

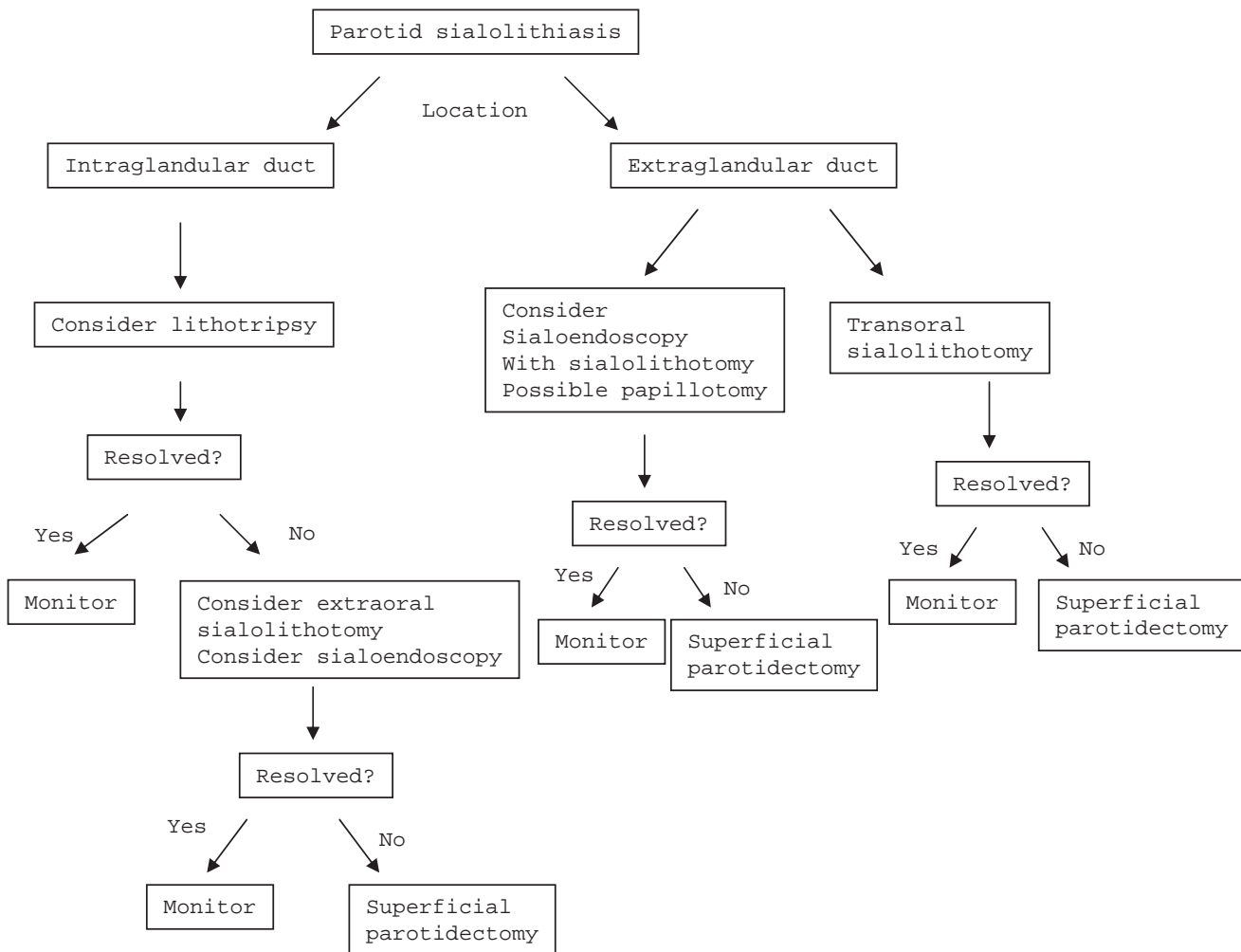
stones so as to achieve a completely non-invasive therapeutic sialoendoscopy.

McGurk, Escudier, and Brown (2004) assessed the efficacy of extracorporeal shock wave lithotripsy, basket retrieval as part of interventional sialoendoscopy, and intraoral surgical removal of salivary calculi. Three hundred twenty three patients with submandibular calculi were managed. Extracorporeal shockwave lithotripsy was successful in 43 of 131 (32.8%) patients, basket retrieval was successful in 80 of 109 (73.4%) patients, and surgical removal was successful in 137 of 143 (95.8%) patients with submandibular stones.

## PAROTID SIALOLITHIASIS

Sialoliths of the parotid gland are divided anatomically into those that are located within the intraglandular duct and the extraglandular duct (Figure 5.14).

Extraglandular duct sialoliths may be removed surgically through an intraoral approach (Figure 5.15). In this procedure, a C-shaped incision is made anterior to Stenson's papilla. Dissection is performed deep (lateral) to the duct such that it is included in the mucosal flap so that the duct is separated from the more lateral soft tissues. A retraction suture may be placed at the anterior aspect of the mucosal aspect of the flap. The duct is dissected from anterior to posterior so as to identify the stone within the duct. Once the stone is located, the duct is incised longitudinally, thereby allowing for retrieval of the sialolith. The mucosal flap is reapproximated; however, the incision in the duct is not sutured. These longitudinal incisions placed in the duct do not appear to result in the formation of strictures, although transverse



**Figure 5.14.** Algorithm for parotid sialolithiasis.