2.4 Selective Neck Dissection in the Treatment of the N+ Neck in Cancers of the Oral Cavity

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We review our experience and the recent literature to delineate the role of SND in the management of the N+ neck in patients with cancers of the oral cavity.

Practical Tips
1. A clinically ‘positive’ node does not always contain metastatic tumor. In a cohort of 164 patients with COC and clinically N1 neck disease involving levels I or II, Kowalski and Carvalho [5] found that these nodes were histopathologically negative (pN0) in 57.4% of the cases.
2. An SND in an N+ case should include at least levels I, II, and III. The overall prevalence of metastases in level IV in clinically N+ cases is about 10% [11]. However, in a recent study by Lodder et al. [12], pathologically positive nodes in level IV were found in only 2% of patients staged N0 or N1 and in 20% of cases staged as N2, suggesting that it may be a safer practice to include level IV whenever an SND is done in patients with COC with a N+ neck and in particular in the presence of N2 neck disease. Extending the dissection does carry a higher risk of development of a chyle fistula, demonstrated in the report from de Gier et al. [13] with an incidence of 0/60 SND, 3/104 modified radical neck dissections, and 6/85 radical neck dissections. This risk should be included in the informed consent discussion.
3. It is now clear that the prevalence of LNM in level V is so low (0.5% in cN0 and 3% in cN+) that...
dissection of this region of the neck is rarely necessary [11].

PORDT is beneficial in terms of locoregional control of tumor in pN+ patients, particularly in cases with adverse prognostic factors such as multiple metastatic lymph nodes or extracapsular spread [5]. Furthermore, when SND is used in combination with PORDT, survival and recurrence results are comparable to those obtained with comprehensive neck dissections [2].

Results
We analyzed our results in a cohort of 22 consecutive patients with COC who had limited pN+ (13 pN1, 1 pN2a, and 8 pN2) confined to levels I and II, and underwent an SND. The primary tumor was in the oral tongue in 7 patients, the lower lip in 6, the floor of the mouth in 4, the alveolar ridge in 2, the retromolar trigone in 2, and the buccal mucosa in 1 patient. In the majority of patients (72.7%) the dissection included levels I–III (11/50%) or levels I–IV (5/22.7%). Six patients had received radiation to the neck previously and 8 patients received PORDT. With a mean follow-up of 28 months, a recurrence in the neck occurred in 3 patients (13.6%), all of whom had received PORDT. In a previous review we encountered a similar neck recurrence rate of 12.5% in 53 patients with pathological N+ disease undergoing SND and radiotherapy. Ambrosch et al. [1] reported a recurrence in the dissected neck in 6.6% of patients with pN+ necks. The same group reported their results with therapeutic SND. The 3-year regional recurrence rate was 4.9% among pN1 cases and 12.1% among pN2 cases [9]. In a recent study of 156 patients with clinically N+ neck, the regional control rate was 96% for the 69 patients who underwent SND (the majority of whom received PORDT) and 86% for those undergoing comprehensive neck dissection [14]. Others have reported similar results [15]. Not surprisingly, 3- and 5-year survival rates have been reported to be significantly better in patients with N1 + N2a disease and in patients without extracapsular spread of tumor [16].

Conclusion
This review and other investigations reported in the literature suggest that SND has a role in the management of patients with COC who have clinically positive LNM in level I or II, particularly when appropriately combined with PORDT.

References