“BLEM OF NODAL DISEASE IN THE SQUAMOUS CELL CARCINOMA OF THE TEMPORAL BONE”

Elisabetta Zanoletti

In our experience bad outcome was seen in cases with positive nodes and pT4 tumors. The failure took place with local recurrence and not in the neck or in distant localization. The presence of clinical or intraoperative nodes can be considered a sign of aggressiveness of the tumor and may again suggest to enlarge the resection on the tumor. The role of neck dissection is universally accepted in cN+ cases but is still at question in cNo cases . In litterature, a 4.5%-31.8% rate of positive nodes after neck dissection was reported, with a cumulative rate of 17.7%. We reported a rate of pN+ in 18% (8/45) including 5 clinically positive nodes and 3 clinically negative necks. The rate of micrometastasis in the clinically negative neck was 7.5% (3/40). We observed a disease-free rate of 25% (2/8) in the group of patholological positive nodes (8 cases), of which all six died for local failures. In the group of pathologically negative nodes (37 cases) the disease free cases were 70% (26/37). A rate of 7.5% of micrometastasis is too low to strongly support the indication to an elective neck dissection in cN0 neck, but the choice of not treating the neck lacks evidence both in our experience and in litterature so that prophilactic neck dissection may be advocated. The type of neck dissection in the clinically negative neck is at discussion . A planned dissection of levels Ib to III allows the en block resection of tumor, parotid and lymphnodes. The risk of potential metastasis at level IV should be considered in case of positive nodes at higher levels, or recurrent tumors after surgery and/or radiotherapy. The extension to level V is generally advised in case of therapeutic neck dissection and of intraoperative positive nodes. Intraoperative frozen section pathology is mandatory.