A 7-year-old child presented to the accident and emergency department with a 2-week history of a progressively enlarging tongue mass. There was no history of trauma or surgery to the oral cavity. He had some difficulty in chewing and in talking. Mouth closure was incomplete due to the mechanical effect of the mass. There was no airway compromise on presentation. Clinical examination revealed a single nontender cystic lesion measuring $50 \times 30$ mm (Figure 1). A noncontrast computed tomography scan was requested that confirmed the clinical findings and excluded involvement of the deep neck spaces (Figure 2). The patient’s family consented to surgical removal of the lesion. At surgery, aspiration of the cyst was followed by complete excision with primary closure of the defect (Figure 3). The child was extubated and observed overnight. Postoperatively the wound had healed and there was no recollection of fluid. The patient was discharged and was regularly reviewed in the ENT-Otorhinolaryngology clinic for a year. The histology of the mass showed a unilocular cyst measuring $50 \times 30 \times 5$ mm. The cyst was lined by respiratory epithelium (Figure 4).

Pediatric tongue cysts are rare clinical entities and are a challenge to the clinician. Pediatric tongue lesions represent 2.4% of all pediatric oral and maxillofacial tumors.1 Benign lesions are more common than malignant lesions. These lesions include both solid and cystic masses. The common differentials of tongue lesions in children include hemangioma, lymphangioma, neurofibroma, pyogenic granuloma, mucocele, osseous choristoma, salivary gland neoplasm, lingual thyroid, irritation fibroma, granular cell tumor, and dermoids.2 Many of these lesions are asymptomatic. Larger lesions may present with obstructive symptoms of the upper aerodigestive tract, essentially related to feeding and swallowing. The management of tongue lesions depends on its precise anatomical location. The lesions may be clinically divided into those of the anterior two-thirds, posterior one-third, generalized; and also, those of the dorsum versus those of the ventral surface. The tongue develops at the end of the fourth gestational week. From the branchial arches, arises the median tongue bud/tuberculum impar. This is a median triangular elevation in the floor of the primitive pharynx. This is rostral to the foramen caecum. Two lateral tongue buds then develop from this median tongue bud. These distal/lateral buds grow rapidly and merge to form the oral part (anterior two-thirds) of the tongue.

The plane of fusion is indicated superficially by the median sulcus of the tongue and internally by the fibrous median septum of the fully developed tongue. The posterior third of the tongue or pharyngeal part develops from 2 elevations, the copula and the hypobranchial eminence which form caudal to the foramen caecum. The line of fusion of the anterior and posterior parts of the tongue is indicated by the terminal sulcus. Branchial arch mesenchyme forms the connective tissue and vascular components of the tongue. The tongue muscles are derived from myoblasts. The hypoglossal nerve accompanies these myoblasts.3,4

Figure 1. A single nontender cystic tongue lesion measuring $50 \times 30$ mm (yellow arrow).

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Received: July 02, 2020; revised: July 13, 2020; accepted: July 14, 2020

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The origin of the tongue cyst is not exactly known but may arise from events during embryological development. It is possible that these tongue cysts form by inclusion of epithelium during union of the 2 sides. Other theories include obstruction to the glandular elements of the tongue. These include the anterior lingual glands of Blandin and Nuhn. The lingual dermoid cyst is also thought to arise from totipotent cells, which would account for all 3 germ layers resulting in a spectrum of epidermoid-dermoid-teratoid cysts. The hematoma and lymphangioma of the tongue are no different to these entities.
occurring in other areas of the body. Pediatric tongue cysts are best appreciated as embryological or developmental entities.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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