

# Second salvage surgery with extended vertical lower trapezius island myocutaneous flap reconstruction for advanced re-recurrent oral and oropharyngeal squamous cell carcinoma

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**Abstract.** The purpose of this study was to evaluate the outcomes of second salvage surgery with extended vertical lower trapezius island myocutaneous flap (TIMF) reconstruction for patients with re-recurrent oral cavity and oropharyngeal squamous cell carcinoma (SCC). The subjects were 23 patients with advanced re-recurrent oral and oropharyngeal SCC undergoing second salvage surgery and reconstruction with a TIMF. A TIMF with a skin paddle measuring 6 cm × 7 cm to 10 cm × 22 cm was used to reconstruct the major defects. Three patients experienced minor complications: minor flap failure ( $n = 1$ ), wound dehiscence at the donor site ( $n = 1$ ), and an orocutaneous fistula ( $n = 1$ ). The patients were followed for 3–72 months. Fifteen patients were alive with no evidence of disease, two were alive with disease, and six died of local recurrence or distant metastases. Second salvage surgery remains an effective treatment modality for select patients with advanced re-recurrent oral and oropharyngeal SCCs, and the extended vertical lower TIMF is a large, simple, and reliable flap for reconstructing the major defect following second salvage surgery.

**Key words:** salvage surgery; oral cavity; oropharynx; squamous cell carcinoma; recurrences; trapezius flap.

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Locoregional recurrences are the most frequent cause of treatment failure in patients with squamous cell carcinoma (SCC) of the oral cavity and oropharynx. Salvage surgery remains the only curative treatment option for patients with

failure after primary radiation and/or surgery. Unfortunately, 39.7–54.9% of patients who undergo salvage surgery

will develop further locoregional recurrence.<sup>1,2</sup>

Second salvage surgery can be considered a potentially curative therapeutic approach for a select group of patients with re-recurrent oral SCC.<sup>3</sup> In these cases, following wide resection of the tumours where the major defects were present, reconstructing the inevitable defect is challenging. We have previously reported the use of the extended vertical lower trapezius island myocutaneous flap (TIMF) in the reconstruction of large defects following salvage surgery for patients with recurrent head and neck SCC, and consider it to be a large, simple, and reliable flap.<sup>4,5</sup> The purpose of this study was to review the functional and survival outcomes of second salvage surgeries with an extended vertical lower TIMF, including a folded pattern reconstruction, for advanced re-recurrent oral cavity and oropharyngeal SCC.

### Patients and methods

The subjects were 23 patients with advanced re-recurrent oral and oropharyngeal SCC who underwent second salvage surgeries and reconstruction with an extended lower vertical TIMF between January 2008 and October 2012. The institutional review board approved the study. There were 17 males and six females; their ages ranged from 16 to 85 years (median 59.9 years). The site of the primary tumour was the oral cavity (buccal mucosa, tongue, floor of mouth, palate, gingiva) in 19 patients (82.6%) and the oropharynx (base of tongue, soft palate, retromolar trigone) in four (17.4%). The clinical staging of re-recurrence (rCS) was classified as advanced rCS III in two patients (8.7%) and rCS IV in 21 patients (91.3%). As the initial treatment, 15 patients were treated with surgery, including ipsilateral radical neck dissection (nine cases) and reconstruction with a pectoralis major myocutaneous flap (three cases) or forearm free flap (two cases), four patients underwent radiotherapy alone, and four patients underwent surgery and adjuvant radiotherapy. As first salvage treatment, 11 patients were treated with salvage surgery including ipsilateral radical neck dissection (four cases) and reconstruction with a pectoralis major myocutaneous flap (two cases) or submental flap (one case), 10 patients underwent radiotherapy, and two underwent surgery and adjuvant radiotherapy (Table 1).

These patients were in generally good health and had resectable tumours, based on clinical examinations, computed



*Fig. 1.* A 69-year-old male presented with advanced re-recurrent squamous cell carcinoma of the right hard palate, rCS IV. He presented with a major tumour mass of 10 cm × 20 cm, invading the orbital region and skull base (patient 10).

tomography (CT) scans, nuclear magnetic resonance imaging, and/or positron emission tomography (PET)-CT. The time interval between the first salvage surgery and the date of the second recurrence in the 23 patients with advanced re-recurrent oral and oropharyngeal SCC ranged from 3 to 13 months (median 6.5 months). All patients had locoregional re-recurrence without distant metastasis and accepted a second salvage surgery (Fig. 1). In total, 21 patients underwent wide resection of

the tumour with mandibulotomy ( $n = 20$ ), maxillotomy ( $n = 6$ ), total glossectomy ( $n = 7$ ), hemiglossectomy ( $n = 2$ ), ipsilateral radical neck dissection ( $n = 8$ ), contralateral radical neck dissection ( $n = 6$ ), or bilateral radical neck dissection ( $n = 2$ ). A craniofacial resection (Figs. 2 and 3) with ipsilateral radical neck dissection ( $n = 2$ ) or mandibulotomy ( $n = 1$ ) was performed for two patients (Table 1).

Frozen-section assessment of the surgical margin should be used routinely in



*Fig. 2.* The incision line outline for wide excision of the tumour.

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