Extraosseous Chordoma of the Nasopharynx


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BACKGROUND AND PURPOSE: Chordoma is a relatively rare tumor of the skull base and sacrum thought to originate from embryonic remnants of the notochord. Chordomas arising from the skull base/clivus region are second only to those in the sacrum, and most are locally aggressive with lytic bone destruction. When chordomas occur in an extraosseous location, they may mimic other lesions of the nasopharynx. We present 5 cases of extraosseous chordoma involving the nasopharynx in an effort to improve the preoperative diagnosis of this rare tumor. In addition, we review regional notochordal embryology to explain this variant tumor location.

MATERIALS AND METHODS: We reviewed the clinical and imaging data of 5 pathologically proved cases of extraosseous chordoma of the nasopharynx seen or reviewed at our institution during the last decade. All cases had both CT and MR imaging. The study had institutional review board approval.

RESULTS: The primary clinical complaint in the 5 patients with extraosseous nasopharyngeal chordoma was nasal obstruction. The extraosseous chordomas were centered in the nasopharynx. Bony lytic changes along the anterior surface of the clivus were seen on 5 of 5 CT studies. A midline sinus tract was seen in 3 of 5 patients. MR imaging showed heterogeneous hyperintense T2 signal intensity (5/5).

CONCLUSIONS: Extraosseous nasopharyngeal chordoma is a rare but important lesion to be considered in the differential diagnosis of nasopharyngeal masses. When a midline nasopharyngeal mass is found with an associated clival sinus tract, extraosseous chordoma moves to the top of the differential diagnosis list. Complete removal of the soft-tissue tumor and the clival sinus tract is the treatment of choice in such cases.
midline clivus, thought to represent the medial basal canal (Fig 2). A narrow zone of transition with a sclerotic margin was seen around the tract in all cases.

On MR imaging, the lesions were predominantly T1 hypointense relative to muscle. Scattered throughout the tumors were areas of mildly hyperintense T1 signal intensity (Fig 1). Following contrast administration, there was heterogeneous enhancement in all 5 cases. Four of 5 lesions demonstrated heterogeneous avid enhancement. Enhancement was seen predominantly in the solid portions of the tumor and along internal septations. One of 5 lesions showed peripheral enhancement.

On T2-weighted sequences, 5 of 5 cases demonstrated heterogeneous hyperintense signal intensity. Scattered areas of very high T2 signal intensity were noted, but all lesions were predominantly mildly hyperintense relative to muscle and less hyperintense compared with CSF. The internal septations on T2-weighted imaging were all uniformly hypointense (Fig 3). Three of the 5 lesions demonstrated a sinus tract extending from the predominant mass lesion posteriorly into the midline clivus (Fig 4). The sinus tract, thought to represent the medial basal canal, was T2 hyperintense in all cases. This sinus tract did not demonstrate enhancement on postcontrast sequences.

**Discussion**

Chordomas account for 1% of all intracranial tumors. In intracranial chordomas generally occur in the vicinity of the clivus, often in the region of the sphenoid synchondrosis. There have been case reports of extraosseous chordomas in the literature, but none have been reported in the nasopharynx, as defined in our series. It is important to consider
extraosseous chordoma in the differential diagnosis of tumors in the nasopharynx because it requires a very different treatment plan and carries its own unique prognosis.

The cases we present are variants of typical clival chordomas in that they were primarily located in the nasopharyngeal soft tissues. Due to the extraosseous location of these lesions, the typical lytic changes in the clivus are absent; thus, the initial diagnosis is difficult. The aggressive features of chordomas, however, are evident in our series with lytic changes along the proximal osseous structures, such as the superficial surface of the clivus and bones of the posterior sinonasal region. Most of our patients had a nasopharyngeal mass with mass effect and scalloping of the anterior margin of the clivus. Most interesting, our patients presented with symptoms referable to their location in the nasopharynx in contradistinction to typical chordomas, which present with neurologic symptoms and cranial neuropathies.1

Chordomas are thought to arise from physaliphorous cells as described by Virchow.2 The notochord is a primitive cell line around which the skull base and axial skeleton develop. In the cases we present, the finding of a sinus tract leading from the soft-tissue component of the chordoma into the clival bone is a critical clue in differentiating extraosseous chordoma from other more common nasopharyngeal tumors. This observation is clinically significant because as is demonstrated in 1 of our patients, tumor recurrence can result from incomplete excision of the sinus tract if not identified preoperatively.

