Author's response to reviews

Title: Pleomorphic adenoma of the nasopharynx: a rare case with therapeutic misadventure

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Author's response to reviews: see over
Sir,

On behalf of all authors, I am thankful to you and reviewers for constructive comments and we feel we have addressed their concerns in a point by point manner. We hope you find our revised manuscript acceptable for publication in your journal.

Yours Sincerely,

J S Thakur

Reviewer: George J Bosl

Reviewer’s report:
I have reviewed the manuscript and the comments of the reviewer. The authors are to be commended for their admission of error. I note the following important sentence in the text regarding the cytologic diagnosis: "A fine needle aspiration biopsy (FNAB) of the mass was done intra-orally and microscopic examination revealed a poor smear with scanty cells. The pathologist suggested the possibility of a squamous cell carcinoma and advised a direct biopsy for definitive diagnosis." Hence, the treating physicians did, in fact, receive a recommendation from the pathologist for a more definitive diagnosis, which is not what lesson #2 suggests: "The Pathologist should always examine the slides thoroughly before making a diagnosis and especially in carcinoma. Diagnosis should not be made in scanty and poor cytology." The clinicians are clearly at fault, not the pathologist, and there should be no suggestion that the cytologic/pathologic diagnosis was misleading.

Authors’ reply: Authors agree with the reviewer, and admit their mistake in manuscript in the ‘Conclusion’ section. The conclusion and lesson #2 has been changed as suggested:

"Who was at fault: clinician by not following the advice of pathologist for direct biopsy, or oncologist who started chemo-radiation without any histopathological proof? We cannot blame anyone rather than ourselves as the clinician are the most accountable.

In this case report, many questions remained unanswered but a lesson learnt was:

1. The possibility of benign tumor should be kept in the differential diagnosis of nasopharyngeal tumor without adenopathy.
2. Clinician should follow pathologist’s advice, carefully interpret the cytological diagnosis, and consult the pathologist, whenever in doubt.
3. An adequate tissue specimen should be obtained especially for cytological diagnosis as pleomorphic adenoma can simulate as a carcinoma.
4. No patient should be taken for chemo-radiation without any histopathological evidence.
Reviewer comment: I looked at the images that were available. I believe that it is impossible to tell whether the tumor is of primary nasopharyngeal origin. If one accepts that the mucosa above the soft palate is the nasopharynx, then I believe one can technically argue that the primary site could be nasoopharyngeal. The images do show the alveolar ridge, so it is hard to tell for me, who is a non-radiologist, to determine the most likely primary site. The presenting symptoms (aural fullness, etc) are consistent with a nasopharyngeal origin, and the tumor DOES involve the nasopharynx.

Authors’ reply: We agree with Dr Bosl, since the patient had clinical features of nasopharyngeal tumor in terms of nasal obstruction, aural fullness. The neck was normal. Parapharyngeal tumor normally present with swelling in the neck or tonsil area. Since patient had symptoms of nasopharyngeal tumor, we presumed this tumor to be arising from nasopharynx. However, we have changed the title and discussed this argument in ‘Discussion’ section.

“Discussion: In retrospective review of CT scans, there could be a possibility of tumor arising in the parapharyngeal space and extending to nasopharynx but clinical progression of the tumor and normal neck examination was in favor of nasopharyngeal origin.

Parapharyngeal benign tumors have classical features of sub mucosal swelling in the lateral pharyngeal wall with or without extension to retromandibular area or the submandibular triangle, and bimanually ballot ability. Patient can have additional symptoms of otalgia, neuralgia, trismus, and paresis/palsies of 9th, 10th or 11th cranial nerves [1-2].

Exact site of tumor origin could be debatable but we present this case because a major mistake occurred by not performing a direct tumor biopsy before starting chemo-radiation.

Reviewer’s comments: If the primary site is the principal reason for accepting or rejecting this paper, then I suggest that a neuroradiologist review all of the films. If the central reason for accepting or rejecting the paper is the key teaching point for the need for a proper biopsy, then whether the tumor is a primary nasopharynx tumor of some type is a secondary but not relevant issue. One could qualify the language a bit and say that the tumor could be of nasopharyngeal origin, and simply emphasize the keys teaching points.

Authors’ reply: We agree to the comment that the mistakes done in this case are the key points, and site of origin of this tumor is secondary issue. As suggested we have changed the title, case presentation and discussion as:

“Pleomorphic adenoma of minor salivary gland with therapeutic misadventure: a rare case report”
“Case presentation: “On examination, there was a mass behind soft palate appeared to be arising from nasopharynx. Neck examination was found normal.”

“Discussion: In retrospective review of CT scans, there could be a possibility of tumor arising in the parapharyngeal space and extending to nasopharynx but clinical progression of the tumor and normal neck examination was in favor of nasopharyngeal origin.

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