

Case Report

Warthin's Tumour in Accessory Parotid Gland

Kazi Atikuzzaman¹

Abstract

The accessory parotid gland is salivary tissue separated from the main parotid gland and lying on masseter muscle. The accessory parotid gland is not rare, according to cadaver studies, but neoplasm in the accessory parotid gland is rare. Surgical excision is the treatment of choice for the accessory parotid gland tumour. It is important to identify the buccal branch of the facial nerve to avoid injury to the facial nerve. Herein we describe a case of accessory parotid gland tumor in a 30 years old lady. Histopathological diagnosis was Warthin's tumour which is very rare in female.

Key words: Accessory parotid gland, Warthin's tumour.

Introduction

The accessory parotid gland is salivary tissue separated from the main parotid gland and lying on masseter muscle. It has secondary duct emptying into the Stensen's duct. The accessory parotid gland exists in 21-61% of individuals.¹⁻³ However, the appearance of an accessory parotid tumor is rare, with a reported frequency of 1-7.7% of all parotid gland tumours.³ These small flat structures were once considered to be mere extension of the main parotid gland, but it is now known that they are independent glandular units with respect to their function and anatomic location. Herein, we describe a case of accessory Parotid gland tumor in a 30 years old lady. Surgical excision is the treatment of choice for the accessory parotid gland tumour. It is important to identify the buccal branch of the facial nerve to avoid injury to the facial nerve.⁴⁻⁷

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Case report

A 30 years old female presented to the ENT & Head-Neck Surgery department on 24th august,2011 with a left nontender mid cheek swelling. The swelling had been present for 5 years, with a recent increase in size. Physical examination revealed about a 2 cm firm, painless & mobile nodular mass in left mid cheek. Parotid gland and duct opening was normal and Facial nerve was intact. There was no cervical lymphadenopathy. Ultrasonography (USG) confirmed a solitary mass separated from the main parotid gland. Rest of the gland was normal. Pleomorphic

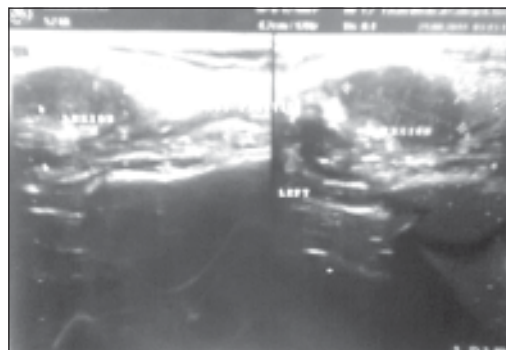


Fig.-1: USG showing Solitary mass anterior to & separated from the main parotid gland on left side. Rest of the gland is normal.

adenoma was diagnosed on the basis of fine needle aspiration cytology (FNAC).

Thus, a benign salivary gland tumor originating from the left accessory parotid gland was suspected. Surgical resection of the tumor was planned and performed using a standard pre auricular incision under general anaesthesia.

The Stensen's duct was identified and a secondary duct emptying into the main duct was found. The tumor was non continuous with the parotid gland. The buccal branch of the facial nerve was identified between the main parotid gland and accessory parotid gland (Figure 2A).

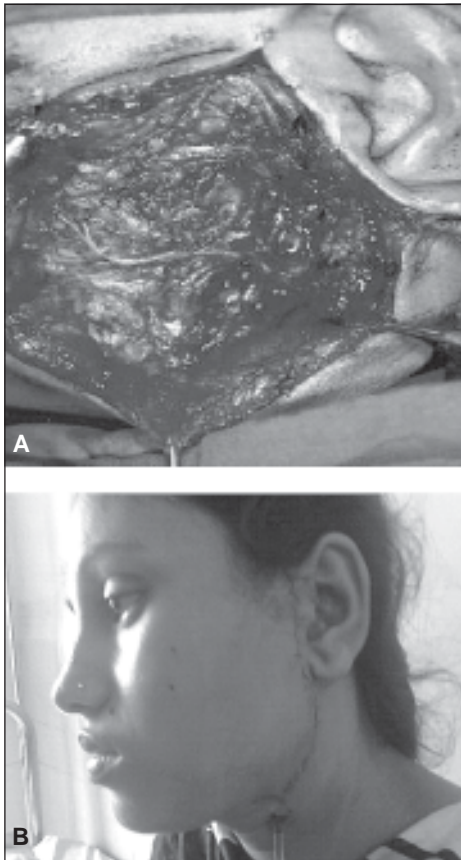


Figure 2: A) Intraoperative figure. Identification of the Stensen's duct, secondary duct and the buccal branch of facial nerve B) Postoperative picture of the patient

The tumor was bluntly dissected from the surrounding tissue without facial nerve injury. The tumor was removed en bloc together with the remaining normal accessory parotid tissue. The resected tumor measured about 15x10x8 mm. It was diagnosed histologically as warthin's tumour (Figure 3).

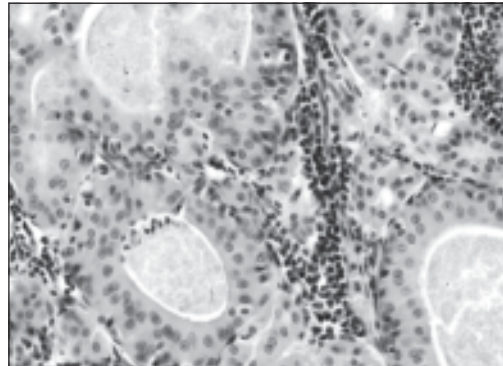


Figure 3: Multiple cystic spaces lined by a double layer of epithelial cells resting on a dense lymphoid stroma. (H&E stain)

Discussion

Among the benign parotid tumours, warthin's is the 2nd most common after pleomorphic adenoma.^{1,2} Warthin's tumour commonly occurs in middle aged male, 8times more in case of smokers. Females are less commonly affected and involvement of accessory gland is even rarer.¹

The accessory parotid gland exists in 21-61% of individuals.¹⁻³ However the appearance of accessory parotid gland tumour is rare, with a reported frequency of 1-7.7% of all parotid gland tumours.^{3,4} Generally, the tumour is asymptomatic initially, irrespective of the histological findings. This tumor is usually found at the midpoint of an imaginary line extending from the tragus to a point midway between the ala of the nose and the vermilion border of the upper lip.

Diagnostic features of the accessory parotid gland tumor do not differ from those of the

main parotid gland tumor. Magnetic resonance imaging and CT are useful for visualizing separation of the tumor from the main parotid gland. USG can be done as an alternative. Surgical resection is the first choice of treatment for the accessory parotid gland tumor. There are two surgical approaches:

an incision in the cheek overlying the tumor and a standard preauricular incision. The latter provides sufficient exposure for dissection of the facial nerve and excision of the accessory parotid gland. The tumor in our case was removed through standard preauricular parotidectomy Incision. Buccal branch of facial nerve was preserved.

Although the incidence of accessory parotid gland tumor is low, physicians should consider the possibility of such a tumor in the differential diagnosis of a cheek mass.

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