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Medical Report

Patient:

DoB:

Patient , was referred to our clinic, suffering from an osteodestructive, heterogeneous lesion within the right maxillary sinus, causing numbness, burning sensation of the right side of the face and epiphora. Imaging was not evident of orbital invasion. Biopsy, already taken elsewhere, was suggestive of an atypical spindle cell neoplasm, possibly myofibroblastic in type.

On September 15, 2021, he was operated on, for tumor removal, through a combined approach: Endoscopic medial maxillectomy/trans-pterygoid approach as well as transoral maxillectomy of the right side. Most of the tumor was removed to facilitate handling. There were no points of adhesion of its boundary to the walls of the maxillary sinus. Erosion of the right orbital wall was identified, but no extension of the pathology was found intraorbitally. The posterior wall of the maxillary sinus and the medial pterygoid plate were completely eroded. The pathology was removed up to the right sphenoid sinus. After sphenoidectomy, the tumor was circumferentially dissected in a retrograde manner. At the level of foramen rotundum, the tumor embraced the maxillary nerve (V2), which was also excised. There was no macroscopic evidence of residual disease at the posterior limit of excision, at the end of the procedure.

The neoplasm was regarded for treatment purposes as sarcoma, low grade. The patient received no chemo/radiotherapy and watchful waiting was selected as a follow-up plan.

MRI imaging 3 months postoperatively, revealed enhancing soft tissue material within the right maxillary sinus resulting in bone erosions/infiltration and extending into the surrounding soft tissues. There was new evidence of enhancement within the right cavernous sinus, close to the right internal carotid artery and the temporal lobe associated with erosive changes of the sphenoid bone. There was also evidence of contrast enhancement within the floor of the right orbit.

On January 13, 2022, he underwent endoscopic examination under general anesthesia and multiple biopsies were obtained, including samples from posterior wall of the right maxillary sinus, right pterygopalatine fossa, floor of the right orbit, lateral medial wall of the right maxillary sinus and posterior ethmoids. Tissue samples from all anatomical sites showed neoplastic texture with morphological and immunophenotypic characteristics similar to the previously known from the patient's history, myofibroblastic sarcoma. Necroses and numerous mitoses -parameters that have been considered in the literature as of unfavorable prognosis- were observed.

As a result, I am referring Mr to your center for evaluation and consideration of appropriate adjuvant therapy.

Sincerely,

Christos Georgalas
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