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PRIKAZ SLUČAJA
CASE REPORT

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Atipični pleomorfni adenom gornje usne: prikaz slučaja

Atypical Presentation of an Upper Lip Pleomorphic Adenoma: Case Report

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Sažetak
Pleomorfni adenom (PA) ili miješani tumor najčešća je neoplazma žlijezda slinovnica i obično se pojavljuje kao nespecifična klinička histopatološka manifestacija. Usne su drugo najčešće mjesto na kojemu nastaju novotvorine malih žlijezda slinovnica. Svrha ovog članka jest predstaviti slučaj 39- godišnje bjelkinje s oteklinom na desnoj strani gornje usne. U anamnezi je navela traumu u tom području nastalu prije osam godina. Prema mišljenju liječnika otekline su se u regiji pojavile zbog periapikalnog procesa vidljivog na ortopantomogramu. Intraoperativno kirurg je pronašao tvrdi čvorić u području oko labijalnog nabora. Histopatološkom analizom potvrđen je benigni miješani tumor žlijezde slinovnice. U ovom članku raspravlja se o devijaciji miješanog tumora žlijezda slinovnica između gornje i donje usne, zatim o kliničkoj diferencijalnoj dijagnozi i histopatološkom uzorku te o pravilnom liječenju.

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Ključne riječi
pleomorfni adenom; usna; žlijezde slinovnice, male

Uvod

Pleomorfni adenom (PA) ili miješani tumor najčešća je neoplazma žlijezda slinovnica i uzrokuje 60 do 65 posto svih većih i manjih tumora žlijezda slinovnica (1). Pojavljuje se kod 53 do 77 posto svih tumora parotide, 44 do 68 posto submandibularnih tumora i 38 do 43 posto svih tumora manjih žlijezda slinovnica (2). Najčešće obolijevaju žene u dobi od 50 do 70 godina, pa je omjer pojave bolesti između žena i muškaraca 1,9 : 1 (3) do 3,2 : 1 (4). (3,4).

Izrazima *pleomorfni i miješani* koristimo se kako bismo opisali svojstva različitih mikroskopskih uzoraka koji se uočavaju u ovom tumoru. Novotvorina se uglavnom sastoji od mješavine žljezdanog epitela, mioepitelnih stanica i vezivnotkivnih elemenata (2). Etiologija PA je nepoznata, ali zna se da su kromosomske anomalije na mjestima 8q12 i 12q15 povezane s tom neoplazmom (5).

Nepce je primarno mjesto gdje nastaje PA manjih žlijezda slinovnica (2 – 8). Tumor se pojavljuje kao asimptomatska čvrsta tvorba s dugim razdobljem rasta, a moguće su i ulceracije, bolovi i krvarenja (9).

Svrha ovog članka jest predstaviti slučaj pleomorfnog adenoma gornje usne koji je bi trebao biti osobito zanimljiv kliničarima zato što se klinički manifestirao kao upalni odontogeni proces.

Introduction

The pleomorphic adenoma (PA), or benign mixed tumour, is the most common salivary gland neoplasm, accounting for 60-65% of all major and minor salivary gland tumours (1). It constitutes 53-77% of parotid tumours, 44-68% of submandibular tumours, and 38-43% of minor salivary gland tumours (2). It occurs frequently in females, with the female-male ratio ranging from 1.9:1 (3) to 3.2:1 (4) and with a peak incidence between the 5th and the 7th decades of life (3, 4).

The terms pleomorphic and mixed are used to describe the characteristic diverse microscopic pattern seen in this tumour, which is composed of a mixture of glandular epithelium, myoepithelial cells and connective tissue elements (2). The aetiology of PA is unknown; however clonal chromosome abnormalities with aberrations involving 8q12 and 12q15 have been associated with this neoplasm (5).

The palate followed by the upper lip appears to be the most affected intraoral site of the minor salivary glands PA (2-8). This tumour presents as an asymptomatic firm mass with a long period of slow growth rate, whereas secondary to trauma the clinical features may also include ulceration, pain or bleeding (9). The aim of this article is to report a case of upper lip pleomorphic adenoma that is of particular interest to dental clinicians due to its atypical clinical presentation by resembling to inflammatory odontogenic lesions.

