



Figure 5.15f. The mucosal flap was sutured without reapproximating the incision in Stenson's duct.

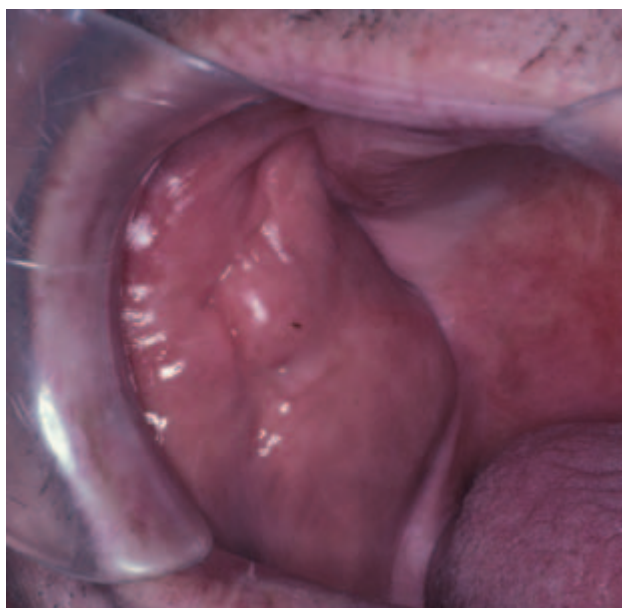


Figure 5.15g. Patent salivary flow was re-established as noted 2 months postoperatively. No further treatment of the gland was required.

incisions in the duct may result in stricture formation (Berry 1995; Seward 1968). Strictures in the parotid duct will respond favorably to intermittent dilation; however, submandibular duct strictures usually require surgical intervention.

Parotid sialoliths located within the intraglandular portion of the ductal system may be addressed through an extraoral approach. Two options exist, one involving a traditional parotidectomy approach (without performing a parotidectomy) with a curvilinear skin incision in the preauricular and upper neck regions (Berry 1995), and the other involving a horizontal incision over the duct in the cheek region (Baurmash and Dechiara 1991). In the former approach, the skin flap is elevated superficial to the parotid fascia, and the duct is identified at the point where it exits the anterior border of the gland. The placement of a lacrimal probe within Stenson's duct may permit accurate identification of the duct. Once the duct is located, it is dissected posteriorly into the gland and the stone is identified. A longitudinal incision is made over the duct and the stone is retrieved (Figure 5.16). As in the case of a transoral sialolithotomy, the incision in Stenson's duct is not closed at the conclusion of the surgery. Sialolithotomy performed with a transcutaneous approach in the cheek may also be accomplished for a diagnosis of parotid sialolithiasis (Figure 5.17).

Extracorporeal lithotripsy seems to be quite effective for the treatment of intraparotid stones. With three outpatient treatments, 50% of patients have been reported to be rendered free of calculus (Williams 1999). Half of the remaining patients may be rendered free of symptoms but having small fragments left in the ductal system. In Ottaviani's cohort of 16 patients with parotid stones, all were relieved of their symptoms with extracorporeal lithotripsy (Ottaviani, Capaccio, and Campi et al. 1996). Nine of their 16 patients experienced complete disintegration and elimination of stones, and 7 patients showed residual stone fragments that were able to be flushed out spontaneously or with salivation induced by citric acid.

McGurk, Escudier, and Brown (2004) found extracorporeal shock wave lithotripsy to be successful in 44 of 90 (48.9%) patients with parotid sialoliths, and basket retrieval was successful in 44 of 57 (77.2%) patients with parotid sialoliths. Interestingly, no patients with parotid stones underwent transoral surgical removal.