

**General and Vascular Surgeon, Dr B**

**A Report by the  
Health and Disability Commissioner**

**(Case 00HDC09540)**



Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*



## Parties involved

Mr A	Consumer
Dr B	General and Vascular Surgeon
Dr C	General Practitioner
Dr D	Neurosurgeon
Dr E	Pain Management Specialist
Dr F	Independent General Surgeon
Dr G	Otolaryngology/Head and Neck surgeon
Dr H	Independent thoracic and vascular surgeon

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## Complaint

On 19 September 2000 the Commissioner received a complaint from Mr A concerning surgery he had in 1997 for the removal of a parotid tumour by Dr B.

The complaint is summarised as follows:

- *On 11 November 1997 at a private hospital, general surgeon Dr B removed a lump from Mr A's face below his left ear. During the surgery Dr B made an error which either severed or damaged the auriculotemporal nerve.*
- *Prior to the surgery Dr B did not fully inform Mr A of the side effects or risks of the surgery.*

An investigation was commenced on 10 November 2000.

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## Information reviewed

- Dr B's notes in respect of Mr A
  - Dr C's notes in respect of Mr A
  - Relevant records from ACC
  - The Private Hospital notes supplied by Mr A
  - Independent expert advice from Dr Rob Robertson, general surgeon
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## Overview

On 11 November 1997 Dr B performed a superficial parotidectomy (removal of outer parotid gland) for a lump on Mr A's neck. Postoperatively Mr A suffered a number of symptoms, including severe pain and gustatory sweating (sweating while eating). He received further treatment from Dr B but was eventually referred to a neurological surgeon, and then a pain specialist. He is still receiving treatment.

Mr A informed me that since his surgery he has lost his quality of life and will be reliant on medication for the rest of his life.

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## Information gathered during investigation

### *Background*

In October 1997 Mr A consulted his general practitioner, Dr C, about a swelling on the left side of his neck. Dr C diagnosed an enlarged lymph node due to infection and prescribed a course of antibiotics. The node was still present six weeks later and Dr C referred Mr A to Dr B, a general and vascular surgeon.

Mr A consulted Dr B on 20 October 1997. Present at the consultation was Mr A's sister. Dr B examined Mr A's neck. He recorded in his notes that the lump had been present for 18 months and that on examination there was a left "parotid tumour at angle of jaw 1½cm. Needs operation". Dr B also recorded that Mr A had had a neck lump removed 15 years ago. Dr B recommended surgery to remove the tumour. He advised Dr C by letter that "clinically this is a parotid tumor".

Dr B did not perform any other diagnostic tests, such as a fine needle biopsy or CT scan. Dr B advised me that there was a palpable tumour in the left lower lobe of the parotid gland which he considered was a pleomorphic adenoma "which is a benign tumour provided it is removed in toto". The correct treatment for a pleomorphic adenoma is to remove the superficial lobe of the gland containing the tumour.

With regard to the risks of surgery, Dr B advised me that he informed Mr A:

"of the probability of paralysis of the facial muscles but that this would almost certainly recover fully. I also told him that he would probably feel some numbness near the operation site and perhaps have a patch of sweaty skin there while eating. I did not tell him there may be severe and prolonged pain for this is a very rare complication of this procedure. Damage to the auriculotemporal nerve is quite common. This sort of pain is very rare."

Mr A advised me that Dr B told him he would be fit to return to work in one to two weeks after his surgery. He acknowledged to me that Dr B informed him there would be a "slight paralysis of his face" but disputes that he was informed about the adverse side effects of the operation or that the surgery posed the risk of the symptoms he suffered: severe facial

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pain, aggravation of the pain with chewing and cold weather, numbness, profuse sweating around the ear and front of his face, irritability and difficulty sleeping. Mr A advised ACC that Dr B informed him that there would be a slight paralysis which would quickly disappear.

Mr A also commented to me that Dr B is a vascular surgeon and not a head and neck surgeon and that Dr B did not tell him that he was not a specialist in head and neck surgery. In Mr A's opinion it would have been better for Dr B to have specialised in one particular field as Dr B was out of his depth and should never have attempted the operation.

On 11 November 1997 Dr B performed a left superficial parotidectomy at a private hospital. Dr B recorded in the operation note:

“[T]he anatomy was abnormal inasmuch as there were a large number of vessels superficial to the nerve, including the facial vein which was divided and ligated at the top and the bottom. This made the dissection rather bloodier than usual but the bleeding never got out of control.”

The histology report dated 13 November 1997 stated that no malignant cells were seen. The tissue sample comprised of major salivary gland tissue with fatty infiltration of the gland.

Postoperatively Mr A complained of a painful left eye. The following day (12 November) his face was numb, the left side of his face was swollen and he had difficulty swallowing. Mr A was visited by his sister, who was upset at his condition. She was “not expecting to see Mr A's face so badly paralysed and so deformed”. Mr A's face remained numb the next day. He was discharged from hospital on 14 November 1997.

Mr A consulted Dr B on 17 November for a follow-up appointment. Dr B informed Dr C by letter that Mr A's facial palsy was improving but that the progress would be slow. Dr B also informed Dr C about Mr A's histology result.

Dr B saw Mr A again on 8 December for further follow-up. Mr A had been suffering from headaches which Dr B suggested might be due to pain in the auriculotemporal nerve. He prescribed Tegretol to reduce the nerve pain. Mr A appeared to Dr B to be symptom free apart from tenderness in the area of the earlobe. Dr B saw Mr A again on 6 January, 6 April and 22 June 1998. Dr B informed Dr C, following the consultation on 22 June, that Mr A's “facial palsy has settled now, he still has a little temporal numbness and some tenderness just behind the lobule of the pinna [projecting part of the ear]”.

Mr A's sister accompanied him to some of his postoperative consultations with Dr B. She also telephoned Dr B's wife (and clinic nurse) to discuss the fact that Mr A appeared to be in “excruciating pain”.

Dr B informed me that by 11 July 1998 “everything seemed to be settling nicely and [he] made no arrangements to see [Mr A]” again.

