
Editorial

The incidence of head and neck cancers (HNSCC) is on the rise globally. A large chunk of these cancers are contributed by oral cancers, with the bulk of these coming from developing countries. The past decades have witnessed further insights into the management of these cancers, particularly regarding neck dissections and adjuvant therapy. A recently published large randomized controlled trial has confirmed the need for neck dissection even in early stage oral cancers. The extent of neck dissection for node-negative and even node-positive necks has been a matter of considerable discussion. The extent of neck dissections is governed by a few important factors, viz the anatomical pattern and order of lymphatic metastases from primary sites, the incidence of skip metastases, their levels, and the oncological safety of lesser than comprehensive, selective neck dissections.

In this issue, Patel et al review the incidence and frequency of skip metastases in oral cancers. The likelihood of skip metastases is a pertinent point in choosing the extent of neck dissection for a particular primary site. On the contrary, Harshita et al narrate their experience with supraomohyoid neck dissection in N1 necks. This, however, in the opinion of the editors, is a modification that is highly individualized and needs caution regarding careful patient selection. The presence of cervical metastatic nodes decreases the survival in HNSCC by a half, while the presence of extracapsular extension further impacts the survival. On this background, the use of a less than comprehensive neck dissection in N+ necks is something that needs extreme patient selection and caution before being utilized generally. An earlier publication based on the lymph node yield at different neck levels has shown that, when the nodal disease is of a small volume (N1, without extranodal extension), and limited to levels IA/IB, the yield of nodes at level V has been rare; thus, recommending selective neck dissection (levels I–IV) for low volume nodal disease confined to level IA/IB. However, there is a dearth of data regarding survivals and outcomes from a large, prospective, randomized study comparing comprehensive and selective neck dissection in N+ necks. In the absence of survival data from a level I evidence paper, the utility of selective neck dissections in N+ necks will continue to be a point of discussion.

The modern head and neck surgeon's workload consists of a substantial chunk of revision surgeries and previously irradiated cases. If a microvascular free tissue transfer would be required in such cases, the issue of suitable recipient vessels becomes an important one.

The scope of head and neck surgery is ever increasing, with newer forays in the last few decades into skull base, minimally invasive surgery, robotic surgery and endocrine surgery. Surgery for parathyroids is an interesting aspect of endocrine surgery that comes in the purview of the head and neck surgeon. Elsewhere in this issue, Ridyard writes about the combined use of methoxyisobutylisonitrile (MIBI) and ultrasonography (USG) in the preoperative localization of parathyroid adenomas. While there still are schools of thoughts regarding the need for exploration of all parathyroids at surgery for an adenoma, an elegant and effective preoperative localization leading to a single-gland surgery is favored by most surgeons for parathyroid adenomas.

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