

Case Report

A rare ectopic localization of pleomorphic adenoma of lip

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ABSTRACT

This case report described a rare and unusual lesion found in a 68-year-old male, which was diagnosed as pleomorphic adenoma of the minor salivary glands in the upper lip. The tumor was a circumscribed, large firm mass, about 2 cm in diameter, characterized by slow growth. Complete excision was performed and the histopathologic analysis showed pleomorphic adenoma.

Keywords: Minor salivary gland tumors, Pleomorphic adenoma, Upper lip

INTRODUCTION

Pleomorphic adenoma (PA) also called mixed tumor is the most common benign salivary gland tumor accounting for 50% of all salivary gland neoplasms.¹ It can involve major as well as minor salivary glands.

Among minor salivary glands (5-10% of cases) the palate, lip, nasal cavity, pharynx, larynx and trachea are the most common sites. It occurs frequently in females, with the female- male ratio ranging from 1.9:1 to 3.2:1 and with a peak incidence between the 5th and the 7th decades of life.^{2,3} Diagnosis is made upon histopathological examination principally it presents two components, epithelial and mesenchymal component.⁴ Wide excision is the treatment of choice to avoid recurrence. We reported a case of ectopic pleomorphic adenoma localized in the right side of upper lip.

CASE REPORT

A 68-years-old male patient visited the department of minimal invasive surgery with the chief complaint of small painless swelling over the right side of upper lip since 1 year causing unesthetic appearance (Figure 1). History of presenting illness revealed that the swelling was gradual in onset, grown slowly to attain the present size. There was

no history of fever, bleeding, pain, sensory changes and disturbance of salivation or trauma. The past dental history and medical history was unremarkable and no other abnormalities were found. Personnel history revealed that patient was married with two kids. The family history was non-significant.

General physical examination showed that patient was of moderate built, height and well-oriented to time and place and all the vitals were in normal limit. On examination, the mass was circumscribed, sessile and firm in consistency measuring 2×1.5 cm in diameter.

The overlying mucosa was smooth with a pinkish purple colour. The skin over the tumour was not fixed. There was no pain or bleeding on palpation. There was no regional lymphadenopathy and her general physical and systemic examinations were normal. The tumour was completely removed with a lip splitting incision.

During the surgical procedure, the lesion was excised without difficulty with a clinically normal margin because the mass was fully encapsulated without any subcutaneous or muscle attachments. Sutures were given with good approximation and cosmetic results. Histopathologic analysis of the surgical specimen revealed PA and there was no evidence of malignancy (Figure 2).



Figure 1: Pleomorphic adenoma upper lip.



Figure 2: Histopathological report of pleomorphic adenoma of upper lip.

DISCUSSION

Salivary gland neoplasms represent about 1-4% of all neoplasms. Generally they affect major salivary glands (with a major predilection for the parotid glands) and rarely minor salivary glands. It presents as a unilateral painless, slowly growing. The PA of minor salivary glands clinically present as painless, slow growing sub mucosal masses. The covering mucosa is seldom affected unless it is secondarily traumatized.

The solid nature of lesion coupled with lack of tissue representing the three germ layers rule out the possibility of mature dermoid cyst. PA should be differentially diagnosed from various other tumors, such as angiofibroma, hamartoma, epidermoid cyst, hemangioma, vascular malformations, nasopharyngeal carcinoma, and nonepithelial tumors.⁵ Incisional biopsy is always a crucial step in the management of these lesions. Although histology is sometimes hard to evaluate, PA is characterized by epithelial tissue mixed with tissues of myxoid, mucoid, or chondroid appearance.

Occasionally, pleomorphic adenomas are composed almost entirely of epithelial cells with few or no stromatic tissue. This can lead to misdiagnosis as a carcinoma. Absence of punctum and freely movable nature of the mass differentiate PA from sebaceous cyst. As on histological picture both epithelial and myoepithelial cells were seen, which rules out mucoepidermoid carcinoma. The negative slip test clinically and absence of lipomatous component histologically rules out lipoma. The absence of perineural invasion and mitotic figures obscure the chances of polymorphic low grade adenocarcinoma. There are three

histological subtypes, myxoid (80% stroma), cellular (myoepithelial cells predominating) and mixed (classic). PA is known to produce recurrence either due to spillage, inadequate removal or enucleation at the time of operation, but is not known to produce distant metastasis. A recurrence rate of 2-44% has been reported in the literature. The ideal treatment of choice for PA is wide local excision with good safety margins and follows-up for at least 3-4 years.⁶

The clinical features contribute to the differentiation between benign and malignant lesions. Several studies have shown that the vast majority of upper lip tumors are benign, while malignant tumors tend to predominate in the lower lip.⁷⁻¹⁰ Benign lesions usually present as asymptomatic slow-growing (average course 3-6 years), well-defined, smooth, and uniform nodular tumors showing a normal overlying surface color, and lack of adherence to superficial or deep tissue layers. Malignant lesions, on the other hand, may be painful, fast-growing (average course of less than one year), and may exhibit bleeding, ulceration, infection, adherence to deeper or superficial layers, and even lymph node involvement.¹¹

CONCLUSION

Pleomorphic adenoma of the upper lip is a rare occurrence. Nevertheless, when faced with a swelling of the upper lip, a diagnosis of pleomorphic adenoma should not be omitted from the differential.

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