On 7 December 1998 Mr A consulted Dr B complaining of numbness in the left parotid and ear area, and advised that he had been suffering from gustatory sweating. Dr B prescribed nortriptyline for the pain, 1 tablet daily, to be increased after 5 days to 2 tablets. A further appointment was made for 21 December 1998 but Mr A cancelled it. On 18 January 1999 Mr A consulted Dr B about pain around his left ear lobe. Dr B recommended Mr A recommence the nortriptyline. (Mr A had discontinued the medication after several days as it had made him “absolutely sick”.) Dr B also recommended Mr A telephone him in three weeks’ time to report on his progress. Mr A did not do so. Mr A developed further pain and, on 14 June 1999, he again consulted Dr B. They discussed steroid injections under local anaesthetic and referral to a pain specialist; however, no decision was made. In July Mr A agreed to a referral to Dr D, a neurosurgeon and member of the Hospital Pain Clinic Team. In his letter of referral to Dr D, Dr B said: “I am sure his problems are from section or damage of the auriculotemporal nerve.” Dr B advised me that Mr A would only attend the consultation with Dr D with him (Dr B) present.

In Mr A’s view, Dr B should have attended the consultation as he was responsible for the outcome of the operation. Mr A advised me that his consultations with Dr D, and later with Dr E, occurred only at his request and instigation, and that he was frustrated and disillusioned with the lack of any significant progress.

Following a consultation with Mr A on 29 July 1999, Dr D formed the impression that Mr A’s pain had been considerably more severe about six months ago and had gradually improved over time. Dr D saw Mr A again on 3 August. He confirmed to Dr B his suspicion that Mr A’s pain was associated with the auriculotemporal nerve. Dr D was optimistic that, given the improvement to date, the level of pain would continue to improve. He requested Mr A let him know of his progress in six to twelve months.

Mr A consulted Dr D again on 4 May 2000. There had been no improvement in his discomfort. Dr D informed Mr A that, in his view, based on Dr B’s description and that of Mr A, the discomfort he suffered was associated with “some contusion particularly in the distribution of the auriculotemporal nerve”. Dr D doubted whether further surgery would benefit Mr A and recommended to Dr B that Mr A be referred to a pain management specialist. He suggested to Mr A that the cost would probably be covered by ACC as “it does appear that the symptoms have been associated with the operative procedure”.

Dr B wrote to Mr A on 19 May 2000 following his telephone conversation with Dr E, a pain management specialist. Dr B advised that after speaking to Dr E, he had “come to the conclusion that the auricular temporal nerve has probably been caught up in scar tissue rather than cut”. Mr A advised that this letter was only written after his specific request to Dr B that Dr B write to him and inform him “what was going on”.

Mr A saw Dr E on 12 June 2000. In Dr E’s opinion Mr A’s symptoms were due to severance of the auriculotemporal nerve and “likely nerve entrapment of cutaneous anterior branches of the great auricular nerve”. He recommended a regime of medication to relieve the symptoms. However, he indicated to Mr A that there was only a moderate chance of obtaining complete resolution and that it was likely to take approximately three months. The medication prescribed by Dr E provided Mr A with some relief from his ongoing pain.

Mr A saw Dr E again on 14 July 2000. In Dr E's view, Mr A had made "considerable progress with approximately 50% reduction in total pain". He prescribed ongoing medication and advised Mr A to focus on resolving his medical problem and let events take their course over time. This comment was made in response to Mr A's enquiry about possible ACC assistance for his financial loss.

#### ACC

In August 2000 Mr A submitted a claim to the medical misadventure unit of ACC in respect of the surgery performed by Dr B. ACC obtained the advice of an independent general surgeon, Dr F. Dr F advised ACC:

"Facial nerve paresis after parotidectomy is not rare and most recover fully, as in this claim, provided the nerves have not been divided. The great auricular nerve is almost always divided in this operation giving rise to numbness and hyperaesthesia. Gustatory sweating occurs in up to 60% of cases of parotidectomy."

On 28 December 2000 ACC advised Mr A that his claim had been declined.

Mr A requested a review of the decision on 20 April 2001. In support of his application he submitted a report dated 13 February 2001, addressed to Mr A's solicitors, by Dr G, an otolaryngology/head and neck surgeon.

Dr G commented in his report on the absence of "preoperative investigations such as ultrasound or fine needle aspiration". Dr G identified issues that contributed, in his opinion, to Mr A's symptoms. They are summarised as follows:

1. the presence of Frey's Syndrome (gustatory sweating) which is quite common after a parotidectomy. He stated that it is "not symptomatic in more than 10% of patients ...";
2. the transection of the posterior branch of the great auricular nerve;
3. probable incorrect dissection of the auriculotemporal nerve; and
4. possible/probable dissection in the mandible joint.

Dr G also stated:

"... [I]t is even more unlikely that Mr A should have had such severe post operative problems with nerve and tissue damage. In such circumstances these events should occur in less than 0.1% of the time."

Dr G's complete report, and his second report dated 1 March 2001, are attached as Appendix I and II. Mr A is currently receiving treatment from Dr G.

ACC obtained a second report from Dr F, who reviewed Dr G's report and advised ACC:

"[T]he level of pain and dysfunction related to the auriculotemporal nerve and temporomandibular joint are significant and of a severity that would occur in less than 1% of parotidectomies."

ACC also obtained a report from Dr H, an independent thoracic and vascular surgeon. Dr H supported Mr A's claim for medical mishap. Dr H also commented that "recent practice would indicate that FNA (fine needle aspiration) and confirmation of the nature of the mass is commonly undertaken preoperatively but that this is not always so, and that if the surgeon is happy with his clinical decision he may proceed straight to superficial parotidectomy".

In April 2001 ACC accepted Mr A's claim as medical mishap as the consequences he suffered after his surgery were both rare and severe.

In June 2001 Mr A submitted a further application for review on the basis that ACC should accept his claim as medical error and not medical mishap. A hearing was held on 29 October 2001 and the application was dismissed. The reviewer stated that "for the error finding to be possible, Dr B must have reasonably foreseen the serious consequences that befell Mr A. On balance that is not probable given the mishap finding that the consequences were very rare".

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## **Independent advice to Commissioner**

The following independent expert advice was obtained from Dr Robert Robertson, general surgeon.

"Complaint that on the 11<sup>th</sup> of November 1997 at a Private Hospital, General Surgeon [Dr B] removed a lump from [Mr A's] face below his left ear. During the surgery [Dr B] made an error which either severed or damaged the auriculotemporal nerve.

The second part of the complaint is that prior to the surgery [Dr B] did not fully inform [Mr A] of the side effects or risks of the surgery.

I have read through the information supplied by the Commissioner's Office and note that on the 11th of November 1997 [Dr B] performed a superficial parotidectomy on [Mr A] for a mass or swelling involving the parotid gland on the left side. As a result of this operation [Mr A] sustained a number of injuries related to the nerves associated with the parotid gland. In particular he sustained damage to the facial nerve which caused weakness that subsequently largely recovered. He also sustained an area of sensory loss to the region of the left side of his face and ear which would usually be associated with the greater auricular nerve.

