Intraparotid Aneurysm of the Posterior Communicating Vein

Aneurisma intraparotídeo de vena comunicante posterior

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We present the case of a 76-year old woman with an apparently cystic, fluctuating, right parotid tumour. It changed size according to head position, had an elastic consistency, was painless and without infiltration or fistulisation to a cutaneous plane. Its evolution was unknown (Fig. 1). It presented symptoms of sialolithiasis. Facial examination was normal. The MRI study reported a "well-defined nodular lesion, consistent with pleomorphic adenoma or Warthin’s tumour", with intralesional calcifications (Fig. 2).

The ultrasound and Doppler studies noted a "homogeneous, central, cystic image 37 x 17 mm in size, although not..."
entirely anechoic. Moderate pulse transmitted from normal vessels’. The hypoechoic image was attributed to sialolithiasis although cystic tumour was not ruled out. We performed extrafacial parotidectomy with a Harmonic Ultracision scalpel, observing a venous vascular tumour dependent on the posterior facial vein or temporomaxillary vein, medial and deep to the mandibular and middle branches of the facial nerve. It elongated and displaced them, but was not adhered to them and did not infiltrate them (Fig. 3). The tumoural nerve was dissected and removed as a single block, together with the deep sialolithiasis lobe. Previously, the ends of the vein of origin were ligated and the aneurysm was emptied, in order to prevent haemorrhage or facial nerve lesion during haemostasis.

In light of the cystic tumour diagnosis, and especially in the absence of a solid component, we reconsidered the radiological diagnosis of Warthin’s tumour and suspected arterial aneurysm (pulsating or not) or venous aneurysm. Vessel dissection was an option, but given the fragility of its walls, we opted for resection as a single block with the adjacent, glandular, sialolithiasis tissue, in order to prevent sialoceles or lithiasis, and also to avoid haemorrhage or lesions to the facial nerve.