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## Giant Submandibular Gland Calculi

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More than 80% of salivary calculi occur in the submandibular gland or its duct.<sup>1,2</sup> These may be single or multiple but are usually less than 3 cm long. Giant sialoliths are very uncommon. A case of an extremely large submandibular sialolith is reported here.

### Report of Case

In 1979, a 28-year-old East Indian man presented with a hard left submandibular swelling (Fig. 1). When he had first noticed it three years before, it had been much smaller. Though painless, it had gradually increased in size, and he sought medical attention for this reason.

On examination, there was a nontender, stony-hard swelling in the left submandibular area. Another large mass could be palpated bimanually, immediately anterior to this. Radiographs confirmed the presence of two submandibular calculi (Fig. 2). With the patient under general anesthesia, a curved incision was made over the cervical mass. There were no signs of acute inflammation, but the lingual nerve, stretched over the submandibular swelling, was very adherent to it. By careful dissection, the nerve was preserved, and the gland and stones were excised. The patient made an uneventful recovery with good preservation of lingual nerve function.

### Discussion

Salivary calculi are found more commonly in the duct than in the gland parenchyma.<sup>3</sup> Thus, they frequently produce recurrent bouts of duct obstruction

and gland inflammation. Since the calculi are usually symptomatic, patients often present to the clinician long before the stone becomes very large. This patient had no pain, although he had palpated the mass three years before and noticed it in-



FIGURE 1 (above, left). Left submandibular swelling caused by large calculi.

FIGURE 2 (above, right). Radiograph showing two giant submandibular calculi.

FIGURE 3 (below). Submandibular calculi after excision. Rule measurement is shown in inches.

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creasing in size during this period. In spite of the absence of symptoms, there was evidence of chronic inflammation in the gland at surgery. Identification and preservation of the lingual nerve was very difficult because of dense fibrous tissue.

Giant sialoliths have been reported by Meyers,<sup>4</sup> Koshal and Naik,<sup>5</sup> and Zakaria.<sup>6</sup> These measured 3 × 5 cm, 2.75 × 5 cm, and 3.3 × 3.2 cm, respectively. The huge stone in the present case measured 3 × 6 cm (Fig. 3), making it one of the largest ever reported.

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## Pancreatic Carcinoma Metastatic to the Mandibular Gingiva

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Malignant tumors seldom metastasize to the tissues of the oral cavity. When they are metastatic, tumors usually involve bone as well as soft tissue. It is rare to find a tumor of the oral soft tissues without bony involvement.<sup>1</sup> Metastatic tumors to the oral soft tissues are mostly adenocarcinomas with a grave prognosis. We report here an unusual case of pancreatic carcinoma metastatic to the mandibular gingiva, which appeared clinically as inflammatory gingivitis. Because malignant lesions metastatic to the oral soft tissue often masquerade as more benign entities, practitioners who are not cognizant of such lesions may overlook the need for histologic examination and delay recognition and appropriate treatment of the patient's disease.

### Report of Case

The patient, a 46-year-old previously healthy black man, was admitted June 9, 1981, to the Department of Medicine at the University of Chicago Hospitals and Clinics with a chief complaint of anorexia, a 20-pound

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weight loss, and sharp continuous midsternal and epigastric pain. The pain increased while he was eating and was relieved with narcotic analgesics. The patient frequently regurgitated after swallowing and reported that solid food felt as though it were stuck in the middle of his chest. The patient had a 30-40 pack per year history of smoking. Although he complained of dyspnea on exertion, his medical history and review of systems were otherwise unremarkable.

Physical examination was remarkable for tenderness of the right upper quadrant and epigastrium, although organomegaly was undiscernible. There were no palpable lymph nodes. Electrocardiogram and routine laboratory showed minor unremarkable variations from normal.

Routine chest radiographs and tomograms revealed masses, the biopsy of which during mediastinoscopy proved to be metastatic, moderately differentiated adenocarcinoma in the parabronchial lymph nodes. Differentiation between primary lung and pancreatic carcinoma could not be made.

Upper gastrointestinal examination demonstrated extrinsic compression of the esophagus and the junction of the duodenal bulb and descending duodenum. Radiographically the esophagus appeared to be spared of tumor. Computed tomography and subsequent endoscopic retrograde cholangiopancreatography revealed evidence consistent with carcinoma of the pancreas. Bronchoscopy revealed no abnormality.

During bronchoscopy several mandibular anterior teeth were traumatized. Teeth 21-27 were extremely mobile. They were attached to inflamed, edematous gingival tissue, the appearance of which was consistent with a history of trauma and of chronic periodontitis. Other dental and soft tissues of the mouth appeared to be normal. Radiographic examination of the involved teeth,