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Non-neoplastic lesions of the salivary glands: New entities and diagnostic problems

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Summary The histopathology of the salivary glands is a complex and difficult area of diagnostic pathology. In the latest WHO classification there are 40 named neoplasms many of which have variable histological features that can challenge even the most experienced specialist pathologist. In addition, the salivary glands can be affected by a range of non-neoplastic conditions, some of which have only recently been described. These often present clinically like tumours and may have pathological features similar to some of the neoplasms, making diagnosis difficult and errors serious. The purpose of this paper is briefly to review non-neoplastic lesions of the salivary glands and to aid the diagnostic pathologist by describing the key histopathological features of each. The entities covered include: sclerosing polycystic adenosis, cheilitis glandularis, salivary gland hyperplasias, necrotizing sialometaplasia, subacute necrotizing sialadenitis, non-neoplastic oncocytic lesions, salivary gland cysts, lymphoepithelial cysts, polycystic (dysgenetic) disease and HIV associated cystic disease.
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Introduction

The histopathology of the salivary glands is a complex and difficult area of diagnostic pathology. In the latest World Health Organization (WHO) classification[1] there are 40 named neoplasms, many of which have variable histological features that can challenge even the most experienced specialist pathologist. In addition, the salivary glands can be affected by a range of non-neoplastic conditions, some of which have only recently been described. These often present clinically like tumours and may have pathological features similar to some of the neoplasms, making diagnosis difficult and errors serious. The purpose of this paper is briefly to review non-neoplastic lesions of the salivary glands and to aid the diagnostic pathologist by describing the key histopathological features of each.

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Sclerosing polycystic adenosis

This is a recently described, rare, reactive inflammatory lesion of salivary glands that can simulate neoplasia both clinically and histologically.[2] The pseudoneoplastic appearances resemble those of benign fibrocystic disease of the breast. Of the 32 reported cases, only two have involved minor glands, two the submandibular gland while the remainder affected the parotid glands.[2–5] Most cases formed slow-growing, painless masses of less than 2 years' duration. Macroscopically most lesions were well circumscribed but unencapsulated, with a minority forming multifocal nodules. Microscopically the lesion is characterized by densely collagenized, sparsely cellular fibrous tissue surrounding ill-defined salivary gland ductal and acinar lobules and areas of cystically dilated ductal structures (Fig. 1). The latter are lined by epithelium which can be attenuated or hyperplastic and may show intraluminal papillary projections. In addition, the lining may contain mucocytes, vacuolated cells, sebaceous cells, apocrine cells and foci of squamous metaplasia (Fig. 2). In some areas interconnecting cellular bridges form a cribriform pattern and this is occasionally associated with hyaline globules of basement membrane material forming collagenous spherules. Areas of atypical hyperplasia of densely granular, eosinophilic acinar cells can be readily mistaken for acinic cell carcinoma. In some cases, ducts show dysplastic changes resembling in situ carcinoma and focal islands of similar cells have also been described.[3] However, the lobular architecture is preserved and a layer of myoepithelial cells has been described surrounding the ducts and lobules. There is a variable mixed chronic inflammatory infiltrate and, in some areas, xanthomatous macrophages are a conspicuous feature. One case with a significant lipomatous component has been reported and oncocytic change may be seen.[5]

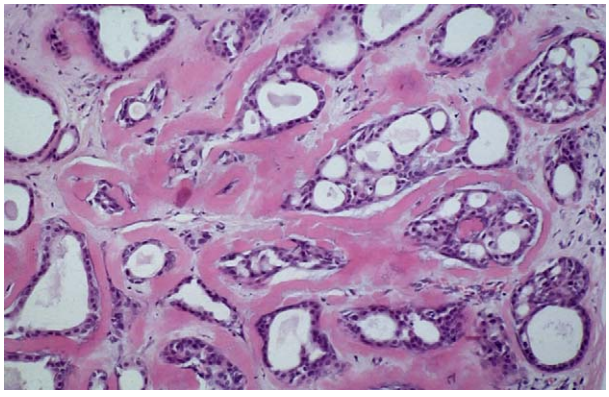

Figure 1 Sclerosing polycystic adenosis showing dilated cyst-like spaces and cells forming a cribriform pattern in a densely hyalinized stroma.

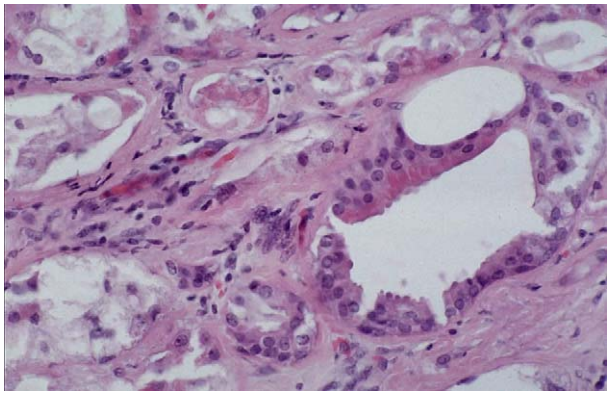

Figure 2 Sclerosing polycystic adenosis showing ducts lined by columnar, eosinophilic and vacuolated cells in a patchily inflamed fibrous stroma.

The most important differential diagnoses are acinic cell carcinoma, adenocarcinoma (NOS) and cystadenocarcinoma. The lobular nature of polycystic sclerosing adenosis, together with the presence of a peripheral myoepithelial layer and the lack of evidence of infiltration should prevent confusion.

The treatment of choice appears to be a complete but conservative local excision. About a third of cases with adequate follow-up, however, have recurred with intervals ranging from ~5–22 years and, in a few cases, the recurrences were multiple. Although these recurrences are probably due to the presence of multifocal disease, the relatively high rate, together with the presence of dysplasia and/or carcinoma in situ means that the possible neoplastic potential of this process has yet to be fully characterized.[4]

Cheilitis glandularis

This is a rare disorder originally described in the minor labial salivary glands and characterized clinically by swelling and focal ulceration. Similar lesions have occasionally been described elsewhere in the oral cavity and the alternative name of *stomatitis glandularis* has been proposed.[6,7] The large majority of cases affect the lower lip and there is a distinct preponderance in adult males. It has been classified into three types: simple, superficial suppurative and deep suppurative, which may represent part of a continuous spectrum.[8]

The initial lesion is typically an exfoliative cheilitis together with focal swellings of minor salivary glands with red or black puncta. These

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