Computed Tomography of the Buccomasseteric Region: 2. Pathology

Part 2 of this article concerns itself with alterations in the normal anatomy (described in part 1) by various disease processes. Ten patients are described with various facial masses. The role of computed tomography in the clinical workup of these patients is stressed.

Materials and Methods

Scanning was performed on the G.E. CT/T 8800, Siemens DR-3, and Philips Tomoscan-60 scanners. The 10 studies chosen for review were from a group of about 50 cases with facial region masses. Axial scans were obtained with the patient supine and head slightly extended, so that nonangled slices were obtained about parallel to the hard palate. Several patients were also scanned in the coronal position. This position was used when corroboration of suspected findings on axial studies was indicated. Contrast material was administered intravenously in all cases. This was helpful in one of our cases for defining the limits of the hemangioma. Contrast material was also administered to enhance carotid sheath structures in cases where retropharyngeal and parapharyngeal adenopathy could have been confused with normal vascular structures. Several studies were performed after administration of sialographic contrast material. The gamut of pathologic entities studied is listed in table 1.

Results and Discussion

Benign Masseteric Hypertrophy

Benign masseteric hypertrophy, a rare disorder, is important because it must be included in the differential diagnosis of parotid-masseteric region masses [2–6]. About one-half of the patients are seen with unilateral enlargement, while the rest are seen with bilateral swelling [7].

While many theories have been advanced, the etiology of this condition remains unclear. Batsakis [2] and Barton [8] believe there is a congenital or familial and an acquired form of this condition. A thin face coupled with prominent muscles accounts for the latter, while habitual teeth-grinding during sleep [4] is responsible for the acquired form. They also believe that primary malocclusion contributes to the condition. Many authors believe that muscular hypertrophy is from a "hyperfunctioning" masseter [9–11]. Others, however, have not found abnormal tooth-grinding habits or other dental problems to account for the swelling [6, 12].
Intramuscular Hemangioma

Intramuscular hemangioma are probably congenital and are distinctly uncommon in the head and neck region. In a 1957 review of 393 cases, Ott [16] reported 28 in the head and 15 in the neck. Sixty percent occurred in trapezius and masseter muscles and 19 involved the masseter exclusively.

These lesions are rarely diagnosed preoperatively [17] and most often present as a localized swelling [18]. Pulsations, thrills, and bruits normally are absent [16, 18]. Pain is a presenting complaint in over one-half of the patients and is thought to be from local pressure caused by the enlarging mass.

The appearance of phleboliths has been reported as a radiologic finding in some cases [16]. These presumably contained a venous component, as in one of our cases. The CT appearance, however, of this lesion has not to our knowledge been reported before. Angiography has been reported to reveal the vascular nature of this neoplasm [16].

Surgical therapy has been used with varying success in most reported cases. We believe that intraarterial treatment using microembolization techniques provides a valuable adjunct to surgery and in inoperable cases it may be the only therapy that can be used [19, 20].

Our second case (fig. 2) presented clinically with a parotid mass. CT clearly revealed the true extraparotid, intramuscular location of this lesion. In addition, the associated bony deformity suggested a benign chronic process diagnosed as an intramuscular hemangioma by subselective external carotid angiography. The cause of the facial swelling in another case was obvious clinically (fig. 3). CT followed by angiography was invaluable, however, in defining the true extent of this mixed capillary and venous hemangioma as well as in defining the relative contributions of each component to the entire lesion. Since each of the two components of the lesion is treated by a different interventional radiologic method (direct puncture with subsequent instillation of absolute alcohol into the venous lesion and transarterial microembolization of the capillary lesion), the importance of this determination cannot be overemphasized.

Guggenheim and Cohen [7] suggest that a severe emotional disturbance is seen in some cases and believe it to be contributory, while Tempest [13] believes a deranged temporomandibular joint is an underlying factor.

The first mention of an area of mandibular bony hyperostosis associated with this condition (and also seen in our patient) was made by Masters et al. [12]. They describe a spinelike, rough, bony projection of cortical bone along the anterior surface and free margin of the mandible at the insertion of the hypertrophied masseter. This finding is, however, inconstant, and it is not known why it is present in some cases and not in others.

Histologic changes of questionable significance have been reported in this condition, while many authors report no abnormalities in either resected muscle or bone [6, 10–12, 14], again consistent with our findings. Interstitial edema with poorly staining muscle fibers [10], muscle fiber enlargement with loss of striations [6], as well as histologic changes consistent with true work hypertrophy [15] have all been reported.

Previous radiologic findings and descriptions in the literature are all from the pre-CT era. Prominence and flaring of the mandible have been reported [6, 8]. Several authors specifically mention the absence of any bony radiographic abnormality [13, 15].

Our first patient was referred for evaluation of a parotid mass. CT clearly revealed an enlarged masseter (fig. 1) as the cause for facial swelling associated with an area of cortical bony irregularity. The absence of any clinical signs to suggest infection, as well as the CT finding of normally preserved fascial and soft-tissue planes, discounted a masstetric abscess with associated osteomyelitis. However, the area of cortical irregularity on CT made a localized neoplasm causing bony destruction a diagnostic possibility. At surgery a normal but enlarged masseter was encountered, along with several areas of bony hyperostosis which were excised. No evidence of malignancy was noted on histologic evaluation.

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Salivary Gland Tumor in Accessory Parotid Tissue

Salivary gland tumors constitute less than 3% of all head and neck neoplasms [21]. Between 75% and 80% of these lesions arise in the parotid gland. Mixed tumor or pleomorphic adenoma is found in the parotid 10 times more often than in the submandibular gland. It is also rarely found in the sublingual glands [22]. Eighty percent of tumors of the parotid are found in the superficial and caudal part of the gland. The mixed tumor is slow growing, well demarcated, and usually found in the tail. It accounts for 65% of all parotid neoplasms [2], is more common in females, and presents as a painless mass that on physical examination is firm, smooth, and mobile. Histologically, both epithelial and mesenchymal components are necessary for the diagnosis.

