

Mucoepidermoid Carcinoma

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Opinion

Mucoepidermoid Carcinoma (MEC) is the epithelial salivary gland neoplasm of the oral cavity. It accounts for <3% of all head and neck tumours. About 5% of these tumours occur in patients younger than 18 years old with women mostly affected. As its name implies, it is composed of mucus producing, squamous and intermediate type cells. About 2/3 arise within the parotid gland and 1/3 arise within the minor salivary glands. When MEC arises in minor salivary glands it can be located on the palate, retro-molar area, floor of the mouth, buccal mucosa, lips and tongue. Rarely, it can arise as primary jaw tumour or as laryngeal, lacrimal, nasal, para-nasal, tracheal or pulmonary tumour. It occurs most frequently in adults during the fifth and sixth decades of life. Although uncommon, it is the main malignant salivary gland tumour in children, particularly adolescents and affects women more often than men [1,2].

Mucoepidermoid Carcinoma was first reported by Massao and Berger in 1942 and by Stewart et al in 1945 as a separate distinct pathologic entity. All mucoepidermoid tumours are malignant, albeit in degree.

Clinically most tumours present as firm, fixed and painless swellings. Sublingual gland lesions may demonstrate pain in spite of small size. Superficial intraoral neoplasms may exhibit a blue-red colour and mimic a mucocele or vascular lesion. The mucosa overlying palatal tumours can be papillary. Cortical bone is sometimes superficially eroded. Symptoms can include pain, otorrhoea, paraesthesia, facial nerve palsy, dysphagia, bleeding and trismus [3,4].

Histologically MECs are classified into low, intermediate and high grade. Low-grade tumours commonly develop a nesting pattern with multiple well-circumscribed squamous nests containing numerous clear cells. Intermediate-grade tumours are less cystic and show a greater tendency to form large sheets of squamous cells and often have a more prominent intermediate cell population. High-grade tumours are predominantly solid, with greater degrees of atypia [5-8].

Differentiation of MEC in low grade, intermediate grade and high grade is at times difficult especially the differentiation between intermediate grade and high grade and between high grade MEC and poorly differentiated squamous cell carcinoma. Histopathological grading is an important prognostic factor regarding 5-year survival outcome (92 - 100% in low grade, 62 - 93% in intermediate grade and 0 - 43% in high grade) [9,10].

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