Case Report

A rare case report of pleomorphic adenoma of the upper lip: An unusual clinical presentation

ABSTRACT

Pleomorphic adenoma is the most common salivary gland tumor which accounts for about 60% of all salivary neoplasms. It is also known as "mixed tumor because of its wide cytomorphologic diversity". Pleomorphic adenoma salivary glands mostly occurs on the palate, but the involvement of the upper lip is rare. The present report describes a case of a 62-year-old male with asymptomatic firm nodular swelling attached with upper lip which was later diagnosed as pleomorphic adenoma in the excisional biopsy.

Keywords: Minor salivary gland tumor, mixed tumor, pleomorphic adenoma, upper lip

INTRODUCTION

Salivary gland neoplasms account for 2%–6.5% cases of all head-and-neck malignancies.[1] Pleomorphic adenoma is the most common salivary gland tumor and accounts for about 60% of all salivary neoplasms.[2] About 80% of pleomorphic adenomas arise in the parotid, 10% in the submandibular gland and 10% in the minor salivary glands of the oral cavity, nasal cavity and paranasal sinuses and the upper respiratory and alimentary tracts. Minor salivary gland tumors are rare and constitute 15%–20% of salivary gland neoplasms. The hard palate is the most common site among minor glands accounting for approximately 50%–60%, followed by the upper lip (15%–20%) and buccal mucosa (8%–10%). The importance of lesions lies in the fact that they are more likely to be malignant when associated with minor salivary glands.[3,4] Patients with pleomorphic adenomas of minor salivary glands usually present in the fourth to sixth decades with a slight predominance in female patients. The unknown etiology of pleomorphic adenoma (PA) is still found to be elusive. It is epithelial in origin, and clonal chromosome abnormalities with aberrations involving 8q12 and 12q15 have been described.[5] This case report describes diagnosis and management of an asymptomatic, slowly growing, firm mass with origin in the upper lip of an old edentulous male thereby reporting a common neoplasm in an unusual site.

CASE REPORT

A 65-year-old edentulous male presented in outpatient department of our hospital for the fabrication of complete denture with a complaint of the painless, mobile hanging mass originated from the middle of the upper lip from the past 15 years when the patient was having teeth. This swelling got slowly increased in size from the past 5 years after the full mouth extractions. At the time of presentation, mouth opening was obstructed by the mass like the hinged barrier originating from the vermillion of the upper lip and completely obliterating the upper vestibule. On clinical examination, there was a well-defined, round, hard, non-tender, non-fluctuant, non-pulsatile, firm consistency

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mobile mass with a size of approximately 3 cm × 5 cm in diameter. The mass was on the middle of the upper lip with attachments toward the right side. The pink color of the overlying mucosa was showing unanimous evidence of superficial vascularity. Figure 1 shows the preoperative view of the tumor for the abovementioned lesion. The skin over the tumor was not fixed. There was no remarkable medical history. X-ray PA mandible obtained which revealed no bony involvement. FNAC was performed, which was suggestive of PA. All preoperative blood and urine investigations were within normal limits. The well encapsulated and mobility in relation to the tumor was showing its benign nature therefore the excisional biopsy was planned for final diagnosis and management. The tumor was completely excised with lip splitting incision with careful dissection and attained the clinically normal margin because the mass was fully encapsulated. The excised mass was 3 cm × 5 cm [Figure 2]. After complete excision of tumor, surgical wound was closed in layers in a tension-free watertight closure with 3-0 silk suture. The excised mass [Figure 3] was sent for histopathological examination and confirmed for PA. The patient’s postoperative course was uneventful [Figure 4]. The healing after 2 weeks was satisfactory. Subsequent follow-up after the 1st and 2nd year showed no signs of recurrence.

Histopathology
Histopathologic examination shows subepithelial capsulated neoplasm of salivary gland origin [Figure 5a-d].

DISCUSSION
Pleomorphic adenoma arising from minor salivary glands of the lips starts at an earlier age compared to other sites. Bernier found the peak incidence of pleomorphic adenoma of the lips was in the 3rd and 4th decades, with an average age of 33.2 years [6] although in our case the origin of the nodule started at the age of 42 years and clinically manifested as slow-growing, painless, firm growth and expanded to the above said size in 20 years. From the past 20 years, patient has gone for multiple extractions by some local quacks nearby.

Figure 1: Preoperative photograph of the lesion
Figure 2: Posteroanterior projection radiograph
Figure 3: Excised mass
Figure 4: Postoperative photograph
Figure 5: Histopathological examination reveals. (a) Well encapsulated subepithelial tumor mass composed of ductal and myoepithelial cells arranged in varied pattern. (b) hyalinized areas with intermixed ductal structures filled with eosinophilic coagulum. (c) Plasmacytoid cells with intervening stroma. (d) Spindle cells arranged in sheets with interspersed small and large vessels filled with red blood cells.

villages considering the swelling as possible cause due to infected teeth in the upper jaw and later on lower teeth due to constant traumatic ulceration to the upper growth. There is a propensity for the benign tumor to occur in the upper lip may be due to differences in embryonic development between upper and lower lips,[7] whereas malignant lesions to predominate in the lower lip.[8,9] We have reviewed the few clinical differential diagnosis of a swelling of the upper lip, as likelihood like in Canalicular adenoma, pleomorphic adenoma, lipoma, fibroma, adenoid cystic carcinoma, mucocoeidermoid carcinoma, and nasolabial cyst. The most successful treatment for PA in major salivary glands is the surgical excision of the tumor with the involved lobe or the entire gland depending upon case. In our case, the tumor was excised en mass with disease-free margins. Our case was also being followed up for 2 years without any evidence of recurrence.

CONCLUSION

Though the Solid mass with a long history of its presence is pointing toward the benign tumor, further clinical and thorough histopathological examination and differentiation is extremely important keeping in view of leaving the important findings which may lend up into misdiagnosis. Such tumors are usually encapsulated so excisional biopsy with adequate surrounding tissue margins should be the treatment of choice.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understand that name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

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