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Is it Time to Change the Standard Practice or Collect Evidence? A Commentary on Current Practice about Level 2B Lymph Node Dissection in Node Negative Early Oral Cancer

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Editorial

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Editorial

There has been plethora of publications in recent past about practice of level 2b lymph node dissection in early node negative oral cancer but the overall consensus is not out despite few prospective series [1,2]. In early stage oral cancer where the prognosis is generally excellent, we have to strive towards the quality of life as another important goal. Surgeons have moved on to conservative surgery from the era of radical neck dissection based on the firm evidence of preserved oncological outcomes with a gain in functionality. The landmark work by Shaha et al led us to the standard practice of supra-omohyoid neck dissection (SOHND) in early oral cancers based on their results, which showed a nodal positivity beyond level I-III being less than 5%. About 31-40% of the patients complain of shoulder dysfunction despite the adoption of SOHND for N0 neck and the plausible explanations have been stretching of the nerve and ligation of the occipital artery during supraspinal accessory nodal basin dissection, which leads to spinal accessory nerve dysfunction [3,4]. A prospective analysis from MSKCC of consecutive 44 patients of oral cavity and oropharynx and demonstrated only one patient had a positive node at the supraspinal accessory nodal basin and none of the patients had isolated metastasis [5]. This particular study began the floodgate for a plethora of studies to solve the question, which didn't reach its ultimate goal [6-8].

Looking into the current evidence, we lack RCTs to base our judgment. Two studies are of paramount importance based on their sample size; Pantvaidya, et al. described a prospective analysis of 583 neck dissections which showed that 3% of patients had IIb involvement in oral cancers, with tongue (5%) and retromolar trigone (6.2%) subsites having the highest incidence of metastasis to level IIb. They further concluded that level IIa involvement predicts IIb positivity [9].

A recently published study by Agarwal et al analyzed 231 patients prospectively and have shown 2/231 (0.86%) had IIb metastasis and 0% had isolated IIb involvement. In both the patients it was associated with IIa involvement and amongst the patients with IIa involvement, 7.4% of them had IIb nodal disease [10]. A recent systemic pooled analysis of 447 patients showed that overall level IIb metastasis in N0 neck is 4% and isolated IIb metastasis is seen in only in 2% of the cases [7]. A relatively small but well-conducted study demonstrated no association between any levels of neck nodal disease with the occurrence of level IIb disease and on analysis, they didn't find any other tumor related factors like T stage, oral subsite, and tumor differentiation affecting level IIb involvement but majority of the evidence are in favor of carcinoma tongue than any other subsite with some suggesting retromolar trigone as the most common subsite associated with level IIb metastasis [6-8,11].

The benefit of dissecting level IIb in N0 Neck, is considered controversial at the most, as existing literature has demonstrated the occult positivity to be between 0-10.4% and it may be omitted in favor of improved shoulder function, which is 31-40% in case of otherwise

standard SOHND. There are words for and against omitting level IIB dissection. The rational for dissecting level IIb says, that there is a small but real possibility of level IIb nodal recurrence, and in case of recurrence, salvage dissection will be more morbid. The evidence against the dissection says, even if we miss the isolated nodal disease at level IIb, it will otherwise be taken care by radiotherapy. Though a small percentage of the cases where isolated level IIb will be missed from radiotherapy, but this possibility is practically less than <2%. Commented two studies definitely add to the existing data and should serve as substantial evidence for future work [1,2]. It will be interesting to know practice orientation of the author based on existing literature, though we haven't changed our approach of dissecting level IIb in all oral cancers [1,2].

The speculation and possibilities are endless but in the absence of overwhelming evidence, it is unlikely that the standard practice will change but we do have enough evidence to initiate a randomized control trial with the goal not only to assess the nodal positivity but also to test the oncological safety in addition to functional benefit, though this is not all this simple as other many unanswered question, which are somehow linked with acceptance of this approach will have their saying on it, like what is N0 (clinical/imaging), whether to send Frozen for level IIa nodes, base the decision on subsites, role of micro staging of LNs on Frozen section.

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