

Peripheral Facial Palsy and Glossopharyngeal Neuralgia Caused by Malignant Myoepithelioma

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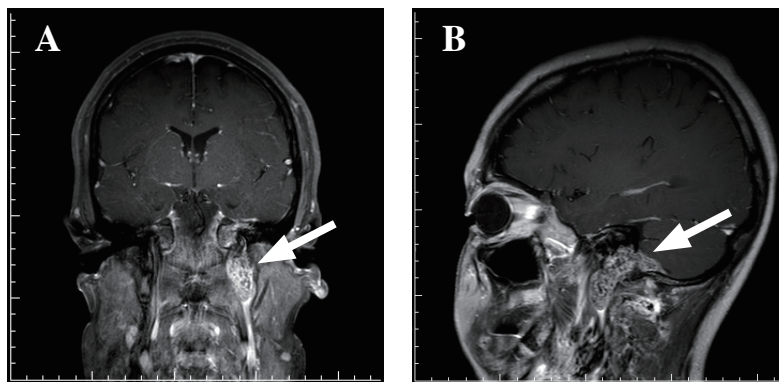


Figure 1. Coronal (A) & sagittal (B) gadolinium enhanced T1- weighted images with fat saturation revealed an irregular lobulated enhancing lesion in left jugular foramen with extension to the left CP angle (arrow).

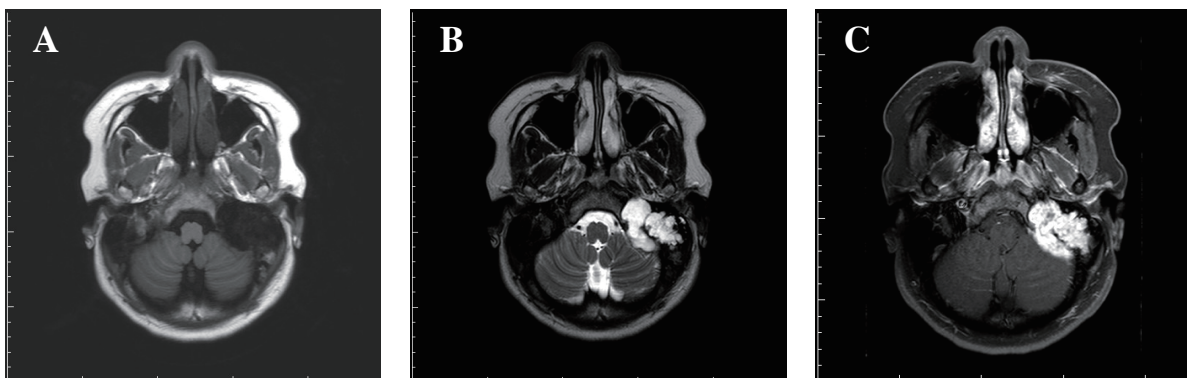


Figure 2. The lesion presented as T1 low signal (A), T2 high signal (B) with significant enhancement (C). The lesion also extended to the mastoid portion of left temporal bone.

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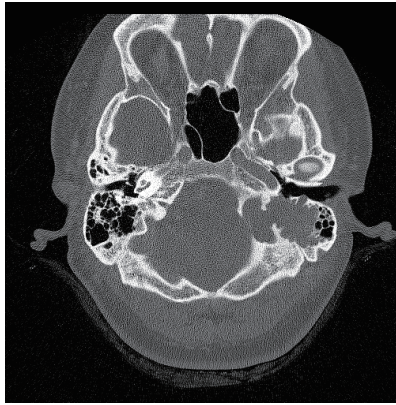


Figure 3. A CT scan with bone window setting revealed permeative destruction of adjacent bone due to the lesion with erosion of the bony wall of middle ear cavity.

A previously healthy 30-year-old female came to neurologic clinic due to intermittent dizziness and persistent left peripheral type facial palsy for more than half a year. Bell's palsy had been diagnosed initially but the symptoms/signs did not improve over months. She also complained severe sore throat and posterior otalgia while swallowing or yawning and ever near fainting recently. There was no hearing loss, lacrimation or salivation impairment, taste abnormality, hyperacusis, dysphagia, dysarthria, tongue atrophy or other focal neurologic signs. The blink reflex and facial nerve conduction study showed absent response of left facial nerve. Brain MRI demonstrated an irregular lobulated enhancing lesion in left jugular foramen with extension to left CP angle and permeative destruction of the mastoid portion of left temporal bone (Figure 1,2,3). The patient was then referred to neurosurgeon for further surgical intervention. Grossly, the tumor was unencapsulated, infiltrated in the temporal bone with necrosis. The mastoid segment of left facial nerve was wrapped by the tumor. Pathology showed the tumor was compatible with myoepithelioma.

Myoepitheliomas are rare salivary gland tumors, account for < 1% of all salivary gland tumors⁽¹⁾. Most myoepitheliomas are benign but occasionally malignant. Malignant myoepitheliomas may show invasive, infiltrative, or metastatic characters⁽²⁾ like our patient. Malignant myoepitheliomas had only been reported approximately 50 cases in literature⁽³⁾. They arose most commonly from parotid glands (50%)^(2,4). There were case reports of malignant myoepitheliomas in submandibular glands⁽⁵⁾, soft palate⁽⁵⁾, hard palate⁽⁴⁾, nasopharynx⁽⁶⁻⁷⁾, tongue base⁽⁸⁾, and cavernous sinus⁽⁹⁾. Our patient is the first case that malignant myoepithelioma grew along with the retropharyngeal space then invaded into the jugular foramen, temporal bone and cerebellopontine angle.

Due to the nerve compression in the mastoid and jugular foramen, our patient suffered from persistently severe peripheral type facial palsy and glossopharyngeal neuralgia. After the operation, her facial palsy improved, House-Brackmann⁽¹⁰⁾ scale decreased from grade V to III, and so did her glossopharyngeal neuralgia. This reminds us when encountered peripheral type facial palsy without any recovery, head and neck tumor is an important consideration other than Bell's palsy.

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