The Journal of Laryngology & Otology, E6, 1 of 7.

doi:10.1017/S0022215110000861

Proceedings of the 137th Semon Club, 15 June 2009, Otolaryngology Department, Guy's and St Thomas' NHS Foundation Trust, London, UK

Chairman: Miss Elfy B Chevretton, Guy's and St Thomas' NHS Foundation Trust.

Secretary: Mr Sherif Haikel, Guy's and St Thomas' NHS Foundation Trust.

Invited panel for pathology: Professor Leslie Michaels and Dr Ann Sandison, University College London.

Invited panel for radiology: Dr Steve Connor and Dr Daniel Bell, Guy's and St Thomas' NHS Foundation Trust.

Professor Leslie Michaels awarded a prize for the best presentation of the meeting to Dr M Dastaran.

Otology and skull base session

Chairman: Mr Dan Jaing

Absent stapedius during stapedectomy

A O Abdelrahim, S A Hannan, R Quiney

From The Royal National Throat, Nose and Ear Hospital, London.

Introduction

The stapedius muscle, the smallest muscle in the body, develops from the second branchial arch. Middle-ear muscle anomalies are rare, and few cases of complete absence of the stapedius have been reported. Stapedectomy is a common operation for conductive hearing loss secondary to otosclerosis.

Case report

A 58-year-old woman was admitted for a routine stapedectomy for adult-onset conductive hearing loss secondary to otosclerosis. Intra-operatively, we were surprised to find complete absence of the stapedius muscle. In its place was a tiny fibrous strand connected to a rudimentary pyramid. No other anomalies were discovered. Surgery was otherwise uneventful, with a successful hearing outcome observed at follow up.

Discussion

None of those present at the meeting had encountered absence of the stapedius muscle or tendon. Dr Connor commented that, as a rudimentary pyramid was present, the structures may be atrophied rather than congenitally absent. Professor Michaels held the opinion that atrophy was a more likely explanation, due to advanced otosclerosis. He added that many pathological specimens with advanced otosclerosis show atrophy of surrounding structures. It was felt that a biopsy of the fibrous strand would have allowed further assessment. Mr Jaing highlighted the fact that the precise function of the stapedius muscle is not yet fully known.

Conclusion and lessons learned

Knowledge of embryological development and potential anatomical variations is essential for the practice of surgery.

Myoepithelioma of parotid gland presenting with facial nerve palsy

A Chakrabortty, A Sampson, P Kirkland

From Conquest Hospital, St Leonards-on-Sea, East Sussex.

Introduction

Malignant myoepitheliomas account for less than 1 per cent of all salivary gland tumours, with the majority of tumours occurring in the parotid gland. These tumours usually present as a slow-growing lump. The mean age of presentation is 50 years, and there is no sex bias.

Case report

An 80-year-old woman presented with a two-year history of right-sided, lower motor neuron facial nerve palsy. Several months later, she was noted to have a palpable lump in the parotid area.

Fine needle aspiration cytology (FNAC) in the clinic and ultrasound-guided FNAC of the parotid lump were reported as pleiomorphic adenoma. A magnetic resonance imaging scan confirmed the presence of a lesion in the deep lobe of the parotid gland, together with a level II lymph node. Both of these increased in size over the following three months.

An excision biopsy of the lymph node was performed. The histology report described small, malignant cells set in a myxoid stroma, with a high mitotic rate and pleiomorphism. Immunocytochemical staining was strongly positive for smooth muscle actin, suggesting a myoepithelial carcinoma.

The case was discussed at the regional multidisciplinary team meeting; palliative management was decided upon. A staging computed tomography scan showed multiple pulmonary metastases.

Discussion and conclusion

'A parotid lump with facial nerve palsy is considered malignant until proven otherwise', stated Mr Ian Hore, who also suggested that a core biopsy of the lymph node may have aided diagnosis.

Dr Sandison agreed that diagnosis of malignant myoepitheliomas remains a cytological diagnostic challenge. This opinion was seconded by Professor Michaels.

Spontaneous resolution of sensorineural hearing loss, facial paresis and hemifacial spasm

M Dastaran, S Haikel, M Gleeson

From Guy's and St Thomas' NHS Foundation Trust, London.

