

Case Report

Ulcerative sialadenitis of minor salivary gland: A short case report

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Abstract

Minor salivary glands have an important role in the physiology and pathology of the oral cavity though they have been neglected at times. Smoking has a direct effect on the palatal minor salivary glands, and their most common presentation is stomatitis nicotina. We report a case of ulceration in the palatal salivary gland presented with intermittent heavy bleeding from the lesion.

Key words: Minor salivary gland, smoking, ulcerative sialadenitis

INTRODUCTION

The minor salivary glands are important components of the oral cavity, present in most parts of the mouth, and their secretions directly bathe the tissues. Individual glands are usually in the submucosa or between muscle fibers and consist of groups of secretory end pieces made up of mucous acinar cells and serous or seromucous demilune cells.^[1] Sialadenitis of minor salivary glands are rarely reported in the literature. We report a case of ulceration in the palatal salivary gland presented with intermittent heavy bleeding from the lesion.

CASE REPORT

A 50-year-old male patient reported with the complaint of bleeding from the swelling in the palate for 4 months. The bleeding started spontaneously while eating or drinking, continued for about 5 min. Bleeding was profuse and was not associated with any symptoms. The patient had consulted a doctor who had diagnosed it to be bleeding from a swelling in the palate. The patient was prescribed some medications, but the lesion did not resolve. Details of medication taken were not known. The swelling was nonprogressive and asymptomatic. Past medical, dental, and family histories were noncontributory. The patient

was habituated to cigarette smoking for 35 years. He smoked about 15 cigarettes/day. General physical examination and extra oral examination did not reveal any abnormalities. On intraoral examination, a small, well-defined, solitary papule measuring about 4 mm in diameter was present in the midpalatal region, on the left side of midpalatal raphe, along a line running from the right second premolar to the left second premolar. Borders were well defined. Mucosa over the lesion was ulcerated in the center. Edges of ulcer were slightly raised. The surface of the ulcer was erythematous. Mucosa adjacent to the lesion was of normal color [Figure 1].

On palpation, it was nontender and soft. The lesion showed some compressibility. Upon compressing, serous discharge exudate from the central ulcerated area. On asking the patient to spit following gargling with water, heavy bleeding was noted from the lesion, which lasted for 5 min. However, no bleeding was noted from the lesion on repeated palpation. However, gargling induced heavy bleeding from the lesion. The case was provisionally diagnosed

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Access this article online

Quick Response Code:



Website:

www.ijdentistry.com

DOI:

10.4103/0975-962X.168521

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How to cite this article: Kashyap RR, Nair R G, Kashyap RS. Ulcerative sialadenitis of minor salivary gland: A short case report. Indian J Dent 2015;6:215-6.



Figure 1: Well defined, solitary papule with central ulceration in the palate

as ulcerative sialadenitis of minor salivary gland with considering minor salivary gland adenoma, adenomatoid hyperplasia, and nonhealing tuberculous ulcer as a differential diagnosis.

The maxillary occlusal radiograph showed no bony changes. Microbial culture of the swab was negative for tuberculous bacilli. Exfoliative cytology report was nonspecific. Excisional biopsy was carried out. Histopathological examination showed hyperkeratotic stratified squamous epithelium and mucous acini collection in the underlying connective tissue. A Minimal amount of chronic inflammatory cells and endothelial lined blood vessels with red blood cells were also seen. Acinar cells showed a disturbed architecture [Figure 2]. Histopathological features were suggestive of a chronic nonspecific ulcer. Based on the clinical features, histopathology report and other investigations, the final diagnosis was given as ulcerative sialadenitis of the palatal salivary gland. The patient was recalled and reviewed periodically. The lesion had healed without scarring, and there was no recurrence observed.

DISCUSSION

Despite their name, minor salivary glands have an important role in the physiology and pathology of the oral cavity. They secrete more or less continuously, providing a steady flow of fluid, and organic substances to protect the oral tissues. Because individual glands open directly onto the mucosal surface, their secretions create and regulate the local environment.^[1]

The effect of smoking on the oral cavity has been well studied for quite a number of years. Stomatitis nicotina is the most common lesion caused due to smoking. The glandular area of the hard palate mucosa shows papular elevations (up to 2–3 mm in height) with central umbilications with or without

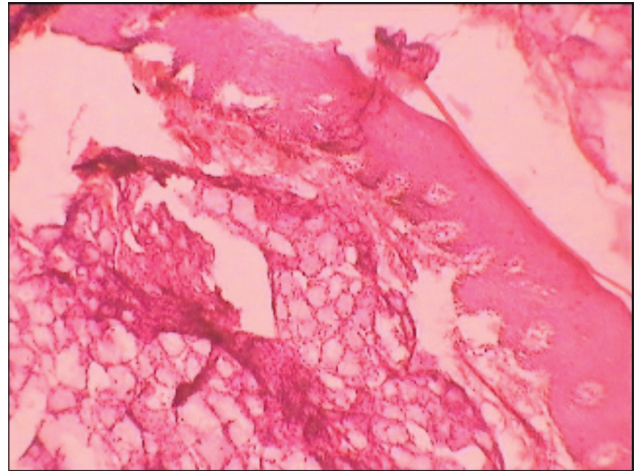


Figure 2: Hyperkeratotic stratified squamous epithelium and mucous acini collection in the underlying connective tissue. Minimal amount of chronic inflammatory cells and endothelial lined blood vessels with red blood cells were also seen (H and E, ×10)

pigmentation of the surrounding mucosa. The central umbilication could be like a red spot in the center of a greyish or pale elevated papule. In mild stomatitis nicotina lesions red dots over blanched elevated areas can be seen, and in severe cases, papular lesions up to 0–5 cm. in diameter or more with umbilications up to 2–3 mm. in diameter. They are found only in the areas of the palate exposed to tobacco smoke. Histologically, they show only chronic inflammation.^[2]

Ulcerative sialadenitis of the minor salivary gland has not been mentioned in the literature so far. Inflammation of the minor salivary gland openings due to smoking and some kind of traumatic irritation would have resulted in ulceration. The ulcerated friable mucosa would have developed the tendency to bleed on applying negative pressure. A further enlightenment on this condition could not be done as this is the first case to be reported on ulcerative sialadenitis of the minor salivary gland.

Acknowledgment

The authors would like to thank A B Shetty Memorial Institute of Dental Sciences, Mangalore.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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