

Facial Nerve Palsy: An Atypical Presentation of Carcinoma Nasopharynx

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Abstract: Nasopharyngeal carcinoma is an uncommon cancer in most parts of the world. The most common presenting symptom is neck mass followed by nasal and aural symptoms. Clinically evident facial nerve palsy is a rare presentation of carcinoma nasopharynx. The cranial nerves V and VI are frequently involved, whereas cranial nerves I, VII, and VIII are rarely involved. This case report describes a case in which facial nerve palsy was the presenting feature of nasopharyngeal carcinoma.

Keywords: Facial Nerve Palsy, Carcinoma Nasopharynx.

1. Introduction

Clinically evident facial nerve palsy is an unusual presentation of carcinoma nasopharynx. The cranial nerves V and VI are frequently involved, whereas cranial nerves I, VII, and VIII are rarely involved¹. After emerging from the brainstem, the facial nerve enters the cerebello-pontine angle, the temporal bone and finally into the parotid; after coming out of parotid it branches out to supply the facial muscles. Tumor involvement anywhere along the course of nerve can cause facial palsy.² Proximity of fossa of rosenmuller to foramen lacerum and middle cranial fossa floor allows direct tumor extension into the cranium and involvement of the adjacent nerves. The incidence of clinically overt facial nerve palsy caused by nasopharyngeal carcinoma is less than 1 %³; however, subclinical involvement is not uncommon.⁴

2. Case History

A 42-year-old male patient presented with complaints of drooping of angle of mouth, inability to open the right eye and right side nasal obstruction from 3 months (figure 1). CECT Head and orbit showed soft tissue attenuating lesion involving the postero-lateral wall of nasopharynx with extension into right infratemporal fossa, cavernous sinus, orbit and nasal cavity along with destruction of sphenoid sinus, petrous apex and clivus. Diagnostic nasal endoscopy showed polypoidal mass in right nasal cavity and nasopharynx. Patient underwent deep nasal polypectomy. Biopsy of the lesion showed well differentiated squamous cell carcinoma. Patient was diagnosed as a case of carcinoma nasopharynx T4N0M0 stage IV A.

Patient received palliative EBRT 20 Gy/5-fractions/5-days.

Post palliative EBRT patient received metronomic chemotherapy with tablet Cyclophosphamide. Patient showed improvement in symptoms and was followed up for a period of 6 months; thereafter patient did not report for follow up.



Fig. 1.

3. Discussion

Nasopharyngeal cancer is extremely radiosensitive tumor and the mainstay of treatment for primary local and regional disease is invariably radiotherapy, almost irrespective of the stage of the disease. Additional chemotherapy is required in patients with advanced disease to improve the overall results. Facial nerve palsy caused by nasopharyngeal cancer is uncommon. The incidence of clinically overt facial nerve palsy caused by nasopharyngeal carcinoma is less than 1 %.

4. Conclusion

Clinical presentation with facial nerve paralysis due to underlying nasopharyngeal carcinoma is uncommon and may lead to missed diagnosis if not addressed promptly. Also, cranial nerve involvement indicates advanced stage of disease which requires multidisciplinary management.

References

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