



**Session III: Oral Cavity**  
Clinical Cases



2ND EUROPEAN PERSPECTIVES IN HEAD & NECK CANCER



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2nd European Perspectives in Head/Neck Cancer, Prague 2009

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**Tumorboard**

**Kopf – Hals Tumorboard**  
**am Universitätsklinikum Leipzig AÖR**  
Klinik für Hals-Nasen-Ohrenheilkunde, plastische Operationen  
Direktor: Prof. Dr. A. Dietz  
Klinik für Mund-, Kiefer- und plastische Gesichtschirurgie  
Direktor: Prof. Dr. Dr. A. Hemprich  
Koordinator: Dr. med. A. Boehm , HNO




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Case: M.E. 03.05.1948

cT4N2cM0 carcinoma of the oral cavity  
CT scan: tumor infiltrates the lower jaw and half of the lateral tongue,  
Midline of the tongue is touched

Risik: 20 pack years, 5 beer/d




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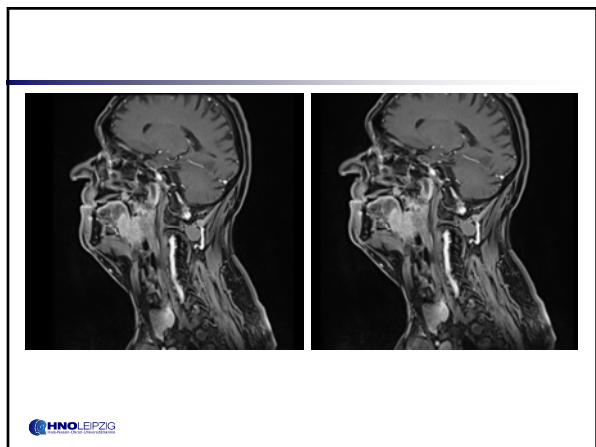
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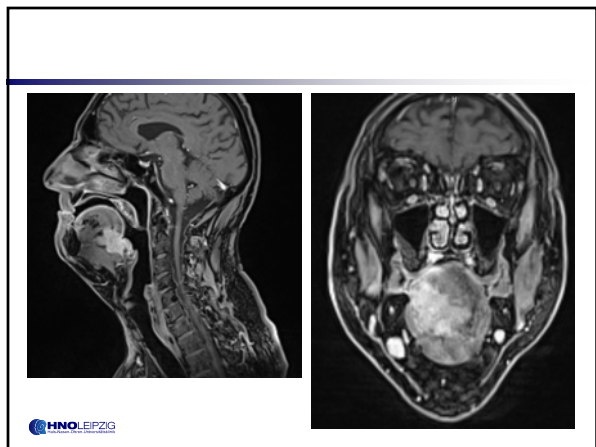
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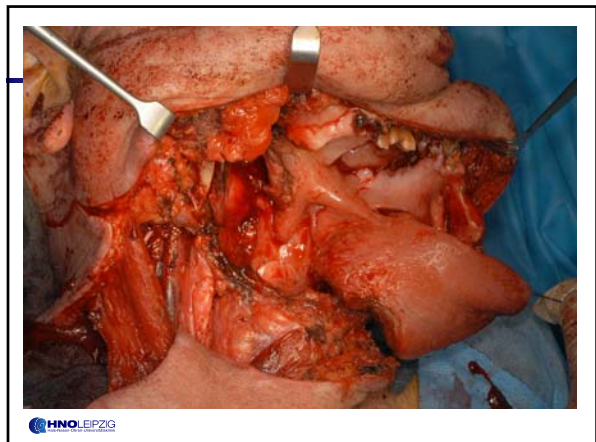
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Case: F.D. 08.10.1948

cT4cN2bcM0 carcinoma of the oral cavity  
CT scan: penetration of the lower jaw and lip

Risik: 20 pack years, 2 beer/d



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Case: R.C. 04.12.1973

cT2N0M0 carcinoma of the oral cavity  
CT scan: tumor touches the lower jaw (no infiltration)

