

ult neck metastasis가 많이 발견되어 이 부위의 원발종양에 대하여서는 병기가 낮더라도 적극적인 예방적 경부치료가 요구된다고 생각된다.

Correlation between clinical and pathologic N stage in HNSCC(N=247, SNUH)

Clinical \ Pathologic	N0	N+	Total
N0	73	18(19.8%)	91
N+	26	130	156
False positive rate=26/99=26.3% : False negative rate=18/148=12.2%			

Occult neck metastasis in HNSCC(N=18, SNUH)

Site \ T stage	T1	T2	T3	T4	Total
Larynx					
Supraglottic	0	0	3	1	4
Glottic	0	1	0	2	3
Oral cavity					
Oral tongue	3	3	1	0	7
Floor of mouth	1	0	0	0	1
Hypopharynx					
Pyriform sinus	0	0	0	1	1
Oropharynx					
Base of tongue	1	0	0	0	1
Tonsil	0	1	0	0	1

• Summary

임상소견상 그리고 CT/MRI 상으로도 경부에 전이가 없는 두경부암 환자를 치료함에 있어서 잊지 말아야 할 사항은 이 환자들의 절대 다수는 진짜로 경부 림프절에 암세포를 가지고 있지 않으며 따라서 작은 가능성을 염려하여 경부를 과도하게 치료해서는 안된다는 점이다.

그러나 객관적인 데이터가 있고 대다수의 의사들이 동의하는 수준 이상의 잠복 전이율을 가진 암에 대해서는 단호히 N0 neck에 대한 치료를 하는 것이 환자를 위하여 그리고 더욱이 medicolegal problem이 자주 제기되는 요즘 같은 상황에서는 필수적인 진료라 생각한다.

최근 CT/MRI의 사용으로 인해 과거의 촉진에 의한 경부전이진단보다 경부전이를 더 잘 발견할 수 있으므로 과거의 occult neck metastasis의 위험도를 임상적용할 경우 이를 고려하여야 하며 진단시 CT/MRI를 포함한 잠복 전이율이 15~20%이상인 두경부종양에 대하여서는 예방적 경부치료를 시행하여야 할 것으로 생각된다. 경부 치료를 수술로 할 것인가 방사선으로 할 것인가는 결과의 차이가 분명하지 않은 만큼 원발부위에 대한 치료방법, 환자의 상태와 의사 본인의 경험, 능력 및 철학에 맞추어 선택하여야 할 것이다.

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Role of Selective Neck Dissection

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Difinition

Selective neck dissection removes lymph nodes from some regions in the neck while preserving all the non-lymphatic structures.

Indications and Choices for Selective Neck Dissection

In general, for cancer in the head and neck region, the

risk of subclinical nodal metastasis increases with increasing T stage. Elective neck dissection reduces the risk of regional recurrence, especially for patients with carcinoma of the tongue. The procedure has also been reported to be associated with a survival advantage of 4–11% for those patients with supraglottic laryngeal or hypopharyngeal carcinoma.

A radical neck dissection should not be performed as a routine for all patients with No neck because the operation is associated with definite morbidity and cosmetic deformity.

The aim of selective neck dissection is to remove those lymph nodes that drain the primary tumour. Our study as well as others have shown that for patients with primary carcinoma of the larynx or hypopharynx, most involved lymph nodes were in levels II, III and IV. In other primary tumours such as carcinoma of the tongue and oral cavity, the affected lymph nodes were in regions I, II and III and for oropharyngeal carcinoma, in levels II and III.

Selective neck dissection should be employed to remove nodes in those levels according to the location of the primary tumour with preservation of all non-lymphatic structures. Pathological examination of the neck dissection specimen provides additional information regarding the incidence of occult metastasis and whether postoperative radiotherapy should be given. The morbidity associated with the operation is low and it should

be carried out whenever indicated.

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Surgical Management of Advanced Metastatic Cancer

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The management of metastases in patients with head and neck cancer requires significant surgical judgement. The two important clinical situations would be the management of systemic metastases in the presence of good loco-regional control and the management of patients with metastases but who require palliative treatment for loco-regional disease. In the first situation, there is now increasing evidence that resection of systemic metastases in highly selected patients will confer survival advantage. In the second situation, the surgical strategy involved would include good loco-regional disease control, planning the strategy with the possibility of backing out, conservation surgery where possible, the use of adjuvant brachytherapy, protection of the carotid vessels, one stage reconstruction and high quality surgery with low morbidity and mortality.