Case report

A 37-year-old woman was referred with a cerebellopontine angle tumour. She had presented with a two-month history of progressive, right-sided hearing loss associated with tinnitus, disequilibrium and ipsilateral hemifacial spasm

while hyperventilating. Examination revealed sustained nystagmus on left gaze, and moderate, right-sided facial weakness. Pure tone audiometry documented a right-sided, sensorineural hearing loss of 120 dB at frequencies over 1.5 kHz. Twelve months later, all signs and symptoms had resolved, and pure tone audiometry confirmed a return to normal hearing.

Radiological findings

Three consecutive magnetic resonance imaging scans over one year demonstrated no change in the tumour (which measured 9×3.5 mm), which had the imaging characteristics of a vestibular schwannoma.

Management

An approach of 'watchful waiting' was adopted.

Discussion

Facial weakness caused by an ipsilateral vestibular schwannoma is uncommon but usually slowly progressive. Recurrent facial palsy is more frequently associated with facial schwannomas or angiomas. Dr Connor felt that such lesions could not be distinguished from vestibular schwannoma on imaging. Hemifacial spasm is often caused by vascular malformations but may also be due to vestibular schwannoma. Degenerative changes caused by compression of the nerve by tumour render it more susceptible to iatrogenic damage during dissection, which could result in permanent facial paralysis.

Fluctuating hearing loss is occasionally caused by vestibular schwannoma. A preceding viral illness or concomitant Bell's palsy could not be ruled out as the reason for this patient's resolving facial weakness.

Hearing issues with bilateral vestibular schwannomas

J R Tysome, A Lee, A F Fitzgerald O'Connor

From Guy's and St Thomas' NHS Foundation Trust, London.

Background

The management of profound hearing loss in the context of auditory neuropathy is challenging, not least in terms of choice of implant.

Case report

A 20-year-old woman presented with progressive, bilateral hearing loss consistent with auditory neuropathy. She had a history of malignant peripheral nerve sheath tumours at T12 and C7, treated two and eight years previously. The last was complicated by a subarachnoid haemorrhage, resulting in complete visual loss and right hemiparesis.

Radiological findings

Contrast magnetic resonance imaging (MRI) scans showed bilateral enhancement of cranial nerves III, V and VII. Dr Connor held the opinion that the bilateral cerebellopontine angle masses were consistent with either vestibular schwannomas or malignant peripheral nerve sheath tumours. In this patient, there was no change in lesion size on serial MRI scans.

Management

Genetic testing was negative for neurofibromatosis types one and two. Excision of the left cerebellopontine angle mass was planned to establish diagnosis, with a translabyrinthine approach proposed to preserve the cochlear nerve and enable cochlear implantation. In order to improve hearing and in view of the auditory neuropathy, the insertion of a new split array implant (comprising a 10 electrode cochlear implant and a 10 electrode auditory brain stem implant) was planned.

Conclusion and lessons learned

The underlying diagnosis was not clear. In this auditory neuropathy case, it was difficult to establish the exact location of the defect. Therefore, the novel implant proposed was considered to represent the best chance for hearing rehabilitation. Mr Jaing reminded the presenter of the risk of damaging the cochlear nerve when excising cerebellopontine angle masses, and Dr Connor suggested that a tissue diagnosis may not be necessary. Mr S Habashi suggested a biopsy of the IIIrd cranial nerve as an alternative.

Paediatric session

Chairman: Mr Ian Hore

Intra-oral mass causing airway obstruction in a neonate

H J D North, C G Jephson, D M Albert

From Great Ormond Street Hospital for Children, London.

Introduction

Neonates are obligate nasal breathers, and respiratory distress is commonly due to nasal obstruction (e.g. due to rhinitis or choanal atresia). A rarer cause is an intra-oral mass such as a teratoma or hairy polyp.

Case report

A male infant born at $35 + 4$ weeks' gestation had respiratory distress at birth due to a large intra-oral mass. The child was intubated and transferred to a tertiary paediatric hospital.

Radiological findings

Magnetic resonance imaging confirmed the presence of a heterogeneous, partially enhancing, soft tissue mass with a fibro-fatty core, consistent with an oropharyngeal teratoma.

Histological findings

Professor Michaels described three germ cell layers: an ectodermal outer zone, an inner core of mesodermal fibro-fatty cells with islets of cartilage, and endoderm-derived notochord cells. This is consistent with a teratoma rather than a hairy polyp, which is derived from only two germ cell layers.

