CASE REPORT

BILATERAL RANULA IN AN ELDERLY PATIENT: A CASE REPORT

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SUMMARY

Ranula is a mucus extravasation cyst arising from the sublingual gland. Ranula usually appears as a painless, fluctuant swelling. It commonly occurs unilaterally and in young adults. Bilateral ranula is extremely rare. A 53 year-old female suffered from bilateral swelling in the floor of the mouth that had been enlarging slowly over the past 6 months. The lesions were resected completely via intraoral approach. No complication was observed during the postoperative period. There was no recurrence in the seven months follow up period.

Keywords: Ranula, sublingual gland, diagnosis, treatment, recurrence

INTRODUCTION

Ranula is a retention cyst arising from the sublingual gland on the floor of the mouth as a result of ductal obstruction and fluid retention. Ranulas can be divided into three types; sublingual, plunging, and sublingual-plunging. A sublingual ranula develops in the floor of the mouth, while a plunging ranula is recognized as a soft cystic swelling in the submandibular or upper cervical region. When a sublingual ranula has a cervical extension through the mylohyoid muscle, the term “sublingual-plunging ranula” is used.

Ranula may be seen at birth or in later life. It is commonly seen in young adult. Ranula commonly occurs unilaterally, and bilateral ranulas are extremely rare. There has no report about simultaneous bilateral ranula occurring in an elderly patient in the English language literature until now.

CASE

A 53-year-old woman suffered from painless, cystic masses, which located on the floor of the mouth bilaterally (Fig 1). They had been enlarging progressively over the past 6 months.

Physical examination revealed tense, fluctuant, bluish, cystic lesions that measured 1x1 cm in the right and 2x2 cm in the left sublingual area. The tongue was painful and displaced on the upper side of the mouth. There was no history of local trauma or surgery. Patient’s medical and family histories were also unremarkable. Under general anesthesia, the cyst was removed with sublingual gland on the left side and by extracapsulary dissection on the right side using an intraoral approach. Histopathologic evaluations of both lesions were performed (Fig. 2). There was no complication during the postoperative period. At the seven months after surgery, there was no recurrence.

DISCUSSION

Most of the patients with oral ranula presented with a gradually enlarging swelling of the floor the mouth. The lesion is painless, fluctuant and round or oval. It may drain spontaneously at intervals. The etiology of ranula is unknown; however, obstruction, trauma, and congenital anomalies have been implicated. The diagnosis of ranula is generally based on the clinical examination and sometimes on computerized tomography or magnetic resonance imaging findings for the plunging lesion. A fine-needle aspiration biopsy may be helpful in demonstrating the mucus with inflammatory cells. Chemical analysis of aspiration fluid can reveal high amylase and protein contents.
Sialography provides minimal information in this lesion. The differential diagnosis of ranula should include masses and swellings in the floor of the mouth and submandibular space region. These are dermoid and epidermoid cysts, branchial cleft cysts, thyroglossal duct cysts, cystic hygroma, lipomas, abscess, and malignant neoplasia. Histologically, ranula consists of a central cystic space containing mucin and a pseudocyst wall composed of loose, vascularized connective tissues. Histiocytes predominate in the pseudocyst wall, but over time, these become less prominent. An important feature in the histologic diagnosis is the absence of epithelial tissues in the pseudocyst wall.

**REFERENCES**


