Letters and comments

Parotid cancer treatment with surgery followed by radiotherapy

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doi 10.1308/147870811X598515

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COMMENT ON

Shah K, Javed F, Alcock C, Shah KA, Pretorius P, Milford CA.

Parotid cancer treatment with surgery followed by radiotherapy in Oxford over 15 years. *Ann R Coll Surg Engl* 2011; **93**: 218–222
doi 10.1308/003588411X565969

We read with interest the paper by Shah *et al* looking at the 15-year experience of parotid cancer in their centre. The review highlights the criticisms frequently aimed at fine needle aspiration (FNA), which often performs poorly outside specialist centres with high non-diagnostic rates. The diagnostic performance of FNA can be improved when undertaken by a cytologist, who can re-aspirate if needed, and with the use of imaging guidance¹ and ancillary techniques, which are expensive and not widely available.

We would suggest that all patients undergoing parotid surgery should ideally have an accurate preoperative cytological/histological diagnosis. We would agree with the authors that preoperative diagnosis is important for operative planning and informed consent of the patients. A non-diagnostic FNA is as unhelpful as a false negative or false positive result. In this paper an accurate preoperative diagnosis was obtained in only 18 of 27 patients. Four patients had a false positive and five patients had non-diagnostic FNA; these results seem high. Twenty-three patients had no preoperative diagnosis at all although this may to some extent reflect the changing trends in preoperative diagnosis.

The authors do not mention the use of ultrasound guided core biopsy (USCB), which has recently been described in the diagnosis of parotid tumours.^{2,3} The procedure is safe, requiring only local anaesthetic, and can be performed on an outpatient basis. This technique utilises a spring loaded biopsy automated device to obtain a core of tissue, usually via an 18G or 20G needle inserted into the parotid lesion. USCB provides a diagnostic accuracy approaching 100% with the advantage over FNA that it provides a core of tissue that can be used for immuno/histochemical analysis, which will allow grading and typing of parotid malignancy (as well as lymphoma). As recognised by Shah *et al*, this ability is a crucial aspect of surgical management, allowing the operation to be tailored according to the tumour. Only 12 of 27

patients (44.4%) who had FNA were accurately subtyped in the study by Shah *et al*.

USCB can be combined with diagnostic ultrasonography to facilitate lesion characterisation and also compartmentalisation (superficial vs deep lobe). Additionally, it can be used to obtain biopsies from the solid parts of necrotic lesions.

We would suggest that USCB is the technique of choice for the diagnosis of parotid tumours. It not only informs the choice of operative intervention but also provides an accurate preoperative diagnosis for the vast majority of patients, which, combined with further staging investigations, should be a baseline requirement for the multidisciplinary team.

References

1. Robinson IA, Cozens NJ. Does a joint ultrasound guided cytology clinic optimize the cytological evaluation of head and neck masses? *Clin Radiol* 1999; **54**: 312–316.
2. Wan YL, Chan SC, Cheung YC *et al*. Ultrasonography-guided core-needle biopsy of parotid gland masses. *Am J Neuroradiol* 2004; **25**: 1,608–1,612.
3. Howlett DC, Menezes LJ, Lewis K *et al*. Sonographically guided core biopsy of a parotid mass. *Am J Roentgenol* 2007; **188**: 223–227.

Authors' response

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doi 10.1308/147870811X598533

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We thank Mandalia *et al* for their interest in our work on the management of parotid malignancy and for their contribution to debate on this difficult issue. We would urge caution, however, in direct comparisons of our published data on fine needle aspiration (FNA) with the published series on ultrasound guided core biopsy (USCB) cited in their comment. It is important to distinguish our retrospective examination of resected malignant tumours from data concerning the entire spectrum of parotid lumps (neoplastic and other), including those for which surgery did not form part of the management. Our study design was able to highlight limitations of cytological assessment in the diagnosis of malignant salivary gland tumours. Despite this, FNA was predictive of malignancy in 18 of 22 patients (81.8%).

