CASE STUDY

Amyloidosis of the Nasopharynx

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Introduction

The term "amyloidosis" encompasses various clinical entities of unknown aetiology, characterised by extracellular deposit of amyloid (acellular protein material that presents yellowish-green birefringence under polarised light after Congo red staining).

Clinical signs and symptoms depend on the anatomic distribution and intensity of the amyloid deposit. There are 2 main forms: systemic and localised. Amyloidosis can present as a diffuse process or as a nodular mass, simulating a neoplasia, called amyloid tumour, amyloidosis tumoral or amyloidoma.1

To diagnose it, the presence of amyloid must be demonstrated. Findings on CAT scans are unspecific.

It is important to determine whether the amyloidosis is systemic or localise, given the different prognosis for each. Systemic amyloidosis has poor life expectancy (especially if it is associated with myeloma). In contrast, if the localised form is diagnosed early and given appropriate treatment, the quality of life can improve dramatically, prolonging survival.

Clinical Case

We present the case of a 43-year-old male patient without relevant history and lacking toxic habits, who presented continual moderate nasal impairment, sensation of a foreign body upon swallowing, and mucopurulent rhinorrhoea for the last year and a half. There was also epistaxis upon coughing strongly. The patient did not report nasal puritus, sneezing attacks, fever, asthenia or weight loss.

Otoscopy was normal, while the endoscopic examination revealed a rounded mass with a polypoid appearance, except a wine-red ulcerated area beginning under the fossa of Rosenmüller from left nasal fossa to uvula. A slightly polypoid mass in cavity was observed on CAT scan (Fig. 1).

This mass was removed through nasal endoscope surgery under local anaesthesia, being reported as type AL localised amyloidosis (Fig. 2), after ruling out secondary amyloidosis. No recurrence has occurred in the 2 years since the operation.
Clinical signs and symptoms usually include nasal obstruction together with oral breathing, recurrent epistaxis, haematemesis and ear pathology secondary to tubaric dysfunction. At the level of the nostrils, it is implanted in the middle turbinate, although it can appear as a septal perforation. Some patients present adenoid hypertrophy. Many authors have described its haemorrhagic potential, attributing this to capillary fragility secondary to the infiltration by the amyloid deposit, although Kurgan et al. described factor V and VII deficiency.

They are generally considered benign tumours, as they are slow-growing lesions, without bone destruction, intracranial extension and lymphadenopathy; however, they can be locally aggressive, producing osteolysis and extension to the base of the skull.

The diagnosis is histological, with it being important to determine if the deposits are localised or systemic using fine needle aspiration of the fat of the anterior abdominal wall.

Immunohistochemically, it can show AL, AA and AP proteins or chain restriction, although it shows the AL type in the localised forms. Consequently, it is recommendable to use a panel of antibodies specific to all the types of amyloid precursors, in addition to the specific search for the population of abnormal plasma cells in the deposit site, together with a study on the monoclonal production of serum immunoglobulins.

The treatment of choice is surgical extirpation using conventional surgery or CO₂ laser. Relapses are common, if the lesion is not removed completely; however, given the lack of case studies and the slow development of the process, spontaneous regression can occur but it is difficult to predict the result. Radiotherapy is contraindicated.

References