



HEAD AND NECK CANCER: WHAT YOU SHOULD KNOW

BRIANNA HARRIS, MD

OTOLARYNGOLOGY- HEAD AND NECK SURGERY



NO DISCLOSURES

- No conflicts of interest

A LITTLE ABOUT ME

- Residency at UC Davis



- Fellowship at University of Pennsylvania
 - Head and Neck Surgical Oncology
 - Microvascular Surgery
 - Transoral Robotic Surgery



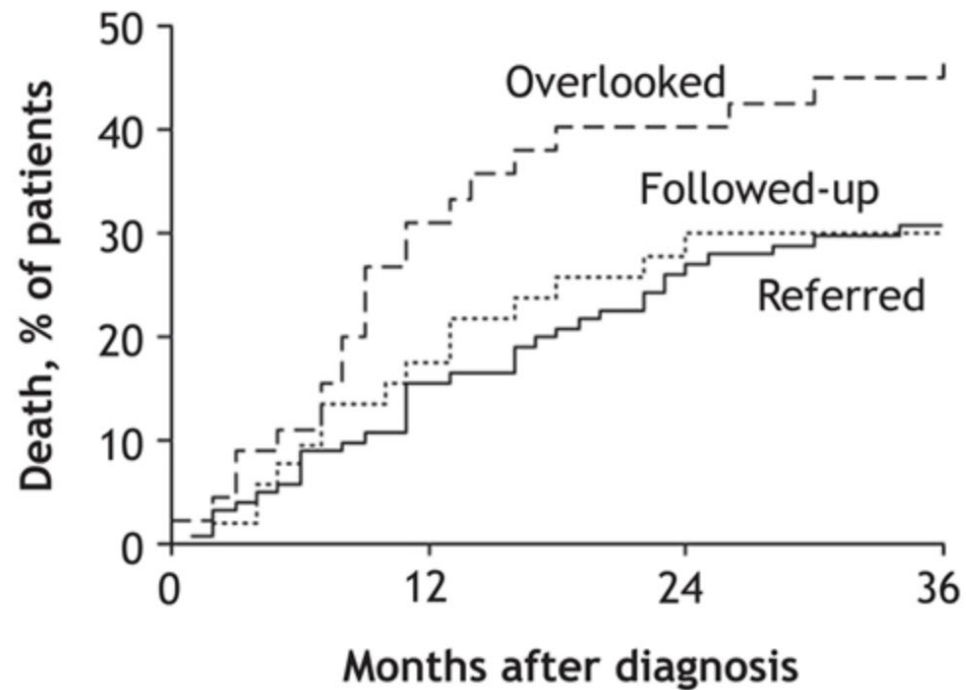
LEARNING OBJECTIVES

- Epidemiology
- Most common types of head and neck cancer
- Most common presentation
- Appropriate workup by Primary Care
- When to send to a specialist
- Brief overview of how we treat

EPIDEMIOLOGY

- Worldwide- 650,000 cases, and 330,000 deaths annually
- US- 3% of malignancies (53,000 cases, 10,800 deaths annually)
- Typically associated with tobacco and alcohol
- Men>women
- Age 60s-80s*
- 5-year survival rate 33-62% (depending on site)

