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# Short Communication of Adenoid Cystic Carcinoma in the Palate

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Adenoid cystic carcinoma (AdCC) is a morphologically diverse but distinct neoplasm that makes up 7.5 percent of all malignant salivary gland tumors. 1st AdCCs are divided into three groups based on their prevailing histological growth pattern: tubular, cribriform, and solid. This histological sub classification is both clinic pathologically and prognostic ally essential.

The tumour has a distinct cribriform histomorphology that has been identified as Swiss Cheese or Sieve-like in the past, but this terminology has proven insufficient in expressing the broad range of histological diversity that can be seen. Total surgical resection and postoperative radiation therapy are the current treatment guidelines for AdCC. Tumor recurrence rates are stated to be as high as 42 percent in the literature. Although the prognosis is poor, the disease is often slow-moving, and AdCC patients will live for several years [1].

Adenoid cystic carcinoma is a malignant tumour that may affect the oral cavity's major or minor salivary glands. Lorain and Laboulbene first described adenoid cystic carcinoma in 1853. Billroth proposed the name cylindroma in 1859. Spies proposed the term adenoid cystic carcinoma to replace cylindroma in 1930, and it has since been generally accepted. The tumour was considered to be a benign version of the mixed salivary gland tumour until the 1940s. Dockerty and Mayo stressed the tumor's malignant nature in 1943. Adenoid cystic carcinoma is a head and neck tumour that is very rare. It accounts for around 1% of all head and neck cancers, as well as 4-10% of all salivary gland tumours [2].

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It develops from the intercalated ducts of mucin-secreting glands and has three histologic subtypes: cribriform (the most common), tubular, and strong (most aggressive). The cribriform version has cylindrical pseudocysts lined with epithelial cells and packed with hyaline material, giving it a "Swiss-cheese" appearance. The tubular version is made up of ducts lined with 1 t of rubber. The tubular variant has ducts lined by 1 to 2 layers of myoepithelial-like cells, while the solid variant has epithelial islands with central areas of necrosis. The solid variant is the most violent of the three, with 40 to 60 percent of cases resulting in hematogenous metastasis. Perineural invasion along the palatine nerves with extension into the pterygopalatine fossa is also a possibility.

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