

Letters to the Editor

An unusual complication of a parotidectomy

Sir,

We would like to present a surgical complication recently noticed in one of our patients that we have not previously seen described in the literature.

A 46-year-old lady presented to clinic with a 4 cm lump in the parotid gland, which imaging and FNA confirmed to be a pleomorphic adenoma. She underwent a selective superficial parotidectomy using a standard technique with preservation of the posterior division of the great auricular nerve and identification of the main trunk of the facial nerve as it entered the gland, and careful dissection thereafter. At the end of the procedure a vacuum drain was inserted, exiting the skin posterior to the skin incision.

Immediately postoperatively there were no problems noted and no facial nerve weakness and normal earlobe sensation. The following day the drain was removed on the ward, and this produced a severe sharp shooting pain from the neck down to the upper arm. Following this she complained of weakness of shoulder movement. Full clinical examination revealed paraesthesia of the skin of the earlobe suggesting neuropraxia of the great auricular nerve weakness of shoulder abduction from approximately 60° and adduction of the scapula, indicating an accessory nerve injury. The latter was confirmed by neurophysiology studies which found reduced nerve conduction along the accessory nerve in the posterior triangle, suggesting a neuropraxia.

The patient underwent physiotherapy and full recovery of accessory nerve function occurred over the following 12 months, together with a more rapid return of normal sensation of the earlobe.

Whilst accessory nerve injury is a well recognised complication of cervical lymph node dissection, it is not reported as a complication of surgery to the superficial parotid gland.¹ Facial nerve and great auricular nerve injury are recognised complications of parotid gland surgery, but only the latter was noted in this patient.² We cannot explain the causation of her accessory nerve injury as the surgical dissection did not explore the posterior triangle. We postulate that the drain must have damaged the nerves at it was being removed, possibly because the suction was not released before removal. We would be interested if any readers have had a similar experience and any theories as to the aetiology.

Conflict of interest

None.

References

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A new finding about leeches?

Sir,

Over the last 18 months we have used leech therapy to treat venous congestion on three intra-oral free flaps. In all cases, the patients were initially returned to theatre for exploration of the neck and confirmation of patency of the anastomosis before leech therapy was commenced. We use our leeches three times per day, which is altered dependant on the clinical appearance of the flap. This is continued until the venous congestion clinically resolves, or it becomes apparent that the flap is not salvageable. This means that both the clinical appearance of the flap and the ‘take’ of the leech are important in deciding whether to continue the therapy or not.

We have however noticed that on several occasions, the leeches have failed to bite and this coincided with application following the administration of mouth care with 0.2% chlorhexidine. This has made us wonder if the leeches have a previously undocumented aversion to chlorhexidine. The Biopharm website¹ does suggest cleaning skin before leech