MANAGEMENT OF HEAD AND NECK TUMOURS

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MANAGEMENT OF HEAD AND NECK TUMOURS

- Teamwork
- Individual patient - individual tumour
- GOAL = cure cancer with satisfactory function and cosmesis
- Optimal Rx = accurate diagnosis, knowledge of Rx options, wisdom in selection, competent physician
- Foundation of decision = careful evaluation of tumour factors, patient factors, physician factors

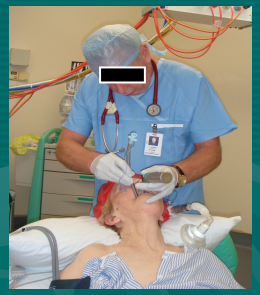
MANAGEMENT OF HEAD AND NECK TUMOURS

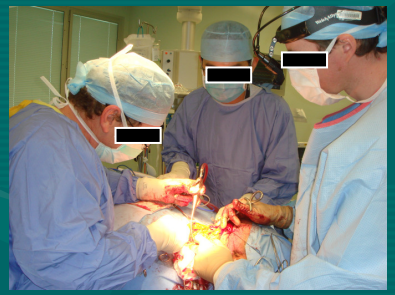
TEAMWORK

- You and the patient

'a partnership that only terminates when you or the patient dies' T.J.H.

- Patient and family/supports
- Multidisciplinary HNC…planning/review
- Theatre





- Ward and allied health staff (peri-op/ post-discharge)

MANAGEMENT OF HEAD AND NECK TUMOURS

INDIVIDUAL PATIENT

- general medical health -'fitness', meds
- personal habits:- smoking, C_2H_5OH, UV expos.
- socio-economic status – cost, PO care, job?
- dental – re. pre-op prep, outcome/ORN
- prior Rx → limits options
- personal desires ? influencing factors

MANAGEMENT OF HEAD AND NECK TUMOURS

INDIVIDUAL TUMOUR

- Site – skin, oral cavity, oro-Phx, neck
- Size – TNM 7th Edition 2010 UICC Sx alone (early stage disease, fit pt); Sx & PO XRT, (indications for +CTX); advanced disease CTX-XRT p16 status
- Type – BCC; SCC; MCCa; lymphoma; sarcoma
- Nodal involvement –T_o N^+, mobile? multiple N^+
- Distant Metastasis – solitary MM lung, brain, liver
- Microscopic pathology – margins (mms), invading front, PNS, LVS, ECS

MANAGEMENT OF HEAD AND NECK TUMOURS

GOAL = cure cancer with satisfactory function and cosmesis

CURE

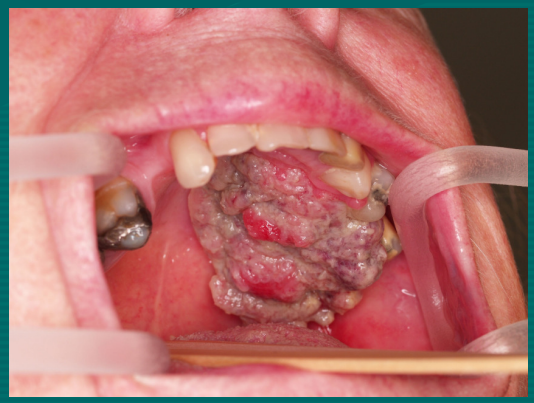
- accurate diagnosis/assessment
- best Rx selection
- competent practitioners
- good oncological Mx

FUNCTION/COSMESIS

- expertise /reconstruction/ primary healing/ after care

MANAGEMENT OF HEAD AND NECK TUMOURS

1. Consultation
2. Investigations
3. Referral Letter to MDC
4. Second consultation
5. Operation
6. After-care
7. Follow up



MANAGEMENT OF HEAD AND NECK TUMOURS

1. Consultation

- Hx lesion – morphology, change, onset, growth rate, symptoms, prior Rx
- GMHx, job, ethnic, tobacco, alcohol, drugs, allergy, PMHX, TED, PSHX, bleeding,
- O/E

