

Letters to the Editor

Thyroid metastasis from nasopharyngeal carcinoma: a case report

Dear Sir,

I read with interest, the case report by Jalaludin *et al.* (1994). The authors claim that a literature search had failed to reveal a previous report of thyroid metastasis from a primary in the nasopharynx.

In fact in 1984, Ivy from Mayo clinic reported a series of 30 cases with clinically significant thyroid metastatic disease. In most of the cases the primary neoplasm was identified without difficulty. The three most common sites of primary were the kidney, breast and the lung. These three sites constituted 23 of the 30 cases. Amongst the remaining seven cases one patient, a male aged 45, had a primary in the nasopharynx five years preceding the thyroid mass and his survival was less than 12 months.

Yours sincerely,

Rajni Amin,
Four Acres,
Exton,
Exeter EX3 0PN.

References

- Ivy, H. K. (1984) Cancer metastatic to the thyroid: a diagnostic problem. *Mayo Clinic Proceedings* 59: 856–859.
Jalaludin, M. A., Rajadurai, P., Umapati Prasad, R. V. (1994) Thyroid metastasis from nasopharyngeal carcinoma: a case report. *Journal of Laryngology and Otology* 108: 886–888.

The diagnosis of inflammatory sinonasal disease

Dear Sir,

'We wish to comment on the recent article on 'The diagnosis of inflammatory sinonasal disease' by Roberts *et al.* (1995). We entirely agree that nasal endoscopy is mandatory and that computed tomography (CT) is not justifiable as a routine diagnostic tool (Maclennan and McGarry, 1995). What we question is the value of plain films, including a high kilovolt lateral, in the management of patients with chronic rhinosinusitis. The article poses the question 'could this type of imaging be useful as the primary radiological investigation of inflammatory sinonasal disease?' We think a more pertinent question is 'is any form of radiological imaging useful in the diagnosis of inflammatory sinonasal disease?'

The authors claim a 90 per cent accuracy in diagnosis using clinical and endoscopic examination together with plain films. However, they have not told us the percentage diagnosed correctly by clinical

and endoscopic examination alone. More importantly, they do not make clear whether the result of the plain films changed the management (the acid test of any investigation) of any of the 21 patients. We believe that the presence or absence of plain film abnormalities, such as mucosal thickening or fluid levels, do not contribute to decisions on management. There is a statutory obligation on clinicians as those 'clinically directing' the radiation exposure to ensure that an examination is justified (Ionising Radiation Regulations, 1988). Plain films cannot be justified if the results do not alter management.

We agree that CT is the greatest cause for concern regarding the increased collective population dose from medical radiology. However, using a low dose technique, coronal CT of sinuses can be performed with a lens dose of approximately 5 mSv (Maclennan, 1995). This is not a great radiation burden, especially if CT is limited to a pre-operative investigation for those patients undergoing endoscopic sinus surgery.

Yours sincerely,

A. C. Maclennan,
Senior registrar in radiology,
Glasgow Royal Infirmary,
Alexandra Parade,
Glasgow G4 0SF.

N. S. Jones,
Consultant otorhinolaryngologist,
Queens Medical Centre,
Nottingham, NG7 2UH.

References

- Roberts, D. N., Hampal, S., East, C. A., Lloyd, G. A. S. (1995) The diagnosis of inflammatory sinonasal disease. *Journal of Laryngology and Otology* 109: 27–30.
Maclennan, A. C., McGarry, G. W. (1995) Diagnosis and management of chronic sinusitis. *British Medical Journal* 310: 529–530.
Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988.
Maclennan, A. C. (1995) Radiation dose to the lens from coronal CT of sinuses. *Clinical Radiology* (in press).

Authors' reply

Dear Sir,

We would like to respond to the comments raised by Dr Maclennan and Mr Jones in their letter regarding The diagnosis of inflammatory sinonasal disease. The authors feel that some form of radiological

imaging is mandatory when managing patients with suspected sinonasal disease. Negative endoscopic findings, even in expert hands, does not preclude the existence of underlying sinus pathology.

In our series the diagnosis of rhinitis was changed to rhinosinusitis in four out of 21 patients (19 per cent) based on the plain X-ray findings. These were patients in whom there were negative endoscopic middle meatal findings by all examiners. CT requests can be rationalized to patients undergoing surgery after a course of medical therapy, and our latest protocols for CT scanning give an average lens exposure of 3.8 MSV for a coronal series.

We do not feel that there is any role for limited 'CT series' imaging as a diagnostic tool in sinusitis as inevitably more detailed scans would be required before surgery.

Yours sincerely,

David Roberts F.R.C.S.,
Senior Registrar, ENT

and Charles A. East F.R.C.S.,
Consultant ENT Surgeon
The Royal National Throat, Nose and Ear Hospital,
Gray's Inn Road,
London WC1X 8DA

Reference

East, C. A., Annis, J. A. D. (1992) Preoperative CT scanning for endoscopic sinus surgery: a rational approach. *Clinical Otolaryngology* **17**: 60–66.