SYNOVIAL SARCOMA OF RETROPHARYNGEAL SPACE PRESENTING AS CARIES SPINE

AMJAD KHAN, JAVED ZAMAN, IFTIKHAR AHMAD AND ABDULLAH JAN

Department of ENT,
Postgraduate Medical Institute,
Lady Reading Hospital, Peshawar.

INTRODUCTION

Synovial Sarcomas are uncommon soft tissue tumours which occur in the region of joints but never involve them. The great majority occurs in patients between the ages of 15 and 35 years but older and younger persons may be affected. The male to female ratio is approximately 1.5:1. Histologically these are mainly biphasic tumours having distinct epithelial and well - defined spindle cell components. In more than half of the cases, these patients present with a tender or painful deep - seated mass in close proximity to the bone or joints[1]. Radiographs may sometimes show erosion or even invasion of adjacent bone. Metastases are rare in slow growing tumours but some tumours are rapidly enlarging and present with metastases to the lungs. The treatment depends upon the site and extent of the disease. Neoplasms of areas where surgical access is not possible or carries high risk, adjuvant therapy consisting of radiotherapy and chemotherapy is the treatment of choice.

CASE REPORT

A 23 years old pregnant girl presented with the history of dysphagia, a lump in the neck and change in voice of 3 months duration. There was no history of haemoptysis or haematemesis. Two weeks before her admission to our department on 20-8-1996, she had developed slight stridor. She was a primigravida of 32 weeks. On examination she was found to be a young healthy looking girl with no visible signs of respiratory distress. Examination of the pharynx revealed a large mass extending from the nasopharynx down to the hypopharynx giving the appearance of a chronic retropharyngeal abscess. There was also a large nontender mass on the left side of her neck. A plain X-ray of soft tissue neck (lateral film) demonstrated a large soft tissue mass with changes in the cervical spine suggestive of caries spine (Fig 1). X-ray chest was normal. A C.T. Scan confirmed a large mass eroding the bones of cervical spine (Fig 2). A wide bore needle (17 F.G.) was inserted in the mass for aspiration of abscess under local anaesthetic but nothing was obtained. It was felt that there was no pus and that the mass was probably a tumour. The neuro-surgeon opinion was sought who attempted transcutaneous aspiration under ultrasound control. Subsequently the patient developed some degree of respiratory difficulty. It was decided therefore to perform tracheostomy before any further manipulation. Having a large mass in the midline on the posterior wall of the pharynx, it was not possible to extend her neck for endotracheal intubation. Tracheostomy was, therefore, performed under local anaesthesia in a head up and

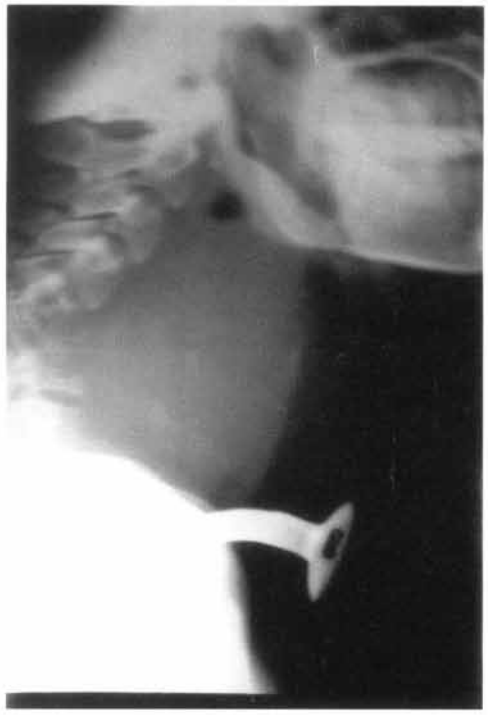

Fig. 1

flexed neck position which was extremely difficult. A very small tracheostomy tube was inserted and a biopsy was then taken under general anaesthesia by connecting the tracheostomy tube to the anaesthetic machine. A vertical incision was made in the midline on the posterior wall of the pharynx by using a 15 size blade and a pharyngeal sucker was introduced through the incision

