Giant monomorphic adenoma of the palate: Transoral resection.

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Citation

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Abstract

We report a case of a giant monomorphic adenoma of the hard palate. Monomorphic adenomas are usually encapsulated and frequently are partially cystic. Their histologic pattern may be confused with that of adenoid cystic carcinoma, but they grow in an expansile fashion and usually are monolobular.

INTRODUCTION

Tumors of minor salivary glands are rare, accounting for 2-4% of head and neck tumors, 10% of the cavity oral and 15-23% of all glands salivary. The most common malignancy of the glands Salivary, the greater is the minor pleomorphic adenoma, accounting for 60 to 89.5% of them, the authors consulted.

Basal cell adenomas tend to occur over the age of 50 years with a slight female predilection of 2:1. They usually occur in the parotid (75%) or submandibular gland (approximately 5%). These lesions are quite rare in the minor salivary glands when excluding canalicular adenomas which were previously categorized with basal cell adenoma. They typically present as a slowly growing solitary painless mass . A special variant of basal cell adenoma, the membranous type (dermal analog tumor) can be associated with multiple trichoepitheliomas and cylindromas (Brooke-Spiegler syndrome). Grossly, these tumors are a well-circumscribed, solid homogeneous gray-white to tan-brown occasionally mimicking an enlarged lymph node. Rarely, cystic change may be seen grossly . Most tumors are less than 2 cm in diameter1.

Usually presents as a tumor rounded asymptomatic slow growth by masses which are often found too large, especially in minor salivary glands. The presumptive diagnosis is made, especially in major salivary glands, with sialography, ultrasound, scintigraphy, FNA and MRI / CT confirmed with the histological study.

Treatment and Prognosis. Except for membranous adenoma, monomorphic adenomas are benign and rarely recur.

Treatment wide surgical excision is the possibility of relapse and lead to a malignant mixed tumor. Introducing the case of a gigant Monomorphic adenoma of the palate hard.2

CASE REPORT

A 26-year old woman with a history of 5-year slow-growing tumour in the region of hard palate. The patient had a previous pathological report performed in other centre consisting in two fine-needle aspiration (FNA) procedures, with result suggestive of low-cytological grade epithelial proliferation. This finding was compatible with a salivary gland pleomorphic adenoma. However, quantity of stroma was minimal, and there were deviations in relation to the standard patterns, so other tumours included carcinoma were not rejected. In the physical exploration, the patient showed a 8-cm mass on the hard palate. No other lymph nodes or masses were observed in the cervical and facial regions.

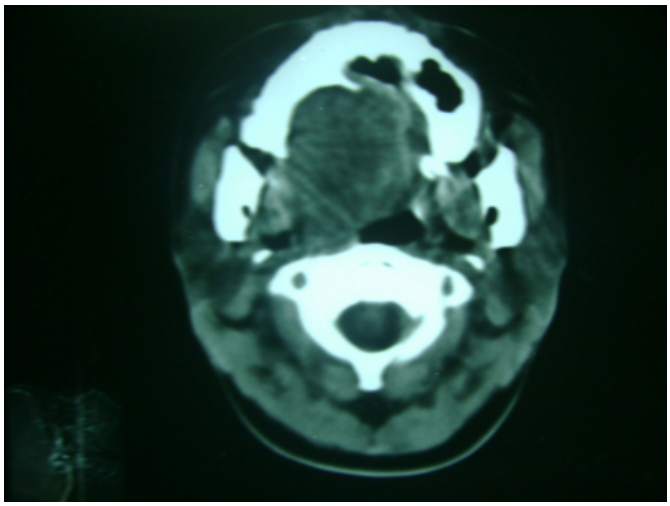
Figure 1

FIG.1. Clinical aspect.

With the suspected diagnosis of pleomorfic adenoma. A 8-cm well-defined hyper-take nodular image in the hard palate. Due to its radiological features and slow progression in 5 years, it was interpreted as a benign tumoral lesion, such as pleomorphic adenoma, Warthin tumour and other benign lesion. Radiologically negative cervical nodes were observed in the submandibular, jugulodigastric and posterior cervical region.

Figure 2

Fig. 2. Tomography. Note airway obtruction.



The patient was intubated nasally to facilitate surgical maneuvers because orotracheal intubation could not be performed. After verifying mouth opening, the tumor was completely resected with tumor-free resection margins via a transoral approach using a Millard bite opener. The tumor wasn´t pediculated and the base cover all palate (Figs. 3 and 4). The postoperative period passed without incident and one year after surgery the patient was asymptomatic and free of clinical and radiologic evidence of recurrence.