The well documented risks of seeding disease (particularly pleomorphic adenoma) to the skin with large gauge core biopsy needles may well be mitigated by newer USCB

techniques. Nevertheless, any needle that breaches the capsule, including during FNA,¹ risks seeding the disease. Identifying such morbidity depends on careful follow-up, which is necessarily poor for the majority of parotid lumps. In addition, it is not clear that USCB is any less operator dependent than FNA.

The choice of preoperative investigations balances the potential diagnostic benefit against the costs and risks of the procedure. Accordingly, there may be a role for USCB in salivary gland tumours but the value of less intrusive FNA cannot be dismissed, especially when cytology expertise is available.

Reference

1. Supriya M, Denholm S, Palmer T. Seeding of tumor cells after fine needle aspiration cytology in benign parotid tumor: a case report and literature review. *Laryngoscope* 2008; **118**: 263–265.

Fingerless gloves for hand trauma cases

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doi 10.1308/147870811X598551

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COMMENT ON

Tang SW, Bebbington A. Fingerless gloves for hand trauma cases. *Ann R Coll Surg Engl* 2011; **93**: 175
doi 10.1308/003588411X12851639107313k

Tang and Bebbington have described a simple yet effective method of minimising contamination from adjacent surfaces during hand surgery with the use of a sterile surgical glove to isolate the surgical site. They also proposed the use of a rolled-down finger portion of the glove to be used as a finger tourniquet. The fact that this rolled-down finger tourniquet is not detached from the surgical glove may reduce the risk of leaving the tourniquet in situ after surgery. Iatrogenic digital ischaemic injuries may therefore be avoided.

However, the use of a surgical glove as a digital tourniquet must be employed with great caution. The National Patient Safety Agency (NPSA) reported incidences of digital necrosis requiring subsequent amputation as a result of rubber or surgical glove finger tourniquets being left in situ.¹ In reducing the risks of digital tourniquets being left after finger or toe surgery, the NPSA recommended that digital tourniquets should be brightly coloured and have a CE mark. The use of surgical gloves was also discouraged.

The finger tourniquet described by Tang and Bebbington was highly visible as the rolled-down portion remained attached to the surgical glove. Nevertheless, the use of non-bright coloured surgical glove/rubber as a tourniquet will need to be exercised with caution.

Reference

1. National Patient Safety Agency. *Rapid Response Report NPSA/2009/RRR007: Reducing risks of tourniquets left on after finger and toe surgery*. London: NPSA; 2009.

Authors' response

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While the use of a single finger cut from a glove should be discouraged as mentioned, it is highly unlikely that a surgeon would leave on a whole rubber glove and fail to remove it. Nevertheless, a simple way to avoid this is to use coloured gloves. (Either bright blue latex free or bright green gloves are widely available.) These would be an even bigger visual warning than commercially available finger tourniquets that a tourniquet had been inadvertently left on!

Consent

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COMMENT ON

Bogod D. Consent. *Ann R Coll Surg Engl* 2011; **93**: 265–267
doi 10.1308/147870811X571127

I read Dr Bogod's article with interest. It raises several important points:

1. The Mental Capacity Act 2005 (MCA 2005) provides for advance decisions to be formulated.
2. The MCA 2005 provides for the appointment of independent mental capacity advocates (IMCAs) but it needs to be clearly understood that the role of these individuals is only to provide background information to the decision maker so that the best interests of the patient can be determined. The IMCA has no role in defining the best interests, is not a decision maker and therefore, most importantly, does not 'act on behalf of incapable patients'. Rather, the IMCA gathers information about the patient that will influence the doctor's eventual decision about what may or may not be in the patient's best interest.

The IMCA would not usually be instructed in the case of Dr Bogod's patient as she is accompanied by her daughter. The IMCAs are generally involved only in the case of 'unbefriended' patients who lack capacity, where there are no other persons who can inform the doctors of matters that may influence the determination of the patient's best interests.