Abstract:
Basal cell adenoma of is one of the uncommon tumour of salivary gland. It usually affects the parotid gland. It occurs in older age group. It is a monomorphous adenoma. It usually appears as a firm and mobile slow-growing mass. In contrast to pleomorphic adenoma, it tends to be multiple and its recurrence rate after surgical excision is high. Histologically, isomorphic cells in nests and interlaced trabecules with a prominent basal membrane are observed. Here we described a case of Basal Cell Adenoma of parotid, its clinical presentation and discussion about the management of this rare entity.

Keyword: Basal cell adenoma, parotid, salivary gland.

INTRODUCTION
Basal cell adenoma (BCA) of the salivary glands is a rare tumour. It is classified in World Health Organisation (WHO) classification of Salivary Gland tumours as a separate entity. It represents 54% of monomorphous adenomas and 1-3% of major salivary glands tumours. It usually affects the fifth and sixth decade with female preponderance. It is a very low grade malignant tumour with high recurrence rate with good prognosis. Its frequent location is the parotid gland but it may occur in other sites like upper lip, buccal mucosa, lower lip, palate and nasal septum. Histologically, 4 characteristic patterns have been described: solid, trabecular, tubular and membranous. It is characterised by the presence of a basaloid cellular layer with a stockade pattern and rounded by hyaline substance. The absence of myoepithelial cells, present in benign mixed tumors and other salivary gland neoplasms, has been referred as characteristic of this tumour.

CASE REPORT A 49 year old female came to our department with swelling in the left parotid region for a duration of two and a half years. The swelling was gradually increasing in size. It was associated with pricking type of pain. Patient had a similar swelling in the same
region about seventeen years back and under- went excision of the swelling and unfortunately no biopsy report was available. For the current swelling we have done two Fine Needle Aspiration (FNA). Both came in favour of basal cell adenoma of the parotid gland. Clinically the swelling appeared to be superficial and proceeded with Ultrasonogram of parotid which implied the tumour is just infiltrating the parotid. Computer Tomography of the Cervicofacial region showed clearly a 2-cm well-defined hyper-take nodular image in the superficial parotid lobe was present. It was occupying the subcutaneous plane and into the left parotid gland. There was no neck nodes. With clinical and radiological investigation, we are dealing with a benign condition so we planned for Left Superficial Parotidectomy with excision of 5x3 cm superficial lobe of the left parotid gland and the specimen sent for Histopathological Examination. No important complications.
HISTOPATHOLOGICAL EXAMINATION:
Histologically, BCA is characterized by the presence of uniform and regular basaloid cells. These cells have two differentiated morphologies and are intermingled. One group consists in small cells with little cytoplasm and intensive basaloid rounded nuclei that are usually located in the periphery of the tumoral nests or islands. The other group is formed by large cells with abundant cytoplasm and pale nuclei that are located in the centre of the tumoral nests. A basal membrane-like structure rounds these tumoral nests, separating them from the surrounding connective tissue. Our case presented histological features similar to those referred, consisting of basaloid cells disposed in an external stockade pattern and pale nuclei cells in the centre of the nests. Basal membrane-like structures surrounding cellular nests showed intense eosinophilia which clearly delimited basaloid cells.

DISCUSSION
Salivary gland tumours are one of the common Head and Neck Tumours. Among them the Parotid Gland tumours are common. Most of the parotid gland tumours are benign (70-80%). Among which the Pleomorphic Adenoma are the frequent type. Monomorphic adenoma are very rare tumours. Basal Cell Adenoma is one of monomorphic adenoma. They are defined as epithelial benign tumours of the salivary glands. This tumour is subdivided into four types. Solid, Trabecular, Tubular and Membranous Clinically the tumour is a slow growing well encapsulated and not exceeding more than 3 cm in size.
. It is firm in consistency and mobile in all
direction and painless. The tumour is usu-
ally superficial and within the glandular
body. Grossly the tumour appears as a yel-
lowish brown in colour. The diagnosis of
pleomorphic adenoma is made only by
histopathological examination. Some may
prefer to diagnosis by FNA if the tumour is
accessible but histopathological examina-
tion of the specimen is confirmatory.
Histologically, BCA is characterized
by the presence of uniform and regular ba-
saloid cells. These cells have two differ-
enced morphologies and are intermingled.7
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nuclei that are usually located in the periph-
ey of the tumoral nests or islands. The
other group is formed by large cells with
abundant cytoplasm and pale nuclei that
are located in the centre of the tumoral
nests. A basal membrane-like structure
rounds these tumoral nests, separating
them from the surrounding connective tis-
sue. Solid BCA are formed by small cells
organized in a compact manner. In the tra-
becular and tubular subtypes, important
groups of cells exist. They are disposed in
narrow bands and ductal structures or in a
combination of both. Membranous subtype
is constituted by external cells in a stockade
pattern and by an intense hyalinized basal
membrane. Some authors have referred the
existence of an association between this
type and cutaneous cylindroma, trichoepi-
thelioma or eccrine spiradenoma of the
scalp.8,9 Differential diagnosis must be
mostly established with some unfavourable
entities, such as the basal cell adenocarci-
no-ma, adenoid cystic carcinoma and basa-
loid squamous cell carcinoma. In contrast to
BCA, an infiltrative growth, more mitotic fig-
ures (>4 mitotic count/10 HPF) and Ki67-
staining of 5% of the cells are observed
in basal cell carcinoma10. In the adenoid
cystic carcinoma, whirlpool of epithelial
cells, dark external cells in a stockade
pattern and a thick basal membrane-like
structure are observed. It is also referred
carcinomatous and perineural invasion.
Moreover, vascularization in the micro-
cystic areas is absent, in contrast to BCA,
in which multiple endothelial canals are
present. Basaloid squamous cell carci-
noma is characterized by the presence of
solid cells in a lobular fashion, close to
the superficial mucosa, in which cells are
small and have scarce cytoplasm with
hyper-chromatic nuclei without nucleoli.
These cells constitute small cystic spaces
filled by mucinous material. In this latter
entity, both populations of basal cells are
not observed, in contrast to BCA. Conti-
nuity of tumoral cells with epithelium of
the surface and squamous dysplasia are
also observed, in contrast to BCA.11 Pri-
mary treatment of BCA is surgical exci-
sion by means of a superficial or total pa-
rotidectomy in cases in which parotid af-
faction exists. Extracapsular excision is
performed in cases in which there is af-
faction of minor salivary glands in the
oral mucosa. Total parotidectomy rather
than superficial parotidectomy has been
proposed in the membranous type of
BCA. It is due to the elevated tendency to
multicentricity, multiple recurrences and
occasional malignant transformation. It is
mandatory not to disrupt the capsule, in
order to minimize the risk of recurrence
which is observed in rare occasions. Ma-
lignization of this tumour has been re-
ferred in two occasions. Despite this be-
nign behaviour, we think that it is com-
pletely necessary a long-term follow-up,
in order to detect recurrences in a prompt
time.
1. Cusheri Textbook of Surgery