Management

The mass was successfully surgically excised on the fourth day of life, with an unremarkable post-operative course.

Conclusions

Teratomas are rare, occurring in one in every 4000 live births; 2 per cent of these occur in the oropharyngeal region. These masses should be managed with a Guedel airway or intubation, followed by surgical excision in a paediatric centre. Our case highlights the importance of examination of the oral cavity and oropharynx in cases of airway obstruction at birth.

Glottic granulation in a child with measles pneumonitis

V Chow, C Panagamuwa, I Hore

From Guy's and St Thomas' NHS Foundation Trust, London.

Background

The scourge of measles continues to be prevalent through Europe, despite an effective vaccine and childhood vaccination programme implemented over 20 years ago. With

https://doi.org/10.1017/S0022215110000861 Published online by Cambridge University Press

growing reports of endemic outbreaks throughout Europe, the World Health Organization's aim to eliminate measles from the European region by the year 2010 looks increasingly unrealistic.

Suboptimal uptake of the measles–mumps–rubella vaccination in the UK has resulted in the re-emergence of measles. Measles laryngotracheobronchitis (or croup), encephalitis and subacute sclerosing panencephalitis are some of the more life-threatening complications.

Case report

We present the case of an ex-premature (27/40 weeks), unimmunised, three-year-old girl who required intubation on the paediatric intensive care unit for measles pneumonitis. She developed florid glottic and subglottic granulation, with subsequent subglottic stenosis.

Radiology

An anterior-posterior chest X-ray demonstrated bilateral consolidation affecting all lung zones, together with paratracheal adenopathy, consistent with measles pneumonitis.

Histopathology

Granulation removed at microlaryngotracheoscopy showed fibrin infiltrated with neutrophils. A throat swab taken for viral polymerase chain reaction analysis confirmed the measles genome and viral RNA, consistent with endemic measles. Pernasal and throat swabs were taken for pneumococcal antigen testing, but were negative.

Management

At the time of writing, three further microlaryngotracheoscopies had been performed to remove granulation and to facilitate balloon dilatation of the larynx. The child had made a good recovery, without the need for tracheostomy. The use of steroids had been avoided at each procedure, as these are contraindicated in cases of measles to avoid further complications.

Intubation itself can lead to laryngeal granulation. However, with the increasing incidence of measles, this case highlights an additional potential cause.

Rapidly enlarging left facial mass causing gross disfigurement in an infant

N Ronan, C Jephson, B Hartley

From Great Ormond Street Hospital for Children, London.

Introduction

We describe a diagnostic challenge presented by a rapidly enlarging facial mass in an infant.

Case report

A 10-month-old, Afro-Caribbean boy presented with a two-week history of a firm, non-tender mass in the left maxillary region, growing rapidly and causing significant nasal blockage. The child was otherwise well.

Radiological findings

Magnetic resonance imaging and computed tomography showed a well circumscribed lesion arising from the left maxillary bone but not invading the skull base.

Histological findings

An incisional biopsy suggested a fibro-osseous lesion, but the resected specimen showed instead a fibroblastic proliferation. Some features were suggestive of aggressive fibromatosis, but the phenotype was unusual for this diagnosis. Therefore, the differential diagnosis was atypical myxoid aggressive fibromatosis or low-grade fibromyxoid sarcoma.

Management

The tumour was excised via a midfacial degloving approach. As both differential diagnoses have a high propensity for recurrence, the child was also commenced on chemotherapy.

Discussion and conclusion

Management of a facial mass in a child requires consideration of the technical challenges of surgery, as well as the need to avoid growth disturbance. Dr Sandison concurred that whilst the biopsy appeared benign, the resected specimen showed an aggressive appearance and behaviour.

Both aggressive fibromatosis and low-grade fibromyxoid sarcoma have a significant local recurrence rate, with high rates of morbidity and associated mortality.

Rhinology session

Chairman: Miss Claire Hopkins

Alternative treatment modality in a case of rhinocerebral mucormycosis

C Butler, K Kulendra, P Clarke

From Charing Cross Hospital, London.

Introduction

We present a case in which a novel alternative treatment modality was sought for a 59-year-old man who had failed standard therapy for extensive paranasal mucormycosis.

Case report

The patient presented with a six-week history of persistent, left-sided, facial headache and trigeminal paraesthesia. Deteriorating left eye vision prompted hospital attendance. A computed tomography scan demonstrated diffuse opacity in the left paranasal sinuses, with bony erosion. Subsequent nasal endoscopy revealed a fungating lesion, from which a biopsy was taken.