Prikaz slučaja

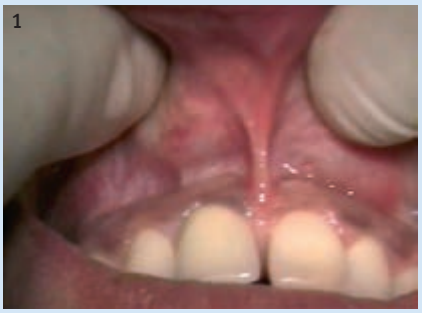
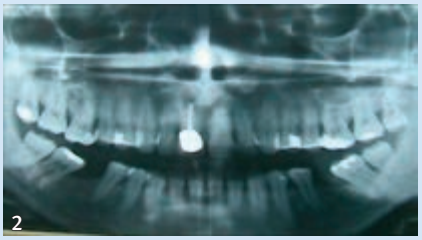
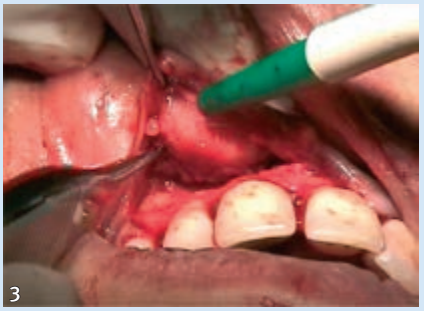
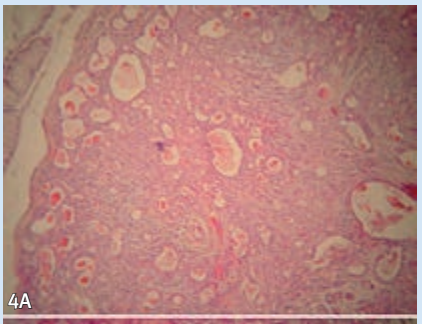
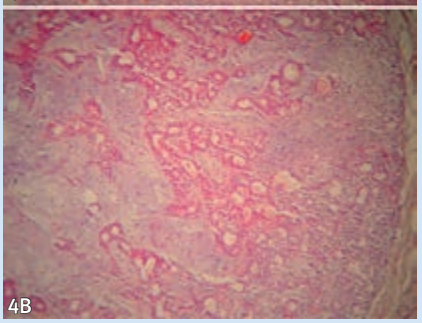
Žena u dobi od 39 godina upućena je u našu privatnu kliniku radi pregleda otekline na desnoj strani gornje usne. Njezina opća anamneza bila je bez osobitosti – bez ikakvih bolesti i alergija. Pacijentica također nije pušila i samo je povremeno popila alkoholno piće. U stomatološkoj anamnezi bila je navedena trauma desnoga maksilarnog centralnog inciziva prije osam godina kada je kao terapija bilo određeno endodontsko zbrinjavanje zuba. Pacijentica je istaknula da vać tri godina može napipati asimptomatski čvorić u predjelu gornje usne. Bol se na tom mjestu počela pojavljivati prije mjesec i pol, a blaga oteklina prije tjedan dana. Tijekom intraoralnog kliničkog pregleda uočena je oteklina u mukolabijalnom naboru iznad desnih maksilarnih inciziva (slika 1.). Kliničkim pregledom nisu zapažene abnormalnosti glave i vrata. Na rendgenskoj slici bila je vidljiva periapikalna lezija iznad desnoga centralnog inciziva, što je upućivalo na to da je potrebna endodontska terapija (slika 2.). Na temelju anamneze te kliničkoga i radiološkog pregleda postavljena je privremena dijagnoza koja je uključivala odontogenu upalnu etiologiju kao što je, primjerice, pariapikalni granulom ili cista. Ordiniran joj je tjedan dana amoksicilin 500mg/6h, pa se oteklina djelomice povukla, a prestali su i bolovi.

