LETTER TO THE EDITOR

Intraoral Excision of Giant Sublingual Angiomyxoma

The Editor,

Sir,

A 29-year-old male patient presented with a painless, slow-growing, solid mass in the left sublingual region, present for 4 months. Clinical examination showed a submucosal mass in the left sublingual region (Fig. 1A).

The lesion was well demarcated, slightly hard on palpation, and covered by normal mucosa. Ultrasound revealed a well-circumscribed, solid mass of approximately 6.5 × 4.7 cm, located between the left submandibular and sublingual glands. Computed tomography scan showed a well-defined, enhancing solid mass, measuring 6.5 × 5 cm, and located in the left floor of the mouth (Fig. 1B). Preoperative informed consent was obtained from the patient. The patient was operated via transoral approach under general anaesthesia. The mass was encapsulated and completely removed with submucosal dissection (Fig. 2).

Histopathologic examination of the mass revealed that the tumour composed of relatively uniform, small, stellate and spindled cells, set in a myxoedematous matrix with scattered vessels of varying calibre. There was no nuclear atypia or mitotic activity and necrosis. Immunohistochemically, the tumour cells were positive for cluster of differentiation (CD) 34 and negative for S-100 protein and muscle-specific actin (Fig. 3). The histopathologic diagnosis was reported as angiomyxoma. Post-operatively, no recurrence was seen during the 12-month follow-up period.

Angiomyxomas are myxoid mesenchymal tumours that are frequently present in the soft tissues of the pelvis and perineal regions of reproductive females. Although there have been many reported cases in the head and neck, only a few angiomyxomas of the oral cavity have been reported in the literature (1–5). Angiomyxomas are most common in the middle age, but they may present at any age. There is a slight male predilection (1, 3). The clinical features of angiomyxoma are not pathognomonic and are similar to many of the sublingual and submandibular masses. Ultrasound, computed tomography and magnetic resonance imaging are helpful to define the lesion in terms of size, location and extension.

The definitive diagnosis is performed with histopathologic examination of the lesion. Histologically, the tumour was characterized by spindle shaped and stellate cells in a loose myxoid stroma, and a prominent vascular

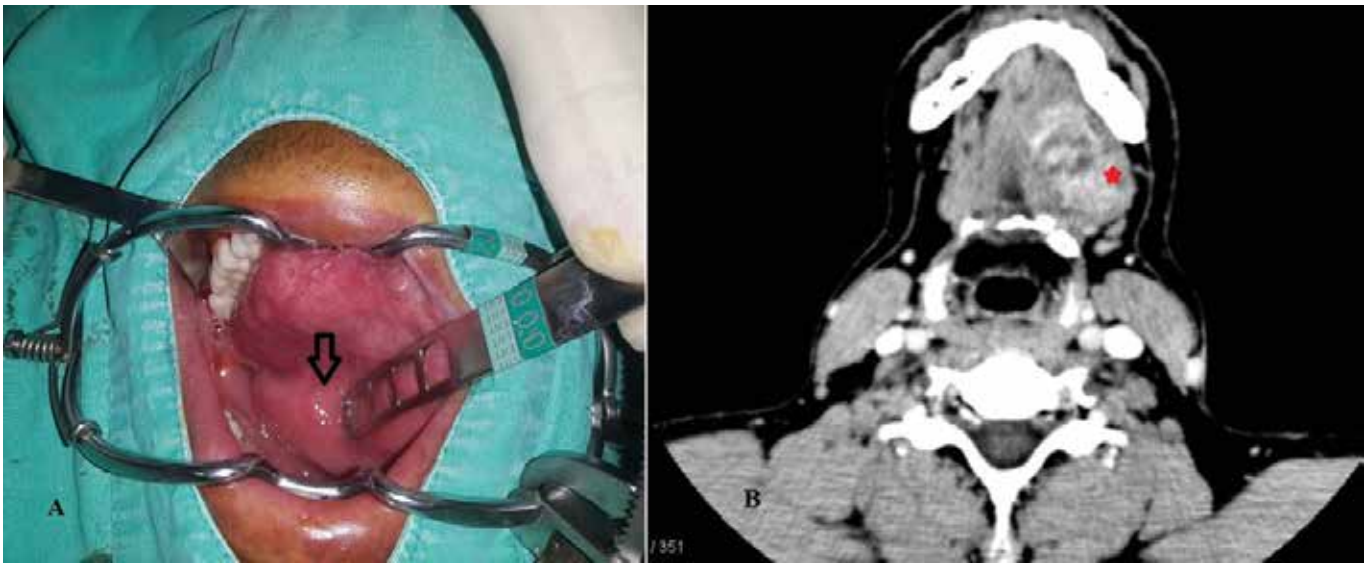

Fig. 1: (A) Preoperative view of the lesion of the left floor of the mouth. (B) Axial contrast-enhanced CT scan demonstrated a well-circumscribed, enhancing solid mass in the left sublingual region.