The sinus tract identified in this case series is believed to be the medial basal canal (canalis basilaris medianus) (Figs 5 and 6). The medial basal canal is considered the cephalad exit tract of the notochord as it moves from its intracaval location ventrally into the midline nasopharyngeal soft tissues. Nasopharyngeal extraosseous chordoma arises in the extraosseous nasopharyngeal soft tissues and may or may not have a smaller intraosseous component along the course of the medial basal canal.6

One common vestigial embryonic tract not to be confused with the medial basal canal is that of the craniopharyngeal canal. The cranial extent of this tract is situated between the ossification centers of the sphenoid bone in the pediatric patient and thus slightly more cranial than the most cranial extent of the notochord (Fig 6).5,6,7 The embryology and development of the craniopharyngeal canal is debated but is generally accepted as a tract connecting the nasopharynx and the pituitary fossa. Lesions in the nasopharynx associated with the craniopharyngeal canal are different from nasopharyngeal lesions associated with the medial basal canal.8 Therefore this anatomic distinction has significant differential diagnosis implications.

### Imaging Characteristics

Both CT and MR imaging are used in the evaluation of chordoma. CT is ideal for evaluating the bony involvement, whereas MR imaging is useful in evaluating the surrounding soft tissues and extension into adjacent structures. MR imaging is considered the gold standard in pretreatment and post-treatment evaluation of chordomas.1,6

On CT, the typical appearance for an extraosseous chordoma is a lobular hypoattenuated soft-tissue mass with areas of dystrophic calcification and lytic changes of affected osseous structures. Scattered areas of hyperattenuation are consistent with descriptions in the literature of blood products and intratumoral hemorrhage in typical chordomas.1,3

The interesting feature in our series is a sinus tract along the expected course of the notochordal remnant. The associated midline bony tract is an important clue to the notochordal origin of this extraosseous chordoma because other nasopharyngeal malignancies may destroy clival bone but do not demonstrate this midline tract. One of 5 cases we present is a Tornwaldt cyst mimic. In this specific example, the subtle sinus tract into the clivus helped distinguish this lesion from a Tornwaldt cyst.

With MR imaging, the features of the extraosseous chordomas are similar to typical skull base chordomas. The lesions were predominantly hyperintense compared with muscle on T2 sequences. The lesions were heterogeneous and demonstrated intratumoral septations. These findings suggest that though extraosseous chordomas can have atypical locations, the tumors will continue to demonstrate typical MR imaging characteristics.

### Treatment

Improving outcomes are being obtained with surgical resection of intracranial chordomas.10–12 The main complication to treatment of chordomas remains local recurrence. In the case of an extraosseous chordoma, the removal of chordoma along the clival bony sinus tract along with the extraosseous tumor may be important to limiting the early recurrence of this lesion. MR imaging remains the standard for evaluating postsurgical patients and surveillance for recurrence. The most commonly cited finding of recurrence is hyperintensity on T2-weighted sequences rather than morphologic changes.13 Contrast-enhanced imaging further aids in detecting areas of recurrence along the surgical margins. Distant metastasis is very rare in chordomas.13

### Differential Diagnosis

Extraosseous chordoma is primarily a lesion of the nasopharyngeal soft tissues. For the purposes of our discussion, due to the location, the differential diagnosis primarily includes nasopharyngeal tumors. The differential diagnosis list is signifi-
cantly different from the standard differential considerations for a classic chordoma. The differential for this variant lesion includes nasopharyngeal carcinoma and non-Hodgkin lymphoma. Nasopharyngeal carcinoma differs from chordoma in that there is a demographic predilection among Chinese and North Africans.14,15 Non-Hodgkin lymphoma of the nasopharynx is a relatively uncommon tumor. The age distribution for non-Hodgkin lymphoma of the head and neck is in the sixth decade.16 Combined chemotherapy and radiation therapy remain the primary treatment modalities for both nasopharyngeal carcinoma and lymphoma. Interestingly, as seen in our small series, a small extraosseous chordoma may mimic a Tornwaldt cyst, a benign notochordal remnant entity.

**Conclusions**

Extraosseous chordoma of the nasopharynx is a rare but important tumor to be considered in the differential diagnosis of nasopharyngeal masses. When a midline nasopharyngeal mass is found with an associated clival sinus tract, extraosseous chordoma moves to the top of the differential diagnosis list. Complete removal of the soft-tissue tumor and the clival sinus tract is the treatment of choice in such cases.

**References**