

Immediate parotid duct reconstruction using an autologous vena comitans of the anterolateral thigh free flap pedicle in ablative head and neck surgery

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A 44-year-old male patient underwent wide resection due to squamous cell carcinoma of the right cheek and was found to have a defect in the distal parotid duct (Fig. 1A).

Before harvesting the anterolateral thigh (ALT) flap pedicle, we harvested one of the two venae comitantes of sufficient length and anastomosed it to the duct (Fig. 1B, C). The distal end of the reconstructed parotid duct was fixed between the flap and the oral mucosa (Fig. 1D). We inserted a silicone tube to prevent a stricture forming in the suture site of the parotid duct and the neo-duct created using the vena comitans.

When a parotid duct is injured, surgical treatment is recommended to avoid salivary fistulas or sialoceles, and a silicone tube is generally inserted during surgical reconstruction to prevent stricture of the anastomosed duct [1-3]. In previous studies, the mean diameters of the distal portion of the parotid duct, the venae comitantes of ALT flap pedicle were about 1.4 mm and 2.5 mm, respectively [4,5].

We have reported satisfactory reconstruction outcomes by performing primary parotid duct reconstruction using venae comitantes of the flap pedicle. The study was approved by the Institutional Review Board of Yeungnam University Medical Center (IRB No. YUMC 2018-07-047-001) and performed in accordance with the principles of the Declaration of Helsinki.

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CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

PATIENT CONSENT

The patient provided written informed consent for the publication and the use of his images.

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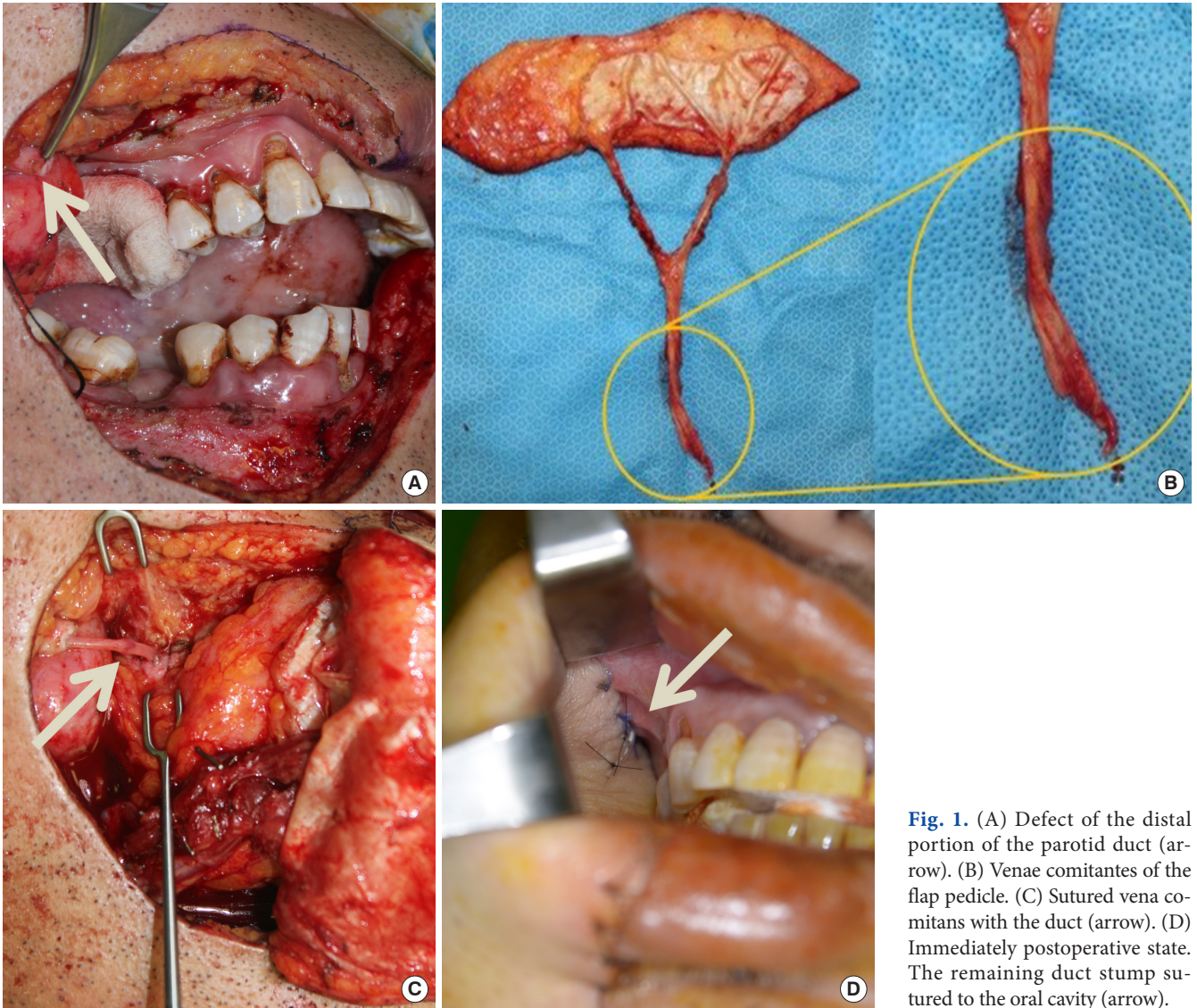


Fig. 1. (A) Defect of the distal portion of the parotid duct (arrow). (B) Venae comitantes of the flap pedicle. (C) Sutured venae comitans with the duct (arrow). (D) Immediately postoperative state. The remaining duct stump sutured to the oral cavity (arrow).