SALIVARY GLAND DISORDERS

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INTRODUCTION

• Four main salivary glands
• Two parotid glands
• Two submandibular glands
• Multiple minor salivary glands in the upper respiratory track
Figure 20.2 The stylomandibular ligament
IMPORTANT STRUCTURES THAT PASS THROUGH PAROTID GLAND

- Facial nerve
- Terminal part and branches of external carotid artery
- Maxillary artery
- Superficial temporal artery
- Retromandibular vein
- Intra parotid lymph nodes
SUBMANDIBULAR GLAND
SALIVARY GLANDS LESIONS

- Congenital
- Inflammatory
  - Viral
  - Bacterial
- Traumatic
- Neoplasm
  - Benign
  - Malignant
INFLAMMATORY DISORDERS

- Viral infections (Mumps)
- acute painful parotid swelling
- children
- airborne droplet infection
- ex on meals

Complications

- Orchitis, oophritis, pancreatitis, SNHL, meningoencephalitis
TREATMENT

- Analgesics
- Fluid intake
- Life long immunity
BACTERIAL INFECTION

- Acute Suppurative Sialadenitis
- May involve parotid or submandibular gland
- Ascending infection
- Staph aureus, strep.
- Dehydrated old/young children
ACUTE SUPPURATIVE SIALADENITIS

Clinical Features:
- Malaise, pyrexia, cx LAP
- Examination: pus from duct opening

Management:
- USG
- I.V Antibiotics
- Drainage
**CHRONIC SIALADENITIS**

- Chronic infection of salivary gland can lead to firm, mild enlargement of the gland with repeated acute infection
- More in parotid gland followed by submandibular gland
- History of recurrent mildly painful enlargement of gland. Massage of gland produces scanty secretions at the opening of the duct
MANAGEMENT

- USG
- Papillotomy
- Removal of calculus
- Antibiotic
- Massage of the gland
- Total gland excision
- Tympanic neurectomy
SALIVARY GLAND TUMOURS

- Tumours of salivary glands represent a complex and histopathologically diverse group of tumour
- Diagnosis and management is complicated by the fact that they are in frequent
- Making up only 1% of head and neck tumour
- Proper management require and accurate diagnosis by the pathologists and physicians
## Salivary gland tumours

<table>
<thead>
<tr>
<th>Location</th>
<th>Benign (%)</th>
<th>Malignant (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parotid</td>
<td>80-90%</td>
<td>10-20%</td>
</tr>
<tr>
<td>Submandibular</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Sublingual</td>
<td>5%</td>
<td>95%</td>
</tr>
<tr>
<td>Minor</td>
<td>10%</td>
<td>90%</td>
</tr>
</tbody>
</table>
PAROTID TUMOURS

- Most common site of salivary neoplasm
- Mainly arise from superficial lobe
- Slow growing painless mass below or infront of pinna
- Deep lobe tumours present as parapharyngeal mass
- Dysphagia / snoring / mass in oropharynx
CLASSIFICATION OF PAROTID TUMOURS

- Adenoma pleomorphic / warthin, adenolymphoma

- Carcinoma acinic cell ca / adenoid cystic ca adenocarcinoma / scc
PLEOMORPHIC ADENOMA

• Most common benign tumour
• Can arise from parotid, submandibular or other salivary gland
• In the parotid it usually arises from tail
• Slow growing tumour
• Seen in 3rd or 4th decade
• More in female
• Both epithelial and mesenchymal elements are seen
DIAGNOSIS

- History
- Clinical examination
- FNAC
- Ultrasonography
- CT Scan
- MRI
TREATMENT

- Surgical Excision
- Superficial parotidectomy
- Total parotidectomy with preservation of facial nerve
WARTHIN’S TUMOUR

- More common in male (5:1)
- Seen between 5th & 7th decade
- Mostly involve tail of parotid
- Bilateral in 10%
- May be multiple
- Rounded, encapsulated at time cystic
- **Treatment**: Superficial parotidectomy
CLINICAL FEATURES OF MALIGNANT SALIVARY TUMOURS

• Facial palsy
• Rapid increase in size
• Hard mass / ulceration
• Cervical lymphadenopathy
SIALADENOSIS

- Non inflammatory swelling affecting salivary glands
  - Diabetes mellitus
  - Alcohol and pregnancy
  - Bulemia
  - Drugs
  - Idiopathic
Sjogren syndrome

- Autoimmune
- Progressive destruction of salivary and lacrimal glands
- xerostomia
- Primary
- Secondary connective tissue disorders
DISEASES OF SUBMANDIBULAR GLAND

• Inflammatory conditions
  - Viral
  - Bacterial

• Obstructive
  - calculus
  - trauma

• Tumours
THANK YOU