Mucinous Adenocarcinoma of Minor Salivary Gland: Case Report and Literature Review

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Abstract

Mucinous adenocarcinoma (MAC) is a glandular tumor characterized by large pools of extracellular mucin. The tumor can arise as a primary tumor of the major salivary glands. However, its occurrence is exceedingly rare and has only recently been recognized. Only few cases in the major salivary glands have been reported. This report is an additional case of MAC with origin in minor salivary gland at the oral floor. Immunohistochemical analysis of the tumor for cytokeratins 7, 8, 10, 13, 14, 18 e 20, vimentin, SMA, CEA, EMA, p53, ki-67 e histochemical analysis for PAS, Alcian blue e mucicarmin was performed. Predominantly, the tumor expressed cytokeratins 7, 18 and 20 that are commonly found in simple epithelia. Therefore, was observed positivity to PAS, Alcian blue and mucicarmine. No other cancer has been detected. The tumor is considered to be a primary mucinous adenocarcinoma, being the twenty-third case in minor salivary gland reported in the literature and the fourth MAC located in the mouth floor.

Keywords: Mucinous adenocarcinoma; Salivary gland; Oral

Case Report

A 52-year-old male non-smoker over 10 years having a tender, firm, swelling at the oral floor, smooth appearance and color of the mucosa for three months duration (Figures 1a and1b). The clinical history and computerized tomography scan discarded systemic involvement. Computerized tomography scan revealed a large, well-defined, soft tissue mass with dimensions of 5 x 4 cm in its largest diameter showing multiple internal cystic spaces, suggesting diagnosis of ranula, dermoid cyst or thyroglossal duct cyst. The paraffyngeal space, pterygopallatine and infratemporal fossae were well preserved, without osteolytic or osteoblastic images. Aspirative puncture was performed in the lesion with negative result. An incisional biopsy was taken, macroscopically the tumor measured 3.5 x 3 x 2 cm and was soft on palpation. The margins appeared besselated and the cut surface was gelatinous and glistening. The surgical specimen was fixed in 10% neutral buffered formalin and following embedded in paraffin. Histomorphological analysis of sections stained with hematoxilin & eosin showed a well-defined lesion, with connective fibrous strands separating variably sized mucous-filled cystic spaces (Figure 2a), many containing suspended irregular-shaped neoplastic epithelial cell nests, clusters and atypical ductal epithelial cells (Figure 2b), separated from the tumor mass by uninvolved salivary gland tissue. The neoplastic cells had atypical large nuclei, and some cells contained small amounts of intracellular mucus (Figure 2c). Mitotic figures were rarely observed. Immunostains using the avidin-biotin technique were performed on the tumor, including stains for cytokeratins (CK) (Table 1). Few of the tumor cells stained positively for some cell types.

Figure 1: (a,b) Extra and intra oral clinical appearance of the tumor. (c,d) Postsurgical extra and intra oral appearance.

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CK 7 (Figure 2d). Prominent staining was found for CK 18 (Figure 3a). Only a few cells were CK 20 positives (Figure 3b), there was observed variably immunostaining for smooth muscle actin (α-SMA), epithelial membrane antigen (EMA) and CEA principally in glandular structures with tubular formation (Figures 3c, 3d and 4a). Tumor cells were negatives for vimentin, ki-67 and p53. There was observed positivity for Alcian blue, mucicarmine and periodic acid-Schiff (PAS) (Figures 4b, 4c and 4d) (Table 2). On basis of the clinic, histomorphological and immunohistochemical features a diagnosis of mucinous adenocarcinoma (MAC) was made. The tumor was surgically removed with margins involved and neck dissection was done with cervical lymphadenectomy. Before therapeutic surgery, radiotherapy was performed and the patient remains free of locoregional and distant disease after eleven months. The result postoperative is showed regarding to patient clinic condition (Figures 1c and 1d).

Discussion

The mucinous adenocarcinoma (MAC) was included in the classification of salivary gland tumors by the World Health Organization, however some authors argue that information provided in the World Health Organization classification is, therefore, insufficient to define MAC as a distinct neoplasm [2].

Twenty-two intraoral MAC was previously described in the literature with minor salivary gland origin [5,8]. These authors observed that MAC is a tumor of older adults (average 64.6 years). Usually, the MAC arises in patients over 50 years of age. Males are affected more frequently than females [1,5]. Approximately 10% of these are located in the submandibular and the sublingual gland [9]. These findings are consistent with the case reported here. According to Barnes et al. [1], the most frequently affected sites are the palate and the sublingual gland, followed by the submandibular gland and the upper lip. Just three cases of MAC were reported in floor of mouth, this is the fourth.

