ORIGINAL ARTICLE

Diagnostic Accuracy of Fine Needle Aspiration Cytology in Parotid Tumours

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KEYWORDS
Parotid gland; Parotid neoplasm; Fine-needle aspiration; Cytology; Salivary glands

Abstract
Introduction and objectives: Fine needle aspiration cytology (FNAC) is a globally accepted technique in the preoperative evaluations of head and neck tumours; however, the effectiveness in the interpretation of salivary glands neoplastic lesions is still controversial. The objective of this study consisted of assessing the efficacy of FNAC in preoperative diagnosis of parotid tumours.

Methods: This retrospective study was conducted using 93 patient samples with parotid gland tumoral pathology, treated at the Otorhinolaryngology Department in our institution during the 2007–2011 period. Preoperative FNAC was employed and the patients subsequently submitted to surgical excision with histopathological diagnosis of the specimen. Cytology results were classified as negative for malignancy, positive for malignancy or insufficient sample, and later compared with the definitive histological diagnosis.

Results: The mean age of the studied sample was 52.9 years (range: 11–88 years); 55.9% were men. The FNAC showed significant sensitivity of 57.1%, with a specificity of 95.1%, for detecting malignancy in parotid gland tumours. The positive and negative predictive values for malignancy were 50 and 96.3%, respectively.

Conclusions: FNAC is considered a simple test but of limited use for diagnostic guidance in tumour pathology of the parotid gland in our environment, mainly because of its low sensitivity. However, the high specificity and high negative predictive value of FNAC make it a more accurate test in benign or negative result cases.

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Introduction

Parotid masses represent some 3% of head and neck tumours.\(^1\) They are characterised by their great histopathological diversity; the majority of them are benign lesions (75%–80%),\(^2,3\) with a malignancy rate of between 14% and 27%, according to the series reviewed.\(^1,4,5\)

Although there are clinical signs and symptoms that demonstrate malignancy (such as peripheral facial paralysis and pain), these present in only 25%–35% of the patients.\(^4\) Bearing in mind the lack of characteristic clinical or radiological features that can provide a definitive diagnosis,\(^3\) fine needle aspiration cytology (FNAC) generally plays an important role in preoperative diagnostic orientation in tumours of the parotid gland.

The FNAC technique is a simple, low-cost method with a very low complication rate.\(^1,6,7\) It is accepted world-wide in preoperative diagnosis of head and neck tumours.\(^8\) Despite being a technique used regularly in saliva gland tumours since the 1980s,\(^9\) its effectiveness in interpreting neoplastic lesions is controversial. This is mainly due to the great variety of morphological patterns, cell diversity and the overlapping of histopathological findings among benign and malignant lesions of the salivary glands; this means that a small sample from the lesion, such as that obtained FNAC, at times does not provide an overall view of the morphological spectrum of the tumour.\(^10\)

FNAC has been questioned due to its low sensitivity and the idea that the majority of parotid gland tumours require surgery.\(^11,12\) Some authors, such as Batsakis et al.,\(^13\) even report that patient management would not change depending on the FNAC result,\(^1\) while other authors promote its use as part of preoperative management in patients with a parotid tumour, given that FNAC results along with some imaging methods, offer information that helps to plan the extent of surgical treatment; in addition, it makes it possible to inform the patient about his or her illness and the expectations following surgery.\(^4,12,14\) Layfield et al.\(^15\) carried out a study on FNAC cost-effectiveness in which they showed that fine needle aspiration can avoid the need for surgery in 35% of parotid masses because this technique presents high sensitivity for distinguishing neoplastic disease from non-neoplastic.

The objective of this study was to assess the efficacy of FNAC in preoperative diagnosis of parotid gland tumours in our environment.

Materials and Methods

This was a retrospective study, in which the case histories of patients with tumoral parotid gland disease that had been treated surgically in the Otorhinolaryngology (ORL) service at our institution from 2007 to 2011 were reviewed. All the patients had previously had a preoperative FNAC of the tumour.

To homogenise the data, we selected only the patients in which the FNAC was performed by our hospital’s pathology department. All the cytologies were carried out by pathologists with an N 23 G or 25 G needle and stained with Papanicolaou stain. However, it was not always the same pathologist who performed the tests.
Cytology results were classified as negative or positive for malignant disease, and as non-diagnostic in the cases in which the pathologist was unable to make a diagnosis due to insufficient sample material.

The FNAC results were compared with the definitive anatomopathological diagnosis following surgery. We calculated sensitivity, specificity, positive and negative predictive value and positive and negative likelihood quotients for malignancy.

