Oral Oncology 88 (2019) 16–17

Contents lists available at ScienceDirect

Oral Oncology

journal homepage: www.elsevier.com/locate/oraloncology

Letter to the editor

A myxoma in the temporomandibular joint: Case report and review of the literature☆

Dear Editor-in-Chief,

In response to the article published in your Journal "Myxoma of the mandibular condyle: Report of a rare case and review of the literature", I would like to describe a new case of this type of tumor in this extraordinarily rare location.

A 38 years old male with facial asymmetry and malocclusion consulted our Department. He had a long evolution mass in its left condyle that had been followed up in other center for 7 years without invasive treatment. In the MRI, a hyperintense with anular enhancement in T2 of 42 × 26 × 22 mm that infiltrated pterygoid muscles, mandibular ramus and condyle with bone erosion was shown (Fig. 1). Comparing these studies with previous ones we could see a slow growth.

An intraarticular jelly, pseudocapsuled mass with medial expansion was found and a condylectomy with a silicone ball placement was made. The typical star-shaped in plentiful estroma compatible with myxoma was found (Fig. 2).

Twelve months after surgery, patient was free of illness. The patient is pending a secondary reconstruction and occlusal correction with an orthognathic surgery with a TMJ prothesis if no recurrence is found.

Myxomas are benign but locally aggressive tumors that are rarely localized in bone tissue [1]. Most of bone myxomas affect maxilla and non-tooth-making areas are unfrequent [2]. Star-liked, multinuclear and hyperchromatic nucleus cells with endotelial, smooth muscle and/or fibroblastic tissue are frequent, all of them in a matrix rich in mucopolysaccharide acid [3,4].

Only two cases of intraarticular myxoma in the TMJ have been published [5,6]. There are other myxomatoid tumors in the literature but they do not seem to be real mixomas [7].

The patients were middle-aged (57, 42 and 38), two women and a man, without history of other important comorbidities. Two tumors were localized in the left condyle and one in the right one.

Mixomas usually show two different patterns. The multilobular pattern is the most frequent one and it's considered to have a similar origin to ameloblastoma or giant cell granuloma [8,9]. The second pattern is the unilocular one that seem to be less aggressive [10]. In all of the cases the pattern was multilobular. However, as the patient has had a follow up in other center, we have had the opportunity to have images of the last 7 years. It can be shown that the tumor has hardly changed. Although odontogenic multilobular myxomas have a tendency to be locally aggressive, we have seen that our tumor has barely affected neighbor structures and that the growth has been very slow. Further studies must be performed in order to determine whether the

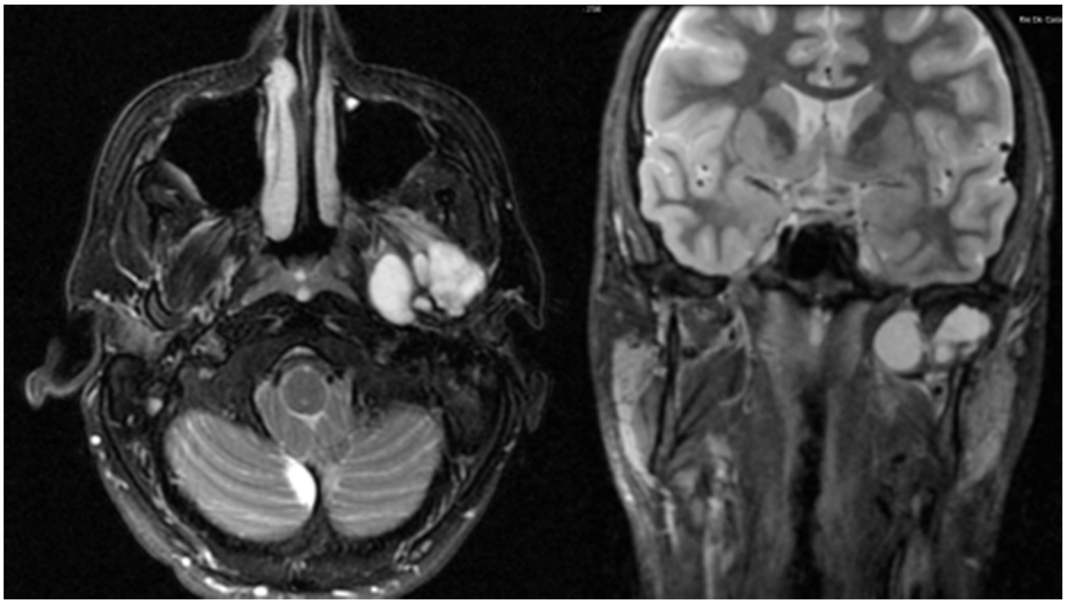

Fig. 1. MRI of the patient before surgery. Hyperintense multilobular image on the left condyle.