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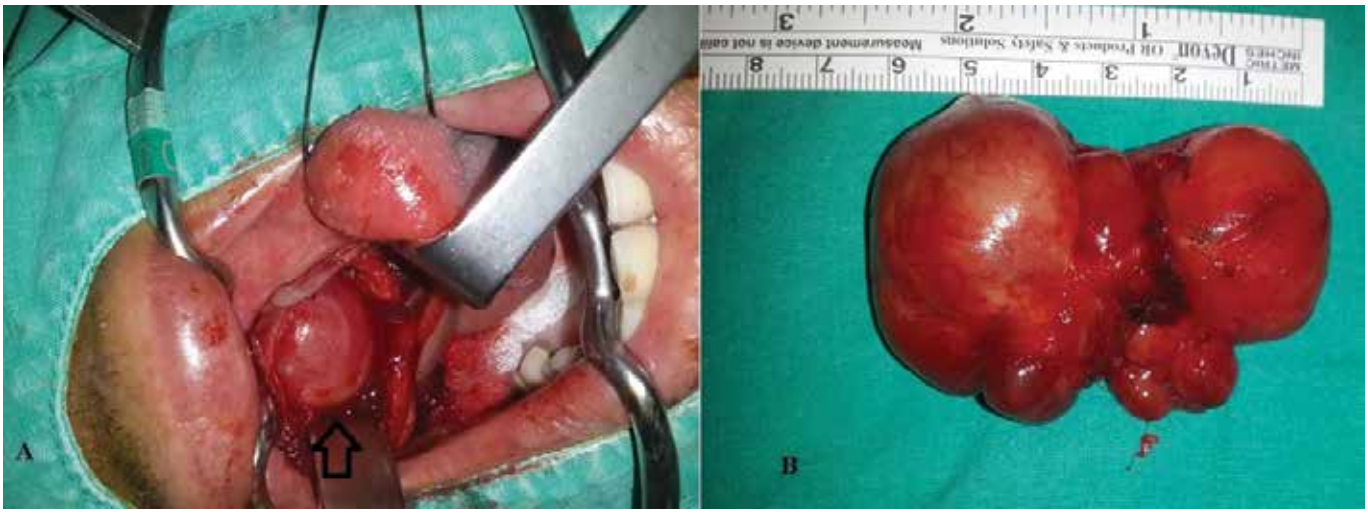

Fig. 2: (A) Intraoperative view of the mass. (B) Post-operatively, the appearance of lobulated, well-circumscribed tumoural specimen.

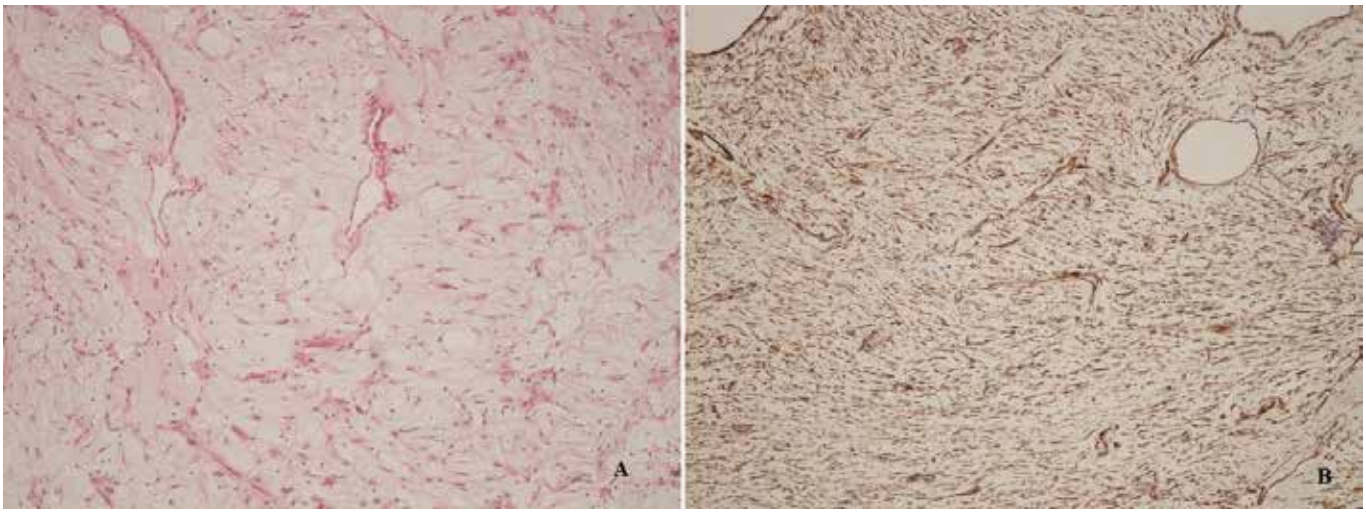

Fig. 3 (A) Tumour composed of relatively uniform, small, stellate and spindled cells, set in a myxoedematous matrix with scattered vessels of varying calibre (H & E, ×100). (B) Cytoplasmic reactivity with immunohistochemical CD34 stain in tumour cells (IHC, ×100).

component. Immunohistochemically, angiomyxomas are generally positive for desmin, vimentin, CD34 and α-smooth muscle actin. They are negative for S-100 protein and muscle-specific antigen (1–4). The differential diagnosis should include myxoid neurofibroma, myxoid liposarcoma, myxoid neurofibroma, epidermoid cysts, lipomas, lymphangioma, fibroma, and other soft tissue tumours (1–5).

Surgery is the most effective method for the treatment of angiomyxomas. The sublingual angiomyxoma can usually be excised by transoral approach and transcervical approach or through combined transoral and transcervical approaches. Angiomyxomas have a high rate of local recurrence between 20% and 40% after primary excision, often due to incomplete excision. Therefore, tumour excision with wide tumour-free margins should be performed for these tumours and should be performed with long-term follow-up (1–4).

Keywords: Angiomyxoma, intraoral excision, recurrence

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