CC is a locally aggressive tumor, and the preferred treatment is en bloc resection with the goal of achieving tumor-free margins.[21,24] Chemotherapy and radiotherapy have been used in a few cases, but their benefit is controversial.[21,27]

Prognosis is favorable, as CC is rarely associated with regional or distant metastasis.[24] Although recurrence is not expected,[19,24] when it does occur, pathologic transformation into conventional SCC is sometimes noted, resulting in a more aggressive clinical presentation.[21]

As is clearly highlighted in the current case, a definitive diagnosis of carcinoma cuniculatum is dependent on correlating the classic, but unusually bland, cytology of the lesion with the clinical and radiographic findings.

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CLINICOPATHOLOGIC CONFERENCE CASE 3: A 75-YEAR-OLD MAN WITH PROGRESSIVE RIGHT-SIDED HEARING LOSS AND DIZZINESS

N Said-Al-Naief, A Pourian, J Cure, R Lopez, Loma Linda University, School of Dentistry, Loma Linda, CA, USA; University of Iowa, School of Dentistry, Iowa City, IA, USA; University of Alabama, School of Medicine, Birmingham, AL, USA; Charlotte Radiology PA, Charlotte, NC, USA

Clinical Presentation: A 57-year-old man presented to the otolaryngology—head and neck surgery department by referral from a Veterans Affairs hospital for further evaluation of dizziness and lightheaded unsteadiness. This was accompanied by vague, nonspecific right-sided temporal bone and temporomandibular discomfort. He also had had progressive hearing loss since 1973 but denied any otologic or any other head and neck symptoms. Thorough head and neck evaluation found intact

cranial nerves II to XII except for decreased hearing on the right side. His vision was also normal. Review of his medical history found hypertension and diabetes mellitus. He was on insulin, omeprazole, citalopram, metoprolol, metformin, potassium, enalapril, and meclizine. He also reported the surgical removal of a right heal spur several years ago with uneventful healing. The physical examination was within normal limits. Examination of the oral cavity and oropharynx demonstrated no abnormalities, and examination of the neck found no palpable lymphadenopathy, thyromegaly, or masses noted. Similarly, the examination of the external auditory canals was clean, and the tympanic membranes appeared translucent and mobile. There were no middle ear effusions, and the nasal passages were clear. However, he underwent an audiogram, which found a profound right sensorineural hearing loss. He does not use any tobacco products and does not drink alcohol. Additionally, there were no known drug allergies to report. Family history was positive for hypertension and diabetes mellitus, and he had a half-brother who was diagnosed with a brain tumor, but he did not recall the exact type.

Axial computed tomography (CT) without contrast found marked endosteal scalloping of the right posterior petrous bone centered over the retrolabyrinthine area, and a slightly enlarged adjacent vestibular aqueduct with respect of mastoid (Figure 3-1). At magnetic resonance imaging, a 3-cm, expansile, well-circumscribed mass could be seen arising from the right petrous bone with an exophytic component extending into the cerebellopontine angle. The mass appeared heterogeneous on both T1- and T2-weighted images, with focal high signal intensities, possibly owing to subacute hemorrhages. The lesion encroached on the vestibular aqueduct. On T1, the majority of the lesion was isointense with the cerebellum, with a nodular area of hyperintensity, which may represent blood- or protein-filled cysts (Figure 3-2). The lesion is mostly hyperintense on T2, with intensity equal to that of the surrounding cerebrospinal fluid, except for a focal nodule centrally (Figure 3-3).

