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Pleomorphic adenoma of the nasal septum: a case report

M. Said*, A. Griscti-Soler*, J. M. Deguara**

ABSTRACT: Polypoid nasal lesions are commonly encountered in clinical practice and all should be examined histologically. We report here a case of pleomorphic adenoma arising in the nasal septum in salivary-type tissue. The interest of this case is both in the relative rarity of the condition, and also in its being the first such report in local practice.

*Dept. of Otolaryngology, St. Luke's Hospital, G'Mangia
**Dept. of Pathology, St. Luke's Hospital, G'Mangia

Correspondence: M. Said, Dept. of Otolaryngology, St. Luke's Hospital, G'Mangia

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Introduction

Salivary tumours occur in most secretory glands. The sites of origin generally conform to the density and distribution of seromucinous elements. Incidence by site of origin is highest in the face, and declines progressively the more distant the site.

Tumours arising in minor salivary glands are most commonly found in the oral cavity, particularly the palate, the cheek and upper lip, less usually the tongue and floor of mouth. Sporadic reports of these neoplasms regularly appear, being encountered at all sites in the respiratory tract, but also in the lacrimal gland, middle ear and external auditory meatus, breast, vagina, vulva and testis[1,2,3].

These salivary-type neoplasms are dominated by pleomorphic adenoma and adenoid cystic carcinoma. All others, benign or malignant, are rarely encountered and are usually biologically and histologically low grade[2].

Pleomorphic adenoma is the commonest tumour found, particularly in the sinonasal tract. The majority of intranasal salivary-type neoplasms originate from the mucosa of the bony or cartilaginous nasal septum, but they also occur on the lateral nasal wall. They may be found at any age, most reported cases occurring in the third to sixth decade.

Although there is no established sex predilection some reports suggest female predominance. No racial patterns have yet been described[4].

Patients commonly present with symptoms of nasal obstruction or the presence of a swelling within the nose, as well as recurrent spontaneous, often mild, epistaxis[5].

Macroscopically the tumours are polypoid typically broad-based swellings. Microscopically, although similar to mixed tumours of major salivary glands, these adenomas differ by being highly cellular (epithelial) with a minimal stromal component, often simulating more aggressive epithelial tumours. Awareness of this difficulty in diagnostic interpretation from an initial biopsy specimen is particularly important if unnecessarily radical surgery is to be avoided[6].

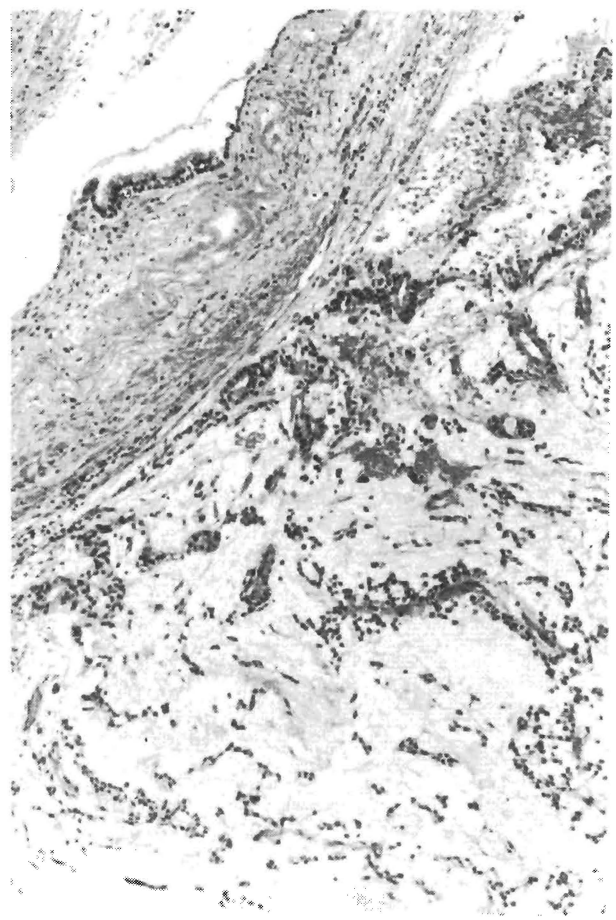

Fig. 1 Pleomorphic Adenoma. Strands of predominantly myoepithelial cells in a mucoid stroma with occasional glandular formulations. A connective tissue capsule is evident and respiratory type mucosa can be seen at the top of the picture