Results

Of the 105 parotidectomies carried out in our service during the 2007–2011 period, 93 patients were included, with each having had a preoperative FNAC at our institution. Of these, 55.9% (52) were male and 44.1% (41) were female, with a mean age of 52.9 years and a range between 11 and 88 years.

A mass on the right side was presented by 60.2% of the patients, and on the left side, 39.7%. The most common clinical presentation was the appearance of a progressively growing parotid mass (80% of the patients); 1 of them presented a mass in the parapharyngeal space at the examination. A rapidly growing mass (<3 months) was presented by 19%, in 3 of which the definitive histopathological diagnosis was malignant neoplasia (mixed malignant tumour, cystic adenoid carcinoma and non-differentiated carcinoma). Only 1 patient presented peripheral paralysis of the facial nerve, and definitive diagnosis of that case was mucoepidermoid carcinoma.

FNAC was not diagnostic in 3 cases, with a benign result for malignancy in 82 cases (88.1%) and with a positive result for malignancy in 8 (8.07%).

In the pathology study of the definitive piece, 92.4% (86 cases) presented benign disease as the definitive diagnosis; 5 of these had non-neoplastic involvement and 81 had neoplastic, with the most frequent tumour being pleomorphic adenoma, con 42 cases (45%), followed by Warthin’s tumour, with 34% of the cases (Fig. 1). Malignant neoplasia was the diagnosis in 7.52% (7 cases), each one presenting a different type of neoplasia (mucoepidermoid carcinoma, cystic adenoid carcinoma, acinar cell carcinoma, non-differentiated carcinoma, lymphoma, melanoma metastasis and oncocytic carcinoma).

The correlation between the cytological and the histopathological diagnoses was evaluated in 90 patients: in 92% of the cases (83/90) there was appropriate correlation between cytology and histopathological diagnosis: 4 true positives (cytology and histology positive for malignancy) and 79 true negatives (cytology and histology benign) (Table 1).

Sensitivity of FNAC for diagnosing malignancy was 57.1% and specificity was 95.1%. Positive predictive value for malignancy was 50% and negative predictive value, 96.3%. Positive likelihood quotient was 11.85, while the negative quotient was 0.45.

The 4 false positive cases corresponded in 3 of them to Warthin’s tumour and 1 to pleomorphic adenoma. Two of the false negative cases were diagnosed by FNAC as pleomorphic adenoma, with the definitive histopathological result being mucoepidermoid carcinoma and mixed malignant tumour.

Figure 1 Definitive histopathological diagnosis.

The third case was a lymphoma, whose cytological result from FNAC was reactive lymphadenitis (Table 2).

In the cases in which FNAC proved insufficient for the diagnosis due to acellular samples, all of them presented a definitive diagnosis of benign neoplasia: 2 cases with Warthin’s tumour and 1 that presented as a parapharyngeal mass but turned out to be pleomorphic adenoma.

Discussion

The main objective of FNAC is to establish if a mass is of inflammatory and/or reactive, benign or malignant nature, and if it is possible to achieve the specific diagnosis.

In this study, we were able to determine that FNAC is a valid test, highly precise in preoperative orientation on parotid gland tumours, with sensitivity of 57.1% and specificity of 95.1% in differentiating malign from benign disease.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Correlation Between Histopathological Diagnosis and Fine Needle Aspiration Cytology (FNAC) Diagnosis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FNAC diagnosis</td>
<td>Histopathological diagnosis</td>
</tr>
<tr>
<td>Benign</td>
<td>Malignant</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Benign</td>
<td>79 (TN)</td>
</tr>
<tr>
<td>Malignant</td>
<td>4 (FP)</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
</tr>
</tbody>
</table>

FN: false negative; FP: false positive; FNAC: fine needle aspiration cytology; TN: true negative; TP: true positive.
Table 2 Diagnostic Errors From Fine Needle Aspiration Cytology (FNAC) in the Parotid Gland.

<table>
<thead>
<tr>
<th>False negatives</th>
<th>Histological diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleomorphic adenoma</td>
<td>Mucopeidermoid ca.</td>
</tr>
<tr>
<td>Pleomorphic adenoma</td>
<td>Mixed malignant tumour</td>
</tr>
<tr>
<td>Non-specific lymphadenitis</td>
<td>Lymphoma</td>
</tr>
<tr>
<td>False positives</td>
<td></td>
</tr>
<tr>
<td>Mixed malignant tumour</td>
<td>Warthin’s tumour</td>
</tr>
<tr>
<td>Mucopeidermoid ca.</td>
<td>Warthin’s tumour</td>
</tr>
<tr>
<td>Suspicion of malignancy</td>
<td>Warthin’s tumour</td>
</tr>
<tr>
<td>Undifferentiated ca.</td>
<td>Pleomorphic adenoma</td>
</tr>
</tbody>
</table>

Ca.: carcinoma; FNAC: fine needle aspiration cytology.

