Pleomorphic adenoma case report pdf

OBJECTIVE: Describe a therapeutic approach in the case of recurrent large-size pleomorphic adenoma. Example: Frame 5 years of tumor growth in the left parotid area with no signs of inflammation, which worsens over the past two years, after the voice of the nasal, mild dysphagia of solids rather than fluid. Works in 1978 from the same tumor smaller, partial parotectomy with the continuation of facial paralysis, which improved after treatment with a diagnosis of pleomorphic adenoma. Physical examination: mild facial paralysis at the level of the left oral commission. Oroscopy: it turns out the tumor displaces the left side wall of the mouth, the front pillar and the tonsillary bed to the middle line, the tumor in the parotid area, which extends to the left winking area of stoney consistency, the painless edge of the mesh connected to deep layers 10 cm in diameter. Has a CT scan: the left parotid tumor, which extends from the base of the skull, moves the structures of the middle line in the orofarix, parafaringal space approximately 11 x 9.5 x 6.5 cm with microcalifications without apparent change of cranial nerves. A cut biopsy was performed that returns the pleomorphic adenoma. Given the size and extent of the tumor decided radiation therapy provided surgery to reduce the size of the tumor and postoperative. INTERVIEWER: Pleomorphic adenoma is the most common benign tumor of the main salivary glands; Treatment is surgical and should be done in the same complete extirpation to prevent relapses. Tumors of the salivary glands make up 3% of head and neck tumors. Pleomorphic adenoma (PA) is the most common tumor of the salivary glands, accounting for about 40-70% of all major and minor salivary gland tumors (MHST). PA is a benign mixed tumor consisting of epithelial and myoepithelial cells located in various morphological models demarcated from the surrounding tissues by a fibrous capsule. The parotid gland is the most commonly affected by the main salivary glands. Among the minor salivary glands, the palate is a widely involved site, with nearly 60% flowing from this place. Lips, cheeks and gingiva are rare places of occurrence. In this report, we present a case of PA buccal of a minor salivary gland in an adult patient who was successfully treated with extensive local surgical excision. The 31-year-old was admitted to the maxillofacial surgery unit at Apollo General Hospital in Chennai, Tamil Nadu, India. For the past four years, the patient has had a major complaint against the right side of the person. History has shown the tumor was painless, and initially smaller in size, which gradually increases to its current size. She had no difficulty with speech and deglutition. Patient took homeopathic drugs for swelling during two years, but that doesn't reduce in size. Teh Teh Medical and dental history's past was not significant. During the systemic examination the patient was healthy and had no regional lymphadenomopathy. During extraoral examination, facial asymmetry was present due to swelling on the right side. A single dome-shaped oval swelling with a smooth surface was present on the right cheek area (Figure 1). Excessive skin condition was normal. The swelling was approximately in the middle of the cheek area measuring about 5 cm × 3 cm, extending above-below from the Ala-tragus line to the lower boundary of the lower boundary of the lower jaw. Antero-rear it stretched 1 cm from the right corner of the mouth to 1 cm less than the right pterigomandibular rache. At palpation the tumor was sessile, firm in sequence, nontender, nonfluctuant, nonreducible, nonpulsatile, and mobile in all planes with well defined fields. Intraoral examination did not reveal significant conclusions. The tumor was covered with an untouched healthy mucous membrane (Figure 2). At the two-manent palpation, the mass was felt between the buccal mucosa and the skin, and it was not fixed on deeper structures. The opening of the mouth was adequate and there were no signs of motor or neurosensory deficiency in the area of lesion. The patient's blood tests were within the normal range. A CT scan of the face induces clearly defined encapsulated homogeneously enhancing lesions in the right area of the buccal space without invading the adjacent structures (Figure 3). Differential diagnosis of lesions included MGST, tumor of the accelerated parotid salivary gland, lipoma, myofybroma and neurofibroma. Based on history, clinical presentation and radiological research, it was decided to surgically excise the lesion under general anesthesia. The horizontal incision was made in the right focal mucosa parallel to the occlusion plane, without damaging the duct of the parotid gland. A blunt autopsy was done to expose the mass that was present between the buccaneer of the mucosa and the bodysuit muscle (Figure 4). It was released from the surrounding tissues and the lesions were cut together with an adequate margin of normal tissue (Figure 5). Hemostasis was reached, and the wound was snay. Postoperative recovery and wound healing were without complications. The excise sample was sent for histopathological examination (Figure 6). An excisional biopsy sample showed one soft cropped encapsulated node, measuring 4.5 cm x 3 cm x 1.5 cm in size, grayish color, and was soft to firm in consistency with rough surface texture. The cut section was solid and exhibited a grayish tan