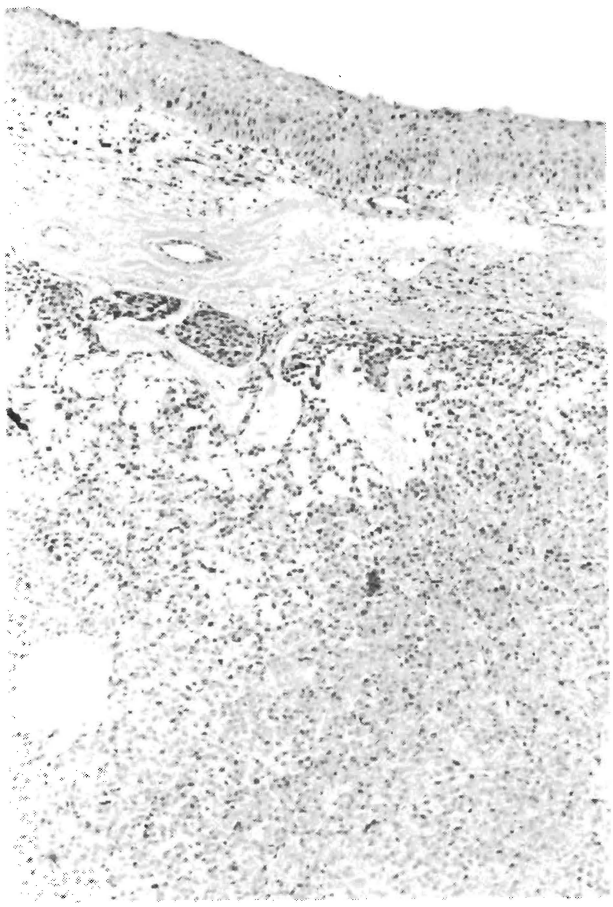

Fig. 2 Pleomorphic Adenoma. An area of this pleomorphic adenoma shows a solid appearance and consists of fusiform, polygonal and stellate epithelial cells, which cannot be clearly distinguished as ductal or myoepithelial. There are mucoid areas and a connective tissue capsule. The squamous stratified nonkeratinising mucosa of the nasal septum is clearly visible at the top of the picture.

Although the behaviour of these tumours is typically benign, there has been report of both lymphatic spread to regional nodes as well as more distant, haematogenous, dissemination[7].

Case Report and Discussion

We report here a case of pleomorphic adenoma of the nasal septum. The patient, a thirty-four year old otherwise healthy woman, presented with progressively increasing left-sided nasal obstruction and the presence of a swelling in the left nostril. In view of the clinically benign characteristics of the lesion, local excision biopsy was decided upon. The operation was carried out under general anaesthesia on the 22nd December 1994. At operation the tumour was found to consist of a firm lobulated mass 25mm x 15mm x 10mm, together with two smaller polypoid swellings 15mm x 5mm each. The lesion was noted to be arising from a broad base on the mucosa over the cartilaginous septum. The tumour together with an adequate margin of cartilage was excised completely.

Microscopically (Figs. 1 & 2), sections from the tumour showed a normal nasal mucosa with underlying connective tissue. In the deeper layers a lesion was noted consisting of cubical cells with regular nuclei, and some normal mitoses and in some areas the lesion was cellular and solid, in others there was an abundant mucoid stroma and dense fibrous tissue. The features are essentially those of a mixed (pleomorphic) adenoma arising in an accessory salivary gland.

Intranasal adenomata typically have a low rate of recurrence when compared with tumours of the oral cavity. The management of benign intranasal pleomorphic adenomata is essentially surgical, most authors agreeing that, regardless of the type of excision biopsy used, recurrence after surgery is unusual. Local, but adequate, excison would appear to be the treatment of choice[4].

At four weeks from operation the tumour bed had healed with no residual evidence of the original lesion, and at follow-up one year later the patient remained well and free from recurrence. This case is reported in view of the relative rarity of the lesion in the world literature and it being the first report of the condition in local otorhinolaryngologic practice.

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