Na ponovnom pregledu nakon tjedan dana uočena je u predjelu mukolabijalnog nabora pokretna dobro ograničena tumorska masa dimenzija 1 x 0,7 centimetara. Umjesto revizije endodontskog liječenja, terapija izbora bila je apikotomija i retrogradno punjenje. Pod lokalnom anestezijom (2-postotni ksilokain s epinefrinom 1 : 100000) pristup apeksu bio je osiguran trokutastim režnjem i horizontalnim intrasulkularnim rezom između zuba 12, 11 i 21, te vertikalnim rasteretnim rezom distalno od zuba 21. Odignut je puni mukoperiostalni režanj te je otkrivena nodularna, čvrsta nakupina tkiva nepovezana s periapikalnom lezijom. Bila je u području mukolabijlanog nabora i pružala se u područje mišića *orbicularis oris* (slika 3.). Učinjena je ekscizijska biopsija meke tkivne mase bez enukleacija te lokalna kiretaža zahvaćene kosti. Nakon uspostavljene hemostaze uklonjena je apikalna trećina korijena i korijenski kanal retrogradno je napunjen Super EBA-om. Režanj je zašiven svilom 3 : 0. Postoperativno razdoblje i cijeljenje proteklo je bez osobitosti. Histopatološkim pregledom meke tkivne tumorske mase ustanovljena je inkapsulirana lezija s područjima prepunima epitelnih stanica poredanih u obliku vrpce i cijevima ispunjenima eozionfilnim materijalom (slika 4. a). Intercelularni matriks sadržavao je fibrozno i hijalino tkivo te miksoidno područje (slika 4. b). Histopatološki dijagnosticiran je pleomorfni adenom. Histopatologija intraosealne periapikalne regije potvrdila je fibrozno tkivo s izrazitim upalnim infiltratima, što upućuje na periapikalni granulom. Na kontrolnom pregledu nakon tri godine nije bio uočen recidiv.

Case report

A 39 year old Caucasian female was referred to our private clinic for evaluation of a swelling on the right side of her upper lip. The medical history was unremarkable, as there was no reference of any other disease, no known allergies, no history of smoking and she was a social drinker. According to the dental history the patient suffered a trauma on the maxillary right incisor eight years ago, and endodontic therapy was the treatment of choice. The patient also reported the presence of a palpable, asymptomatic nodule in the above region for the past three years. Furthermore, approximately one and a half months ago the patient started feeling a subtle pain in the upper lip followed by a swelling for the past week. On intraoral clinical examination, an obliterated mucolabial fold was observed in the region of the right central and lateral maxillary incisors corresponding to the aforementioned upper lip swelling (Figure 1). Head and neck abnormalities were not noted on clinical evaluation. Radiographic examination revealed the root canal therapy of the right maxillary central incisor, whereas a radiolucent periapical lesion was also apparent (Figure 2). Based on the history, the clinical and radiographic features, the provisional diagnosis included lesions of odontogenic inflammatory aetiology, such as the periapical granuloma or periapical cyst. Thus, amoxicillin 500mg/6h was prescribed for a week, resulting in a moderate recession, while the pain had subsided.

On re-examination after one week, a persisting mobile, well circumscribed tumor-like lesion measuring 1cm x 0.7cm was seen in the mucolabial fold. Apicoectomy and retrograde filling were decided on over repeating the root canal therapy. Under local anaesthesia (xylocaine 2% with 1:100000 epinephrine) access to the apex of the tooth was achieved through a triangular flap consisting of a horizontal intrasulcular incision of the teeth 12,11and 21 and a vertical releasing incision distal to the tooth 12.A full thickness mucoperiosteal flap was elevated and a nodular, firm soft tissue mass was revealed which was not related to the periapical lesion. The mass was located at the depth of the mucolabial fold and was extended into the orbicularis oris muscle (figure 3). Excisional biopsy of the soft tissue mass was performed followed by enucleation with local curettage of the intraosseous periapical lesion. Haemostasis was achieved, the apical third of the root was resected and the retrograde filling was completed using Super EBA. The area was sutured with 3:0 silk and the post-operative course and healing was uneventful. The histopathologic examination of the soft tissue tumour revealed an encapsulated lesion that showed cellular areas with epithelial cells arranged in cord and duct-like structures filled with eosinophilic material (figure 4A). The intercellular matrix demonstrated fibrous, hyaline and myxoid areas (figure 4B). The histopathological diagnosis was pleomorphic adenoma. The histopathology of the intraosseous periapical lesion demonstrated fibrous connective with intense inflammatory cell infiltration consistent with periapical granuloma. There was no evidence of recurrence after three years follow up.

