



SHORT COMMUNICATION

Sentinel lymph node biopsy in adenocarcinoma of minor salivary gland

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Summary Adenocarcinoma of the minor salivary gland (MSG) is a rare neoplasm. It represents about 2% of all MSG malignant tumours. It is more common in the palate and in females. This tumour occurs in a mean age of sixty and its mean size at presentation is 1.5 cm. Microscopically, the neoplasms classified as adenocarcinoma not otherwise specified (NOS) are a histologically heterogeneous group: they vary from highly anaplastic adenocarcinoma to moderate and well-differentiated lesions. This report describes a case of adenocarcinoma of MSG occurring in the buccal mucosa of a 24-year-old male. The patient underwent a sentinel node biopsy as a staging tool in association with the primary surgical treatment. In the histological examination of sentinel lymph node (SLN) there was no evidence of metastatic disease. The patient presents no evidence of recurrent disease after 4 years of follow-up. We believe that the use of SLN biopsy can be indicated in similar cases considering the tumoural biology (well-differentiated) because prospective randomized studies would be very difficult to be performed due to the rarity of this neoplasm.

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Introduction

Salivary gland tumours are uncommon neoplasms. There is no Brazilian estimate for this kind of tumour. An inci-

dence of 2.2–2.5 cases per 100.000 people is estimated annually in the United States, constituting only about 2% of all head and neck neoplasms.^{1,4} Nearly 80% of these tumours occur in the parotid glands, 15% in the submandibular glands and the remaining 5% in the sublingual and MSG.² There are approximately 450–750 MSG in the oral cavity. They are distributed in the palate, tongue, cheek, floor of mouth, tonsil, etc. Any submucosal nodule or mass in the oral cavity or in the nasopharynx and pharynx

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should be considered, unless otherwise proved, a MSG tumour, being the palate the most common site.^{1,5} It is difficult to know the real prevalence of benign and malignant MSG tumours because it depends on the institution that is doing the study. For example, in reference centres for cancer, malignant tumours are prevalent, while in other studies the benign neoplasms are more common.^{6,7} Adenoid cystic carcinoma and mucoepidermoid carcinoma are the most common malignant histologic types (about 55% of cases). Adenocarcinoma represents 2% to 4% of all cases, whereas only 3% of these neoplasms are low-grade adenocarcinoma.^{2,6} This kind of MSG malignant tumour is more often in the hard palate and frequently occurs in females (male-to-female ratio from 1:1.02 to 1:2).⁷ Tumours arising in the MSG are staged according to the anatomic site of origin (e.g., oral cavity and sinuses)^{2,4}. Treatment for adenocarcinomas includes conservative but complete surgical excision, neck dissection with clinical evidence of cervical lymph node metastasis. Postoperative radiotherapy may be beneficial in high-grade lesions, gross residual lesion or when the wide local surgical clearance is compromised.³ With the exception of polymorphous low-grade tumours, adenocarcinomas tend to recur locally. The prognosis depends on the size and grade of the primary lesion as well as on its histology, and if the tumour involves other adjacent structures. The biopsy of SLN has been done in some centres for parotid carcinomas, however there was not a description of this technique for MSG tumours.²⁻⁴ The main objective of this paper is to describe a rare case of a patient presenting well-differentiated adenocarcinoma of MSG treated with conservative surgery: a combination of complete resection of primary lesion and SLN biopsy followed by radiation therapy.

Case report

A 24-year-old man was referred with a complaint of a nodule in the internal face of the oral cavity for the period of 2 years. Previously, he asked for medical care and underwent lesion biopsy. The diagnosis was a well-differentiated adenocarcinoma of MSG. On examination, he presented a nodule of 1 cm with central ulceration and partially imprecise limits in the left cheek (Fig. 1). Lymph nodes were not identified in the neck region. The patient underwent a preoperative lymphoscintigraphy to identify the SLN. Technetium 99mTc-labeled human serum albumin was administered in the submucosal area around the lesion and lymphatic drainage patterns was established (Fig. 2). The SLN biopsy was performed using intraoperative gamma probe (Navigator GPS® – Tyco Healthcare Group LP, 2002) followed by intraoral resection with large margins of primary lesion and preservation of the cutaneous layer. The patient had nice postoperative recovery, and he was discharged after the first day. A microscopical examination of the tumour revealed features similar to the ones detected in the previous biopsy (Fig. 3) with free resection margins (deep margin of the 0.1 cm). Neither vascular nor neural invasion were identified. The SLN did not present metastasis. The patient underwent adjuvant radiation therapy



Figure 1 Intra oral lesion in the left cheek. Note the partially limited edges and central area with ulceration (arrow).

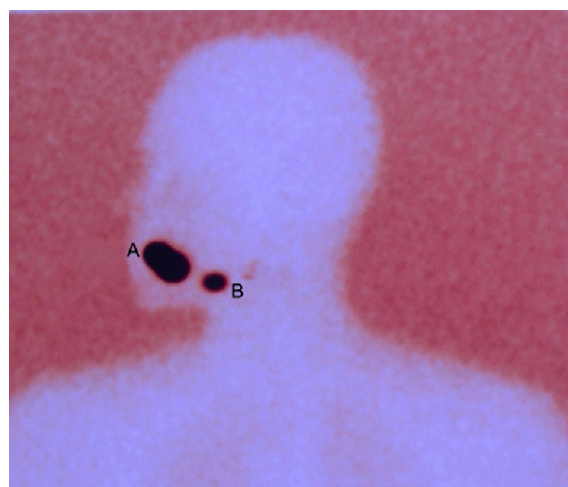


Figure 2 Lymphoscintigraphy showing the injection site of 99mTc (A) and lymphatic drainage for submandibular SLN (B).

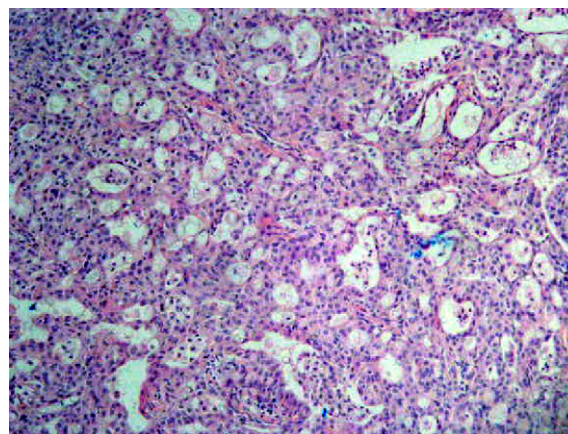


Figure 3 Histological aspect of the well-differentiated adenocarcinoma of MSG (H&E 100X).

apy (65 Gy during 6 weeks) having satisfactory evolution. No signal of relapse was identified in 4 years of follow-up (Figs. 4 and 5).

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