Microbiology

Histological analysis with India ink demonstrated broad, nonseptate hyphae with right-angled branching, confirming the infective agent as a rhizopus species, from the fungal order mucorales.

Management

After establishing optimal glycaemic control, the patient underwent further surgical debridement. Despite medical therapy with amphotericin B lipid complex (AmBisome), the disease progressed, prompting extensive resective surgery with maxillectomy and orbital exenteration. Attempted hyperbaric oxygen therapy was aborted due to poor patient tolerance. Treatment was further complicated by amphotericin B induced hepatitis. Medical treatment was converted to a minimal dose of AmBisome, continued together with the novel treatment of long-term antifungal posaconazole. One year later, there had been no further progression of disease. There was debate during the meeting as to the need for orbital exenteration.

Conclusion and lessons learned

Rhinocerebral mucormycosis is a challenging disease with a high mortality rate, despite aggressive and multimodal treatments. The efficacy of posaconazole is unknown. We present to the Semon club this novel adjunctive therapy

https://doi.org/10.1017/S0022215110000861 Published online by Cambridge University Press

as a possible effective treatment option, to be considered as part of the ENT surgeon's armamentarium.

Bilateral discharging ears and a nasal mass: a diagnostic challenge

S Muna, C Butler, E Benjamin
From Charing Cross Hospital, London.

Introduction

We present a case of an 18-year-old woman with features of chronic suppurative otitis media and an extensive nasal mass that proved to be a diagnostic challenge.

Case report

The patient had a long-standing history of bilateral hearing loss, ear discharge, nasal obstruction, fever and generalised malaise. Initial examination revealed chronic inflammatory ear changes, an extensive nasal mass and generalised cervical lymphadenopathy. Inflammatory markers were raised; however, classical antineutrophil cytoplasmic antibody tests were negative.

Radiological findings

A computed tomography scan confirmed the presence of a soft tissue nasopharyngeal lesion with bilateral retropharyngeal and cervical lymphadenopathy. Bilateral opacification of the mastoid antrum was seen, with features suggestive of ossicular erosion. A left upper zone pulmonary nodule was identified.

Histological findings

Biopsies of the ears revealed acute and chronic inflammation. A left post-nasal space biopsy revealed reactive lymphoid hyperplasia and a necrotising, granulomatous, inflammatory lesion.

Management

The above results prompted urgent tuberculosis treatment combined with high dose corticosteroids. Despite aggressive therapy, symptoms progressed over the following three months, prompting further biopsy. This was consistent with Wegener's granulomatosis, a diagnosis supported by a serial rise in classical antineutrophil cytoplasmic antibody levels. Treatment was changed to appropriate immunomodulatory medications, and the patient responded well.

Conclusions and lessons learned

Professor Michaels held the opinion that, in most cases, it is difficult to distinguish Wegener's granulomatosis from other forms of autoimmune vasculitis, and it is common for classical antineutrophil cytoplasmic antibody tests to be negative in early disease. He reminded the meeting of the importance of basing the diagnosis on clinical features such as the presence of lesions in the kidney and nose. This case was presented to the Semon club to highlight the fact that Wegener's granulomatosis may sometimes have an unusual presentation, making its diagnosis challenging.

Facial swelling: a complication of Wegener's granulomatosis (or so we thought)?

K Kulendra, C Skilbeck, P Andrews
From the Royal National Throat, Nose and Ear Hospital, London.

Introduction

We report an unusual presentation of extranodal, natural killer T-cell lymphoma in a patient with previously diagnosed Wegener's granulomatosis.

Case report

A 44-year-old Moroccan man presented to our ENT department with a three-day history of right facial pain and swelling, with green nasal discharge. Similar episodes had occurred on the left in the preceding four weeks, and had been treated with intravenous antibiotics and steroids.

The patient had been diagnosed with Wegener's granulomatosis following a nasal biopsy one year ago at his local hospital.

Examination revealed an erythematous swelling distorting the right nasolabial angle, with heavy crusting in the nasal cavity. The patient had anaesthesia of the nasal cavity and the first four right upper teeth.

Haematological tests were normal.