WHY IS THIS IMPORTANT



No. at risk of death

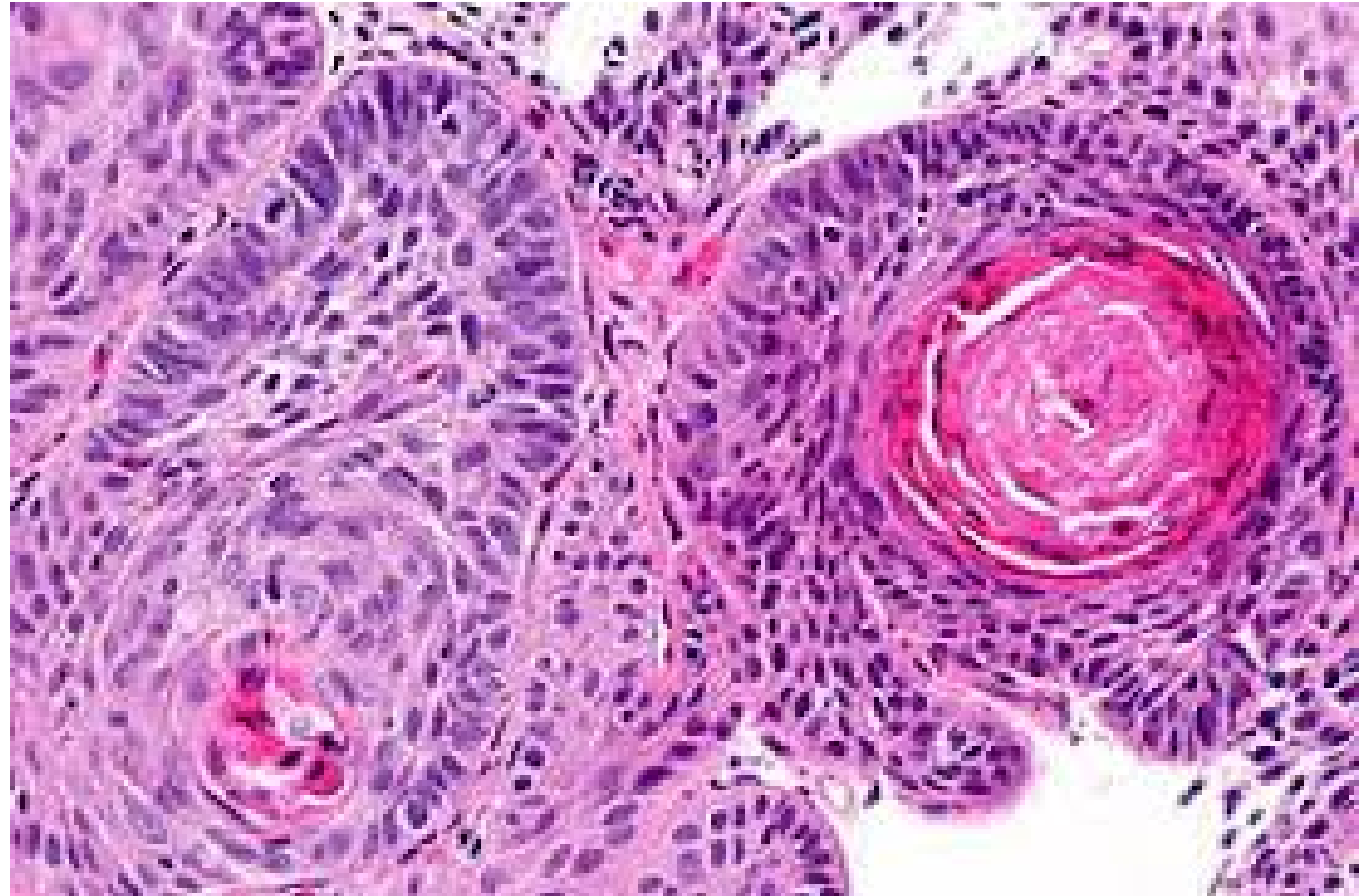
Referred	123	100	80	71
Followed-up	53	40	35	34
Overlooked	45	31	26	23

LEARNING OBJECTIVES

- Epidemiology
- Most common types of head and neck cancer
- Most common presentation
- Appropriate workup by Primary Care
- When to send to a specialist
- Brief overview of how we treat

