Sublingual Schwannoma Masquerading as Submandibular Lymphadenopathy

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Introduction

Schwannomas are benign peripheral nerve sheath tumours arising from Schwann cells. Around 25–45% occur in the head and neck, but a tongue or floor-of-mouth origin is rare and can closely mimic more common salivary or nodal pathology at presentation. We report a case where a lesion suspected to be a submandibular gland tumour was ultimately found to be a large, incidentally located tongue-base schwannoma.

Case Presentation

A 52-year-old carpenter, an ex-smoker, presented with a 7-week history of a painless right submandibular swelling, initially thought to be a lymph node. He was systemically well with no dysphagia, dysphonia, otalgia, cranial neuropathy, or B-symptoms.

Examination: 1.5cm mobile, non-tender right submandibular node; no other cervical or supraclavicular lymphadenopathy. Bloods and chest radiograph normal.

On later clinic review, the lesion was palpable as a 2–3cm submandibular/sublingual mass with mass effect causing mild tongue deviation on protrusion; cranial nerve exam otherwise normal. Significant sublingual swelling noted, soft and compressible on palpation.

Fine-needle aspiration and core biopsy of the lesion were performed; cytology and immunohistochemistry were consistent with schwannoma, with no malignant cells identified.

MDM outcome: imaging, biopsy and clinical photographs all consistent with benign schwannoma, with no features of malignancy. Consensus for surgical excision given lesion size and progressive local distortion; case waitlisted non-urgently given the benign nature of the lesion.

Operative findings: firm, well-encapsulated ~5cm midline floor-of-mouth mass, delivered intact via transoral capsule dissection (harmonic scalpel + finger dissection); incision deliberately placed away from the submandibular ducts. Recovery uncomplicated; discharged post-operative day 1.

Imaging

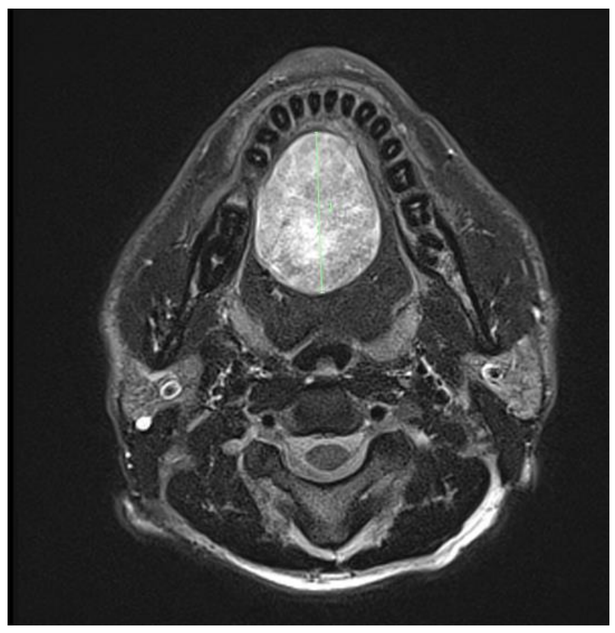

Image 1 – MRI scan showing large large well-defined T2 hyper intense mass within the tongue that demonstrates distortion of tissues rather than invasion

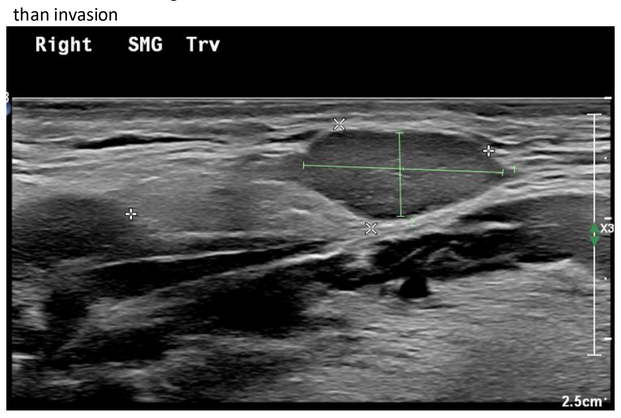

Image 2 – USS scan of the lesion

Discussion

Marked discordance between imaging modalities — an ultrasound suggesting a small submandibular gland lesion, with CT and MRI subsequently revealing a much larger, separate tongue-base mass not seen on the initial study — illustrates the limitations of ultrasound for deep or base-of-tongue lesions and reinforces the value of cross-sectional imaging when clinical suspicion persists despite a discordant initial result.