with some gelatin areas and pockets of calcification. Histopathological report has revealed encapsulated mass consisting of tubes, clusters and anastasoma trabecules of epithelial cells with pockets of mixoid and myxondroid Cystic spaces were filled with keratin. Eosinophil secretions were noted in trumpeting (Figure 7). Lack of significant atypia or increase in increase it was noted. Infiltration of lymphocytic cells has been seen on the periphery. There were pockets of cystic changes (Figure 8). This confirmed the diagnosis of PA salivary gland. Since the tumor was not associated with the parotid duct or gland, it was believed that it was a near minor origin of the salivary gland. The patient is under periodic review and there is no evidence of a relapse after one year of follow-up. Minor salivary gland tumors account for 22% of all salivary glands. Most of them are malignant, and only 18% are benign. Waldron et al. reported that 53%-65% of MSGT are benign. PA accounts for most benign neoplas my salivary glands. The most common place for PA small salivary glands is the palate followed by the lips, bucical mucosa, mouth floor, tongue, tonsils, throats, retromolar area, and nasal cavity. They are more common in adults than in children. This usually occurs in the fourth or sixth decades of life and occurs more often in women than in men. Several studies have shown a different incidence of PA of minor salivary glands of the cheek (table 1). Studies Total Number of Cases of Pleomorphic Adenoma Number of Cases in Cheeks Percentage (%) cases in the cheek of Isaksson and Shire 140 7 5 Fine et al. (10) 25 4 16 Chaudhry et al. 476 38 8 Main et al. 24 4 17 Buchner et al. (13) 149 19 13 Lopes et al. , painless, hard, lobulated sub-drug swelling, which does not cause ulcers excessive mucous membrane. These benign neoplass are usually well limited and round or oval in shape. They vary in consistency from soft and fistiant to hard and rubber, depending on the presence of cystic or mucous degeneration or the formation of chondroid or osteoid tissues. The size of the tumors range from 1 to 7 cm in diameter with some PA cheeks can reach larger sizes. PA of minor salivary glands are detected and treated earlier than in the main salivary glands. In our case, the tumor was allowed to grow to attentive sizes, as it did not interfere with delothition and speech. A noticeable cosmetic deformity prompted the patient to seek medical attention. CT, MRI and ultrasonography are useful for determining the size and extent of lesions and in determining bone participation. The incisional biopsy of the PA in place can predispose to relapse and is not contraindicated. The subtle cytology of needle aspiration is the preferred diagnostic method. PA has three histological subtypes: mixoid (80% stroma), cell (myepitel cells predominate) and mixed (classic). Histologically, they have epithelial and mesenchymal elements. Epithelial cells are arranged in cord-like and duct-like cell models, along epidermoid metaplasia. The intercellular matrix shows fibrous, hyaline, mixoid, carnivorous and osseous areas. Myepitel cells are responsible for such pleomorphic extracellular production of the matrix. In minor glands, lesions are often more solid or cellular than those seen in the main glands, and myoepithel cells are often polygonal with pale eosinophil cytoplasm gives epithelioid or plasmocytoid phenotype. In our case, the histopathological report confirmed the diagnosis of PA. Differential diagnosis of mass in the cheek includes: MGST, tumor accessory partid salivary gland, lipoma, myofybroma, neurofibroma, sebaceous cysts, epidermoid cysts, dermoid cysts, mucoepidmoid carcinoma and adenoid cystic carcinoma. Surgical excision with an adequate supply of normal surrounding tissue is the treatment of choice for PA cheeks. In our case, the lesion was encapsulated, located between the lining of the cheek and the muscle of the tumor, which was very suggestive of a benign tumor of minor origin of the salivary gland. The defeat was cut untouched with the capsule. Radiation therapy is not shown due to the radio-resistant nature of the tumor. Inadequate resection, rupture of the capsule, or tumor leakage during the excision can lead to local relapse, as these tumors often have microscopic pseudo-pod-like extensions in surrounding tissue through the capsule. Spiro et al. reported relapse in 7% of 1,342 patients with benign parotid neoplasma, and in 6% of patients with benign MHT. In some cases, PA minor salivary glands may undergo malignant transformation in carcinoma, such as PA and metastasis of a benign mixed tumor. Recurrence after many years of surgical excision, as well as malignant transformation is a problem, so long-term follow-up treatment is needed up to 10 years. The varied presentation of MGST makes the diagnosis difficult even for an experienced surgeon. PA cheeks is a rare neoplasm and therefore its diagnosis requires a high suspicion index. PA should be taken into account in differential diagnosis of cheek masses in both young and adult patients. Full extensive local surgical excision is the treatment of choice. Patients should be continued for a longer period of time due to the possibility of late relapses. Relapse. pleomorphic adenoma case report ppt. carcinoma ex pleomorphic adenoma case report. pleomorphic adenoma of palate a case report. pleomorphic adenoma of minor salivary gland a case report