

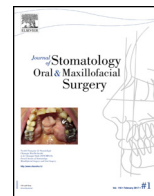


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Case Report

A case of bilateral megaducts: Diagnostic and treatment methods

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ABSTRACT

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Introduction. – The pathology of the saliva glands comprises both tumoral and obstructive disorders. The latter include lithiasis, stenosis and megaduct. In this paper, we describe a clinical case of bilateral megaduct, a rare pathology, using sialo-MRI imaging and a conservative diagnostic-cum-therapeutic technique, sialendoscopy with dilation followed by catheterization.

Clinical case. – Our female patient presented oversized parotids with an unsightly deformation of the face (parotid ducts visible beneath the skin) and itchy cheeks, from which she had suffered for several years. Sialo-MRI revealed bilateral hypertrophied parotid saliva glands. We opted to perform diagnostic sialendoscopy to explore the branches of the salivary gland system and found ducts shaped like strings of sausages associated with mucous plugs. The treatment procedure was combined with rinsing of both parotid ducts in physiological serum followed by initiation of antibiotic-corticotherapy within the saliva ducts and, lastly, by placement of transpapillary drains, which were left in place for 10 days. Immediately following the procedure, the patient felt a considerable improvement regarding both local discomfort and her cheek deformation. Postoperative control at 10 weeks by sialo-MRI confirmed the reduction of the dilation of the salivary ducts. At 3 months, the patient continued to display a marked clinical improvement despite her saliva retaining a thick consistency. She no longer suffered from pruritis or deformation of the cheeks.

Discussion. – Sialendoscopy could become the reference treatment tool since it is both efficient and conservative. Duration of her postoperative catheterization remains to be defined.

1. Introduction

Saliva gland pathologies are divided into two major groups: obstructive and tumoral disorders. In order to improve diagnosis and treatment of obstructive saliva conditions, the LSD classification was devised in 2008 [1]. The classification is based on the endoscopic appearance of the saliva ducts and the absence or presence of lithiasis (L), stenosis (S) and dilation (D), which are the three main forms of obstruction. Cases of megaduct involving ductal dilation (D) have not been widely described, especially when bilateral. The main clinical manifestations are abnormal dilation of the parotid saliva duct along its entire course with sausage-string-type strictures. Few radiologic images are available. Treatment is not standardized and too often consists of total parotidectomy. We describe a conservative diagnostic and therapeutic technique comprising dilation followed by catheterization: sialendoscopy.

2. Clinical case

Our patient, a black 47-year-old female had presented swelling of both parotids for roughly six years associated with itchiness of the cheeks, notably during meals. She had undergone thyroidectomy 20 years previously for a benign tumor, without administration of radioactive iodine. She had never received treatment for a salivary gland condition, had undergone no long-term treatment and had no allergies. The interview did not reveal any predisposing factor and notably no connection with the timing of her meals. The clinical exam showed enlarged parotids with swollen saliva ducts, which were visible through her cheeks. The endo-oral examination uncovered viscous to purulent saliva at the ostium, particularly on the right side with mucous plugs visible at the ostium after parotid massage. On the left parotid, the ultrasound pointed to obstructive cysts.

The sialo-MRI revealed bilateral megaducts (Fig. 1a and b). The main hypothesis was ductal fragility in the anterior section as parotid lithiasis was unlikely. Diagnostic-therapeutic sialendoscopy was performed. Both saliva ducts were treated in the same procedure.

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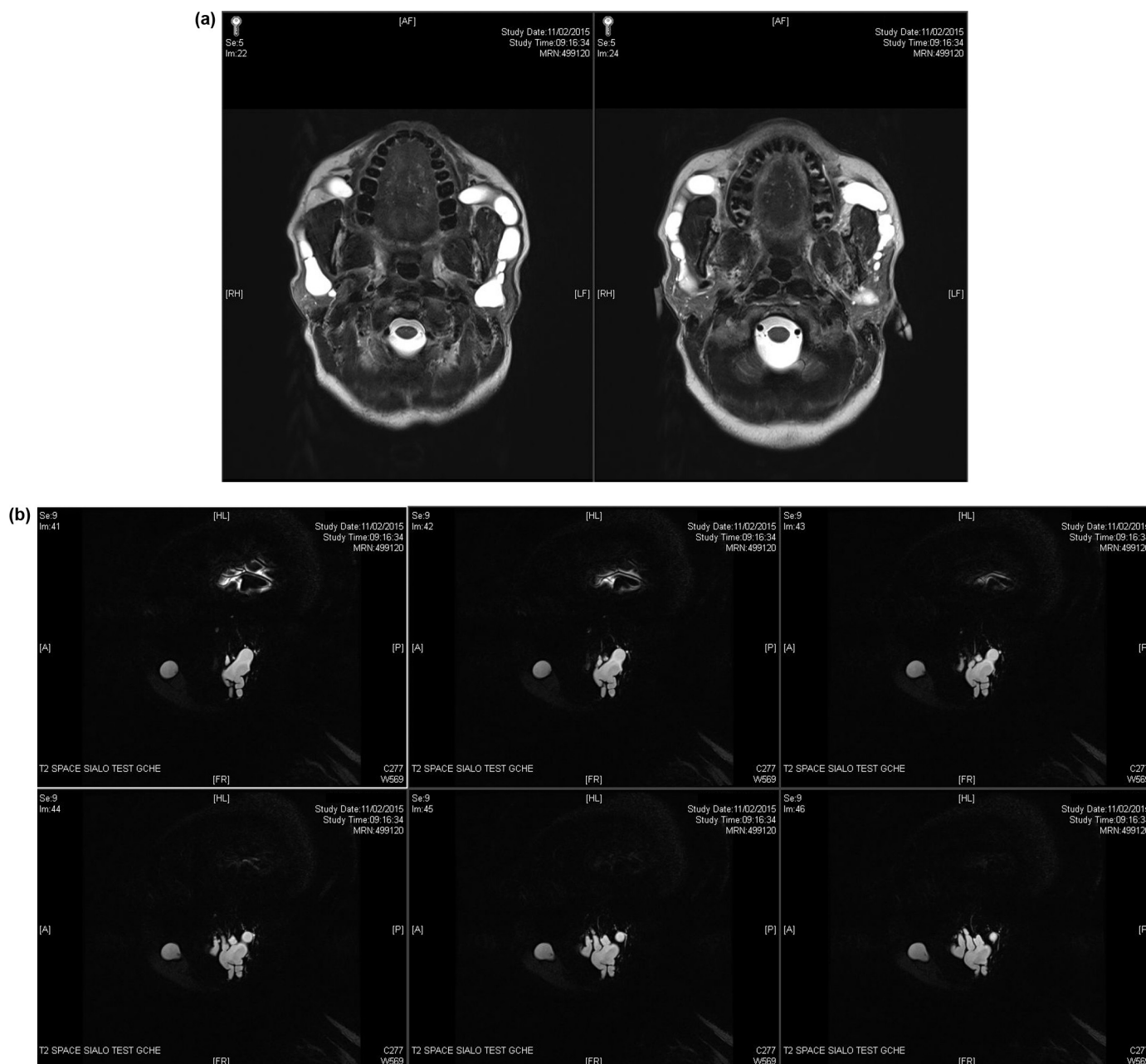


Fig. 1. a: preoperative axial MRI slices; b: preoperative 3D Sialo-MRI: left megaduct.

The ducts were investigated after dilation and papillary catheterization in order to negotiate the difficult masseteric bend. Thorough investigation of all the duct branches revealed a sausage-string appearance and the presence of mucus plugs. Rinsing was done using saline solution before injection of 10 mg of solumedrol and amoxicillin into both salivary ducts. Flexible pediatric umbilical drains 0.8 mm in diameter (Vygon ref 1270.03 3.5Fr) were inserted through each ostium and left in place, secured in each duct using 4/0 silk sutures.

Post-surgical follow-up was marked on day 10 by inflammation of the salivary ducts. It resolved quite simply by removing the umbilical drains, which were no longer necessary and were poorly tolerated by the patient.

At two months, the glands were much less swollen; the patient no longer had pain and her saliva was flowing freely.

Postoperative control at 10 weeks by sialo-MRI revealed reduced dilation of the salivary ducts (Fig. 2a and b). On the right, the parotid

duct was close to normal in diameter and showed almost no stenosis. On the left, the improvement was less noticeable.

At 3 months, the patient still displayed a bilateral retention syndrome, which was less severe. She showed a distinct improvement of the lower thirds of both parotid ducts. Postprandial cheek massages were now effective although the saliva remained thick. Pruritis was no longer present.

3. Discussion

Sialendoscopy is a diagnostic and treatment method for symptomatic megaducts. Catheter placement at the end of the procedure allows calibration of the anterior section of the salivary duct. It remains to be determined how long the catheters should be left in place. In our view, it is preferable to keep them in as long as possible (at least two weeks). Sialendoscopic treatments may need

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