Clinical records

Chondrosarcoma of maxilla

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Chondrosarcoma of the maxilla is a rare but a distinct clinical entity. The tumour belongs to the group of osteogenic sarcoma, which, according to Dahlin (1957) may be osteoid, chondroid or fibromastoid, depending upon the predominant cells. Ewing (1939) and Lichtenstein and Jaffe (1943) however, stressed the need for its separation from osteogenic series. Only sixteen cases of maxillary chondrosarcoma have so far been reported up to 1966 in the medical literature. Batsakis and Dito (1962) reported the largest single series of 3 cases.

Because of the rarity of this lesion, the case is being reported.

Case report

A.K., 45 years, female, was admitted on 15 June 1970 with the complaint of progressive painless swelling of the left cheek and posterior part of alveolus for the last five months. There was history of extraction of first and second left maxillary molars, when a local dentist attributed this swelling in the mouth to dental condition. There was no history of nasal obstruction, trauma or bleeding from nose.

On examination there was a bony swelling on the left side of cheek, extending laterally to the zygoma, medially to the lateral nasal wall and above to the orbital margin. The swelling was smooth, ill-defined, hard, and non-tender. There was slight proptosis of left eye with no restriction of movements of the eyeball. The vision was fairly normal (Fig. 1).

Oral cavity examination revealed obliteration of the gingivolabial sulcus and swelling of the posterior part of the left alveolus. It was firm to feel. Left first and second maxillary molars were missing and last molar was carious. Anterior rhinoscopy revealed naso-antral wall pushed medially and there was no mass in the nasal cavity.

There were no palpable lymph nodes in the neck.

Transillumination revealed opacity of the left maxillary sinus.

X-ray of the paranasal sinuses showed left antrum to be opaque, with destruction of its infero-lateral and orbital margins and a sclerotic area in the lower part of antrum (Fig. 2). Lateral view showed posterior wall of antrum to be intact. X-ray of the chest was normal.

The growth was exposed through Caldwell Luc's approach and biopsy taken. Neoplastic tissue gave a grating sensation when cut. Histopathological examination revealed it to be chondrosarcoma (Fig. 3). She was given a short course of 1,000, r units of deep X-ray therapy. After an interval of 4 weeks on 26 August 1970, left maxillectomy was performed. The tumour was found eroding the antero-lateral wall of the maxilla and floor of the orbit, but orbital periosteum was intact. The tumour was extending into the infratemporal fossa.

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The posterior wall of sinus, pterygoid plates and pterygopalatine fossa escaped. A well-circumscribed growth along with left maxilla was removed. The cavity was lined with split-thickness skin graft.

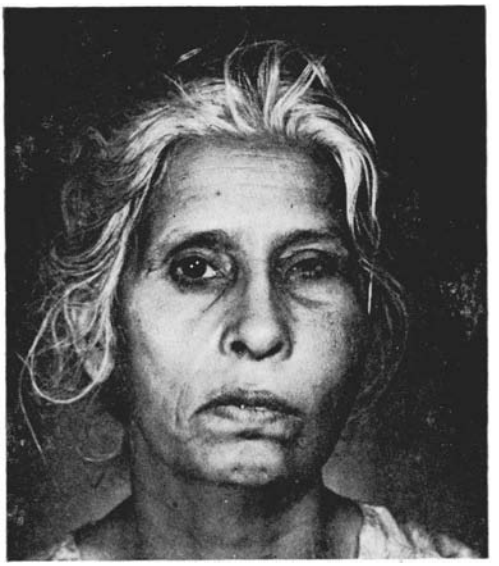


FIG. 1.
Showing swelling of left cheek.