Risik: 15 pack years, 6 beer/d



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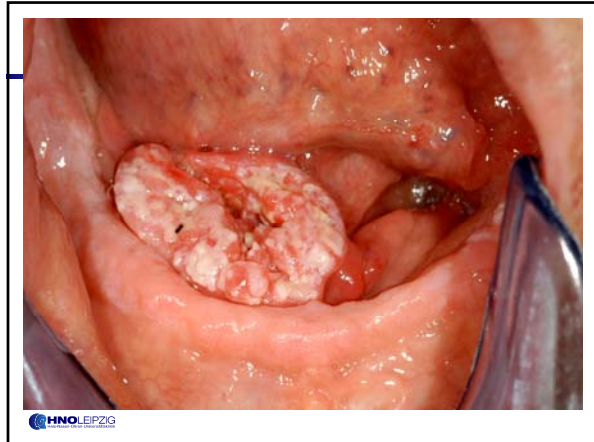
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Case: P.H. 03.07.1953

cT4N0M0 carcinoma of the oral cavity  
CT scan: tumor infiltrates the lower jaw

Risik: 22 pack years, 5 beer/d

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Case: M.E. 04.06.1953

cT1N0M0 carcinoma of the oral cavity  
CT scan: tumor reduced to floor of the mouth, no jaw infiltration

Risik: 10 pack years, 2 beer/d



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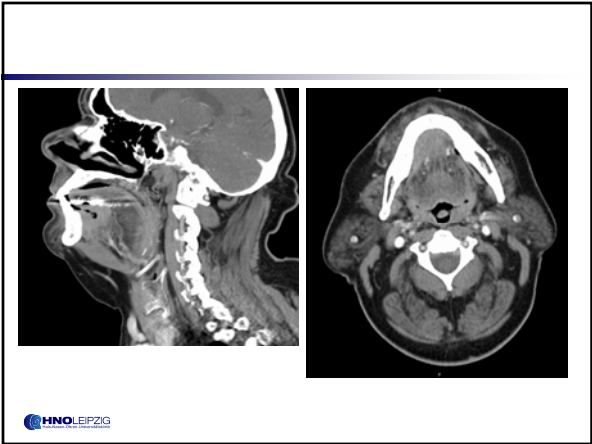
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Case: F.E. 10.06.1958

cT4N0M0 carcinoma of the oral cavity  
CT scan: tumor of floor of the mouth, no jaw infiltration

Risik: 10 pack years, 3 beer/d



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Case: F.P. 12.07.1948

cT4N2bM0 carcinoma of the oral cavity  
CT scan: tumor floor of the mouth, jaw infiltration

Risik: 20 pack years, 5 beer/d



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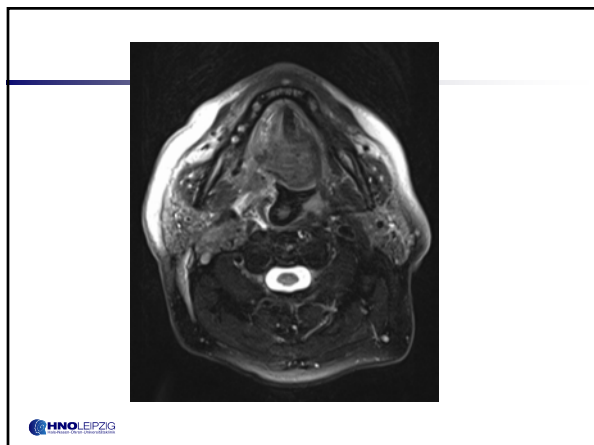
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Case: Z.H. 18.12.24  
T3N0M0 Larynx carcinoma  
T2N0M0 Adeno carcinoma colon descendens  
Emergency tracheostomia at first visit in hospital

Risik:  
Diabetes mellitus Typ II  
Chronic ischemic heart disease

Risk: 25 pack years, 3 beer/d

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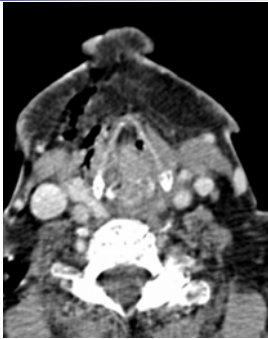
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first CT scan



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General surgery decision:

curative resection  
poor differentiated adeno carcinoma colon descendens G2  
pT2pN0(0/17) cM0V0Pn0  
UICC-Stage 1, R0

No adjuvant chemotherapy  
Pseudomembran. Colitis: vancomycin therapy

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How to treat the laryngeal cancer?