Radiological findings

Computed tomography scans of the patient's sinuses, performed one month apart, demonstrated progression of an extensive, irregular septal perforation, together with mucosal thickening of the maxillary and ethmoid sinuses. Soft tissue swelling was noted extending from the upper lip to the right nasolabial angle, with low attenuation, in keeping with necrosis. The findings were consistent with Wegener's granulomatosis, but the differential diagnosis included lymphoma and mucormycosis.

Histological findings

Histological analysis established the diagnosis of an extranodal, natural killer T-cell lymphoma.

Management

Initial management included intravenous co-amoxiclav and corticosteroids. The patient underwent decrusting, debridement and biopsy of his nasal cavity. Voriconazole was prescribed until the histological diagnosis was established, after which the patient was referred to the haematologists.

Conclusion

Inflammatory nasal conditions are difficult to diagnose. Malignant differential diagnoses should always be considered, even when patients have a pre-existing benign diagnosis.

A rare tumour of the middle turbinate

J Magill, R Hewitt, H Saleh
From Charing Cross Hospital, London.

Introduction

We report a 28-year-old man from Dubai who presented with right-sided nasal obstruction and facial swelling. Initial imaging suggested fungal rhinosinusitis; however, histological examination confirmed an ossifying fibroma of the middle turbinate.

Case report

The patient presented with persistent, right-sided nasal obstruction and facial swelling, with displacement of the globe. Clinical examination revealed a right-sided, polypoid nasal lesion. An initial computed tomography scan, undertaken abroad, was suggestive of fungal rhinosinusitis, although this diagnosis was revised following repeated imaging at our institution. The lesion was endoscopically removed. Histological examination was consistent with an ossifying fibroma.

Radiology

A well defined, 3×2 cm, calcified lesion was present in the right nasal cavity, displacing the medial wall of the right

https://doi.org/10.1017/S0022215110000861 Published online by Cambridge University Press

orbit laterally and the nasal septum medially. The appearance was consistent with a benign tumour of mesenchymal origin, although fibrous dysplasia could not be excluded.

Histology

Histological examination demonstrated polypoid, respiratory-type mucosa together with tissue composed of cellular fibroblastic stroma and containing calcified structures. There was a peripheral rim of reactive host bone, consistent with ossifying fibroma.

Management

Macroscopic clearance was undertaken endoscopically, with close follow up.

Conclusions

Ossifying fibromas rarely occur in the middle turbinate; only two previous cases have been reported. Although considered a benign entity, these lesions can be locally aggressive, and complete surgical excision is therefore recommended. This case highlights the importance of a multidisciplinary approach in order to establish the correct diagnosis and concomitant management.

Unilateral nasal obstruction and intermittent sinusitis over a year

H Elhassan, P Das, J Weighill

From The Royal Sussex County Hospital, Brighton.

Case report

A 20-year-old woman presented to the out-patients department with severe, right-sided nasal obstruction. She had developed continuous, purulent discharge from the right nostril and a swollen, watery right eye. Over the past year, she had been treated in primary care for intermittent sinusitis, unsuccessfully. A recent examination at the dentist revealed no pathology.

On examination, there was a right periorbital swelling that was not warm, red or tender. Right flexible nasendoscopy was not possible due to nasal obstruction from a displaced lateral wall. The left nasal cavity was normal.

Radiology

Computed tomography revealed an expansile mass in the right maxillary sinus containing soft tissue and a displaced tooth in the right antrum, with blurring of the right infraorbital rim. Dr Bell noted that the appearance of two separate bony layers was in keeping with a diagnosis of a dentigerous cyst.

Management

The patient underwent functional endoscopic sinus surgery and a right Caldwell–Luc procedure for excision of the cyst and tooth. Post-operative recovery was unremarkable.

Histology

Professor Michaels confirmed a non-keratinising squamous cyst.

Conclusion

Dentigerous cysts develop within the normal dental follicle enveloping the crown of an unerupted tooth. These benign cysts may grow to a large size, and are lined with non-keratinising squamous epithelia. Cysts usually develop from impacted or late-erupting teeth, and are twice as likely to occur on the mandible as the maxilla.

Therefore, an unerupted maxillary third molar (i.e. 'wisdom tooth') can lead to a dentigerous cyst presenting with unilateral nasal obstruction.

Head and neck section

Chairman: Mr Ricard Simo

An unusual parotid mass in a patient with chronic lymphoid leukaemia

R Sharma, B Fu, T Odutoye

From St George's Hospital, London.