Slika 1. Obliteracija mukolabijalnog nabora u području desnoga maksilarnog centralnog inciziva
Figure 1 Obliteration of mucolabial fold in the region of the upper right central and lateral incisor
Slika 2. Ortopantomogram – vidi se endodontski zahvat i periapikalna lezija desnoga maksilarnog centralnog inciziva
Figure 2 Panoramic radiograph. Root canal treatment and periapical lesion of the upper right central incisor are observed
Slika 3. Intraoperativni izgled čvoraste lezije u mukolabijalnom naboru
Figure 3 Intraoperative view of the nodular lesion in the mucolabial fold.
Slika 4. A Lezija je dobro definirana i ima tipične histopatološke naznake pleomorfnog adenoma; hematoksilin i eosin, povećanje x 100
Figure 4 A The lesion was well defined and showed the typical histopathological features of pleomorphic adenoma, hematoxylin and eosin stain magnification X100
Slika 4. B Vrpčasti cjevasti prostori u miksoidnom matriksu; hematoksilin i eosin; povećanje x 200
Figure 4 B Cords and ductal spaces in mixoid matrix, hematoxylin and eosin stain magnification X200

Tablica 1. xxx
Table 1 Clinical differential diagnosis of PA

Mekotkivne tvorbe na gornjoj usnici • Soft tissue masses of upper lip	**Posebne karakteristike za diferencijalnu dijagnostiku • Special characteristics for differential diagnosis**
Iritacijski fibrom • Irritation fibroma	Obično normalne boje • Usually normal in color
Tumor žlijezde slinovnice • Salivary gland tumor	Obično adenom kanala (iznad 40 godina), ili pleomorfni adenom (kod mlađih od 40 godina) • Usually canalicular adenoma(> age 40) or pleomorphic adenoma(<age 40)
Cista žlijezdanog kanala • Salivary duct cyst	Može biti plavkasto • May be bluish
Nazolabijalna cista • Nasolabial cyst	Fluktuirajući otok lateralnog labijalnog vestibuluma • Fluctuant swelling of the lateral labial vestibule
Dentigerozna cista • Dentigerous cyst	Najčešće zahvaća i donje treće molare • Most often they involve mandibular third molars
Mali kamen u žlijezdi • Minor gland sialolith	Mala, tvrda submukuzna tvorba, može biti osjetljiva • Small, hard submucosal mass; may be tender
Drugi mezanhimalni tumori • Other mesenchymal tumors	Primjeri: hemangiom, neurofibrom, neurilemom • Examples: hemangioma, neurofibroma, neurilemoma
Mukokela • Mucocele	Tipično blijedoplava, često otiče i puca. Češće na donjoj usnici. • Typically pale blue; often exhibits cyclic swelling and rupturing. Appears more often in lower lip.
Karcinom skvamoznih stanica • Squamous cell carcinoma	Tumor s hrapavom, granuliranom i nepravilnom površinom, na granici vermiliona. Češći na donjoj usnici. • Tumor with rough, granular, irregular surface; usually on vermillion border. Appears more often in lower lip.
Keratoakantom • Keratoacanthoma	Vulkanska tvorba s keratinskim čepom u sredini, brzo raste, samo na granici vermiliona. Češći na donjoj usnici. • Volcano-shaped mass with central keratin plug; rapid development; vermillion border only. Appears more often in lower lip.

Prema Nevilleu 2002, str. 798 • Cited in Neville 2002, p.798

Rasprava

U ovom slučaju bile su dvije etiološki različite lezije locirane u istoj anatomskoj regiji koje su utjecale na oteklinu na usni. Diferencijalna dijagnoza takve otekline uključuje širok raspon novotvorina ili upalnih patoloških promjena – benigne i maligne tumore žlijezda slinovnica, oralne ciste (mukokele, ciste izvodnih kanala žlijezda slinovnica, nazolabijalna cista), manje sijalolite te mezenhimalne tumore kao što su hemangiom, neurofibrom, neurilemom ili sekundarne infekcije nastale zbog reakcije na strano tijelo. Nekoliko bolesti i sindromi kao što su orofacijalna granulomatoza, Melkersson – Rosenthalov sindrom, tuberkuloza i aktinomikoza popratno mogu uzrokovati otekline na usni (2, 10 – 12).

