ADENOCARCINOMA WITH APOCRINE DIFFERENTIATION OF THE LACRIMAL GLAND

ADENOCARCINOMA CON DIFERENCIACIÓN APOCRINA DE LA GLÁNDULA LAGRIMAL

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ABSTRACT

Case report: A 74-year-old male presented with an orbital tumor located in the left lacrimal fossa. Ocular examination showed hypotropia, exophthalmos and palpebral ptosis.

Discussion: Removal of the tumor was performed by a lateral orbitotomy. The histopathologic study showed a tumor consistent with an adenocarcinoma of the lacrimal gland with apocrine differentiation (Arch Soc Esp Oftalmol 2007; 82: 229-232).

Key words: Adenocarcinoma, lacrimal gland, orbit, apocrine, lacrimal fossa.

INTRODUCTION

Tumors originated in the lacrimal gland account for about 10% of orbital tumors (1,2) and have a large diversity of anatomic and pathological types (3). Aprocine-differentiated neoplasias rarely occur in the ocular region (4) and even less frequently in the lacrimal gland (4), which is an ecrine gland. This short communication describes a case of lachrymal gland adenocarcinoma with aprocine differentiation.

RESUMEN

Caso clínico: Se presenta el caso de un varón de 74 años con una tumoraclón orbitaria localizada en la fosa lagrimal izquierda. La exploración oftalmológica mostró hipotropia, exoftalmos y ptosis palpebral del ojo izquierdo.

Discusión: La tumoraclón se extirpó mediante una orbitotomía lateral y el resultado anatomopatológico fue de adenocarcinoma de la glándula lagrimal con diferenciación apocrina.

Palabras clave: Adenocarcinoma, glándula lagrimal, orbita, apocrina, fosa lagrimal.

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CASE REPORT

A 74 year-old male, referred due to a tumoration in the left lachrymal fossa. The finding was detected by change during an computerized axial tomography (CAT) to discard a cerebrovascular accident. The ophthalmological exploration showed exophthalmos of the left eye (LE), palpebral phthosis and hypertrophy (Fig.1), with restricted mobility. The patient’s visual acuity in both eyes was finger counting at two meters, which was attributed to his possible cerebrovascular accident (CVA). He referred never having pain in the left orbitary region. The tumor observed in the CAT (fig. 2) was located in the lachrymal fossa and had a size of approximately 2x2 cm, which contacted the eye without producing significant compression and with the external straight muscle without apparent compromise. In addition, the patient exhibited discontinuous calcifications with sclerous edges in the superior and lateral orbit bone walls adjacent to the lesion. An additional study made with Nuclear Magnetic Resonance (NMR) revealed similar findings (fig. 3).

Surgical treatment was indicated and the tumor was accessed via a lateral orbitotomy, observing a rounded white-grayish mass in the lachrymal fossa which was pseudoencapsulated and with a hard and firm consistency (fig. 4) adhered to the surrounding tissue which eroded and perforated the adjacent bone. The exeresis was complete and the anatomic-pathological result was lachrymal gland adenocarcinoma with apocrine differentiation. After the surgery the patient was treated with antibiotics, oral corticoids, corneal lubricants and artificial tears.

Twenty-four days after surgery, a corneal ulcer appeared which required conjunctival covering. After consulting with the Oncology Service due to the general condition of the patient (cerebrovascular disease, comicial confusion syndrome), it was initially decided to abstain from additional therapeutic or diagnostic measures.

The patient died one year after the tumor extirpation due to a new cerebrovascular accident.
DISCUSSION

The mean age of appearance of lachrymal gland tumor is of 49 years, although they may appear at any age. Of said tumors, 45% are of epithelial origin (2). In our case, the anatomic and pathological diagnosis was of adenocarcinoma. The initial sign of lachrymal gland malign tumors is the emergence of an exophthalmia which evolves relatively quickly with inferonasal eye displacement, characterized by frequently exhibiting bone erosions as in the case of the instant adenocarcinoma. Benign lesions do not produce bone lesions or, if they do, they consist in expansions of the lachrymal fossa but without osteolysis signs (3). This case exhibited interruptions in the bone walls which were in contact with the tumor and which were subsequently confirmed during surgery. As confirmed by the subsequent anatomopathological study, the tumor was malignant. In addition, this type of lachrymal gland tumor usually produce bone sclerosis and sometimes calcifications as confirmed by the CAT scan made on our patient (3). In contrast with the benign tumors of the lachrymal gland, malignant tumors usually develop with painful exophthalmos (3). However, in our case, even though the patient exhibited a marked exophthalmos, he did not refer pain at any time, probably due to the low inflammation signs.

The lachrymal gland epithelial malign tumors comprise adenoid cystic carcinoma, the squamous cell carcinoma and the mucoepidermoid carcinoma (1). In this case, the anatomopathological diagnostic was of adenocarcinoma with apocrine differentiation. The number of patients studied with lachrymal gland adenocarcinoma is small because they are infrequent. For this reason it is difficult to determine the most adequate treatment. A retrospective study of 13 patients (5) concluded that exenteration followed by radiotherapy is the most effective treatment. In this case, as there was not apparent inflammatory component and the tumor was well defined, the initial treatment was only extirpation. Once the anatomopathological diagnostic was known, the Oncology service was consulted about the approach to be followed. Considering the concomitant pathologies and the general condition of the patient, it was decided to keep him in observation. No signs of relapse were observed before his demise by a CVA one year after tumor extirpation.

REFERENCES