Submandibular Gland Removal

What is the Submandibular gland?
The submandibular glands are a pair of salivary glands which sit below the jaw bone.

Why do they need to be removed?
The most common problem is blockage of the drainage system of the gland with a small “stone” which is formed from the secretions of the gland itself. This can cause swelling and discomfort in the gland which may be worse when eating. Alternatively, some patients have a small lump in the gland which may be as a result of a tumour growing in the gland. The tumour may be benign or malignant (cancerous). We would normally advise removal of the gland in these circumstances.

What does the operation involve?
Before the operation:
Arrange for a couple of weeks off work.

Check that you have a friend or relative who can take you home after the operation.

You must not drive for at least 24 hours after a general anaesthetic.

Make sure that you have a supply of simple painkillers at home.

The day of the operation:
Admission is almost always on the day of surgery. The nurses will complete some routine paperwork and tests. You will be asked to change into a gown ready for theatre. The anaesthetist will come to see you and discuss the anaesthetic side of things. A member of the ENT team will also see you before your operation.

The anaesthetic:
In children, the operation is performed under general anaesthetic. In adults, it may be possible to perform the operation under local anaesthetic.

The operation itself:
A small cut is made in the neck about 5 cm below the jaw in the line of a skin crease. This is often a bit lower than the swelling that you may have felt. The reason for this is to avoid damaging the nerve to the corner of the mouth which travels over the gland in the neck, just below the skin. The gland is removed and sent to the histology laboratory for analysis. The skin is closed with stitches. Mostly these will be buried under the skin and will dissolve. Occasionally, the stitches need to be removed and this is normally done at your GP’s surgery 5-7 days after the operation. A small plastic tube (drain) is sometimes inserted into the wound and left overnight – this is in case there is any bleeding into the neck after the operation. Once any drainage has stopped, the drain will be removed and you will be sent home. In some cases, this may mean staying in the hospital for more than one night.

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After the operation:
After a short time in the recovery area, you will be taken back to the ward. You will be encouraged to drink and then eat as soon as the anaesthetic has worn off. You will be given painkillers as required. You will be discharged after the drain has been removed.

Your discharge from hospital:
Following general anaesthesia, you will need to arrange for a responsible adult to pick you up from the hospital, take you home and stay with you for 24 hours after discharge. Depending on how fit and active you are before your operation, you may need to arrange for someone to stay with you for a few days

What should I do when I leave the hospital?
Activity:
You may find that your neck is a little stiff but you should be able to resume full activity a few days after the operation.

Driving:
You should not drive for at least 24 hours following your operation. You can then drive when you are able to perform an emergency stop safely.

Wound care:
If needed, stitches should be removed 5-7 days after your operation.

Work:
You should be fine to return to work/school within a couple of days.

Are there any risks involved in this operation?
Although modern surgery and anaesthetics are considered to be safe, all medical procedures carry some risks. The surgeon will discuss all these risks with you.

Risks associated with the operation are:
• Wound infection. Usually treated with antibiotics.

• Scar formation. A thickened (hypertrophic or Keloid) scar may form needing corrective surgery

• Bleeding. Bleeding from the edge of the wound is usually no more than a nuisance and soon stops. If there is bleeding from a larger vessel deep in the wound a Haematoma may develop which may require drainage in theatre. A drain may be inserted to try to prevent this problem.

• There are three important nerves that can be injured in this operation. Permanent injury to any of these nerves is uncommon (less than1 in 100):

• The nerve to the muscles of the lip (marginal mandibular nerve) can be damaged leading to a weakness at the corner of the mouth. This is uncommon and more likely to occur if there has been a lot of inflammation. In some cases, this may be permanent.

• The nerve that supplies sensation to the side of the tongue closest to the operation (Lingual nerve) is attached on the deep side of the gland. It is identified and separated from the gland during the operation. Damage to this nerve will give numbness and loss of sense of taste to that side of the tongue. Again this is uncommon.

• The nerve that moves the muscle of the tongue (Hypoglossal nerve) on the side of the operation is close to the gland but is unlikely to be damaged. If it was damaged, weakness of the tongue would occur, affecting tongue movement.

• Salivary Fistula. This may result in leakage of saliva through the wound. This usually settles but may require further surgery.

• Altered sensation to the skin around the scar.

Risks associated with a general anaesthetic are rare and include:
• Infection can occur, requiring antibiotics and further treatment.

• Bleeding can occur and may require a return to theatre. Bleeding is more common if you are on blood-thinning drugs.

• Chest infection. Small areas of the lung can collapse, increasing the risks of chest infections. This may need antibiotics and physiotherapy.

• Blood clots in the legs (DVT) can cause pain and swelling of the legs. Rarely pieces of the clot can break off and can travel to the lungs (pulmonary embolism). This is a particular problem in obese patients. Patients may wear tight stockings and are advised to keep moving their legs to help the circulation. Blood-thinning injections are often given to prevent this.

• Heart attack or stroke could occur due to the strain on the heart.

• Increased risk in obese patients of wound infection, chest infection, heart and lung complications and thrombosis (DVT).

• Death as a result of a general anaesthetic/ this procedure is possible.

Are there any alternatives to this operation?
It may be possible in some cases to remove stones from the duct of the gland via a small incision in the mouth. Needle biopsies may be done to try to make a diagnosis of cancer in a lump in the gland. If the biopsy shows that the lump is a benign (non-cancerous) growth then surgery may not be necessary.
If the biopsy showed that the lump was cancerous then you should have it removed to prevent the spread and eventual death from the tumour.

The needle biopsies do not always give us the answer and therefore if a mass is present in the gland and we are unable to be sure it is not a cancerous growth, we would advise surgery.
If you would like a second opinion about the proposed surgery please ask your G.P or Surgeon to arrange this.

Are there any risks of not having this operation?
Your symptoms may persist or worsen in the case of a stone in the duct.

A benign growth will continue to slowly enlarge.

If there is a cancerous growth, this will continue to grow and spread.

Where can I find out more about the operation?
Royal Australian College of Surgeons
http://www.surgeons.org

Australasian Society of Otolaryngology and Head & Neck Surgery (ASOHNS)
http://www.asohns.org.au

Alternatively, visit the following websites:
ENT UK has a patient information leaflet:
https://entuk.org/docs/patient_info_leaflets

If you have any questions about general anaesthetics, the Royal College of Anaesthetists website has a lot of information:
http://www.rcoa.ac.uk/patientinfo

Further information and advice
If you experience pain not relieved by painkillers or heavy bleeding after your operation please contact your GP or go to the Accident & Emergency Department.