Klinički izgled otekline uglavnom utječe na diferencijaciju između dobroćudnih i zloćudnih lezija. U nekoliko istraživanja istaknuto je da je većina tumora gornje usne benigna (7, 13 – 15), a maligni se uglavnom pojavljuju na donjoj usni (13 – 15). Dobroćudne lezije uglavnom rastu sporo (u prosjeku 3 – 6 godina), asimptomatske su, dobro definirane i glatke, po obliku su čvorasti tumori s normalnom bojom na površini te nisu povezane s površinskim i dubljim slojevima tkiva. Maligne lezije brzo rastu (u prosjeku manje od godinu dana), mogu biti bolne ili krvariti, ulcerirati i inficirati se te adherirati s površinskim ili dubljim slojevima ili čak s limfnim čvorovima (10).

Gornja usna je druga najčešća lokacija intraoralnog PA, s učestalošću od 6 : 1 (3, 13, 16). U istraživanju Krolla i Hicksa (16), 14, 5 posto od 445 slučajeva PA malih žlijezda slinovnica pronađeno je na gornjoj usni, a samo 2, 5 posto na donjoj. Razmjerno češći nastanak PA na gornjoj usni može se pripisati njezinu kompliciranijem embriološkom razvoju u usporedbi s donjom usnom. Srastanje triju embrijskih izdanaka tijekom formiranja gornje usne povećava mogućnost da ostane nešto embrijskih stanica. Tu tvrdnju možemo potkrijepiti činjenicom da se PA gornje usne uglavnom pojavljuje na objema stranama središnje linije koja nastaje stapanjem embrijskih izdanaka (11, 17 – 19). Najčešća intraosealna glandularna neoplazma je mukoepidermoidni karcinom (20, 21), a PA je vrlo rijedak (20). Mehanizmi patogeneze te novotvorine uključuju zaostalo žljezdano tkivo tijekom razvoja ili metaplaziju epitelne ovojnice odontogene ciste (20). Tumori žlijezda slinovnica u središnjoj liniji mogu klinički i radiografski izgledati kao odontogene upalne lezije zbog blizine korijena zuba te navesti dijagnostičara na pogrešnu dijagnozu. Postoje određeni kriteriji koji se moraju poštovati kako bi se odredila dijagnoza tumora žlijezda slinovnica u centralnoj regiji. Prvo – ne smije postojati prijašnji ili sadašnji primarni tumor žlijezda slinovnica. Drugo – kortikalis iznad lezije mora biti očuvan, a treće najvažnije jest pozitivna histološka dijagnoza neoplazme žlijezda slinovnica (22). Sinkronizirani razvoj odontogene ciste i PA na istom anatomskom mjestu moguć je i zabilježen je u literaturi (21). U našem slučaju PA se od male žlijezde slinovnice pružao u mukolabijalni nabor i nije bio povezan s centralnom periapiklanom lezijom zbog toga što je kortikalna kost bila intaktna. Simptomi nastali zbog odontogene periapikalne upale naveli su pacijenta da potraži pomoć u našoj klini-

Discussion

In the case presented here, lesions of two different aetiologies, located in the same anatomic region resulting clinically in lip swelling. Clinical differential diagnosis of upper lip swellings includes a wide range of neoplastic or inflammatory pathological entities: benign and malignant salivary gland tumours, oral cysts (mucocele, salivary duct cyst, nasolabial), minor salivary gland sialolith, mesenchymal tumours, such as hemangioma, neurofibroma, neurilemoma or infection secondary to foreign body's reaction. Several diseases such as orofacial granulomatosis, Melkersson-Rosenthal syndrome, tuberculosis and actinomycosis include lip swelling in their range of clinical manifestations (2,10-12).

The clinical features contribute to the differentiation between benign and malignant lesions. Several studies have shown that the vast majority of upper lip tumors are benign (7,13-15), while malignant tumors tend to predominate in the lower lip (13-15). Benign lesions usually present as asymptomatic slow-growing (average course 3-6 years), well-defined, smooth, and uniform nodular tumors showing a normal overlying surface color, and lack of adherence to superficial or deep tissue layers. Malignant lesions, on the other hand, may be painful, fast-growing (average course of less than one year), and may exhibit bleeding, ulceration, infection, adherence to deeper or superficial layers, and even lymph node involvement (10).