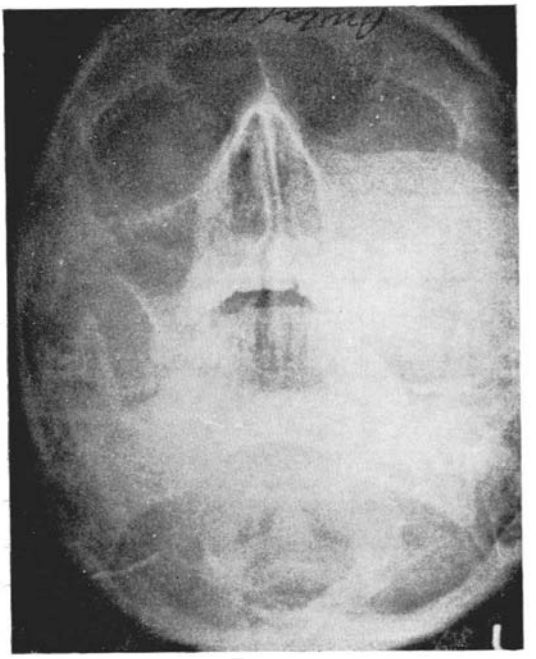


FIG. 2.
X-ray paranasal sinus showing opaque left antrum with destruction of its infero-lateral and orbital wall.

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Post-operative period was uneventful. Growth was sent for histopathological examination and was again reported to be chondrosarcoma. Unfortunately, there was some delay in obtaining the obturator with the result that the left cheek had receded. Patient is now wearing full denture plate and is being followed regularly for any evidence of recurrence or pulmonary metastasis (Fig. 4.)

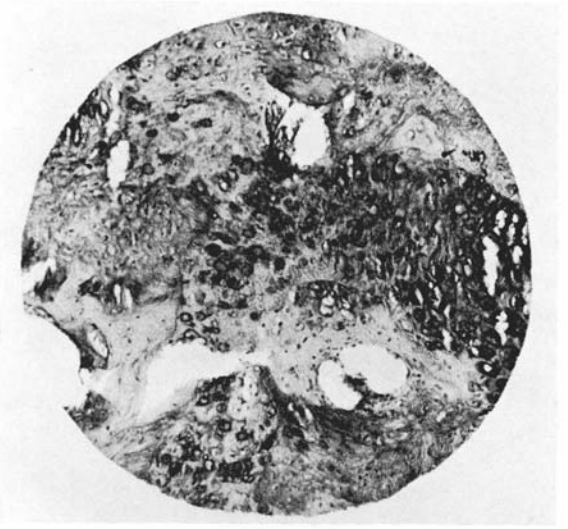


FIG. 3.
Histopathology of the chondrosarcoma under high power.



FIG. 4.
Post-operative full face view.

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Pathology

Gross examination revealed lobulated grey, firm neoplastic tissue measuring 6 cm × 5·5 cm × 5 cm occupying the entire left maxillary sinus. The superior and anterolateral walls of the maxilla were destroyed. The medial surface of s ecimen showed inferior and middle turbinates on it (Fig. 5).

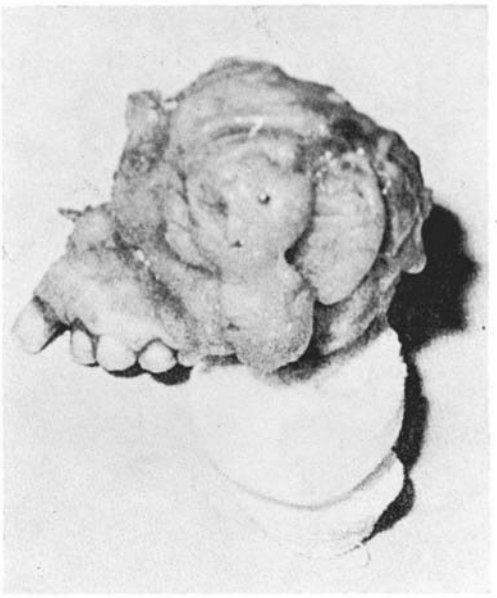


FIG. 5.
Showing resected maxilla with growth.

Discussion

Chondrosarcoma of the maxilla is a rare lesion. Radical surgery appears to be the most effective method of treatment for any prospect of cure, as spread to regional lymph nodes is infrequent. Metastasis usually occurs by haematogenous dissemination to the lungs.

The prognosis of chondrosarcoma of the maxilla is surprisingly good as is evident from the review of literature. Four of the sixteen cases are known to have lived for more than five years, with one of this group having survived for 30 years. These cases were reported by Harmer (1935), Sandler (1957), and Kragh *et al.* (1960). None of the three cases reported by Batsakis and Dito (1962) survived for one year. Botstein and Marcus's (1963) case lived for two years. Long term accurate follow-up in remaining eight cases is not available.

Summary

A case of maxillary chondrosarcoma is reported. One year follow-up has not revealed its recurrence.

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