

Myxofibrosarcoma Of The Maxillary Sinus

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Citation

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Abstract

Myxofibrosarcoma was originally described as the myxoid variant of malignant fibrous histiocytoma (MFH). It is one of the commonest sarcomas of the extremities and retroperitoneum. The head and neck region is an uncommon site.

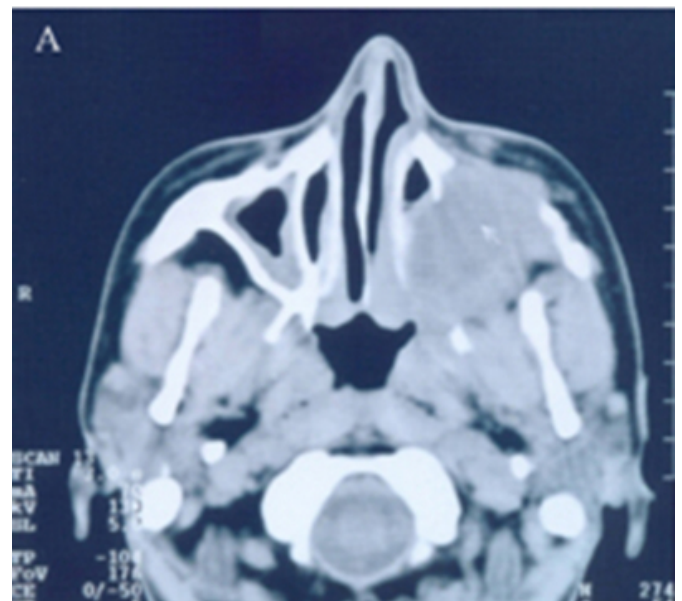
CASE REPORT

36-year-old woman. complained left facial swelling with spontaneous pain, nasal obstruction and difficulty of eye movement for four months. She visited the another clinic and biopsy from left maxillary sinus anterior wall was made at there. Histopathological examination of biopsy material was showed well differentiated fibrosarcoma. She referred to our clinic for management. On examination was found filling the left nasal cavity, swelling on the front of the left maxillary sinus and ptosis of the left eye. Pain was described by the patient at last month. Patient medical history was unremarkable. Three node was found at left neck III. and IV. regions.

A CT scan revealed 4x5x5.5 cm tumoral mass filling the left maxillary sinus, destructed anterior wall and infiltrating surrounding tissue (Fig I A).

Figure 1

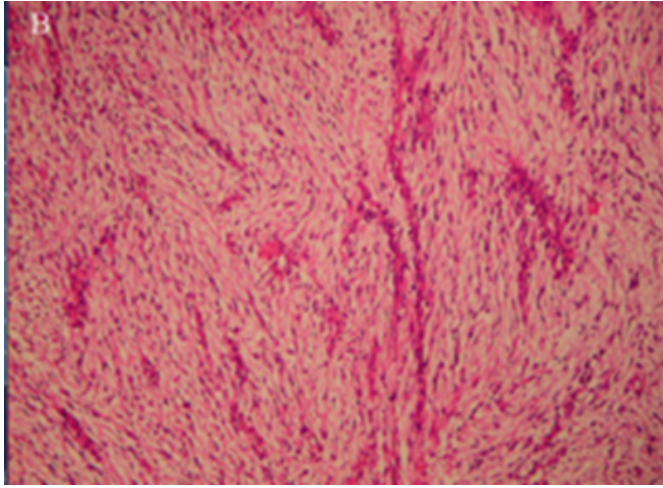
Figure 1a: Computerized tomographic (CT) scan of paranasal sinuses, 4x5x5.5 cm tumoral mass filling the left maxillary sinus (white arrow) , destructed anterior wall and infiltrating surrounding tissue.



We made left radical maxillectomy with Weber Fergusson Approach, left modified radical neck dissection type I. Histopathological examination of surgical specimen showed that myxofibrosarcoma (Fig I B).

Figure 2

Figure 1b : The tumor of spindle cells embedded in an abundant myxoid matrix. There is a striking arborizing vasculature composed of small caliber vessels (H&E, original magnification 100x).



The postoperative course was uneventful. There isn't a sign of local recurrence or metastasis for 2 years already.

DISCUSSION

MFH occur predominantly in the subcutaneous tissues of the extremities and retroperitoneal space, thus the incidence of head and neck MFH is relatively low. Head and neck MFH has been reported to account for 3-10% of MFH formed in various part of the body⁽¹⁾.

Myxofibrosarcoma was the originally described as the myxoid variant of MFH. Histologically, myxofibrosarcomas may range from hypocellular, mostly myxoid lesions (low grade, myxoma-like) to hypercellular, high grade and pleomorphic neoplasms (classic myxoid MFH) with areas of extensive necrosis⁽²⁾.

The differential diagnosis includes benign and malignant myxoid neural lesions, superficial angiomyxoma, intramuscular myxoma, low-grade fibromyxoid sarcoma and myxoid liposarcoma⁽³⁾.

MFH in the sinonasal tract usually exhibits features similar to other soft tissue neoplasm, namely epistaxis, Nasal obstruction, rhinorrhoea and non-specific nasal discomfort. CT scan and MRI show the extent of tumour involvement and malignant features such as adjacent tissues invasion, but are not in themselves diagnostic.

Complete tumour resection with adequate resection margin is essential⁽⁴⁾. It is often difficult to conduct resection of head and neck lesions with a wide margin of safety.

Adjuvant radiotherapy is reserved for recurrent, unresectable or large lesions with a high chance of microscopic resection margin involvement. However efficacy of radiotherapy and chemotherapy are controversial^(4, 5). In our case, examination of the resected specimen suggested the tumour had not been completely resected. Accordingly the postoperative treatment included radiotherapy with total dose of 6000 rad (200rad/day, 30 sessions) and chemotherapy using Adriamycin and 5-Flourourasil. Local recurrence or metastasis was not found for 2 years.

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