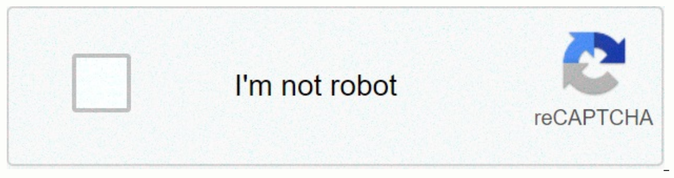

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Angiofibroma juvenile pdf

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Accessed December 14th, Definition/ general Locally aggressive fibrosis neoplasm developed almost exclusively in adolescent and young male patients Essential features Nassau site Affects adolescent or young male patients Histologically composed of different sizes of vascular and cell fibrosis stroma with fibroblasts Terminology Juvenile nasopharyngeal angiofibroma, juvenile fibroma, angiofibroma SSC coding SSC-O: 9160/0 - angiofibroma, NOS ICD-10: D10.6 - benign neoplasm in insuring Etiology still unclear There may be hormonal effects, given the predilection of adolescent men Diagnosis Diagnosis is usually made using angiography, which allows visualization of feeding vessels and preoperative embolization Given the risk of mass bleeding, preoperative biopsy and fine needle aspiration is very courageous Radiology description Angiography allows identify highly vascularized mass with central feeding vessel Radiology imagesDeveloped hosted on other servers AngiographyTherapy completion Complete surgical resection is an optional treatment for preoperative embolization through angiography can be performed Clinical imagesDevelop on other servers : Facial swellingGross description Polyporoid firm mass Color varies from yellow to dark red or black, depending on the volume of surgery Gross imagesContributed by Kelly Magliocca, D.D.S., M.P.H. Gross appearance, incision surface Gross appearance with ink Images arranged on other servers: Polypoid, bee to brown, firm, fibrosis massMicroscopic (histological) description Benign fibrovascular lesions, consisting of 2 components of vascular space of different sizes, ranging from an enlarged branching vessel of different thicknesses to a gap similar to capillary fibrostic or collagen stromal with fibroblasts Central area of the tumor usually consists of cells, consisting of fibroblasts or miOfibroblast with shaft, round or stellate morphology Stroma can be fibrous, Anesthetic or collagen clot can be seen in expanded vessels Often containing (abundant) mast cells Mythotic figures usually not available Reference: Chan: WHO head and neck tumor classification , 4th edition, 2017 Microscopic (histological) imagesU bin Xu, M.D., Ph.D. Polypoid mass Large caliber vessels Gap-like vascular Cellular cellular stroma Bland fibroblasts Edema or collagen stromal Beta catonine AR Contributed by Kelly Magliocca, D.S., M.P.H. Corithes with gross appearance with ink Vascular canal, low buildup Vascular canal, higher increaseCidological description Given the nasopharynl rye and the very vascular nature of the lesion, fine needle aspiration should be avoided Sample pathology report Nasopharyng, resection: Nasopharynal angiofibroma, 1.8 cm, difference negative tumor comment: Immunostain shows that the tumor is focal positive in AR. There is an abnormal accumulation of the beta catheterine nucleus. Immunoprofile supports diagnosis. Differential diagnosis of Hemangioma: Can affect both sexes of any age and not limited to the ignition lack of cell stromal enriched with fibroblasts Vessels are usually the same size, whereas angiofibroma usually contains central large caliber vessels and peripheral fissure-like vascular space does not show AR immunopozititivity or nuclear beta catenin Inflammatory sinon polyp: May contain fibrous toe stromal, but usually hypocellular Lack of rich vascularity seen in angiofibroma Does not show AR immunosuppressive or nucleus beta nin nin occurring in the nasal cavity or paranasal sinus, instead of nasopharynl gasp turbinate: Normal nasal turbinate is vascular rich, containing large caliber blood vessels with a muscular wall lacking hypercellular stromal and slit-like vascular angiofibroma board review-style issue #1 a 15-year-old boy undergoing resection of nasopharynal mass. Which of these statements is true? It is usually S100+ and desmin + It is locally aggressive with a 20% risk of local recurrence It is usually diagnosed in preoperative using endoscopic biopsy This often harbors a PAX3 translocation Board review style issue #2Which of such statements about the incension angiofibroma is true? It usually affects adolescent women It is the hormonal profile of ER+, PR+, AR + It is a