Figure 3

FIG.3 Transoral approach. Digital dissection.

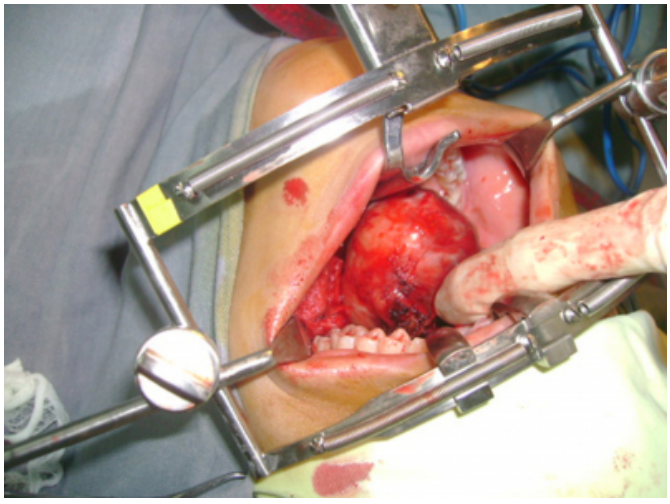
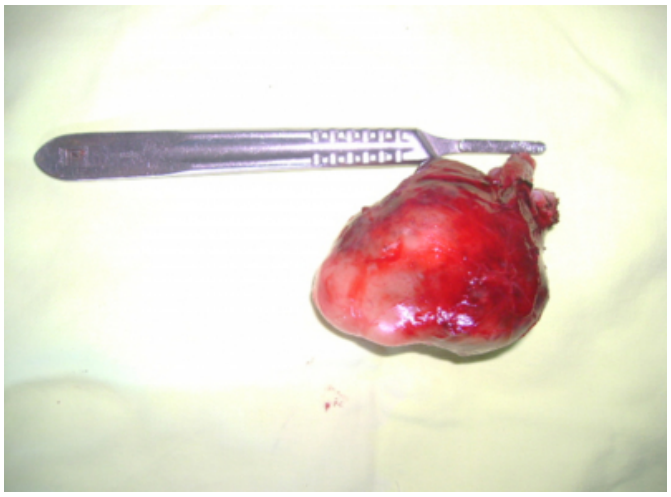


Figure 4

Fig. 4. Specimen. Handle Bard-Parker #4



DISCUSSION

Tumors of the minor salivary glands are responsible for 2-4% of tumors of the head and neck, 10% of tumors of the oral cavity, and 15-23% of tumors of the salivary glands.3 The most frequent location of MoNOmorphic adenoma of a minor salivary gland is the hard palate, followed by the lips, oral mucosa, floor of the mouth, tonsil, pharynx, retromolar area, and nasal cavity.5 Monomorphic adenomas do not usually present a sexual predisposition and they can appear at any age with the same clinical behavior.3 They are generally round, slow-growing tumors that are painless and firm in consistency. Microscopically, pleomorphic adenomas of the minor salivary glands consist of epithelial cells and mesenchymal elements that tend to be more cellular, with less myxoid or chondroid component, and located within the submucosa, in contrast with tumors of the major salivary glands. Tumors of the minor salivary glands do not have a fibrotic capsule (they have a very thin capsule) and they may have a false infiltrative appearance. One consequence of this is that CT and MRI imaging diagnosis will be necessary to evaluate as exactly as possible the extension and anatomic relations of the tumor in order to plan a suitable surgical approach. After studying the case, we decided to excise the tumor transorally.5 Despite the drawbacks of this approach (limited access, poor maneuverability, and need for nasal intubation), sufficient access can be obtained using a Davis Boyle bite opener after previously verifying the functionality of both temporomandibular joints (orthopantomography) and adequate cervical mobility. Like other authors,6-7 we think that, in light of the initial benignity of the process, the most conservative possible surgical technique is preferable whenever resection is possible. The prognosis will be excellent if resection is adequate. Irradiation is reserved for recurrences and inoperable cases.8 Malignant transformation has been reported (2-9%), generally to adenocarcinoma or undifferentiated carcinoma. The risk of malignization increases with the duration of the tumor and mean age of the patient.7

Regular follow-up is required to detect local recurrence and malignization. We currently consider the transoral approach to be adequate and sufficient for correctly resecting benign tumors of the palate once it has been determined that there are no anatomic limitations that contraindicate the technique.

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