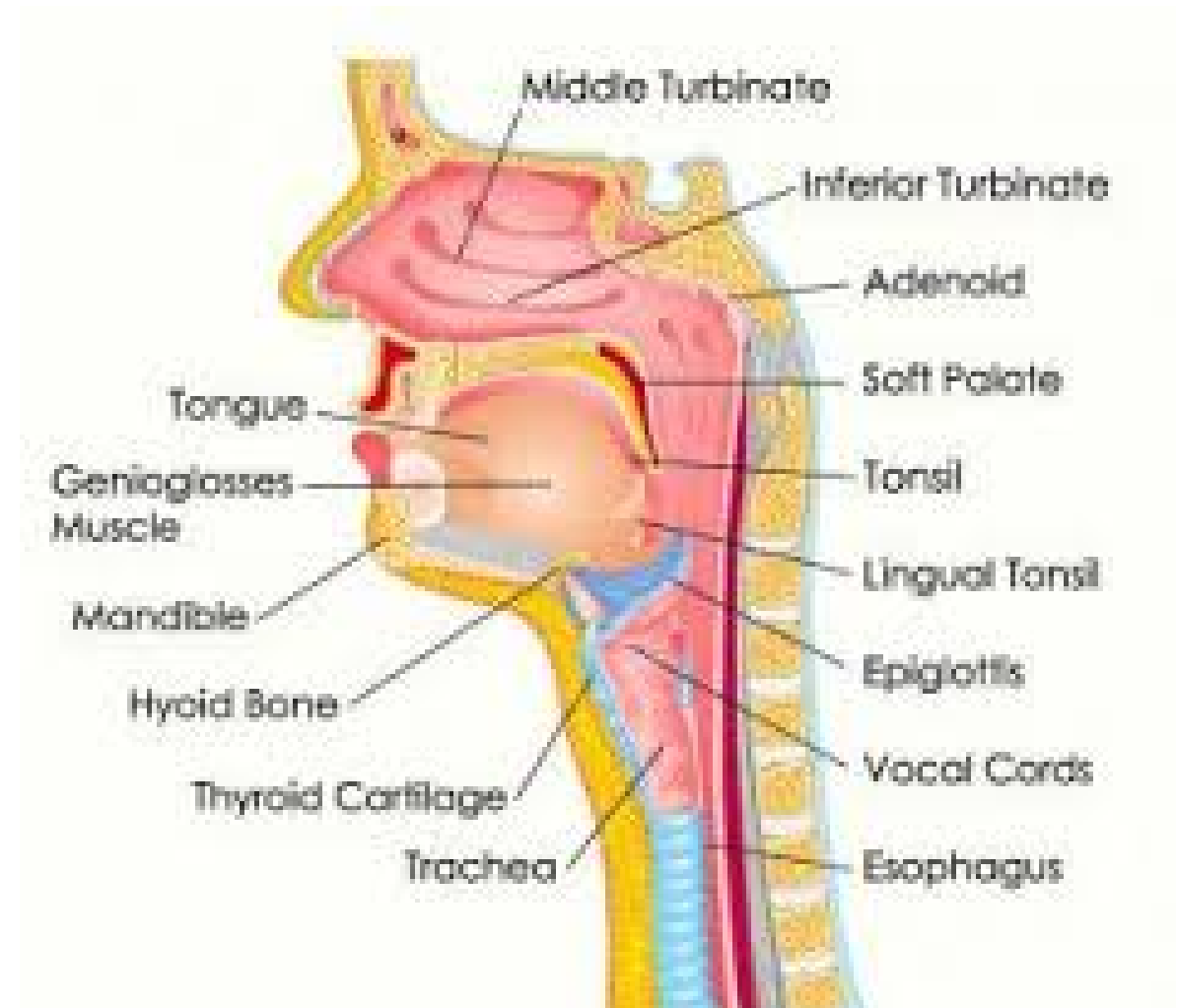
MOST COMMON TYPES OF HEAD AND NECK CANCER

- Squamous cell carcinoma
- Squamous cell carcinoma
- Squamous cell carcinoma
 - 90% of Head and Neck Cancers
- Adenocarcinoma
- Lymphoma
- Salivary gland tumors
- Sarcomas
- Melanoma
- Non-melanoma skin cancers



COMMON SUBSITES OF HEAD AND NECK CANCER

- Oral cavity
 - Oropharynx
 - Nasopharynx (<1 per 100,000)
 - Hypopharynx (<1 per 100,000)
 - Larynx (3.6 per 100,000)
 - Sinonasal cavity (~2,000 annually)
 - Thyroid*
 - Skin*
- } (11.4 per 100,000)



