- **55 year** old male Mr. Saleem coming from Virugambakkam , shopkeeper by occupation , belonging to lower middle class

  presented with chief complaints of

  SWELLING BELOW AND BEHIND THE RIGHT EAR FOR PAST 3 WEEKS

HISTORY OF PRESENTING ILLNESS

Patient was apparently normal 3 weeks back after which he developed a swelling behind the right ear

- -duration 3 weeks
- -insidious in onset
- -initially small in size & gradually increased in size to attain the current size.
- -Not associated with pain
- -No h/o sudden increase in size of the swelling

-No h/o difficulty in opening the mouth
- No h/o difficulty in swallowing
- No h/o increase in size or pain during chewing
-No h/o trauma
-No h/o fever
-No h/o ear discharge , ear pain
- No h/o of drooling of saliva , difficulty in closing eyelid
-No h/o swelling elsewhere in the body
-No h/o loss of weight and appetite

- No h/o dry mouth, dry eye
- No h/o cough with hemoptysis
- No h/o bone pain

- PAST HISTORY :
  - No H/o similar complaints in the past
  - No H/o TB , asthma , DM , hypertension , epilepsy , jaundice
  - No H/o chronic drug intake
  - No H/o previous surgeries/ hospitalisation
  - No H/o radiation exposure

PERSONAL HISTORY:

-normal bowel & bladder habits

-consumes mixed diet

-non smoker & non alcoholic

FAMILY HISTORY : no relevant family history

- GENERAL EXAMINATION
  – conscious, oriented ,moderately built & nourished

  –No pallor ,
  icterus ,
  cyanosis ,
  clubbing,
  pedal edema ,
  generalised lymphadenopathy

Pulse rate : 82 /min , regular in rhythm ,normal in volume and character , no vessel wall thickening , no radioradial/radiofemoral delay
Felt in all peripheral vessels

Respiratory rate : 16/min , abdominothoracic

Blood pressure : 110 /70 mm Hg measured in left upper arm in sitting posture

Patient is **afebrile**

LOCAL EXAMINATION

- After explaining the procedure and getting consent , examination was done under bright light

- **INSPECTION**
  -A single hemispherical swelling of size 3*3 cm below and behind the right ear is seen
  -borders well defined
  - extent upper border 3 cm above angle of mandible
    lower border just above angle of mandible
    anteriorly 1 cm in front of angle of mandible
    posteriorly upto mastoid

- Skin over the swelling – normal
- no scars , sinuses , dilated veins , visible pulsation
- lifting of ear lobule is present
-Retromandibular groove obliterated
-On opening of mouth swelling becomes less prominent
-On clenching of teeth swelling becomes more prominent

PALPATION

- Not warmth & not tender
- Inspectory findings of site, size , shape and extent are confirmed
- Surface – smooth Skin- pinchable
- Consistency – firm
- Swelling is mobile in both horizontal and vertical direction but not above the zygoma **(curtain sign)**
- No induration in surrounding area
- On clenching the teeth mobility not restricted
- No preauricular or postauricular lymphadenopathy

- Bidigital Palpation of stenson duct- saliva oozes out no discharge
- Bimanual palpation of parotid gland – no deep lobe enlargement

- Examination of left parotid region –normal
- Examination of submandibular gland– normal
- Examination of oral cavity–
  - –lips
  - –ant and posterior commisure
  - –gums/alveolus/floor of mouth
  - –buccal mucosa
  - –anterior 2/3 of tongue
  - –hard palate
  - –uvula in midline

  } normal

  - –tonsil normal not pushed medially
  - –Dental formula $\frac{2\ 1\ 2\ 3 \mid 2\ 1\ 2\ 3}{2\ 1\ 2\ 3 \mid 2\ 1\ 2\ 3}$

- EXAMINATION OF OF FACIAL NERVE
  - -wrinkling of forehead present
  - -able to close eyelids against resistance
  - -nasolabial folds normal
  - -no deviation of angle of mouth
  - - able to blow cheek
  - - anterior 2/3 of tongue taste normal
  - -corneal reflex -normal
    conjunctival reflex- normal

- EXAMINATION OF HEAD AND NECK NODES – normal on inspection and palpation

-**Respiratory system** :

Normal vesicular breath sounds heard . No added sounds

-**Cardiovascular system** :

S1 S2 heard . No murmurs

-**Central nervous system** :

No focal neurological deficit

-**Abdomen** :

Soft , non tender , no organomegaly , no free fluid , hernial orifices free , external genitalia normal

-**Spine and cranium** : normal

- DIAGNOSIS

  swelling in the right parotid region most probably pleomorphic adenoma without deep lobe or facial nerve involvement
- DIFFERENTIAL DIAGNOSIS:
- warthin tumour

  beningn oncocytoma

  parotid lymph node enlargement

Management :

Baseline Investigation:

- Blood – CBC, TC , DC, ESR , hb % , blood grouping and typing
- serum –sugar , urea , creatinine
- urine – sugar , albumin, deposits
- ECG & CHEST X-ray
- Serology : HIV , VDRL , HBsAg

- SPECIFIC INVESTIGATIONS
  - USG neck
  - FNAC
  - CECT neck MRI NECK
- TREATMENT
  - SUPERFICIAL PAROTIDECTOMY WITH FACIAL NERVE CONSERVATION ON RIGHT SIDE