

## A Rare Case of Parotid Tumour

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**Abstract:** Kimura's disease, common pathology in the East, responsible of chronic neck swelling and is rarely reported.. This was a young 27-year-old male, with no particular disease history, who had recurrent non-inflammatory swelling next to the left parotid region. Biology revealed an pleomorphic adenoma , eosinophilia and increased serum IgE. The histological examination of the mass biopsy concluded to Kimura disease. His painless character and chronic evolution delay the time of diagnosis. This case proves the reality of this disease, which must find a place in the diagnosis approach of head and neck swelling.

**Keywords :** parotid, kimura disease

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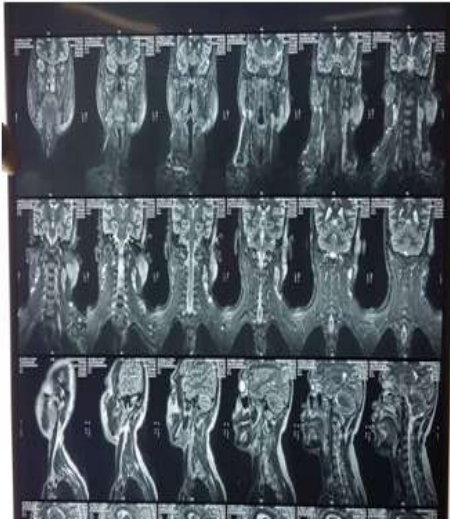
### I. Introduction

Kimura's disease or eosinophilic hyperplastic lymphogranuloma is a chronic inflammatory disease of unknown etiology. It is manifested by swelling of subcutaneous sitting in the cervical region; they are accompanied by satellite lymphadenopathy associated with hyper eosinophilia and elevated serum IgE [1]. The prognosis is good.

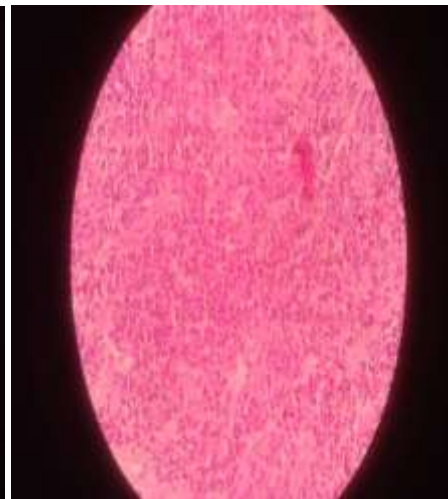
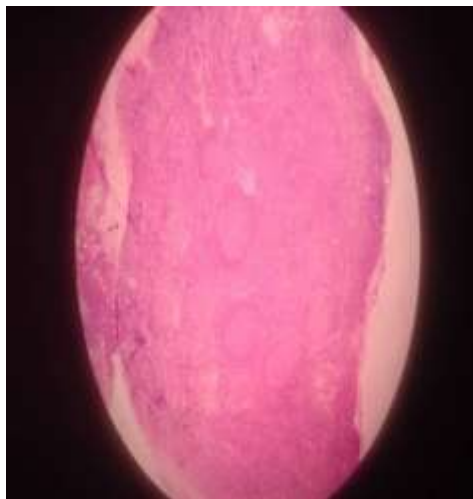
### II. Case Report

A 27 years old male presented with chief complaints of swelling below and behind left ear for past 2 years which was insidious in onset and gradually increased in size. There was no variation in size on food intake. Patient had history of pain over the swelling which was dull aching, intermittent, not radiating, not aggravated by food intake and got relieved by medications. patient had no history of fever/ evening rise of temperature / chronic cough. There was no history loss of appetite / loss of weight /difficulty in chewing / difficulty in closing eyes. No history of trauma. Patient was not a known DM/SHT/BA/TB/Heart disease/Epileptic. Patient had a history of previous left superficial parotidectomy surgery done 4 yrs back for pleomorphic adenoma of left parotid. On examination patient had a swelling of size 5X 4 cm in the left parotid region, oval shaped with margins well defined, surface was smooth and induration was present over the swelling and no redness. There was a lazy s surgical scar seen in left preauricular region. There was no sinus / no discharge from the swelling / no dilated vein over the swelling / no pulsation seen/ no other swelling seen. The swelling was not warm or tender and was firm in consistency. The skin over the swelling indurated, not pinchable and swelling had restricted mobility. Examination of right parotid region – normal. Examination of oral cavity was normal. There was no evidence of facial nerve palsy and there were multiple nodes, largest of size 2\*1 cm , mobile, not tender noted in level II,III,IV on the left side. Probable diagnosis of malignant left parotid tumour was predicted. Proceeded with the investigation. Chest Xray was normal. usg left parotid region was done which showed features suggestive of pleomorphic adenoma.USG neck revealed multiple enlarged nodes in Left level II , III , IV nodes. FNAC of the swelling was done and it showed features suggestive of pleomorphic adenoma. USG GUIDED FNAC of neck nodes showed features of granuloma formation suggestive of tuberculosis. MRI NECK was done and it showed hyperintense mass involving superficial and deep lobe of left parotid gland extending into subcutaneous plane posterosuperiorly to temporal region inferior to submandibular region. Multiple intra parotid lymph nodes was present.

