

ENT Conditions and Procedures

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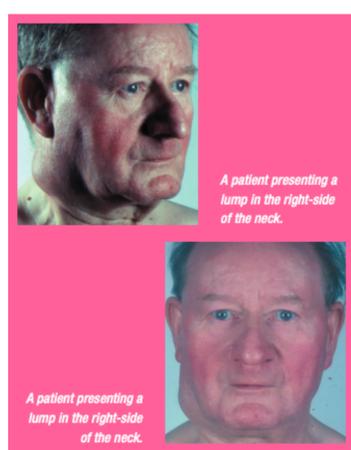
Neck Dissection

How do cancers spread?

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Most cancers which start in the head and neck region have the ability to spread to other parts of the body; these are called metastases ('mets') or 'secondaries'. Cancers can spread in a number of different ways, most often by the lymph system to lymph nodes and sometimes by the blood to other distant organs like the liver.

In the head and neck region, localised lymphatic spread is quite common, but spread by blood to distant parts of the body is uncommon. Lymph nodes (also called lymph glands) catch bacteria, viruses or cancer cells in the body. Each node drains a particular area of the body. The nodes in the neck drain the skin of the head and neck and all the swallowing and breathing tubes. Once one cancer cell has been 'caught' by a lymph node it can grow and multiply there, and in time can spread to the next node down the chain and so on.



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What is a neck dissection?

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There are two basic types of neck dissection:

A radical neck dissection is a surgical operation, which aims to remove all the lymph nodes in the neck between the jaw and the collarbones. This operation may be carried out if there is evidence that there are one or more nodes affected with cancer in the neck. The nodes are often small and stuck to structures in the neck, so we usually remove other tissues as well to ensure that we remove all parts of the cancer nodes. We only remove structures which you can safely do without, and those which do not leave serious long-lasting effects.

A partial neck dissection is performed when there are strong suspicions that there may be only microscopic amounts of cancer cells in nodes in the neck. In this case we tend to only remove those groups of nodes which are most likely to be affected in your type of cancer.

In both sorts of operation we send all the tissues away to the laboratory to search for cancer cells and to see how extensive the spread has been.



What can I expect from the operation?

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Most patients will be admitted one or two days before their operation. In many cases the neck dissection is only part of the surgery and the patient may also be having some other procedure aimed at removing the primary or original tumour. The operation is performed under general anaesthetic which means that you will be asleep throughout. There will usually be two long cuts made in the neck. At the end of the operation you will have 1 or 2 drain tubes coming out through the skin and stitches or skin clips to the skin. Most patients do not have much pain after the operation. We may remove one of the large muscles from the neck so that patients find that the neck looks a little flatter on the side of the operation, and their neck can be stiff after the operation.

Possible complications

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Numb skin:

The skin of the neck will be numb after the surgery. This will improve over time to some extent, but you should not expect it to return to normal.

Stiff neck:

Some patients find that their neck is stiffer after the operation.

Blood Clot:

Sometimes the drain tubes which were put in during surgery can become blocked, causing blood to collect under the skin and form a clot (haematoma). If this occurs it is usually necessary to return to the operating room to remove the clot and replace the drains.

Chyle leak:

Chyle is the tissue fluid, which runs in lymph channels. Occasionally one of these channels called the thoracic duct leaks after the operation. If this occurs, lymph fluid or chyle can collect under the skin, in which case we need to keep you in hospital longer and sometimes need to take you back to the theatre to seal the leak.

Injury to the Accessory nerve:

This is the nerve to one of the muscles of the shoulder. We try hard to preserve this nerve but sometimes it needs to be removed, because it is too close to the tumour to leave behind. In this case you will find that your shoulder is a little stiff and that it can be difficult to lift your arm above the shoulder. Lifting heavy weights, like shopping bags, may also be difficult.

Injury to the Hypoglossal nerve:

Very rarely, this nerve (which makes your tongue move) also has to be removed due to involvement with the tumour. In this case you will find it difficult to clear food from that side of the mouth and it can interfere with your swallowing.

Injury to the Marginal Mandibular nerve:

This nerve is also at risk during the operation, but we also try hard to preserve it. If it is damaged you will find that the corner of your mouth will be a little weak. This is most obvious when smiling.

Will I need any other sort of treatment?

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This will depend on what treatment you have had already, where your tumour is and what type of tumour it is. Sometimes we add radiotherapy to surgery if we think this may give a better chance of a cure.

How long will I need off work?

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This will depend on the type of treatment you have had and you should discuss it with your ENT surgeon; but as a general rule you will need at least three weeks off work.

by Chris Milford

Disclaimer: This publication is designed for the information of patients. Whilst every effort has been made to ensure accuracy, the information contained may not be comprehensive and patients should not act upon it without seeking professional advice.