Neoplasms of the Nose and Paranasal Sinuses

Kevin Katzenmeyer, MD
Anna Pou, MD
June 7, 2000

Sinonasal Neoplasms

- 3% of aerodigestive malignancies
- 1% of all malignancies
- 2 to 1 males
- Sixth to seventh decades
- Symptomatology difficult

Sinonasal Neoplasms

- Nasal cavity (benign = malignant)
  - Benign - inverting papilloma
  - Malignant - SCCA
- Sinuses (malignant)
  - SCCA
  - Maxillary most common

Epidemiology

- Occupational exposure in >40%
  - nickel workers - SCCA
  - hardwood dust & leather tanning - adenoca
- Viral - HPV
- Cigarettes & alcohol

Presentation

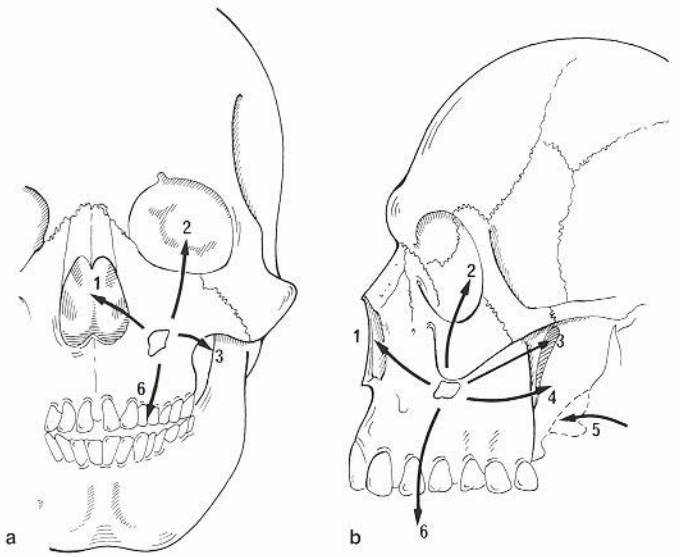
- Similar sx to common problems
- 6 to 8 month delay in diagnosis
- Cranial neuropathies & proptosis
  - RARE

Presentation

- Oral - 30%
  - tooth pain, trismus, palatal fullness, erosion
- Nasal - 50%
  - obstruction, epistaxis, discharge, erosion
- Ocular - 25%
  - diplopia, proptosis, tearing, pain, fullness
- Facial
  - V2 numbness, asymmetry, pain
- Auditory - CHL

Advanced Disease

- Classic Triad
  - facial asymmetry
  - tumor bulge in oral cavity
  - nasal mass
- All three - 40-60%
- One - 90%