☆ This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

https://doi.org/10.1016/j.oraloncology.2018.11.017
Received 16 October 2018; Received in revised form 7 November 2018; Accepted 12 November 2018
Available online 16 November 2018
1368-8375/

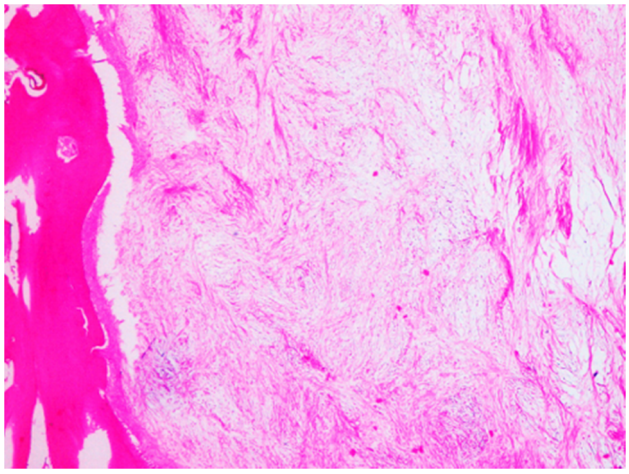

Fig. 2. Hematoxylin eosin tinction of the piece.

multilobular pattern that affects non-odontogenic bony areas have the same origin and behavior than odontogenic ones.

Although recurrence is rare, cases ten years after surgery have been reported [11]. The main theory proposed is an incomplete resection [12]. In three cases a complete resection has been performed, although the margins obtained have been different because in two cases a condylectomy was performed while the other case was treated with a curettage and cryotherapy. In any of the cases a recurrence has been reported. However, a long term follow up must be performed.

Although this is an extraordinary rare localization for mixomas in human, seven cases have been reported in dogs [13,14].

This possible diagnosis must be kept in mind for condylar tumors and included in the literature.

Conflict of interest

The authors indicated no potential conflicts of interest.

Acknowledgments

The present study was not funded by any organization.

References

[1] McClure DK, Dahlin DC. Myxoma of bone. Report of three cases. Mayo Clin Proc 1977;52:249–53.
[2] Williams HK. Advanced central myxoma of the jaws in Nigeria: clinical features, treatment and pathogenesis. Int J Oral Surg 1984;13:177–86. https://doi.org/10.1016/j.ijlcj.2011.05.007.
[3] Kumar V, Abbas AK, Fausto N, Mitchell RN. Robbins Patología humana, 8 ed.; 2008. p. 432.
[4] Stout AP. Myxoma, the tumor of primitive mesenchyme. Ann Surg 1948;127:706–19. https://doi.org/10.1097/00000658-194804000-00013.
[5] Halfpenny W, Verey A, Bardsley V. Myxoma of the mandibular condyle. A case report and review of the literature. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2000;90:348–53.
[6] de Andrade Lima EP, de Moraes Ramos-Perez FM, de Hollanda Valente RO, León JE, Ferreti Bonan PR, da Cruz Perez DE. Myxoma of the mandibular condyle: report of a rare case and review of the literature. Oral Oncol 2018;79:88–90. https://doi.org/10.1016/j.oraloncology.2018.03.003.
[7] Colburn JF, Epker BN. Myxoma of the mandibular condyle–surgical excision with immediate reconstruction. J Oral Surg 1975;33:351–5.
[8] Slootweg PJ, Wittkampf ARM. Myxoma of the jaws. An analysis of 15 cases. J Maxillofac Surg 1986;14:46–52. https://doi.org/10.1016/S0301-0503(86)80258-2.
[9] Shafer W, Levy BM. A textbook of oral pathology; 1983. http://doi.org/10.1016/j.enbuild.2018.06.028.
[10] Cuestas-Carnero R, Bachur RO, Gendelman H. Odontogenic myxoma: Report of a case. J Oral Maxillofac Surg 1988;46:705–9. https://doi.org/10.1016/0278-2391(88)90118-8.
[11] Harrison D, Lund VJ. Tumours of the upper jaw; 1993. https://doi.org/10.1288/00005537-199503000-00023.
[12] Bucci E, Muzio L Lo, Mignogna MD, de Rosa G. Odontogenic myxoma: report of a case with peculiar features. J Oral Maxillofac Surg 1991;49:91–4. https://doi.org/10.1016/0278-2391(91)90276-R.
[13] Dennis R. Imaging features of orbital myxosarcoma in dogs. Vet Radiol Ultrasound 2008;49:256–63. https://doi.org/10.1111/j.1740-8261.2008.00361.x.
[14] Parslow A, Taylor DP, Simpson DJ. Clinical, computed tomographic, magnetic resonance imaging, and histologic findings associated with myxomatous neoplasia of the temporomandibular joint in two dogs. J Am Vet Med Assoc 2016;249:1301–7. https://doi.org/10.2460/javma.249.11.1301.

A. Cinza[a,*], F. Monje[a], J.J. Fernandez de Mera[b]
[a] *Oral and Maxillofacial Surgery Department, Infanta Cristina Hospital, Badajoz, Spain*
[b] *Pathology Department, Infanta Cristina Hospital, Badajoz, Spain*
E-mail address: aitor.cinza@gmail.com (A. Cinza).

* Corresponding author at: Hospital Infanta Cristina, Avda. Elvas s/n, 06006 Badajoz, Spain.