STAGE GROUPING IN HEAD AND NECK CANCER:

I T1 N0 M0
II T2 N0 M0
III T3 N0 M0
T1-T3 N1 M0
IVA T4 N0-N1 M0
T1-T4 N2 M0
IVB T1-T4 N3 M0
IVC T1-T4 N1-N3 M1

RISK GROUPS FOR CLINICALLY NEGATIVE NECK:

Low risk (<20%) T1 Oral cavity
Intermediate risk (20-30%) T1 Oropharynx (except BOT)
T1 SG Larynx
T2 Oral cavity
High risk (>30%) T3-T4 Oral cavity
T2-T4 Oropharynx (except BOT)
T2-T4 SG Larynx
T1-T4 Base of Tongue, P.Fossa, Nasopharynx

TREATMENT OF N0 NECK:

Neck should be treated if risk of nodal metastasis is greater than 20%. The risk of distant metastasis is more in these cases if neck is only observed.
Surgery (MRND) and RT are equally effective (90%).
If primary is to be treated by surgery, neck should be treated by MRND. If after neck dissection multiple pathologically positive neck nodes or extracapsular extension are seen then post-op RT to neck should be given.
If primary is to be treated by RT, neck also should be treated by RT. Neck dissection should be added for residual disease.

TREATMENT OF N+ NECK:

N1 neck: If primary is to be treated by surgery, then neck should be treated by MRND. If multiple pathologically positive neck nodes (pN2b,N2c,N3) or ECE are seen, then post-op RT should be given to the neck.
If primary is to be treated by RT, then neck should also be treated by RT.

N2,N3 neck: If primary is to be treated by surgery then neck should be treated by MRND followed by post-op RT to neck (2-3 weeks after surgery).
If primary is to be treated by RT , then neck should be treated by RT followed by post-RT MRND for residual nodal disease 2-3 weeks afterwards.

RADICAL NECK DISSECTION:

Structures removed are:
(1) Superficial and deep fascia of neck
(2) Lymph nodes of levels I-V
(3) Muscles—SCM and omohyoid
(4) Nerve-spinal accessory nv
(5) Vessels-External and Internal Jugular Vein
(6) Submandibular gland

Any dissection short of RND is known as MRND .

Indication of MRND:

(1) If neck is N0 or N1(selected mobile cases)
(2) If neck dissection is done for residual disease following significant disease regression following RT in N2-N3 neck.

Complications of neck dissection:

Hematoma
Seroma
Lymphoedema
Wound infection
Wound dehiscence
Carotid exposure
Carotid rupture
Damage to 7^{th},10^{th}-13^{th} cranial nerves.

Indications of post-op RT:

(1) N2b,N2c or N3 neck
(2) Extra-capsular extension

Indications of pre-op RT:

(1) For fixed nodes
(2) If open biopsy done and primary is to be treated by surgery