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Case: K.D. 08.10.1948  
cT4cN3cM0 Oro-Hypopharynx-Larynx-CA  
Cartilage penetration  
Infiltration of the thyroid gland  
  
Risiko: 24 pack years, 3 beer/d



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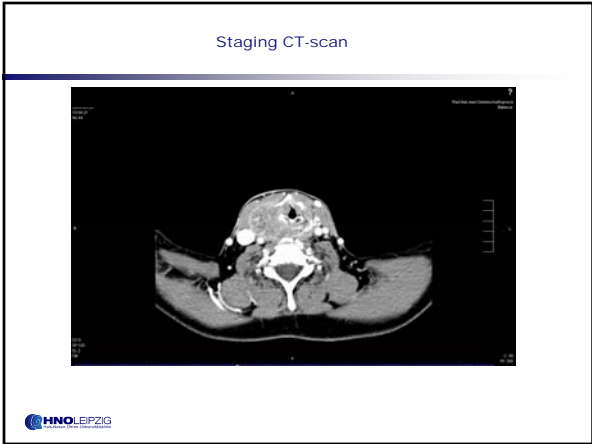
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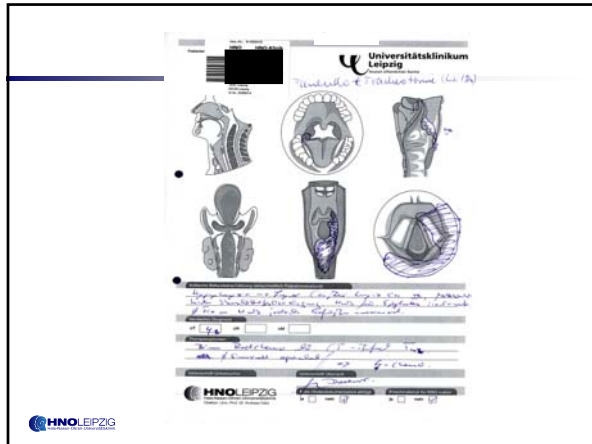
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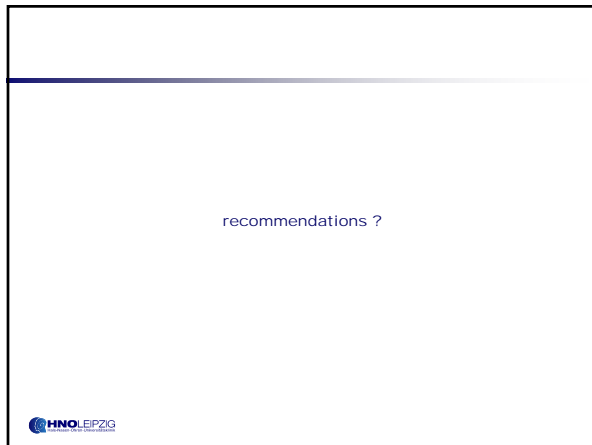
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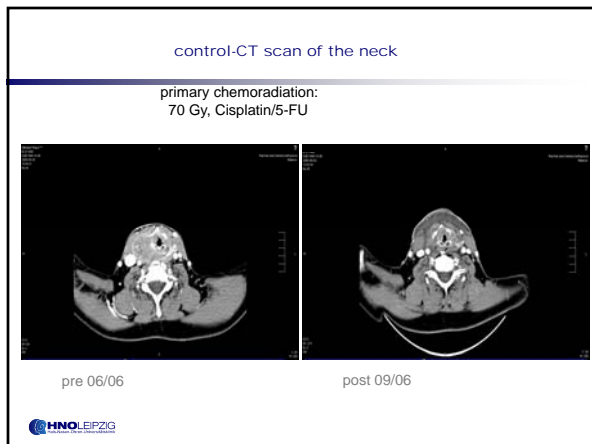
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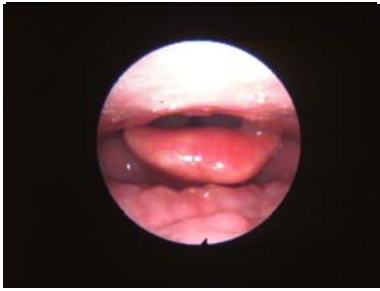
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January 2007 (4 months later)



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Dysphagia after primary chemoradiation

