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Squamous Cell Carcinoma of the Parotid Gland: Report of a Rare Case in an Old Lady with Complete Cure.

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Abstrasct: *Malignant neoplasms of the salivary glands are relatively rare, accounting for approximately 6% of all head and neck malignancies. True primary SCC of the parotid gland is even rarer (0.3-1.5 %) but SCC involving the salivary gland is much more common. This paper reports a case of parotid gland squamous cell carcinoma in an old lady and describes its management. An old lady presented with swelling in the rt.Parotid region with no other significant complaints.*
In depth knowledge of the anatomical course of the facial nerve though the parenchyma of the gland is mandatory in dealing with Parotid surgeries.
Key Words: *Parotid gland, Facial Nerve, Squamous cell carcinoma.*

I. Introduction:

Parotid means "near the ears" hence the name parotid gland. Of all the cancers treated by head and neck oncologists, malignant salivary gland tumours are arguably the most difficult. Patients are not infrequently young and cure rates are very poor for most histological types. The most common tumor among all salivary tumors ismucoepidermoid carcinoma (29.3%), less common is SCC (6%). Little is known about specific environmental or genetic risk factors that contribute to the development of salivary malignancy. The other related agents are ionizing radiation or radiation from atomic fallout, skin cancer, rubber industry, nickel compound, hair dye & silica dust etc.

We present one case report of SCC in parotid gland and advocate aggressive surgical resection with regional lymphadenectomy and postoperative radiation therapy.

II. Case Report

A 70 year old female presented with complaints of swelling over rt. Parotid region since 9 month withloss of weight and appetite ofsame duration. This female from lower socio economic status was on antihypertensive treatment since 5 years.

On clinical examination a swelling of size 6 ×4 cm, firm, mild tender, mobile was present in the parotid region. The skin overlying the swelling was stretched, shiny & hyper pigmented.

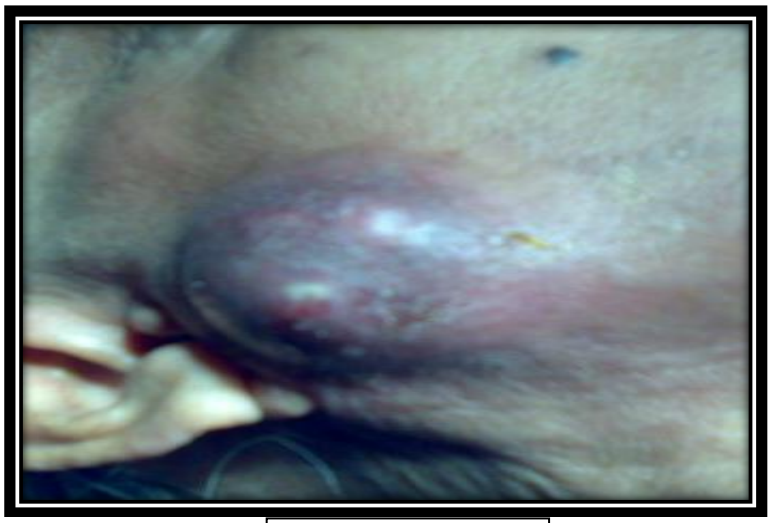

Fig1: Preoperative.

Her routine investigations were within normal range. All blood serology reports were negative. Ultrasonography of rt. Parotid gland showed intra parotid and cervical lymphadenopathy and neoplastic lesion in superficial lobe of rt. parotid gland(? malignant). Fine needle aspiration cytology findings were also favoring

the diagnosis of primary squamous cell carcinoma: CT scan showed ill demarked, markedly enhancing soft tissue mass at right parotid region in preauricular location appear to be arising / infiltration superficial lobe of rt. Parotid gland and rt. Cervical lymphadenopathy OrthoPantomography showed no mandible involvement.

After confirming the diagnosis the patient was taken for surgery. Informed consent, including risk, benefit and alternatives given to the patient and family & documented.

A modified face lift incision given with the lower limb of the incision extending forward along the line of relaxed skin tension in sub mandibular region by clearly separating and dissecting away the facial nerve, superficial parotid gland tumor and overlying skin removed in bulk. The skin defect was closed by split thickness skin graft taken from groin.Specimen send revealed PSCC on histopathology. Recovery was uneventful and patient is on regular follow up with us. Postoperative radiotherapy was given.