After obtaining opinion from surgical oncologist, patient was taken up for conservative superficial It parotidectomy. Specimen sent for HPE. Microscopic multiple section studied shows portion of salivary gland parenchyma and adjoining lymphnode exhibiting marked hyperplasia of lymphoid follicles with inter follicular areas showing dense sheets of eosinophils forming EOSINOPHILIC MICROABSCCESS. Focal areas shows high endothelial vascular proliferation. Portion of parotid gland is also involved. Features suggestive of KIMURA DISEASE



[mri neck]



[Hpe Of Kimura Disease]

### III. Discussion

The disease was first described in China by Kim and Szeto in 1937 under the term Eosinophilic hyperplastic lymphogranuloma and finally systematic description made by Kimura et al in 1948. Kimura disease is commonly seen in Asian males affecting in the mean age of 32 yrs with a male : female ratio of 6:1<sup>2</sup>. It is a rare chronic inflammatory disorder that involves subcutaneous tissues and occurs predominantly in the head and neck region, frequently associated with lymphadenopathy and salivary gland involvement<sup>3</sup>. It is a benign condition of unknown etiology and is always confused with another rare entity named Angiolymphoid Hyperplasia with Eosinophilia (ALHE) which occurs in superficial skin layer<sup>4</sup>. It usually presents as painless subcutaneous mass in the head and neck region along with blood and tissue eosinophilia.

There will be elevated Ig E levels. It is a benign condition and is usually self limiting occasionally presenting with renal involvement with nephrotic syndrome being the most common association and proteinuria occurs in 12 – 16% of cases<sup>5</sup>. Typical histological features are Follicular hyperplasia with abundant lymphocytes, plasma cells, eosinophilic microabscess and has numerous proliferating small blood vessels. Treatment maily consist of oral corticosteroids,leflunomide if unresponsive to corticosteroids,Cyclosporine, IVIG,Oral pentoxifylline, all trans retinoic acid, Imatinib, may be an effective treatment. Surgical treatment involves conservative surgical excision. The main concerning problem is recurrence which is common. Radiotherapy can also be tried for recurrent cases with a dose of 20-45 Gy.<sup>6</sup>

#### **IV. Conclusion**

Although Kimura disease is very rare, nevertheless it shows the universal distribution of this disease. since it usually presents as a painless swelling and chronic evolution of the lesion which may last several years but also the absence of malignancy, diagnosis should be always kept in mind.

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#### **References**

- [1]. Yuen, H.W., Goh, Y.H., Low, W.K., et al. (2005) Kimura's Disease: A Diagnostic and Therapeutic Challenge. Singapore Medical Journal, 46, 179-183.
- [2]. Herrero-Basilio, M.Y., Valenzuela-Serrano, M.I., Arranz-Salas, I.M., et al. (2006) Kimura Disease in an African Patient. British Journal of Oral Maxillofacial Surgery, 44, 317-319.
- [3]. Larroche, C. and Blétry, O. (2005) Kimura's Disease. Orphanet Encyclopedia.
- [4]. Dib, N., Benhammou, A., Nazih, N. and Essahali, L. (2008) Kzadri Maladie de Kimura à propos d'un cas J Tun ORL.
- [5]. Chong, W.S., Thomas, A. and Goh, C.L. (2006) Kimura Disease and Angiolymphoïde Hyperplasia with Eosinophilia: Two Disease Entities in the Same Patient; Case Report and Review of the Literature. International Journal of Dermatology, 45, 139-145.
- [6]. Gentilini, M. (1993) Gentillini Marc Médecine Tropicale. 5th Edition, Médecine-Sciences, Flammarion.

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