Metastatic Spread Of Oral Squamous Cell Carcinoma To Level 2b: A Retrospective Study

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INTRODUCTION

Due to the high levels of occult lymph node metastasis in oral cavity squamous cell carcinoma, the vast majority of patients undergo selective neck dissection levels 1-4. Level 2b nodal metastasis, however, is uncommon. The current standard of treatment is dissection of level 2b as part of treatment for cancer but this has comorbidity associated with it which includes spinal accessory nerve dysfunction and related shoulder pain and disability.

AIMS

1. To describe the rate of metastasis to 2b from oral cavity squamous cell carcinoma
2. Identify specific subsites, features of the primary and patient factors leading to higher metastasis rate
3. Review recommendations for 2b dissection in all oral cavity carcinoma

METHOD

A retrospective cohort study on all neck dissections performed as part of treatment for OSCC over a period of 5 years from 2013 -2017. All neck dissections done at this centre are pinned out by the surgeon post operatively onto a standardised laminated template, with 2b identified by a silk stitch intraoperatively. Details regarding the primary tumour characteristics, lymph node dissection features and nodal distribution were collected and tabulated. Specific metastases to 2b could be identified in most reports given the intraoperative suture labelling.

REFERENCES:

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RESULTS

- 348 neck dissections for oral cavity squamous cell carcinoma were recorded
- 135 patients were found to have metastasis to the neck (38.8 % of total)
- 9 patients had metastasis to level 2b (6.7 %) alone
- 48 patients were found to have disease spread to level 2 (2b indistinguishable)
- 44.4 % of patients with metastasis to level 2b had primary SCC of lateral tongue
- A further major contribution to this group also came from retromolar trigone SCC (33.3%)
- Higher T Stage, older age at diagnosis, and poor differentiation were all significant risk factors for metastasis to 2b
- Primaries with a cohesive front were less likely to metastasise to this zone

CONCLUSIONS

- Our results support current evidence that the incidence of metastasis to level 2b from oral cavity squamous cell carcinoma remains low
- Incidence is higher with lateral tongue primary, high T Stage and poorly differentiated primary. Super selective neck dissection should not be employed in such cases
- We have not identified any subgroups for whom the risk of 2b metastasis is significantly low enough to recommend limiting neck dissection in this area