بسم الله الرحمن الرحيم

شبكة المعلومـــــات الجامعية

التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

جامعة عين شمس

التوثيق الالكتروني والميكروفيلم

﴿ قـــســـم ﴾

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
علي هذه الأفلام قد اعدت دون آية تغيرات

يجب أن

تحفظ هذه الأفلام بعيداً عن الغبار

في درجة حرارة من 15 – 20 مئوية ورطوبة نسبية من 20-40 %

To be kept away from dust in dry cool place of
15 – 25c and relative humidity 20-40 %

بعض الوثائق الأصلية تالفة

بالرسالة صفحات

لم ترد بالأصـــل

PAROTID GLAND TUMORS RE-EVALUATION

CLINICOPATHOLOGICAL STUDY

Thesis
Submitted for partial fulfillment of
M.Sc. Degree in

GENERAL SURGERY

Presented by

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CONTENTS

LIST OF TABLES

INTRODUCTION

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INTRODUCTION

Tumors of the salivary gland have perplexed pathologists since Billroth originally described cylindroma in 1859.

The mixed tumor was identified by Virchow in 1803 and Nasse is credit with first description of acinic cell carcinoma in 1892. Although papillary cystadenoma lymphomatosum was recognized by Albacht and Arzt in 1910, the first cases described in American literature were reported by Warthin in1929 and the tumor is frequently referred by his name. In 1930 Spies and then 16 years later, Quattfebaum Dockorty and Mayo made important contributions to the knowledge of adenoid cystic carcinoma.

At about the same time an excellent study of mucoepidermoid carcinoma by Stewart, Foote and Baker appeared; recognition of this tumor as distinct pathological entity dates from this account, although the tumor has been described by earlier investigators. In 1952 Godwin used the term "benign epithelial lesion" to designate a pathological entity which had been previously reported under such terms "Mikulicz's disease" and chronic inflammation. This entity is frequently called Godwin's tumor.

In 1954 Godwin, Foote and Frazell described 27 cases of acinic carcinoma, current interest seems from this report. In the late nineteenth and early twentieth centuries most investigators concentrated on the histogenesis of mixed tumors. Currently, the most widely accepted theory is that of Ehrich

who believed these tumors to be unicellular in origin consisting of salivary epithelial cells. The myxoid substance being composed of sloughed epithelial cells trapped in inspissated mucous. Of more practical importance, however, are the difficulties encountered in determining the malignant or benign nature of these tumors.

The histological criteria for definition of various types of salivary gland tumors were clearly defined in 1954 by Foote and Frazell who at the same time established a practical classification. Despite recent advances in diagnosis, however, some tumors are not always readily defined.

In recent changes in the treatment of patients with parotid gland tumors, most clinicians now appreciate that the sound treatment decisions must be based on tumor extent (i.e. stage) as well as histologic appearance. Fewer radical procedures are now being performed and the facial nerve is usually spared unless involved by the tumor.

Salivary gland tumors constitute less than 3% of all neoplasms of the head and neck **(Van de Wal et al., 1997)**. Between 75% and 85% are found in the parotid gland. Benign tumors are much more common than malignant ones; they account for over four-fifths of parotid tumors ***(Batsakis, 1979)***.

The classification of salivary gland tumors has proved a most difficult and frustrating exercise. One of the major stumbling blocks is that most of the salivary gland tumors arise from or differentiate towards the same cell line;