

LETTER TO THE EDITOR

Dear Editor

We present a 50-year-old caucasian woman with pain in the left maxillary area for 1.5 month. The pain had started after excision of the first upper left molar tooth, which was accompanied by bleeding, and left-sided epistaxis. Clinical signs included swelling, tenderness and deformity of the left side of the face, which extended from the orbit to the mandible, plus hyposthesia. A 1×1 cm soft tissue mass was found, causing minor thrismus and swelling in the left maxillary area. On the oral examination, a 5×5 cm irregular soft tissue mass which was brittle and hemorrhagic was seen in the left cheek.

On panoramic X-ray, a tumoral lesion occupied the entire maxillary antrum, which had destructed the lat-

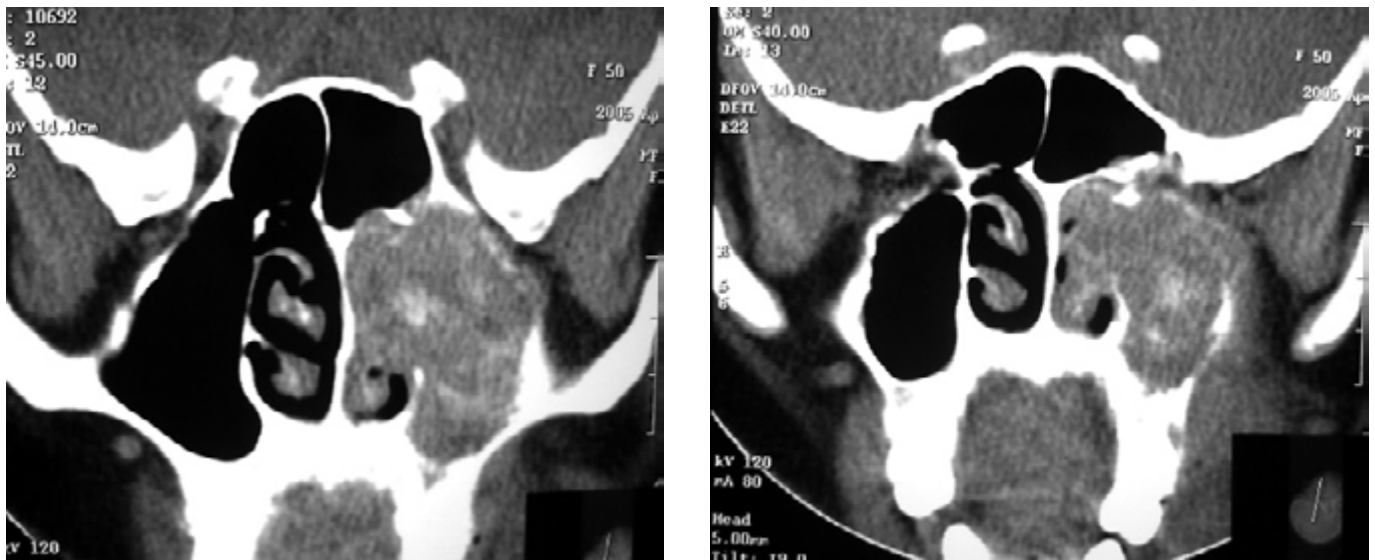


Fig 1, a&b: Axial and coronal view of paranasal sinuses shows tumoral lesion in the left maxillary sinus with destruction of medial and lateral walls, sphenoid sinus buttum, zygomatic process, and invasion to the ethmoidal sinus.

