Epitheliaal myoepitheliaal carcinoom

Please comply with the orders for medical information. If you have health problems, consult a doctor. Carcinoma is a medical term for malignant (malignant) reproduction of epithelial cells. Epithelium is the common name of the cells that form the upper layer of the skin or mucous membranes. Like other malignant tumors (cancerous tumors), carcinomas are caused by uncontrolled, division of hostile cells of the body and are specifically manifested through infiltrative growth (penetration of the tumor into the surrounding tissues), the formation of blood vessels in the tumor, the presence of mitosis figures in histological preparation and sometimes the remnants of dead cells. Histopathological picture of small lung cell carcinoma The medical name of a specific carcinoma is determined by the corresponding body tissue in which carcinoma appeared. The most important factor in the development of carcinomas is the negative influence of the environment, such as: too much sun (skin cancer); poor eating habits (in case of cancer of the lining of the stomach or intestinal mucosa); contaminated outdoor air, exposure to asbestos and smoking (cancer of the lining of the lungs). These effects take time to grow tissue into malignant tissue; therefore, carcinoma is rare in children or young adults. Hereditary predisposition and stupid failure also play an important role in the development of carcinomas. Various types of carcinoma: adenocarcinoma mammacarcinoma basal cell carcinoma squamous cell carcinoma Also carcinoma in situ - a pre-stage taken from the Netherlands is one of the leaders in the field of cancer research. Most research money goes to colon cancer, lung cancer, breast cancer and prostate cancer. They are the most common that makes sense, says Mischa Stubenitsky of KWF. But we always keep money free for research of rare species. How do you decide where the money goes? Scientists can submit a plan for KWF to raise money. This is appreciated by the international team of people in this field and by the Patient Advisory Committee. We are strict and give money to the very best research, says Stubenitsky. The kwf approach is also being criticised. Ingrid Desar is a Radboudumc internist and oncologist. With it comes cancer patients like Daisy, who are just a boat of all specialties. It also conducts research, but it knows that funding options for KWF are limited. The research proposal must be consistent with a number of points: preliminary work on promising results, impact on health care and a very large difference for a large group. I have almost no chance, says Desar. Medical journal Lancet inventory shows that one in a row four cancer patients in Europe have a rare cancer, but not a quarter of the money is being used. Tumors of the salivary glands occur in the mumps of the glands, submandibular, polyefish and small mucous salivary glands in the oral cavity and pharynx. The tissue of the salivary gland is a tissue with the largest number of histological tumor diagnoses. Therefore, this Directive does not specifically refer to each diagnosis. Histology The general rule is that the lower the salivary gland that the tumor assumes, the higher the likelihood of malignant tumors. Parotistumors are 80% benign, glandula submandibularis tumors 50%, and 80% of the tumors of the remaining salivary glands are malignant. Classification (WHO 1991) 1. Adenomas Pleiomorf adenoma (mixing cell tumor) Myoepithelioma Basalceladenoom Warthin (adenolymphoma) Oncocytoma Rare: tubular adenoma, Fatty adenoma, Duct papilloma, Inverted duct papilloma, Intraductal papiloom, Sialadenoma papilliferum, Cystadenoma, Papillary cystadenoma, Mucinous cystadenoma 2. Carcinoma Acinic cell carcinoma Mucoepidermoid carcinoma Adenoid cystic carcinoma Polymorphic low-quality adenocarcinoma (terminal ductal adenocarcinoma) Carcinoma-ex-pleiomorphic adenoma Epitelio-myoehelpital carcinoma Basaalceladenocarcinoma: fatty carcinoma, Papillary cystadenocarcinoma, Mucineus adenocarcinoma, Oncicious adenocarcinoma, Salivary canal adenocarcinoma, Adenocarcinoma, Maligne mioepithelioma, Squamous cell carcinoma, Small cell carcinoma, Undifferentiated carcinoma Other carcinoma 3. Lymphoma (including MALT, B-cells) 4. Non-epithelial tumors: sarcoma, fibroids, etc. 5. Metastases 6. Neoplastic swelling: cystic lymphoid hyperplasia (AIDS), cysts, necrotic sialometaplasia, onocytosis, sialoadenosis, chronic sclerosing sialoadenitis Brief description of some tumors Pleiomorf adenoma The most common benign parotis tumor (70-80%), mainly in the superficial lobe (paroti : submandibular : poblingual = 100 : 10 : 1). Has a slow progressive course and may develop (rarely) malignant. Occurs at all ages, with a peak of 40-60 years. A large number of localization occurs almost exclusively in case of relapse. After proper surgical resection, local relapses occur in 1-4%, often only after 10-20 years. Metastases are described, but very rare. Malignant degeneration (carcinoma ex pleiomorf adenoma) is very rare and occurs more often if the tumour exists longer (9.5% > 15 years). Warthin tumor The second most common benign parotis tumor (5-10%). Rare in other localizations. This is especially true in men. Has a slow progressive course, but infection can lead to a sudden increase. 