Monophasic Synovial Sarcoma of the Infratemporal Fossa—Case Report and Review of the Literature

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Synovial sarcoma (SS) represents about 10% of all soft tissue sarcomas. It is believed that its origin would be found in cells that are related neither to ultrastructural nor to histological features of the synovial tissue. Head and neck is very rarely affected, with the lower extremities being most frequent. Complete resection with or without radiotherapy and chemotherapy is currently considered the best available therapy. This time we present the case of a patient with SS located in the infratemporal fossa, its diagnosis, treatment and evolution. According to our knowledge it is the first reported case in South America.

Keywords
Synovial sarcoma, head, neck, infratemporal fossa, computed tomography, magnetic resonance

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Case report
A 32-year-old man showed at the dental office in March 2014, due to pain in his left mandibular temporomandibular joint with about 3 months of evolution. Bruxism was diagnosed and a plane relaxation for 3 months was prescribed; however, the patient did not experience a good response.

In June 2014 he was referred to a maxillofacial surgeon who confirmed a volume increase in the left zygomatic region (see Figure 1). A computed tomography (CT) scan was performed, revealing a multilobulated large, aggressive, expansive, and destructive heterodense solid mass centered in the left masticatory space. The lesion also involved the oval foramen, ipsilateral infratemporal, pterygopalatine fossa. There was osteolitic compromise of the mandible, temporomandibular joint, pterygoid process, middle cranial base, and sphenoid wing. At its largest diameter, the lesion measured 8 cm and enhancement was seen following intravenous contrast administration with central hypodense areas suggestive of necrosis. Lymphadenopathy was observed with hypodense center in the II ganglionic level as large as 10 mm were present (see Figure 2C).

Subsequently, a magnetic resonance imaging (MRI) study was performed revealing in T1 sequence a solid isointense expansive process warping the posterior wall of the maxillary sinus and
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In this context, it was decided to perform incisional biopsy of the lesion; the histological analysis was reported as SS (see Figure 3). The study for metastasis was negative. Based on the size of the tumor, the Head and Neck Tumor Board (HNTB) recommended intensity modulated radiation therapy (IMRT) in order to reduce its volume and try posterior surgical resection.

After IMRT, with total dose of 70 Gy, a reduction in tumor mass is achieved; however, this is not enough to raise the total security resection margins, 6 months after treatment was completed, a follow-up computed tomography (CT) exam showed presence of lung nodules suggestive of metastasis. Following additional review by the HNTB, palliative chemotherapy was recommended. He received five cycles of Doxorubicin and ifosfamide with mesna, showing good tolerance, pain decrease and stabilization of pulmonary nodules. Upon finishing this article, 2 years after diagnosis, the patient remains in palliative care, with local complications and deterioration of his performance status.

Discussion

An epithelial form with columnar cells and other non-epithelial cells with fusiform are observed: SS in two different histological forms. The most common SS showing two types of shapes is known as biphasic. Tumors with only epithelial components are rare, and are called monophasic.
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Differentiation of the latter type with other types of neoplasias is difficult.11 The variety of our case corresponded to a monophasic SS; we performed the diagnosis through intense diffuse positive staining to vimentin and Bcl-2, and the positive focal dialing EMA and KAE1/3, which is typical of these tumors.

The current treatment of the SS is based on surgical resection with safety margins, with or without chemoradiotherapy. In HN, complete resection with adequate margins is difficult, and impossible in many cases, given the complex anatomy; however, it generates better results in terms of recurrence and survival. Regarding chemoradiotherapy, several strategies have been reported, with different results.

Some studies reported that postoperative dose radiotherapy of 50–65 Gy in patients with clear safety margins or microscopic residual tumor was effective in reducing local recurrence, but not survival,10–12 nor the chemotherapy before or after surgery in two different research works.17,18 Therefore, surgical resection with safe margins is most important; chemoradiotherapy effectiveness remains uncertain.

Distant metastases occur in up to 50–70% of cases, and are frequent in cervical lymph nodes by 10–20%. Overall, it is a poor prognosis, with a five-year survival rate of 25–62% and 10–30% for 10 years.1 Predictors of worse prognosis for SS have been proposed, such as diameter >5cm, biphasic type, primary site based skull, bone involvement, and positive margins after surgical resection.15,16

The causes of death in SS are recurrences and distant metastases (jungs after cervical lymph nodes). Although local control is difficult, it has been improved with the development of new surgical techniques. In our patient, IMRT treatment was decided due to the size of the tumor, and virtually no possibility of surgical resection with negative margins.

According to our knowledge it is the first reported case in South America. We present the limits of treatment of an infratemporal fossa SS. A more effective therapeutic confrontation is required, especially for tumors that cannot be completely resected.

Conclusions
According to our knowledge, this is the first reported case of an infratemporal fossa SS in South America. We present the limits of treatment of an infratemporal fossa SS. A more effective therapeutic confrontation is required, especially for tumors that cannot be completely resected.

References