Embryonal rhabdomyosarcoma tongue in a male child

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CASE REPORT

We report a two and half years old male child, who at the age of 2 years developed a small 3 x 3 cm, reddish lesion on his right side of dorsum of tongue. There was a history of bleeding from the lesion, off and on. There was no family history of malignancy or history of exposure to radiation, etc to the child. Incision biopsy was done on July 2005 and the histological findings were consistent with an embryonal rhabdomyosarcoma. Parents of the child were reluctant for any further treatment. He was re-admitted in September 2005 with a massive growth over the tongue, protruding from the mouth [Figure 1]. The child was unable to close his mouth and was also unable to swallow solid food. He was accepting liquids only in small amounts. The growth was arising from the anterior part of tongue and extending up to the base of it. On examination, the growth was 8x6x10 cms, red, bosselated, with nodular ulcerated surface, well defined margins and was hard in consistency. Lower lip was ulcerated and compressed. There was no cervical lymphadenopathy. Other systemic examinations were normal. Skiagram of mandible and chest and ultrasonography of abdomen were normal. The patient was assigned a clinical stage 1 and international rhabdomyosarcoma study (IRS) Group III. Near total excision of mass was done [Figure 2]. Histopathological examination showed embryonal rhabdomyosarcoma. He received one cycle of combination chemotherapy (vincristine, actinomycin D & cyclophosphamide). The child is now able to swallow liquids as well as solids and he is on regular follow-up for chemotherapy and is doing well.

DISCUSSION

Rhabdomyosarcoma (RMS), the most common soft tissue sarcoma in infants and children, represents about 5-15% of all malignant solid lesions. Head and neck RMS occurs most commonly in the orbit, nasopharynx, paranasal sinuses, cheek, neck, middle ear and larynx.[1] The occurrence of RMS in the tongue is uncommon.[2] The annual incidence of RMS is about 8 / million children.[3] There is a bimodal distribution of presentation with an initial peak incidence between 2-5 years of age and a second surge at 10-19 years. RMS belongs to the class of “small round blue cell tumor of childhood”. It
is classified as embryonal, alveolar and pleomorphic. RMS is a highly malignant tumour with extensive local invasions and early hemorrhagic & lymphatic dissemination. Clinical findings, diagnostic evaluation and therapy depend upon location of the primary tumor and age of the patient.\[3\] It is possible to detect intraoral mass (RMS tongue) by antenatal ultrasound scan and it warrants a careful perinatal multidisciplinary team approach.\[4\] The treatment of RMS is site-specific and multidisciplinary efforts offered best results.\[5\] An initial complete primary resection of tumor with negative gross and microscopic margins is ideal, if possible. Another option is initial incisional biopsy followed by neoadjuvant therapy, to preserve the organ and secondary excision if required. As the sole radiation modality, fractionated high-dose-rate (F-HDR) brachytherapy achieved excellent local control and disease free survival, in properly selected children with soft tissue sarcomas, while preserving normal bones and organ development.\[6\] The overall survival rate for patients with RMS has improved remarkably since the initiation of the IRS Group.\[1-6\] Recently, additional emphasis has been placed on the quality of life.

REFERENCES