

Cutaneous Malignancy of the Head and Neck



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KEYWORDS

- Head and neck • Nonmelanoma skin cancer • Melanoma
- Squamous cell carcinoma (SCC) • Basal cell carcinoma (BCC)
- Wide local excision (WLE) • Sentinel lymph node biopsy • Radiation therapy

KEY POINTS

- Nonmelanoma skin cancer (NMSC) is the most common malignancy in the United States, and surgical resection is curative in 95% of patients when treated early.
- Understanding the complex anatomy and lymphatic drainage patterns when managing melanoma is key because involvement of the regional nodes has the strongest impact on survival.
- Advanced and aggressive tumors merit comprehensive physical examination, radiographic and histopathology evaluation, and treatment by a multidisciplinary team of cutaneous oncology experts.
- Surgical resection with clear margins is essential for the oncologic control of disease.
- Advanced and aggressive lesions demand multimodality treatment entailing surgical resection, staging of the regional lymph node basins, and adjuvant radiation therapy to maximize locoregional control.

INTRODUCTION

Cutaneous malignancy represents a worldwide public health problem, with a rapidly rising incidence, decreasing age at presentation, and significant health care costs.^{1–6} Head and neck skin cancers encompass a broad range of histologies, the most commonly encountered entities being basal cell carcinoma (BCC), squamous cell carcinoma (SCC), and melanoma. Many health care providers diagnose and treat skin cancer, from providers at rural primary care clinics to those at urban dermatologic surgery practices and large tertiary care head and neck cancer centers. Some of these tumors prove to be diagnostic and treatment challenges, with associated increased morbidity and mortality.⁷

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Most cutaneous malignancies, BCCs, and SCCs can effectively be treated through a variety of means when diagnosed early enough. Some NMSCs and melanoma spread to regional lymph nodes, can be aggressive, and recur locally. Aggressive and more advanced lesions demand multimodality treatment entailing surgical resection, staging of the regional lymph node basins, and radiation therapy, as the survival from aggressive disease remains poor because of locoregional recurrences and distant metastasis. Potentially advanced and aggressive tumors merit more comprehensive evaluation and treatment by a multidisciplinary team of experts in cutaneous oncology. This article reviews the management of skin cancer of the head and neck, including BCC, SCC, and melanoma.

EPIDEMIOLOGY

Cutaneous BCC and SCC are the most commonly diagnosed NMSCs in the United States and account for over 1 million new cancers annually.^{1,3,5,6,8,9} Approximately 70% to 80% of all skin malignancies are BCCs, whereas 15% are SCCs. The remaining 5% are primarily melanoma and other uncommon entities, particularly adnexal tumors and Merkel cell carcinomas.^{1,8,9} The clinical behavior of BCC is distinct from that of SCC. BCC is locally aggressive with a low propensity for metastasis; SCC may display aggressive biological behavior, characterized by perineural invasion and potential for regional metastasis.^{8,9}

Although melanoma represents less than 5% of the cases, it is responsible for more than 75% of skin-cancer-related deaths.³ In the United States, each year about 70,200 patients are diagnosed with melanoma and 8800 die of this disease. The incidence of melanoma has risen dramatically over the past several decades, with an increase of greater than 200% in the age-adjusted incidence from 1975 to 2008.¹⁰⁻¹⁵ This increase is manifested across all age groups and primary tumor thicknesses. The mortality rate has also increased approximately 60% over time, primarily because of increased mortality in patients aged 65 years or older, particularly among men.^{10,14,15} However, many patients who die of melanoma are young and healthy, so melanoma is among the cancers with the highest life years lost per fatality.^{16,17}

RISK FACTORS

Sun exposure is the single greatest risk factor for the development of NMSC. Both the duration and intensity of UV radiation (UVR) exposure, primarily UV-A (320–400 nm) and UV-B (290–320 nm) radiations, contribute to DNA damage at the cellular level of the epidermis.^{8,9,18,19} Thus, these cancers usually arise in sun-exposed areas and progress from premalignant actinic lesions to invasive carcinomas. Similarly, individuals with a history of facial or neck irradiation are at an increased risk for the development of skin cancer.^{8,9,20}

For melanoma, there is also strong evidence that increased exposure to UVR plays a role.^{6,21} Multiple studies support a causative role for UVR in cutaneous melanoma.¹⁰ A history of sunburns from natural UVR and the use of tanning beds (artificial UVR) are risk factors for melanoma. Public surveys have reported increasing prevalence of both behaviors among US adults.²² Intermittent sun damage/exposure has consistently been identified as a risk factor, whereas some studies suggest that long-term sun exposure is associated with a decrease in the risk of melanoma.²³ Other risk factors for cutaneous melanoma include a family history of the disease, multiple nevi, dysplastic nevi, freckled or fair skin, blue or green eyes, and red hair.^{22,24}

It is increasingly recognized that patients who have undergone organ transplant have a 30-fold increased risk of developing cutaneous SCC and 10-fold increased risk of

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