METASTATIC MAXILLARY ANTRUM SEMINOMA

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Review

METASTATIC deposits in the maxillary antra only number seven to date in the world literature since 1900 (Friedmann and Osborn, 1965). Four of these were renal in origin, two from seminomas (Garrett, 1959) and one from a gastric carcinoma.

The paucity of cases prompts the recording of a further antral metastasis.

Garrett's two cases were aged 61 years and 69 years, and their brief histories were as follows:

The first man presented in 1955 with a tumour of the right testicle, and a tumour of the nose and antrum. Both were histologically recognizable as a seminoma and the patient died 2 months later with skin metastases.

The second man presented with a tumour of the right maxilla in 1950, and though definitely neoplastic the exact histology could not be determined. Five years later a similar tumour appeared in the opposite maxillary antrum, followed by the recognition of a left testicular seminoma. The histology of all three growths was found to be similar, and the patient died, with abdominal metastases, 4 months after the exact pathology was known.

Case Report

The case under discussion is a man of 53 years who presented with haematuria in 1962, due to two bladder papillomata, which were fulgurated. Check cystoscopy was normal 3 months after, but he could not be persuaded to return for further follow up.

In *October 1965* his haematuria returned for 3 weeks and he also noted a swelling of the left testicle over a similar period, and a swelling of the left cheek for 3 days.

He looked fairly healthy with slight pallor but no recent evidence of weight loss. The left cheek was slightly swollen and there was numbness in the distribution of the infra-orbital nerve on that side. There was no epiphora. The nose contained a little blood-tinged discharge, but no tumour, and the left lateral nasal wall was bony hard. Clinically there was no evidence of spread outside the antrum. The left testis was swollen and hard, and a discrete nodule could be felt in the left spermatic cord. No other abnormalities could be found.

His fever of 99° F. on admission lasted for 3 days, and then settled, apart from the physiological response to operative trauma. Investigation showed his haemoglobin to be 11·2 gm./100 ml., W.B.C. 12,000 c.mm. and the corrected E.S.R. 56 mm./1 hour (Westergren). His urine was sterile and the blood urea was 49 mg. per cent. Radiologically there was uniform opacity of the left maxillary antrum with no evidence of bony erosion and a chest X-ray revealed no secondary deposits. An intravenous pyelogram was normal.

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Treatment

Initially cystoscopy and retrograde pyelography were performed and no cause could be found for his haematuria.

Later a left orchidectomy, with excision of the spermatic cord as high as possible to include the secondary deposit, was performed in conjunction with an exploration of the left maxillary antrum through a Caldwell-Luc approach. The antrum was completely filled with white friable tumour whose origin could not be seen. All the antral walls were intact and no softening could be detected by gentle probing. A biopsy was taken from the central part of the tumour and no intranasal antrostomy performed in view of the possible spread to the nose after this procedure (Macbeth, 1965). The wound was not sutured and it was healed in 7 days.

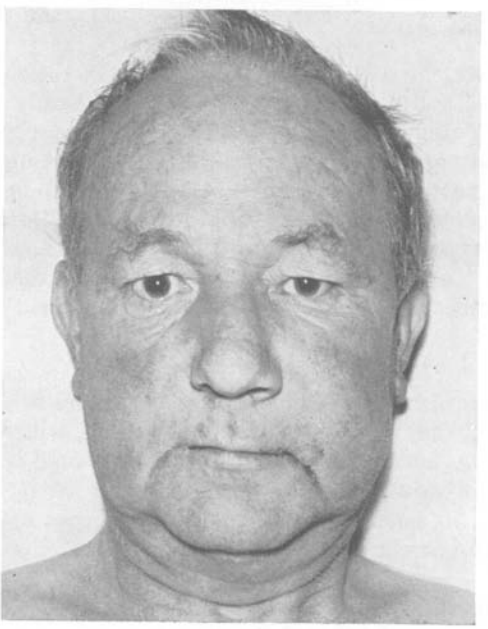


FIG. 1.

Showing the slightly swollen left cheek.

Pathology

The cut surface of the testis showed a little white tumour 4 cm. in diameter partially replacing its substance.

Histologically there was massive seminoma invasion of the testis with a similar small mass, 2 cm. from the epididymis, in the spermatic cord, and the secondary maxillary deposit was morphologically comparable with the primary growth.

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Management

He was treated with deep X-ray therapy to the para-aortic and left maxillary regions simultaneously with a total dose of 3,500 r. to each site over 4 weeks and the left cheek rapidly shrank down leaving no residual swelling. The para-aortic nodes could never be felt but it was assumed that they must be involved.

It was not felt justifiable to fenestrate the palate in view of the tumour being a secondary deposit.

Six months after treatment he is well, carrying out his work as a barman It will be interesting to see if the prognosis is better than Garrett's case with the above treatment. It should be.

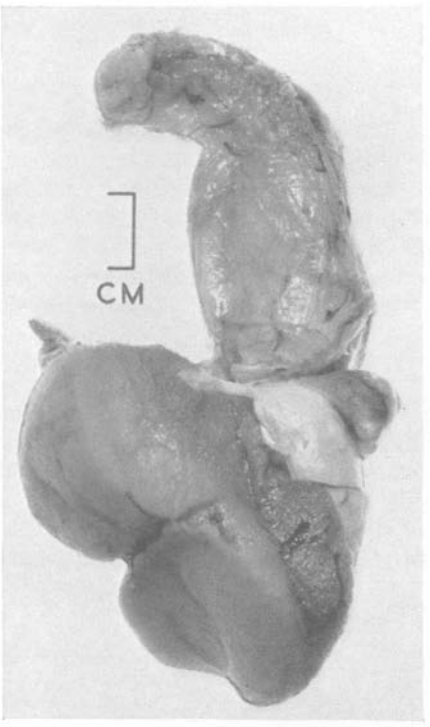


FIG. 2.

The left testis, epididymis and spermatic cord with tumour invasion of the testis and a secondary deposit in the cord.

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