INTRODUCTION

Malignant neoplasms of the salivary glands are relatively uncommon; they account for less than 7% of head and neck cancers. Of these, about 10% have been diagnosed as the cystic adenoid carcinoma (CAC)1. This tumor is thought to originate from segment cells of the intercalar duct or the terminal tubular complex2. It commonly affects subjects between the fifth and seventh decades of life, and is closely related with smoking and alcohol intake. There is no racial preference, but the tumor affects mostly women. It typically grows slowly that usually presents clinically as a hard nodule or enlarged mass covered by intact mucosa3.

CASE REPORT

A brown male patient aged 48 years reported moderate pain in the left lower molar region for the past two months. The physical examination of the face revealed no facial asymmetry and enlarged local lymph nodes. On the intraoral examination, the vestibular mucosa along the left lower molars was normal and there was no mass. The oropharynx was hyperemic, and the mucosa was blackened along the lateral portion of the tongue; this area was somewhat hard and painful upon palpation. Orthopantomography revealed a radiolucent image in the periapical areas of the left lower second molar region (Figure 1A). Cone beam computed tomography showed a solid erosion, root resorption of the teeth in question canal (Figure 1A). Surgery showed a solid tumor with unclear borders and low density canal. Histopathology showing islands of hypercellular cells forming cribriform structures in which hyaline material surrounds tumor cells. The CAC is a slow growing neoplasm that generally manifests as an enlarged mass covered by intact mucosa; it is painful upon palpation and metastasizes late in the progression of the disease. Radical surgery is recommended, as this approach reduces the likelihood of metastases.

DISCUSSION

The CAC is a slow growing asymptomatic tumor, although in most cases there are palpation-induced painful events due in theory to the fact that this tumor is markedly neurotropic. In the present case the patient had moderate pain in the lower molar region, especially upon palpation. Perineural invasion is a common finding in this disease, but it is not a pathognomonic factor, as it arises in other salivary gland neoplasms such as in low grade polymorphic adenocarcinoma4. Histopathology in the present case revealed low grade polymorphic adenocarcinoma. Immunohistochemistry to confirm the diagnosis in fact resulted in a diagnosis of CAC.

Radical surgery combined with postoperative radiotherapy has been the treatment of choice according to some authors; this approach appears to reduce recurrence rates significantly compared with surgery alone5. This was the treatment in the present case, as the patient had a solid intra-osseous more aggressive tumor. This approach provides for local control but does not necessarily increase survival. Most authors agree that lymphatic neck dissection should be done only in cases where there neck metastases are clinically demonstrated6, which was not the case in this patient.

REFERENCES