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內文：

I. Introduction

1. Necrotizing sialometaplasia (NS)-1973 by Abrams et al.:an inflammatory necrotizing reactive process affecting minor salivary glands of the hard palate.
2. Proposing histopathological criteria:
   (1) Necrosis of acinary cells of seromucinous glands
   (2) Squamous metaplasia of salivary ductal epithelial and acini
   (3) Pseudoepitheliomatous hyperplasia of the epithelium lining the gland
   (4) Mucous release
   (5) Inflammatory response associated with granulation tissue in or around the glands
   (6) Intact lobular architecture
3. Modified by Brannon (1991)- necrosis of acini in early lesions and of squamous metaplasia and reactive fibrosis in later lesions.
4. Anneroth, Hansen and Imbery, Edwards described five histological stages of NS: infarction (necrosis), sequestration, ulceration, repair and healing.
5. NS is an uncommon, benign and self-limiting reactive inflammatory process involving minor and major salivary glands.
   (1) All sites with salivary tissue .Most:hard palate (58%)
   (2) Mainly a deep crateriform ulcer with indurated and well-defined edges. Less often, as a non-ulcerated mass
   (3) Generally unilateral(12% bilateral)
   (4) Bone involvement in only a few cases.
   (5) Painful or asymptomatic, while some patients present with fever, malaise or paraesthesia/anaesthesia of the area .
   (6) Most in Caucasian males aged between 40 and 50 years.
6. Etiology is uncertain, but an underlying cause appears to be gland tissue ischemia. Numerous risk factors including:
   (1) Local trauma(e.g., surgery, poor-fitting prostheses)
   (2) Fellatio or local pressure
   (3) Alcohol, tobacco or cocaine use

(4) Radiation
(5) Respiratory infections or allergies
(6) Previous adenoidectomy or surgery for other lesions (e.g., tumors, mucoceles)
(7) Adjacent tumors or other lesions producing compression and ischemia
(8) Bulimia and chronic vomiting
(9) Diabetes
(10) Drepanocytic anaemia,

7. Local dental anaesthesia to the hard palate is thought to play a role in NS (1996, Shigematsu et al.)
8. Management of these lesions:
   (1) An incisional biopsy and close follow-up
   (2) Administering analgesics in cases of pain.
   (3) Usually no recurrences or sequelae.
   (4) NS lesions heal without treatment within 4-10 weeks
   (5) The healing time is primarily related to the size of the lesions
9. The severity of the ulceration and tissue destruction over a short time period:
   (1) Frequently misdiagnosed as mucoepidermoid carcinoma, squamous cell carcinoma
   (2) Incisional biopsy is therefore essential to establish a correct diagnosis

II. Case Report

1. A 21-year-old woman, smoker of 10 cigarettes/day,
   (1) With a one-week history of bilateral palatal swellings that had developed into two deep ulcers after the first three days.
   (2) The swellings had been painful and her temperature had risen to 38ºC during the initial three-day period
   (3) But both the pain and fever disappeared with the appearance of the ulcers.
2. Clinical examination
   (1) Two deep ulcers (3x1 cm and 2x1 cm), one on either side of the midline of the hard palate (Fig. 1).
   (2) The edges of the lesions were elevated but not indurated,
   (3) The base was covered with necrotic debris.
   (4) No pain, and no abnormities were observed in the rest of the oral cavity.
   (5) Haematological and radiographic findings were normal.
3. An incisional biopsy of the peripheral margin was taken under local anaesthesia.
   (1) Mucosa composed of parakeratotic, stratified squamous epithelium.
   (2) Submucosa contained numerous degenerating mucus-producing salivary glands with mucus spillage.

(3) Some areas showed extensive necrosis of glandular acini and squamous ductal metaplasia (Fig. 2).

(4) The connective tissue was infiltrated by a mixed inflammatory infiltrate.

4. The ulcers resolved spontaneously without treatment over the following 8 weeks (Fig. 3).

Fig. 1. Palatal ulcers at presentation.

Fig. 3. Lesions resolved at 8 weeks from the onset.

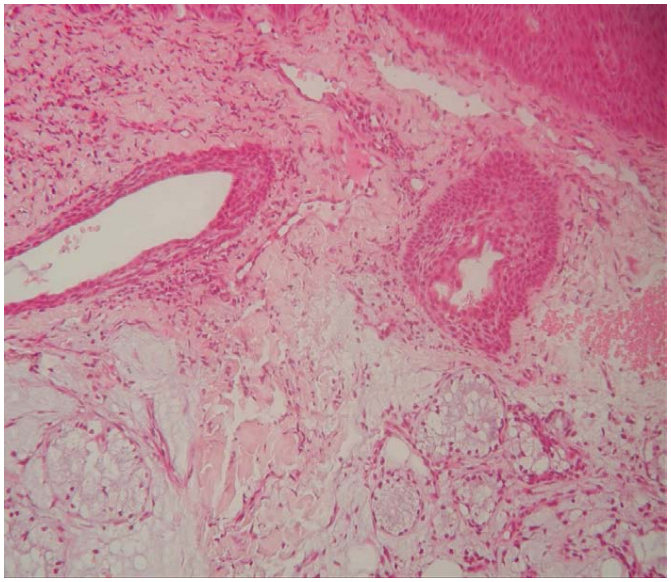

Fig. 2. Necrosis of acini and acute inflammatory infiltrate (HE 200x).

III. Discussion

1. D.D. of NS should consider other ulcerous and erosive lesions:

(1) Dental fissures,

(2) Major aphthae,

(3) Tuberculosis,

(4) Tertiary syphilis

(5) Deep fungal infection in patients with AIDS

(6) Under immunosuppressive treatment

(7) Cancerous origin, e.g., squamous cell carcinoma, mucoepidermoid carcinoma.

2. NS is differentiated from tuberculosis, syphilis and fungal ulcers by:
(1) Serologic tests
(2) Staining histopathological samples

3. Histological criteria to distinguish NS from a malignancy are:
(1) Preserved general lobular morphology
(2) Bland appearance of squamous islands or nests with no cytological evidence of malignancy
(3) No findings of residual ductal lumina in any nest. .

4. Rizkalla and Toner: Expression of calponin, smooth muscle actin and focal staining with cytokeratin 7 are characteristic of NS but not normally expressed in carcinomas.

5. The possibility of a subacute necrotizing sialadenitis should also be taken into account. According to Fowler et al.:
(1) A non-specific acute inflammatory condition of unknown origin,
(2) Histologically characteristic:Focal acinar necrosis and atrophy of duct cells, without ductal metaplasia, pseudoepitheliomatous hyperplasia or fibrosis.
(3) Non-ulcerated erythematous nodular lesions on the palate accompanied by acute pain and has been reported in young people living in groups.
(4) Usually last for around two weeks and it has been suggested that the aetiology may be infectious (viral) or allergic.

題號	題目
1	Numerous risk factors of necrotizing sialometaplasia excluding? (A) Upper Respiratory Infections (B) Ill-fittng dentures (C) Previous sugery (D) Virus infection
答案(D)	出處：Oral & Maxillofacial Pathology second ED P.405
題號	題目
2	The microscopic appearance of necrotizing sialometaplasia is characterized by ?
	(A) Acinar necrosis (B) Acinar metaplasia (C) Ductal squamous necrosis (D) Lobular architecture loss
答案(A)	出處：Oral & Maxillofacial Pathology second ED P.406