

SUPRAOMOHYOID NECK DISSECTION

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Excision of regional lymph nodes has been practised for many years in an attempt to control metastatic spread of carcinoma. In 1906 Crile advocated clearance of the *complete* node field, a view further strengthened by Martin in 1941.

Most cases of head and neck cancer treated in this unit over the past 16 years had had previous primary radiotherapy and often their general medical condition was poor. Radical neck surgery was thus associated with a significant morbidity. It was therefore thought that more conservative surgery to the neck nodes in selected cases might reduce this morbidity. Clearing less than the complete node field has, however, been frowned upon because potentially involved nodes remain, particularly with suprahyoid dissections. However, supraomohyoid dissections *do* remove the major node groups.

Supraomohyoid neck dissection is a well recognised, although generally unaccepted form of treatment. The upper neck field is cleared as for a radical dissection with the exception of the sternomastoid and omohyoid muscles, which are retracted, and the internal jugular vein. The important jugulo-digastric nodes are removed along with the rest of the upper and most of the lower deep cervical nodes, unlike a suprahyoid dissection which cuts across the jugulo-digastric group (Brown and McDowell, 1954).

In order to compare supraomohyoid dissections with radical node dissections, 62 patients who had one or other or both were studied. Only patients with squamous carcinoma of the lower lip, tongue or alveolus were included in the series. The dissection was carried out prophylactically when the carcinoma was close to the regional nodes; otherwise when nodes were palpable.

There were 19 patients with unilateral supraomohyoid dissections, 11 patients with bilateral supraomohyoid dissections, 10 with a radical on one side and a supraomohyoid on the other, and 22 with unilateral radical dissections. It was possible therefore to compare 32 radical dissections with 51 supraomohyoid dissections.

The following points were looked for:

- Recurrent tumour in the dissected area;
- Involvement of nodes beyond the dissected area;
- Metastatic disease elsewhere.

RESULTS

In the event when such variables as site, histology, age and frailty, number of nodes involved and many others were taken into account, the resultant numbers were so small as to have little statistical significance. Overall however there was no significant difference in the results of the 2 types of node dissections.

CONCLUSION

There is a significant mortality and morbidity from a radical neck dissection particularly in the elderly who have had previous radiotherapy. The less radical supra-

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omohyoid dissection in this relatively small series of 62 patients gave similar and no worse results and it is felt that less than radical neck dissections require further exploration.

I would like to thank Mr T. J. S. Patterson for allowing me to review his patients, and the records staff of the radiotherapy department at the Churchill Hospital for their help in tracing records.

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