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AN INSIGHT INTO VERRUCOUS CARCINOMA

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Abstract: Verrucous carcinoma (VC) is a variant of squamous cell carcinoma often referred to as snuff dippers cancer because of its high rate of incidence in those who use snuff. A patient aged 57 years reported with a chief complaint of white growth in the left cheek region since 1 year. The growth was gradual in onset, and increased size since the patient noticed it. No history of pain, bleeding, or difficulty in swallowing was reported. No history of any topical application and no similar growths were noticed elsewhere in the body. The left cervical lymph nodes were involved to level 3 which were around 1 cm diameters soft and movable. Intraorally, a well-defined keratotic mass with finger-like projections on the surface was present of 5 cm × 4cm, roughly oval in shape, well-defined borders on buccal mucosa at the level of occlusal plane near the molar region extending anteriorly till the commisure of the lip. Based on the clinical appearance provisional diagnosis of VC was given after which incisional biopsy taken confirmed the lesion as verrucous hyperplasia (VH).Verrucous carcinoma is best treated with surgical excision of the lesion, which was already proven and has less chances of recurrence.

Keywords: Verrucous carcinoma, verrucous hyperplasia, surgical excision, Reoccurrence.

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INTRODUCTION

Verrucous carcinoma (VC) is a variant of squamous cell carcinoma often referred to as snuff dippers cancer because of its high rate of incidence in those who use snuff[1].Most patients with verrucous carcinoma have a good prognosis. Local recurrence is not uncommon, but metastasis to distant parts of the body is rare.

Oral cavity is the most common site of the VC with predilection for adult male patients and has preponderance in smokers or those consuming tobacco products. Patients with oral verrucous carcinoma may be at greater risk of a second oral squamous cell carcinoma, for which the prognosis is worse[2].

Clinical manifestations of the verrucous carcinoma include a slow growing, diffuse, exophytic lesion usually covered by leukoplakic patches. Invasive lesions quickly invade bones and can rapidly become fixed with underlying periosteum and cause gradual destruction of jaw bone.

Lesion shows painful multiple rugae-like folds and deep clefts between them[3].Verrucous carcinoma may occur in various head and neck locations, as well as in the genitalia. The oral cavity is the most common site of this tumor. The ages range from 50 to 80 years with a male predominance and a median age of 67 years. VC may grow large in size, resulting in the destruction of adjacent tissue, such as bone and cartilage[4].

Surgery is considered the treatment of choice, but the extent of surgical margin and the adjuvant radiotherapy are still controversial.

CASE DESCRIPTION

A patient aged 57 years reported with a chief complaint of white growth in the left cheek region since 1 year. The growth was gradual in onset, and increased size since the patient noticed it. No history of pain, bleeding, or difficulty in swallowing was reported. No history of any topical application and no similar growths were noticed elsewhere in the body. The left cervical lymph nodes were involved to level 3 which were around 1 cm diameters soft and movable. Intraorally, a well-defined keratotic mass with finger-like projections on the surface was present of 5 cm × 4cm, roughly oval in shape, well-defined borders on buccal mucosa at the level of occlusal plane near the molar region extending anteriorly till the commisure of the lip. Based on the clinical appearance provisional diagnosis of VC was given after which incisional biopsy taken confirmed the lesion as verrucous hyperplasia (VH). H and E section of the submitted tissue showed stratified squamous parakeratinized epithelium which was hyperplastic in nature with its down growth into the cellular connective tissue (Fig 1). The proliferating epithelium showed pushing rete pegs into the connective tissue. Numerous cleft like spaces were seen with parakeratin plugging within them. The epithelial cells exhibited increase in the basal cell layer, some cells exhibited pleomorphism, hyperchromatism and mitotic activity. The underlying connective tissue showed infiltration of numerous darkly staining inflammatory cells. All the features are indicative of verrucous carcinoma.The case was planned to be

treated surgically with topical excision of the lesion was done intraorally along with level 3 lymph nodes excision by selective neck dissection and reassessed after 6 months for the requirement of radiotherapy. An extra oral approach was carried out to have an access of cervical lymphnodes as well as for submandibular gland. Incision was given 1.5 cm lateral to lower border of mandible to preserve the marginal mandibular nerve (fig2). Incision was carried out till the platysma muscle which was later carefully dissected to access the lymphnodes as well the lesion. 1cm of tissue surrounding the lesion was excised (fig3). The case was followed up currently for a period of 6months to evaluate for any recurrences.

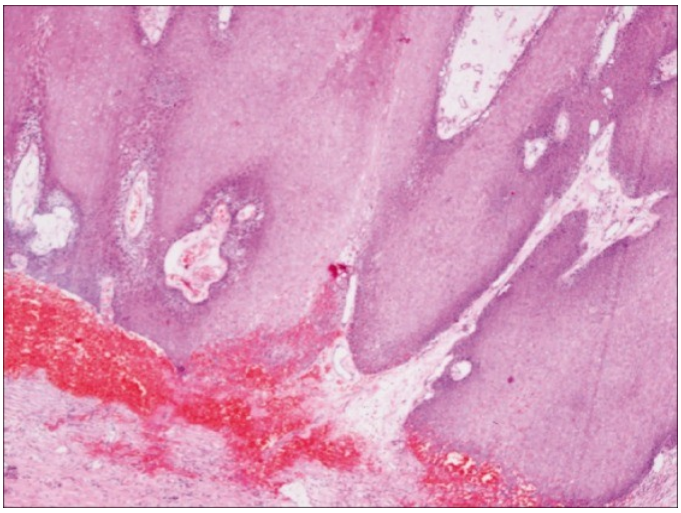

FIG 1. Histopathological examination showing infiltration of connective tissue with atypical epithelial cells

FIG 2: Deep neck dissection

FIG No :03SubMandibular salivary gland along with lynph nodes

CONCLUSION

Verrucous carcinoma is best treated with surgical excision of the lesion, which was already proven and has less chances of recurrence.

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