The greater auricular nerve is a branch of the cervical plexus. It arises from the second and third cervical nerves and has two branches, an anterior and posterior branch. The anterior branch is distributed to the skin of the face over the parotid gland and may communicate in the substance of the gland with the facial nerve. The posterior branch supplies the skin over the mastoid process and on the back of the auricle. It also communicates with other nerves in this area. This nerve is commonly divided through



mobilisation of the parotid gland and it is common for patients to have numbness particularly to the lower lobe of the ear as a result of this operation.

The third neurological abnormality that occurred as a result of this operation was due to injury of fibres that originate in the glossopharyngeal or ninth cranial nerve which are described as parasympathetic or secretomotor and eventually reach the otic ganglion and are relayed by the auriculotemporal nerve and conveyed to the parotid gland. They result in a vasodilator effect as well as a secretomotor effect. The auriculotemporal nerve is a branch of the mandibular nerve which is the third division of the trigeminal nerve also known as the fifth cranial nerve. It communicates with the facial nerve and the otic ganglion and it is via this route the parasympathetic fibres run. The filaments from the otic ganglion join the route to the auriculotemporal nerve near the origin and these various branches are labelled the anterior auricular, branches to the external acoustic meatus articular, parotid and superficial temporal. The anterior auricular branches supply the skin of the tragus while the branches to the external acoustic meatus supply the skin of the meatus and tympanic membrane. The articular branches go to the temporomandibular joint. The parotid branches convey secretomotor fibres to the parotid gland. The pre-ganglionic fibres are originally derived from the glossopharyngeal nerve through its tympanic branch and travel by the lesser petrosal nerve to the otic ganglion whence the post ganglionic fibres pass to the auriculotemporal nerve and so reach the gland. They also contain vasomotor fibres to the blood vessels of the parotid gland. These fibres are directly continuous with the fibres of the sympathetic route of the otic ganglion. The superficial temporal branches accompany the superficial temporal artery and its terminal branches; they supply the skin of the temporal region and communicate with the facial and zygomatico temporal nerve.

From the above one can see that the longer term side effects suffered by [Mr A] could be related to damage to the auriculotemporal nerve in a condition labelled as gustatory sweating as one recognised when the secretomotor fibres regrow into the subcutaneous tissue rather than the parotid tissue which has now disappeared. It is also noted that sensory loss can be attributed to the greater auricular nerve but there are also sensory branches from the auriculotemporal nerve.

Of note the operation note of 11.11.97. The anatomy was described as abnormal in as much as there were a large number of vessels superficial to the nerve including the facial vein which was divided and ligated at the top and at the bottom. This caused a lot more bleeding than usual. It is also noted that the facial nerve was seen throughout the dissection although presumably had been traumatised and this would account for the weakness associated with trauma to the facial nerve post operatively. It is possible that some of the damage to auriculotemporal nerve fibres has occurred during this part of the dissection as these fibres have both a secretomotor and vasodilator effect in the parotid. It is also possible it could have been damaged during dissection of the initial identification of the facial nerve where it emerges from the base of the skull. It is at this level where it exits from its stylomastoid foramen that there is communication with glossopharyngeal vagus, great auricular and auriculotemporal nerves. It is therefore

clearly established that damage to nerve fibres of the auriculotemporal nerve have left [Mr A] with a long term disability.

The second part of the complaint relates to information [Mr A] was given with respect to side effects of surgery. It is hard to clearly establish this as it is not normally always written down in a specific format. [Dr B] states that he informed [Mr A] of the probability of paralysis of the facial muscles and that this would almost certainly recover fully. He also states that he had informed [Mr A] that he would probably feel some numbness near the operation site and perhaps have a patch of sweaty skin there while eating. He states that he did not tell him that there may be severe and prolonged pain.

I would assume it would be normal to warn patients of the risk of facial paralysis when any operation on the parotid gland is contemplated and also to inform patients of potential numbness especially to the lobe of ear as this can be expected as almost the normal outcome of the operation. It would also be appropriate to warn the patient. The complication of severe pain or parasthesia as a result of nerve damage is also very uncommon and it is unlikely that the surgeon would dwell on this as the likely outcome of surgery. It is sometimes a feature to have chronic pain when there has been malignancy involving the gland especially if malignant cells have invaded the lymphatics associated with the various nerves but often these patients have pre existing neurological damage prior to surgery. As most lesions in the parotid gland are benign one does not normally expect these types of complications to be especially severe. It is however standard to perform a superficial parotidectomy for most tumours which occur in the superficial lobe of the gland as this usually gives complete control and adequate treatment of the condition.

You ask a number of specific questions:

1. What specific professional and other relevant standards apply in this case and did [Dr B] meet those standards?

From information supplied by [Dr B] he certainly appears to have undertaken the operation with care and demonstrated appropriate care in the immediate and longer term follow up of the patient's course and in particular informed the General Practitioner of ongoing developments and management of his condition. He referred the patient both to a neurosurgeon and pain management specialist and tried simple measures and remedies prior to this which would be normal practice. Of interest [Dr E's] report does show that [Mr A's] condition was gradually improving as time went by.

2. You asked for comment on the type of surgery and was this surgery performed in accordance with good professional practice?

I note that he was originally referred in October of 1997 with an eighteen month history of a lump on the left side of his face and neck. It was clinically felt to be a parotid tumour and the recommendation was for this to be removed. This was undertaken on the 11.11.97. I note that there was no pre operative investigations which some people

might undertake e.g. fine needle aspiration cytology of the lesion to more clearly determine its nature, plus or minus a CT scan which some operating surgeons may also have or undertake prior to surgery. While neither of these tests is absolutely necessary they certainly may influence the surgeon in his approach to the operation. Of note the lesion was not a specific parotid tumour and having such information could have caused a change in management with a further period of observation.

3. You asked for comment on the side effects [Mr A] experienced after the removal of his parotid tumour.

I believe in my introductory paragraphs these are covered and explained with respect to the neurological damage.

4. What is Frey's syndrome? What is an amputation neuroma? Are these common side effects after this type of surgery?

Frey's syndrome is also referred to as gustatory sweating and is a result of the parasympathetic nerve fibre damage as previously indicated. An amputation neuroma is a fibrous reaction that occurs at the end of a divided nerve. These can be painful and uncomfortable. They are not common side effects after this type of surgery although they are well recognised.

5. Is it possible to establish in this case what damage to [Mr A's] auriculotemporal nerve was caused by?

As indicated in earlier paragraphs damage has been caused to the nerve or nerve fibres during the dissection of the facial nerve and the parotid gland. I am not entirely sure at which level this would necessarily have been undertaken but assume it is probably near the origin of the facial nerve once it has emerged from the stylomastoid foramen.

