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Case Report

Giant epithelioid hemangioma of the external auditory canal: Role of imaging in clinical management

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ABSTRACT

Being uncommon neoplasms of elusive origin, epithelioid hemangiomas are benign vascular tumors found in young adults.¹ These epithelioid hemangiomas are mostly found in the head and neck region, presenting as solitary or multiple lesions, and they vary between 2 and 3 cm in diameter, and morphologically manifest as intradermal papules or subcutaneous nodules.² More eloquently termed as angiolymphoid hyperplasia with eosinophilia on pathological basis, these tumors are amenable to surgical excision, though rare instances exist where they might regress on their own.³ A 23-year-old male, who we report, had a bizarre unusual presentation with an extremely large mushroom shaped mass occluding the left external auditory canal. He had considerable facial disfigurement, pulsatile tinnitus and unilateral deafness. Even though it was clinically thought to be a malignant mass, cross sectional imaging gave clue to its highly vascular yet benign nature. Despite its large size, the tumor did not cause osseous destruction and had simply traveled into adjacent anatomical structures and overlying subcutaneous tissues and skin. The characteristic histologic picture was pathognomonic. This case report highlights the unusually large size and atypical clinical presentation of the tumor.

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1. Introduction

Angiolymphoid hyperplasia with eosinophilia (ALHE) is a benign, locally proliferating tumor with a predilection for the periauricular area and scalp. The nodules are usually 2–3 cm in diameter, though rarely, larger and deeper neoplasms may

occur. These tumors can cause significant morbidity because of recurrent bleeding, pain, and disfigurement.^{1–3}

We report a case of epithelioid hemangioma, which occurred in a 23-year-old male, in whom it was thought to be malignant because of its overwhelming gross appearance (Fig. 1), and yet, when evaluated on computed tomography (CT) and magnetic resonance imaging (MRI), the benign highly

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Fig. 1 – Large, pink, glistening, lobulated, firm mass of 5.4 cm × 5.3 cm occupying and overlying the left external auditory canal and causing a lateral displacement of the pinna.

vascular nature of the tumor was elicited. On the basis of these findings, the lesion was surgically excised, and the histopathology of the specimen left the issue in no doubt.

2. Case report

This 23-year-old male, who came from north India, presented to the Department of Otorhinolaryngology with a large

lobulated pinkish painless left ear tumor. First noticed as a small nodule about 2 years prior, when the patient had met with a road traffic accident, the tumor had, since then, increased progressively in size, until advancing to its present ungainly size, when it blocked the left external auditory canal (EAC).

The patient had complaints of facial disfigurement, pulsatile tinnitus and unilateral deafness. He did not have bloody or purulent ear discharge, pruritus or otalgia; also this patient had no fever, headache, nausea, vomiting, giddiness, facial asymmetry, loss of appetite, or loss of weight. His physical examination demonstrated a 5.4 cm × 5.3 cm firm, non-tender, swelling with a smooth surface occupying and overlying the left EAC (Fig. 1). The mass was displacing the pinna laterally, while its medial extent could not be defined. The mass obscured the left tympanic membrane. Left sided cervical lymph nodes were palpable. No neurologic deficit was observed. Right sided otoscopy was normal. A left sided conductive hearing loss with an air-bone gap of 47 dB was observed on a pure tone audiogram. Weber test at 512 Hz lateralized to the left, and Rinne test suggested greater duration of bone conduction than air conduction. The total and differential blood counts were

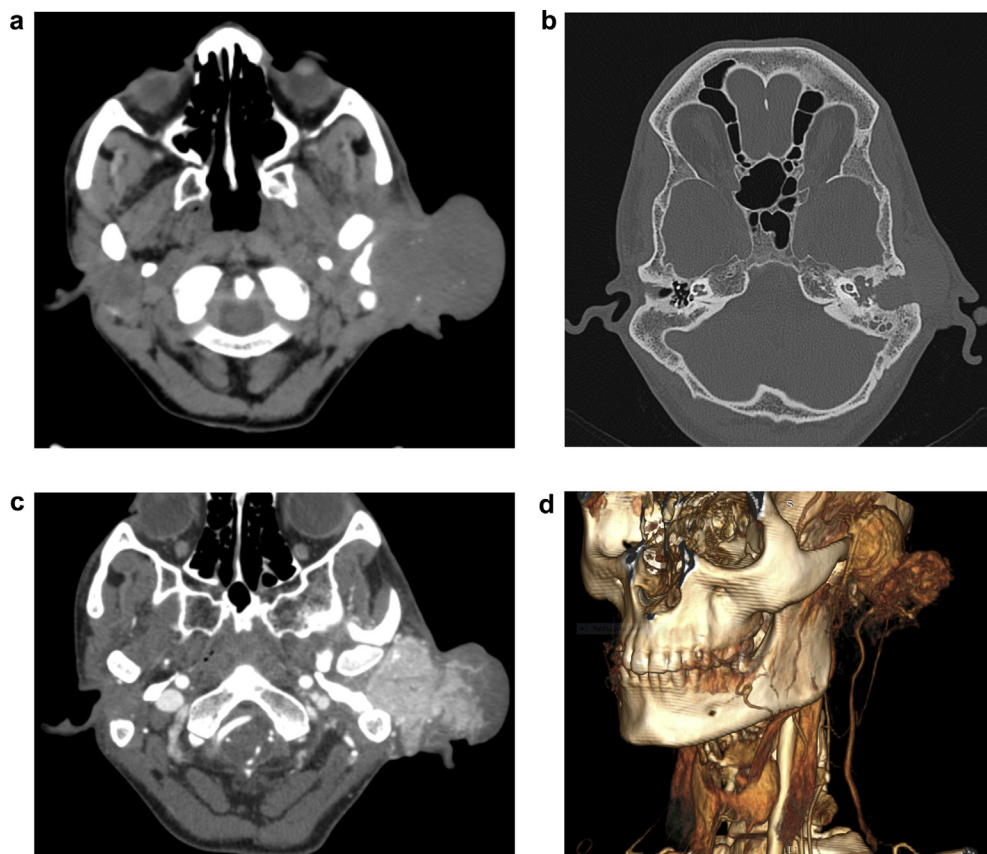


Fig. 2 – (a) Pre-contrast CT (axial): large, 6.6 cm × 5.8 cm × 4.8 cm, soft tissue density mass with multiple hyperdense calcific foci filling the left EAC, middle ear cavity, and mastoid sinus. The mass had a lobulated external component, emerging from the EAC. (b) Lesion is causing widening of external auditory canal with remodeling and erosion of anterior and posterior wall of EAC, posterior wall of glenoid fossa and mastoid part of temporal bone. (c) Post-contrast CT (axial): avidly enhancing vascular mass filling the left EAC, middle ear cavity, mastoid sinus and emerging outside the EAC. A lobulated external component is seen protruding outside through the EAC. (d) 3-D volumetric reconstructed image obtained from a CTA after IV contrast correlates well with the physical findings demonstrated in Fig. 1 and also demonstrates the extensive vascular supply of the tumor, primarily from the posterior auricular and superficial temporal branches of the left external carotid artery.

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