



CASE REPORT

CASE REPORT OF MYOEPITHELIAL CARCINOMA OF MAXILLARY SINUS

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ABSTRACT

Myoepithelial carcinoma of the salivary gland is extremely rare malignancy. It may arise either in recurrent or pre existing pleomorphic adenoma or de novo in salivary glands. We herein present the case report of 35 years old male patient who presented to us with myoepithelial carcinoma of minor salivary gland of right maxillary sinus. Right total maxillectomy was done and orbital floor reconstruction was done with titanium mesh.



INTRODUCTION

Myoepithelial carcinoma (MC) is rare salivary gland tumor and comprises of less than 1% of all salivary gland tumors.¹ It is defined as malignant neoplasm of salivary gland with exclusively myoepithelial differentiation.² In 1975, Stromeyer et al for the first time described it. MC has been included in the World Health Organization (WHO) classification in 1991 as a distinct clinicopathological entity.³ Approximately 75 cases have been reported in world literature till 2000.⁴ Because of the rarity of the tumor very little data is available about its diagnosis, pathogenesis and prognosis.

CASE REPORT

A 35-year-old male presented to Oral and Maxillofacial Surgery Department of King Edward Medical University with the chief complaint of swelling on right cheek region from last five years. According to the patient he felt a small swelling in his right buccal vestibule 5 years back. There was no pain or pus discharge from it. Throughout the clinical course it remained painless. In last one year it has developed abruptly and

attained its maximum the size of approximately 7x6cm. On clinical examination, there was well demarcated firm swelling measuring approximately 7x6cm on the right cheek. Medially swelling was starting from lateral wall of right side of the nose and laterally up to zygomatic region. Superiorly it was causing the pushing effect to the right eye and inferiorly up to the level of right oral commissure. Overlying skin was normal in color, texture and isothermic to surrounding skin. Nasal patency was intact and all cranial nerves were intact including facial and trigeminal nerves.

Intraorally there was well demarcated firm swelling of approximately 6x4 cm starting from the right maxillary central incisor to the right second maxillary molar obliterating the right buccal vestibule. Overlying mucosa was normal in color and texture. Right Stenson's duct was not appreciated due to tumor mass. Mouth opening was adequate and tongue movements were normal. Right submandibular lymph node was palpable which was painless, mobile, upto 3 cm in size, and firm in consistency. Incisional biopsy was performed intraorally which showed it be the myoepithelial carcinoma of maxillary minor salivary glands.



Figure 1: Pre-operative picture showing swelling of right maxilla



Figure 2: Coronal view of CT Scan showing lesion

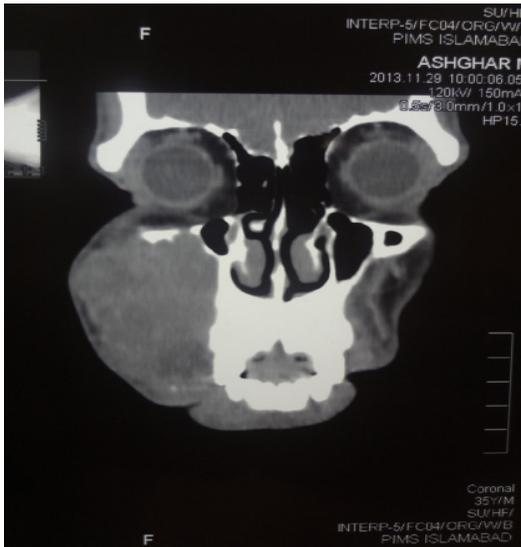


Figure 3 Axial view of CT scan showing lesion

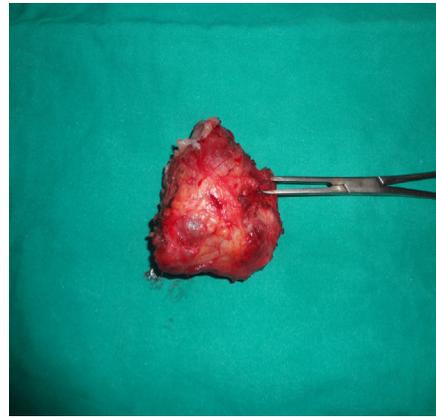


Figure 4: Resected specimen



Figure 5: Post-operative picture after 5 years

Informed consent was taken and all base line investigations were done including metastatic workup. Chest x-rays and abdominal ultrasonography showed no metastasis. CT scans showed a well-defined mass measuring 6.3xU3.5x3.9cm in AP x T x CC extend mass on right side of face. Few necrotic components were also noted in mass. Under general anesthesia tumor resection was done with safe margins, that is, right total maxillectomy was done along with functional neck dissection on right side. To support the right eye and avoid the post-operative diplopia, right orbital floor was reconstructed with titanium mesh. Definitive maxillary reconstruction was delayed to see the tumor recurrence as it was difficult to take safe margins in midface. Surgical obturator was provided intraorally for better post op healing and pain control. Resected specimen was subjected to the histopathological examination which revealed it to be the myoepithelial carcinoma. Patient was put on follow up. On 7th post op day face stitches and on 10th post op day neck stitches were stitched out. Oral hygiene was well maintained by normal saline gargles and 0.2% chlorhexidine mouth wash. Patient was followed up post operatively for any recurrence. He remained disease free for almost one and half year when he had local recurrence intra orally at the same side. The lesion was small which was excised with safe margins and

patient was subjected to radiotherapy post operatively. But long follow up is necessary to see and control any other local recurrence or distant metastasis.

DISCUSSION

Myoepithelial carcinoma is rare malignant salivary gland tumor comprising 0.4% to 0.6%² and less than 1% of all salivary gland tumors.¹ In North American population, among the 380 minor salivary gland neoplasm Buchner et al⁴ found 1 MC (0.26%), in Thais Dhanuthai et al⁵ found 1 MC (0.32%) among 311 minor salivary gland tumors, and Pires et al⁴ found 1 MC (0.2%) among 546 minor salivary gland tumor. In china, MC was 3.3% of all the intraoral minor salivary gland tumor and 6% of carcinomas.⁴ The clinical and biological behavior of the MC is not well known. Distal metastasis is only in 10%. It metastasizes to local lymph nodes or distal metastasis to the kidney, brain, rib, scalp and lung.² In our case there was cervical lymph node metastasis. Tumor resection with wide safe margins is the treatment of choice. Prognosis doesn't seem to be improved by the adjuvant radiotherapy.² Surgical resection is treatment of choice for the tumors which are approachable and resectable.⁶ Radiotherapy either with or without chemotherapy is reserved

for those tumors which are not resectable.⁵ Five-year survival rate is 80% following surgical resection. In our case we did surgical resection and then followed the radiotherapy to control the local recurrence. There is no specific imaging appearance for this tumor and macroscopically it's a well circumscribed mass with grayish white to tan color.⁵

CONCLUSION

Although myoepithelial carcinoma is a very rare tumor of salivary glands but its occurrence in minor salivary glands is evident by this case report. So, it should be included in the differentials of the carcinomas arising from the salivary glands. Surgical resection followed by the chemo-radiotherapy is the treatment of choice according to the tumor stage.

In summary, we reported a case of necrotizing pancreatitis with peritonitis due to infestations with ascaris, which is rare cause in young child. The child was surgically managed and recovered completely.

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