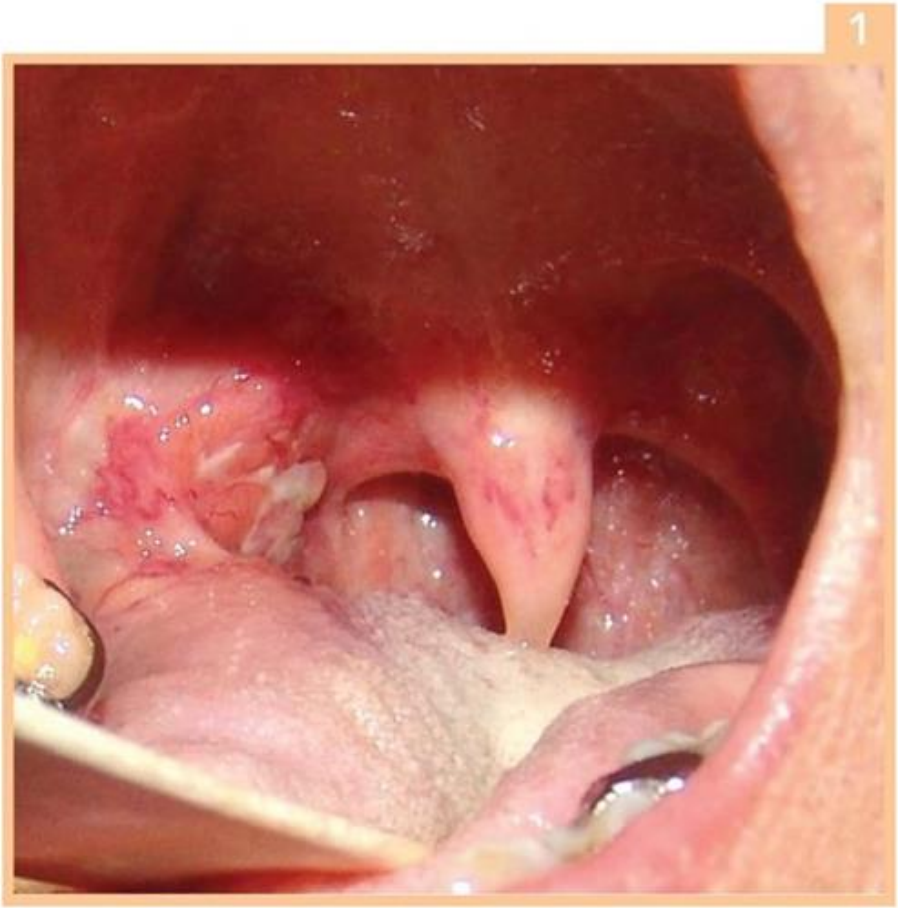
CASE 1

QUESTIONS 1

A 39-year-old male presents with a 2-month history of right throat pain. There is no significant past medical history and he is a lifelong non-smoker who drinks 20 units of alcohol per week. Examination of the neck reveals a 1 cm right level II lymph node. Examination of the oropharynx reveals the following:



i. What is the likely diagnosis?

ii. What are the major risk factors for this condition?

iii. How would you investigate this patient?

iv. Outline the T staging classification for this condition.

v. This patient has a TNM stage of T1, N1, M0. Outline the treatment options.

vi. Should the N0 neck be treated in T1–T2 disease?

Answers 1

i. The right tonsil is enlarged and ulcerated – it is likely to be a squamous cell carcinoma.

ii. Smoking, alcohol, human papilloma virus (HPV) and betel nut chewing.

iii. Fine needle aspiration cytology (FNAC) of the neck node.

Magnetic resonance imaging (MRI) of neck – to assess primary tumour and cervical metastasis.

Computed tomography (CT) of thorax – for staging purposes.

Panendoscopy and biopsy for definitive histological diagnosis, HPV testing of biopsy specimen.

Tonsillectomy should not be carried out in the presence of obvious malignancy as this will limit the treatment option of future transoral laser surgery.

iv. Tx: primary tumour cannot be assessed.

T0: no evidence of primary tumour.

Tis: carcinoma *in situ*.

T1: tumour 2 cm or smaller in the greatest dimension.

T2: tumour larger than 2 cm but 4 cm or smaller in the greatest dimension.

T3: tumour larger than 4 cm in the greatest dimension.

T4a: tumour invades the larynx, deep/extrinsic muscle of tongue, medial pterygoid, hard palate or mandible.

T4b: tumour invades lateral pterygoid muscle, pterygoid plates, lateral nasopharynx, or skull base or encases carotid artery.

v. As with all head and neck malignancies, this patient would be formally discussed at a multi-disciplinary team (MDT) where a treatment plan would be formulated. Early stage disease (T1–T2) should be treated with a single modality, which may be primary radiotherapy or transoral surgery and neck dissection. The transoral approach is preferred to open surgery and is associated with good functional outcomes. If treated surgically, selective neck dissection involves levels II–IV and possibly level I. If there is no disease evident in level IIa then Level IIb can be omitted. Chemotherapy is not routinely used in early-stage disease.

vi. Occult neck metastases are present in 10%–31% of patients with T1–T2 disease and the treatment of a N0 neck remains a controversial topic. Those undergoing primary surgery can undergo a selective neck dissection and for patients treated with primary radiotherapy, prophylactic treatment of the neck is often advised. Sentinel lymph node biopsy is another option unless cervical access is required at the same time as primary surgery.

These decisions should be discussed at the local MDT and based upon any national guidance, which varies from country to country.