

TIG cleft fellows to substantive jobs in NHS trusts concerns about a bottle-neck effect have been exacerbated. A lack of success for OMFS trainees in TIG application processes is open knowledge via social media and other forums, with a suspicion that a less than meritocratic approach has been taken by some involved in the recruitment process. Disenchantment with the TIG process is also a significant problem in other subspecialty areas of OMFS, most notably head and neck oncology, where a number of leading units have actively withdrawn participation.

In my experience OMFS trainees are amongst the highest achievers overall and most dedicated in their training journey through necessity. It seems unlikely that they will be significantly assisted therefore by intensified interview preparation sessions, in contrast perhaps to trainees in sister specialties.

Ultimately, given that it is unlikely to prove feasible to reverse historical trends of centralisation of services, the best recourse would appear therefore to facilitate an increase of flow in to cleft and craniofacial training opportunities from OMFS. This could be achieved through reform of the current TIG process to make competitive selection more meritocratic and provide equal opportunities for candidates regardless of specialty of affiliation, as was originally intended. Alternatively, the creation of designated RCS approved fellowships in cleft and craniofacial around the UK would also serve to increase OMFS participation in this area, and consideration should be given to this idea at association level.

Conflict of interest

Not applicable.

Ethics statement/confirmation of patient's permission

Not applicable.

Reference

- Fullarton M, Sweet C, Robertson B, Begley A, Magennis P. Cleft and craniofacial surgery — how do we inspire and recruit the next generation of oral and maxillofacial surgeons? *Br J Oral Maxillofac Surg* 2019;57:395–6.

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Functional compensation of a hypertrophied sublingual gland and the absence of the ipsilateral submandibular gland

Sir,

The absence of the submandibular gland and the enlargement of the ipsilateral sublingual gland has been reported previously, and may occur unilaterally or bilaterally. The finding may be incidental, as a symptom associated with reduced saliva, or an enlarged gland, or it can manifest as a mass in the neck.^{1–5} Although aplasia or atrophy of the submandibular gland is thought to cause hypertrophy of other glands, including the sublingual gland, compensation of function by the glands has not been shown so far. To the best of our knowledge, 4 cases of the bilateral absence of the submandibular gland and hypertrophy of the sublingual gland have been reported to date^{1–4}; one had relatively poor oral hygiene and several cavities, and the others had no symptoms of salivary gland dysfunction. A 41-year-old woman was also diagnosed with aplasia of the submandibular gland and ipsilateral hypertrophy of the sublingual gland (with symptoms such as xerostomia and dysphagia), but showed no uptake on ^{99m}Tc-pertechnetate scintigraphy in the submandibular-sublingual area.⁵ We think, therefore, that functional compensation may be independent of hypertrophy of the sublingual gland.

We report a patient who presented with enlargement of the sublingual gland that appeared to compensate for the atrophied ipsilateral submandibular gland. To the best of our knowledge, no reports on this condition have been published before.

A 66-year-old man visited the otorhinolaryngology department with a 7-day history of voice change. He was had no dryness of the mouth and his oral hygiene was good. Past diagnoses included Behçet's enteritis and uveitis, and ischaemic heart disease, but there was no history of cervicofacial surgery, radiotherapy, or salivary gland-related disease.

Physical examination showed no ulceration or scarring indicative of Behçet's disease in the oral cavity. Bimanual palpation, however, indicated an absence of the right submandibular gland, and no saliva was being expelled through the papilla. Laryngitis was diagnosed on endoscopy, then after informed consent was given, computed tomography (CT), magnetic resonance imaging (MRI), and sialoscintigraphy were also done. CT showed no abnormality except the absence of the right submandibular gland, and a 3.3 × 1.3 × 2.9 cm enlargement of the ipsilateral sublingual gland. T2-weighted MRI showed complete replacement of the right submandibular gland with fatty tissue, with isointense and enlarged right sublingual and left submandibular glands (Fig. 1). The maximal uptake on ^{99m}Tc-pertechnetate scintigraphy occurred 30 min after the injection in the right submandibular-sublingual region, and was reduced in comparison with the left side (Fig. 2).