6. Was the damage to [Mr A's] auriculotemporal nerve a known complication of the surgery he had and if so, how common is this complication?

It is a known complication but quite an uncommon complication. Gustatory sweating will probably occur in between one and five percent of cases but may be transient and not long term. The more severe complication of severe pain is very uncommon.

7. You ask for my opinion as to the risks and side effects of parotid surgery.

The prudent doctor should advise the patient prior to such surgery, in particular of what damage to the auriculotemporal nerve or complication that any prudent doctor would inform a patient of prior to surgery.

I have already detailed the risks and side effects of parotid surgery with respect to nerves. There is also a very slight possibility of a salivary fistula, wound infection can occur and a seroma or haematoma may develop under the wound. While these may be mentioned they may not necessarily be dwelt on as the most significant side effect is that of facial nerve paralysis and this is the particular complication which most

surgeons would reinforce. The experience of each surgeon will differ according to their practice and their own previous experience. My own experience is to undertake a CT scan of the parotid gland based on the fact that almost twenty years ago I operated on a parotid gland of a patient for what was presumed to be a tumour of the gland which proved to be a tumour of the nerve and the dissection of the nerve caused a facial paralysis. I personally therefore like to have more clear information with respect to the anatomical changes so as the patient can be more clearly warned with respect to this particular side effect. It is more common for the facial nerve to be injured if the tumour is in the deeper lobe of the gland or the tumour is causing local pressure effects on the gland or if the tumour is a cancer.

Were the actions taken by [Dr B] to address [Mr A's] pain appropriate and reasonable in the circumstances?

I believe that these were and note that I have already commented he referred him to both a neurosurgeon and pain specialist as well as trying specific simple treatments first.

Any other issues raised by the supporting documentation?

One of the concerns expressed by [the] Lawyers is the relative delay in obtaining second opinions and more specific treatment for the underlying and ongoing condition. While on the face of things this may seem true, with respect to nerve injuries such as this, there may be quite a delay while any recovery is determined. This was noted with respect to the facial nerve where there was initial paralysis but this gradually improved. There may therefore not be too much benefit from exploring separate forms of treatment until some considerable time has elapsed to determine how much recovery there may be. However this may have been helped by earlier referral to help reinforce this point and reinforce the use of the simple remedies such as antidepressant medication and Tegretol in what may have been a reinforcing environment to the patient.”

Dr Robertson provided the following clarificatory advice:

“I am responding to your letter of 16 September 2002 regarding the above complaint. I spent some considerable time thinking about your questions and have consulted colleagues both in General Surgery and Otolaryngology regarding the questions you asked. I note that you enclosed relevant documents from the complaint file, most of which I have previously seen and include further information provided by [Mr A] and [Dr B]. The information from [Dr B] appears to be essentially letters from his lawyer, ... and this does not provide me with any further information to that I have already seen regarding [Dr B's] position and an interesting series of correspondence from [ ], Lawyers, including a record of interview with [Mr A], consumer. They note that this is a brief summary of matters discussed and is not intended to be a verbatim account. It makes the most interesting reading and I note that ... the lawyer for [Mr A] had a fair degree of input in the interview and that [Dr G] whom I presume is [the] Ear Nose & Throat Specialist (Otolaryngologist), [who] had been consulted and subsequently is now treating [Mr A]. Much of what is stated during this interview is of a subjective

nature and I think must be considered in this light. It does mention in this interview that a number of people, [Mr A] particularly, considered [Dr B] as a Vascular Surgeon, although I see he holds the Fellowship of the Royal College of Surgeons and lists himself as a General Surgeon which normally that College would give the Fellowship for and believe that Surgeons of [Dr B's] vintage would have been trained primarily as General Surgeons in a primary sense and undertaken any sub specialisation subsequently.

I also note and point out that up until approximately 15-20 years ago in New Zealand Ear, Nose and Throat Surgeons as they were known then, by and large took fairly limited interest in the complex head and neck surgery and it is only the younger generation of Ear, Nose and Throat surgeons who have evolved into Otolaryngologists and Head and Neck Surgeons and are now seen to have a more specialist interest in this area than they previously did. In fact, there remains a major division between General Surgeons who wish to undertake surgery involving head and neck structures and Ear, Nose and Throat Surgeons (Otolaryngologists) in this area. This has proved a major dilemma in the Royal Australasian College of Surgeons and there are certainly many of the Otolaryngologists who undertake head and neck surgery together with General Surgeons who do this and it is an area that creates friction and may have an influence on a certain degree of protection of one's patch. Increasingly, many surgeons are restricting their surgery to particular areas of the body when it comes to undertaking elective procedures and this will remain one of those areas that will continue to be somewhat divisive. Of interest when I sat my Fellowship examination in General Surgery in 1982 I note one of my anatomy questions was on the facial nerve which is really the anatomy of the parotid gland. A patient I had to examine had a parotid tumour and in our written examination, we had to discuss parotid tumours. I sat that examination in [a city] and I would still not be surprised to see such cases and such conditions discussed in the FRACS Part II Examination in General Surgery today.

That to one side, your question: Was [Dr B's] examination of the growth appropriate in the circumstances?

I believe examination of the parotid gland is relatively simple. Most of it is by observation, palpation of the gland and one would also normally palpate the gland from inside the mouth. Simply visualising the patient one can see if there is facial nerve injury especially if one observes the patient while they are talking, blinking, shutting their eyes or undertaking a facial expression. While there is no record that all of these things may or may not have been done it certainly sounds, from [Mr A's] comments, that the gland was palpated and one would have expected the other observations to have occurred. It would not necessarily be expected that all of these observations should be recorded individually as it is not possible to record everything from any clinical interview.

Was [Dr B's] determination that the growth was a pleomorphic adenoma reasonable in the circumstances?

The common tumour of the parotid gland is a pleomorphic adenoma. It accounts for approximately 80% of all parotid tumours and is a benign tumour as are most of the lesions of the parotid gland and it is normal for this to be excised as there is a risk that pleomorphic adenomas can undertake malignant change.

Is a fatty infiltration of the parotid gland a common occurrence? If so, should [Dr B] have advised [Mr A] of such a possibility?

Fatty infiltration of the parotid gland occurs as it can occur in other organs also. In my experience it is relatively uncommon and one might expect such an occurrence to be bilateral. I doubt very much that it would be appropriate for [Dr B] to have advised [Mr A] of such a possibility as one would normally consider a unilateral swelling of the parotid gland to be a tumour until proved otherwise.

