

SUMMARY

Salivary gland tumours are rare. Their incidence ranges between less than 3% and 6% of all head and neck tumours. About 80% of their tumours occur in the parotid gland which are mostly benign tumours in 75%. Tumours arising from the submandibular salivary gland are less often than inflammatory processes, consequently the diagnosis and treatment may be delayed. The ratio between benign to malignant tumours in the submandibular gland is 45% to 46% while in the minor salivary gland the ratio is 35% to 65% respectively. Neoplasm of the sublingual glands are unusual, 90% of them are malignant. Metastasis in the parotid gland are unusual, when they do occur, the primary sites are usually head and neck squamous cell carcinomas or melanomas often involving the skin, but occasionally from distant site such as lung, breast and kidney. The metastasis may be the initial manifestation. Less than 5% of all salivary gland tumours occur in children and fewer than 0.25 percent are found in children under 10 years of age.

The etiology of most salivary gland neoplasms remains obscure, but exposure to ionizing radiation, alcohol consumption, prolonged use of mouth-Wash, hair-dye usage and infection by human immunodeficiency virus (HIV) and Epstein Barr virus (EBV), genetic factors have been suggested in several studies which report a positive family history in patients of salivary gland carcinoma. An increased incidence of salivary gland carcinoma has also been reported in Greenland families.

The typical presentation of salivary gland carcinoma is

asymptomatic swelling, however this complaint may present for several years or occasionally even a decade or more. Pain is reported in small percentage; however, long time presentation does not ensure a benign diagnosis. Patient with minor salivary gland carcinoma presenting with a variety of symptoms as painless swelling, nasal obstruction, sore throat, bleeding and/or change of voice according to the site of origin. Diagnosis can be made by clinical assessment, radiographic studies, fine needle aspiration biopsy (FNAB) and open biopsy. Plain radiographs may demonstrate bone destruction; computed tomography CT with or without sialography can differentiate between benign and malignant neoplasms and also the tissue invasion by the tumour. Magnetic resonance image offer a better resolution of soft tissue than CT. Sialography has little to offer in the diagnosis. F.N.A.B. can provide adjunctive role on histologic information about salivary gland neoplasms but it has 24.5% false negative result compared to a small percentage of false positive. Sonography has been found to be a useful technique in the diagnosis of salivary gland tumours, beside its safety and non invasive technique. Open biopsy always accurately predict the histologic feature, however it carries the risk of contamination of the operative field.

The treatment of salivary gland tumour can be made on the basis of careful examination and radiographic evaluation and depend on the type of the tumour. The benign tumours of the parotid are treated by superfical parotidectomy which are preferred on binocular microscopic limited excision or enucleation. While in malignancy, total parotidectomy with sacrificing

part or all of the facial nerve; with high stage tumours mastoidectomy and partial mandibulectomy may be necessary. Surgical excision of the submandibular gland is the minimal treatment in cases of benign and malignant tumours confined to the capsule of the gland; Radical excision including the gland, lingual and hypoglossal nerve, digastric and mylohyoid muscles and occasionally mandibulectomy and the floor of the mouth, benign tumour of the sublingual gland is treated by local excision of the gland. Local monoblock resection including the ipsilateral gland, surrounding musculature and part of the submandibular gland and adjacent mucosa in cases of low grade malignancy while in aggressive carcinoma, composite resection including the contra - lateral side of the gland and nerves and submental and submandibular dissection. Adequate monoblock resection, is the treatment of minor salivary gland malignancy although it differ according to the site. Lymph node dissection is indicated in high grade malignancy or node metastasis. Adjuvant radio-therapy improving loco-regional control in advanced local malignancy. Systemic and local infusion of chemotherapy proved to reduce local recurrence.

Prognosis of salivary gland tumours depends on several factors. The histologic grading; grade I and II have good prognosis while grade III and IV have poor prognosis. Survival of patients of the parotid gland tumours is prologed compared with that in the submandibular and sublingual glands while in the minor glands; patients with oral lesions have much better prognosis than those in the paranasal sinuses, larynx and palate. The prognosis of stage III and IV tumour have bad

prognosis. The presence of bone invasion decreases the cure rate. In general, prognosis is better in younger age. Postoperative complications are; frey's syndrome; facial nerve paralysis; salivary fistulae; tissue hollow depression and skin defect.