



# Thymic Carcinoma Metastatic to the Mandible Mistaken for Medication-Related Osteonecrosis of the Jaw: A Case Report and Review of the Literature

Lee CYS<sup>1\*</sup>, Rahman M<sup>2</sup>, Lee KL<sup>3</sup> and Hirata KY<sup>4</sup>

<sup>1</sup>Department of Periodontology and Oral Implantology, Temple University, USA

<sup>2</sup>Department of Pathology, University of Hawaii, USA

<sup>3</sup>Department of Oral and Maxillofacial Surgery, Highland Hospital, USA

<sup>4</sup>Department of Pathology, University of Hawaii, USA

## Abstract

Thymic tumors usually metastasize locally to the liver, lung, bone and brain. Thymic carcinoma metastasizing to the mandible is a rare occurrence. This case report describes metastatic thymic carcinoma that was presumed to be medication-related osteonecrosis of the jaw after extraction of a molar tooth. To our knowledge, there have been no reported cases of metastases from the thymus gland to the mandible in the medical and dental English literature. We report a case of metastatic thymic carcinoma to the mandible that was mistaken for Medication-Related Osteonecrosis of the Jaw (MRONJ).

**Keywords:** Thymic carcinoma; Extrathoracic metastasis; Medication-related osteonecrosis of the mandible (MRONJ)

## Introduction

Metastatic carcinoma of the jaws represents 1% of all malignancies of the oral cavity [1-3]. The mandible is the primary anatomic site of metastases [4]. In women, metastasis has been reported to occur from distant sites such as the breasts, kidneys, genitals, colorectal region and thyroid gland. In men, they can metastasize from the lungs, kidneys, prostate gland, and colorectal region [1,5,6-8]. Metastasis via vascular dissemination from abdominal organs to the oral and maxillofacial region is considered rare because malignant cells must circulate through organs such as the lung and liver [9]. To the best of our knowledge, there have been no reported cases of extrathoracic metastases from the thymus gland to the mandible. We present a case of metastatic thymic carcinoma to the mandible that was mistaken for medication-related osteonecrosis of the jaw (MRONJ).

Thymic neoplasms are rare tumors of the anterior mediastinum with an incidence estimated at 1 to 3 cases per 10 million individuals [10,11]. Thymic carcinoma is usually diagnosed during the fifth to seventh decade of life. Although most metastatic sites were not biopsied and histology not available, Ichino et al. [12] was able to document 83 cases of extrathoracic metastasis from the thymus gland. In a more recent study, Huang and colleagues [13] described 120 cases of thymic tumors treated at Memorial-Sloan Kettering Cancer Center from 1995 to 2006. Of the 120 patients, eight developed extrathoracic metastatic thymic carcinoma. As in the previous study, this was not confirmed histologically, as all 8 patients did not complete biopsy procedures. However, in review of thirty-five cases of extrathoracic metastasis of thymus origin, liver and lymph node were the most frequent metastatic sites and 9 cases were biopsy positive for lymph node metastasis [14].

Thymic tumors are derived from thymic epithelium of the thymus gland, which is important in childhood immunity. In adults, the gland is still present, but in an atrophic state [15,16]. It is the most common tumor of the anterior mediastinum in adults [11,17]. Patients with thymic carcinoma may have any of the following clinical symptoms: chest pain, back pain, dyspnea, voice changes, cough, dysphagia, and fatigue and weight loss [18]. Rarely, polymyositis or dermatomyositis are observed in the patient with thymic carcinoma [19-21]. There are two types of tumors derived from the thymus gland, thymomas and thymic carcinoma. Thymomas make up about 50% of tumors of the anterior mediastinum. Thymic carcinoma is a rare malignancy and accounts for 5% of all

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### \*Correspondence:

Cameron YS Lee, Department of Periodontology and Oral Implantology, Temple University, USA,

E-mail: clee555294@aol.com

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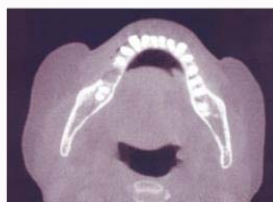
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**Figure 1:** Panoramic radiograph showing osteolytic lesion with ill-defined margins and what appears to be bone fragments in the right posterior mandible.



**Figure 2:** Axial cone beam CT scan reveals osteolytic lesion with erosion of the buccal cortex of the right posterior mandible.

malignancies of thymic origin. Compared to thymoma, thymic carcinoma has a greater metastatic potential and invasiveness that result in a poor prognosis [22-25]. Of the 11 different subtypes recognized by the 2004 World Health Organization classification, squamous cell carcinoma is the most common subtype and accounts for up to 40% of reported cases. Histologically, it is undistinguishable from carcinoma from other organs [22,26-28].