With respect to the CT scan my own practice is to undertake a CT scan and fine needle aspiration of parotid tumours if at all possible. I do not think it is absolutely necessary to undertake a CT scan or, for that matter, to perform a fine needle aspiration although my own practice is to do so. Having said that the last patient I treated with a parotid tumour did not have a fine needle aspiration because she refused to have one and I think that a recommendation that either or both of these investigations is undertaken is one to consider individually at the time and one could argue that it may be appropriate for more information but it is not absolutely necessary.

Having discussed this particular issue with other colleagues, the consensus from their opinion and my own is that it is not necessary to undertake these tests and one might argue that if the diagnosis of a tumour of the parotid is made, the treatment is a superficial parotidectomy which, of course, carries the risk of damage to the facial nerve. It is possible that [Dr B] may have discussed CT scan with [Mr A] and they may have come to a consensus that it wasn't necessary if they were going to remove the tumour anyway. [Mr A] indicates in his interview that once he heard the word tumour, he obviously feared the worst and may have wanted to get on with things and I think with hindsight and the subsequent outcome, one's view at the time of consultation may be somewhat jaundiced or misrepresented. I don't believe there is a black and white answer to your questions."

## Response to Provisional Opinion

Dr B advised the following in response to the Commissioner's provisional opinion:

"Thank you for your letter of 3rd December inviting my comments on your comments about my pre-operative testing.

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I have also looked through the surgical textbooks in the Medical School Library and enclose photocopies of extracts from three major textbooks. The first one entitled "Surgery – Scientific Principles and Practice" by Greenfield, Mulholland, Oldham, Zeleknock & Lillimoe, published in 1997 by Lipincot Raven, states that for pleomorphic adenoma of the parotid gland, superficial-lobectomy is the treatment. There is no mention of ultrasound. Perhaps of significance is the fact that in other sections on breast and thyroid lumps, fine needle aspiration is suggested.

The next book is "Current Surgical Diagnosis and Treatment" by Way, 10th edition 1998. Under the heading Treatment it states '... benign salivary tumours should be excised ...' It also states later under Treatment that '... unless the diagnosis of cancer is obvious, that in general, complete local excision with a margin of normal tissue is the appropriate form of biopsy' which in the parotid region means superficial parotidectomy.

In the Oxford Textbook of Surgery by Morris & Wood, 2nd edition, Oxford University Press published in the year 2000, it is stated that '... the proper approach to most parotid neoplasms is to perform a parotidectomy'. This statement is made in two parts of the chapter. It is also stated that '... biopsy by fine needle aspiration may be used to aid in accurate diagnosis. CT and MRI scans do not differentiate benign from malignant tumours and rarely alter the therapeutic approach.' There is no mention anywhere in this chapter of ultrasound.

Fine needle aspiration cytology is not infallible. In fact, there have been some well publicised instances of its fallibility in the last two or three years in a different part of the anatomy. If one does a fine needle aspiration biopsy and it comes back negative, the question then is what does one do. The current surgical teaching is that a parotid tumour should be excised together with an adequate margin of normal parotid, which in fact means doing a superficial parotidectomy to avoid damage to the facial nerve. The question would arise if one had a negative biopsy and did not remove the tumour and it became malignant would the patient then have a legitimate cause to complain ... that the Surgeon had been negligent. ..."

## Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

### *RIGHT 4*

#### *Right to Services of an Appropriate Standard*

1) *Every consumer has the right to have services provided with reasonable care and skill.*

### *RIGHT 6*

#### *Right to be Fully Informed*

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*

- a) An explanation of his or her condition;*
- b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; ...*

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## Opinion: No breach

### *Standard of surgery*

Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. Mr A complained that during his surgery, Dr B made an error which either severed or damaged the auriculotemporal nerve.

Mr A's complaint essentially concerns the ongoing symptoms he has suffered since his surgery in 1997. Mr A alleged that the reason for his symptoms is that Dr B made an error when performing the surgery.

To support Mr A's review of the initial ACC decision to decline his claim, he obtained advice from Dr G, an otolaryngology surgeon. Dr G advised that the pain suffered by Mr A in the distribution of his auriculotemporal nerve is something that would not usually occur as a result of a parotidectomy as the nerve is not usually exposed or dissected. In Dr G's view, the occurrence of the pain is "probably the result of dissecting in an incorrect plane". Dr G expanded his opinion in his second letter and stated that it is "even more unlikely" the severe pain suffered by Mr A is due to nerve and tissue damage since there was no tumour mass that required removal during the surgery.

There is no dispute Mr A has suffered, and continues to suffer, symptoms from his surgery. He has significant facial pain and sweating, both of which impact upon the quality of his life. Such significant symptoms would lead one to assume that an error by the surgeon is the reason for those symptoms. I do not accept that for the reasons set out below.



My advisor said that in his view Dr B “certainly appears to have undertaken the operation with care” but, nonetheless, it is “clearly established that damage to the nerve fibres of the auriculotemporal nerve has left Mr A with a long term disability”. My advisor considered what may have caused the damage to the nerve fibres. He said:

“Of note the operation note of 11.11.97. The anatomy was described as abnormal in as much as there were a large number of vessels superficial to the nerve including the facial vein which was divided and ligated at the top and at the bottom. This caused a lot more bleeding than usual. It is also noted that the facial nerve was seen throughout the dissection although presumably had been traumatised and this would account for the weakness associated with trauma to the facial nerve post operatively. It is possible that some of the damage to auriculotemporal nerve fibres has occurred during this part of the dissection as these fibres have both a secretomotor and vasodilator effect in the parotid. It is also possible it could have been damaged during dissection of the initial identification of the facial nerve where it emerges from the base of the skull. It is at this level where it exits from its stylomastoid foramen that there is communication with glossopharyngeal vagus, great auricular and auriculotemporal nerves.”

It has not been established exactly what caused the damage to the nerves fibres of Mr A’s auriculotemporal nerve, and further investigation will not clarify the matter. Even if it were established that Dr B incorrectly dissected the nerve (as suggested by Dr G), that may well have occurred as a result of the difficulty Dr B encountered with the abnormal anatomy – as recorded in the operation note.

Similarly, the great auricular nerve may have been damaged during the surgery owing to the unexpected complexity of Mr A’s anatomy.

Dr E opined that Mr A’s symptoms were due to severance of the auriculotemporal nerve and likely entrapment of cutaneous branches of the great auricular nerve. Dr F, the advisor to ACC, said that the great auricular nerve is almost always divided, while Dr G stated that in most cases preservation of the posterior branch of the great auricular nerve will prevent the pain and discomfort following a parotidectomy. He also said that even where the nerve is transected, “a high proportion of people have good recovery of sensation ...”.

