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SUPERFICIAL PAROTIDECTOMY FOR SIALECTASIS A MORBIDITY STUDY.

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ABSTRACT

The initial management for sialectasia affecting the parotid gland is conservative, but the presence of a persistent mass or intractable pain are accepted indications for surgical intervention. I compared the long term morbidity associated with superficia parotedectomy in patients suffering with sialectasia with those who underwent the same operation for benign tumour, with a 5-20 year follow-up. In all 185 patients were studied and the results show that operations for sialectasia, although few in number, carry a higher complication rate (70% overall) compared with those for tumours (22% overall; $p<0.001$).

INTRODUCTION

Sialectasia results from chronic sialadenitis and generally presents with pain and swelling in one of the parotid glands. It is treated medically with antibiotics and analgesics usually with satisfactory results. The only indications for surgical intervention are failure to respond to conservative measures or the presence of a persistent mass, which fortunately only occurs in a minority of cases.

Operations for sialectasia are often technically difficult because of previous or persistent inflamation in the gland. The aim of this study was to determine if there was an increased morbidity in patients undergoing parotidectomy for sialectasia compared with patients undergoing parotidectomy for benign tumours.

PATIENTS AND METHODS

During a 15 year period (1971-1986) 194 parotidectomies were performed by one surgeon with a follow-up period of between five and 20 years. Five patients died from unrelated causes and four patients were lost to folow-up, leaving a total of 185 patients avaiable for the study. Of these, 168 patients had operations for tumour and 17 for sialectasia. The indication for operation in a case was the presence of a persistent mass in the parotid gland.

Statistical analysis was by Chi square with Yate's correction for small numbers.

RESULTS

Total parotidectomy was carried out in eight cases, all of whom had tumour situated in the deep portion of the gland. All other patients underwent superficial parotidectomy. Pain was a feature in 10 of the 17 patients subsequently found to have sialectasia and 12 of the patients with pleomorhic adenomas. A sialogram was performed in all the patients in the sialectasia group but was normal in eight cases. The final diagnosis was made on histological examination of the excised gland.

There were no deaths. Two patients were found to have malignant growths, which were chance findings, and both underwent a course of radiotherapy with no reported recurrence. The complications following surgery are summarised in Table 1. Of the patients undergoing parotidectomy for sialectasia 12 out of the 17 (70%) suffered one or more complications compared with 37 out of the 168 (22%) patients with tumours ($p<0.001$).

With the exception of recurrence all reported complications were higher among patients with sialectasia, the most common of these being Frey's syndrome. The two patients with infected wounds required surgical drainage, one five days and the other eight days after the operation, following which they experienced no futher trouble. The one patient with the salivary fistula had intermittent problems which failed to settle. He was given a course of radiotherapy which produced no real improvement and he declined further treatment. He subsequently failed to turn up for follow-up after seven years and was found to have left the district.

TABLE I
INCIDENCE OF COMPLICATIONS

COMPLICATION	TUMOURS	SIALECTASIA
Frey's Syndrome	27 (16%)	8 (47%)
Recurrence	8 (5%)	0 (0%)
Facial Nerve Palsy	2 (1%)	1 (6%)
Suppuration	0 (0%)	2 (12%)
Salivary Fistula	0 (0%)	1 (6%)

Three patients had permanent facial nerve weakness following their operations. This affected only the mandibular branch of the facial nerve and was not considered to be a significant problem by any of them. Of the eight patients who had

recurrences of their peomorphic adenomas, five were treated sucessfully with radiotherapy while the remaining three underwent further surgery without complications.

As stated, Frey's syndrome was the commonest reported complication in both groups occuring in 27 (16%) patients with pleomorphic adenomas and eight (47%) with sialectasia. Fortunately, although irritating, none of the patients considered it to be debilitating or significantly interfering with their life styes.

DISCUSSION

In experienced hands the morbidity of parotidectomy should be low. This study shows that, following parotidectomy for tumour, there was a 5% recurrence rate, 1% had facial palsy and 16% had Frey's syndrome to some extent. This compares favourably with other reported series [1-4].

Conversely, the complication rate following parotidectomy for sialectasia was high. As already stated, operative intervention in this group is seldom required[5] and is only indicated for intractable pain or a persistent mass.

It is, of course, difficult to draw firm conclusions from any study in which the size of the two study groups is so different, even when statistical differences can be shown. The patients were operated upon by the same surgeon, which would suggest that the differences shown are a result of the underlying disease process, rather than due to any other variable.

Some authors advocate total parotidectomy as the treatment of choice for sialectasia[5]. This may be appropriate for patients known preoperatively to be suffering from sialectasia and where intractable pain is the main complaint. In the study reported here the presenting complaint was of a persistent mass in the superficial portion of the parotid gland, and pain was a feature in only 59% of cases. All had preoperative sialography, but this was found to be helpful in only half.

The results of this study strongly suggest that parotidectomy in the management of sialectasia should only be attempted if prolonged medical management has failed and that patients should be informed of the increased complication rate associated with surgery in this disease.

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