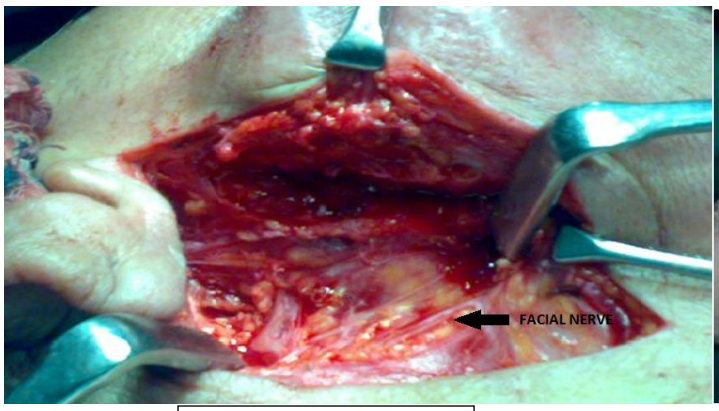

Fig 2: Intra operative

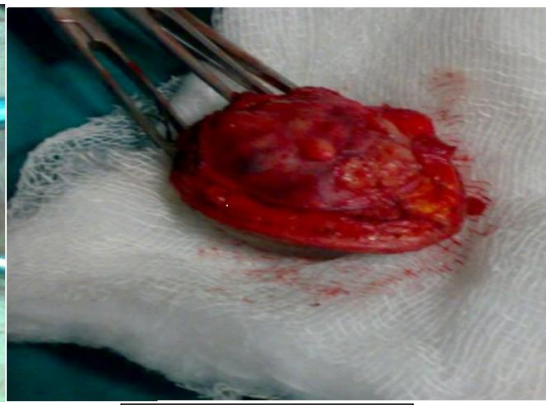

Fig3: Excised tumor

III. Disccussion

The common malignant neoplasm of major salivary gland[1]are mucoepidermoid carcinoma (36%), adenocarcinoma (14%) and adenoid cystic carcinoma (20%) and less common are SCC (6%) and other (6%).

Spiro[2]reported that primary squamous cell carcinoma of salivary gland makeup 4% (53 of 1278), of all salivary gland malignancies. Similarly primary SCC of parotid gland has been reported to comprised 0.9% to 1.8% of parotid tumors and 1.9 % to 6.9% of parotid malignancies[5,4]. Most patients are initially seen with mass without any other complaint and weakness of facial nerve in 17% to 58%, nearly half of all patientshave neck node metastasis at the time of presentation. Shemenand others [5]reported on 50 patients, with SCC origin in the parotid gland (42 of 50), distant metastasis occur in approximately 10% of patients shemen et al[6]when discussing prognostic factors noted that advance age, tumor fixation and lymph node metastasis associated with poor prognosis. FNAC is the main stage of early diagnosis and can have a sensitivity of 91% and specificity of 100%. Chest radiograph, MRI of head and neck, MRI of brain and chest to rule out any metastasis. Bone scan is not usually necessary[7], and obviously TNM staging is must.

Even the best postoperative radiotherapy is no substitute for adequate enblock resection.

If facial nerve is grossly involved it must be sacrificed and immediately nerve repair carried out. Surgical treatment is primary treatment modality followed post operative radiotherapy in most centers.

We currently advocate aggressive surgical resection and regional lymphadenectomy and postoperative radiation therapy.

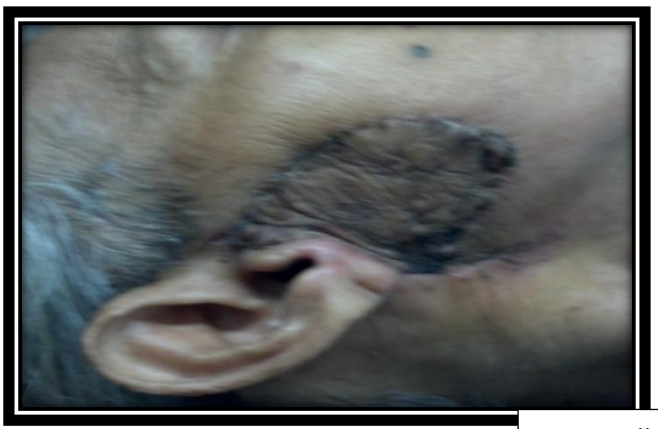

Fig 4: Follow up

IV. Conclusion

Primary squamous cell carcinoma of parotid gland is relatively uncommon, malignant tumors may enlarge rapidly and facial nerve paralysis is not uncommon. To conclude it is very important to have correct diagnosis of parotid malignancies, facial nerve involvement and its anatomy during parotid surgery, for proper outcome of management.

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