Letter to the Editor


Bhandary S
Department of ORL and HNS, BPKIHS, Dharan

I would like to add few salient things and recent updates regarding management of oral cancer including verrucous carcinoma based on evidence based practice which in turn would raise several queries regarding overall approach and management of this 34 year young adult presenting with verrucous cancer of lower lip, who subsequently had several local and regional recurrences.

Verrucous carcinoma (VC) first described in 1948 by Lauren V. Ackerman is a distinct variant of differentiated squamous cell carcinoma (SCC) with low grade malignancy, slow growth and no or only low metastatic potential. It is often associated with long-term use of smokeless tobacco although examples occur among nonusers as well. Betel nut chewing, poor dental hygiene and Human Papilloma Virus (HPV) infection have been implicated in the development of oral VC. Various premalignant conditions like SMF, leukoplakia, lichen planus etc have been associated with this condition.

Difficulties remain as to the appropriate classification of those lesions with dominant features of VC which also contain small foci of squamous cell carcinoma. In 20% of VC coexistent foci of less-differentiated SCC could be found. No matter what the treatment is, the rate of local recurrences is said to be high ranging from 30% to 50% and not unusually is the result of inadequate surgery but because of the size of the tumor and left dysplasia close to the verrucous carcinoma. Recently successful treatment of an extensive VC with intra-arterial infusion of methotrexate or topical 5-aminolevulinic acid-mediated photodynamic therapy was reported.

There have been evidences in literatures which clearly states that surgery is the treatment of choice for all oral cavity tumors (except early lip cancers) and radiotherapy (RT) is reserved only for advanced stage III or IV diseases as adjuvant therapy or in cases where the histopathology reveals close or positive margins, high grade tumor, thick tumor infiltrating muscles and soft tissues or perineural extension. RT is also justified in large bulky nodes, multiple level nodal involvement and metastatic node showing perinodal extension. This modality of treatment is usually avoided in young patients in view of the risk of radiation induced cancer unless the lesion is inaccessible or the surgery is mutilating, like in cases of oropharyngeal and nasopharyngeal carcinomas.

In the article the author has not very clearly mentioned if the patient was managed at the same institution or outside in the past. The fact that there was various sub-sites of oral cavity involved subsequently should also raise possibility of field cancerization in this patient. The clinical details including the size, proper site in lower lip and staging of disease, rational for various treatment modalities this patient was being subjected to and also histopathological reports (HPR) are missing in the case report.

The author has mentioned that margins could not be commented upon due to lack of frozen section facility, whereas it could have been looked for in HPR subsequently, a pathological staging of disease made and managed accordingly. The patient here has been subjected to radiotherapy without any rationale as to the stage of disease or the margins of specimen, whereas the author himself has stated that HPR revealed no invasion of muscles or lymphovascular invasion.

Another important aspect of management of any head and neck malignancy is that the treatment of the neck should not be seen in isolation but rather in the context of the overall management plan. The appropriate management of the clinically negative neck among patients with SCC of the oral cavity and oropharynx continues to be a therapeutic challenge.

In the oral cavity and oropharynx, the incidence of occult nodal disease varies broadly with the tumor site and stage. More than 50% of patients with squamous cell carcinoma of the oral cavity have lymph node
metastases and histological confirmation of metastatic
disease is the most important prognostic factor. The
high incidence rates of occult cervical metastases (> 20%-25% in T2 disease) in oral cavity cancers have been
reported in literature. Among patients with a clinically
negative neck, the incidence of occult metastases varies
with the site, size and thickness of the primary tumour.
Additional factors that may predict possible occult nodal
involvement in oral cancers are tumor grade, vascular
invasion, depth of invasion, and DNA aneuploidy. It
has been recommended that an appropriate threshold
for treatment of the clinically negative neck is when
there is a 15%-20% or greater risk of occult disease.
This recommendation was based on an analysis of the
utility of the management options taking into account
the incidence of node involvement, complications of
treatment, and disease control rates. This threshold
would include most oral cavity cancers staged T2 or
higher and nearly all oropharyngeal cancers, including
those staged T1.

