INTRAMUSCULAR CAVERNOUS HAEMANGIOIMA-
A RARE FINDING IN ITS ASSOCIATION WITH MASSETER.

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ABSTRACT

We report here a case of intramuscular cavernous hemangioma of the left masseter muscle in a 23 year-old girl. Preoperative diagnosis of intramuscular cavernous hemangiomas of the masseter muscle is problematic. In that their might be confusion with parotid tumor or other muscular lesions. In a patient with soft-tissue mass suspected of representing a hemangioma, MR imaging may provide more specific information regarding the characteristics, the origin, and the extent of the lesion than other imaging modalities.

Key Words : Intramuscular Cavernous Hemangioma, Masseter

INTRODUCTION

Haemangioma are noncancerous growths that form due to an abnormal collection of blood vessels. They are usually found on the skin or internal organs. They constitute for 1% in head and neck region involving trapezius and masseter muscle but are misdiagnosed as parotid swellings. Hemangiomas are usually small, but in some cases they may grow large, or develop lesions and require removal. Haemangioma develop when blood vessels group together into a single lump. Experts are not sure why blood vessels group together like this, but they suspect it is caused by certain proteins that are produced in the placenta. Hemangiomas do not normally cause symptoms during or after their formation. However, they may cause some symptoms if they grow large, if there are multiple hemangiomas, or if they grow in a sensitive area.

CASE REPORT

A female aged 23 years old reported to the department of oral and maxillofacial surgery with a chief complaint of swelling and pain in the left cheek region below the buttress. Patient was apparently well when the pain started 1 month back. The Swelling was noticed by the patient as a small mobile nodule 1 year back. Thenodule grew in size with time and became painful on palpation a month back. The mass was palpated bimanually but could not be visible all the time and was slightly bigger the size of a strawberry. It was soft, mobile and slip sign was positive making the differential diagnosis as a lipoma. An excisional biopsy was planned and routine investigations like BT, Hb CT, E.S.R were normal. The nodule was continuously palpated bimanually while a 1.5cm incision was placed below the opening of parotid duct at the level of occlusion adjacent to mandible 2 molar. The tissues were bluntly dissected and the nodule which seemed encapsulated was stabilized extraorally with a finger and a thumb. A suture thread was passed through the lesion which could be seen within the tissues and was tied to the opposite molar. The lesion was bluntly dissected with a dissecting scissors from the fibres of masseter. The lesion was taken out in total it was pink in colour, 3-0 silk sutures were placed. Bleeding was uneventful. The histopathological report showed numerous large cavernous spaces lined by flattened endothelial cells and filled with R.B.C suggestive of cavernous haemangioma.

DISCUSSION

Intramuscular hemangioma (IMH) is believed to be hamartomatous congenital neoplasm, and proliferation of benign vascular channels within the skeletal muscle. Intramuscular hemangiomas are rare and constituting 1% of all hemangiomas. Only 0.8% of all hemangioma and 10-20% of all intramuscular hemangioma are located in the head and neck region. Due to the fact that IMH has
nonspecific clinical findings it forms vascular channels which are benign making preoperative diagnosis difficult. It tends to be relatively well circumscribed, and insidiously infiltrates the muscle resulting in a mass with deceptive gross margins. Intramuscular hemangioma in the masseter muscle is also known as erectile hemangioma because it bulges when a patient chews. Unlike cutaneous capillary hemangioma they do not regress spontaneously and their deep location and unfamiliar presentation may cause a diagnostic dilemma.

Haemangioma generally occur in the first 3 decades of life. It has been suggested that they arise from malformed tissue because of repeated trauma or hormonal factors.

The diagnosis of intramuscular hemangiomas requires a high index of suspicion. Whenever a soft tissue density is encountered in the region of skeletal muscle in a young adult haemangioma should be considered in the differential diagnosis. FNAC usually shows the presence of haemorrhagic specimen and is commonly non-diagnostic but helps in exclusion of other soft tissue tumors and can be an investigative tool. Intramuscular haemangioma should always be considered in differential diagnosis of isolated muscle enlargement in a patient presenting with soft, fluctuant painless lesion. The management of IMH should be individualized based on such factors as tumour location, age, depth of invasion, Cosmesis. Most haemangioma are recognized clinically and do not require any investigation or any treatment as they will subside spontaneously. However imaging is needed in deep hemangiomas with normal overlying skin.

Many treatment modalities like cryotherapy, radiation therapy, steroid administration and embolization have been advocated but the treatment of choice at present remains surgical excision.

RESULT

The haemangioma was excised intraorally and the sutures were removed after 1 week. Healing was uneventful and the initial complaint of the patient with the swelling.

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