Myxoma Of Maxilla - Our Experience Of Two Cases

Dr. Collin Roy, M.S., M.Ch.
Dr. I. Saha, M.S., M.Ch.

KEY WORDS
Rare, Origin uncertain.

ABSTRACT

At S.S.K.M. Hospital Calcutta, two cases in last eight years of this rare condition were treated. Their exact nature of origin is still debatable and is discussed in this presentation.

INTRODUCTION

Myxoma is a neoplasm of mesenchymal origin that usually develops in soft tissue. Myxoma of bone is a rare entity, usually occurring in mandible or less commonly in maxilla. In the present article, experience of two cases of myxoma of maxilla, is discussed.

CASE REPORT

Sixteen years old male, presented with fullness of left cheek, increasing gradually over the period of 7 years. He further stated that swelling has recently started extending laterally in malar region.

Examination revealed a smooth, rounded, painless mass and soft in consistency. Temperature of the skin over it was not raised. There were no palpable glands in the region. X-Ray revealed a hazy

left sinus with expanded antral cavity. Maxillectomy was carried out through Weber-Fergusion incision. The anterior, superior and medial wall of maxilla looked thinned out. Antrum was opened through a medical wall osteotomy. A huge pink coloured soft tissue mass was seen occupying the whole of antrum. The whole of maxilla along with inferior orbital wall was then removed along with the soft tissue mass. Illiac bone graft was then harvested and placed at the inferior orbital wall to provide adequate support to suspensory ligament of the eye. Wound was closed over a stent compositum prosthesis. This was removed on the 10th day. He was given a permanent maxillary prosthesis with denture, and discharged. Histopathology showed myxoma. Six year follow up has not shown any sign of recurrence.

Case No.II Seventeen year old male presented in OPD with the complaints of fullness of left cheek gradually increasing in size over past eight years causing left nasal blocked airway. This swelling of 10cm x 8cms. Size had distorted left nasal alae, left lower lid, and lateral smoothness of the cheek. Hard palate and mucosa over it was tense. Temperature of the affected region was not found to be raised. There were however prominant vascular marking on the surface. There were no secondaries palpable in the neck. X RAY Confirmed a multicystic swelling, Occupying left maxillary antrum with wide expansion and thining of walls of antrum but no breach of bony cartex:

Tumour was approached through a Weber Fergussion incision with an object to do an open Biopsy. Anterolateral and superior walls of Maxilla were found to be expanded to egg shell thinness.

A huge Pinkish soft tissue mass was found to be occupying whole of left antrum, extending into left nasal vestibule, blocking left Nasal airway.

After enucleation, bony antrum appeared enlarged on Left side.

maxillectomy was carried out and because of involvement of bony hard palate and soft palatal tissues, and extension of it Posteriorly in retromaxillary Sub tempral region, en block dissection of all the affected tissue could not be achieved.

DISCUSSION :

Myxomas involving facial bones probably represent a true but rare clini-co-pathologic entity. Stout (1948) reported 49 personally studied myxomas. Zimmer mann and Dahlin (1958) in reveiwing 2276 primary bone neoplasms, described 26 myxamatous tumours of the jaws and found no myxomas of bone outside facial skeleton. Ghose et al (1973) reported 10 myxomas, six in the mandible, four in the maxilla. These lesions were identified among 8723 primary bone neoplasms, attesting to the rarity of the tumour.

Most authors agree that these myxoid tumors occurring in facial bones are locally aggressive lesions which do not metastasise, but which may recur locally, if not adequately excised, enblock.

The true nature of myxoma has produced debate among various authors. Stout believed myxomas were tumours of primitive messenchyme. Other authors have discussed the possibility that myxomas occur in facial bones & arise in dental analage. Still others have pointed out that myxoma tumour cells might originate from osteogenic tissues. Myxomas, of course, may be also seen in tissues other than bone.

Macroscopically, bone does not show any reaction, maxoma does not present as encapsulated growth and is multicystic. Further more myxomas-contain relatively few fusiform and stellate cells which lie in a mucoid or myxoid ground substance. The nuclei are spindly shaped. Gorlin et al and Thoma and Goldman considered local excisions, including enucleation, adequate treatment for these lesions.

In our instance, excision in the first patient was essentially curative, because of relatively early presentation and limited extension, exemplified by a

six year recurrence free interval. In the second patient, one could not go beyond the tumour, because of its extension beyond maxilla into both hard and soft palate and base of skull.

The authors who have studied the effects of radiation treatment have reported that myxomas are not radiosensitive.

CONCLUSION

The relevant literature on histogenicity, pathology and treatment of the myxoma of maxilla is briefly discussed.

REFERENCES:

1. Attar, S : Myxoma. a clinico pathological study. An. J. Surg. 91: 755 - 760, 1958.
2. Barros, R.E., Dominique, F.U. and Cabrini, R.L. : Myxoma of the Jaws. Oral Surg. 97, 225-236, 1960.
3. Bochetto, J.etal : Antral fibromyxoma presenting as a giant nasal pbolyp. Oral Surg. 23 : 201-206. 1967.
4. Buchner, A. and Ramon, Y : Fibromyxoma of the maxilla, J. Oral Surg. 23 : 145 - 148, 1965.
5. Candy, E.J. : Myxoma of bone involving orbit, Arch. Optth. 109(7): 919-920, 1991.
6. Fu, Y.S. and Perzin, K.H. : Non-epithelial tumours of the nasal cavity, Paranasal sinuses and nasopharynx. A clinico-pathologic study I, general features and vascular tumours : Cancer, 33 : 1275-1288, 1974.
7. Fu, Y.S. and Perzin, K.H. : Non-epithelial tumours of nasal cavity, paranasal sinuses and nasopharynx. A clinico-pathologic study-II, Cancer 39 : 195-203, 1977.
8. Ghosh, B.C. et al : Myxoma of the Jaw bones. Cancer 31 : 234-240, 1973.
9. Gorlin, R.J. et al : Odontogenic tumours, classification. histyopathology and clinical behaviour in man and domesticated animals, cancer 14: 73 - 101. 1961.
10. Hovnamian, A.P. : Myxoma of the maxilla. oral surg. 6 : 927-936, 1953.
11. Kangur, T.T. et al : myxomatons tumours of the Jaw. J. Oral Surg. 33, 523-528, 1975.
12. Stout, A.P. Myxoma. the tumour of primitive mesenchyme. Ann. Surg. 127 : 706-709, 1948.
13. Thoma, K.H. and Goldman, H.M. : Oral Pathology. 5th Ed., St. Bouis C.V. Mosby and Co., 1960.
14. Thoma, K.H. and Goldman H.M. : Central Myxoma of the Jaw, Am. J. Orthod. 33, 532-540, 1947.
15. Young, W.G. and Ball, A.T., : Central myxofibroma of the jaw, J. Oral Surg. 26 : 408-410, 1968.
16. Zimmerman, D.C. et al : Myxomatous tumours of the Jaws, Oral. Surg., 11 : 1069-1080, 1958.

AUTHOR'S NAME AND ADDRESS:

1. Dr. Collin Roy, M.S., M.Ch., Medical Officer.
2. Dr. I. Saha M.S., M.Ch. Associate Professor.

Dept. of Prastic surgery
I.P.G.M. M.E. & R. Calcutta.