Vocal Cord Hemangioma: A Rare Entity

To the Editor: Laryngeal hemangioma is a rare clinical condition. In this article, we report a patient who was diagnosed with vocal cord hemangioma with clinical and histopathologic findings.

A 45-year-old man with hoarseness for 10 years was referred to the outpatient clinic. He had no associated symptoms, such as dysphagia or dyspnea. His medical history was insignificant.

On videostroboscopic examination, a red mass was seen on the left side of the vocal cord, protruding to the laryngeal passage (Fig. 1). The patient underwent direct laryngoscopy, and the mass was excised using carbon dioxide laser techniques under general anesthesia. Histopathologic examination showed a cavernous hemangioma (Fig. 2). At 6 months after the operation, findings of laryngeal examination was normal.

The most common benign pathologies of the larynx are papillomas (95%) and, on the other hand, oncocytic tumors, pleomorphic adenomas, lymphangiomias, neurofibromas, fibromatosis, paragangliomas, and rhabdomyomas.1 Hemangiomas are rarely seen in the larynx. Incidence of laryngeal hemangiomas is not known exactly in adults because of infrequency of certain reports, but it is thought to be 4.5% to 5% in the pediatric population.1 In adults, vocal abuse, cigarette smoking, and laryngeal trauma (ie, intubation) are thought to be etiologic factors.2 Vocal hoarseness is the main symptom. Laryngeal endoscopy has to be performed for each patient, and magnetic resonance imaging or angiography can help in the diagnosis and operation planning for large hemangiomas.3 Biopsy is not suggested because of the risk for severe bleeding.4 Certain diagnosis of hemangiomas is histopathologic. Systemic steroids, intralesional steroid injection, laser ablation, interferon, microdebrider, cryosurgery, and open surgical excision have all been used for treatment.5

Fatih Sari, MD
Murat Topdag, MD
Murat Ozturk, MD
Selvet Erdogan, MD
Ahmet Cihad Doruk, MD
Department of Otorhinolaryngology
Kocaeli University Medical Faculty, Kocaeli, Turkey
fatihsari84@hotmail.com

REFERENCES

Giant Epidermal Inclusion Cyst Over the Parotid Gland Mixing Parotid Tumor

To the Editor: Epidermal cysts are common subcutaneous tumors that usually involve the scalp, face, neck, back, or trunk generally

Fatih Sari, MD
Murat Topdag, MD
Murat Ozturk, MD
Selvet Erdogan, MD
Ahmet Cihad Doruk, MD
Department of Otorhinolaryngology
Kocaeli University Medical Faculty, Kocaeli, Turkey
fatihsari84@hotmail.com

REFERENCES
with unknown etiology. An epidermal inclusion cyst refers to a cyst that results from the proliferation and implantation of epidermal elements within a circumscribed space in the dermis during trauma or developmental processes. These cysts grow through accumulation of epithelial and keratinous debris.1

Most of the cystic lesions in the preauricular area are also epidermal cysts.2 However, this kind of giant cystic lesion just totally cover the whole parotid area mixing parotid tumor has not been reported in the literature yet.

CLINICAL REPORT

A 58-year-old male patient presented with a giant painless mass on his face over the parotid gland (Fig. 1). The mass was present for nearly 30 years and had been growing rapidly during the last 2 to 3 years. On his physical examination, a soft semi-mobile mass was palpated. He had no systemic disease or abnormal laboratory examination. Preoperative magnetic resonance imaging (MRI) showed a well-circumscribed, 8 × 7 cm cystic lesion originated from the left superficial parotid lobe (Fig. 2). A complete excision was performed under general anesthesia. Firstly, an elliptic incision was made, then the mass was exposed from just over the superficial parotid gland and totally resected. After the resection of the mass, the excision of reductant skin was planned according to the preauricular line and the angle of mandible to hide the scar. A Penrose drain was inserted under the skin flap and taken at the postoperative second day. There was no complication postoperatively (Fig. 3). In gross appearance, the mass had an outer membranous capsule with inner yellow and brown debris (Fig. 4). The histopathological review showed a cyst lined by mature stratified squamous epithelium filled with laminated keratin (Fig. 5).