Upper lip stands second in predilection for location of intraoral PA with a ratio of 6:1; (3,13,16). In the study of Kroll and Hicks (16), 14.5% of the 445 cases of minor salivary glands PA were located in the upper and only 2.5% in the lower lip. The higher relative frequency can be attributed to the more complex embryologic development of the upper lip compared to the lower lip. The fusion of the three embryonic processes that form the upper lip comes with a higher possibility of entrapment of embryonic cell nests. This is further supported by the fact that the upper lip PAs are commonly located on either side of the midline corresponding to the fusion lines (11,17-19). Intraosseous glandular neoplasms most commonly mucoepidermoid carcinoma have been reported in the literature (20,21), whereas the incidence of the central PA is rare (20). Salivary tissue entrapment during the embryonic development, or metaplasia of the odontogenic cysts epithelial lining have been suggested to be involved in the pathogenesis of these neoplasms (20). The central salivary gland tumours may mimic clinically and radiographically odontogenic inflammatory lesions, because of their close relationship with teeth, resulting in an unsuspected diagnosis. There are certain criteria to evaluate in order to render a diagnosis of a salivary gland tumour of central origin. First, there should not be any preexisting or concurrent primary tumour of salivary glands. Second, the cortical bone above the lesion should preserve its integrity, and last, a positive histological diagnosis of salivary gland neoplasm is needed (22). The synchronous development of PA and odontogenic cyst within the same region has also been reported (21). In our case, the PA potentially arising from the minor lip salivary glands extended to the mu-

ci, što je na kraju rezultiralo dijagnosticiranjem i liječenjem intraoralnoga PA.

Zloćudna preobrazba PA moguća je i zabilježena je kod 1,9 do 23,3 posto svih registriranih slučajeva (23 – 31). Pritom su znakovi koji upućuju na malignost, regionalne i distalne metastaze histopatološke zloćudne promjene, invazivnost i atipične stanice. Tri su podvrste zloćudnog PA – karcinom iz pleomorfnog adenoma (čini 12 % malignih neoplazmi), karcinosarkom ili pravi maligni miješani tumor te metastazirajući miješani tumor. Najčešće se pojavljuje karcinom iz pleomorfnog adenoma i njegova su svojstva maligna transformacija epitela inicijalno benignoga PA. U takvim slučajevima pacijent u anamnezi navodi oteklinu ili naglo naraslu tumorsku masu te bolove ili ulceracije. No zabilježene su i kratkotrajne lezije bez nagloga rasta i bolova, a ipak su dijagnosticirane kao zloćudni PA. Ta činjenica ističe koliko je važno odgovorno i savjesno liječiti PA (2).

Maligna transformacija može biti posljedica nepotpune kirurške obrade benignoga PA (10), ali najvažniji rizični čimbenik jest vrijeme proteklo od početka liječenja inicijalnog PA. Što se dulje PA ne liječi, to je veća opasnost od malignosti (2, 23). Prema podatcima iz literature, maligno može postati 9,4 posto slučajeva koji se ne liječe dulje od 15 godina, a oni koji se počnu liječiti pet godina nakon što su se pojavili imaju rizik od 1,6 posto. Podatci govore u prilog rane i točne dijagnoze te konačnog tretmana PA (33).

Metoda izbora za uklanjanje novotvorina manjih žlijezda slinovnica jest kirurški zahvat. Lezija bi trebala biti uklonjena zajedno uz jedan do dva centimetra okolnog rubnog tkiva, ako se radi o malignoj neoplazmi. Prije su se benigni tumori samo enukleirali, ali samo taj postupak bez uklanjanja okolnog tkiva uglavnom je povezan s većom stopom remisije. Naime, u tom slučaju ostanu otočići stanica, pogotovo ako je riječ o nepotpunoj enkapsulaciji tumora (34). Manje žlijezde slinovnice imaju veće postotke remisije – otprilike 5 do 30 posto ako se radi o nepotpunom kirurškom uklanjanju. Postotak remisije raste i do 65 posto ako je riječ o malignim neoplazmama žlijezda slinovnica. Remisija je usko povezana s histopatološkim svojstvima tumora, posebice s vrstom inicijalnog tretmana (10). U ovom slučaju uklonjena je cijela enkapsulirana lezija i nije bilo znakova remisije tri godine nakon zahvata. Kontrolni pregledi vrlo su važni i trebali bi biti redoviti zbog moguće kasne remisije.

colabial fold; the tumour was not associated with the central periapical lesion, since the cortical maxillary bone was intact based on the intraoperative findings. The symptoms of the odontogenic periapical inflammation were the reason for the patient's visit to our clinic leading to the diagnosis and management of the intraoral PA.

