Multiple myeloma presenting as dysphagia

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Figure 1 - Computed tomography scan of the neck showed bulky epiglottis with ill-defined lesion in its right aspect, ill-defined mass in the left side of supraglottic larynx.

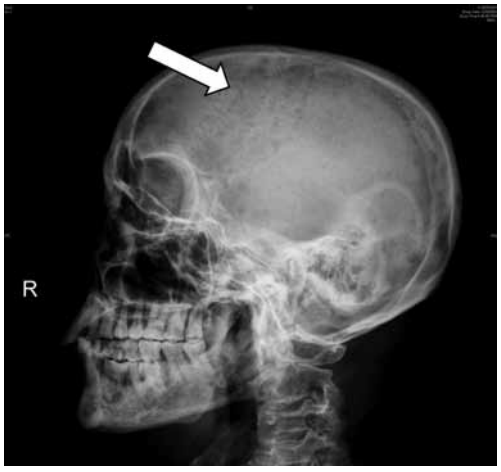

Figure 2 - Skull x-ray showed multiple lytic lesions.

the patient was a pilgrim he elected to go back to India with all relevant medical reports to continue his therapy and there was no further follow up.

Discussion. Malignant plasma cells in the bone marrow produce monoclonal antibodies which are typically found in urine and blood samples.[1,10] Multiple myeloma classically present with lytic lesions on bones, anemia, decreased renal function, and susceptibility to infections.[10] Those characteristic lytic lesions are due to the increased osteoclastic activity from bone

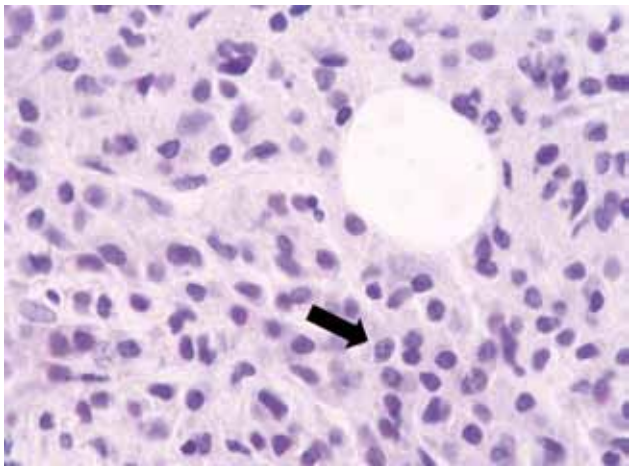

Figure 3 - Hematoxylin and eosin stain of bone marrow biopsy showing massively infiltrated bone marrow by plasma myeloma rounded tumor cells with large nuclei and nucleoli with prominent chromatin.

marrow infiltration.[10] Less than 100 cases of laryngeal EMP have been reported in the world literature.[2,4] Two reports from India reported a similar case like ours of laryngeal plasmacytoma.[2,9] Another report from Poland described a similar case where some therapeutic options were discussed.[4] Tesei et al from Italy reported 22 cases of EMP of the head and neck observed over 20 years period; of which only 2 cases were laryngeal.[5] The cause of MM is unknown. However, it was noted that exposure to ionizing irradiation might increase the incidence of MM.[1,10] Nickels, agricultural chemicals, petroleum products, aromatic hydrocarbon, benzene, and silicon have been also considered a potential risk factors.[10] Treatment options have increased significantly since the last 2 decades.[10] Melphalan plus prednisone has been the gold standards for the treatment of this condition for the last 40 years.[10] Salvage therapy for relapses or primary refractory disease usually undergo vincristine plus doxorubicin plus dexamethasone (VAD) regimen. This produces 40-50% response in relapses and 30% in primary refractory disease.[10] The most active agent in the combination therapy is known to be dexamethasone.[10] High dose dexamethasone pulse therapy alone induces responses in approximately 30-50% of patients, regardless of prior response.[10] The effectiveness of immunomodulatory agents such as thalidomide and lenalidamide, as well as bortizomib; a proteosome inhibitor, has greatly expanded the treatment options.[10] Localized external beam radiotherapy has also been used successfully.[8]

In conclusion, the incidence of extramedullary manifestation of MM in the larynx is rare, but many

therapeutic options exist. We recommend a high index of clinical suspicion to exclude this rare possibility while investigating a mass lesion in this region to avoid diagnostic and therapeutic delays.

References

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