Abstract:
Infantile myofibromas are benign mesenchymal tumors that are commonly found in the dermis and subcutaneous tissues of head and neck. Although most lesions are recognised during infancy and early childhood, several cases have been reported in older children and adults. We describe a case of 6 month old male child with left facial swelling for four months. The tumour is progressively increasing in size intraorally with a proliferating type of growth. CT scan showed well defined homogenous mass left cheek. The tumour was excised into to without residual tumour with excellent cosmesis using Weber Farquason incision.

Keyword: Infantile myofibroma, Weber Farquason incision

CASE REPORT:
A six month old male child presented with swelling left side of face, with proliferative growth inside cavity (Fig-1). The swelling was noted by his mother since two months of age which gradually increased in size. The child had difficulty in taking semisolid food and intermittent bleeding intraorally. On examination there was a large proliferative growth of about 4x3 cms intraorally in the left buccal region, about 1 cm below gingivo labial sulcus and 2 cms from retromolar trigone and mandible is free with intact skin. The swelling was soft, which bleeds on touch. CT scan face (plain & contrast) showed well-defined lobulated homogenous mass of about 4x3x3 cms in the soft tissues of the left cheek overlying the maxilla with no bony involvement (Fig-2). Intra oral biopsy of the lesion turned out to be Malignant fibrous histiocytoma.
Immunohistochemistry showed Actin, Vimentin positivity, suggestive of Myofibroma. By Weber Farquason incision (Fig-3) (an inverted L shaped incision extending from below left lower eye lid flanking left nose with upper lip split) left facial flap was raised, the proliferative lesion was dissected from left cheek and excised into to (Fig-4). The mucosal defect was covered with split skin graft harvested from thigh. Histopathological report confirmed to be infantile myofibroma. Child is on follow up without residual tumour with good cosmesis.

**Fig - 3 Showing proliferative tumour**

**Fig - 4 Showing tumour specimen**

**DISCUSSION:**
Myofibromas are mesenchymal tumors commonly found in dermis or subcutaneous tissue (1). First described by Stout (2) in 1954 and further classified by Chung and Enzinger (1) in 1981. Infantile myofibromas are characterized histologically by a proliferation of fibroblast. Fibroblasts A type of...
cell found in connective tissue; produces collagen. Infantile myofibromas are unusual lesions that involve the head and neck in approximately one-third of cases. The most common sites are the skull, scalp, and oral cavity, but cases involving the nose, pinna and auditory canal. Most cases of myofibroma occur in infants; presentation in older children and in adults is rare. Infantile myofibromatosis is generally considered to be a benign process, unlike aggressive fibromatosi

s and fibrosarcomas, which are invasive lesions with metastatic potential. Bony destruction may occur in myofibromatosis, and some authors have described aggressive and infiltrative lesion behavior(3). There are three types of infantile myofibromas: solitary myofibroma, multicentric fibromatosis without visceral involvement, and multicentric fibromatosis with visceral involvement(4). Solitary myofibroma and multicentric myofibromatosis without visceral involvement have good prognosis because these lesions often regress spontaneously. Conversely, myofibromatosis with visceral involvement can be fatal within days or weeks of birth, due to pulmonary or gastrointestinal involvement. Lesions are typically painless and range in size from 0.5 to 7.0 cm. Superficial tumors usually present as palpable, rubbery, firm nodules that are freely mobile, while deeper lesions are typically fixed. Skin changes, such as a purplish discoloration similar to a hemangioma may be present. Ulceration and skin atrophy have also been described. The nonspecific nature of the clinical presentation and the relative rarity of myofibromas present a diagnostic challenge. Even when a pathologic specimen has been obtained, these lesions continue to elude diagnosis because many other lesions display areas of myofibroblastic cells. Other cutaneous and subcutaneous lesions that are considered in the differential diagnosis include hemangiopericytoma, leiomyoma, fibrous hamartoma of infancy, cutaneous inflammatory pseudotumor, desmoid tumor, nodular fasciitis. The appropriate treatment varies according to the clinical situation. In cases of isolated lesions, especially in infancy, expectant management is adequate because these lesions typically involute during the first 2 years of life(4). Functional impairment or cosmetic deformity needs complete surgical excision. Complete surgical excision should be undertaken in cases of symptomatic visceral lesions. In some cases, intimate involvement of vital structures may dictate a more conservative excision. In cases where surgery might cause major morbidity, chemotherapy is an option for reducing the size of the lesion and alleviating associated symptoms(3). Recurrence rates for solitary myofibromas are low. Risk factors for recurrence include a location on the extremities, age greater than 5 years at presentation, and a previous incomplete excision. (5).

REFERENCES: