



**Figure 5.17c.** A finger was inserted in the oral cavity to create better access to the duct, thereby permitting stone retrieval.



**Figure 5.17d.** A primary closure was obtained. Reprinted with permission from Ord RA. 2000. Salivary gland disease. In: Fonseca R (ed.), *Oral and Maxillofacial Surgery*, Volume 5, Surgical Pathology. Philadelphia: W.B. Saunders Co., pp. 273–293.

### Miscellaneous Sialolithiasis

The incidence of sialolithiasis of the sublingual gland and the minor salivary glands is very rare. In McGurk, Escudier, and Brown's (2004) study of 455 cases of salivary calculi, no cases were present in the sublingual gland or minor salivary glands. As such, swellings of these glands are most likely to engender a clinical diagnosis of neoplastic disease, with the diagnosis of sialolithiasis made only after final histopathologic analysis of the gland occurs (Figure 5.18). One report examining sialolithiasis of the minor salivary glands found that only 20% of cases were correctly clinically diagnosed as sialolithiasis (Anneroth and Hansen 1983). The paucity of accurate diagnosis may also stem from the frequent spontaneous resolution of

the problem due to ejection of the calculus (Lagha, Alantar, and Samson et al. 2005). Two stages of minor salivary gland sialolithiasis have been described, including an acute stage characterized by inflamed overlying soft tissue whereby the most common clinical diagnosis is cellulitis of the soft tissue. The chronic stage follows and calls to mind a differential diagnosis of neoplasm, irritation fibroma, or foreign body. An anatomic distribution of 126 cases of sialolithiasis of the minor salivary glands identified a significant majority occurring in either the upper lip or the buccal mucosa. As such, sialolithiasis should be included on the differential diagnosis of an indurated submucosal nodule of the upper lip or buccal mucosa, and surgical excision should be performed.