



Review

Is neck dissection needed in squamous-cell carcinoma of the maxillary gingiva, alveolus, and hard palate? A multicentre Italian study of 65 cases and literature review

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SUMMARY

The occurrence of occult cervical metastases due to squamous-cell carcinoma of the hard palate and maxillary alveolar ridge has not been studied systematically. We have observed that many patients return with a delayed cervical metastasis following resection of a primary cancer at these sites. Some of these patients have died as a result of a regional or distant metastasis, despite control of the primary cancer. The literature contains few recommendations to guide the treatment of maxillary squamous-cell carcinoma; prospective studies are difficult due to the rarity of such tumours. The aim of this study is to define the incidence of cervical metastasis and to investigate whether elective neck dissection is justified.

We present a retrospective multicentre study of 65 patients with squamous-cell carcinomas of the maxillary alveolar ridge and hard palate and review of the existing literature.

The overall incidence of cervical metastases was 21%. We evaluated the significance of primary-site tumours as indicator of regional disease.

The maxillary squamous-cell carcinoma cases in our multicentre study and in the literature review exhibited aggressive regional metastatic behaviour, comparable with that of carcinomas of the tongue, mouth floor, and mandibular gingiva. Based on our findings, we recommend selective neck dissection in clinically negative necks as a primary management strategy for patients with maxillary squamous-cell carcinomas involving the palate, maxillary gingiva, or maxillary alveolus.

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Introduction

The involvement of regional lymph nodes in head and neck cancers depends on various factors, including site, size, depth, and other histological features of the primary tumour.¹ Elective treatment of the cervical nodes is widely accepted in such patients when the risk of occult metastases exceeds 15–20%.^{2–5} Many stud-

ies have evaluated the need for elective neck dissection at common sites of oral primary tumours in patients with no sign of metastasis in the neck. In a randomised prospective study, Kligerman et al.⁶ found significantly improved survival rates after selective neck dissection in the management of clinically negative neck in patients with stage 1 oral SCC of the tongue. The current management of patients with palatal, maxillary gingival, or maxillary alveolar SCC in the absence of palpable or radiographically suspicious lymph nodes, is usually to ‘watch and wait’, based on the low risk of occult cervical metastases. This regional subset of oral SCCs occurs more rarely than other oral cancer locations and we lack prospective, evidence-based studies.

Some recent studies have recommended elective neck dissection for patients with SCC of the hard palate and alveolar ridge with NO neck.^{7–14} In this retrospective study, we defined the risk of cervical metastasis in patients with palatal SCCs and make recommendations for treatment based on that risk.

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Patients and methods

A retrospective multicentre study included patients treated for maxillary SCC from 2000 to 2010 at four Italian Maxillofacial Surgery Departments (Istituto Ortopedico Galeazzi, Milano; Azienda

Ospedaliero-Universitaria of Parma, Parma; Policlinico Umberto I, Roma; Azienda Ospedaliero-Universitaria of Sassari, Sassari). All patients were staged using the International Union Against Cancer (UICC) TNM classification, based on clinical head and neck examinations and magnetic resonance imaging or computed tomography

Table 1
Patients data.

Case no. (months)	Age (yrs)	Site	Stage	N treatment	Follow-up	Recurrence on N
1	66	II	T2NxM0	None	112	No
2	78	II	T4N0M0	SND	95	No
3	72	II	T4NxM0	None	83	No
4	62	II	T2NxM0	None	81	No
5	70	II	T4N2bM0	MRND – RT	67	No
6 ^a	81	I	T4N2bM0	MRND – RT	12	No
7	80	III	T2NxM0	None	51	No
8	84	III	T4N0M0	SND	36	No
9	72	II	T4N0M0	SND	27	No
10 ^a	54	II	T4NxM0	None	12	No
11	95	I	T4NxM0	None	32	Yes
12	53	III	T2NxM0	None	30	Yes
13	77	II	T4NxM0	None	34	Yes
14	81	III	T2NxM0	None	30	No
15	67	III	T2N0M0	SND	33	No
16	65	II	T4N0M0	SND	22	No
17	78	I	T4N1M0	SND	22	No
18	75	III	T4NxM0	None	22	No
19	57	III	T4N0M0	SND	41	No
20	52	II	T1NxM0	None	39	No
21	55	II	T4N0M0	SND	44	No
22	64	I	T2N0M0	SND	118	No
23	75	I	T4NxM0	None	0	No
24	84	II	T4NxM0	None	115	No
25	78	I	T4N0M0	SND	78	No
26	60	II	T1NxM0	None	115	No
27	72	II	T4NxM0	None	111	No
28	34	III	T1NxM0	None	103	No
29	63	III	T4N2bM0	MRND – RT	82	No
30	47	III	T4N2bM0	MRND – RT	48	No
31	74	II	T4NxM0	None	108	No
32	70	II	T4N0M0	SND	24	No
33	62	III	T4aN2bM0	MRND – RT	25	No
34	77	II	T4aNxM0	None	52	No
35	73	II–III	T3NxM0	None	20	No
36 ^a	51	III	T4aNxM0	None	54	Yes
37	63	III	T1NxM0	None	29	No
38 ^a	65	II	T4aNxM0	None	61	No
39	69	II–III	T4aN1M0	MRND	16	No
40	67	II–I	T4aNxM0	None	28	No
41	84	II	T4aNxM0	None	51	No
42	60	III	T4aNxM0	None	30	No
43	76	III	T4aNxM0	None	6	No
44	60	III	T2NxM0	None	26	Yes
45	72	III	T4aNxM0	None	60	No
46	40	III	T4aNxM0	None	60	No
47	71	III	T4aNxM0	None	8	No
48	84	III	T2NxM0	None	24	No
49	63	III	TisNxM0	None	75	No
50	52	III	T4aNxM0	None	15	No
51	83	III	T4aNxM0	None	13	No
52	84	III	T4aNxM1	None	12	No
53	55	I	T4aNxM2	None	27	No
54	79	III	T3NxM0	None	15	No
55	60	III	T1NxM0	None	44	No
56	77	III	T2NxM0	None	18	No
57	65	III	T3N0M0	SND	32	No
58	67	III	T1NxM0	None	60	No
59	74	II–III	T2N0M0	SND	16	No
60	75	III	T2N0M0	SND	6	No
61	51	II	T2N0M0	SND	3	No
62	90	III	T2NxM0	None	24	No
63	63	III	T3N0M0	SND	22	No
64	86	II–III	T4aNxM0	None	52	Yes
65	62	III	T3N2cM0	MRND – RT	3	No

SND, selective neck dissection; MRND, modified radical neck dissection; RT, radiotherapy.

^a Died of disease.

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