Surgical removal of a submandibular megalith

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DESCRIPTION

A 50-year-old male patient reported with a chief complaint of pain and intraoral swelling on the left side of the floor of the mouth since last 3 months (figure 1). Initially, owing to poor financial condition, he ignored the lesion and took self-medication and reported only when the pain and swelling became severe, especially during swallowing. Upon examination, the swelling was hard and both swelling and pain aggravated during eating. Occlusal radiographs and orthopantomographs were taken which confirmed sialolith’s presence and determined its location (figures 2 and 3). The final diagnosis revealed presence of a salivary calculus in the submandibular gland duct.

A submandibular sialolith should be distinguished from a torus which are usually painless, calcified lymph nodes that appear radiolucent and radiopaque with irregular borders and phleboliths which are associated with discernible varicosity.1

In cases of small sialoliths, the patient must be well hydrated and the clinician must apply moist warm heat, gland massage with administration of sialogogues.2 In the present case, as the sialolith was single, large, bimanually palpable and radiographically localised, it was surgically removed (figures 4–6).3

The postoperative function of salivary gland was normal. The patient has been asymptomatic ever since.

Though mostly asymptomatic, such swellings should not be ignored as the persistence of ductal blockage for a long period may result in fibrosis of the gland and even chronic sialoadenitis. In the present case, the patient resorted to self-medication of antibiotics and analgesics owing to which we suppose that he did not suffer any infection in

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Figure 1 Preoperative intraoral picture presenting a swelling on the left side of the floor of the mouth.

Figure 2 Orthopantomograph presenting a radiopaque structure on the left side of mandible.

Figure 3 Occlusal radiograph showing a large sialolith.

Figure 4 Surgical excision of the sialolith.
associated salivary gland. However, literature states that such sialoliths have an increased chance of causing infections or sialadenitis and thus need to be removed soon.

Learning points

▸ Sialoliths of such large sizes are extremely rare and should always be treated after considering their size and shape. If not removed soon, may cause sialadenitis.
▸ Few hypomineralised stones cannot be visualised through conventional radiographs. In these cases other advanced imaging modalities should be considered.

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REFERENCES