



ORIGINAL ARTICLE

Discrepancy between clinical and pathological neck staging in oral cavity carcinomas

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KEYWORDS

Oral cavity;
Squamous cell carcinoma;
Lymphatic metastases;
Neck dissection;
Survival;
Tumor staging

Abstract

Introduction: The presence of cervical lymph node metastases in patients with oral cavity squamous cell carcinoma reduces survival by up to 50%.

Objective: The aims of this study are to assess the accuracy of clinical N staging versus pathological N staging and its impact on survival in order to identify predictive factors associated with the presence of occult neck metastases.

Methods: Outcomes of 105 patients with oral cavity squamous cell carcinoma who underwent surgical treatment of the primary tumor and neck were retrospectively evaluated.

Results: For pN0 and pN+ patients 5-year overall survival was respectively 53% and 27%; disease specific survival was 66% for pN0 and 33% for pN+. Patients with clinical negative lymph nodes were pathologically upstaged in 62% of cases. Disease specific survival according to staging discrepancy had statistically significant impact on survival ($p=0.009$).

Conclusion: Clinical staging usually underestimates the presence of nodal disease. Neck dissection should be performed in cN0 oral cavity squamous cell carcinoma.

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PALABRAS CLAVE

Cavidad oral;
Carcinoma epidermoide;

Discrepancia entre el estadiaje clínico y patológico cervical en los carcinomas de cavidad oral

Resumen

Introducción: La presencia de metástasis ganglionares cervicales en los pacientes con carcinoma de la cavidad oral reduce la supervivencia hasta en un 50%.

Abbreviations: OCSCC, oral cavity squamous cell carcinomas; OS, overall survival; DSS, disease-specific survival; NRFR, neck recurrence-free rate; ECS, extracapsular spread; FU, follow-up period.

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Metastasis
ganglionares;
Vaciamiento cervical;
Supervivencia;
Estadíaaje tumoral

Objetivos: Los objetivos de este estudio son evaluar la exactitud del estadiaje N clínico frente al estadiaje N patológico y su impacto en la supervivencia, de cara a identificar los factores predictivos asociados a la presencia de metástasis ocultas cervicales.

Métodos: Se han evaluado retrospectivamente los resultados de 105 pacientes con carcinoma epidermoide de la cavidad oral tras tratamiento quirúrgico del tumor primario y vaciamiento cervical.

Resultados: En los pacientes pN0 y pN+ la supervivencia global a los 5 años fue del 53 y del 27%, respectivamente, y la supervivencia específica libre de enfermedad fue del 66% para los pN0 y del 33% para los pN+. En los pacientes estadiados clínicamente como negativos se verificó un subestadiaje en el 62% de los casos. La supervivencia específica libre de enfermedad en función de la discrepancia del estadiaje tuvo un impacto estadísticamente significativo en la supervivencia ($p=0,009$).

Conclusión: El estadiaje clínico suele subestimar la presencia de enfermedad ganglionar. La disección cervical debe realizarse en los carcinomas de cavidad oral aunque se trate de uno cN0.

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Introduction

Oral cancer is the sixth most common cancer worldwide with an estimated 300,000 new cases and 145,000 deaths in 2012.^{1,2} These tumors represents 30% of all head and neck solid tumors and histologically over 90% are squamous cell carcinomas. Oral cavity cancer biological behavior depends, among other factors, on the primary tumor location. Hard palate, superior alveolar ridge and buccal mucosa are known as having relatively indolent nature with a low risk of regional lymph node metastases, on the opposite oral tongue, floor of the mouth and inferior alveolar ridge have a high risk of apparent and occult cervical lymph node metastases.^{2,3}

The presence of cervical lymph node metastases in patients with oral cavity squamous cell carcinomas (OCSCC) is an important adverse prognostic factor, decreasing the overall survival and disease-specific survival up to 50% and increasing neck recurrence and distant metastases rates.^{4,5}

In fact, the seventh edition of the AJCC TNM Classification of Malignant Tumors for Head and Neck Cancers places the patients with a single regional metastatic node at an advanced stage regardless the T stage. Current lymph node staging guidelines for OCSCC are based on the clinical evaluation of lymph node size, the number of lymph nodes, and the presence of contralateral or bilateral regional disease.⁶ Still, this is a clinical staging system that does not incorporate pathologic data who could have the potential of altering the lymph node stage by revealing occult or additional positive lymph nodes not identified on routine physical examination or radiological evaluation. Indeed, discrepancy between clinical and pathological staging has been reported. However, the possible impact on survival, of the discrepancies between cN and pN evaluations, are still under debate. To accomplish these goals, a retrospective analysis was performed to assess the accuracy of the clinical N staging versus the pathological N staging and its impact on

survival. Patients with distant metastases and patients classified as cN3 were censured due to the different prognostic survival outcome.^{7,8}

Methods

All patients with a primary diagnosis of OCSCC proposed by the Head and Neck Interdisciplinary Tumor Board for surgical treatment with primary curative intention between the 1st of January of 2007 and the 31st of December of 2013, were enrolled in this study. The number of institutional affiliation, age, gender, histopathologic tumor classification according to the WHO International Classification of Diseases for Oncology (ICD-O-3), tumor localization, clinical TNM, cTNM, and histopathologic, pTNM, classification was registered. All patients performed neck dissection. Type and extent of neck dissection, histopathological variables were also considered points to be fulfilled in each patient. Bilateral elective neck dissection was performed for lesions located on the midline.

During the follow-up period (FU), patients were considered as being alive with and without oncologic disease, dead with local, regional or distant disease, dead without oncologic disease, and finally lost to FU. The cut-off point for statistical analysis was January 2016, encompassing a minimum FU of 24 months.

Clinical preoperative N classification was determined by neck palpation and by computed tomography and/or magnetic resonance imaging (MRI), supplemented by a positron emission tomography in advanced loco-regional disease. A clinical positive neck (cN+) notify the presence of metastatic nodal disease, and clinical negative neck (cN0) in the absence of any of this findings.

When postoperative histology proved nodal metastases the neck was classified as pathological positive neck (pN+) and the opposite were classified as pathological negative necks (pN0).

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