

Letters to the Editor

Non-Hodgkin's lymphoma presenting as an isolated temporal soft tissue swelling

Dear Sir,

We have read with interest the case report entitled 'Non-Hodgkin's lymphoma presenting as an isolated temporal soft tissue swelling' by Benson-Mitchell *et al.* (1996), but feel their report needs comment.

The diagnosis of primary lymphoma in this case is very controversial, partially because its existence as a pathological entity can be questioned. The major controversy regarding this case lies in the difficulty of knowing whether it is a primary lesion, or an occult lymphoma with an initial manifestation in the soft tissue of temporal region, or a secondary from a lymphoma elsewhere. It is very likely to be the latter based on the nature of this disease. Furthermore, the case was insufficiently investigated, and not followed up long enough to substantiate the diagnosis.

In the last few years, there have been detailed studies of the natural history and treatment of localized Non-Hodgkin's lymphoma of unfavourable histology (as this case). As a result, the role of surgery in the management of these cases has been sharply modified. Since malignant lymphoma is by nature a systemic disease, metastasizes haematogenously, and chemo- and radio-sensitive, surgery appears to be contra-indicated and should be used only after failure of chemotherapy and/or radiotherapy. This combined approach has been shown to be effective in localized aggressive lymphomas in improving disease free survival and overall survival (Miller and Jones, 1983; Connors *et al.*, 1987).

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References

- Benson-Mitchell, R., Warwick-Brown, N., Chappell, M. (1996) Non-Hodgkin's lymphoma presenting as an isolated temporal soft tissue swelling. *Journal of Laryngology and Otology* 110: 161–162.
Connors, J. M., Klimo, P., Fairey, R. N., Nicholas, V. (1987) Brief chemotherapy and involved field radiation therapy for a limited stage, histologically aggressive lymphoma. *Annals of Internal Medicine* 7: 25–30.
Miller, T. P., Jones, S. G. (1983) Initial chemotherapy for

clinically localised lymphoma of unfavourable histology. *Blood* 62: 413–418.

Author's reply

Dear Sir,

I read with interest the letter from Dr El-Sharkawi and Mr Williams and I would like to make the following comments in reply to the points raised:

(1) I agree with their comment that it is difficult to be absolutely sure that the soft tissue mass was a primary lesion. However, the patient was extensively investigated with a bone marrow and CT of thorax, abdomen and pelvis all of which were negative. Of interest is that follow-up at 12 months still shows no evidence of recurrence or any systemic involvement.

(2) I do not advocate surgery as a sole treatment for Non-Hodgkin's lymphoma and this is mentioned in the discussion. However, in this patient surgery was diagnostic and in the absence of systemic involvement has become therapeutic.

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Should nasopharyngeal biopsy be mandatory in adult unilateral glue ear?

Dear Sir,

We read with interest the above article by Lee *et al.* (*JLO* January 1996 110: pp 62–64) to which, as a result of a case we have recently managed, we would suggest adding the proviso 'despite non-contributory CT scan findings'.

We have recently seen a 64-year-old woman who presented with a unilateral middle ear effusion and whose nasopharynx on nasendoscopy looked entirely normal and whose high resolution CT scan whilst demonstrating maxillary sinus opacity was otherwise unremarkable. Biopsy of the ipsilateral fossa of Rosenmuller however, demonstrated an undifferentiated non-keratinizing nasopharyngeal carcinoma. This case and the two reported in this paper (whose CT scans were abnormal) illustrates that blind biopsy of the nasopharynx which may in the age of high clarity endoscopic views and modern radiological imaging techniques seem to a degree to be an outmoded investigation, nevertheless remains an essential part of the management of a unilateral middle ear effusion in an adult.

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Authors' reply

Dear Sir,
We were pleased to read the comments of Dr Melchor and Mr Shotton in support of our suggestion. However, we would like to stress the point that biopsy, not CT, should be the first investigation. It is recognized that routine nasopharyngeal biopsy in

adult unilateral glue ear is likely to have a low diagnostic yield, but given that it is simple, cheap and adds nothing to an anaesthetic for examination of the nasopharynx we feel it is cost effective. In comparison, CT is a relatively cumbersome tool which is far from cheap. The role of CT is in the assessment of proven lesions. We hope that this makes our position clear.

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