

Figure 8.12e. Mucicarmine stain confirms intracellular mucus.

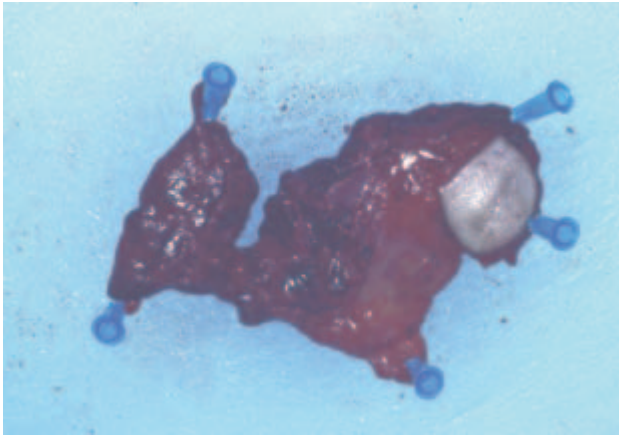


Figure 8.12f. Surgical specimen.

dectomy plus skin, muscle, and bone as indicated with radical neck dissection and postoperative RT (see chapter 11, Figure 11.16).

Controversy exists in the exact indications for RT, neck dissection, and facial nerve sacrifice. The majority of recent papers do show that RT is indicated for advanced parotid carcinoma and confers a survival benefit (Bhattacharyya and Fried 2005) or longer disease-free survival (Hocwald, Korkmaz, and Yoo et al. 2001). However, there is a move toward suggesting RT for earlier stage disease. Zbaren, Nuyens, and Caversaccio et al. (2006) retrospectively analyzed T1-2 carcinomas with and without postoperative RT and found local recurrence rates of 3% and 33%, respectively, and actuarial and disease-free survival of 93% and 92% with and 83% and 70% without RT. In an earlier publication from the same unit RT was suggested

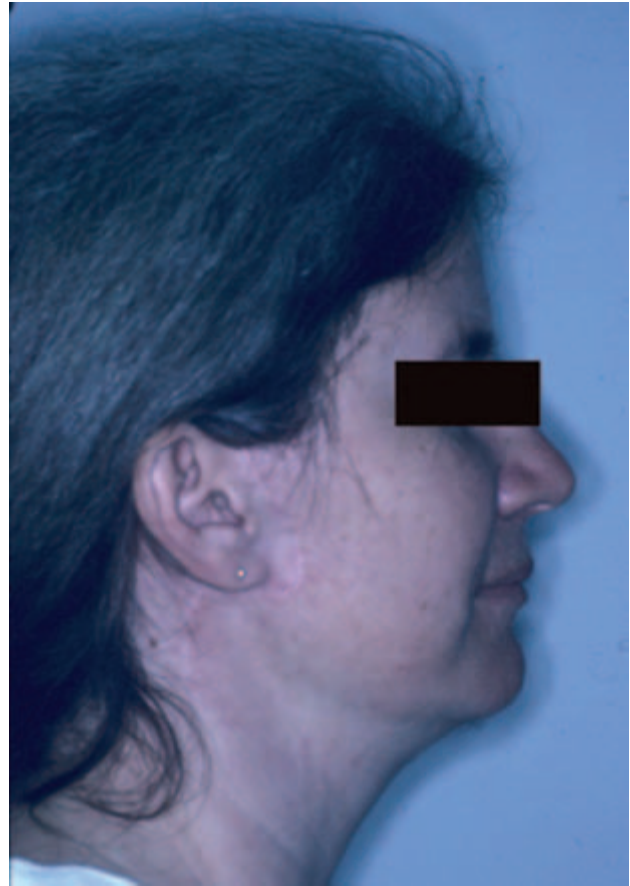


Figure 8.12g. The patient is alive and disease-free 14 years postoperatively.

not just for high-grade tumors but low-grade T2-4 (Zbaren, Schupbach, and Nuyens et al. 2003). So perhaps RT is indicated for earlier stage disease than was previously recommended. The latest data regarding fast neutron therapy in the management of advanced salivary cancer with gross residual disease shows a 6-year local-regional control of 59%, and 100% with no evidence of gross residual disease (Douglas et al. 2003.) Benefits of chemotherapy have not been clearly demonstrated for parotid cancer.

Similarly, although lymph node dissection was recommended for positive nodes and high-grade tumors, there is an increasing interest in the N0 neck. Occult metastasis rates of 22–45% led Stennert, Kisner, and Jungehuelsing et al. (2003) and Zbaren, Schupbach, and Nuyens et al. (2003) to recommend an elective neck dissection in the