

A PAROTID TUMOUR PRESENTING AS UNILATERAL FACIAL NUMBNESS, EPIPHORA AND ABSENT BLINK REFLEX

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Head and neck tumours usually present in an easily recognised way. Occasionally, as in the present case, they give rise to a bizarre series of symptoms which baffles diagnosis. The case is reported because similar tumours could be encountered; over 2 years elapsed before the diagnosis was made and although the immediate outcome is good, the delay could have had disastrous consequences.

The patient was a 55-year-old truck driver who had suffered for over 2 years from the following symptoms:

Epiphora in his right eye;
Weakness of the right orbicularis oculi;
Absent blink reflex on the right eye;
Anaesthesia over part of the right face.

He was examined by ophthalmologists, neurologists and neurosurgeons and had innumerable tests including every variety of X-ray examinations, electroencephalograms, nucleotide brain scans and right brachial cerebral angiograms. All were normal apart from a sialogram which was interpreted as showing an extrinsic compression of a superior branch of the right parotid duct. Because of this he was referred to us for a parotidectomy.

At operation the superficial and deep lobes of the right parotid were excised, sparing of course the facial nerve. Frozen sections showed only normal parotid tissue. It was only after excising what was believed to be the whole parotid that the tumour was found lying beneath the right zygoma (Fig. 1). A frozen section showed a poorly differentiated carcinoma in accessory parotid tissue. An *en bloc* resection of the temporal fossa, including the accessory parotid gland, the zygomatic arch, the temporal artery, the masseter and temporalis muscles, was performed. A mucoepidermoid carcinoma of the parotid was found with perineural invasion of the zygomatic facial branch of the maxillary division of the trigeminal nerve. The accessory salivary tissue was composed entirely of serous cells, confirming the parotid-like nature of the tissue, rather than the mucus or mixed mucus and serous usually found in simple accessory salivary glands. The tumour was a little unusual, there being no single focus of tumour, but multiple small tumour nodules. The most disturbing feature was the perineural infiltration (Fig. 2), very similar to that seen in adenoid cystic carcinoma.

Postoperatively the seventh nerve function was normal except for inability to close the right eye, and a temporary tarsorrhaphy was done. The patient remains free of tumour.

DISCUSSION

The reason for the patient's symptoms was now clear. Perilymphatic invasion of

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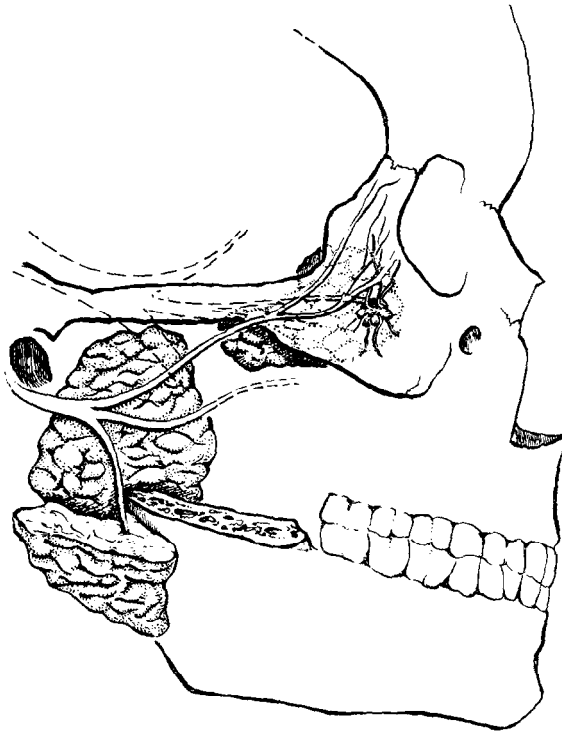


FIG. 1. Only after both lobes of the parotid had been removed was the tumour found arising in accessory salivary tissue deep to the zygoma.



FIG. 2. The marked perineural infiltration which was responsible for the patient's symptoms.
H. & E. $\times 180$.

the tumour along the zygomatic facial branch of the trigeminal nerve, as it pierced the zygoma, produced the area of anaesthesia on the right cheek. Extension of the tumour external to the zygoma involved the zygomatic branches of the facial nerve innervating the right orbicularis oculi muscle and resulted first in weakness of the blink reflex and later lagophthalmos. The main mass of tumour hidden medial to the zygoma remained unsuspected until after the deep portion of the parotid had been removed.