. *Metastatic cervical adenopathy from tumors of unknown origin: The role of CT. Radiol* 1984;152:749-53.
- 20) Lefebvre JL, Coche-dequeant B, Van JT, Buisset E, Adenis A. *Cervical lymph nodes from an unknown primary tumor in 190 patients. Am J Surg* 1990;160:443-46.
- 21) Tawley SE. *Malignant neoplasm of the oropharynx. In: Cummings CW, Fredrickson JM, Harker LA, Krause CJ, Schuller DE, editors. Otolaryngology-Head and Neck Surgery. 2nd ed. St. Louis: Mosby Year Book;1993. p.1326-28.*
- 22) Bataini JP, Rodriguez J, Jaulerry C, Ghossein NA. *Treatment of metastatic neck nodes secondary to an occult epidermoid carcinoma of the head and neck. Laryngoscope* 1987;97:1080-84.
- 23) Shah JP. *The unknown primary: Surgical treatment. In: Chretien PB, Johns ME, Shedd DB, et al. Head and Neck Cancer. 1st ed. St. Louis: Mosby Press;1985. p.289-300.*
- 24) De Braud F, Heilbrun LK, Ahmed K, Sakr W, Ensley JF, Kish JA, et al. *Metastatic squamous cell cancer of unknown primary localized to the neck: Advantage of an aggressive treatment. Cancer* 1989;64:510-15.
- 25) Glynne-Jones RT, Anold AK, Young TE, Berry RJ, Phil D. *Metastatic carcinoma in the cervical lymph nodes from an occult primary: A conservative approach to the role of therapy. Int J Radiation Oncol Biol Physics* 1990;18:289-94.
- 26) Harper CS, Mendenhall WM, Parsons JT, Stringer SP, Cassisi NJ, Million RR. *Cancer in neck nodes with unknown primary site: Role of mucosal radiotherapy. Head and Neck* 1990;12:463-9.
- 27) Fitzpatrick PJ, Kotalik JF. *Cervical metastases from an unknown primary tumor. Radiol* 1974;110:659-63.