## Case Presentation

In January 2017, a 74-year old Asian female was referred from her dentist for a non-healing extraction site. A molar tooth of the right posterior mandible that was extracted in October 2016 due to mobility and pain. One month after the tooth extraction, the dentist performed a local curettage for a post-operative infection. As the infection failed to resolve and was unresponsive to antibiotic therapy, the family dentist was concerned about the possibility of medication-related osteonecrosis of the jaw. The patient was treated for osteoporosis for greater than 5 years with the bisphosphonate drug, fosamax (70 mg/week) for osteoporosis. At the time of clinical presentation, the patient was also diagnosed with stage IVb thymic carcinoma (Masaoka staging system) and treated with combination systemic chemotherapy consisting of carboplatin (300 mg/m<sup>2</sup>/day) and paclitaxel (200 mg/m<sup>2</sup>/day) every three weeks. Panoramic radiograph revealed a mixed radiolucent-radiopacity in the area of the extraction site (Figure 1). The patient reported that there was a constant aching pain in the right posterior mandible that failed to resolve by both narcotic and non-steroidal over the counter medications after the molar tooth was extracted by her dentist. She also reported a history of paresthesia over the skin of the right chin and right lower lip. Based on the patient's medical history and clinical findings, metastatic disease to the mandible could not be excluded. The differential diagnosis included medication-related osteonecrosis of the mandible, osteomyelitis and thymic carcinoma metastatic to the mandible.

The patient's medical history was significant for osteoporosis, hyperlipidemia, depression and stage IVb thymic carcinoma diagnosed in January 2015 by supraclavicular lymph node biopsy. At the time of presentation, the anterior mediastinal tumor was inoperable. No allergies to medication were reported by the patient. She was a former

Figure 3A

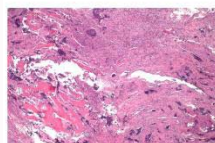
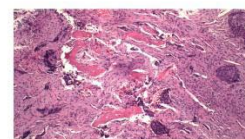


Figure 3B



**Figure 3:** Histopathologic analysis of specimen from right mandible (hematoxylin and eosin stain). **3A:** Lower power view (original magnification x 10) shows infiltration of large islands of polygonal neoplastic cells of varying size. **3B:** High power view (original magnification x 20) shows bone infiltrated by neoplastic epithelial cells with enlarged nuclei, marked pleomorphism, eosinophilic glassy cytoplasm and hyperchromasia.

Figure 4A

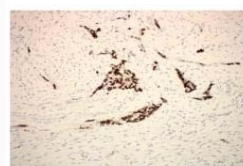


Figure 4B



**Figure 4A and 4B:** Immunohistochemical analysis of specimen from right mandible. Neoplastic cells are positive for p40 and CD5 suggestive of squamous cell thymic carcinoma metastatic to the mandible.

smoker for 20 years who quit in 1980. Physical examination revealed a female in mild distress from the chronic, unrelenting pain in the right mandible. No facial swelling, asymmetry or orocutaneous fistula was observed. Cranial nerve examination revealed a V3 paresthesia over the skin of the right chin and right lower lip. Head and neck examination was positive for lymphadenopathy.

Oral examination of the right posterior mandible revealed teeth #30 and 32 missing. The gingival tissues in the area of missing tooth #30 were edematous and erythematous with signs of inflammation. Purulent discharge was observed from the non-healing extraction site. No exposed bone was observed in the extraction site. Cone beam CT scan revealed an osteolytic lesion with destruction of the buccal cortical plate of the right posterior mandible (Figure 2). Under local anesthesia, the extraction site was debrided of non-vital necrotic osseous and granulation tissue under local anesthesia. The tissue specimens were sent to the laboratory for histopathologic examination.

## Histopathology

Decalcified sections of bone from the right posterior mandible revealed devitalized bone infiltrated by nests of neoplastic cells associated with a desmoplastic response. Tumor cells demonstrated atypical enlarged nuclei with prominent nucleoli. Occasional mitotic figures were observed (Figure 3A and 3B). The results are consistent with squamous cell carcinoma of the mandible and are similar to a supraclavicular lymph node biopsy performed at another medical center.

## Immunohistochemistry

Immunohistochemical analysis revealed that the neoplastic cells stained immunopositive for p40 (Figure 4A) and CD5 (Figure 4B).

## Discussion

Bisphosphonates are the cornerstone in the management of osteoporosis and prevention of skeletal related events [29-31]. Patients prescribed bisphosphonates who complete surgery that involves the

jaw bones are at risk for developing MRONJ. They may experience delayed wound healing that results in dehiscence of soft tissues with exposed necrotic bone, pain, infections involving both hard and soft tissues of the affected area and altered neurosensation [32-35].

