Case 1: Surgeon's Two Cents

ANDREW COWAN, MD, PHD

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Tonsil?

- 2.8 x 2.6 cm mass in the left pharyngeal space [assume oropharynx]
- The oropharynx is bounded anteriorly by the oral cavity, superiorly by the nasopharynx, and inferiorly by the larynx and the hypopharynx.

Nasopharynx

- Bounded anteriorly by the nasal cavity, superiorly by the skull base, posteriorly by posterior pharyngeal wall, and inferiorly by the oropharynx.
- Treatment of malignancies in this area (primarlly nasopharyngeal carcinoma) is with definitive chemoradiation therapy.
- Surgery can be considered in certain circumstances (e.g. salvage), but it can be quite morbid due to the difficulty in accessing the area.

Nasal cavity and paranasal sinuses

- Endoscopic resection can be considered for resectable, early-stage malignancies.
- Larger tumors may require an open approach (which is more morbid and potentially disfiguring) with adjuvant therapy.

Oral cavity and oral vestibule

- Tongue, floor of mouth, labial and buccal mucosa, gingiva, retromolar trigone, and hard palate.
- Surgical resection is attempted whenever feasible, followed by risk-adjusted adjuvant therapy.

Glottis

- Including supraglottis, glottis, and subglottis.
- Surgical resection is considered for salvage, and in cases of small tumors that can be removed without greatly affecting function (speech and swallowing).

Hypopharynx

- Surgical resection is only considered in cases of small tumors that can be resected while preserving the function of the larynx.

Back to the oropharynx

- Treatment of squamous cell carcinoma in this compartment has been influenced by two major developments in the last 2 decades:
  - The study of human papillomavirus-associated (p16-positive) squamous cell carcinoma.
  - The development of trans-oral robotic surgery, and other minimally-invasive techniques.
- For p16-positive cancers, surgery is generally only considered if there is a chance of avoiding or reducing chemoradiation therapy.
- In brief, the need for and nature of risk-adjusted adjuvant therapy is determined by the answers to 3 questions (from the path report):
  - Are there negative margins around the main specimen?
  - How many lymph nodes from the neck dissection (2a, 2b, 3, and 4) contained cancer?
  - Was there any extranodal extension?

…but this tumor is p16-negative

- For p16-negative squamous cell carcinomas, which have a markedly poorer overall survival, I am more likely to recommend surgery *even if* I anticipate the need for adjuvant therapy.
- In other words, I am more likely to attempt a resection of a large tumor in a patient with multiple involved nodes.
- In other other words, I tend to offer surgery as a means of intensifying therapy. (A clinical randomized clinical trial was launched to test this very concept, but it closed due to lack of accrual.)

…so surgery is, in fact, an option.

- Comorbidities such as antiphospholipid antibody syndrome and a mechanical or porcine mitral valve would certainly affect the perioperative management of this patient's anticoagulation, but they are not absolute contraindications to surgery.
- If in doubt, have your head and neck cancer patients evaluated by a head and neck surgeon. There are 6 of us at UNM:
  - Mike Spafford
  - Garth Olson
  - Nate Boyd
  - Andy Cowan
  - Noah Syme
  - Ryan Orosco