PA may infrequently undergo malignant transformation with an incidence between 1.9% and 23.3% of the cases (23-31). Local clinical manifestations of malignancy, regional or distant metastasis, in addition to histopathological features, such as invasion and cellular atypia, usually lead to the diagnosis of malignant transformation. The three common subtypes of malignant PA are: carcinoma ex pleomorphic adenoma (representing 12% of malignant neoplasms), carcinosarcoma or true malignant mixed tumour and metastasizing mixed tumour. The carcinoma ex pleomorphic adenoma is the most common, characterized by malignant transformation of the epithelial element of an initially benign PA. In such cases, the patient's medical history may usually reveal the long duration of the tumour that presented rapid growth accompanied by pain and/ or ulceration. However, some lesions may manifest short duration without recent sudden growth and even without pain, leading to a malignant PA indistinguishable from a benign lesion. This highlights the importance of the awareness and high suspicion essential for the treatment of PA (2).

Malignant transformation may be associated with incomplete surgical removal of a benign PA (10), and the most important risk factor appears to be the elapsed period without the necessary treatment. The longer the PA remains untreated, greater is the risks (2,32). According to the literature, when treatment has been delayed for more than 15 years, malignant transformation applies for 9.4% of cases, compared to 1.6% of tumours remaining untreated for less than 5 years. The latter underlines the importance for early and correct diagnosis with an early and definite treatment of PA (33).

Surgical removal is the treatment of choice for minor salivary gland neoplasms. The lesion should be removed together with a margin of the surrounding normal tissue, of at least 1 to 2 cm in the case of a malignant neoplasm. In the earlier years benign mixed tumours were enucleated, but the simple tumour enucleation may be associated with a higher recurrence rate. Aggregates of tumour cells are often left behind and especially when this is combined with an incomplete encapsulation of the tumour (34). Minor salivary gland tumours have a high recurrence rate 5-30% when surgical removal is inadequate, while the percentage rises to 65% in case of malignant salivary neoplasms. This capacity to relapse is related to the histopathological characteristics of the tumour, and particularly to the initial treatment provided (10). In our case the encapsulated lesion was totally removed and there are no signs of recurrences three years after the surgery. The follow up of patients is essential and should be long due to the possibility of late recurrence.

Zaključak

Klinička dijagnoza intraoralnih žljezdanih neoplazmi na mukogingivalnom rubu zahtjevna je zbog mogućeg preklapanja kliničkih i radioloških znakova upalnih promjena čeljusti i tumora. Iako se dvije patološke lezije rijetko kada zajedno pojavljuju na istom anatomskom lokalitetu, stomatolog kliničar mora biti oprezan kad je riječ o oteklini usne i parodontne regije.

Conclusion

The clinical diagnosis of the intraoral salivary gland neoplasms located near the teeth-bearing oral mucosa sometimes may be challenging, because of the potential overlapping clinical signs and radiographic features between inflammatory jaw lesions and oral tumours. Despite the rare incidence of two different pathologic entities within the same anatomic region, vigilance on behalf of the dental practitioner is always required concerning the lip or perioral swellings.

Abstract
The pleomorphic adenoma (PA) or mixed tumour is the most common neoplasm of the salivary glands, usually presenting with a non-specific clinical manifestation and a diverse histopathological pattern. The region of the lips is the second most common site for minor gland neoplasms. The aim of this paper is to report the case of a 39 year old Caucasian woman presenting with a swelling on the right side of the upper lip combined with a history of trauma in the region of the upper right central incisor, eight years ago. The swelling was attributed to the periapical lesion of the upper right central incisor that was observed on the panoramic radiograph. Intraoperatively, the surgeon came upon a nodule of firm consistency in the mucolabial fold. The histopathologic diagnosis of this lesion was a benign mixed tumour of the salivary gland. This report discusses the deviation in frequency of mixed salivary gland tumour between upper and lower lip, the clinical differential diagnosis, the histopathological pattern and the appropriate treatment.

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