National Institute for Health and Clinical Excellence

354 – Therapeutic sialendoscopy

Comments table

IPAC date: Thursday 15th March 2007

Consultee name and organisation	Sect. no.	Cmt no.	Comments	Response Please respond to all comments
Individual consultee – clinician	**1**	1	1. With respect, this review has missed the point. To some extent it is similar to the arrival of a new car on the market and you reviewing the new weels on the vehicle rather than the object as a whole. Sialoendoscopy has limited application on its own but has a significant contribution to make when used in conjunction with other techniques for the treatment of obstructive salivary gland disease. It has not found a role in diagnosis of salivary conditions as yet and has no application in the management of salivary timours. So you need to consider it as part of a package! I know all the individuals you have contacted and I do not believe any of them have used a salivary endoscope in their clinical practice. If you want practical advice from people using endoscopes in their day to day practice then may I suggest you contact Prof [X] and Prof [X] in [X], Dr [X] in [X], Dr [X] in [X] and Dr [X] in [X]. In England only Mr [X] in [X] and us in [X] are using the endoscopes regularly.	The procedure was notified to NICE as Sialendoscopy alone. The Specialist Advisors were nominated by Specialist Societies as people who had sufficient knowledge to comment on this procedure

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Individual consultee – clinician	**1**	2	1. Scientific evidence indicates that there is the potential for a functional recovery of the glandular parenchyma. Sialendoscopy favours glandular preservation rather than excision	Noted, thank you.
Individual consultee – clinician	**2.1**	3	2.1 At present the majority of stones and strictures in the middle and proximal duct are treated by gland excision.	Section 2.1.3 states that “removal of the affected salivary gland may be required for large or less accessible stones and also for salivary tumours”.
Individual consultee – clinician	**2.1.1**	4	2.1.1 also for mucous plugs, polyps and small stones missed on USS or conventional sialography	The Committee considered this comment but decided not to change the guidance.
Individual consultee – clinician	**2.1.2**	5	2.1.2 classical symptoms are peri-prandialmealtime syndrome (swelling followed by discomfort). Dry mouth v unusual as there are 5 other major functioning glands.	The Committee removed “dry mouth” from Section 2.1.2.
Individual consultee – clinician	**2.1.3**	6	2.1.3 Stones ,6mm in diameter can be removed by basket sialendoscopy, larger ones by open surgery. The potential problem is that the fragile basket may become caught in the duct. The bigger the stone, the easier the surgery, provided the stone is not within the glandular parenchyma.	There were insufficient data to report on case selection by size
Individual consultee – clinician	**2.2**	7	2.2 There are technical issues that impact in the introduction of the endoscopes and there are criteria we use to select stones suitable for basket retrieval.	This is covered in Section 2.1.3.
Individual consultee – clinician	**2.2**	8	2.2 A retropapillary incision may be utilised to improve access for instrumentation of submandibular ductal obstructions, which permits preservation of the natural ostium. Parotid ducts are more difficult to navigate due to their sigmoid course. Submandibular ducts are more or less straight. Alternatively, endoscopic location of stones allows a smaller cutaneous incision in parotid obstruction in a combined approach. Placement of a post-operative stent postoperatively for up to 28 days may maintain ductal patentcy.	The Committee added: “A stent may sometimes be left in the duct postoperatively” to the end of Section 2.2.1.

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Individual consultee – clinician	**2.3**	9	2.3 It is very difficult to establish the efficiency of endoscopy when taken in isolation for the authors are not usually applying the technique in its appropriate situation, complimented with other techniques. We have just submitted a paper dealing with 5,000 stones treated by combination therapy and this article gives a better idea of the place of endoscopy in the over all mangement of salivary calculi.	This guidance does not cover combination therapy. The Committee will consider unpublished data only in very exceptional circumstances.
Individual consultee – clinician	**2.3**	10	2.3 There is a steep learning curve, which may affect the outcome percentages in studies based upon small numbers.	The Committee considered this comment but decided not to change the guidance.
Individual consultee – clinician	**2.4**	11	2.4 No, the real complications are infection, particularly in a chronically infected gland. Perforation is uncommon and inconsequential. We have never had ranulas or a lingual nerve injury as a result of endoscopy. Wire baskets don't break, the risk is securing a stone within the basket and then finding it impossible to retrieve the stone with the result that the wire is locked in the duct an cant be released!	Infection is included in section 2.4 These were potential complications listed by Specialist Advisors
Individual consultee – clinician	**2.4**	12	2.4 Complications related to personal experience and perforations more likely with more kinky duct systems.	Noted, thank you.
Insurer	**General**	13	Agree that this is safe and efficacious. No other comments.	Noted, thank you.