LEARNING OBJECTIVES

- Epidemiology
- Most common types of head and neck cancer
- **Most common presentation**
- Appropriate workup by Primary Care
- When to send to a specialist
- Brief overview of how we treat

ORAL CAVITY CANCER

- Pain
- Dysphagia
- Odynophagia
- Otalgia
- Trismus
- Adenopathy
- Loose dentition



OROPHARYNGEAL CANCER

- Painless neck mass
 - HPV related tumors
- Dysphagia
- Odynophagia
- Muffled voice
- Oral bleeding



NASOPHARYNGEAL CANCER

- Neck mass
- Epistaxis
- Nasal obstruction
- Cranial nerve palsy



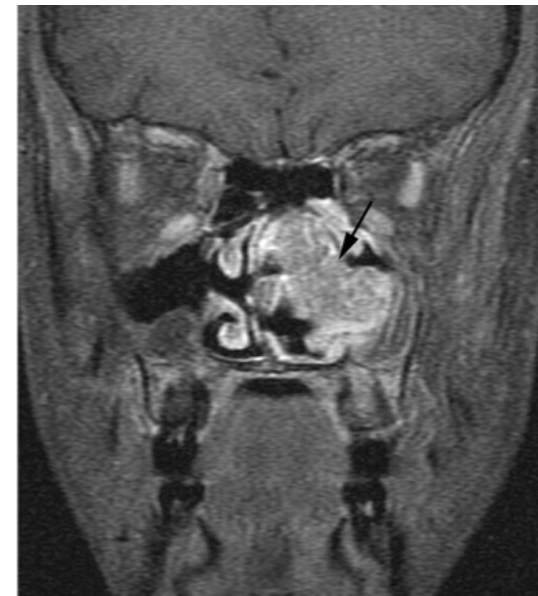
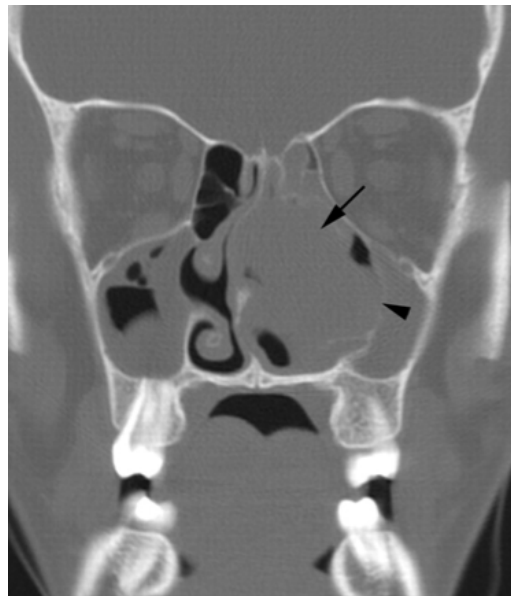
	Epidemiology	Overall survival	Local control	Distant metastasis-free survival
HPV-negative/EBV-positive	Endemic regions	Most superior	Most superior	Lowest
HPV-positive/EBV-negative	Non-endemic regions	Moderate	Moderate	Moderate
HPV-negative/EBV-negative	Non-endemic regions	Lowest	Lowest	Moderate

HPV=human papillomavirus. EBV=Epstein-Barr virus.

Table 1: Characteristics of the different types of viral-associated nasopharyngeal carcinoma

SINONASAL TUMORS

- Epistaxis
- Nasal obstruction
- Anosmia
- Headache
- Cranial nerve palsy, especially V2



HYPOPHARYNGEAL AND LARYNGEAL CANCER

- Dysphagia
- Dysphonia
- Shortness of breath/Stridor
- Odynophagia
- Hoarseness
- Hemoptysis