Radiological distortion rather than invasion of adjacent structures is a useful discriminator favoring a benign nerve sheath tumour over malignancy, even ahead of histological confirmation. Schwannoma remains an important, if uncommon, differential for a slow-growing floor-of-mouth or tongue mass.

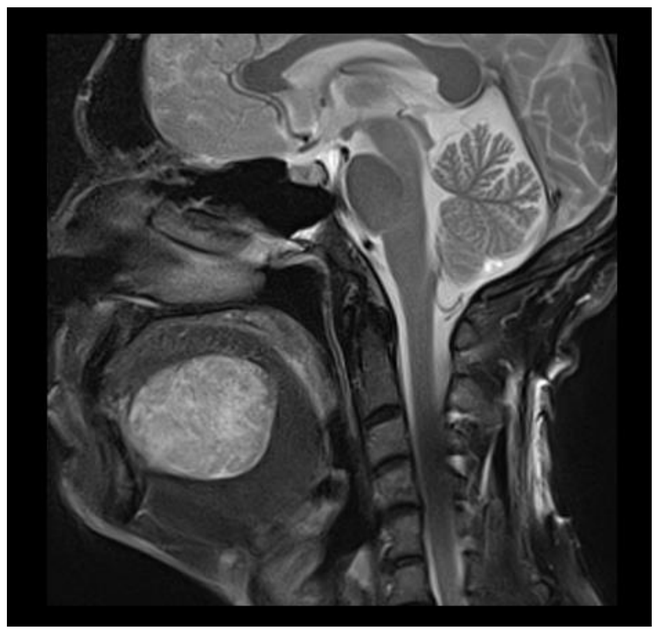

Image 3 – Sagittal section of MRI scan

Conclusion

Benign peripheral nerve sheath tumour should remain in the differential for an atypical, slow-growing submandibular or floor-of-mouth mass — even when initial imaging suggests more common salivary or nodal pathology. Staged cross-sectional imaging and multidisciplinary review were central to reaching the correct diagnosis and an appropriate surgical pathway.

Key Learning Points

- Ultrasound can miss or mischaracterise deep or base-of-tongue lesions — escalate to cross-sectional imaging when clinical suspicion persists.
- Tissue distortion rather than invasion on MRI favours a benign nerve sheath tumour over malignancy, ahead of biopsy.
- Multidisciplinary review is central to managing rare, incidentally discovered head and neck masses.

Diagnostic Timeline

Dec 2025
Patient notices hard lump, right submandibular region

GP referral
7-week painless right submandibular node; no red flags; bloods & CXR normal

Ultrasound
7 x 17mm hypoechoic right submandibular gland lesion — ?pleomorphic adenoma

CT neck (contrast)
No submandibular/parotid mass. Incidental 42mm tongue-base mass with Wharton duct obstruction. MRI recommended

MRI tongue
39–51mm well-defined T2-hyperintense lesion; distorts rather than invades tongue musculature; genioglossus splayed; strong heterogeneous enhancement; bilateral submandibular duct dilatation; right gland atrophy. Favours nerve sheath tumour

FNA + core biopsy
Cytology & IHC consistent with schwannoma; no malignant cells

Head & Neck MDM
Benign schwannoma confirmed on imaging/biopsy/photographs; excision recommended; waitlisted (non-urgent)

Transoral excision
5cm well-encapsulated floor-of-mouth mass excised via capsule dissection; uncomplicated recovery.

Histology – Confirming Schwannoma fully excised

Post op has minor tongue paraesthesia, no other concerns, patient very happy with the outcome

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