Cutaneous Head and Neck Malignancies in the Elderly

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KEYWORDS

• Cutaneous • Malignancy • Geriatric • Elderly • Skin cancer
• Multidisciplinary treatment

KEY POINTS

- Management of cutaneous head and neck malignancy in the elderly requires a multidisciplinary approach tailored to each individual.
- The incidence of cutaneous malignancies in the elderly is increasing.
- In most cases, first-line treatment of cutaneous malignancies is surgical.
- Radiotherapy and/or chemotherapy are often used as adjuvant therapy but in selected cases may be used as first-line therapy.

Cutaneous head and neck malignancies are primarily diseases of the geriatric population. Although adjuvant treatments, such as radiation, chemotherapy, monoclonal antibodies, and immunotherapy, have a role, the primary treatment of all types remains surgical. Elderly patients are more likely to have comorbidities that increase their perioperative risks. Several preoperative risk assessment tools have been developed to help stratify general postoperative risk based on frailty. However, none of these are specific to head and neck surgery.

Most head and neck cutaneous malignancies are relatively small and involve skin-only excision with minor local reconstruction. However, at times, more invasive surgery is required, such as neck dissection, parotidectomy, lateral temporal bone resection, or major free tissue transfer reconstruction. Although advanced age itself is not a contraindication for any of these procedures, the perioperative risks associated with many of the comorbidities present in the geriatric population have led to the investigation of other treatment modalities. Radiation therapy, chemotherapy,

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monoclonal antibodies, and immunologic treatments are all used to varying degrees in cutaneous malignancies; although they all have associated risks, they may be tolerated in selected geriatric patients.

The 4 most common types of cutaneous head and neck malignancies are presented in the following sections, with background information, demographics, and treatment options discussed. Special considerations of the geriatric population are discussed for each.

NONMELANOMA SKIN CANCER

Basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (cSCC) are the two most common malignancies in the United States.[1,2] They are frequently referred to together as nonmelanoma skin cancer (NMSC). Although NMSCs are not included in most major cancer registries, in 2012 there were an estimated 2.8 million new diagnoses of BCC and 700,000 of cSCC.[3] In fact, the incidence of cSCC has increased 200% over the past 30 years. Despite the overall favorable prognosis of most NMSCs, 10% will recur and 3% to 5% are associated with regional or distant metastasis.[4,5] As the risk of NMSC is associated with cumulative sun exposure, the light-skinned geriatric population is at significantly higher risk. It is estimated that 40% to 50% of Americans will have at least one NMSC by 65 years of age.[6] This finding creates a significant economic health care impact, with $4.8 billion per year spent treating NMSC in the United States.[7] Although many similarities exist in the treatment options for BCC and cSCC, there are several differences, especially regarding nonsurgical therapy. NMSC are diseases primarily of the geriatric population, and multidisciplinary care and management plays an important role.

Basal Cell Carcinoma

BCC is the most common cancer in the United States; it is in fact more common than all other cancers combined and twice as common as cSCC, which is the second most common cancer.[8] BCC risk is related to cumulative sun exposure and is, therefore, high in the geriatric light-skinned population.[9] BCC is more common in men, and the incidence in the geriatric population is increasing. Regional and distant metastasis from BCC is very rare and reported to occur in less than 0.1% of cases.[10] The relative 5-year survival is 99%. Despite this favorable prognosis, if left untreated, BCCs of the head and neck can be locally destructive; surgical treatment can be associated with significant functional and cosmetic difficulties.

Risks factors for aggressive BCCs include diameter greater than 2 cm, location in the H region of the face, incomplete prior excision, long-standing presence, perineural invasion, and aggressive histologic subtype (morpheaform and basosquamous)[9] (Table 1). Other risk factors for BCC include UV exposure, radiation exposure, immunosuppression, and human immunodeficiency virus (HIV)+ status.[11] Although still unlikely to be associated with distant spread, these lesions may be locally invasive and may end up extending farther than is evident clinically, resulting in larger surgical defects. In general, treatment of small, superficial BCC is tolerated well in elderly patients; however, larger more aggressive lesions may require multi-modality treatment, which can be challenging in the geriatric population.

Histologic subtypes of BCC associated with aggressive tumor behavior include the morpheaform, basosquamous, sclerosing, and mixed infiltrative types.[12] Excision is the recommended treatment of BCC.[13] For low-risk lesions, curettage or electrodessication may be considered. Photodynamic therapy may also be an option for thin superficial and nodular BCCs.[14] This procedure is generally tolerated well, and treatment

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