

tumors will be retromandibular and lie inferior to the trunk of the nerve. The space inferiorly is larger and by gentle retraction of the nerve trunk and blunt dissection around the tumor it can usually be delivered into the neck. In larger tumors the neoplasm may be impacted between the mandible and the mastoid with no means of mobilizing it without either dislocating the mandible forward or a subsigmoid or "C" osteotomy to give more space. As contemporary surgery has evolved, more emphasis has been placed on reducing morbidity. Deep lobe tumors may be removed without removing the superficial lobe but leaving it attached anteriorly and then replacing it after excising the deep lobe tumor (Coleela et al. 2007). This technique preserves facial contour and 84% of glandular function compared to the contralateral parotid.

In those tumors with parapharyngeal extension, blind finger enucleation may lead to capsular rupture or cause brisk hemorrhage. In order to visualize and safely remove these tumors an osteotomy of the mandible with or without lip split is utilized (Kolokythas, Fernandes, and Ord 2007) (Figures 8.7 and 8.8).

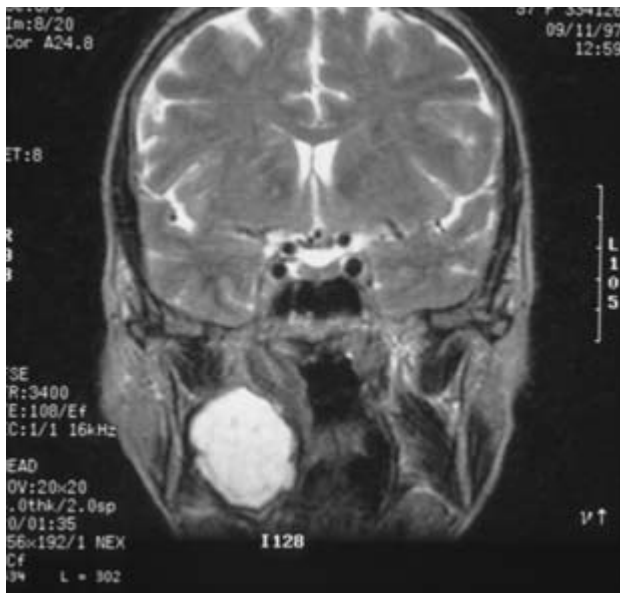


Figure 8.7a. MR shows parapharyngeal pleomorphic adenoma.

There is currently a controversy among surgeons regarding superficial parotidectomy or extra-capsular dissection. This important topic will be discussed below in the section on pleomorphic adenomas.



Figure 8.7b. Standard lip split incision for mandibulotomy.

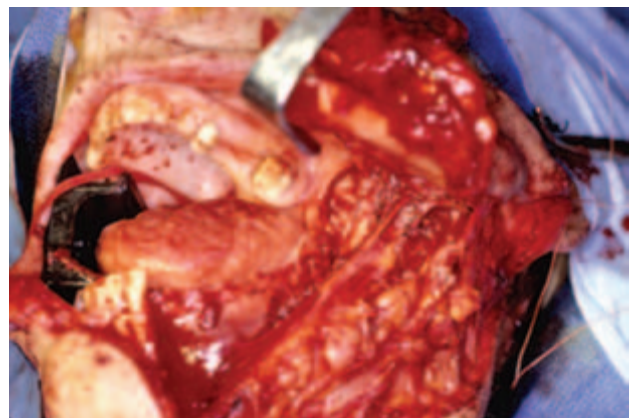


Figure 8.7c. Mandible is retracted out of the field and the pleomorphic adenoma is dissected preserving the overlying lingual nerve.