A 2-year-old boy sustained a two-story fall. He was found by his parents to have bleeding from his mouth but no trouble breathing. He was transferred to the regional Level 1 trauma center for further workup after CT imaging demonstrated a non-displaced symphyseal and right condylar fracture of his mandible.

On examination, the patient was sleeping comfortably with no increased work of breathing, but was gurgling his secretions. A large sublingual hematoma was evident, and the tongue was elevated almost to the hard palate (Figure 1). Further review of the CT scan demonstrated elevation of the tongue due to sublingual swelling (Figure 2); there was no intracranial injury or any evidence of abuse.

The patient was admitted to the pediatric intensive care unit, and received one dose of dexamethasone. Serial examinations (initially q2 hours and subsequently q6 hours) demonstrated gradual diminishment of the hematoma. The patient was taken to the operating room 18 hours after presentation for extraction of loose teeth and assessment of his mandible. He was orally intubated without difficulty. The hematoma was not drained due to its reduced size (Figure 3) and the mandible was deemed stable enough to treat without fixation. The patient tolerated a soft diet and was later discharged home.

Pediatric sublingual hematoma is rare entity, only described in case reports as a complication of hemophilia or as a sign of child abuse. Management of sublingual hematomas first requires assessment of the airway. In cases of respiratory distress, tracheostomy or cricothyrotomy is the preferred method to establish an airway. Fiberoptic nasal intubation or laryngeal mask anesthesia (LMA) intubation are also viable options in situations of non-emergent respiratory distress. A nasal trumpet may also be beneficial in establishing a nasopharyngeal airway.

Once the airway has been established or deemed to be stable, the sublingual hematoma can be addressed. The decision to drain the hematoma remains controversial. While incision and drainage appears to be necessary for hematomas resulting from operative procedures, several authors argue against drainage due the potential for infection and/or resolution with nonsurgical treatment. Further, treatment of the underlying cause (i.e. reversal of anticoagulation) may also resolve the hematoma.

In our case, the hematoma resolved after close monitoring and administration of anti-inflammatory agents. In our view, attempting drainage in an awake pediatric patient would be difficult and potentially provoke airway distress. The patient was anesthetized later in his course, and by then he was clinically improved.

REFERENCES