**Table 1. Chemoradiation Toxic Therapeutic and Functional Outcomes**

Trial	Radiation Therapy	Chemotherapy	Mucositis Grade 3 + 4	Swallowing Toxicity
RTG 98-14 <sup>14</sup>	72 Gy over 6 weeks; single arm, phase II	Oxiplatin	67%	FT rates, 82.9%; 1 year, 40.9%; 2 years, 23.9%
Star <sup>15</sup>	60.3 Gy over 30 days	Fluorouracil + carboplatin	48% v 52%, P = .01	3-year FT rates, 51% v 25%, P = .02
RTG 91-11 <sup>16</sup>	70 Gy over 7 weeks	Oxiplatin	43% v 24%	1 year, 50% or liquid only, 23% v 9%; 1 year, FT, 3% v none; 2 years, 14% v 16% of both groups had "difficultly swallowing"
Intergroup 0128 <sup>4</sup>	70 Gy over 7 weeks	Oxiplatin	43% v 32%, P = .08	52% v 40%, P = .06, acute FT rates
Abbott <sup>17</sup>	74.4 Gy over 16 weeks	Oxiplatin, fluorouracil + irinotecan	65%	5% pharynx soft tissue necrosis, 6% aspiration pneumonia chronic, 18% FT dependent chronic, 7%, liquid only
Estroff <sup>18</sup>	70 Gy, single arm, phase I	Gemcitabine	Grade 3 or higher for all	Acute FT rate, 82% at 12% > 10 mg/dL chronic FT rate, 28% associated with pharyngeal dilation, aspiration, and obstruction not relieved by dilation
GORTEC 04-01 <sup>19</sup>	70 Gy over 7 weeks	Carboplatin + fluorouracil	Grade 3/4, 71% v 39%	FT rates overall, 37% v 15%, P = .02; 15% > 10% weight loss, 16% v 6%, P = .04
Kiser <sup>20</sup>	75 Gy over 9 weeks; single arm, phase I	Paclitaxel, carboplatin, fluorouracil		1-year FT rate, 20%

Abbreviations: RTG, Radiation Therapy Oncology Group; GORTEC, Groupe Oncologie Radiotherapie Tete Et Cou; FT, feeding tube.  
 Rosenthal DJ, JCO 2006  
 2-year FT rates, 51% v 25%; P = .02

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Dysphagia after primary chemoradiation

**Table 4. Ten Recommendations to Maximize Postirradiation Swallowing Recovery**

- Avoid any unnecessary mucosal irritation, especially to the larynx, CP, BOT, and PVV.
- Optimize radiation treatment plans to minimize dose, as general, and especially "hot spots" to the BOT, larynx, PVV, and CP.
- Maximize patient swallowing expectations by minimizing xerostomia with IMRT, cytoprotection, and salivagogues (parasympathomimetics), chewing sugar-free "soft" gum that may also strengthen muscles, reduce risk for cancer, and stimulate salivary flow.
- Speech-language pathologists should evaluate all patients before, during, and after RT to start appropriate exercises and evidence-based swallowing strategies such as the super-esophageal swallow and the Mendelsohn Maneuver, as well as postural, dietary, and postural strategies.
- Delay feeding tube placement/use as long as appropriate.
- Consider NG-feeding tubes rather than gastrostomy feeding tubes.
- Patients should swallow the maximally tolerated bolus size and viscosity as much as possible to maintain swallowing ability even if feeding tube is placed.
- Even brief NPO attempts should be avoided.
- Follow radiation swallowing exercises (Table 3).
- Optimize psychological support and pain management to facilitate above.
- Set reasonable, time-based swallowing steps with the goal of maximizing recovery by 4 months after RT, that predicts long-term function for most patients.

Abbreviations: BOT, base of tongue; CP, oropharyngeal inlet; IMRT, intensity modulated RT; NG, nasogastric; NPO, nothing by mouth; PVV, posterior pharyngeal wall; ROM, range of motion; RT, radiation therapy.  
 Rosenthal DJ, JCO 2006  
 Delay feeding tube placement/use as long as appropriate  
 Consider NG-feeding tubes rather than gastrostomy feeding tubes

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Case: K.M. 01.08.1961

T1N3M1 Oropharynx carcinoma (tonsil)  
unilateral infiltration parotid gland and external carotid artery  
Singular metastasis left lateral chest wall

Heavy smoker, drinker



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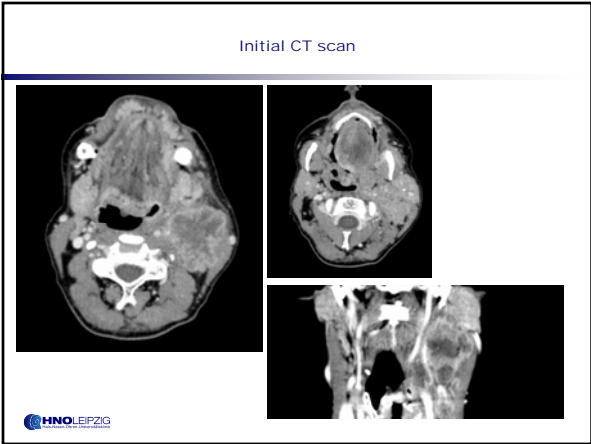
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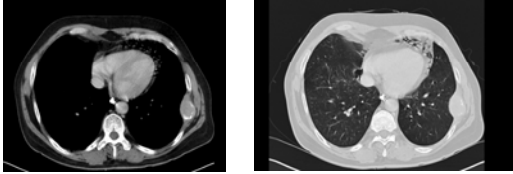
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Thorax-CT



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recommendations ?