There have also been reports of patients treated with the cancer medications carboplatin and paclitaxel that may develop MRONJ. Wang et al. [36], reported three cases of osteonecrosis of the jaw associated with systemic cancer chemotherapy for metastatic breast cancer. The risk of developing osteonecrosis of the jaws is approximately 1% for patients treated with both drugs [37,38]. Paclitaxel is an antimicrotubulin agent that binds to microtubules during mitosis and prevents cell division in malignant and normal cells [39]. Such antitumor effect at the cellular level may lead to osteonecrosis. Carboplatin is a derivative of the chemotherapy cancer alkylating agent, cisplatin [37,40]. It binds to DNA and inhibits synthesis by cross-linking the DNA strands. Such action results in cell death. Cancer polychemotherapy is the standard of care, as both drugs have their primary effect at different phases of the reproductive cell cycle.

Because metastatic lesions to the oral cavity are rare and may be mistaken for MRONJ, they can pose a diagnostic challenge [41-43]. Bedogni et al. [44] reported two cases that were mistaken for MRONJ based on medical history, clinical and radiographic findings. In both cases, biopsy of the jaw was not performed and the patients underwent surgical resection of the jaw because of failure to resolve the osteonecrosis with antibiotic treatment and constant pain. In our case, thymic carcinoma metastatic to the mandible was also a diagnostic challenge as the clinical and radiographic signs and symptoms were not pathognomonic for MRONJ. Therefore, the authors recommend that incisional biopsy for histopathologic analysis be routinely performed in patients with documented malignancy [11,41-46,47].

Based on the medical history of stage IVb thymic carcinoma, no exposed bone observed and that our patient was experiencing paresthesia of the right lower lip and chin, metastatic disease was an important consideration in the differential diagnosis even though she was referred by her dentist for suspected MRONJ. Altered neurosensory function involving the chin and lower lip is considered a major clinical symptom of metastatic disease to the oral cavity [48-50].

Clinical signs and symptoms of metastatic lesions of the oral cavity are similar to MRONJ and may include edema, erythema, pain, mobility of teeth, soft tissue masses, pathologic fractures and altered neurosensation [1,6,51-53]. The clinician must always be aware that MRONJ and metastatic lesions to the oral cavity have many similar pathognomonic radiographic signs [41,42,44,47]. In an analysis of 390 cases, Hirshberg et al. [54], discovered that 5.4% did not demonstrate any radiographic changes suggestive of metastatic disease to the jaws. In a retrospective study of 114 metastatic tumors in the jaws, D'Silva and colleagues [7], reported that no radiographic evidence was detected in 5% of the cases studied. However, intraosseous carcinoma on computed tomography may appear as a homogenous mass with irregular borders and bone destruction [55].

Although treatment of thymic carcinoma is beyond the scope of this case report, it is important to realize that the prognosis of metastatic lesions to the oral cavity usually have a poor prognosis [56]. In a Japanese study, 46.5% of patients with stage IVb thymic carcinoma have more advanced disease at the time of presentation and

therefore, are unresectable compared to patients that are diagnosed with stage IV thymoma [57]. Such poor prognosis is usually due to a delay in the initial diagnosis [2,3,25,27]. The 5-year survival rate is less than 10% [25,58,59]. At the time of presentation, our patient had already been diagnosed at an advanced tumor stage with metastases to the liver and skeleton. The patient expired five months later after the biopsy procedure of the mandible.

In the evaluation of the patient with metastatic thymic disease, it is important to rule-out other neoplasms [46,60]. The differential diagnosis of metastatic squamous cell thymic carcinoma to the jaw should include metastasis from other mediastinal organs such as the lung and esophagus. Because there is no current immunohistochemical marker for thymic carcinoma and the morphologic variation of this neoplasm, exclusion of metastatic disease from the thymus gland must rely on clinical and imaging studies, and examination of biopsy samples when available. For the patient with an anterior mediastinal mass, clinical symptoms described earlier and no tumor discovered in another part of the patient, thymic carcinoma must be included in the differential diagnosis [14].

## Conclusion

This case report emphasizes the importance of obtaining a careful medical history in addition to a thorough clinical examination. This is especially with the patient that presents with presumed medication-related osteonecrosis of the jaws but has a significant medical history of metastatic disease. Imaging studies such as plain radiographs and computed tomography are not specific for either MRONJ or metastasis to the jaws. For a definitive diagnosis for either pathologic entity, we recommend routine incisional biopsy for histopathologic examination of all patients with metastatic disease.

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