

doi:10.1017/S0022215108002284

Magnetic resonance identification of an accessory submandibular duct and gland: an unusual variant

J Laryngol Otol 2007;**121**:E18

Dear Sirs

Gadodia and colleagues¹ present excellent radiological images of Bartholin's duct and the greater sublingual gland, which they have interpreted as an accessory submandibular duct and gland.

This error is understandable because the detailed anatomy of the sublingual gland is much more complex than is generally appreciated. Leppi² discovered that the sublingual gland consists of a constant, lesser sublingual gland and a greater sublingual gland. The latter is posterior to the lesser sublingual gland in the paralingual space and was only found in 10 out of 28 people, and usually only unilaterally. Bartholin's duct runs from the greater sublingual gland to either join or open independently of Wharton's duct. The lesser sublingual gland consists of between eight to 30 small glands, from every one of which a duct of Rivinus passes to open independently on the sublingual fold.

Thus, the sialograms in the paper by Gadodia and colleagues¹ show Bartholin's duct running parallel to the dilated Wharton's duct, which indicates that these ducts join, and the sublingual gland. The authors mention that there was stasis in Wharton's duct following stimulation by lemon. It would be interesting to know the situation in Bartholin's duct, where stasis would not be expected, particularly as the sublingual gland is a spontaneous secretor and continues to secrete in the absence of stimulation, and also exhibits a great resistance to obstruction.³

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References

- 1 Gadodia A, Seith A, Neyaz Z, Sharma R, Thakkar A. Magnetic resonance identification of an accessory submandibular duct and gland: an unusual variant. *J Laryngol Otol* 2007;**121**:E18
- 2 Leppi TJ. Gross anatomical relationships between primate submandibular and sublingual salivary glands. *J Dent Res* 1967;**46**:359–65
- 3 Harrison JD, Sowray JH, Smith NJD. Recurrent ranula. A case report. *Br Dent J* 1976;**140**:180–2

Author's reply

I am grateful for J D Harrison's comments on our article.

We diagnosed our case of accessory submandibular gland and duct on the basis of the presence of two ducts originating from the same orifice, the lower one leading to glandular tissue. Our case is similar to that reported by Towers,¹ which this author labelled as duplication of the submandibular duct.

However, we appreciate J D Harrison's comment that the accessory submandibular gland and the sublingual gland can simulate each other. To the best of our knowledge, the features differentiating these two entities have not been described in the literature.

In our case, there was stasis in Wharton's duct and not in Bartholin's duct, as pointed out by J D Harrison. This was secondary to a small calculus just distal to the punctum.

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References

- 1 Towers JF. Duplication of the submandibular salivary duct. *Oral Surg Oral Med Oral Pathol* 1977;**44**:326
- 2 Harrison JD, Sowray JH, Smith NJD. Recurrent ranula. A case report. *Br Dent J* 1976;**140**:180–2

First published online 21 April 2008.

doi:10.1017/S0022215108002223

Quinsy trainer

J Laryngol Otol 2007;**121**:1194–6

Dear Sirs

I read this article with interest and believe that the technique described will be useful for teaching. However, the illustration provided shows the trainee holding the syringe in one hand whilst depressing the tongue with the second hand. Trying to pull back the syringe plunger with the same hand that is attempting to hold the barrel is a traditional technique that I am sure many of your readers will remember trying to master. It is difficult to control the syringe and may result in the needle being misplaced. A better alternative is to use a syringe holder, such as those used for fine needle cytology aspirations.¹ I have been teaching this technique for about 10 years and believe it makes drainage much simpler.

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Reference

- 1 Vats A, Ingrams D. Fine needle aspiration cytology gun for easier drainage of peritonsillar abscesses. *CME Bulletin Otorhinolaryngology, Head And Neck Surgery* 2001;**5**:19

Authors' reply

Dear Sirs

We are grateful for D Ingrams's comments on our article. To date, we have not encountered any trainees who have not been able to master the technique we have described, and we are not aware of any complications resulting from difficulties in holding the syringe. However, we accept that a syringe holder, such as those used for fine needle cytology aspirations, may be of benefit to any trainee who struggles with the technique illustrated. The use of a syringe holder would depend on its availability in specific departments, and may require some additional instruction.

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First published online 17 April 2008.