Surgical techniques are not static and specialists may introduce new practices. Dr G, as a head and neck specialist, may perform a superficial parotidectomy using different methods to that used by general surgeons. But as a general surgeon performed Mr A’s surgery, it is appropriate that I rely on independent advice from a general surgeon in forming my own opinion of the appropriate standard of care. I note that my advisor said that the great auricular nerve “is commonly divided through mobilisation of the parotid gland”. As noted above, this is consistent with the advice provided to ACC by its expert general surgeon.

Dr G also referred in his report to the careful closure of the Superficial Musculo-Aponeurotic System (SMAS). He stated that the careful closure of the SMAS might have avoided the gustatory sweating from which Mr A suffers, and he noted that Dr B did not refer to the SMAS in the operation note. Even if Dr B did perform a careful closure of the SMAS, Mr A may still have suffered those side effects due to the abnormal anatomy recorded by Dr B. As my advisor noted, Dr B appears to have undertaken the operation

with care. I note that an unfortunate surgical outcome does not necessarily indicate a departure from the appropriate standard of care.

Having carefully considered all of the information provided to me, I am satisfied that Dr B provided surgical services with reasonable care and skill when he performed Mr A's parotidectomy. The adverse symptoms suffered by Mr A are rare and there is no reason, on the available evidence, to assume that negligence on the part of Dr B resulted in Mr A's symptoms. In my opinion, therefore, Dr B did not breach Right 4(1) of the Code.

*Decision to perform surgery*

Mr A also commented that Dr B, as a general and vascular surgeon, should not have performed the surgery on his neck as he had not specialised in the field of neck and head surgery, unlike Dr G, who is currently treating Mr A.

The issue about the extent or appropriateness of surgery performed by general surgeons is not new. It is a subject that has caused, and no doubt will continue to cause, friction amongst general surgeons and those surgeons who practise within a sub-speciality. The question for me is whether it was reasonable for Dr B to perform a superficial parotidectomy on Mr A. In my view it was. There are many general surgeons who perform head and neck surgery. I do acknowledge, however, that some issues arise around the matter and note the comments of my advisor:

“I also note and point out that up until approximately 15–20 years ago in New Zealand Ear, Nose and Throat Surgeons as they were known then, by and large took fairly limited interest in the complex head and neck surgery and it is only the younger generation of Ear, Nose and Throat surgeons who have evolved into Otolaryngologists and Head and Neck Surgeons and are now seen to have a more specialist interest in this area than they previously did. In fact, there remains a major division between General Surgeons who wish to undertake surgery involving head and neck structures and Ear, Nose and Throat Surgeons (Otolaryngologists) in this area. This has proved a major dilemma in the Royal Australasian College of Surgeons and there are certainly many of the Otolaryngologists who undertake head and neck surgery together with General Surgeons who do this and it is an area that creates friction and may have an influence on a certain degree of protection of one's patch. Increasingly, many surgeons are restricting their surgery to particular areas of the body when it comes to undertaking elective procedures and this will remain one of those areas that will continue to be somewhat divisive.”

The difference in the techniques used to perform a superficial parotidectomy has been discussed above. Some of the differences may be due to the fact that Dr G is a head and neck surgeon and it is possible that, in the future, superficial parotidectomies will only be performed by such surgeons. In Mr A's case, however, he was referred to a general surgeon by his general practitioner, who clearly felt the referral was appropriate.

While head and neck surgery and the question of who should perform it is, in the words of my advisor, “an area that may create friction”, I note that both my independent advisor and the advisor to ACC have experience in this area of surgery.

*Duty to inform*

Right 6 of the Code entitles a consumer to receive information that a reasonable consumer in that consumer's circumstances would expect to receive. Before making a choice or giving consent to the removal of the lump in his neck, Mr A had the right to the information that a reasonable patient in his circumstances would expect to receive, including an explanation of his condition and information about the expected risks of that type of surgery.

Mr A alleged that Dr B did not fully inform him about the side effects or risks of surgery. Mr A informed ACC that had he known the benign nature of the lump in his neck before surgery, he would never have consented to the operation. He alleged that "risks which are clearly known to the medical profession were never mentioned" to him.

Dr B advised me that he informed Mr A of the probability of paralysis of his facial muscles, but that he would almost certainly recover. He said that he told Mr A that he would probably feel some numbness near the operation site and perhaps have a sweaty patch while eating.

Mr A advised me that Dr B informed him that he would have a slight paralysis of his face, and he acknowledged to ACC that "[Dr B] said there would be a slight paralysis which would disappear quickly".

There is no dispute that there was a discussion about Mr A's intended surgery. What is unclear is the breadth and level of detail of that discussion.

My expert advisor stated that "it is common to have numbness particularly to the lower lobe of the ear as a result" of a parotidectomy. He also said that "gustatory sweating will probably occur in between one and five percent of cases but may be transient and not long term".

Dr F, the advisor to ACC, said that "facial nerve paresis after parotidectomy is not rare and most fully recover ... gustatory sweating occurs in up to 60% of cases of parotidectomy". Dr G informed Mr A's solicitors that gustatory sweating is not symptomatic in more than 10% of patients. He also stated that it "probably occurs more than 1% of the time after parotidectomy in most surgeons' hands".

With regard to the extent of Mr A's symptoms, Dr G, who has most recently examined Mr A, said that the severity of pain Mr A has experienced "is extremely uncommon and it is rare for someone to have to lose his occupation as a result of such surgery". Dr G stated that the degree of postoperative problems experienced by Mr A would occur in less than 0.1% of cases. Dr F advised ACC in his second report that "the level of pain and dysfunction related to the auriculotemporal nerve and the temporomandibular joint are significant and of a severity that would occur in less than 1% of parotidectomies".

The comments of Dr F and Dr G are supported by my expert advisor, who said that "the complication of severe pain or parasthesia as a result of nerve damage is ... very uncommon and it is unlikely that the surgeon would dwell on this as the likely outcome of surgery".

In summary, it appears that Mr A could have expected to have some adverse side effects following his surgery, including temporary facial numbness and sweating. Dr B advised me that this is the information that he provided to Mr A. Dr B did not inform Mr A, however, of the possibility of severe, ongoing pain, as “this sort of pain is very rare”.