benign lesion that can be safely managed by long-term observation, even if the large most common molecular changes in this lesion are CTNNB1 somatic mutations Lateral naloma, transcleral, transmaxillary, or sphenoethmoidal pathway is used in small tumors (Fisch I or Stage II). The infratemporal fossa approach is used when the tumor has a large lateral extension. The midfacial degloving approach, with or without Le Fort osteotomy, improves posterior access to the tumor. (The De Mello-Filho study in 40 patients showed that JNA can be successfully treated with Le Fort I osteotomy resection, surgery is effective even if the tumor has invaded the central nervous system. [9] The facial translocation approach is combined with the Weber-Ferguson incision and coronary extension for frontotemporal cranitomy with mid-facial osteotomy access. An extended uterine subcranial approach facilitates en-block tumor removal, optic nerve decompression, and exposure to the cavernous sinus. Some authors advocate the use of intranasal endoscopic surgery for lesions with limited extension to the infratemporal fossa. Image-guided, endoscopic, laser assisted removal has also been used. Hackman et al (2009) reviewed 31 cases of JNA at the University of Pittsburgh Medical Center from 1995 to 2006. open approaches or postoperative radiotherapy. Radical removal of a large JNA can be difficult because of its extreme vascularity and expansion to the cavernous sinus, orbit, middle fossa, and uterine fossa. However, most JNAs with intracranial extension can be resected in the first operation with minimal morbidity through facial degloving and a further combination of extended endoscopic endonasal approaches. [11] In a retrospective review, Battaglia et al (2014) assessed the use of endoscopic endonous surgery for radical resection of benign or non-metastatic malignancies that have developed or been enlarged to the infrared foss or upper parapharyngeal space. [12] According to investigators, results obtained from 37 patients, including 20 with JNA, suggest that only endoscopic endonatal radical resection can be safely used to treat selected tumors involving these facilities. In the review article, Cloutier et al (2012) reported 72 patients who had been in operation over a period of 10 years. [13] They concluded that progress in cranial base surgery allowed the indications for endoscopic removal of JNA to be extended. This approach is a better result in terms of blood loss, hospital stay, and complications. Of course, the external approach should be considered only in the selected cases, because of the massive intracranial extension or entrapment of the optic nerve or internal carotid artery with the tumor. In a meta-analysis of the endoscopic results of the JNA, covering 92 studies and a total of 821 patients, Khoueir et al (2014) estimated that the mean operative blood loss from endoscopic JNA surgery was 564.21 ml. Randomised estimates for relapse, complications and residual tumour were 10%, 9.3% and 7.7%, respectively. The authors stated that endoscopic treatment is currently considered an treatment of choice for JNA, but also commented that they cannot find randomized, controlled studies for their analysis. They suggested that further studies propose a new, endoscopic approach based on the classification system. [14] The Overdevest study showed that surgical blood loss in JANVS tends to be greater when damage is delivered by the internal carotid artery or is a bilateral arterial supply. [15] Yi et al (2013) described a simplified classification system and management option for juvenile nasopharyngesic angiofibrom, as follows [16] : Type I includes a tumour localised in the nasal cavity, sinuses, nasopharyngate or pterygoatine fossa. Transnasal cavity approach with endoscopic indications is suitable for this type. Type II is where the lesion extends to the infratemporal fossa, cheek area, or orbital cavity, with aeed and/or minimal mid-skull fossa extension, but intact dura mater. The transantral-infratemporal fossa-nasal cavity combined approach is reliable type II. Type III is calabashlike, a massive tumor lobe in the middle of the skull fossa. For type III tumours, complete removal is A combined extracranial and intracranial approach is often required. Radiation therapy is useful for treating the remaining intracranial part .part.