In support of elective neck treatment is the fact that
when patients initially managed by observation
subsequently return with nodal involvement, their
metastatic disease is often advanced, making regional
treatment of the clotting associated metabolic disease
more difficult. In addition, the increasing use of
microvascular free flaps for reconstruction in the
oral cavity and oropharynx mean that the neck is very
frequently entered for the reconstructive procedure,
and therefore it is appropriate to remove the at-risk
nodes during supraomohyoid neck dissection (SND).
Several retrospective studies and one randomized
clinical trial have shown SND of levels I through III
to be highly efficacious and widely accepted as the
appropriate selective neck dissection for patients with
oral cavity cancer and a clinically negative neck. There
has been however a recent debate about whether level
IV should be included or not. The risk of contralateral
occult neck involvement in the oral cavity squamous
cell carcinomas above the T3 stage or those crossing
the midline with unilateral metastases was high, and
patients who presented with a contralateral metastatic
neck had a worse prognosis than those whose disease
was staged as N0. Therefore, in literature they advocate
an elective contralateral neck treatment with surgery
or radiotherapy in patients with oral cavity squamous cell
carcinoma with ipsilateral node metastases or tumors,
or both, whose disease is greater than T3 or crossing
the midline. The evidence based guideline for managing cancer
includes proper diagnosis and staging, appropriate
treatment modality after discussing with the patient
regarding options, risk, benefits and oncological
safety while performing surgery which includes taking
adequate margins and performing a good reconstruction.
Functional restoration and quality of life should be taken
into consideration as far as practicable while treating
the patient. At no point should the oncological safety be
compromised while managing the disease. HPR details
and radiological evaluation are invaluable in decision
making as well as overall management of the case.

Gillies, Webstes’s flap and other reconstructive methods
have been well accepted and described in the past
literature for reconstruction of lip and oral cavity defects
post-operatively. In the recent years free flaps have been
a major advance in oral cavity defect reconstruction,
where well trained plastic surgery team is available.
However the basic principle of planning any flaps would
be to ensure that resection has been complete
with adequate mucosal as well as bony and soft tissue
cut margins and taking care of regional metastasis.
The pictures of recurrence shown of this patient clearly
reveal disease extending from one angle of mouth to the
other as well as presence of paramandubular disease.
The need for marginal mandibulectomy here further
upstages the disease to T3 or T4 where probability of
nodal metastasis is as high as 40-60%. Moreover this
was a recurrent disease which is known for aggressive
behavior, hence requires equally aggressive approach.
The ideal in above situation would have been to perform
bilateral supraomohyoid neck dissection (SOHD),
frozen section if possible and then proceed further
for modified neck dissection (MND) if any nodes
come positive. Where frozen section facilities are not
available one can explain to the patient preoperatively
about the risk of nodal metastasis, seek consent and go
for an upfront MND. Finally, a policy of observation
can be used selectively and applied mainly to patients
with early stage disease who require close follow–up.
However, a likelihood of poor follow-up is believed to
be a valid reason for electively treating the neck.

In this young man the neck should definitely have
been addressed at the time of surgery and before
contemplating any kind of reconstruction. We have seen
that patient has come back with nodal disease within 3
months. Any recurrence less than 6 months interval has
grave prognosis. The author has also failed to mention
what has the duration of follow up had been in this case
after last surgery as any cancer requires close follow up
for at least 5 years and most recurrences occur within a
period of 6 months to 2 years.

It is a well accepted fact that any article published
should have some take home message for readers and
contribute to the literature in some way. The intentions
of the comments are not to challenge anyone’s skill and
abilities here. However, considering that the disease was
recurrent (for the fourth time) in this young patient, lack
of proper clinical, histopathological and surgical details
and approach, adopting a well established reconstruction
method without considering the complete oncological clearance does make one critically view the objective and the message the author wishes to highlight through this article.

References


