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Squamous cell carcinoma invading the right temporomandibular joint in a Belgian mare

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Abstract – This report describes a rare case of squamous cell carcinoma invading the right temporomandibular joint, right guttural pouch, and calvarium. Radiography, computed tomography, and histopathology were performed in the diagnostic workup. Computed tomography depicted more accurately than radiography the invasive nature, exact location, and extent of the lesion.

Case description

Upon presentation, the mare was emaciated (body score 3/9) and appeared depressed but alert. A moderate amount of mucopurulent fluid was draining from the draining tract. Mild bilateral mucopurulent nasal discharge was also noted (right worse than left). Other aspects of the physical examination were within normal limits.

Neurologic examination revealed an obtunded animal with a wide-based stance and a head tilt to the right. Cranial nerve deficits were detected for the right trigeminal (V), facial (VII), vestibulocochlear (VIII), and hypoglossal (XII) nerves. The presence of cranial nerve deficits, lethargy, and head tilt to the ipsilateral side were suggestive of a central lesion. Differential diagnosis included neoplasia, trauma, abscess, guttural pouch infection, and arthritis, osteomyelitis, or sepsis of the right temporomandibular joint (TMJ) and/or temporohyoid joint.

Lateral and lateral oblique radiographs of the skull were taken and revealed small amounts of gravitational fluid with gas interface in the area of the conchofrontal sinus and around the ethmoid bone. On dorsoventral and lesion-oriented oblique radiographic projections, soft tissue swelling with internal mineralization was noted over the rostroventral aspect of the right pinna (Figure 1A). The radiolucent outline of the right guttural pouch was reduced (Figure 1B). Radiography confirmed the previously listed differential diagnosis but did not narrow it down, except for ruling out major trauma.

Given the extent of the clinical findings and poor prognosis, the mare was euthanized. Computed tomography (CT) of the head and histopathology were performed postmortem. Computed tomography of the severed head and cranial neck in ventral recumbency was performed using 5-mm slice width and interval (axial mode), medium- and high-frequency reconstruction algorithm, 45-cm diameter display field of view, 140 kV, 200 mA, and 1 s rotation time settings. Imaging findings included a compressed air-filled left guttural pouch and a fluid- and gas-distended right guttural pouch. The proximal part of the right stylohyoid bone was osteolytic but not fractured. The right tympanic bulla contained soft tissue material. There
was extensive osteolysis of the right petrous temporal bone and tympanic bulla, the ramus, condyle, condylar and coronoid process of the right mandible and the right calvarium at the level of the middle ear (Figure 2A). The calvarial osteolysis was penetrating the internal margin of the brain case and thereby exposed the brain to the pathologic process. Marked irregular periosteal reaction was noted over the right temporal bone and mandible (ramus and coronoid process), zygomatic arch, and calvarium (Figure 2B). Soft tissue swelling with gas opacity was also noted just rostral to the right ear. Finally a small amount of free fluid was noted within the right frontal sinus and there was mild new bone formation over the medial aspect of the left TMJ.

The presumptive diagnosis was aggressive soft tissue neoplasia involving the right TMJ, secondary cranial cavity invasion, and right guttural tympany due to Eustachian tube obstruction. An infectious process could not be ruled out.

Necropsy and histopathology revealed a 9 cm × 9.5 cm necrotic area with green/tan inspissated debris at the center 1 cm rostroventral to the base of the right pinna. Irregular fragments of sequestrated bone were found within the lytic lesions. The right guttural pouch was filled with green/tan liquid. The wall of the right guttural pouch, superficial to the internal carotid, displayed irregular thickening of the submucosa by a white, multilobulated mass that bulged on cut section with bands of connective tissue separating the lobules. Similar tissue incorporated the right mandibular salivary gland and extended to the level of the right thyroid gland. There was severe bony lysis of the caudal ramus of the mandible. The largest identifiable lymph node in the cervical region measured 6 cm × 3 cm × 2 cm and there was neoplastic tissue partially effacing the nodal architecture. Retropharyngeal lymph nodes could not be identified but within the region there were coalescing masses of similar previously described firm and lobulated neoplastic tissue. Firm tan nodules measuring 1 to 3 cm in diameter were scattered throughout all lung lobes. No lesions were found in other organs.