10-15% is a lot of localization (ipsi / contralateral parotis). Malignant deravation occurs No. Local relapses are rare after proper cutting. Mucoepidermoid carcinoma Most commonly malignant tumor. There are several classification systems to distinguish high quality and low-quality tumors within these tumors. Classification of mucoepidermoid carcinoma only says something about tumors assuming parotitis. Mukoepidermoid carcinomas of small salivary glands should always be considered high quality. Dominated by mucinoic cells or >10% of cysts indicate low tumor degree of mumps (low degree: 6-12% recurrence and non-metastases vs. high degree: recurrence 50%, metastasis 70-80%). Operation staging and radicalization are also determined by local repetitive and forecasting. Acinic cell carcinoma occurs mainly on a parotitis, sometimes bilaterally. These tumors can metastasize (16-19%), sometimes only after many years. But first of all, there is a risk of local recurrence. The latter is sometimes with an interval of 30 years. Several cell types and growth patterns are distinguished, which have no prognostic interest. The stage is prognostic important. Adenoid cystic carcinoma There are three types of growth regimes (glands, tubules and solid) with a tendency to infiltrative, perius growth and poor restriction. First of all, adenoid cystic carcinomas with a solid method of growth have an unfavorable clinical course. The course is usually slowly progressive and although it is often possible to control the locoregional, 30-50% of these tumors metastasize in the long run, even after many years, into the lungs and bones. The stage of the tumor and the radicalization of the operation are the determination of the prognosis. Malignant lymphoma It may localize Hodgkin's disease (15%) non-Hodgkin's lymphoma (85%) Concern. NHL often contains MAL (lymphoid tissue associated with the mucous membrane) lymphoma, but all malignant lymphomas may occur in the salivary gland. SALYKLO lymphoma occupies a special place, since these tumors can sometimes be treated surgically. Patients with Sjogren's disease have a higher chance of having mumps in the NHL (40x). This is often a very insatiable form that does not require treatment. Diagnostic clinic Benign tumors almost always have slow progressive swelling without additional complaints. Rarely is a rapid progression (Warthin). When there is a deep lobe, the tumor is often less mobile and/or parafarynal swelling is visible. There may also be snoring (OSAS) or tubular dysfunction. Malignant neoplasms can also be slowly progressive and do not differ clinically from the benign process. Rapid growth (NHL), tumor fixation, pain, paralysis/paralysis, ulceration and /or suspicious glands in the neck indicate malignant tumors. Cytological studies Cytological examination is designed to eliminate lesions that are not reactive glands, infections, lymphoma or metastases. Benign difference – the tumor of the malignant salivary glands is also very important. The accuracy of cytological studies for this difference is about 80-90%. In case of small or cystic lesion, ultrasound behavior can be performed with a more reliable aspiration. In most cases, it is cytologically possible to recognize the exact type of tumor. However, when classifying a tumor based on cytological examination, the sampling error (carcinoma ex pleiomorf adenoma) should always be taken into account. In addition, there are several notorious traps. Cystic squamous cell damage (dd squamous cell carcinoma, cystic warthin). Cell-rich basoid vs mioepithelial lesions (dd adenoid cystic carcinoma, cell-rich pleiomoral adenoma, basal dialady) Imaging Imaging diagnostics is indicated only by a minority of tumors. Ultrasonic and ultrasonically controlled cytological puncture is very sensitive and can show tumors of 3 mm in size. Ultrasound can have a special value in detecting several disorders, distinguishing cystic abnormalities and diffuse swelling. Indication of use: Suspected cystic lesion (palpation – aspiration) Before failed cytological puncture: ultrasound puncture to repeat malignant tumor: research lymph node metastases MRI is preferred over CT, because MRI provides more information on the development of soft tissues. Indications are: Cytologically confirmed malignant tumor Suspicion of deep lobe tumor (less mobile, paraphic swelling) Recurrence or residue after previous cutout M staging chest photo, liver dysfunction or glandular little neck: CT thoracic balance + liver / ultrasound upper histological examination When there is cytological malignancy (and no metastases) surgical resection is almost always necessary. In lymphoma, to be able to accurately classify, other primary tumors as part of treatment. The exception is the NHL Sjögren, where the clinical and cytological picture is sometimes sufficient to comply with future policies. Since benign tumors usually have insufficient certainty about the diagnosis, these tumors progress slowly and can also develop, surgical resection is usually recommended here. A true biopsy often provides too little material to classify the NHL and has a risk of metastasis carcinoma. An open biopsy