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therapy

Transoral resection (R0)  
radical Neck dissection and right side parotidectomy (R0)  
resection metastasis chest wall (R0)  
adjuvant chemoradiation (CisPl./5FU)

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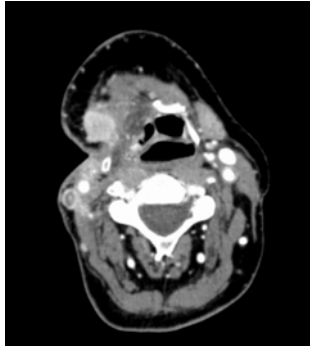
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1 year later



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recommendations ?

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case: O.M. 26.11.1971

*Alia loco*  
partial glossectomy, SND (Level2-4) right side  
T1N1M0 right lateral tongue in 2005  
no adjuvant treatment

Now: SND Level 1-2, stop of surgery because of advanced disease in the submandibular area

Question to the board: what to do?

Heavy smoker, drinker

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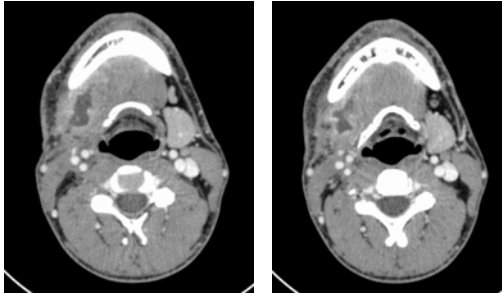
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Pretherapy CT scan



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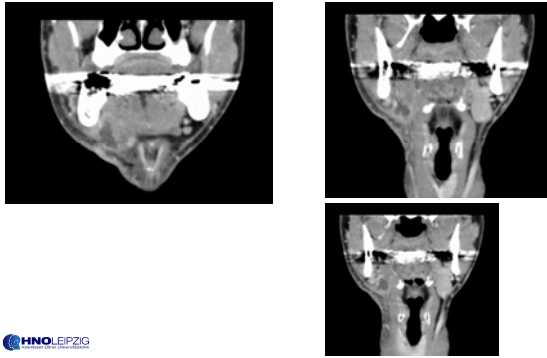
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Pretherapy CT scan



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recommendations ?  
What is about treatment of the lower jaw ?

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Therapie

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SND right, Periost lower jaw negative frozen section  
- which caused no jaw resection  
SND left

Resection recurrent submandibular tumor R0?  
Positive node, extracapsular spread right side  
poor diff. Verh. Squamous cell carcinoma G2, infiltration of surrounding tissue

Left neck negative



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Adjuvant treatment?



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Case: R.B. 10.02.1948  
cT2N0cM0 Oropharynx carcinoma (base of tongue,  
vallecula)

Symptoms: recurrent hoarseness, pain at the neck

Heavy smoker, drinker



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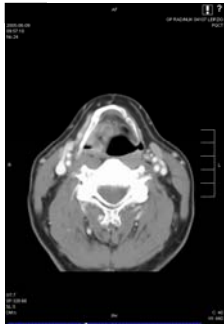
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Pre CT scan



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recommendations?

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therapy

- Transoral laser surgery Oropharynx- und Larynx right side and SND bl.
- postoperative TNM-classification: cT2pN0cM0, R0



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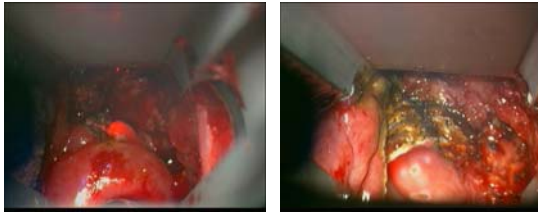
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Endoscopic surgery



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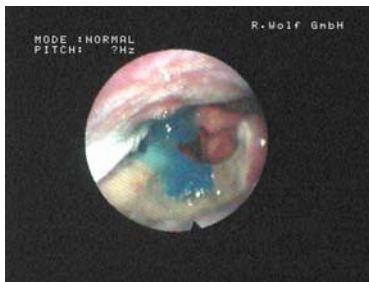
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Swallowing testing (1 bzw. 4 weeks postoperative)



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Adjuvant treatment?



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Therapy

- Transoral laser surgery Oropharynx- und Larynx right side and SND bl.
- postoperative TNM-classification: cT2pN0cM0, R0
- postoperative radiation (61,2 Gy)
- no PEG, no TT



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