This means that FNAC is of greater usefulness in confirming a diagnosis than in establishing one in a population.

Our results were similar to those published in recent literature. In these results, FNAC sensitivity ranged between 54% and 98%, and specificity, between 86% and 100%.\textsuperscript{12,16-19} Diagnostic precision had a range from 78% to 98%.\textsuperscript{20}

The meta-analysis performed by Schmidt et al.\textsuperscript{11} showed that FNAC sensitivity and specificity was located around 0.80 (confidence interval [CI] 95%; 0.76–0.83) and 0.97 (CI 95%; 0.96–0.98) respectively. These values were considerably higher in sensitivity compared with those of our study.

The variability of results among the various studies could mainly be due to the pathologist’s skill, as well as to technical factors: whether the sample is or is not taken by pathologists, if cytology is carried out just after extraction to verify if the sample is satisfactory, or whether it is performed guided by sonography or blind. This last point is important, given that it has been shown that when FNAC is associated with a sonographic guide, its precision increases.\textsuperscript{4} In fact, sensitivity of even up to 38% has been published when FNAC is carried out blindly.\textsuperscript{5} Consequently, it can be said that for appropriate cytological diagnosis by FNAC, you need good sample quality and in-depth experience from both the pathologist and the individual that carries out the needle aspiration.\textsuperscript{12}

In our study the majority of the FNAC tests were performed blindly. In addition, it was not always the same pathologist that interpreted the cytology and the definitive piece. These facts could explain the lower sensitivity in our results.

Of the diagnoses established using FNAC, 7.8% were erroneous. Among the most frequent diagnostic errors, it is notable that in almost all of the false positives the definitive diagnosis was Warthin’s tumour, a benign neoplasia that generally presents metaplastic changes in the epithelium, and that is sometimes accompanied by cytological atypia, which could lead the pathologist to a false diagnosis of carcinoma.\textsuperscript{6,8}

Different series show that false negatives are frequently observed in malignant tumours of the parotid gland, between 13% and 29%.\textsuperscript{6,19} In general, malignant tumours can be difficult for the pathologists to diagnose, above all for those whose experience in this field is limited; this is because such tumours are of low incidence and have an extensive variety of histological patterns that present very seldom.\textsuperscript{21}

In this study only 57.14% of the malignant tumours were diagnosed by FNAC; the rate of false negatives was 42.8%, in which the definitive diagnosis was mucopidermoid carcinoma (1 case), mixed malignant tumour (1 case) and lymphoma (1 case). This rate of false negatives is very high compared with that of other studies. We can attribute this to the low prevalence of malignant tumours in our sample (7.52%), as well as to their histological variability (given that all corresponded to different histopathological forms).

Both mucopidermoid carcinoma and mixed malignant tumour are tumours that present great cell heterogeneity, with various degrees of atypia, so low grade lesions can be mistaken for benign lesions and give false negative results.\textsuperscript{10,16} That is why it is important for cytopathologists to have in-depth experience in parotid gland disease, as the precision of FNAC depends in great part of them.

Cytological diagnosis using FNAC should never prevail over the surgeon’s clinical impression; faced with a benign FNAC result, but with suspicion of a malignant process from the clinical data or imaging, performing a intraoperative biopsy is recommended to confirm the diagnosis and guide appropriate treatment.

Conclusions

The FNAC test is simple but it has limited usefulness as a diagnostic guide in tumoral disease of the parotid gland in our environment. This is mainly due to its low sensitivity and high rate of false negatives. However, its high specificity and elevated negative predictive value make it a test with greater precision when faced with a benign or negative result.

This test plays a role in treatment planning, above all considering the patient’s informed consent and in special situations such as with individuals having high surgical risk and suspicion of benign or non-neoplastic disease. In these circumstances, the FNAC can make it possible to choose conservative management.

We have to make a cautious interpretation of the FNAC results, which along with the characteristics of the physical examination and imaging tests will allow for a more precise diagnosis and, consequently, appropriate management.

Conflict of Interest

The authors have no conflicts of interest to declare.

References

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