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Case report

Masticator space metastasis from a male breast carcinoma: A case report[☆]

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ABSTRACT

The aim of this case report is to highlight the importance of clinical examination, the correct treatment modalities and effectiveness of multidisciplinary approach in managing a metastatic jaw tumour with poor prognosis.

A 60 year old male patient reported with complaints of trismus and pain in the Lt side of the face for the past eight months. Patient gave history of multiple teeth extraction. Case was initially diagnosed as chronic osteomyelitis mandible secondary to submasseteric infection. The lump in the left breast was a suspicious finding which was further investigated using US and FNAC. The cytomorphological picture was suggestive of infiltrating ductal carcinoma. The 99mTc-MDP bone scan was done and showed multiple bony metastasis. The case was diagnosed as metastatic tumour of masticator space from carcinoma breast. The patient was in his terminal stage of illness with widespread metastasis. Palliative treatment was then instituted to reduce the pain. Patient's condition became worse and finally he succumbed to his illness.

Metastatic tumours to the jaws and oral tissues are uncommon and represent less than 1% of all malignant tumours affecting the oral cavity. The breast being a primary site for metastasis to a jaw bone in a male patient is a rare entity and less documented.

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1. Introduction

Metastasis, the process by which a malignancy spreads from a primary to a distant site, is responsible for the majority of recorded cancer-related deaths and metastatic tumours to the jaws and oral tissues are uncommon and represent less than 1% of all malignant tumours affecting the mouth [1]. Certain malignancies exhibit osteotropism or an extraordinary affinity to target and proliferate in bone, of which breast carcinoma is the most researched example [2]. The primary site of metastatic deposits to the jawbones in males is the lung, followed by the prostate, kidney, bone, and adrenals [3]. The breast being a primary site for metastasis into a jaw bone in a male patient is a rare entity. This is a unique presentation of a cytopathologically proven case of infiltrating duct carcinoma in a 60-year-old male patient who showed multiple bony metastasis to vertebra, pelvis and masseter region, with a purpose to alert

the clinician that swelling in the jaw bones in an elderly patient could be metastatic. Though in this case the treatment modality from there on was only palliative, correct diagnostic modalities had alleviated the patient from further hardship of blind treatments and helped USG to learn that simplest clinical sign like trismus can hint such a serious underlying condition. Therefore general dentist or dental specialist should obtain the patient's complete medical history and carefully evaluate unusual clinical and radiographic findings because these lesions are associated with a poor prognosis hence early detection is of extreme importance.

2. Case report

A 60-year-old male patient reported to Dept of Oral and Maxillofacial Surgery of this college with chief complaints of pain and limitation of mouth opening for the past eight months. The patient underwent extraction of lower anterior teeth four months back and left side lower molar teeth two months back following increased mobility. The socket healing was uneventful but his mouth opening progressively decreased with gradual increase in pain and stiffness in the left pre-auricular region. There was no history of fever, dysphagia, and hoarseness of voice, colic pain or haemoptysis. On examination diffuse swelling on the left side of the face was noted which was hard and tender on palpation (Fig. 1). Skin overlying was not fixed with any change in colour or laxity. There was no

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Fig. 1. Diffuse swelling Lt side of face.

regional neurosensory deficit or alopecia. Left side peri-areolar region showed single, sessile, lobulated and hyper-pigmented lump of approximately 5 cm × 4 cm in dimension (Fig. 2). The lump was hard, fixed and tender. There were multiple nodules in the left infra-mammary and infra-axillary region. Levels I, II and left axillary lymph nodes were palpable. Intraorally there were multiple missing teeth with poor oral hygiene. The inter-incisal opening was 5 mm. The mucosa was non-inflamed with no draining sinus. The socket healing was satisfactory. Routine blood and urine examination including liver and renal function test and blood sugar level were within normal range. Chest radiograph showed no abnormalities. Radiograph of jaw bone, PA view mandible showed ill-defined cortical plate and cotton-wool marrow space of the left gonial and ramus region. The case was provisionally diagnosed as osteomyelitis mandible following submasseteric space infection. CT, MRI and ultrasonography (USG) of middle third of the face were done to find the hard and soft tissue pathological changes. CT imaging showed irregular thickening of the cortical margin in left ramus region. The density, volume and configuration of left masseter muscle were also altered (Fig. 3). USG of the masseter region revealed thickened disorganised muscle fibres of left masseter that showed intermingling heteroechoic infiltration and oedema, suggestive of infiltrative pathology of masseter muscle. T1 and T2 weighed MRI of temporomandibular region showed loss in normal intensity of marrow space in the ramus with focal areas of cortical breach and periosteal reaction, with pterygoid and masseter muscles



