

Table 1
Patients' details.

Variable	Patient 1	Patient 2
Age (years)	34	28
Sex	Female	Male
Initial symptoms	Vertigo and headache	Incidental finding during examination of a lingual lesion
Surgical approach	Earlobe and retrotragus extension	Earlobe
Tumour side and size (mm)	Right: 50 × 40 × 30	Left: 45 × 35 × 27
Duration of operation (minutes)	190	95
Volume of drainage (ml)	< 100	< 100
Duration of hospital stay (days)	2	2
Postoperative complications	None	None
Follow up (years)	4	1
Relapse	No	No

culoaponeurotic system flap repositioned, and the wound sutured in two layers.

The patients' characteristics at baseline, surgical observations, and postoperative outcomes are shown in Table 1. Postoperatively, neither patient had infection in their wounds, necrosis of the flaps, haematoma, permanent facial nerve palsy, hypertrophic scarring, or first bite or Frey syndromes.

We evaluated the subjective satisfaction of the surgeon and patients with the aesthetic outcome at 6 and 12 months of follow-up using a 0–10 visual analogue scale (0 = complete dissatisfaction, 10 = maximum satisfaction), and all scored 10.

Excellent aesthetic outcomes can therefore be achieved because: the minimally-invasive incision avoids necrosis of the flap and reduces unsightly scars; hiding the incision in a natural skin crease and behind the earlobe or the tragus affords an invisible scar; and the operative site can be prevented from sinking by means of a superficial musculoaponeurotic system flap and normal preservation of the parotid tissue.² Such a minimally-invasive approach requires a certain learning curve, however, and our team has had over 10 years of experience with the technique.¹ On the other hand, the transparotid route allows constant control of the facial nerve.

In oncological terms, an accurate preoperative diagnosis is essential to establish the appropriate approach (more, or less, aggressive), and clear resection margins are crucial to avoid relapse, regardless of the method of resection (enucleation, extracapsular dissection, or partial, total, or radical parotidectomy).^{3–5}

In conclusion, our results suggest that the minimally-invasive resection of benign tumours of the parotid gland in the parapharyngeal space affords satisfactory results, without unsightly scars or increased relapse.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Ethics approval not required. Patients' permission was obtained.

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Video-recording using smartphones during surgical procedures in outpatients

Sir,

Photography is an essential technique to record clinical practice in modern dental aesthetics. In particular, it can be used on patients having oral and maxillofacial surgery to obtain high-quality images before, during, and after oper-

ation. The images can be available for surgeons to reflect on themselves, develop their surgical skills, facilitate their communication with patients, and improve the patient's knowledge. Currently, a number of designs and equipment are available for surgical photography and video, but they are, unfortunately, expensive.^{1–3} By contrast, smartphones are prevalent in today's society, and they can be used to take high-quality pictures. Accordingly, we have developed a simple method using a smartphone to produce high-quality images of outpatients in oral and maxillofacial surgery.

Conventionally, four photographic techniques are used to record the process of oral and maxillofacial surgery. First, the camera can be held by a photographer, but this often causes a problem related to the field of view. The surgeon must work in coordination with the photographer to ensure the optimal angle and frame, but the surgical process may be interfered with, there may be problems with blurred images, and the disinfection of the operating room may be compromised. Secondly, the camera can be installed on the wall with a camera-support arm. This avoids problems resulting from the manual control of the camera, but the camera-support arm and dental operation lamp may block the view. Thirdly, the camera can be installed on the ring-shaped dental operation lamp, which is less likely to be obstructed by the surgeon. Fourthly, the surgeon can wear a head-mounted camera.¹ The movement of the surgeon's head may, however, result in camera shake. Also, outpatient clinics generally do not have ring-shaped dental operation lamps in their surgical theatres, and the price for installing such lamps and the additional photography equipment is extremely high.

By comparison, almost all people have one or more smartphones, as they have become an indispensable product in today's society. They are typically equipped with a powerful operating system, a high-resolution camera with flash, and a media player. Extra mobile applications can be installed to save and play pictures and videos, and by connecting to the internet, smartphones can also enable high-speed transmission of data and access to the cloud.

We used a smartphone to film surgical procedures in an outpatient clinic. A smartphone holder was first fixed on to the instrument tray of the dental chair, and we adjusted it to have the optimal camera angle (Fig. 1). The camera was zoomed in and focused on the patient's oral cavity to capture clear images of adequate size, and we made sure that it did not interfere with the light from the operation lamp that was installed on the dental chair (Fig. 2).

When necessary, the flash on the smartphone can be switched on to increase illumination and therefore the clarity of the image. Smartphone holders are relatively cheap, there are many different types available, and their installation and removal are both quick and easy.

Conflict of interest

We have no conflicts of interest.



Fig. 1. A smartphone holder fixed on the tray of the dental chair in a location suitable for filming that would not obstruct the light from the dental lamp.

Ethics statement/confirmation of patients' permission

None necessary.

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Fig. 2. The front-facing camera allows the surgeon to clearly see the area being filmed and does not interfere with the surgical process.

Oral mucosal desquamation induced by sodium lauryl sulphate

Sir,

We describe a 49-year-old white woman who presented to the oral diagnosis clinic with a 10-year history of asymptomatic desquamation of the oral mucosa. Her medical history showed Hashimoto's thyroiditis that had been treated with 50 mg of levothyroxine sodium daily for 20 years. No history of allergy or local trauma was reported. Intraoral examination showed greyish-white strips coming off the buccal mucosa. These layers came off spontaneously, or could be peeled off easily, leaving beneath a clinically normal mucosa with no erosion (Fig. 1).

Exfoliative cytology showed a group of epithelial cells and bacterial colonies, but no hyphae or yeast-like structures.



Fig. 1. Grey-white strips sloughing from the left buccal mucosa.



Fig. 2. Complete resolution of the peeling after oral hygiene products containing sodium lauryl sulphate was stopped.

In the absence of any other sign, we made the diagnosis of desquamation of the oral mucosa. We instructed the patient to use toothpaste and mouthwash that did not contain sodium lauryl sulphate, and after two days without it, the peeling stopped (Fig. 2). To confirm that the desquamation had been caused by the products, we asked her to use them again, and the symptoms recurred. The final diagnosis was therefore oral desquamation caused by toothpaste and mouthwash containing sodium lauryl sulphate. There was complete resolution of the peeling 2 days after discontinuation.

This condition is characterised by partial loss of the integrity of the oral epithelium, and may be caused by certain oral hygiene products, although in some cases it seems to be idiopathic.¹ Different terms have been used for it, including oral peeling, oral epitheliolysis, and shedding of the oral mucosa, but the term oral mucosal desquamation induced by oral care products seems to be the most commonly used