The significant adverse consequences that Mr A has suffered are rare, affecting fewer than 1 in 1,000 patients undergoing a parotidectomy. Dr B did not anticipate that Mr A would suffer such significant ongoing pain and, given the lack of frequency with which such pain occurs, he did not inform Mr A about the possibility. I doubt that a reasonable patient would expect to receive information about the very unlikely occurrence of such severe pain and its possible impact. Accordingly, in my opinion Dr B did not breach Right 6(1) of the Code.

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## **Other comments**

### *Preoperative testing*

The issue of appropriate preoperative testing has arisen during my investigation. Mr A made his complaint to the Commissioner in September 2000. Some time after, Mr A submitted a claim to ACC seeking a review of the decision declining his claim. In February 2001 Dr G submitted a report to Mr A’s solicitors to support his application for a review of the initial decision by ACC. In his report, Dr G referred to the absence of a fine needle biopsy or CT scan prior to Mr A’s surgery.

My expert advisor has also commented on this issue. He stated in his initial report to me that while neither a fine needle aspiration or CT scan is absolutely necessary, they may certainly influence the surgeon in his approach to the operation. My advisor commented that either or both of these investigations may be undertaken, but that the decision should be considered individually at the time.

Dr B informed me that the reason for his recommending a superficial parotidectomy to Mr A was that there was a palpable tumour in the lower lobe of Mr A’s parotid gland. Dr B’s view was that Mr A had a pleomorphic adenoma. My advisor stated that the most common tumour of the parotid gland is a pleomorphic adenoma and that it accounts for 80% of all parotid tumours. It is a benign tumour and it is normal for this to be excised as there is a risk that pleomorphic adenomas can undergo malignant change.

Performing preoperative tests may not be absolutely necessary. However, fine needle aspirations and CT scans are relatively straightforward procedures. In my view, a prudent doctor would have considered performing such tests even though it was likely that the tumour was benign. As my advisor said, having information that the lump was not a specific parotid tumour “could have caused a change in management with a further period of observation”.

Patients are entitled to an explanation of their condition from their doctor (Right 6(1)(a)). In my opinion, a reasonable patient consulting a surgeon about a lump in his or her neck

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would expect to be told that there are standard diagnostic procedures available to confirm the precise nature of the tumour; that delay in waiting for full information would not be harmful; and that the nature of the tumour could influence the decision whether to operate. Mr A was not given any of this information.

This issue did not form part of Mr A's original complaint to me. I note that Mr A's comment that he would not have consented to surgery had he been informed (if a fine needle biopsy had been performed) that the lump in his neck was benign is one made with hindsight. (Mr A had previously had a lump in his neck removed.) The usual treatment for a pleomorphic adenoma is complete surgical removal.

In my provisional opinion, I stated that I considered that a prudent doctor in Dr B's situation would have ordered appropriate preoperative tests before proceeding to surgery and would have given his patient the information about such tests (along the lines set out in the discussion of Right 6(1)(a) above) as part of an explanation of the patient's condition.

Dr B, in response to my provisional opinion, enclosed references from several surgical textbooks, which he referred to as "three major textbooks". All references stated that a parotidectomy, or surgical removal, of a pleomorphic adenoma of the parotid gland is recommended. The *Oxford Textbook of Surgery* by Morris and Wood states that biopsy by fine needle aspiration may be used to aid in accurate diagnosis. However, the proper approach to "most parotid neoplasms is to perform a parotidectomy". Dr B informed me that the current surgical teaching is that a parotid tumour should be excised together with an adequate margin of normal parotid, which in fact means doing a superficial parotidectomy to avoid damage to the facial nerve.

While a fine needle aspiration may have been appropriate, there is some difference of opinion about whether a CT scan should have been performed. I accept, on the basis of the information provided to me, that preoperative testing may not have been necessary. However, I remain of the view that Mr A should have been told that some surgeons would perform a fine needle aspiration, and should have received an explanation of the nature and reliability of such a test, as part of the explanation of his condition.

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## **Actions**

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be sent to the Royal Australasian College of Surgeons, and placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

## Appendix I – Dr G’s report dated 13 February 2001

Re: [Mr A] (ACC ref no. S1652175/003)

### Background

The facts of this case are well recorded. [Mr A] underwent a superficial parotidectomy on 11 November 1997 for a presumed tumour of the parotid gland. There were no preoperative investigations such as ultrasound or fine needle aspiration and the subsequent pathology showed that there was indeed no tumour present in the gland but merely fatty infiltration, a not uncommon finding in a somewhat diffusely enlarged parotid gland.

The surgeon comments in a hand-written note to [Dr C] that the facial nerve was “on quite a deep plane” and that postoperatively the patient had “the usual facial palsy”. It seems to have been a complete facial palsy which took several months (until 22nd June 1998) to recover.

From the operation note, it would appear that the surgeon encountered difficulty because of bleeding. Despite this, only a small “manovac (*sic*) drain” was inserted. The platysma was closed with a rather large (“2/0 chromic catgut”) suture but no comment was made regarding closure of the Superficial Musculo-Aponeurotic System (“SMAS”) in the region of the parotid gland. The skin was closed with fine (5/0 prolene) sutures. The patient had an episode of severe pain when the sutures were removed on the third postoperative day. This is hard to explain unless a suture was passed through the Great Auricular nerve. Another explanation is that it was the drain rather than sutures that was being removed at that time. This issue should be clarified by a review of the nursing notes from his admission at [the Private Hospital].

### The Issue

The issue is that [Mr A] has on-going pain and discomfort that should not be expected as a result of his surgery.

His current situation is that he is still troubled by persistent pain on the left side of his face, the left temple region and the left side of the neck. From the moment of becoming aware postoperatively, [Mr A] has had severe and unrelenting pain in the left side of his face and neck. Since consulting [Dr E], pain specialist, the severity of the pain has diminished. He has a tightness in his left face and finds clothing such as close collars quite irritating. It is difficult for him to shave and he finds having a haircut quite an ordeal. His pain is aggravated by bending down, lifting or digging, and these activities also lead to dys-equilibrium. Exposure to cold weather causes a severe exacerbation of his pain. He finds that he is generally tired, lacking in energy during the day. This is likely to be a function of a combination of persistent pain and the medication he is on for the pain. He also has troublesome Frey’s syndrome (gustatory sweating) which can

be extremely severe for him; on most occasions it causes him to use a cloth to mop the fluid away. This is embarrassing for him, as well as physically uncomfortable.

### Clinical Assessment

I examined [Mr A] on 1 Feb 2001. I noted that he had tethering of the skin to the temporo-mandibular joint ("TMJ") and the deep tissues posterior to the joint. He was tender over the TMJ. He was also tender on palpation of the muscles of mastication. The stump of the Great Auricular nerve was very sensitive, effectively acting as a trigger point for pain. Other pain was in the distribution of the Auriculo-temporal nerve. He had no discernible facial weakness but on gustatory stimulation with citric acid the presence of Frey's syndrome (gustatory sweating) was confirmed.

