

methods of reconstructive surgery (both hard and soft tissues). Adding to the misery, the medical specialties of plastic surgery and otolaryngology also (mis)treat disorders in the realm of the maxillofacial surgeon, due to the anatomical overlap between specialties.

The final controversy is in the minds of referring colleagues, in terms of whom to approach for the management of a maxillofacial problem.

The young graduate who undergoes training tries to follow the type of training he has undergone. Will the International Association of Oral and Maxillofacial Surgeons take the lead and issue evidence-based treatment protocols which can be followed by all, so that patients may benefit?

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#### BERNARD-HORNER'S SYNDROME: UNUSUAL COMPLICATION AFTER NECK DISSECTION

*To the Editor:*—A 69-year-old man referred to our department for a squamous cell carcinoma of right anterior tonsillar pillar associated with cervical lymph node metastases located in the supraretrospinal nodal group (sublevel IIB) of the neck (cT2N2bM0) (Figs 1A-C). The patient submitted to a surgical intervention consisting of a radical neck dissection (RND) associated with “en bloc” tumor removal.

Although the patient's postoperative course was uncomplicated, we noticed slight blepharoptosis, enophthalmos, and miosis of the right eye, typical features of Bernard-Horner's syndrome (Fig 2A).

Bernard-Horner's syndrome or oculosympathetic palsy is a clinical syndrome caused by damage to the sympathetic nervous system. Although most causes are relatively benign, Bernard-Horner's syndrome may reflect serious pathology in the neck or chest (such as a Pancoast tumor or thyrocervical venous dilatation). In the presented case, the damage concerned the cervical sympathetic nerve trunk, which lies deeply posterior to the carotid sheath and anterior to the transverse processes of the cervical vertebrae. The trunk was damaged during the RND, when a plane of dissection deeper than the carotid artery was entered inadvertently. After radiotherapy, the syndrome persisted but the patient did not require any further ophthalmic care (Fig 2B).

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**FIGURE 1.** A, Preoperative view of the patient. B, Squamous cell carcinoma of right anterior tonsillar pillar. C, A Tc scan with contrast medium reveals lymph node metastases located in the supraretrospinal nodal group (sublevel IIB) of the neck.



**FIGURE 2.** A, Postoperative view of the patient characterized by blepharoptosis, enophthalmos, and miosis of the right eye, typical features of Bernard-Horner's syndrome. B, Patient after radiotherapy: clinical features of the syndrome persist.