OBJECTIVES: To review our experience with transoral excision of the submandibular gland

STUDY DESIGN: A retrospective review

METHODS: Patients with benign submandibular gland pathology who underwent transoral excision of the submandibular gland were identified. Data pertaining to patient demographics, conversion to open approach, recurrence of disease, length of operative procedure, length of hospital stay as well as incidence of neurologic complications was collected.

RESULTS: 43 patients underwent transoral excision of the submandibular. 1 transoral case required conversion to an open procedure and therefore 98.6% of patients avoided a neck scar. 34/42 (80%) of patients reported transient tongue paresthesias. No patient experienced hypoglossal or facial nerve dysfunction.

CONCLUSION: Transoral submandibular gland excision is a safe and effective procedure. The approach allows for avoidance of an unsightly neck scar as well as lower rates of injury to the lingual, hypoglossal and facial nerves when compared to a transcervical operation. This should become a routine part of the surgical armamentarium of the well trained otolaryngologist.

All patients had benign pathology

Surgical Technique

Figure 1: The patient is nasally intubated. Wharton’s duct is then cannulated with a 20Fr angiocath and secured with a 4.0 silk suture.

Figure 2: Mucosal incisions are made around the sublingual gland, which is removed. This allows for visualization of the lingual nerve.

Figure 3: The relationship of Wharton’s duct (blue arrow) and the lingual nerve (black arrowhead) can be observed.

Figure 4: Wharton’s duct is tunneled underneath the lingual nerve. The submandibular ganglion is freed to allow retraction of the lingual nerve.

Figure 5: Digital pressure is applied and the gland is carefully dissected and excised.

Figure 6: The wound is closed loosely with interrupted suture. At four weeks postoperatively, the wound has completely healed without tethering.

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