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Tuberculosis of the parotid gland

Although tuberculosis is common in India, tuberculous infection of the parotid gland is uncommon.[1] Kant and associates[2] in 1977 reported 35 cases, and Yaniv and Avedillo[3] added 2 more cases in 1985. We recently had a case of parotid tuberculosis simulating a parotid neoplasm.

Case report

A 9-year-old boy presented with gradually progressive swelling over 1 year in the left parotid region. Physical examination revealed no other abnormality. Examination of the parotid area revealed a firm, nontender swelling that lifted up the ear lobe. The mass was fixed to the underlying structures, but the facial nerve was spared. He had a family history of tuberculosis. Hematologic and biochemical investigations revealed only a raised erythrocyte sedimentation rate (56 mm/h). Chest x-ray films appeared normal. The Mantoux test gave borderline results. The preoperative diagnosis was a parotid tumour. The boy underwent a superficial parotidectomy. There was evidence of calcification of the mass with central caseation. Histologic examination of the operative specimen disclosed tuberculous parotitis.

Discussion

Tuberculosis of the salivary glands is rare. Granulomatous lesions may be present as localized nodules and can make the diagnosis difficult. The source of the infection in parotid tuberculosis is controversial. Van Stubenrauch[4] postulated extension of infection along Stenson's duct from the oropharynx and Bockhorn[5] postulated a vascular mode of spread from any primary focus in the body or through wounded oral mucosa. According to Berman and Fein[6] spread by lymphatic vessels, particularly from infected tonsils and the external auditory canal, plays an important role. Carmody[7] formulated a canalicular mode of spread from infected molar teeth. With respect to the types of mycobacteria involved, bovine strains have been considered an important etiologic agent, with or without pulmonary involvement.[3,6] The causative role of atypical mycobacteria in infection is remote. If the diagnosis is made preoperatively, parotid tuberculosis can be treated with antitubercular drugs only. Otherwise parotidectomy must be performed, followed by a full course of antitubercular therapy. With the increasing incidence of tuberculosis along with immunodeficiency syndromes, this association may be an important one to bear in mind when cases of parotid tuberculosis are encountered.

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Renal autotransplantation

In response to Taguchi's editorial (*Can J Surg* 1996; 39: 93), concerning the paper on renal autotransplantation (*Can J Surg* 1996; 39: 121–125), his scepticism is understandable and mirrors my own when first asked to consider autotransplantation for loin pain–hematuria syndrome. Experience with renal autotransplantation is limited; up to 1993, only 40 patients had reportedly been treated with this procedure for intractable pain. Pain is, of course, a subjective complaint, but the patients considered for surgery had failed other options and were disabled by their pain.

Until I was presented with my first case in 1990, I, too, had never knowingly seen a case of loin pain–hematuria syndrome nor had such a case been discussed at university rounds. However, loin pain–hematuria syndrome obviously exists, although it represents only a very small fraction in individuals presenting with flank pain. Autotransplantation is used as a last resort and only after symptoms have been present for some years. Approximately 30% of patients in one series[1] had spontaneous resolution of their

symptoms over a mean period of 3.5 years. Whereas relief of pain is thought to be the result of denervation, in-situ denervation by pedicle stripping does not appear to be of benefit. Would orthotopic autotransplantation help? Perhaps, but there may be benefit in moving the kidney to a new location, partly from a psychological perspective and possibly from the effect of reinnervation. As Taguchi pointed out, the decision to perform this procedure is made as a last resort, the alternative for these patients being nephrectomy.

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Open versus arthroscopic acromioplasty

The article comparing open and arthroscopic acromioplasties by Kinnard and associates in the February 1996 issue of the Journal (pages 21 to 23) is of great interest. The authors are to be congratulated for attempting to compare the relative benefits of the two procedures. However, there are a couple of points that merit clarification.

First, they did not report on the power of their study. This is important since they conclude that there was no significant difference in time off work between the two procedures. With a total sample of 20, they would only have an 80% power of determining a difference in the means of one standard deviation, which is considered a "large-effect" difference. Also, they did not report the confidence interval for the difference in means. Considering that the data may well be skewed rather than normally distributed, these data would be important.

The authors state that "in reality, it [arthroscopic acromioplasty] is much more difficult that open acromioplasty . . . . " Many would take strong exception to this statement. Although surgeons recognize that arthroscopic acromioplasty is an exceedingly difficult operation for some to learn, the majority of surgeons experienced and skilled in this technique find that the procedure is easier and faster to perform than open acromioplasty.

Finally, the difference in morbidity between these two procedures is striking. Having had an arthroscopic acromioplasty myself, I can attest to the fact that I was able to take part in a scientific meeting later on the day of the procedure and take an international flight and drive for 1 hours by myself the next day. I would not anticipate being able to do this after an open acromioplasty.

I do not believe that every orthopedic surgeon who has mastered the open technique should feel obliged to learn the arthroscopic technique. Nevertheless, the advantages of the arthroscopic technique should not be underestimated and should be evaluated in a rigorous scientific fashion.

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Dr. Kinnard replies

I thank Dr. O'Driscoll for his useful comments and criticisms.

Undertaking a retrospective study is always a frustrating experience because it is difficult to retrieve patients, and this weakens the study.

It is possible that arthroscopic acromioplasty, as Dr. O'Driscoll mentions, may allow a speedier recovery, but, by using the smallest incision possible, many of my patients were able to return to work after 1 or 2 days. The difficulty with arthroscopic acromioplasty lies in the learning curve, which is much longer than for the open technique. Dr. O'Driscoll's pointed remarks have opened a debate, and the final answer will come from large-centre studies. If the findings of such studies corroborate Dr. O'Driscoll's comments, I will certainly learn the arthroscopic technique.

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