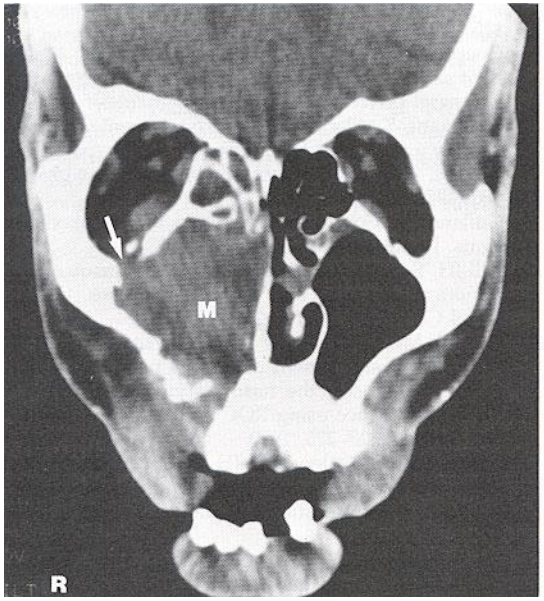


Diagnosis

- Physical exam
- Nasal endoscopy
- Biopsy
- Radiography

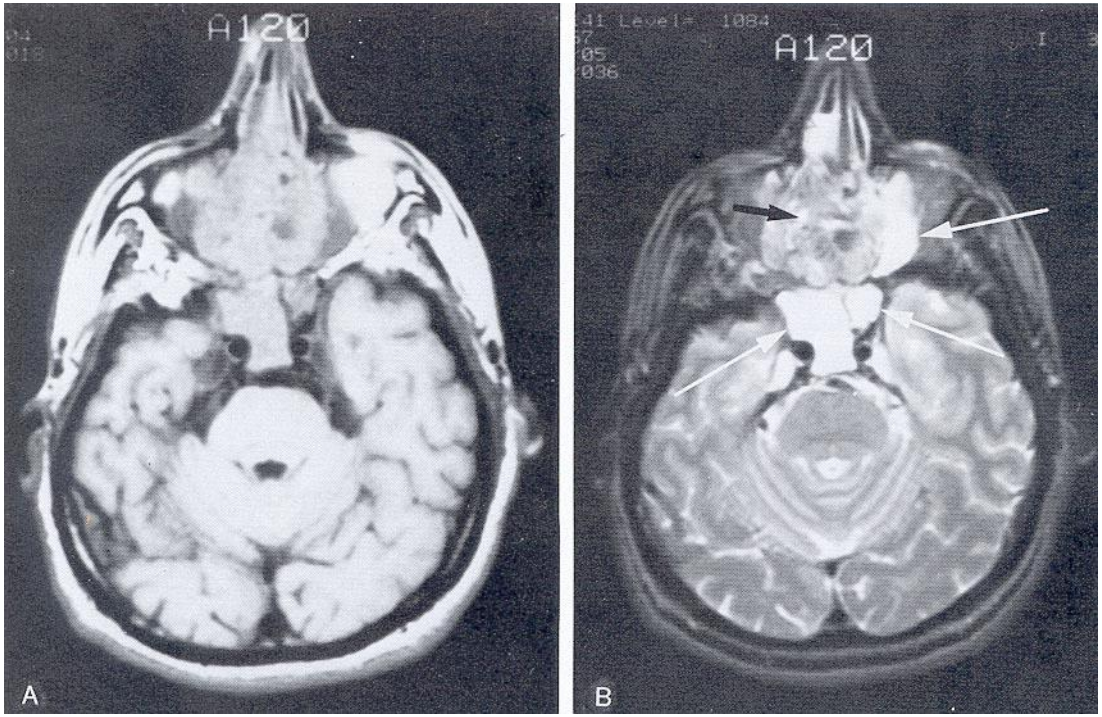
Computed Tomography

- Bone erosion
  - orbit, cribiform plate,
  - fovea, post max sinus wall,
  - PTPF, sphenoid, post wall
  - of frontal sinus
- 85% accuracy
- ? Tumor vs. inflammation vs. secretions



MRI

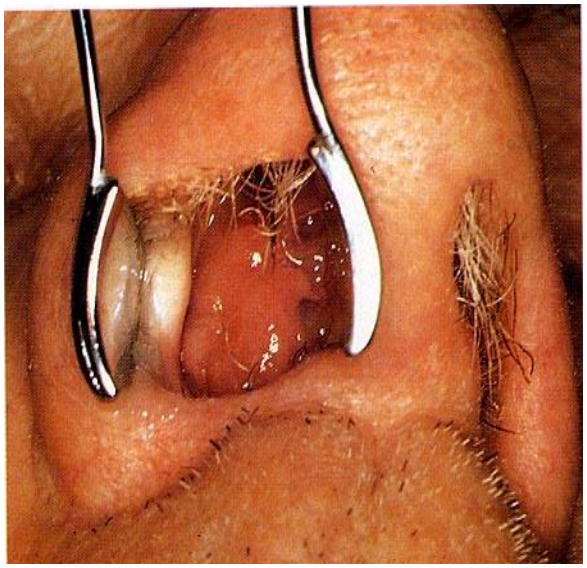
- Superior to CT
  - multiplanar
  - no ionizing radiation
- Inflammatory tissue & secretions - intense T2
- Tumor - intermediate T1 & T2
- 94% accuracy
- 98% accuracy with
- gadolinium



Schneiderian Papillomas

- Fungiform (50%) - septum
- Cylindrical (3%) - lateral nasal wall
- Inverting (47%) - lateral nasal wall
  - recurs, locally destructive, malignant potential
  - men, 6th-7th decades, unilateral
  - SCCA - 2-13%
  - Recurrence - 0-80%

