Introduction
There are several minor conditions of the oral cavity found in newborns. Fortunately, most are benign and self-limiting. The general practitioner may be familiar with the more common conditions such as alveolar and palatal cysts (also known as Bohn’s nodules, Epstein’s pearls and dental lamina cysts), natal teeth (present at birth), and neonatal teeth (those erupting in the first month of life). In contrast to these common conditions, which are seen in all ethnic groups, the alveolar lymphangioma is a benign but relatively rare condition found only in the oral cavities of black infants.

Case 1
A five-month-old male, born in Ireland to Nigerian parents, was referred by his cardiologist to the Dental Department at Our Lady’s Children’s Hospital, Crumlin. The reason for referral was a “fleshy overgrowth on the lower gum”. The patient had an unremarkable birth, and was diagnosed post-natally with Tetralogy of Fallot. At the time of examination, he was awaiting open heart surgery, but was stable. The patient’s mother gave a history of bilateral oral lesions of three months’ duration. These lesions did not appear to cause any discomfort and did not interfere with feeding. Examination revealed the presence of two lesions, one on each side at the lingual surface of the mandibular ridge. The lesion on the right hand side was yellowish in colour and 6mm in diameter. The lesion on the right had a bluish colour and was 3-4mm in diameter. No treatment was necessary, and anticipatory guidance in relation to oral health for children with congenital heart disease was provided to the patient’s mother. On review two months later, both lesions had completely resolved, and the oral cavity was found to be normal.

Case 2
A four-week-old male, born in Ireland to a Nigerian mother and Sierra Leonean father, was referred by his cardiologist to the Dental Department at Our Lady’s Children’s Hospital, Crumlin. This patient had a diagnosis of hypoplastic left heart syndrome made antenatally. He had undergone a Norwood procedure when he was three days old. Now stable, his cardiologist referred him to the Dental Department in relation to swellings in the mouth. The duration of these lesions was unknown. On examination, four lesions were identified, one in each quadrant. The bluish, fluctuant swellings were approximately 6mm in diameter, located on the crest of the ridge in the upper arch, and on the lingual surface of the ridge in the lower arch, all at the first primary molar region. Their clinical features were highly characteristic of the alveolar lymphangioma and no further investigations were necessary.

Alveolar lymphangioma in infants: report of two cases

Précis
Two cases are presented of alveolar lymphangiomas found in newborns. Presentation, diagnosis and management are discussed. Photographs are shown to help practitioners to recognise these lesions.

Abstract
The alveolar lymphangioma is a benign but relatively rare condition found only in the oral cavities of black infants. Dentists practising in Ireland may be unaware of this condition due to its racial specificity. This paper presents two case reports of multiple alveolar lymphangiomas found in black infants in a children’s hospital in Ireland. The epidemiology, aetiology, clinical presentation, histology, and management options are discussed. The photographs should aid the practitioner in recognising these lesions.

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The alveolar lymphangioma was first described in 1976 but was not reported in the dental scientific literature until 1986. It is reported to occur in 2.2% to 4% of healthy black infants, and it is not found in any other racial group. Clinically, the lesions resemble a mucocoele or an eruption cyst. They range in size from 1mm to 9mm in diameter (averaging 3-4mm) and have a bluish domed fluid-filled appearance. The lymphangiomas have a characteristic site preference, being found at the first primary molar region of the developing alveolar ridge. They are located at the crest of the maxillary ridge, and at the lingual surface of the mandibular ridge. Generally, only one lesion is found per quadrant, although there is one report of a case in which multiple lesions were found in a single quadrant. At biopsy, these lesions are reported to collapse readily, releasing a clear fluid. Histologically, these lesions have been interpreted as lymphangiomas. Microscopy shows a benign proliferation of endothelium-lined lymphatic structures loosely supported by thin, fibrous connective tissue cores. The lymphatic channels can be found to contain scattered lymphocytes and a finely fibrillar material. Rests of dental epithelium may be found but are not thought to be significant. The lesions are not associated with erupting teeth, and as the crest of the alveolar ridge contains no salivary gland tissue, they are not mucous-retention phenomena. The aetiology of the alveolar lymphangioma is unknown. There is no known relationship between the alveolar lymphangioma and any other congenital defects. The racial specificity and the bilateral site-specificity suggest a developmental, possibly genetic aetiology. Treatment is generally conservative, allowing for spontaneous regression, which may take several months. Surgical removal has been suggested, but only in cases where the lesions are interfering with feeding. Excision is generally not required for diagnosis, as the clinical features are sufficiently distinctive to allow for differentiation from other oral lesions such as the dental lamina cyst, eruption cyst, mucocele, and congenital epulis of the newborn.

Dentists practising in Ireland would have been unlikely to have come across the alveolar lymphangioma in the past, but with increased immigration to Ireland from Africa, it is now quite possible that an infant with one or more of these lesions might present to the general dentist. Many commonly used textbooks of oral medicine and paediatric dentistry contain no reference to the alveolar lymphangioma, and it is infrequently reported in the scientific literature. As such, it may be a diagnostic dilemma for many practitioners. Fortunately, no intervention is needed, and once these lesions are recognised and diagnosed, providing reassurance for the parents along with monitoring of the lesion is the only treatment required.

References