Introduction

Leiomyosarcoma, a malignant neoplasm of smooth muscle, commonly affects the digestive tract, uterus and retroperitoneum. A primary leiomyosarcoma of the parotid gland is a very rare clinical entity, which to date has only been reported six times in the English language literature.

Case report

We present the case of a 74-year-old man with known chronic lymphoid leukaemia. Whilst under surveillance for this, the patient was referred to the head and neck department after a short history of a left parotid mass.

Radiological findings

Computed tomography (CT) showed a focal enlargement in the left parotid gland measuring 1.8 cm in diameter, along with cervical lymphadenopathy. This was initially believed to be related to the patient's chronic lymphoid leukaemia. Widespread lymphadenopathy of mediastinal and inguinal nodes was noted; this had been seen on previous surveillance CT scans.

Management

The patient underwent excision of the left parotid gland, followed by post-operative radiotherapy.

Histological findings

Initial fine needle aspiration cytology (FNAC) was inconclusive but showed features of giant cell carcinoma. Repeat FNAC demonstrated features consistent with leiomyosarcoma. The main resection showed a well delineated tumour which involved the parotid gland and extended into the subcutis and dermis. The overlying skin was not involved. The main tumour consisted of leiomyosarcoma. The deep margin also contained foci of chronic lymphoid leukaemia.

Conclusions

We present the seventh reported case of parotid gland leiomyosarcoma. To our knowledge, this is the first reported case of parotid leiomyosarcoma in a patient with chronic lymphoid leukaemia. It was decided that a magnetic resonance imaging scan would be of use in detecting peri-neural invasion. We also discussed the importance of full assessment of new neck lumps, irrespective of previous pathology.

An unlikely diagnosis in suspected squamous cell carcinoma of the soft palate

R Tavares, S Muna, P Clarke

From Charing Cross Hospital, London.

Introduction

We present a young patient referred with a suspicious lesion in the soft palate, extending into the left tonsil.

Case report

A 30-year-old male dentist presented with a one-year history of a painless, 4 cm, sclerotic, ulcerated lesion

https://doi.org/10.1017/S0022215110000861 Published online by Cambridge University Press

located on the soft palate and extending to the left tonsil. He had noticed increasing dysphagia one month prior to presentation. On examination, friable mucosa was found, with significant crusting. Microbiological analysis showed normal respiratory flora. The working diagnosis was squamous cell carcinoma.

Radiological findings

Computed tomography and magnetic resonance imaging (including repeated scans) displayed an abnormal, bulky left tonsil, with bilateral pathological, level II lymph nodes, supporting the clinical impression of malignancy.

Histological findings

Biopsy showed hyperplastic squamous epithelium with marked acute inflammation, overlying a subepithelial accumulation of clear cells containing Gram-negative, Giemsa-positive bacilli (klebsiella). This confirmed the diagnosis of rhinoscleroma.

Management

Ciprofloxacin antibiotic therapy was started. Three months into treatment, the lesion had shrunk and the patient's dysphagia resolved.

Conclusion and lessons learned

This was an unusual diagnosis in an uncommon location, which mimicked squamous cell carcinoma. Despite the patient's age and lack of risk factors, the correct diagnosis was delayed. This case highlights the importance of early referral to a specialist centre in the case of suspicious lesions in young patients, in order to enable a multidisciplinary approach.

Self-limiting parotid lump mimicking a pleomorphic adenoma

I Kwame, S A Hannan, C East

From the Royal National Throat, Nose and Ear Hospital, London.

Introduction

Nodular fasciitis is a benign proliferation of fibroblasts and myofibroblasts which rarely presents in the head and neck. We describe a patient whose pre-operative radiology and cytopathology results correlated with a diagnosis of pleomorphic adenoma of the parotid. The diagnosis was changed after parotidectomy.

Case report

A 26-year-old man presented with a three-month history of a left, non-tender parotid lump.

Clinical examination revealed a firm, hemispherical lump overlying the left parotid gland, with no overlying skin changes and no cervical lymphadenopathy.

After ultrasonography and fine needle aspiration cytology (FNAC), a left parotidectomy was undertaken for suspected pleomorphic adenoma.

Radiological findings

Ultrasonography revealed a well defined, $1.3 \times 0.8 \times 1.2$ cm, hypoechoic swelling within the left parotid gland.