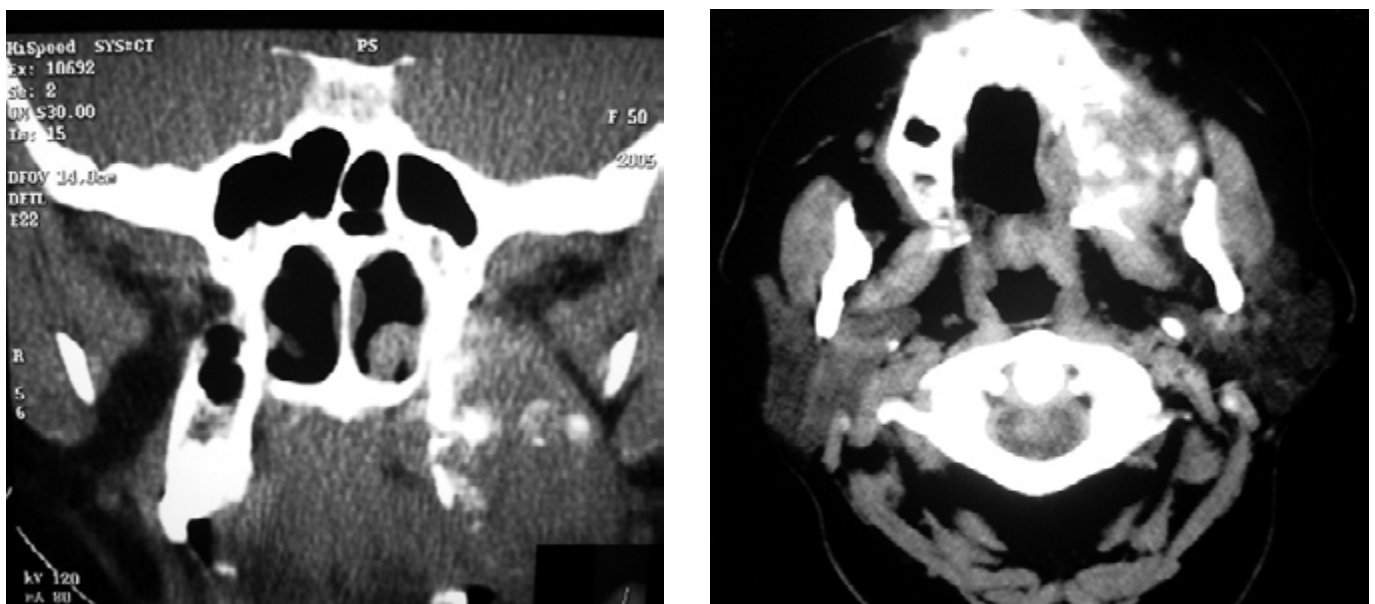


Fig 2. a&b: Axial and coronal MRI of the patient's face show destruction and ossification of the left maxillary bone and tumor expansion to the mouth and nasal cavity.

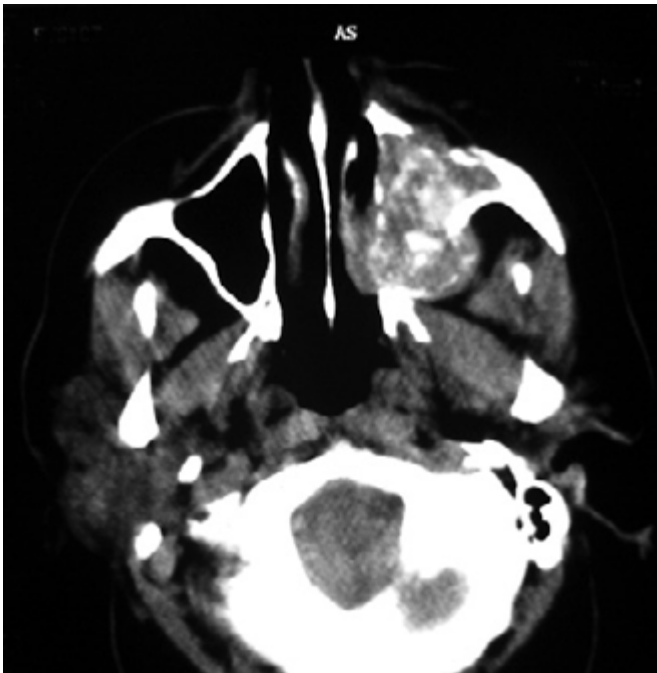


Fig 3. a&b: Tumor extension to the orbit and infratemporal cavity, and involvement of the inferior rectus muscle.

