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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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