Inflammatory conditions of salivary glands and their mimics

March 17, 2020: Gitta Madani, London/UK

Dr. Gitta Madani

I am a Consultant Radiologist at Imperial College NHS Trust and an Honorary Senior Lecturer at Imperial College London. I am currently the Treasurer for the British Society of Head and Neck Imaging (BSHNI) and advising radiologist to the National Large Airway Collapse Group.

I carry out all aspects of head and neck including image-guided salivary intervention for the removal of calculi and balloon dilatation of strictures. I am involved in research, training and teaching and contribute to a variety of committees and steering groups. I have authored (and co-authored) several book chapters, various peer-reviewed articles and national imaging guidelines.

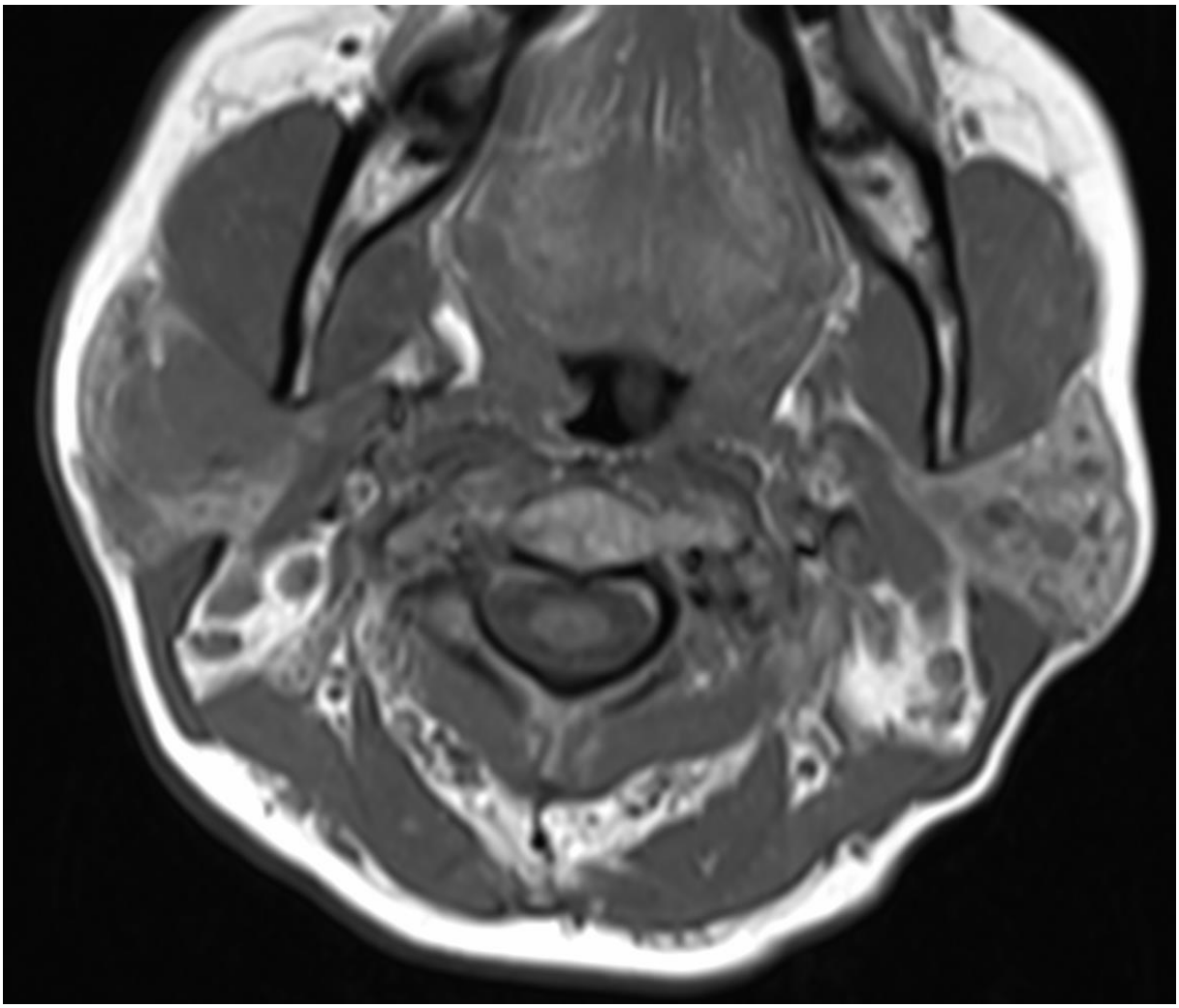
My research interests include thyroid and large airway disease. I am on the management team of the ELATION trial - a multicentre NIHR-funded trial in the role of real time elastography in the assessment of thyroid nodules. I collaborate with the Department of Aeronautical Engineering at Imperial College in the analysis of compressed airways. I also collaborate with the department of Surgery at Imperial College, using MRI to assess the success of Robotic-assisted surgery in obstructive sleep apnoea.

Learning Objectives

1. To know the diverse aetiologies of inflammatory salivary disease and their presentation
2. To recognise their imaging findings and appreciate the strengths and weaknesses of different imaging modalities
3. To identify cases amenable to minimally invasive treatment (radiological or sialendoscopic-guided)
4. To identify pathologies which mimics inflammatory salivary disease and those requiring fine needle aspiration

Teaser

Q: 33-year-old woman with DRY mouth. What is the diagnosis?



Test Your Knowledge

1. Regarding obstructive sialadenitis, which of the following is untrue?
   a. 90% of salivary calculi occur in the submandibular and ducts
   b. Parotid obstructive sialadenitis is most commonly seen in middle-aged women
   c. Mucous impaction may cause obstructive sialadenitis
   d. Submandibular calculi are bilateral in 2% of cases
   e. 80% of calculi occur is submandibular

2. Which causes sialectasis and dry mouth?
   a. Sjögren's syndrome
   b. HIV sialopathy
   c. IgG 4 disease
   d. Sarcoidosis

e. All of the above

3. Which of the following is not a recognized cause of chronic subtotal sialadentis may be due to:
   a. Ductal calculi
   b. IgG4 disease
   c. Autoimmune disorders
   d. HIV
   e. All of the above

4. Regarding Sjögren's syndrome, which of the following is untrue:
   a. MR sialography is now considered the gold standard for grading of Sjögren's syndrome
   b. T cell lymphomas are the most common type of lymphoma in Sjögren's syndrome
   c. The typical ultrasound findings in Sjogren's are multiple hypoechoic foci (representing sialectasis) which increase in size and number depending on the severity of disease
   d. Sjögren's syndrome may cause duct dilatation
   e. Gland atrophy is seen in established long standing disease

5. Which of the flowing is true:
   a. Sialosis is an uncommon cause of parotid gland enlargement
   b. Parotid gland involvement is uncommon in sacoidosis
   c. Kimura and Kikuchi Disease are precursors to lymphoma
   d. Benign Lymphoepithelial cysts can always be distinguished from tumour
   e. Ductal calculi up to 3 times the diameter of the duct may be removed by radiologically guided basket retrieval.