Benign tumours

Benign tumours

Pleomorphic adenoma These are the most common benign salivary gland tumours. They can occur at all ages, but are most commonly seen between the third and sixth decade. The average age of presentation is 45 years and they are more frequently seen in women. They occur most frequently in the parotid glands (>80%), but are also seen in the submandibular gland and hard palate. Pleo - morphic adenoma presents as a painless, well-defined solitary mobile mass with gradual progression over many years and can reach enormous proportions (Figur e 54.10). Occasionally they can present as metachronous and synchronous tumours. When they arise from the deep lobe of the parotid they may present as a paratonsillar bulge. A sudden increase in size or facial nerve palsy is associated with malignant transformation, which is rare. Treatment involves surgical excision with a cu ff of surrounding normal tissue, where possible, to include the pseudopods from the tumour capsule. Enucleation may result in capsular breach and tumour spillage, increasing the possi bility of local recurrence; it should be avoided. Histopathology On gross examination, pleomorphic adenoma presents as a well-circumscribed, nodular, firm mass with a white to tan cut surface, sometimes showing cartilaginous areas. Large tumours may show areas of degeneration and cystic changes. On microscopy , the tumour comprises mixed epithelial, myoepi thelial and stromal components. A spectrum of architectural and cellular features is seen, including oval, epithelioid, spindle shaped, plasmacytoid and clear cells, in variable amounts of myxoid to chondroid and hyalinised stroma. The pr esence of ductal atypia, di ff use fibrosis and necrosis should be evaluated further to rule out malignancy . In immunohistochemistry , luminal cells express CK7 (strong and di ff use) and myoepithe lial cells express p63, S-100, SOX10 and SMA. Warthin’s tumour Warthin’s tumour, also known as adenolymphoma or cysta denoma lymphomatosum, is a benign tumour composed of oncocytic epithelial cells lining ductal, papillary and cystic spaces in a reactive lymphoid tissue. They are the second most common benign salivary gland tumours (5–15%) and are mainly seen in older men, after the sixth decade of life. They ha ve been associated with cigarette smoking as well as radiation exposure. They are almost exclusively seen in the parotid gland, especially in the inferior pole, and are rarely seen in the periparotid nodes. They can occur synchronously or metachronously in the same or bilateral glands. They are also known to occur with other salivary gland neoplasms such as pleomorphic adenoma and salivary duct carcinoma. Clinically , they present as painless, slow-growing swellings. Facial palsy is rare. Malignant transformation is extremely rare (<1%) and can occur in both the epithelial (Warthin’s adeno carcinoma) and lymphoid (lymphoma) components. Complete surgical excision with an adequate margin is the treatment of tumours. Histopathology On gross examination, they are well circumscribed and ovoid to spherical with a cut surface showing solid and cystic areas containing mucoid to brownish fluid and papillary projections. On microscopy , the tumours have papillary and cystic struc - tures lined by bilayered oncocytic epithelial cells in a lymphoid stroma with germinal centres. The epithelium may show metaplastic changes, including squamous , sebaceous, ciliated and mucous cells.

Figure 54.10 Double head: large pleomorphic adenoma grown over 15 years.

Benign tumours

Pleomorphic adenoma These are the most common benign salivary gland tumours. They can occur at all ages, but are most commonly seen between the third and sixth decade. The average age of presentation is 45 years and they are more frequently seen in women. They occur most frequently in the parotid glands (>80%), but are also seen in the submandibular gland and hard palate. Pleo - morphic adenoma presents as a painless, well-defined solitary mobile mass with gradual progression over many years and can reach enormous proportions (Figur e 54.10). Occasionally they can present as metachronous and synchronous tumours. When they arise from the deep lobe of the parotid they may present as a paratonsillar bulge. A sudden increase in size or facial nerve palsy is associated with malignant transformation, which is rare. Treatment involves surgical excision with a cu ff of surrounding normal tissue, where possible, to include the pseudopods from the tumour capsule. Enucleation may result in capsular breach and tumour spillage, increasing the possi bility of local recurrence; it should be avoided. Histopathology On gross examination, pleomorphic adenoma presents as a well-circumscribed, nodular, firm mass with a white to tan cut surface, sometimes showing cartilaginous areas. Large tumours may show areas of degeneration and cystic changes. On microscopy , the tumour comprises mixed epithelial, myoepi thelial and stromal components. A spectrum of architectural and cellular features is seen, including oval, epithelioid, spindle shaped, plasmacytoid and clear cells, in variable amounts of myxoid to chondroid and hyalinised stroma. The pr esence of ductal atypia, di ff use fibrosis and necrosis should be evaluated further to rule out malignancy . In immunohistochemistry , luminal cells express CK7 (strong and di ff use) and myoepithe lial cells express p63, S-100, SOX10 and SMA. Warthin’s tumour Warthin’s tumour, also known as adenolymphoma or cysta denoma lymphomatosum, is a benign tumour composed of oncocytic epithelial cells lining ductal, papillary and cystic spaces in a reactive lymphoid tissue. They are the second most common benign salivary gland tumours (5–15%) and are mainly seen in older men, after the sixth decade of life. They ha ve been associated with cigarette smoking as well as radiation exposure. They are almost exclusively seen in the parotid gland, especially in the inferior pole, and are rarely seen in the periparotid nodes. They can occur synchronously or metachronously in the same or bilateral glands. They are also known to occur with other salivary gland neoplasms such as pleomorphic adenoma and salivary duct carcinoma. Clinically , they present as painless, slow-growing swellings. Facial palsy is rare. Malignant transformation is extremely rare (<1%) and can occur in both the epithelial (Warthin’s adeno carcinoma) and lymphoid (lymphoma) components. Complete surgical excision with an adequate margin is the treatment of tumours. Histopathology On gross examination, they are well circumscribed and ovoid to spherical with a cut surface showing solid and cystic areas containing mucoid to brownish fluid and papillary projections. On microscopy , the tumours have papillary and cystic struc - tures lined by bilayered oncocytic epithelial cells in a lymphoid stroma with germinal centres. The epithelium may show metaplastic changes, including squamous , sebaceous, ciliated and mucous cells.

Figure 54.10 Double head: large pleomorphic adenoma grown over 15 years.

Revision #1
Created 2025-12-31 15:20:32 UTC by Omar Ayman
Updated 2025-12-31 15:20:32 UTC by Omar Ayman