



**Figure 8.13a.** MR of parotid tumor that radiologically was diagnosed as a pleomorphic adenoma, but fine needle aspiration biopsy showed adenoid cystic carcinoma.



**Figure 8.13b.** In view of the cytologic diagnosis, proposed treatment includes resection of overlying skin (which clinically was felt to be tethered) and level II cervical nodes.

N0 neck for parotid cancer (Figure 8.14). Elective neck dissection for high-grade tumors and >T2 low-grade tumors should encompass levels I–III and upper V (Teymoortash and Werner 2002). In comparing elective neck dissection for the N0 neck against observation, Zbaren et al. (2005) found an



**Figure 8.13c.** Surgical specimen shows parotid with skin. The arrows show where level II nodes and fat are in continuity with the parotid tail. Final diagnosis was cellular pleomorphic adenoma with the FNAB diagnosis being a false positive.

actuarial and disease-free survival of 80% and 86% for the elective neck dissection patients vs. 83% and 69% for the observation group in a retrospective study.

Regarding the facial nerve, Spiro and Spiro (2003) recommend preservation unless the nerve is adherent to/embedded in the tumor. They feel that close margins to the nerve can be treated successfully by RT. This view is supported by the work of Carinci, Farina, and Pelucchi et al. (2001), who found that sacrifice of the nerve was not always able to improve survival rate. In a series of 107 patients with parotid cancer, 91 had normal nerve function preoperatively and facial nerve preservation was possible in 79 patients. The 5-year disease-free rate and 5- and 10-year survival rates were 65%, 83%, and 54% in the preserved nerve cohort and 56%, 62%, and 42% in the patients with nerve sacrifice. The authors felt that