Secondary carcinoma

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Metastatic spread of squamous cell carcinoma to the cervical lymph nodes is a common occurrence from head and neck primary cancers; occasionally , this may be the sole presenting feature of the disease (Figure 52.70). The upper aerodiges - tive tract mucosa must be carefully examined for a primary site before considering surgery to the neck nodes. When a primary site is not seen on clinical examination, they are most often found in the orophar ynx. Appropriate radiological investigations (MRI, PET-CT) must be undertaken to define subclinical primaries, as management will be dictated by this. If radiological assessment shows no primaries, tonsillectomy and robot-assisted tongue base mucosectomy are performed as a diagnostic procedure because the oropharynx is the most common site for a clinically and radiologically unknown primary cancer. Management The management of malignant cervical lymph nodes depends on the overall treatment regime: /uni25CF if surgery is being used to treat the primary disease and the cervical nodes are palpable and <3 /uni00A0 cm, they may be excised with the primary lesion as part of a neck dissection; /uni25CF if radiotherapy or chemoradiotherapy is used initially with resolution of the primary tumour, but there is subsequent residual or recurrent nodal disease, then this situation will require cervical lymph node dissection. Type of neck dissection Classical radical neck dissection (Crile) The classic operation involves resection of the cervical lymph nodes (levels I–V) and those structures closely associated: the internal jugular vein, the accessory nerve, the submandibular gland and the sternocleidomastoid muscle. These structures are all removed en bloc and in continuity with the primary disease if possible. The main disability that follows the operation is weakness and drooping of the shoulder due to paralysis of the trapezius muscle as a consequence of excision of the accessory nerve. Bulky nodal disease may dictate the need for a radical neck dissection, but this operation is less commonly performed owing to a better understanding of the lymphatic drainage of George Washington Crile , 1864–1943, Professor of Surgery , The Western Reserve University , and one of the founders of the Cleveland Clinic, Cleveland, OH, USA. the primary sites and as most patients with advanced disease need adjuvant radiation. Modified radical neck dissection This term denotes a procedure in which one or more of the non-lymphatic structures are preserved (the accessory nerve, the sternocleidomastoid muscle or the internal jugular vein) with clearance of all nodal levels (I–V). Selective neck dissection In this type of dissection, one or more of the major lymph node groups is preserved along with the sternocleidomastoid muscle, accessory nerve and internal jugular vein. In these circumstances, the exact groups of nodes excised must be documented. It must be noted that, when neck dissections are performed for residual disease after (chemo)radiation therapy , the neck is often fibrotic and scarred and the opera tion may not fall into any of the above categories. For instance, lymph nodes in levels II and III may be removed, along with the sternomastoid mus - cle for access; thus, meticulous annotation of the procedure is more important than ascribing a name to the operation.

Figure 52.69 Magnetic resonance imaging scan demonstrating a large parapharyngeal tumour. The imaging characteristics of the tumour suggested a paraganglioma or a schwannoma. Resection con

/f_i rmed the latter. Figure 52.70 Axial computed tomography scan demonstrating a large cystic metastatic node from an unknown primary. Core biopsy con /f_i rmed a squamous cell cancer.

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