has a higher risk of tethering the facial nerve and tumor rotation and is therefore contraindicated (exception: ulcerative tumors). Both histological material and treatment require (partial) superficial or complete parotidotomy. (UICC 2002) T1 tumor < 2 cm in diameter without development for gland T2 tumor > 2 cm and ≤ 4 cm in diameter without development for the gland T3 tumor > 4 and / or development of non-glandparenchym T4a tumor invades the skin, mandibula, ear canal, facial nerve is t4b tumor invade skull base, processi pterigoidea or encasement t4a stadium classification (see general) N- and M classification: see introductions Prognosis scale for NCA / KUL treatment benign tumors If clinical studies and cytology indicate benign tumor, proper treatment is (partial) superficial parotidectomy for superficially located parotis tumors and total conservative parotidectomy of deep tumors. The goal is to completely remove the tumor covered with a layer of normal tissue, if possible. Facial nerve (or several branches) ante degree or retrograde is sought, clearly prepared and spared. Nerve auricularis magnus can sometimes be partially spared, but its usefulness is controversial. In the case of pleiomorphic adenoma, it is recommended to conduct a peroperative examination of freezing sundae of subdizogastic glands, since cytology is not completely reliable. Benign tumor of other localization is also surgically treated (exsoluble gland submandibularis / suprahyoidal dissection, etc.). After macroscopic and microscopic complete resection, there are no signs of radiotherapy. As a general rule, incomplete resection or contamination of the active field in the pleiomorphic part of adenoma, re-cutting and/or radiotherapy shall be reported. Even after the recurrence of surgical treatment, postoperative radiotherapy will basically have to take place. Primary malignancies If clinical studies and/or cytology indicate a malignant tumor, further treatment depends on the classification of TNM. If acting, surgical resection is always indicated (parotidotectomy: partially superficial or almost total – radical, level II). Treatment of tumors of the salivary glands should be evaluated on a case-by-case basis. They are classified according to the criteria for sublocalization squamous cell carcinomas (UICC 1997). In addition to the undisturbed function N VII always tries to save the nerve. If the nerve can be prepared responsibly, microscopic irradiation is acceptable. In the case of preoperative paralysis or paralysis, the nerve branch(s) concerned must normally be donated. If N VII is sacrificed, initial reconstruction should take place if possible (including those under 70 years of age). As a result, nerve auricular magnus/ suralis can often be used. Secondary static reconstruction (blepharoplastics, etc.), mime therapy, electrostimulation, etc. can be useful for aesthetic rehabilitation. Resection with skin, it can be reconstructed with graft, full-thickness skin graft, local rotation flap or free vascular rag, depending on the size and localization of the defect. Neck glands preoperative, neck is evaluated palpation and echo-led puncture. If this test is positive, a detailed cervical gland is performed. If the echo-led puncture is negative (as in pleiomorphic adenoma), a subdigastre lymph node (level II) test is performed in the sundae. If positive: a detailed cervical gland. If negative: there is no treatment for the neck. In the case of cervical gland metastases, postoperative radiotherapy should be carried out a detailed cut out of the neck (I-V). Radiation therapy After surgical treatment of malignancies, postoperative radiotherapy is necessary in the case of: cervical gland metastases, tumors larger than 4 cm, T3-4 tumors, facial nerve invasion, extraglandular development, perilymphatic development, high degree of malignant tumors (adenocarcinoma, 3 degree mucoepidermoid carcinoma, salivary duct carcinoma, squamous carcinomas). Radiation therapy is also indicated in adenoid cystic carcinomas or with severe radical resection or the development of a deep lobe. Low-grade carcinomas such as acinic cell carcinoma, low-grade mucoepidermodermal carcinoma and epithelial myoepithelen carcinoma usually do not require irradiation. (Think about visiting a dentist and dietitian before the onset of radiation) NO – 1-4 levels of elective radiation in the above indications N+ – unilateral locoregional radiotherapy after cervical glands Rapid neutron irradiation and acceleration and/or hypergroup radiotherapy may be of added value in disused tumours or recidyve. The value of chemotherapy has not been demonstrated. Follow-up in patients with tumors of the malignant salivary glands is observed for 5 years with an increasing interval (1-8 years every 6-8 weeks, 2 years every 3 months, 3rd year every 4 months, 4 years every 6 months. Adenoid cystic carcinoma: from 5 years 1x per year. Every year metastases are x-thorax. Patients with benign tumors can be discharged after a few months of explanation of Frey syndrome, risk of recurrence, neuromics, etc. Irradiated patients will continue to monitor local problems every year, if necessary. Problems.

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