Inverting Papilloma



Authors	Lateral rhinotomy–medial maxillectomy	Conservation resection[a]
Benninger et al. (1991)	0% (0/20)	36% (5/14)
Myers et al. (1990)	5% (1/22)	0% (0/4)
Pelausa and Fortier (1992)	7% (1/14)	77% (37/48)
Outzen et al. (1991)	7% (3/44)	27% (3/11)
Lawson et al. (1989)	9% (7/77)	10% (1/10)
Segal et al. (1986)	10% (1/10)	70% (10/14)
Kristensen et al. (1985)	12% (7/57)	38% (8/21)
Phillips et al. (1990)	13% (9/72)	44% (4/9)
Smith and Guliane (1987)	27% (3/11)	57% (4/7)
Dolgin et al. (1992)	29% (4/14)	44% (4/9)
Weissler et al. (1986)	29% (37/126)	67% (103/153)
Bielamowicz et al. (1993)	30% (60/20)	74% (17/23)
Averages	16% (79/487)	60% (209/350)

Osteomas

- Benign, slow-growing
- 15 to 40 years
- frontal > ethmoid > maxillary
- local excision

Fibrous Dysplasia

- Normal bone replaced by collagen, fibroblasts, and osteoid material
- < 20 years
- ground-glass appearance
- treatment?
- No irradiation

Neurogenic tumors

- Schwannomas
  - surface of nerve fibers
  - no malignant degeneration
  - along trigeminal & ANS
- Neurofibromas
  - within nerve fibers
  - von Recklinghausen's disease
  - malignant degeneration in 15%
- Complete excision

SCCA

- Most common - 80%
- Max > nasal cavity > ethmoids
- Males
- Sixth decade
- 90% have eroded walls of sinuses

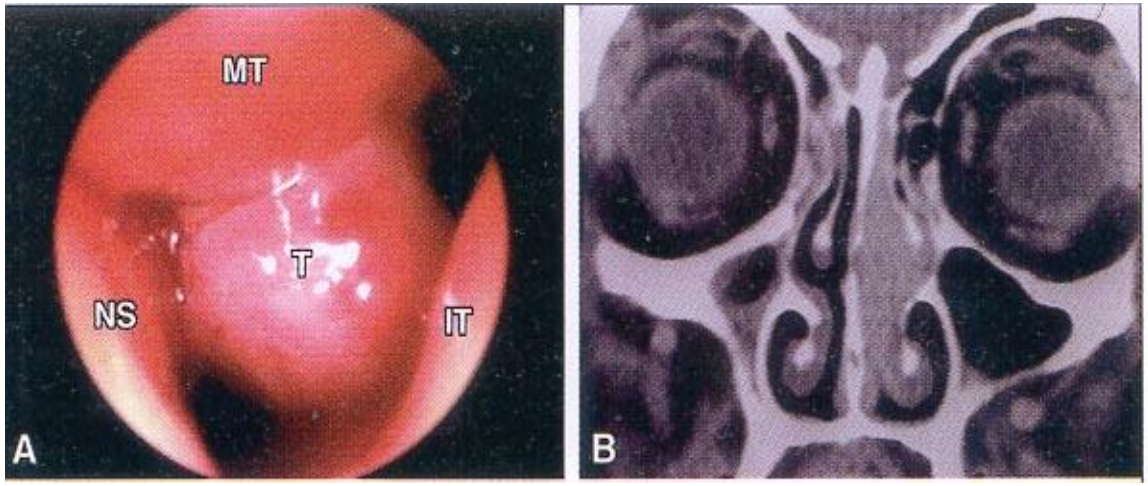
Adenoid Cystic Carcinoma

- Palate > major salivary glands > sinuses
- Resistant to tx
- Multiple recurrences, distant mets
- Perineural spread
- Long-term followup necessary

- Mucoepidermoid Carcinoma
  - rare, widespread local invasion
- Adenocarcinoma
  - 2nd most common, 5-20%
  - ethmoids
  - occupational exposures

