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Letters and comments

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Facial surgical incisions – role of maxillofacial surgeons

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COMMENT ON

Wasson J, Karim H, Yeo J, Panesar J. Cervicomastoidfacial versus modified facelift incision for parotid surgery: a patient feedback comparison *Ann R Coll Surg Engl* 2010; **92**: 40–3.

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Whilst I read the above paper with great interest I was disappointed that the authors did not feel able to consult and include the maxillofacial surgical team at their trust who in fact carry out the majority of the parotidectomies.

Facial surgical incisions need to provide adequate access, excellent cosmesis, and ease of use. A face-lift incision provides all of the above. Maxillofacial surgeons are familiar with this approach, not only for cosmetic practice but also for gaining access to the temporomandibular joint and the open reduction of mandibular condyle fractures.

I have used the face-lift incision widely for benign parotid disease over the last 10 years and found this approach to be extremely well accepted by patients. In addition, the approach enables excellent access to parotid tumours of all sizes and locations and does not add to operating time. A useful modification, sometimes required, is a temporal extension within the hair line to help with anterior access if required.

Scar assessment is very valuable in our specialty and several tools are available to aid this. The authors would have found the patient assessment scale component of the patient and observer scar assessment scale (POSAS) more specific, helpful and consistent for surgical scar evaluation by the patient.[1]

Facial paraesthesia and especially paraesthesia of the pinna is a result of sacrifice of the great auricular nerve during parotid surgery.[2,3] The authors surely had access to this information from their operation notes and analysis of this could have benefited the audit.

In a detailed analysis of 610 conservative parotidectomies, no risk factors were identified for the development of Frey's syndrome,[4] although anecdotally it has been suggested that Frey's syndrome is more likely if facial skin flaps are raised with the knife rather than scissors.

The notable exclusion in their morbidity evaluation in the postal questionnaire is the depression deformity post-parotidectomy which has been found to cause mild-to-moderate cosmetic problems (mean VAS score 4) after scar cosmesis (4.3) and ear numbness (5.2).[2]

This audit by it weaknesses, highlights the importance of co-operation between those specialties who work within a similar anatomical region, so that they may work together for the common good of our patients.

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AUTHORS' RESPONSE

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We would like to thank Mr Majumdar for his interest in our

paper and re-assure him that permission to utilise parotidectomies performed by the maxillofacial department was sought at a joint ENT/maxillofacial audit meeting. Two consultant maxillofacial surgeons representing the department were present, both were supportive of the proposed study and neither raised any objections. We would also like to emphasise the excellent co-operation and communication that exists between the two surgical departments at the Luton and Dunstable Hospital, highlighted by joint monthly audit meetings and weekly head and neck MDT meetings. We appreciate Mr Majumdar's constructive criticism and will consider his contribution should a repeat prospective study be conducted.

Complication of oesophagoscopy and anticoagulation

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Most reported injuries of the oesophagus are due to endotracheal intubation or oesophagoscopy.[1] Procedures that involve intubation of the pharynx are commonly performed and currently anticoagulation is not thought to be a contra-indication. We highlight a case that may have been prevented, if anticoagulation had been stopped prior to the procedure.

A 58-year-old man attended for an elective transoesophageal echocardiogram (TOE). Transthoracic echocardiography had previously been unrewarding due to large body habitus. The patient was anticoagulated with warfarin (chronic AF) and had a persistent cough. Coughing during oesophageal intubation forced the examination to be abandoned. On waking, the patient described pain in the left anterior neck. ENT identified a tender swelling in the left neck, left submucosal supraglottic swelling and dysphonia. A CT scan showed surgical emphysema and a 4-cm haematoma. His INR was 1.5 and warfarin was stopped, but not reversed. He was transferred to the ENT unit, where he was managed with steroids, antibiotics and fluids. His symptoms and signs resolved after several days and he was discharged uneventfully.

Injuries to the pharynx and oesophagus may have life-threatening sequelae. In recent history, TOE is performed in anticoagulated patients during cardiac valve replacements, which may be more commonly seen in the future in an ageing population. This case raises interesting questions such as should anti-coagulated patients undergoing oesophagoscopy have their anticoagulation reversed (when medically safe)?[2] Further, should we have a higher threshold for surgical intervention given the uncomplicated resolution of symptoms in this patient?

Procedures involving pharyngeal intubation may be traumatic with potentially severe consequences but may be managed conservatively on occasion.

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Splenic injury following colonoscopy

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COMMENT ON

Skipworth JRA, Raptis DA, Rawal JS, Olde Damink S, Shankar A, Malago M, Imber C. Splenic injury following colonoscopy – an underdiagnosed, but soon to increase, phenomenon? *Ann R Coll Surg Engl* 2009; **91**: on-line case report

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I agree with the authors that splenic injury following colonoscopy has been under-reported and is likely to increase with an on-going National Bowel Screening Programme.

In this particular case, re-anticoagulation with warfarin seems to be one of the predisposing factors causing secondary bleed. The spleen was found to be shattered with very little enhancing tissue on the computed tomography scan highlighting that injury was due to traction injury to the atheromatous splenic vessels rather than the capsular tear as seen in our case report.[1] Although possible mechanisms of injury have been postulated in this case report and previous publications,[1] the type of injury to the spleen (capsular or vessel) will help delineate the exact mode of injury to the spleen.

It leaves the dilemma of whether splenic trauma should be mentioned on the consent form as a complication of colonoscopy. The true incidence remains unknown as authors have high-lighted that it may remain undiagnosed or be misdiagnosed as post-colonoscopy discomfort.

Reference

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