1. INTRODUCTION

Nasopharyngeal carcinoma is a malignancy that grows in the nasopharynx region and originates from the nasopharyngeal epithelium with predilection in the pharyngeal recess (Rosenmüller’s fossa). [1-6]. The location of growth of hidden nasopharyngeal carcinoma and non-characteristic clinical symptoms often complicates diagnosing nasopharyngeal carcinoma at an early stage [1]. The incidence of nasopharyngeal carcinoma is closely related to certain ethnic. So that the spread of nasopharyngeal carcinoma looks unique. The highest incidence is found in China. Some provinces in China have high cases of nasopharyngeal carcinoma, 15-30 per 100,000 populations. In southern China, especially Hong Kong and Guangzhou, 10-150 cases per 100,000 population a year [1, 7, 8]. In Indonesia Nasopharyngeal carcinoma is the most malignant tumor found in the head and neck area. Fifth place of all malignancies in the body. The incidence of nasopharyngeal carcinoma in Indonesia ranges from 6.2 per 100,000 population each year [1, 2, 7-10].

Nasopharyngeal carcinoma is caused by multifactorial such as: genetics, virus Epstein-Barr infection and environmental influences [1, 8, 11]. Genetic factors in correlation analysis indicate a relationship between the susceptibility of nasopharyngeal carcinoma with HLA (human leukocyte antigen) and p502E (CYP2E1) enzyme coding genes. In many literature it is stated that Epstein-Barr virus infection is the dominant etiology for nasopharyngeal carcinoma. Relationship between nasopharyngeal carcinoma with Epstein-Barr virus was found in 1966, based on serological studies, found EBV DNA and EBV Nuclear antigen (EBNA) in patients with nasopharyngeal carcinoma [8, 9, 11, 12].

Symptoms and signs of nasopharyngeal carcinoma can be divided into 4 groups: 1) nasopharyngeal symptoms can be mild epistaxis or nasal obstruction [1, 2, 5]. At an advanced stage the tumor enters the nasal cavity and the paranasal sinuses. Nasopharyngeal examination need to be done carefully. The examination is done using a glass or nasopharyngoscope. Often the tumor has grown in the nasopharynx but symptoms have not yet appeared. 2) Disorders of the ear are early symptoms that arise because the tumor site is close to the Eustachian tube. The tumor closes the Eustachian tube. The disorder can be tinnitus, feels full in the ear, pain in the ear and hearing decreases. 3) Disorders of the eye occur because the tumor extends to the intracranial via the foramen lacerum. This causes interference with cranial nerves III, IV, VI. Impaired eyeball movements cause diplopia. Advanced tumor processes can extend to the cranial nerves IX, X, XI, XII if the tumor passes through the jugular foramen. 4) Metastasis to the neck lymph nodes in the form of a lump in the neck. Enlargement of neck lymph nodes is a disorder that often causes patients to come for treatment [1, 2, 5].

Histopathology, WHO in 1982 classified nasopharyngeal carcinoma into 3 types histologically: Squamous cell cratinaized carcinoma (WHO type 1); squamous differentiated non-keratin carcinoma cells (WHO type 2); squamous non-differentiated non-keratin carcinoma cells (WHO type 3). WHO type 1 is found in North America while in South China only 2%, for WHO type 2 12% is found in North America while in South China only 3% and WHO type 3 is the most common type in South China which reaches 95% [7, 8, 13].

1.1 Staging

Clinical staging of the tumor represents 4 stages. Based on the 8th edition of AJCC, staging Primary Tumors (T); Tx is a primary tumor that cannot be defined. T0, does not contain primary tumors but EBV positif cervical node(s) involvement. Tis, Carcinoma in situ. T1 the tumor is confined to the nasopharynx or extends to the oropharynx and/or nasal cavity without parapharyngeal involvement. T2, the tumor extends to parapharyngeal space and/or adjacent soft tissue involvement (medial pterygoid, lateral pterygoid, prevertebral muscle). T3 Tumor enters bone structure at skull base, cervical vertebra, pterygoid structures, and/or paraanatal sinuses. T4, the tumor extends to the intracranial, cranial nerves, hypopharynx, orbit, parotid gland, and or extensive soft tissue infiltration beyond the lateral surface of the lateral pterygoid muscle.

Regional Lymph Nodes (N). Nx Regional lymph nodes cannot be defined. N0 There is no metastasis to regional lymph nodes. N1 Unilateral metastasis in cervical lymph node(s), and/or unilateral/bilateral metastasis in retropharyngeal lymph node(s), measuring 6cm or less above the caudal border of caroid cartilage. N2 bilateral metastasis in cervical lymph nodes size 6 cm or less above the caudal border of caroid cartilage. N3 unilateral/bilateral metastasis in...
The population in 2015 was 430,894 people [16]. Topographically, Mandailing Natal is an area consisting of lowlands, mountains, and beaches. This topography has made it difficult for residents to access health facilities. This condition makes the detection of nasopharyngeal carcinoma increasingly difficult.

Early detection of nasopharyngeal carcinoma in areas such as Mandailing Natal is very dependent on health workers in the villages and at the primary care unit. Health services in villages organized by midwives and paramedics and general practitioners are not always able to detect nasopharyngeal carcinoma at an early stage.

The all of patients who have been diagnosed with nasopharyngeal carcinoma have clinical symptoms at an advanced stage. Enlarged neck lymph nodes were found in all patients. Other symptoms such as diplopia are advanced symptoms of nasopharyngeal carcinoma.

All patients who were reported were diagnosed with nasopharyngeal carcinoma at an advanced stage. Non-specific symptoms in the early stages caused this disease to be difficult to detect. Nasopharyngeal examination using laryngeal glass in detecting abnormalities in the nasopharynx is needed. The ability of health workers in the primary care unit to recognize symptoms of nasopharyngeal carcinoma is needed for early detection. In district hospitals nasopharyngeal carcinoma can be detected using nasopharyngeal endoscopy so that detection is easier to do. However, a definite diagnostic through anatomy pathology examination still does not exist so that biopsy samples are still sent to the Anatomy Pathology laboratory in Medan or Padang.

5. CONCLUSION

Nasopharyngeal carcinoma is a malignant tumor originating from the nasopharyngeal epithelium. The patient NPC were diagnosed at an advanced stage. All of patients showed enlargement of neck lymph nodes and some showed diplopia.

REFERENCE