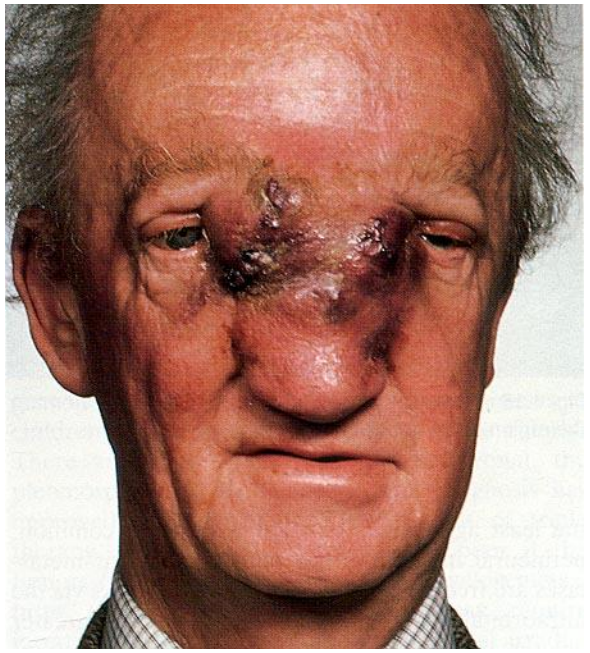
Hemangiopericytoma

- Uncommon
- pericytes of Zimmerman
- 80% of sinonasal tumors in ethmoids
- resembles nasal polyps
- average in 55 yo
- excision, XRT for (+) margins



Melanoma

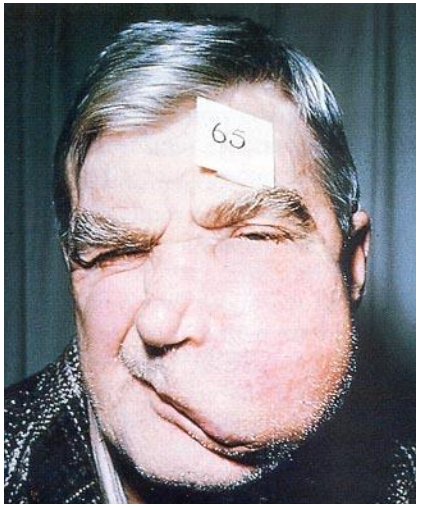
- 1% originate in sinonasal cavity
- 5th-8th decades
- anterior septum
- maxillary antrum
- polypoid mass,
- pigmentation?
- 5 yr = 38%
- 10 yr = 17%



Olfactory Neuroblastoma

- Neural crest origin
- no urinary VMA or HVA
- bimodal distribution at 20 and 50
- locally aggressive
- rosettes are hallmark
- Kadish staging
- local recurrence 50-75%
- metastasis 20-30%

- Osteogenic Sarcoma
  - most common primary bone tumor
  - only 5% in H & N, mandible most involved
  - sunray appearance



- Fibrosarcoma
  - rarely seen in sinuses

- Chondrosarcoma
  - 3rd-5th decades
  - histologic dx difficult
  - slow erosion of skull base, (+) margins
- Rhabdomyosarcoma
  - most common in children
  - 35-45% in H&N, 8% in sinuses
  - embryonal, alveolar, pleomorphic
  - triple tx

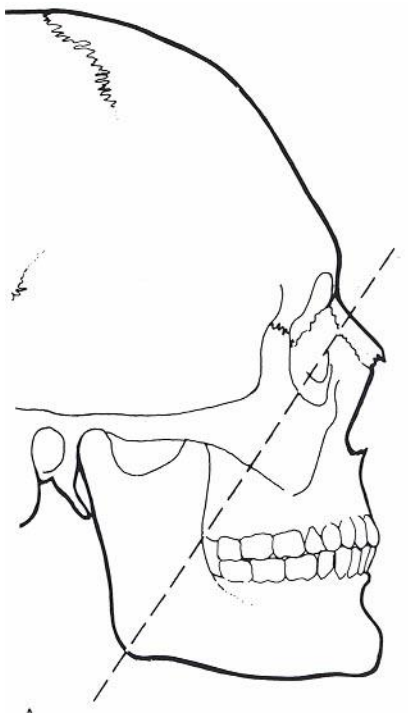
- Lymphoma
  - bimodal presentation
  - NHL
  - irradiation +/- chemo
- Extramedullary plasmacytoma
  - 40% in paranasal sinuses/nose
  - “benign”
  - must r/o myeloma
  - excision or irradiation