    1. skin lesion (colour, size, shape, ulceration, consistency, fixation, infiltration, photo documentation/diagram)

MANAGEMENT OF HEAD AND NECK TUMOURS

1. Consultation (cont)

- O/E 2. patient

  <u>local Ex</u> skin lesion, rest of skin

(Intra-oral → lighting, glove, spatula, dentition, mucosa, tumour, cranial nerves, tissues, IDL)

<u>regional Ex</u> (patient positioning, nodal status, tissues)

<u>systemic Ex</u>

interim TNM

MANAGEMENT OF HEAD AND NECK TUMOURS

2. Investigations

- Biopsy
- Bloods LFT/FBC/special
- FNA (office, ultrasound)
- OPG
- CTS H&N, Chest, Abdo
- ? MRI specifically for PNS
- ? PET

MANAGEMENT OF HEAD AND NECK TUMOURS

3. Referral Letter to MDC Chairman

Letter construction

- Summary Re: including name, DoB, diagnosis, TNM staging
- Request to MDC = advice or treatment
- Patient & tumour details + findings
- Results of investigations; advise if ordered
- Patient to bring XRays; list of meds

MANAGEMENT OF HEAD AND NECK TUMOURS

- HEAD AND NECK CLINIC ASSESSMENT

TEAM = Specialist surgeons (ENT MF PRS), Radiation Oncologists, Medical Oncologists, Dentist, Prosthodontist, Oral Therapist, Speech Therapist, Physical therapist, Dietician, H&N Radiologist, Nuclear Scan Radiologist, Interventional Radiologist, Pathologist, Respiratory Physician and trainees. Palliative care, psychiatric liaison. Social worker.

All patients examined by all clinicians with appropriate instrumentation; Nasendoscopy with video; Clinical photograph patient and lesion

Recommendation for completing assessment prn, recommended treatment outlined and undertaken if requested

Extra investigations include NBI to assess premalignant change and visualise very superficial lesions hard to see otherwise

PET and other more specific radiology may be required for diagnosis, pre-op assessment & Rx

MANAGEMENT OF HEAD AND NECK TUMOURS

Second consultation

Explain overall Mx plan

Explain specifics of surgery planned, do consent

Complete pre-op prep, i.e. cease smoking, alcohol, blood thinner Mx, review Ix. Other specialist consultations/liaison ? ICU PO? Booking, ?funding.

MANAGEMENT OF HEAD AND NECK TUMOURS

SURGICAL PRINCIPLES

- Appropriate pre-op assessment, explanation, preparation
- Multidisciplinary involvement pre/intra/post op
- Competent surgeon, anaesthetist, assistant
- ?Tracheostomy if intra-oral; ND after XRT
- Complete excision of tumour with clear margins (recurrence rate)
- Frozen section control?
- Appropriate reconstruction prn
- Primary wound healing
- Avoidance of complications
- XRT to commence within 6 weeks of Sx
- Follow up commitment

MANAGEMENT OF HEAD AND NECK TUMOURS

MINIMISING COMPLICATIONS

Prevent infection:- antibiotic prophylaxis, aseptic technique, avoid/treat contamination, prevent seroma (drains and dressings).

Wound healing:- Careful planning incisions/flaps, gentle tissue handling, judicious use diathermy, careful haemostasis, layered accurate wound closure

Minimise bleeding:- positioning, LA infiltration, diathermy, ligation, controlled hypotension (IDC)

Airway protection (tracheostomy, naso-pharyngeal tube)

PO chest physio. Decannulation.

? ICU ? HDU initially post-op

Alcohol withdrawal

TED SCD's; subcut heparin; early mobilisation

NGT(nutrition, feeding commencement),

Intra-oral incision care :- PO mouth wash, NBM or H_2O?

At 5-7 days, clear → free fluids → vitamised → soft diet

Speech therapist

Skin sutures out 5 to 7 days (XRT slower healing)

MANAGEMENT OF HEAD AND NECK TUMOURS

OUTCOME

Depends on tumour factors, patient factors and physician factors

FURTHER INFORMATION

Management of specific tumours, neck nodes and the place for radiotherapy…other speakers at this course

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THE END