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.