At the level of the draining tract, sections of the skeletal muscle were partially effaced and replaced by anastomosing, moderately cellular islands of neoplastic epithelial cells. Neoplastic cells presented moderate to abundant eosinophilic cytoplasm, indistinct cellular borders with large oval to irregular nuclei, coarsely stippled chromatin, and simple to multiple prominent nucleoli. Mitotic figures ranged from 0 to 2 per high power field (HPF). There was moderate anisocytosis and anisokaryosis. The same features were noted in the right guttural pouch and secondary metastasis to the lungs was also noted. At the request of the owner the head was not sectioned; therefore, detailed dissection was limited and extension into the calvarium and/or brain could not be assessed.

The histopathologic diagnosis was SCC of the right TMJ and right guttural pouch with metastasis to the lungs. It could not be determined with certainty whether or not the TMJ lesion was a metastasis from the previous right 3rd eyelid SCC or a primary neoplasia.

**Discussion**

Various pathologies of the equine TMJ have been reported, but they often remain unrecognized and are therefore underdiagnosed (1,2). Clinical signs may include but are not limited to dysphagia, masticatory problems, malocclusion, localized pain, fistulous tract formation, and neurological signs (1,3,4). Among the most commonly encountered conditions reported are degenerative joint disease, infection, and trauma; luxation and neoplasia are rare (1,2,5).

Squamous cell carcinoma is the 2nd most common tumor encountered in the horse (6). It is an epithelial neoplasia commonly located at the eyelids and external genitalia (6). Reports of SCC as primary tumors in other locations are isolated and rare (7–9). To the authors’ knowledge, there is only 1 report describing a central vestibular syndrome secondary to neural SCC invasion in a horse and the metastatic nature of the lesion was suspected but not proven (8). Squamous cell carcinoma is often malignant and locally invasive with metastasis to regional lymph nodes and salivary glands (6). In up to 15% of the patients metastatic changes may also be seen in the lungs (6). The parotid lymph nodes are located very close to the TMJ and receive lymph from the eyelids, including the 3rd eyelid.

**Figure 1.** A – Lesion-oriented oblique radiograph of the right caudodorsal head demonstrating soft tissue swelling containing amorphous mineralization (arrowhead). B – Lateral radiograph of the caudal head and pharynx. One of the guttural pouches is fluid- and gas-distended, displacing the dorsal pharyngeal wall ventrally (arrow). An additional, smaller gas lucency representing the other guttural pouch is, visible in the dorsal neck area (arrowheads).
hypothesis is that the SCC metastasized from the 3rd eyelid to the parotid lymph nodes; however, clinical presentation and histopathology could not be definitive in this matter. Given the history, previous histopathology results, and physical examination, we believe that in our case the primary lesion was the 3rd eyelid lesion followed by metastatic lesions in the TMJ and lungs.

Diagnostic techniques for TMJ diseases include clinical examination, palpation, arthrocentesis, and imaging techniques (1,2). Imaging of the TMJ, however, can be challenging. Among the most commonly used techniques are radiography, ultrasonography, and scintigraphy (10,11). Magnetic resonance imaging (MRI) and CT have evolved to a gold standard for the equine head in recent years with several imaging anatomy (10,12–18) and pathology studies being available (18–20). In one report a lesion of the head or central nervous system in 8 of 12 horses presented for neurological disease localized rostral to the foramen magnum was identified with MRI (18). Similarly, a CT evaluation of head diseases in 15 horses was successful in diagnosing periosteitis, ethmoid hematomas, dental malformation, abscessation, neoplasia, and fractures (19).

In our case report, radiography accurately confirmed the presence of a clinically suspected lesion but CT substantially narrowed down the differential diagnosis. Intracranial extension, which carries a grave prognosis, was diagnosed with CT, but not radiography. Unfortunately, the limited necropsy performed at the owner’s request prevented histological assessment of the extent of the lesion into the calvarium and/or brain, but previous reports (19,20) have demonstrated an accurate relationship between CT images and pathology findings. It is reasonable to assume that the lesion would also have been detected and described accurately in vitro in a CT-unit suitable for live horses. Given the increasing availability of CT for equine patients this report emphasizes the diagnostic value of CT for equine patients with diseases of the head.

References