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Letters to the Editor

Parotidectomy—Total or Superficial?

Dear Sir,
I found the paper by Drs. Alajmo, Polli and De Meester interesting but I felt that certain points needed to be made since some of the statements made in this presentation do not accord with my own experience which centres mainly on the operation of superficial parotidectomy with exposure and preservation of the facial nerve. They quote the paper by Gant *et al.*, 1981, in which the recurrence rate of 17% after parotidectomy for pleomorphic adenoma is mentioned. This figure is much higher than that quoted in most publications which should be in the order of 3%. It is also commonly accepted that recurrence relates not so much to the omission of removal of the deep lobe of the parotid but to other factors such as spillage of the tumour and implantation; or the inadequacy of the surgical margin, as when the tumour abuts against the facial nerve, and when a large tumour completely fills the sulcus between the ascending ramus of the mandible and the mastoid process.

The notion that pleomorphic adenoma is multicentric in origin is not accepted in this country or in North America, a view based on serial sectioning of the parotid gland, and experience has borne out this viewpoint. Equally in cases of small malignant tumours without obvious clinical evidence of malignancy, if the disease is confined to that part of the parotid which lies superficial to the facial nerve and there is no obvious involvement of the nerve, it would seem unnecessary to subject the patient to a total conservative parotidectomy, but if subsequently the histology reveals inadequate margins, external beam radiotherapy will suffice to control a local recurrence.

I wholeheartedly agree, however, that in cases of chronic parotitis in which the architecture of the parotid gland has been badly disrupted by the disease, a total conservative parotidectomy is the treatment of choice, not withstanding the fact that this is often a difficult operation and may result in some degree of temporary weakness of the muscles of the face.

In discussing the disadvantages of total parotidectomy depression of the parotid area following a total operation is rarely resented by the patient and I would not consider this to be a significant disadvantage, nor have I found the incidence of Frey's syndrome to be necessarily higher in this type of patient.

As far as cases of cystadenoma lymphomatosum, this is frequently a multicentric tumour and smaller deposits are visible at the time of the surgery, but I have never been so naive as to believe that I have removed all of these smaller deposits. Recurrences, however, very rarely occur after superficial parotidectomies. In any case the deep lobe of the parotid gland contains so little lymphoid tissue that it would be hard to justify resorting to a total parotidectomy in such cases.
Yours sincerely,
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Dear Sir,
I would like to thank Mr. Shaheen for the attention he paid to the paper on 'Total Parotidectomy' written by Drs. Polli, De Meester and myself. We are also indebted to him for his agreement with some of our statements, even though he disagrees with others, and for giving us the opportunity to stress the soundness of our surgical results obtained with the quasi-routine performance of total conservative parotidectomy in our series of 239 pleomorphic adenomas and of 88 cystoadenomas lymphomatosa: no recurrence in the latter, only two recurrences in the former (0.8%). Considering only the 166 patients operated on over two years, the recurrence rate was 1.2%; in addition, as one of these two recurrences proved to be an adenoid-cystic carcinoma, the recurrence rate of pleomorphic adenomas should be considered 0.6% (1/165), i.e. much less the 3% quoted in most publications.

We were also pleased to hear from Mr. Shaheen that (1) he does not consider depression of the parotid area following a total parotidectomy a significant disadvantage, and (2) he did not find a higher incidence of Frey's syndrome in patients who underwent a total parotidectomy. Indeed, his opinion confirms our current belief and our own observations. As a consequence, only an increased incidence of *temporary* weakness of the muscles of the face is the real disadvantage of total parotidectomy if compared with lateral lobectomy. We deem it acceptable for the patient who is so given the highest chances to be definitely cured.

We are concerned at the *possibility* of a multicentric origin of pleomorphic adenoma and cystoadenoma lypmphomatosum; many surgeons have met cases of multiple primary tumours, as have we. Nobody is obliged to agree with this possibility, but such cases do exist.
Professor Ettore Alajmo
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