

Ponderous Pleomorphic Adenoma of Parotid Obscuring a Grievous Tumor of the Head and Neck: A Rare Case Report

Abstract

We present a rare case of simultaneous occurrence of pleomorphic adenoma of the left parotid gland and squamous cell carcinoma (SCC) of left buccal mucosa in a 59-year-old patient. The synchronous occurrence of these two entities has not been reported in the literature. A PubMed database search did not yield any results for search words involving “Oral Cancer,” “Synchronous Oral Cancer and Pleomorphic Adenoma of Parotid gland” and “Oral SCC and Pleomorphic Adenoma of Parotid gland.” Furthermore, synchronous development of these two tumors may give rise to diagnostic and management conundrums as the parotid growth may be considered to be a nodal metastasis.

Keywords: Oral cancer, salivary gland tumors, squamous cell carcinoma, synchronous tumors

Introduction

Oral squamous cell carcinoma (OSCC) arises from the lining of the oral cavity, which accounts for 90% of oral malignant neoplasms and 30% of all types of all malignancies.^[1] The chief risk factors for the development of OSCCs are tobacco consumption and alcohol abuse, which a majority of patients who develop OSCC practice.

Pleomorphic adenoma is the most common of salivary gland tumors, accounting for 50%–70% of parotid tumors, 40%–60% submandibular tumors, and 10% minor salivary gland tumors. Age groups commonly affected are fourth, fifth, and sixth decades; 60% of these are females.^[2,3]

OSCC is a commonly occurring cancer in India, while pleomorphic adenoma is the most prevalent among the histological variants of salivary gland tumors. However, the synchronous occurrence of these two entities has not been reported in literature. Furthermore, synchronous development of these two tumors may give rise to major diagnostic and management conundrums as the parotid growth may be considered to be a nodal metastasis or the treating surgeon may be misguided by the humongous appearance of extraoral swelling leading to inadequate treatment for the patient.

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Case Report

A 59-year-old female reported to our outpatient department with the complaint of huge extraoral swelling on the left side of the face for 5 years. The swelling was initially smaller in size and had progressively increased over time. The patient gave a history that she had consulted a private practitioner 2 months ago who had planned for excision of salivary gland tumor. A well-defined, ovoid, multilobular swelling of size 8 cm × 9 cm with superoinferior extent from left zygomatic arch to about 4 cm below the lower border of the mandible and anteroposterior from the anterior border of masseter to 1 cm beyond posterior border of mandible was noted. The left ear lobe was slightly raised and everted [Figure 1]. Facial and eye movements were normal on examination. Intraoral examination reveals a nonhealing suspicious ulcer over the left posterior buccal mucosa distal to second molar of size 1 cm × 1 cm. Clinically there were no neck nodes. Fine needle aspiration cytology (FNAC) of the extraoral swelling was done, which was suggestive of a benign mixed tumor. Incisional biopsy was performed for intraoral lesion, which was suggestive of well-differentiated squamous cell carcinoma (SCC) [Figure 2].

After obtaining presurgical workup and written informed consent, surgery was

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**Punit Singh Dikhit,
Satadru Roy,
Ankita Srivastava¹,
Dhara P. Sirodaria²**

*Department of Oral Oncology,
Kidwai Memorial Institute
of Oncology, Bengaluru,*

*²Department of Head and Neck
Oncology, Karnataka Cancer
Therapy and Research Institute,
Hubli, Karnataka, ¹Department
of Dentistry, AIIMS,
Bhubaneswar, Odisha, India*

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Address for correspondence:

*Dr. Punit Singh Dikhit,
Department of Oral Oncology,
Kidwai Memorial Institute
of Oncology, Bengaluru,
Karnataka, India.*

E-mail: dikhit.punit@gmail.com

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planned. The skin incision was given over the prominent part of tumor to remove the excess skin paddle, which was extended to the lower part and tunneled to perform supraomohyoid neck dissection in the same sitting. The marginal mandibular nerve was identified from beneath the lower incision margin and retrograde tracing was performed to locate the main nerve truck, which was preserved [Figure 3]. Intraoral mucosal malignancy was excised with safe margins and reconstructed using the buccal fat pad. Postoperative period was uneventful [Figure 4]. Final histopathological report of extraoral tumor suggested pleomorphic adenoma, while Intraoral tumor was Grade 1 SCC with negative margins. None of the neck nodes were found harboring metastatic tumor. There was no apparent clinical recurrence with regard to parotid gland tumor and oral mucosal lesion on a 2 years follow-up.

Discussion

The major problem with this case was the accurate diagnosis of the two synchronous lesions of the head

and neck with unrelated etiology, different presentation, and totally different treatment strategies. A study done by Bordoloi *et al.*^[4] from northern India suggested that delay in diagnosis of OSCC in most of the cases (66.32%) was around 2–6 months. This can be caused by factors such as patients' negligence due to lack of awareness, illiteracy, poverty, and home remedies. Professional delay in making a confirmatory diagnosis was another important factor. Sharma *et al.* also reported the fact that unawareness is a major cause of delayed reporting as most of these patients were illiterate and from lower socioeconomic status.^[5] This delay in rendering treatment to the primary OSCC can lead to nodal metastasis which is associated with poor disease control and reduces overall survival by 30%–50%.^[6]

On the other hand, pleomorphic adenoma is a benign salivary gland tumor which can be managed surgically and carries small risk of malignant transformation.^[7] The newer techniques of resection like nucleoresection give excellent result with minimal postoperative nerve dysfunction, minimal recurrence.^[8]



Figure 1: Preoperative extraoral



Figure 2: Preoperative intraoral

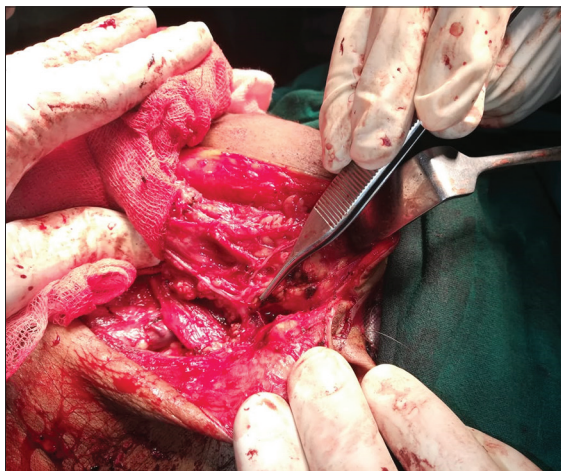


Figure 3: Intraoperative facial nerve



Figure 4: Postoperative intact facial nerve function

In the present case scenario where both of these unrelated tumors existed synchronously, thorough clinical examination becomes imperative as treatment of clinically obvious lesion only can lead to incomplete treatment or vice versa. Nupehewa *et al.* reported an unusual case of simultaneous occurrence of OSCC and warthins tumor with a strong emphasis on thorough preoperative examination to preclude over the treatment of OSCC due to false-positive diagnosis of warthins tumor as metastatic node in ultrasound.^[9]

Analyzing the above studies and the present case, we can conclude that comprehensive head and neck clinical examination is crucial before formulating any treatment plan.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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