

# TONSILLAR CARCINOMA : A REVIEW

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Tonsillar carcinoma is the second most common malignancy of the head and neck after laryngeal carcinomas in the United States. 90-95% of these lesions are squamous cell carcinomas on histopathology. The authors<sup>(2)</sup> (Guay, Laverty ; 1995) have reviewed the available information on etiology, diagnosis, treatment and prognosis of this disease.

The causes of malignancy of the tonsillar region are similar to those of other tumors of the upper aerodigestive tract: namely, tobacco and alcohol. These abuses and longer life expectancy have led to a gradual increase in the incidence of carcinoma of the tonsillar region (Johansen) et al, 1990<sup>(3)</sup>.

Many patients with tonsillar carcinoma present with advanced disease because early lesions are generally asymptomatic when small, the lack of symptoms is responsible for 67-77% of patients presenting with tumors larger than 2 cm. and often with regional nodal metastasis. At presentation, 45% of anterior tonsillar pillar lesions and 76% of tonsillar fossa lesions have clinically positive necks<sup>(2)</sup>.

Final diagnosis of a primary tonsillar tumor requires abnormal cytology and tissue biopsies, contrast-enhanced CT or MRI help to determine the extent of deep tumor infiltration.

In general, treatment decisions are influenced by tumor size, the presence or absence of nodal or metastatic disease, the availability of radiation therapy or surgical facilities, general patient health and patient preference. T<sub>1</sub> and T<sub>2</sub> tumors of the tonsillar region are most often treated with radiation therapy. With a therapeutic dose of 6000-7000 cGy, 5 years disease free rates range from 76% to 87% for T<sub>1</sub> tumors and 54% to 81% for T<sub>2</sub> tumors (as quoted by the authors). Medial extension to the base of tongue is the most common cause of recurrence. Surgery for T<sup>1</sup> & T<sup>2</sup> tumors is indicated (1) if the region has

received prior radiotherapy or (2) if the situations preclude radiotherapy such as lack of facilities for radiation.

Combined radiation therapy and surgery have been advocated by the authors<sup>(2)</sup> to improve locoregional control and survival that is obtained with either modality alone. Treatment of the N<sup>o</sup> neck with either radiation or concomitant neck dissection of levels I-IV has been recommended to reduce the risk of occult disease. Clinically positive nodes may be treated with neck dissection, while postoperative radiation may be indicated for extracapsular spread or multiple positive nodes.

Survival is most influenced by T&N stage, extension of the primary tumor e.g. Dimarco et al<sup>(1)</sup> have shown that survival decreases when base of tongue is involved while Mizono<sup>(4)</sup> et al showed that presence of nodal disease decreased survival by 50%. The absolute survival for stage I and II tonsillar carcinoma ranges from 37% to 93%<sup>(2)</sup> while cause specific survival is higher for patients with stage III disease (56-85%) or stage IV disease (26-60%)<sup>(2)</sup>. However, because of death from other causes and second primary tumors, patients with stage III tumors have an absolute 5 - year survival of 27-55% and those with stage IV tumors have an absolute survival of 3-35%. The authors<sup>(2)</sup> hope that improvement in therapeutic protocols, advances in chemotherapy and immunotherapy may contribute to better clinical management.

## REFERENCES

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