DISCUSSION

The epidermal inclusion cyst is one of the most frequently observed subcutaneous benign tumors in the facial area, and it is known to develop by the migration of epidermal components to the dermis or subcutaneous tissue during trauma or developmental processes. Histopathologically, it is surrounded by several layers of squamous epithelial cells, with its cyst lumen filled with loosely packed lamellae of degenerated keratins and crumbs, known as keratin pearl.3

Conventional epidermal cysts are less than 5 cm in diameter.4 Giant epidermal cysts with a diameter of 5 cm or more are like our case as it was 8 × 7 cm. However, several giant epidermal fascial cysts have been reported in the literature,3,5 but this kind of
huiwe cystic lesion just over the parotid gland have not been reported yet. So it led us to think parotid tumors in differential diagnosis.

The benign parotid cystic salivary lesions have a relatively low incidence. These cysts account for 5% of all the parotid lesions. Both men and women are equally affected, and they are commonly seen between the fifth and seventh decades of life. Clinically, they present as painless swellings without any attachment to the overlying skin or involvement of the facial nerve. The cystic lesions of the parotid can be either congenital or acquired. The congenital lesions are most often ectodermal in origin, and they include branchial cleft cysts/lymphoepithelial cysts. The acquired cysts can be due to obstructions, neoplasms, calculi, and trauma. The neoplasms of which can present as cystic lesions.6

Iatrogenic epidermal cysts of parotid gland has also been reported, especially after endaural incisions, surgeons may implant squamous epithelium into the underlying tissue. An epidermoid cyst is formed by the implantation of keratin material.7 There was no history of trauma or surgery in our patient. Although MRI showed the cystic lesion originated from the parotid gland, during our surgical exploration we were able to skim the mass totally just over the superficial parotid gland without the need for superficial parotidectomy.

During the excision, intraepidermal layer should be included for complete excision and to prevent recurrence. Malignant change of benign epidermoid cysts is rare, but their prognosis remains poor. Therefore, all excised epidermal cysts should undergo a pathologic examination to exclude malignancy.8

Before thinking more complex diagnosis for this kind of giant cystic lesions located in the parotid area, epidermal cyst should be kept in mind as differential diagnosis.

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Esthesioneuroblastoma of the Parotid Gland

To the Editor: A 63-year-old man who complained of a large, painless mass around his right ear for a duration of 4 months was referred to our hospital. The patient’s medical history showed that he had been previously diagnosed with esthesioneuroblastoma (ENB) 4 years ago and received radiotherapy. The previous magnetic resonance imaging results indicated a Kadish stage C tumor at that time. The tumor mainly involved the right orbital apex, but no other metastasis was detected. The following examination revealed a 4 × 3-cm firm and painless mass in his right parotid gland. The boundary of the mass was not clear, but the skin over it was normal. A computed tomographic scan showed the presence of a space-occupying mass in the right parotid gland (Fig. 1). On the basis of the medical history, a possible diagnosis of metastatic ENB was made, although it rarely happens in salivary glands from the literature review. A biopsy was then performed. The results of histopathologic and immunohistochemical examinations indicated that the mass met the criteria for metastatic ENB. Specifically, hematoxylin–eosin staining showed large islands of small round cells with hyperchromatic nuclei (Fig. 2). The immunohistochemistry results showed that the mass was positive for chromogranin A, Ki-67, proliferating cell nuclear antigen, and synaptophysin. The patient was then transferred to the department of oncology and suggested for radiotherapy.

Esthesioneuroblastoma, also known as olfactory neuroblastoma, is a rare malignant tumor that arises from the olfactory epithelium. It accounts for 3% to 6% of cancers of the nasal cavity and paranasal sinus.9 The histologic pattern is similar to that of the sympathetic ganglia, retina, and adrenal medulla, and it has only recently been recognized as a distinct pathologic entity, probably as a result of the introduction of immunohistochemistry and electron microscopy techniques.9 It frequently invades the cranial base, cranial vault, and orbit but was very rarely reported to metastasize to the salivary glands.10 Hence, it