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Oropharyngeal Carcinoma (with comments on nasopharynx and hypopharynx)

1. GROSS DESCRIPTION

Specimen

— fine needle aspirate/biopsy/tonsillectomy/adenoidectomy/pharyngectomy/pharyngooesophagectomy ± laryngectomy/neck dissection.
— weight (g) and size (cm), number of fragments.

Depending on the anatomical site of the lesion, patients can present with dysphagia, hoarseness, deafness, cranial nerve palsy or cervical lymphadenopathy. Investigation is by endoscopy with biopsy and cervical node FNA to obtain a diagnosis. CT and MRI scan are used to assess local tumour spread and metastasis to the neck and elsewhere. Chest X-ray can detect concurrent lung cancer. Extent of resection depends on tumour site, stage, lymph node spread, fitness of the patient and any concurrent tumour. Tonsil is submitted when there is asymmetrical enlargement or as a possible site of an occult primary in FNA-proven cervical node metastases. Carcinoma in the post nasal space is a not infrequent source.

Tumour

Site

Oropharynx: lies between the soft palate and tip of the epiglottis. Most tumours arise in the posterior third of tongue and the tonsil.
Boundaries:

1. anterior wall	posterior third tongue, vallecula
2. lateral wall	tonsil, tonsillar fossa and pillars
3. posterior wall	
4. superior wall	inferior surface soft palate, uvula.

Nasopharynx (post nasal space): superiorly from the skull base and delineated inferiorly by the superior surface of the soft palate.

Hypopharynx: delineated anteriorly by the larynx and aryepiglottic folds, laterally the piriform sinus and superiorly the oropharynx at the level of the hyoid bone. It lies below the tip of the epiglottis down to the start of the oesophagus at the postcricoid area. The majority (75%) of tumours arise in the piriform fossa.

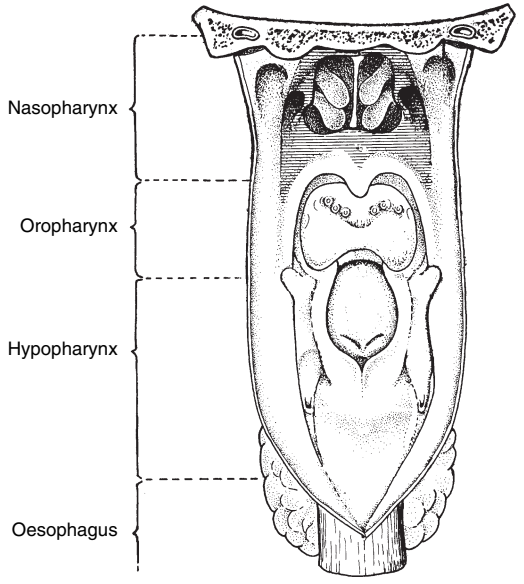

FIGURE 12.1. Pharynx.

Size
— length × width × depth (cm) or maximum dimension (cm).

Appearance
— polypoid/sessile/ulcerated/fleshy.

Edge
— circumscribed/irregular.

2. HISTOLOGICAL TYPE

Squamous cell carcinoma
— 80% of cases and predominantly well-differentiated keratinizing.
— keratinizing/non-keratinizing.

variants:

— verrucous: elderly, tobacco usage, broad based exophytic and "church spire" hyperkeratosis with a pushing deep margin of cytologically bland bulbous processes. Locally invasive (75% 5-year survival) but may become aggressive after radiotherapy.
— papillary: >70% exophytic or papillary malignant epithelial fronds with focal invasion at the base (70% 5-year survival).