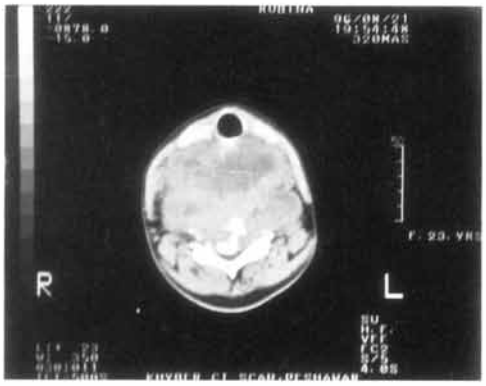

Fig. 2

for aspiration. However, no free fluid or pus was obtained. The vertebral column could be felt through the sucker. It was therefore realised that it was not an abscess but a tumour. A wedge biopsy was taken and sent for histological examination. An attempt was made to put a nasogastric tube down for feeding purposes but it was not possible because of the over-hanging mass at the level of cricopharynx. The histological report showed synovical sarcoma. At this stage, about two weeks after her admission, we were faced with two problems. First, to have a live baby and secondly to establish natural feeding. The gynecologist decided to induce her at 34 weeks which was successfully done but unfortunately the baby died of jaundice on the 3rd day. A gastrostomy was performed for feeding purposes. Intra venous line was established for intra venous antibiotics, cyto-toxic drugs and intra venous fluids. At this time the patient developed severe chest infection and was pouring out frank pus. However, there

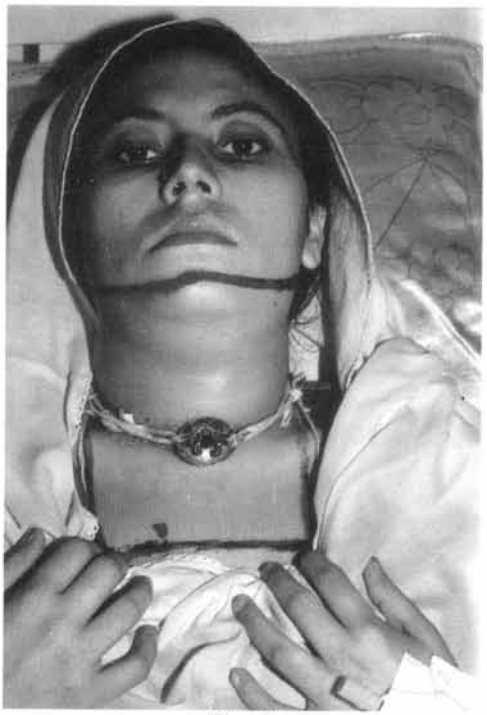

Fig. 3

was no evidence of metastases in the lungs. Extensive physiotherapy, good antibiotics and efficient nursing care with good nourishing diet, including blood transfusion, improved her state. It was obvious from the extent and site of the disease that surgical treatment was out of question. The department of radiotherapy therefore started her on adjuvant therapy of radiotherapy and chemotherapy. The patient responded very well to the chemotherapy and showed definite signs of improvement. She started to swallow fluids and semi-solids. She was discharged home on 28/12/1996, on her own request, with the tracheostomy tube still in situ (Fig 3). She died at home, after 11 months of diagnosis, due to asphyxia secondary to blockage of tracheostomy tube.

DISCUSSION

Synovial Sarcoma is a rare tumour and more so in the head and neck region. Very few cases have been reported in the pharyngeal and para-pharyngeal area. Verma (1990)[2] reported a case of primary synovial sarcoma of the naso-pharynx which was treated with surgery, followed by radiotherapy. Eio et al (1993)[3] reported a case of synovial sarcoma of hypopharynx in an eleven year old boy who was treated by supra-glottic laryngo pharyngectomy. Onerci et al (1993)[4] reported a case of synovial sarcoma in the neck of a 10 year old child and was described by him as a rare tumour. We agree with the views of these authors about the rarity of these tumours because it is the first case that we have come across in our department over a period of nearly 17 years. The treatment of choice by all these authors is described as surgical, if they are surgically accessible, such as in limbs or larynx. However, in our case as is obvious from radiographs and the C.T. Scan, surgical treatment was not possible.

REFERENCES

1. Robbins L, Stanley, Kumar V, Cotran SR. Robbins pathologic basis of disease, 4th edition, 1378.

2. Verma A, Metha S, Mann SB, Radiotra BD. Synovial sarcoma of the nasopharynx, Ear Nose Throat Jouranl, 1990; 69: 347.

3. Eio J, Bajtai A, Hidvegi J, Labas Z. Synovial sarcoma of the hypopharynx in an eleven year old boy Eur Arch Otorhinolarygol, 1993; 249: 499.

4. Onerci M, et al. Synovial sarcoma in the neck int J Pediatr Otorhinolaryngol, 1993; 27(1): 79.