

Pleomorphic adenoma of the hard palate

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DESCRIPTION

A 43-year-old woman reported to the outpatient department with complaint of painless swelling in palatal region since 9 months. On examination there was 3 cm×2.5 cm well demarcated swelling over hard palate in midline (figure 1). The overlying mucosa was intact but bulging at places. On palpation the swelling was non-tender, firm and fixed to underlying bone. There was no cervical lymphadenopathy. Fine needle aspiration cytology suggested benign tumour with features characteristic of pleomorphic adenoma. CT showed 3×2.4×2.3 cm swelling on midline hard palate with underlying bone resorption (figure 2). The patient was operated upon, under general anaesthesia. Wide excision of tumour with safe margin and drilling of under surface bone was done to avoid recurrence. There was no complication postoperatively and the raw area healed well within 1 month. There has been no recurrence in 1 year follow-up.

Salivary gland tumours account for less than 3% of the head and neck tumours.¹ Among all salivary gland tumours, pleomorphic adenoma is the most frequently encountered lesion, accounting for approximately 60% of all salivary gland neoplasms.² Pleomorphic adenoma is also the most common benign tumour of minor salivary glands and the palate is the most common site. The second most common site is the upper lip followed by buccal mucosa.³ It is also called mixed tumour because it has both epithelial and connective tissue elements.

Intraoral pleomorphic adenoma appears as slowly growing painless mass usually in the fourth or fifth decade of life. Patients typically present with a smooth painless enlarging mass. Although it is a benign tumour, it lacks fibrous capsule, thus has a tendency to be locally aggressive. In a small number of cases, a benign pleomorphic adenoma may degenerate into a malignant tumour. Simple enucleation of this tumour has a high local recurrence rate and thus treatment is wide local excision with the removal of periosteum or bone if they are involved. Rupture of the capsule or tumour spillage is also believed to increase the risk of recurrence, so meticulous dissection is important. The differential diagnosis includes palatal abscess, odontogenic and non-odontogenic cysts, fibroma, lipoma, neurofibroma, neurilemmoma and common intraoral diseases like condyloma acuminata, oral papilloma and squamous cell carcinoma. The palatal abscess or cyst will have fluctuation on palpation, the malignancy of minor salivary gland or of epithelium will often present with erosion of overlying mucosa and bleeding or pain, the benign growth-like torus palatinus will be bony hard on palpation and has irregular appearance, the tumour extension from nasal cavity or maxillary sinus may be ruled out on radiological investigation like x-ray paranasal sinus Water's view



Figure 1 Clinical photograph showing 3×2.5 cm intraoral midline palatal mass.

or CT. The soft tissue benign tumour can only be differentiated by the histopathological investigation like FNAC or incisional biopsy.

Learning points

- ▶ Intraoral pleomorphic adenoma appears as slowly growing painless mass, thus patients often seek medical attention late.
- ▶ Since the majority of minor salivary gland neoplasms arising in the palate are malignant, careful patient evaluation and a preoperative diagnosis of pleomorphic adenoma by cytopathology and radioimaging is advised.
- ▶ Complete surgical excision with a wide margin provides definitive diagnosis and treatment for this rare tumour.



Figure 2 Sagittal reconstructed CT image showing hard palate mass with underlying bone erosion.

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