Superior vena cava syndrome due to metastasis from acinic cell carcinoma of the parotid gland

Sir,

Acinic cell carcinoma is a rare malignancy of salivary gland origin.[1] The parotid gland is the most common primary site. It can recur many years after the primary diagnosis and subsequent removal.[1,2] Distant metastases from salivary gland tumors are relatively atypical and their occurrence is associated with high-grade tumors.[2] We report the first case of a patient with superior vena cava syndrome (SVCS) due to an acinic cell carcinoma of a parotid gland metastasizing to the mediastinum 2 years after resection of the primary tumor.

A 53-year-old Hispanic female presented to the emergency department with complaints of progressive increase in size of a painful mass in the right mandibular area. Her physical exam was significant for a 5 × 4 cm nontender, mobile, firm mass over right mandibular area with normal overlying skin. Rest of the physical exam was unremarkable. Lab studies were within normal limits. The computed tomography (CT) scan of the neck revealed a parotid gland tumor. A total right parotidectomy with sacrifice of the facial nerve was carried out. The final pathologic diagnosis was consistent with acinic cell carcinoma and the facial nerve showed fibroneural tissue with tumor deposits. The patient refused chemotherapy so only radiation was given for 6 months. Two years later, the patient came to the emergency department again with complaints of painful right mandibular swelling associated with dyspnea, facial plethora and edema. The CT scan of the neck and chest with intravenous contrast revealed an abnormally enhancing lesion with a necrotic center at the site of the right parotid bed extending into the right preauricular subcutaneous fat. It also showed a right suprahilar lung mass with massive mediastinal adenopathy invading the superior vena cava and right pulmonary artery [Figure 1]. Histopathology of the biopsy specimens of the mass in parotid bed and right lung mass and the clinical presentation together were consistent with a diagnosis of SVCS secondary to recurrent acinic cell carcinoma of the parotid gland [Figure 2a and b]. The patient refused chemotherapy and hence was discharged home on pain relief medication and palliative radiotherapy for symptomatic relief. She is currently under hospice care. Management for SVCS associated with malignancy involves both treatment of the underlying malignancy and relief of the obstructive symptoms.[3-5] In our patient, palliative radiation therapy was initiated to reduce

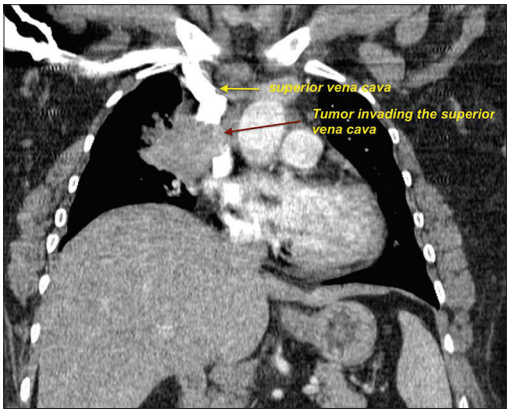

Figure 1: Computed tomography scan demonstrating a right suprahilar lung mass with massive mediastinal adenopathy invading the superior vena cava and right pulmonary artery

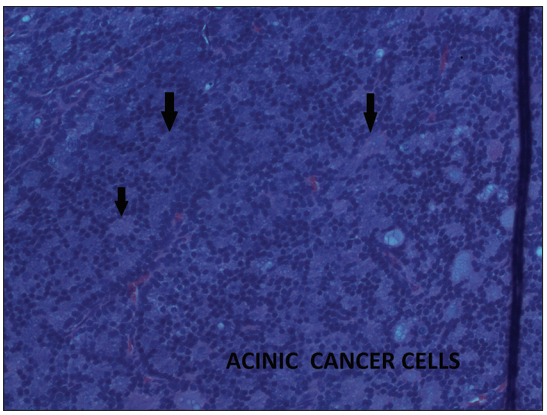

Figure 2a: Photomicrographs of tissue biopsy from parotid bed showing acinar arrangement of malignant tumor cells (H and E, x100)

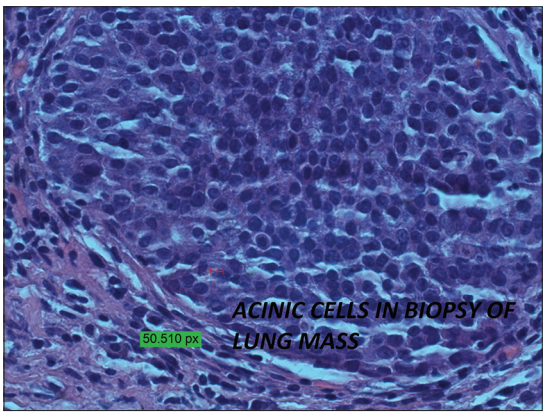

Figure 2b: Photomicrographs of tissue biopsy from the lung revealing acinar differentiation of malignant tumor cells (H and E, x200)

hydrostatic pressure and edema of the face. Patients with this condition usually have a poor prognosis and median life expectancy is approximately 6 months.[4]

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