Fig. 2. Hyper pigmented nodules peri-areolar and sub-axillary region.

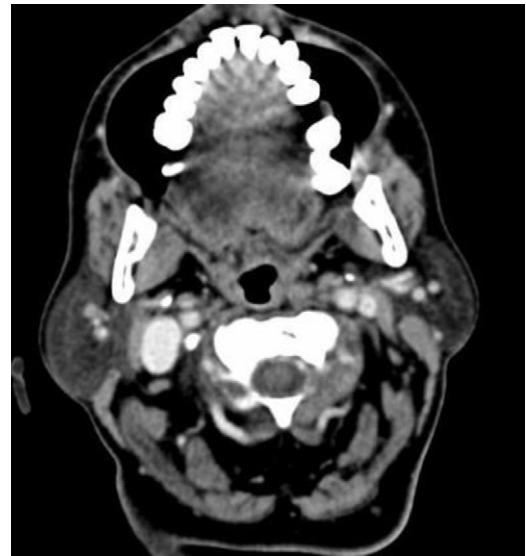


Fig. 3. Axial CT image showing infiltrative pathology of left masseter muscle.

showing pockets of necrosis and the antral lining was thickened, all suggestive of infective and infiltrative pathology of ramus extending into left masseteric space (Fig. 4). USG left mammary region and abdomen was done to detect the nature of the lump. The left retroareolar region on USG showed well defined lobulated solid hypoechoic mass of 11 mm × 28 mm in size. USG abdomen revealed normal liver, spleen, gall bladder, pancreas and prostate with no evidence of ascitis and no mesenteric or retroperitoneal lymph node enlargement. FNAC was done from left breast including periareolar nodules, nodes of left axilla and masseter region. The microscopic picture of the smear from breast lump showed oval to polygonal cells having scanty cytoplasm, large irregular pleomorphic nuclei, coarse chromatin and prominent nucleoli (Fig. 5). The smears from axillary nodes showed cells with lymphoglandular bodies (Fig. 6) and the smears from masseter muscle showed cells of similar morphology to that of breast lump (Fig. 7). The overall cytomorphology showed features of an infiltrating duct carcinoma of left breast with metastasis to skin ipsilateral axillary nodes and masseter muscle region. Now the attempt was made to

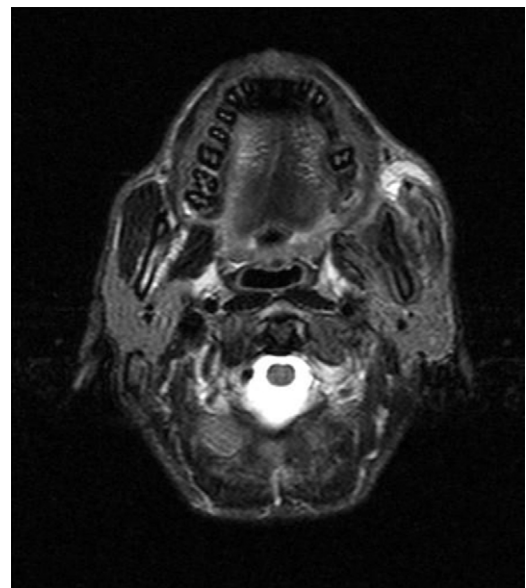


Fig. 4. MRI, axial section, showing focal areas of necrotic patches.

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