

# Endoscopically assisted extracapsular dissection of pleomorphic adenoma of the parotid gland through a postauricular sulcus approach in young patients

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## Abstract

We evaluated the aesthetic outcomes in 11 young patients (mean (range) age 21.7 (16–28) years) who had endoscopically assisted extracapsular dissection of benign pleomorphic adenomas of the parotid gland through a postauricular sulcus approach. The tumours varied in size from  $1.5 \times 1.0$  cm to  $2.5 \times 2.0$  cm, and all were removed completely without rupture. The cosmetic result was excellent in 10 patients and good in one. Patients were followed up for eight to 40 months, and there was no recurrence. The technique is simple and feasible, and it achieves excellent aesthetic results in young patients.

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*Keywords:* parotid tumours; salivary gland neoplasm; endoscopy; surgery; facelift incision; young patient

## Introduction

Pleomorphic adenoma is the most common benign tumour, and 69% of cases involve the parotid gland.<sup>1</sup> Excision is commonly done through a modified Blair incision, but this can result in obvious scars and a poor aesthetic outcome. Other points of incision that allow good exposure and complete excision, that have low rates of complication and recurrence, and do not leave a visible scar on the neck, can be challenging for the surgeon. We have previously described extracapsular dissection of parotid pleomorphic adenomas in children through minimal preauricular and retroauricular incisions,<sup>2</sup> endoscopically assisted transoral resection of large benign parapharyngeal space tumours,<sup>3</sup> and endoscopically assisted

resection of benign tumours of the accessory parotid gland.<sup>4</sup> In this paper we evaluate the feasibility of endoscopically assisted extracapsular dissection of benign pleomorphic adenomas of the parotid through a postauricular sulcus approach in young patients, and assess the outcomes.

## Patients and methods

Between April 2012 and September 2015, 11 young patients had endoscopically assisted extracapsular resection of pleomorphic adenomas of the parotid gland through a postauricular sulcus approach at the Department of Oral and Maxillofacial Surgery, Sun Yat-sen Memorial Hospital, Sun Yat-sen University, Guangzhou, China. The study was approved by the Institutional Review Board of the university. The patients (eight male, three female) had a mean (range) age of 21.7 (16–28) years at the time of operation. The tumours varied in size from  $1.5 \times 1.0$  cm to  $2.5 \times 2.0$  cm

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Table 1

Patients' details, clinical characteristics, and outcomes in 11 young patients with pleomorphic adenoma of the parotid gland. No tumours recurred.

Case no.	Age (years)	Sex	Site and size of tumour (cm)	Complication	Aesthetic results	Follow up (months)
1	24	M	Superficial lobe, 2.0 × 2.0	None	Excellent	24
2	18	M	Superficial lobe, 1.8 × 1.5	None	Excellent	30
3	26	F	Superficial lobe, 2.5 × 2.0	None	Excellent	40
4	24	M	Superficial lobe, 2.0 × 2.0	None	Excellent	40
5	16	M	Superficial lobe, 1.5 × 1.0	None	Excellent	12
6	19	M	Deep lobe, 1.8 × 1.5	None	Excellent	18
7	23	F	Superficial lobe, 2.5 × 2.0	None	Excellent	10
8	20	M	Superficial lobe, 2.5 × 2.0	None	Excellent	8
9	19	M	Deep lobe, 2.0 × 2.0	Transient facial paresis <sup>✱</sup>	Good	33
10	28	F	Deep lobe, 2.5 × 2.0	None	Excellent	13
11	22	M	Superficial lobe, 2.5 × 2.0	None	Excellent	38

<sup>✱</sup> Transient facial paresis resolved spontaneously within 6 weeks.



Fig. 1. A 24-year-old man with a 2.0×2.0 cm pleomorphic adenoma in the left parotid gland.

(median 2.1 × 1.8 cm). Nine were in the superficial lobe of the parotid gland and three in the deep lobe (Table 1). The diagnoses were based on clinical history, physical examination, and computed tomography (CT) or magnetic resonance imaging (MRI), and were confirmed histopathologically.<sup>2</sup> Patients with histologically confirmed malignant tumours were excluded. Three senior maxillofacial surgeons from our hospital assessed the clinical outcome, which included the cosmetic appearance based on preoperative and postoperative photographs, and locoregional recurrence.

### Surgical technique

All operations are done under general anaesthesia through nasotracheal intubation. After positioning the patient so that the neck is extended and the head rotated away from the lesion (Fig. 1), we make a skin incision in the postauricular sulcus and extend it upwards to the middle or upper third of the sulcus to a length of about 3.0 cm (Fig. 2). We then raise the skin flap with the superficial musculoaponeurotic system (SMAS) superficially to the tumour and explore the lesion using a 0° 5 mm diameter endoscope (Karl-Storz



Fig. 2. Cutaneous markings on the postauricular sulcus, and the tumour.

Corp, Tuttlingen, Germany) through a postauricular sulcus approach. Under endoscopic guidance, we use Harmonic ACE<sup>®</sup> + 7 shears with advanced haemostasis mode (Ethicon, Somerville, NJ, USA) to separate the tumour extracapsularly from the surrounding tissue and seal the vessels. After checking the mobility of the tumour, we decide whether to proceed to extracapsular dissection. Dissection of the SMAS adequately exposes the parotid gland and the tumour. The great auricular nerve, which runs within the SMAS, is then identified and preserved to maintain sensation in the ear lobe, and the tumour is carefully separated and removed (Fig. 3), preventing injury to the facial nerve. We check the wound bed for haemostasis and any questionable areas if the capsule has been disrupted, and cover the defect with the flap. Finally, a pressure dressing is applied for two weeks.

### Results

All tumours were completely removed without rupture, and there were no permanent postoperative complications (no haematomas, salivary fistulas, or Frey syndrome). One patient with a tumour in the deep lobe had slight transient postoperative facial paresis, but it resolved spontaneously within 6 weeks. No scars were visible, and the postoperative cosmetic

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