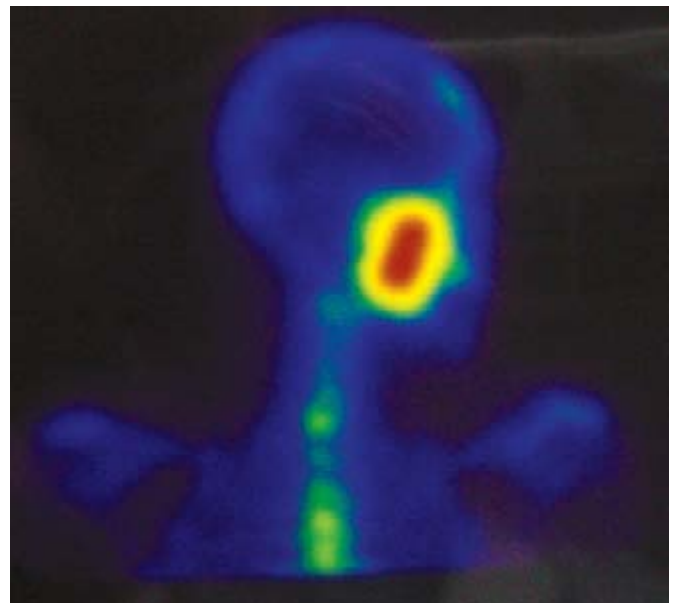
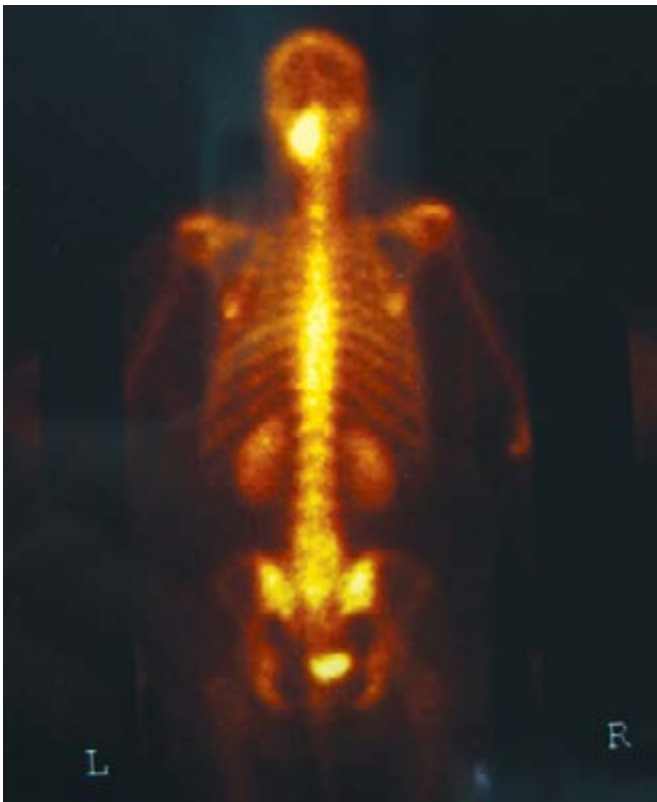


Fig 4. a&b: Increased uptake in the maxillary area on radioisotope scan.

eral and medial walls on the left.

On CT scan, a large soft tissue mass occupied the left maxillary antrum with extension to the left ethmoid, orbit, nasal cavity, alveolar ridge, oral cavity, and the zygomatic process. Bone destruction of the lamina papyracea, the medial and inferior orbital rims, walls of the maxillary sinus, alveolar ridge, nasal septum with extension to the opposite side and the lateral part of the hard palate were seen with calcification and ossification of soft tissue component of mass (Figures 1-3).

Radionuclide scanning showed an intensive increase in radium tracer uptake in the left maxilla (Figure 4).

The patient subsequently underwent surgery. The pathologic examination after surgery showed **osteogenic sarcoma**, with bony margins free of tumor.

This case is unusual because most osteosarcomas (OS) occur in the 3rd and 4th decades of life and the most frequent location of these malignancies is in the metaphyseal regions of tubular long bones.^{1,2}

Approximately 10% of all osteogenic sarcomas are found in the head and neck, usually in the mandible or maxilla.³ These neoplasms occur as slowly growing indolent swellings, affecting the mandible more commonly than the maxilla.⁴ Generally, these tumors have a more favorable prognosis than those of the lower extremities.⁵ Large series of head and neck OS, however, show no correlation between the histological characteristic and prognosis.

Radiographic evaluation of this patient began with Vaters and the panoramic radiography of the jaw because fibrous dysplasia was presented—based on the clinical, CT and histopathological findings. Later, panoramic and periapical radiography suggested a malignant neoplasm.

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