Histological findings

The FNAC sample demonstrated a mixture of cells with eccentric nuclei together with spindle cells with sporadic long cytoplasmic processes. There were occasional fibrillar tufts, consistent with a pleomorphic adenoma.

Post-operative immunohistochemical analysis revealed a circumscribed, unencapsulated, extra-parenchymal nodule, comprising irregular bundles of spindle cells. These were positive for smooth muscle actin and cluster of differentiation 68 glycoprotein, confirming nodular fasciitis.

Management

The mass was completely excised.

Conclusion and lessons learned

Nodular fasciitis is a self-limiting process which should be considered as a differential diagnosis for suspected parotid pleomorphic adenoma. Professor Michaels commented about their similarities on FNAC. Immunohistochemical analysis may help distinguish the two entities, as pleomorphic adenoma stains positive for cytokeratin and S-100 protein, whilst nodular fasciitis is negative for both, but positive for smooth muscle actin and cluster of differentiation 68 glycoprotein. A high index of clinical suspicion may help avoid unnecessary parotidectomy.

A rare submandibular gland tumour

R Glore, P Sloan, D Meikle

From the Freeman Hospital, Newcastle.

Background

Small blue round cell tumours are uncommon malignancies in the head and neck region. We present a patient with such a tumour affecting the submandibular gland.

Case report

A 38-year-old man presented with a nine-month history of a right submandibular swelling associated with localised pain radiating to the right ear. He had been treated for acute myeloid leukaemia in 1998. Clinically, there was a firm, slightly tender, right submandibular gland. Ultrasound-guided fine needle aspiration cytology suggested malignancy. Total excision of the right submandibular gland and surrounding lymph nodes was performed.

Radiological findings

Ultrasonography and computed tomography of the neck revealed a mass within the inferior aspect of the right submandibular gland, together with a cluster of surrounding nodes but no sialolithiasis. The appearance was strongly suggestive of malignancy.

Histological findings

The differential diagnosis included desmoplastic small round cell tumour and extraskeletal Ewing's sarcoma. Cytogenetic staining for antibodies to the C-terminal of the Wilms' tumour protein was positive, suggesting a diagnosis of desmoplastic small round cell tumour. Histologically, one of the tumour resection margins was close, and the lymph nodes were free of malignancy.

Management

Management was discussed at the multidisciplinary team meeting. Due to previous chemotherapy for acute myeloid leukaemia, the patient was treated with adjuvant radiotherapy, and made a good recovery.

Conclusion

Immunohistochemical and cytogenetic studies have made it possible to differentiate desmoplastic small round cell tumour from other malignant small round blue cell tumours.

Recurrent parotid mass associated with acute facial nerve palsy

A Cunningham, M Elliott, R Simo

From Guy's and St Thomas' NHS Foundation Trust, London.

https://doi.org/10.1017/S0022215110000861 Published online by Cambridge University Press

Introduction

We present a case of a benign lymphoepithelial cyst in the parotid associated with facial nerve palsy.

Case report

A 50-year-old man was referred with a two-year history of a parotid mass and sudden onset, ipsilateral facial nerve palsy. On two previous occasions, ultrasound had demonstrated a parotid cyst, with benign cytology on aspiration. The patient was otherwise well, and a non-smoker.

On examination, there was a discrete swelling of the right parotid gland and a House–Brackmann grade IV facial palsy.

Radiological findings

Ultrasound demonstrated a 14×8 mm, cystic lesion. Fine needle aspiration cytology was inconclusive.

Post-aspiration magnetic resonance imaging found no mass lesion or cystic abnormality remaining in the parotid. However, there was asymmetrical enhancement of the right labyrinthine segment of the facial nerve.

Management

The patient was initially commenced on oral steroids and antivirals. His palsy improved to House–Brackmann grade III. He then underwent a right superficial parotidectomy with excision of level II lymph nodes and intra-operative frozen section.

Histological findings

Histopathological analysis demonstrated a lymphoepithelial cyst, with no evidence of malignancy in the primary tumour or the lymph nodes of the neck.

Conclusion

This case represents a rare presentation of a benign parotid lesion together with facial palsy, which we believe to be Bell's palsy, as supported by magnetic resonance imaging findings and clinical improvement prior to surgery. Discussion at the Semon Club concluded that the majority of those present would also have made this diagnosis.

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