Histologically, mucinous adenocarcinoma is so characteristic that it rules out any other salivary gland carcinoma as a differential diagnostic possibility. Some authors argue that mucinous appearance itself is not pathognomonic of MAC and many salivary gland carcinomas may exhibit this trait [3,10,11]. In this sense, the histologic diagnosis of MAC is usually by exclusion [3]. The differential diagnostic consid-

### Table 1: Antibody sources, dilutions, antigen retrieval and immunostaining results

<table>
<thead>
<tr>
<th>Antibody</th>
<th>Source</th>
<th>Dilution</th>
<th>Antigen retrieval</th>
<th>Result</th>
<th>Localization</th>
</tr>
</thead>
<tbody>
<tr>
<td>CK 7</td>
<td>DAKO</td>
<td>1:50</td>
<td>Citrate</td>
<td>+</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>CK8</td>
<td>Novocastra</td>
<td>1:50</td>
<td>Citrate</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CK 10</td>
<td>Novocastra</td>
<td>1:25</td>
<td>Tripsin 0.1%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CK 13</td>
<td>Novocastra</td>
<td>1:100</td>
<td>Citrate</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CK 14</td>
<td>Novocastra</td>
<td>1:20</td>
<td>Citrate</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>CK 18</td>
<td>Novocastra</td>
<td>1:20</td>
<td>Citrate</td>
<td>++</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>CK 20</td>
<td>Novocastra</td>
<td>1:20</td>
<td>Citrate</td>
<td>+</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>Vimentin</td>
<td>DAKO</td>
<td>1:50</td>
<td>Citrate</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>α-SMA</td>
<td>Novocastra</td>
<td>1:50</td>
<td>Citrate</td>
<td>++</td>
<td>Nuclear</td>
</tr>
<tr>
<td>CEA</td>
<td>DAKO</td>
<td>1:30</td>
<td>No treatment</td>
<td>+</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>EMA</td>
<td>DAKO</td>
<td>1:40</td>
<td>No treatment</td>
<td>+</td>
<td>Cytoplasmic, luminal cells</td>
</tr>
<tr>
<td>Ki-67</td>
<td>DAKO</td>
<td>1:100</td>
<td>Citrate</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>p53</td>
<td>DAKO</td>
<td>1:50</td>
<td>Citrate</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(-) No immunostaining; (+) weak immunostaining; (++) strong immunostaining
erations in the realm of MAC are cystadenocarcinoma [12], mucoeipidermoid carcinoma [13], mucin-rich salivary duct carcinoma [14] and signet-ring cell adenocarcinoma [15]. The primary differential diagnosis seemed to be a metastatic tumor, since there is a definite structural resemblance to mucinous adenocarcinomas of the gastrointestinal tract or the breast and to sweat gland carcinoma of the skin. Metastatic tumors in the salivary glands are uncommon. Forty-seven cases out of 10,944 tumors were collected during a twenty-year period in the files of the Hamburg salivary gland tumor register [16]. The metastatic tumors were localized in the parenchyma of the parotid or the submandibular gland. The sublingual gland was free from metastatic tumors [9]. Due to their homologies, distinction of primary MAC from metastatic mucin-carcinoma is impossible on histologic grounds alone [3, 5].

Immunohistochemistry has been shown to be useful in the supportive diagnosis of salivary gland tumors [17], mainly myoepithelial cell markers such as cytokeratins, a-SMA, vimentin and S-100 protein. The immunotyping of CK7/CK20 may aid in substantiating a tumor origin. It is mentioned that the CK7(+) / CK20(-) phenotype may be a rationale for a salivary primary [9, 17–20], whereas a immunoprofile CK7(-)/ CK20(+) may serve as a clue to an intestinal origin [5, 21]. Metastasis from a primary tumor of the gastrointestinal tract or pancreas is not very likely if the tumor shows a pronounced expression of CK 7 and only single cell positivity of CK 20 [9]. In this case, the tumor presented expression for CK 7, but a few isolated cells were weak positives for CK 20, suggesting a primary MAC.

It is known, however, that CK pattern of MAC and its cutaneous and mammary counterparts are comparable [5, 21], making a discrimination between them untenable. The cytokeratin profile of the present tumor showed a mixed pattern dominated by the strong expression of CK 18, which are found in simple epithelia.

Other immunomarkers show differential potential, but prove to be less discriminating. It was reported that by immunostaining for CEA in oral mucinous adenocarcinoma and in intestinal carcinomas, variably staining had been observed in skin and breast tumors [5, 22]. The biologic behavior of MAC was evaluated through Ki-67 and p53 immunomarkers and was found negatives to this tumor. Association has been reported in cell proliferative index, by immunohistochemical expression of Ki67 with a poor prognosis in many salivary gland tumors [23]. Ide et al. [5] found an average percentile to Ki-67 of 38% in mucinous adenocarcinoma. A high Ki-67 index (>30%) has been found to correlate well with poor overall survival in salivary carcinomas [24]. However, there has been no association between p53 expression with survival in patients with these tumors [25].

Based on this information, the case reported here has analyzed the expression of these proteins in order to infer information about the biological behavior of the lesion, however, both were negative, it can be inferred that this case probably would have a biological behavior and prognosis more favorable, which can be corroborated by clinical follow-up of the patient, who did not show tumor recurrence, no sign of secondary tumor.

Based in the immunohistochemical profile and the negative scan for any other primary malignancy, we are convinced that this case represents an example of a primary mucinous adenocarcinoma of the minor salivary gland. The patient had been followed-up for ten months without recurrence or disseminated disease. Treatment included total enucleation of the lesion, part of the tongue and, an upper neck dissection. From these cases it is difficult to compare the behavior of mucinous adenocarcinomas of the major salivary glands to a similar tumor in a different location. Tumors of the breast and stomach are associated with a better prognosis, whereas those of the colorectal tract have a more sinister one. In this case the patient had a local tumor confined to the buccal floor region without any metastases. The prognosis of salivary gland tumors varies with location, histological type and grade. The clinical stage of the disease is considered the single most important prognostic factor [25].

References