In our case, CT revealed a well defined mass of higher attenuation than normal parotid tissue, distinctly separate from the main parotid gland and underlying masseter (fig. 4). The mass appeared radiographically benign because of its sharp outline, but a more precise histologic diagnosis was impossible on the basis of the images. Connective or neural tissue neoplasm such as fibroma or neuroma should be included in the differential diagnosis.

Infectious Processes of the Masticator and Buccal Spaces

The superficial layer of the deep cervical fascia investing the muscles and organs of the buccomasseteric region segregates these structures into clinically important potential spaces. Infections may be confined early in the process. However, avenues of communication exist between all of them, and an infection may spread along fascial and muscle planes, blood vessels, nerves, salivary ducts, and fat pads and thus can involve multiple contiguous spaces relatively quickly [23]. Infectious processes that spread by direct extension do so by following the path of least resistance. The superficial layer of the deep cervical fascia within the face varies in structure from coarse areolar tissue to dense, fibrous sheets of connective tissue with obviously varying abilities to contain infectious processes [23].

Involvement of the masticator space most often results from dental infections of the second or third molars (fig. 5) [24]. Osteomyelitis of the zygomatic and temporal bones and mandible, usually after trauma, can involve the masticator space secondarily [25]. Infection of this space most easily spreads superiorly to the superficial and deep temporal spaces and to adjacent fat pads. Inferior extension is prevented by firm attachment of the fascia to the periosteum of the inferior border of the mandible. Abscesses within this space, when situated anteriorly, will point to the anterior aspect of the masseter and therefore may present as a cheek mass when directed laterally (figs. 5 and 6).
The buccal space is limited medially by the buccinator. In most adults the roots of the molars are inferior to the attachment of the buccinator, so root abscesses are usually confined to the oral vestibule medial to the cheek [23]. In adults with long roots, however, or in children with incompletely erupted maxillary or mandibular teeth whose roots extend beyond the insertion of the buccinator, infection can more easily involve the buccal space [26].

Clinically, infections of the masticator space are manifested by cheek swelling, pain, and trismus. Treatment consists of surgical drainage and appropriate antibiotic therapy. Gaughran [27] considers it important that a preoperative determination be made as to whether the fat pad or the muscle is involved within the masticator space. The particular component of the involved masticator space should be approached directly to effect proper drainage with a minimum of tissue destruction. It is apparent that this preoperative determination can be aided by CT.

If drainage is postponed, osteomyelitis of the neighboring osseous structures is likely, along with possible extension of the infectious process to adjacent contiguous areas such as the temporal, parotid, and parapharyngeal spaces. CT can accurately and noninvasively determine the extent of the infection as well as preoperatively assessing the degree of bony involvement, if any, of the underlying osseous structures. This preoperative CT determination can aid the head and neck surgeon in planning a surgical approach, as well as in determining whether or not the patient should be placed on long-term intravenous antibiotic therapy.
Miscellaneous Masses

Lipomas of the head and neck are benign lesions usually found within the subcutaneous tissues. They are usually well encapsulated and of little clinical significance. Over one-half involve the buccal mucosa [2]. While they are rarely large enough to be detectable as a mass, they can do so, as shown by the patient illustrated in figure 7, who presented with a cheek mass. CT was able to accurately define the extent of and determine the histological diagnosis of this lesion because of the negative attenuation value of fat.

Carcinoma of Stensen duct is a rare lesion that may be either mucoepidermoid, squamous, or adenomatous [2]. Patients usually present with a cheek mass. Our representative patient had a well defined mass in the course of the duct, simulating a benign neoplasm (fig. 8). A diagnosis of malignancy is difficult to arrive at, given this CT picture. Parotidectomy, along with a very wide excision of duct and adjacent soft tissues, is the treatment of choice [28].

Patients with osteosarcoma of the jaws usually present at a later age than patients harboring this neoplasm elsewhere in the skeleton [2]. This entity is usually seen in males, with the mandible being the most likely site of occurrence.

Radiographically the lesion may be predominantly blastic or lytic. A local recurrence of a blastic bone-producing lesion is illustrated (fig. 9). In this patient with a recurrent cheek mass, the tumor was noted to involve the substance of the masseter as well as neighboring structures. CT in both the axial and coronal planes accurately depicted the extent of the neoplasm and directed further radical surgery.

Squamous cell carcinomas of the tonsil are second in frequency to carcinoma of the larynx among malignancies of the upper respiratory tract [29]. Men are afflicted more often than women by this disease seen in older age groups. Since the tonsillar region is relatively insensitive from a clinical point of view, patients often present with a sore throat, neck mass, or, as in our example, a cheek mass (fig. 10). Local extension of tonsillar carcinomas is common and occurs early in the disease. Radiation therapy is the treatment of choice [2].

Conclusions

CT is the imaging method of choice for patients with buccomasseteric region masses. In cases of neoplasm, the extent of involvement of neighboring vital structures is usually seen easily. The assessment of malignancy versus benign disease, however, may be difficult (fig. 8). In cases of infectious disease, CT can accurately reveal which fascial spaces and planes are involved as well as if underlying bone is affected and will direct the best surgical approach based on the altered anatomy. CT provides important anatomic detail not previously available to the head and neck surgeon, and we believe has made, and will continue to make, a great impact on the treatment of patients with facial masses.

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