

A Rare Case of Laryngeal Salivary Gland Choristoma

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Abstract: This case report of a 65-year-old male who presented with progressively hoarse, weak voice and frequent throat clearing who on laryngeal examination revealed a single broad based right vocal cord mass at the junction of anterior one-third and posterior two-third with normal left vocal cord, having phonatory gap due to mass effect which on surgical excision by micro-laryngeal surgery followed by histopathology concluded as salivary gland choristoma. Choristoma is a normal salivary gland tissue at an abnormal location.

Keywords: Choristoma, Micro laryngeal surgery, Heterotopic salivary gland tissue

1. Background

Choristoma is defined as the presence of histologically normal cells in abnormal locations due to defects during embryological development (1). The criteria for the diagnosis of choristoma are a tumour-like growth, an ectopic tissue with a normal pattern and without neoplastic features histologically, and a mislocated tissue topographically. It is different from hamartoma because the hamartoma appears in normal locations. Laryngeal choristomas are rare lesions and are usually relevant to glial or thyroid tissues (2). Salivary gland choristomas (SGC) in the cheek, middle ear, neck, jaw, thyroid gland, pituitary gland, mediastinal lymph nodes, breast, anterior chest wall, oesophagus, duodenum, jejunum, rectum and amygdala have been reported (3). However, SGC of the larynx is very rare (4).

2. Procedure

A 65-year-old male patient presented with 15-month history of progressively hoarse, weak voice and frequent throat clearing. He denied weight loss, fever, chills, cough, dysphagia and odynophagia. The patient had been smoking cigarettes for 15 years (18 cigarettes per day) and consuming alcohol for 20 years. There was neither intubation history nor any other previous history of laryngeal trauma in the patient's past. Laryngoscopic examination was performed and a single broad based right vocal cord mass at the junction of anterior one-third and posterior two-third with normal left vocal cord, having phonatory gap due to mass effect. Rest of the laryngeal examination was within normal limits [Figure 1].



Figure 1: Pre- operative laryngoscopic examination showing right vocal cord

Written and informed consent was taken. After complete Pre-anaesthetic work-up and routine investigations, the patient was planned for Micro laryngeal surgery.

Suspension laryngoscopy (direct laryngoscopy) was performed under General Anaesthesia using a laryngoscope (Karl Storz 8590J) after intubation with No.5 spiral endotracheal tube. The tube was retracted posteriorly by laryngoscope to gain access to anterior commissure region. The mass was removed by cold steel method and haemostasis achieved. Macroscopically, the lesion was 1cm in diameter, soft and polypoid. Microscopically, the section was lined by stratified squamous epithelium and underlying stroma shows mild chronic inflammatory infiltrate and normal salivary gland tissue suggestive of Choristoma (Ectopic salivary gland tissue). No Granuloma/atypia was seen [Figure-2].

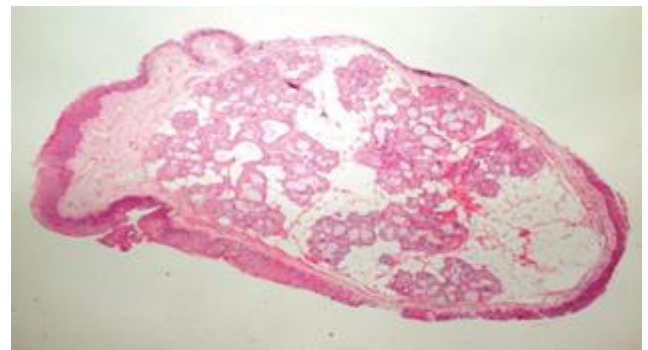


Figure 2: Right Vocal Cord with normal salivary gland acini

Post-operative voice rest was advised for 1 week, following which patient was kept on speech therapy. Patient was kept on regular follow-up until six months, when laryngoscopic examination revealed normal right vocal cord with normal phonation and respiration [Figure-3].



Figure 3: Post- operative laryngoscopic examination showing healed right vocal cord

Salivary gland Choristoma (SGC) are infrequent benign lesions classified under Heterotopic salivary gland tissue defined as normal salivary gland tissue occurring outside of normal distribution of the major and minor salivary glands (5). Three cases of vocal cord choristoma have been reported in the literature to date (2, 4, 6). The pathogenesis of this entity is still uncertain and is related to developmental anomalies. The differential diagnoses of these masses in the larynx comprise benign lesions such as laryngeal cyst, laryngeal nodules, contact ulcers, squamous papilloma, amyloidosis or granulomatous lesions such as Wegener's granulomatosis, sarcoidosis and tuberculosis (2). These conditions can be excluded by careful histopathological examination. Simple excision is sufficient for the treatment of these lesions to avoid infections and neoplastic transformation, although there is no evidence to support this recommendation. (7). SGC should also be differentiated from some infrequent malignant lesions. Some of these lesions are primary laryngeal adenocarcinomas, metastatic adenocarcinoma, salivary glandular tumours like acinic cell carcinoma, mucoepidermoid carcinoma or adenoid cystic carcinoma of the larynx. These uncommon tumours are also located in other areas (8).

3. Conclusion

Surgical excision is sufficient for treatment. Histopathological findings are useful for distinguishing this rare lesion. In conclusion, awareness of this rare entity is essential to avoid misdiagnosis.

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