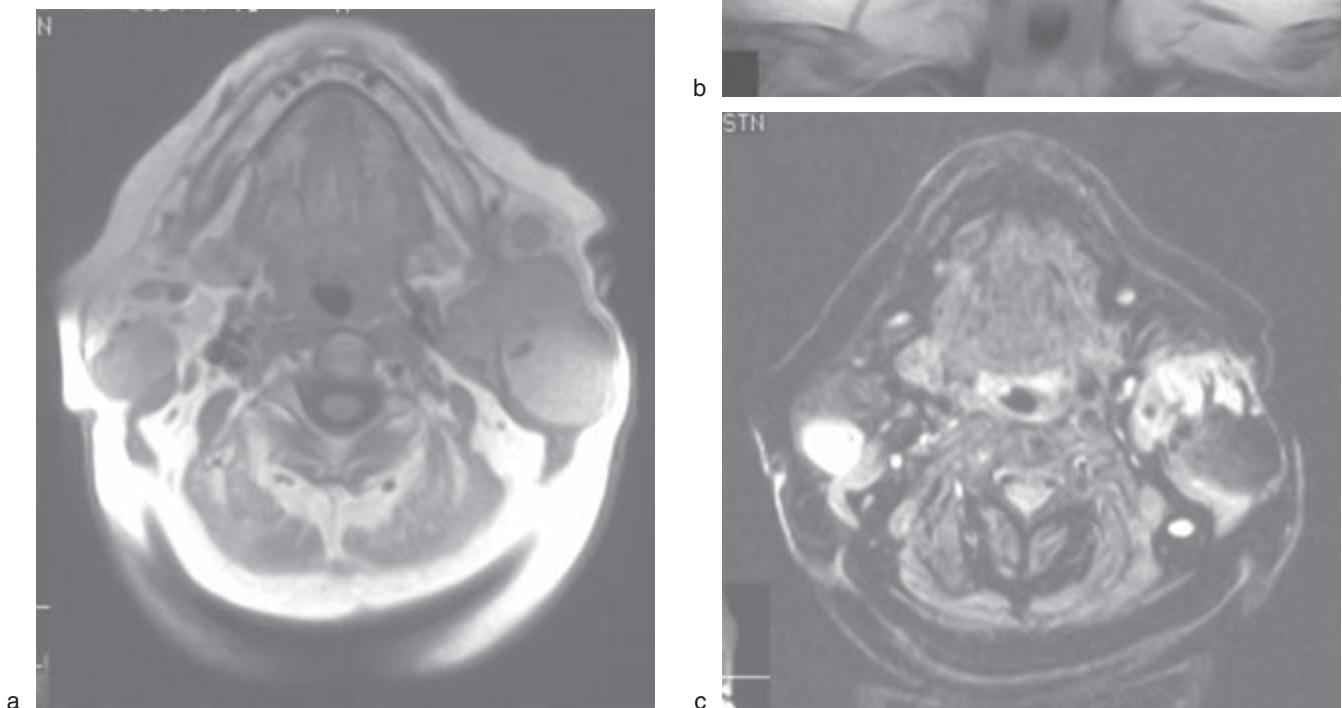


removal of PA remains controversial. A criticism of extracapsular dissection has been that even if this technique is suitable for a presumed benign PA, what should the surgeon do if the final histopathologic diagnosis turns out to be malignant? In a review of 662 clinically benign parotid tumors, 503 treated by extracapsular dissection and 159 by superficial parotidectomy, 5% were malignant and there was no difference in 5- or 10-year survival or recurrence rates between the malignant tumors in the two surgical groups, although morbidity was significantly lower in the extracapsular dissection group (McGurk, Thomas, and Renehan 2003).

A superficial lobe parotid tumor clinically benign and diagnosed as a PA on FNAB may also be treated with a limited superficial parotidectomy (without complete dissection of the facial nerve) and may not require a complete superficial parotidectomy for cure (O'Brien 2003). This is probably most commonly undertaken for tumors in the parotid tail (Figure 8.9).

Deep lobe PAs are usually larger and frequently will have less surrounding parotid tissue, especially deeply, where they abut the prevertebral muscles of the neck. However, the inability to obtain a surrounding cuff of parotid does not seem



Figures 8.9a, 8.9b, and 8.9c. MR images of large cystic benign tumor in the parotid tail.