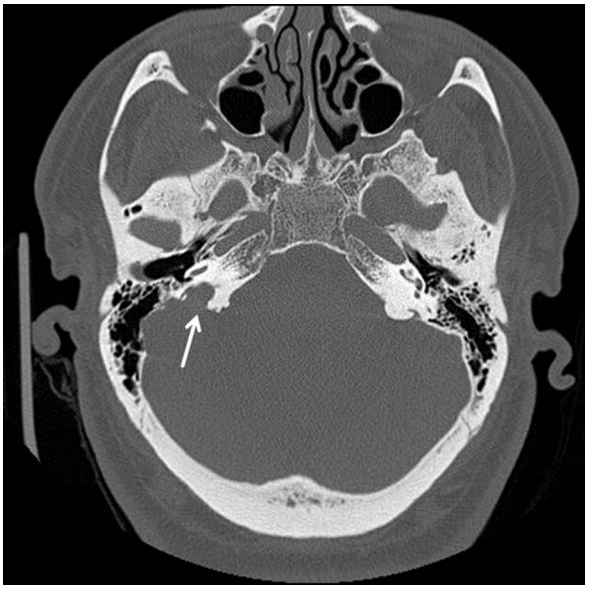

Fig. 3-1. An axial computed tomography scan without contrast showing marked endosteal scalloping of the right posterior petrous bone at the cerebellopontine angle (arrow) and a slightly enlarged adjacent vestibular aqueduct with respect of mastoid.

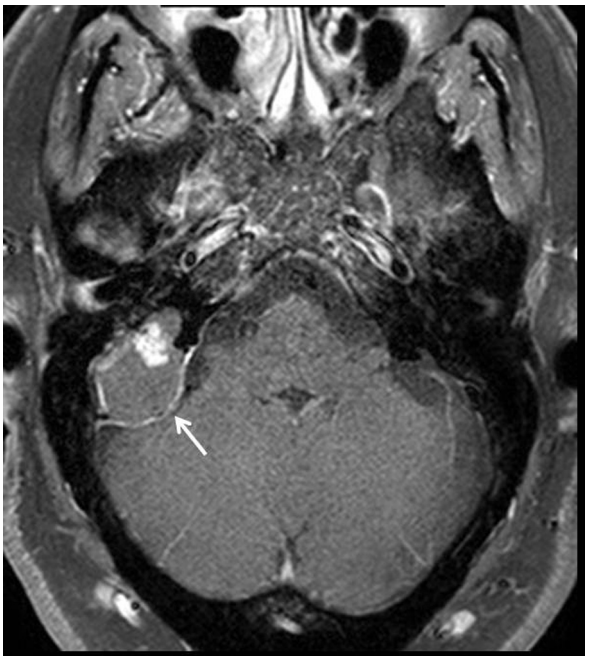

Fig. 3-2. Axial T1-weighted magnetic resonance imaging scan with no contrast, showing a well-demarcated isointense lesion (to dura) (arrow) in the right cerebellopontine enclosing distinct hyperintense foci.

Differential Diagnosis: Considering the radiographic and histomorphologic pattern combined, a thorough clinical,

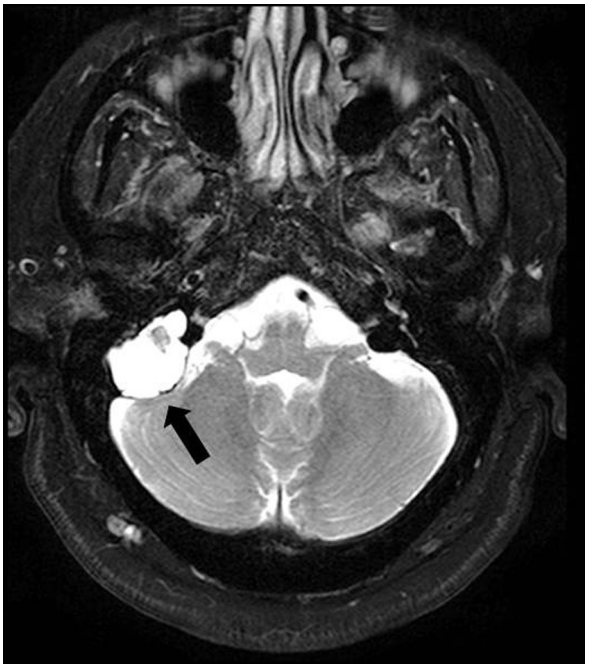

Fig. 3-3. T2-weighted postgadolinium magnetic resonance imaging scan showing a well-circumscribed lesion present in the right cerebellopontine angle with heterogeneous enhancing signal with the exception of a central hypotenuse nodule (arrow).