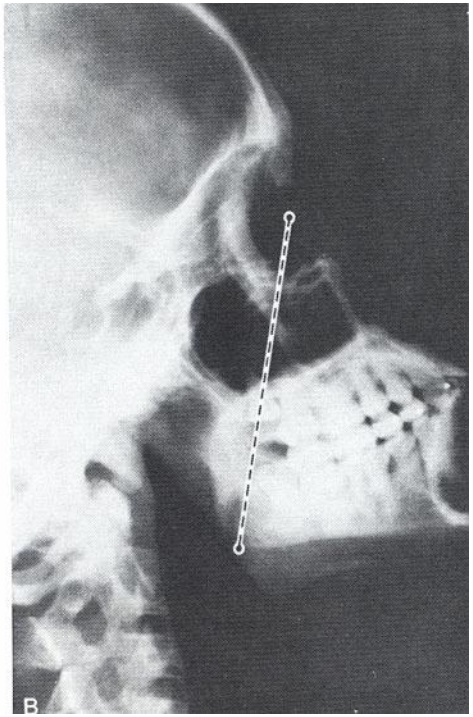
Metastatic tumors

- Renal cell carcinoma
- lungs
- breasts
- urogenital tract
- gastrointestinal tract
- Palliation necessary

Ohngren's Line

- Suprastructure
- Infrastructure





Staging

- AJCC - Maxillary sinus carcinoma

TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis	Carcinoma in situ
T1	Tumor limited to the antral mucosa with no erosion or destruction of bone
T2	Tumor with erosion or destruction of the infrastructure, including the hard palate and/or the middle nasal meatus
T3	Tumor invades any of the following: skin of cheek, posterior wall of maxillary sinus, floor or medial wall of orbit, anterior ethmoid sinus
T4	Tumor invades orbital contents and/or any of the following: cribriform plate, posterior ethmoid or sphenoid sinuses, nasopharynx, soft palate, pterygomaxillary or temporal fossae, or base of skull

Treatment

- T3 and T4
- 60% local recurrence
  - Surgery
  - Irradiation
  - Chemotherapy

Surgical resection

- Unresectability (Sisson)
  - extension to frontal lobes
  - invasion of prevertebral fascia
  - bilateral optic nerve involvement
  - cavernous sinus extension

Surgical resection

- Endoscopic excision
- WLE
- medial maxillectomy
- total maxillectomy
- radical maxillectomy +/- exenteration
- craniofacial resection

Orbital Preservation

- *Harrison* - proptosis, limitation of EOM, bony erosion of orbit = exenteration
- *Conley* - save eye whenever possible
- *Sisson* - preoperative XRT, decreased exenterations without change in survival
- *Stern* - nonfunctional eye without inf/med support = exenteration

Orbital preservation

- UVA - McCary & Levine
  - 50 Gy preop XRT to orbit
  - periorbital bx
  - resect (+) periorbita
  - functional eye

Pterygopalatine Fossa

- 10-20% involvement
- *Som* - PTPF invasion = unresectable lesion
- Craniofacial resection (MCF)
- Postop XRT

Neck Dissection

- Retropharyngeal and jugulodigastric nodes
- 10% (+) necks
- neck dissection
  - palpable nodes
  - radiographic evidence of disease
- 40% cervical mets at 4 yrs

Radiation therapy

- Primary tx only for palliation
- 10-15% improved 5 year survival
- XRT = 23% vs. Surgery + XRT = 44%
- preoperative vs. postoperative
- protection of CNS and globe
  - XRT 12-20% unilateral visual loss, 0-8% bilateral visual loss
  - Surgery 10-20% useless globes, 2X with XRT

Chemotherapy

- Palliation, unresectable disease
- (+) margins, perineural spread, surgical refusal, ECS
- Intraarterial chemotherapy
  - Robbins - 86% response of T4 lesions
  - Lee - 91% satisfactory response