

# Sialadenitis

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Inflammation of a salivary gland can be acute or chronic ( Table 54.2 ). Acute causes include viral and bacterial infection. It mainly affects the young adolescent population. Parotid glands are more commonly involved than submandibular glands. /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Viral infections are more common than bacterial infections. The causative organisms are most commonly paramyxovirus (mumps), followed by cytomegalovirus, coxsackievirus, human immunodeficiency virus (HIV), parainfluenza virus types I and II, influenza virus A and herpesvirus. Staphylococcus aureus is the most common Among bacteria, organism and usually results in a retrograde spread of infection through the duct. Duct obstruction and xerostomia in the elderly population are predisposing factors. The patient will present with a painful red swelling over the gland region. Viral sialadenitis is self-limiting in most cases , requiring symptomatic supportive care, while bacterial infection will require antibiotics. Human immunodeficiency virus sialadenitis This is mainly characterised by bilateral enlargement of the parotid glands. This may mimic SjS. HIV sialadenitis is usually seen in young individuals with an absence of any serological antibodies, whereas SjS is mainly seen in middle-aged women. The prevalence is between 5% and 10% and it has been postulated that it is more common in women on highly active antiretroviral therapy (HAART) (mainly protease inhibitors). HAART or parenchymal disease of the salivary gland as a result of HIV ( Figure 54.5 ). Biopsy reveals perivascular, periductal and periacinar areas predominantly infiltrated with CD8 cells. Abnormal deposition of fat seen in the parotid gland (parotid lipomatosis) as well as in the abdomen and dorsal cervical areas may be associated with the use of protease inhibitors. Benign lymphoepithelial cysts are HIV-related reactive lymphoproliferation, which may occur in the intraparotid lymph nodes ( Table 54.1 ). The parotid glandular epithelium may get trapped within the normal intraparotid lymph nodes, resulting in cystic enlargement or migration of HIV-infected cells into the parotid gland, which could trigger lymphoid proliferation, salivary duct dysplasia, ductal obstruction and cyst formation. Ultrasonography is usually diagnostic. There may be a rare conversion into lymphoma. Diffuse infiltrative lymphocytosis syndrome manifests with bilateral enlargement caused by constant infiltration of CD8 in the parotid glands. Summary box 54.4 - HIV sialadenitis /uni25CF /uni25CF /uni25CF /uni25CF Recurrent parotitis of childhood This is characterised by rapid swelling of one or both parotid glands that is aggravated by chewing and eating. Systemic upset with fever and malaise is variable. The symptoms usually last about a week and are followed by a quiescent period for weeks to several months. It is mainly seen between the ages of 3 and 6 years. It is postulated to be caused by an incompetent parotid duct punctum, leading to ductal contamination with oral fluids. The diagnosis is based on the characteristic history . In addition, sialography shows a characteristic punctate sialectasis (snowstorm). The condition is difficult to manage if it becomes established and the initial treatment is important. The treatment consists of long courses of antibiotics and endoscopic washouts. Sialadenosis This is a non-inflammatory bilateral enlargement of the parotid glands. The swelling is generally painless with reduced saliva and is associated with chronic

malnutrition, obesity, alcoholism, liver disease, diabetes and drugs such as guanethidine, thioridazine or isoprenaline. It requires differentiation from any neoplastic disorder. Treatment mainly consists of management of the underlying systemic disorder.

sialadenitis. Acute sialadenitis Chronic sialadenitis Viral: Granulomatous: Mumps TB Coxsackie Cat scratch disease Cytomegalovirus Actinomycosis Paramyxovirus Sarcoidosis Bacterial: HIV Staphylococcus aureus Abscess (parotid and (acute suppurative submandibular) parotitis) Recurrent subacute parotitis Radiation sialadenitis HIV, human immunodeficiency virus; TB, tuberculosis. Figure 54.5 Lymphoepithelial cysts in a human immunodeficiency virus-infected patient. Incidence 5–10% More common in women on HAART Mimic SjS, but absent antibody Infiltration of CD8 in the parotid glands

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