### Opinion/Comment

There are several issues that contribute to [Mr A's] current unfortunate situation. These are:

[Mr A] has quite marked gustatory sweating which is a result of severed secretomotor nerves normally serving the salivary gland regrowing and making their way to the surface to stimulate the sweat glands. This phenomenon (Frey's syndrome) is reportedly quite common after parotidectomy. However, it is not symptomatic in more than 10% of patients and for the last 10 years or more it has been known that by preserving and then resuturing the SMAS carefully, the clinical syndrome phenomenon can be avoided in nearly all cases.

There is no doubt that [Mr A] has a very sensitive traumatic neuroma on the stump of the Great Auricular nerve. This is not uncommon when the nerve is transected completely. For the past several years there have been reports on preserving the posterior branch of the Great Auricular nerve and this seems to prevent this phenomenon. Certainly this is my current practice in performing this kind of surgery, but from my early practice experience, a small proportion of people develop amputation neuromas. I have seen patients from other surgeons in whom this has also occurred. Simple excision of the neuroma tends to remove the sensitivity to touch.

[Mr A] has pain in the distribution of the auriculotemporal nerve. This nerve runs very close to the neck of the mandible and while it is at risk in TMJ surgery it is not normally exposed or dissected during a parotidectomy and generally regarded as safe from trauma in that surgery. Branches of the nerve (secreto-motor fibres) supply the parotid gland itself but the occurrence of auriculotemporal pain is extremely rare and probably the result of dissecting in an incorrect plane. Certainly pain of the severity that [Mr A] describes is excessively rare following parotidectomy.

TMJ dysfunction and myofascial pain dysfunction may occur following parotidectomy. This presumably is a result of retraction on the mandible and (rarely) dissection in the vicinity of the joint. In several hundred parotidectomies for benign and malignant tumours or persistent sialadenosis, I have performed, I have had only one case where

significant temporomandibular joint problems persisted postoperatively. This was in a lady with pre-existing TMJ disease. More commonly, muscular dystonia may develop in the muscles of mastication causing myofascial pain dysfunction which does not normally persist and in any event is not normally as severe as that found in [Mr A]. The tethering of the tissues to [Mr A's] joint suggests there has been some dissection in the region of the joint causing unexpected trauma in that area. This probably is a major factor in [Mr A's] myofascial pain dysfunction.

[Mr A] has anaesthesia and sensitivity resulting from the transection of the Great Auricular nerve. The ACC's advisor, Mr [Dr F], has focused on this. Indeed, about 15% of patients have clinically significant complaints related to pain or discomfort following parotidectomy, mostly from a transection of the Great Auricular nerve. (Faber and Pedersen, *Ugeskriftfor Laeger*, 1996; 158:270-273). Preservation of the posterior branch of the Great Auricular nerve will prevent this occurrence in most cases. Even when the nerve is transected, a high proportion of people have good recovery of sensation to the cheek and pinna. (Porter et al, *Clin Otolaryngo*, 1997). In my personal series of patients, I find that a degree of hyperaesthesia is quite common in the distribution of the nerves of the cervical plexus (including the Great Auricular nerve). This diminishes with time and after 12 months is usually trivial or absent.

#### Conclusion:

I agree that, while the degree of gustatory sweating is quite pronounced, it probably occurs more than 1% of the time after parotidectomy in most surgeons' hands. Moreover, the amputation neuroma on the Great Auricular nerve is not uncommon and can be treated. However, it is my opinion that the other problems experienced by [Mr A] are both unusual in extent (auriculotemporal nerve and TMJ) and severity. The severity of pain that [Mr A] has experienced overall is extremely uncommon and it is rare for someone to have to lose his occupation as a result of such surgery. I do not ascribe [Mr A's] response to a mere "subjective" response as suggested by [Dr F], who I note has not seen the patient. The response [Mr A] has had to [Dr E's] treatment is gratifying but it occurred after [Mr A] was forced to give up his job. It could therefore be argued that [Mr A] should have received this sort of management at a much earlier stage.

[Mr A's] prognosis is dependent on further intervention:

Surgical resection of the Great Auricular nerve amputation neuroma would be helpful but it is unlikely to deal satisfactorily with his overall pain. This is because of temporomandibular joint dysfunction, and pain originating from the Auriculo-temporal nerve.

I do not know if further surgery in the region of the Auriculo-temporal nerve would have any beneficial effect. However, if nothing further is done his pain and discomfort from that region will persist indefinitely, as will his need for medication. An oral surgeon's opinion should be sought in this regard.



The gustatory sweating, while a relatively common phenomenon in many series, can be avoided by careful closure of the SMAS. Having developed, it can be managed by a programme of Botox injection. [Mr A] should be offered this opportunity of managing this troublesome and distressing symptom.

## Appendix II – Dr G’s report dated 1 March 2001

I would like to add the following as a supplement to clarify points in my earlier report (dated 3 February 2001) regarding the specific eligibility of [Mr A] for Medical Misadventure.

1. Medical Error I think there is an issue in respect of the absence of significant pathology in the surgical specimen. It is apparent that the general practitioner, the patient and the surgeon all thought that there was a tumour in the parotid gland. (As indeed did the ACC’s independent assessor.) Normally an attempt is made to confirm the presence and nature of such a tumour prior to proceeding with definitive treatment (i.e. parotid surgery). There is no sign that [Dr B] conducted either a fine needle aspiration (FNA) of the parotid gland or requested any form of organ imaging before surgery. Either an ultrasound or a CT scan is appropriate. Rarely a sialogram may be indicated. If an FNA or ultrasound had been done the patient may well have been spared the surgery. This is an issue that needs to be addressed and explained. There may be good reasons why [Dr B] felt that such investigations were not appropriate or not necessary.
2. Medical Mishap In my conclusion I state that not only the pain and discomfort associated with trauma to the auriculo-temporal nerve and temporo-mandibular joint, but also the myofascial pain dysfunction symptoms are so severe and so uncommon as to qualify for medical misadventure. These phenomena occur less than 1% of the time after parotidectomy. In the present situation – where there was no tumour mass to take into consideration when removing the superficial lobe of the parotid gland – it is even more unlikely that [Mr A] should have such severe postoperative problems with nerve and tissue damage. In such circumstances these events should occur less than 0.1% of the time.

Any further comments regarding the events in hospital would be subject to my review of the hospital records.

Appendix III

