Mucocele is a common lesion of the oral mucosa that results from accumulation of saliva, as a result of obstruction or trauma to the salivary gland duct. There are two histological types of mucocele – extravasation type and retention type. Clinically they consist of a soft, bluish and transparent cystic swelling.

The history of present illness consisted of swelling present on right side of the lower lip since 1 month. The swelling was soft in consistency, non-tender, fluctuant, compressible, non-reducible, normal in color and non-pulsatile, with no increase in temperature. Patient also had difficulty in biting. Patient had given history of reoccurrence and increase in size of the lesion from few mm to cm. A detailed history elicited from the patient showed etiology to be trauma from lip biting habit. On extra oral examination swelling was found on the right side of the lower lip making the lower lip asymmetrical. On intraoral examination a solitary, well-defined, dome-shaped swelling was seen measuring 1 cm × 1 cm size on right side of the lower lip. On the basis of history and clinical examination a provisional diagnosis of mucocele was made. Routine blood investigations BT, CT, Hbs Ag, TLC, DLC were done, and the values obtained were in the normal range. The differential diagnoses were Lymphangioma, Haemangioma, Hematoma, Soft fibroma, Soft tissue abscess. The treatment planning consisted of the surgical removal of the lesion. The treatment procedure includes local infiltration was given in the lower lip with 2% lignocaine. Incision was made on the highest peak of the swelling by scalpel. (Fig. 2)

Bleeding was controlled with the help of sterilized absorbent gauze. Incision of the lesion was done from the base with removal of minor salivary gland duct. (Fig. 3)
Surgical site was irrigated with povidone iodine and saline solution after that interrupted sutures were placed with 3-0 silk suture. (Fig. 4)

Postoperative instructions were given. Sutures were removed after 5 days and the healing was uneventful. Lesion was then sent for histopathological investigation. (Fig. 5)

Histopathology: Submitted H & E stained soft tissue section shows the presence of cystic cavity enclosing eosinophilic material with minor salivary gland tissue in the vicinity. (Fig. 6)

On higher magnification presence of fibrous connective tissue with variable collagen fibrous, plump fibroblast and chronic inflammatory cells along with minor salivary glands was seen. (Fig. 7)

The final diagnosis was formulated on the basis of the history of lip biting habit, clinical features and histopathological findings as a mucous extravasation type mucocele.

**DISCUSSION:**

The incidence of mucocele in the general population is 0.4-0.8%. Histologically, two type of mucocele exists mucous extravasation type and retention type, depending on presence or absence of epithelial lining. In children prevalence of mucous retention phenomena is low due to inability of ductal structure to contain an exaggerated accumulation of secretion. Whereas as mucous extravasation is common in children because extravasated saliva is first surrounded by inflammatory cell followed by granulation tissue composed mainly of fibroblast due to absence of epithelial lining, this phenomenon is categorized as a pseudocyst or false cyst.

**REVIEW OF LITERATURE ON MUCOCELE:**

Literatures have reflected that oral habits such as lip biting/sucking is one of the etiologic factors for the oral lesions such as irritation fibroma and mucocele. Radiographic evaluation is needed to rule out if sialoliths are considered a contributing factor in the formation of oral and cervical ranulas. The fine needle aspiration cytology demonstrates the mucus retention phenomenon. The chemical analysis could disclose protein content and high amylase. Palpation can be helpful for a correct differential diagnosis. Lipomas and tumors of minor salivary glands present no fluctuation while cysts, mucocele, abscess, and hemangiomas show fluctuation. Bodner L et al and Yamasoba T al reported that 92% of mucocele found was extravasation type mucocele whereas only 8% mucocele found was retention type in children. When considering the site of mucocele in the oral cavity, most reviewers consider the lower lip to be the most frequently affected location (40% to 80% of all cases) which is also reported in the present case, followed by the cheek mucosa and floor of the mouth. Nilo MM et al found 83.3% of mucocele occurs at lower lip, Wu CW et al found 89.1% whereas Joshi SR et al found 56.1% of the lesion (mucocele) occurs at the lower lip. Generally mucocele occurs more in children as compared to adult, Patel RK et al stated the mean age for occurrence of mucocele as 10-11 years, according to Dr Jones and Franklin mean age was 10.57 years, Wu CW et al found the mean age of 11.8±5.0 years, Yamasoba T et al found that most commonly occurs in children with less than 20 years of age whereas according to Nilo MM et al lesion occurs at less than 15 years of age. There are many ways of treating the mucocele such as excision with a scalpel, electro surgery, cryosurgery, laser. Wu CW et al compared the reoccurrence rate with Carbon dioxide laser vaporization and surgical excision but no significant difference was found. Disadvantage of treating mucocele with laser is that the lesion gets destroyed and histopathological investigation is not possible. Over this it has many advantages like less bleeding, no sutures are required, saves time and therefore suitable for children.

**CONCLUSION:**

Mucocele are one of the most common soft tissue lesions of the oral cavity which are mainly benign and self-limiting in nature, easily diagnosed based on clinical appearance and accurate history. Most lesions have some history of trauma in that region. Simple surgical excision with care is also the treatment of choice that can relieve the patient fear and anxiety, and recurrence has been associated if the lesion excision is incomplete.

**References:**