Non-Hodgkin’s Lymphoma of Parotid Gland

Sanat Kumar Bhuyan, Ruchi Bhuyan, Chowberg Naik

1Professor, Department of Oral Medicine and Radiology, Institute of Dental Sciences, Bhubaneswar, Orissa, India
2Professor and Head, Department of Oral Pathology and Microbiology, Institute of Dental Sciences, Bhubaneswar, Orissa, India
3Lecturer, Department of Oral Surgery, Institute of Dental Sciences, Bhubaneswar, Orissa, India

Correspondence: Sanat Kumar Bhuyan, Professor, Department of Oral Medicine and Radiology, Institute of Dental Sciences Bhubaneswar, Orissa, India, e-mail: drsanatkumar@rediffmail.com

ABSTRACT
A 4-year-old female presented with painless mass on left side of neck, biopsy of which was done from referring place. As the report was not available, FNAC of the mass was done, which was pleomorphic adenoma of left parotid gland. CT shows large heterogeneous mass in relation to the left parotid gland and mass was contiguous with the carotid artery. Parotidectomy was positive for malignancy. Histopathology report of the resected specimen turned out to be non-Hodgkin’s lymphoma.

Keywords: Non-Hodgkin’s lymphoma, Salivary gland, Parotid gland.

INTRODUCTION
Lymphomas primary located in the salivary gland tissue are very rare and constitute about 2 to 5% of all salivary gland neoplasms. Most cases of lymphoma involve the major salivary glands, frequently the parotid (50-93%) and submandibular glands. These neoplasms may arise from an intraparotid lymph node or in the gland itself. In the normal parotid gland, there are intraglandular lymph nodes, that is why it is often difficult to make a distinction between lymphoma arising primarily in the salivary gland and those of the lymph node origin embedded in the salivary gland. If these lymph nodes are affected by a malignant lymphoma and the glandular parenchyma is not, then the lymphoma should be considered as nodal type. The differential diagnosis is not always easy to do because these are cases of lymphomas originated from intraglandular lymph nodes and with extensive parenchyma involvement. We consider a primary salivary gland lymphoma, the cases, in which the main disease occurs here and the parenchyma of the gland is involved. The morphology and prognosis are similar for both origin places.

Primary malignant lymphomas of the salivary gland are predominantly B-cell type lymphomas.

Salivary gland T-cell lymphomas are very rare.

Extranodal NK/T-cell lymphoma of nasal-type can affect in rare occasion the salivary glands. Hodgkin’s lymphoma as a primary salivary gland neoplasm is uncommon—it has been reported both classical Hodgkin’s lymphoma and nodular lymphocyte predominant Hodgkin’s lymphoma, but involving only the parotid gland. In rare cases, Hodgkin’s lymphoma arises from a preexisting Warthin’s tumor.

Non-Hodgkin’s lymphoma of salivary gland origin accounts for 5% of all primary extranodal non-Hodgkin’s lymphomas and 2% of all salivary gland tumors. Most cases of non-Hodgkin’s lymphoma arising in salivary glands are of B-cell lineage including low-grade B-cell lymphomas of mucosa-associated lymphoid tissue (MALT), diffuse large B-cell lymphomas and follicular lymphomas.

Follicular lymphomas interest salivary glands, but for the head and neck region. These are found predominantly in the lymph node and also in the orbita and thyroid gland; there are studies in which these types have originated in the lungs.

CASE REPORT
A 4-year-old female presented with painless swelling in left side of neck since 3 months. Incisional biopsy of the swelling (90% of parotid lymphomas present as firm painless swelling) was done from the referring place, but histopathology report was not available (Fig. 1). Fresh FNAC of the swelling showed...
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Following these reports, patient was put on chemotherapy (Chop regime).

DISCUSSION
Lymphoma originating in the parotid gland is rare and occurs in 1 to 5% of tumors where parotid gland is the original site of tumor. About 80 to 85% of parotid gland tumors are benign and 15 to 20% are malignant. Ninety percent of salivary gland lymphomas are present as firm painless swelling and more than 90% occurs in parotid gland. The differentiation of lymphoma originating in the parotid gland from other tumors, including benign tumors is difficult; however, some authors have reported that malignant lymphomas show tumor homogeneity surrounded by well-defined margins and are rarely associated with necrosis. In general, malignant lymphoma originating in the parotid gland is histologically described as low-grade non-Hodgkin’s lymphoma.

If the lymphoma is confined to the parotid gland, treatment is by parotidectomy with postoperative radiotherapy. If, there is evidence of spread beyond salivary gland, treatment is by polychemotherapy, according to protocol, this protocol being followed in our case.

REFERENCES