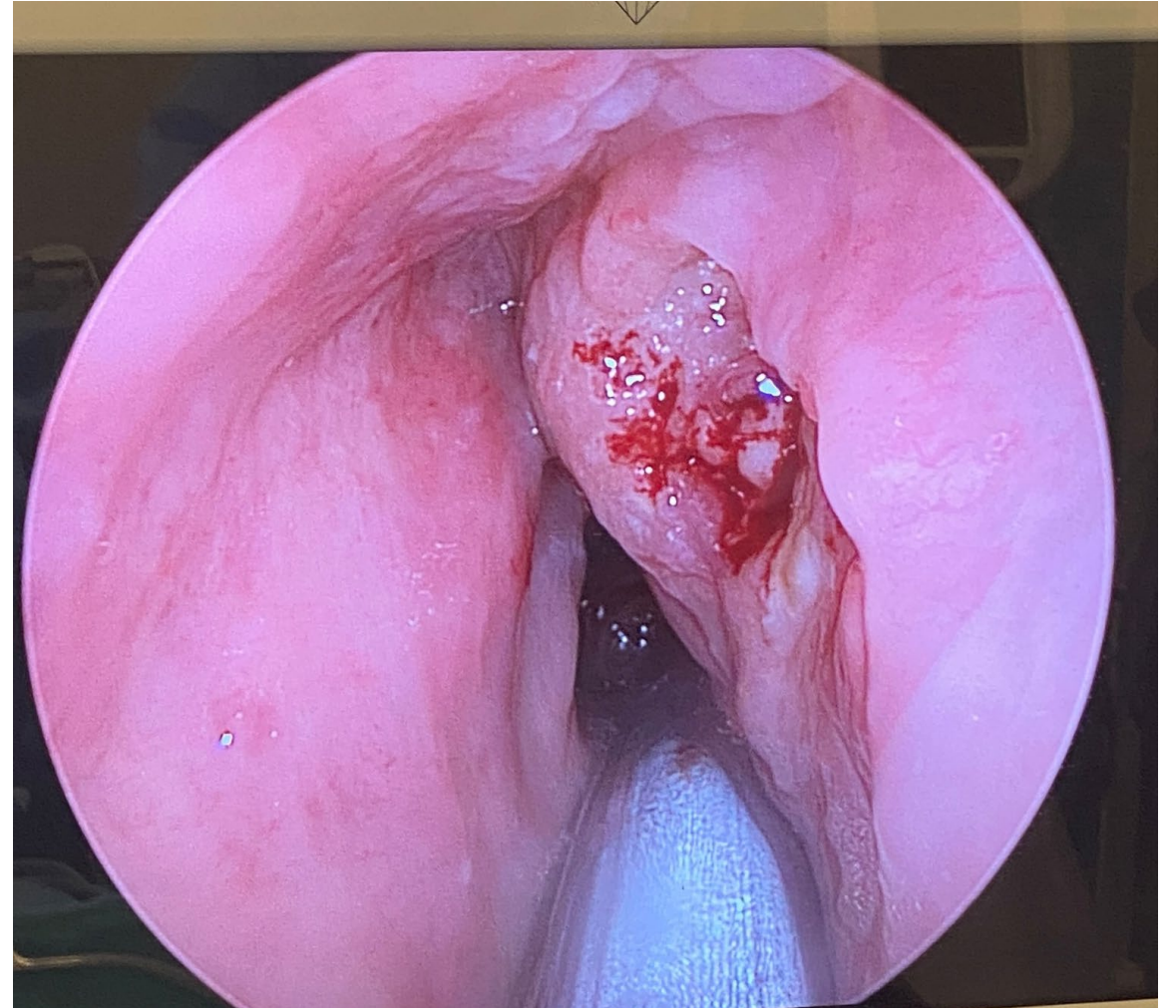


Table 1: Primary symptom reported at initial primary care visit in a cohort of patients with head and neck carcinoma and by patients in the general population

Primary symptom*	Patients with head and neck carcinoma, no. (%) <i>n</i> = 221	Patients and their characteristics reporting the same symptoms in primary care visits† <i>n</i> = 5646		
		No. (%)	Mean age (SD), yr	Men, no. (%)
Hoarseness	61 (28)	24 (0.4)	35 (20)	8 (33)
Throat pain	45 (20)	150 (2.7)	32 (20)	52 (35)
Change in the tongue	24 (11)	4 (< 0.1)	13 (19)	1 (25)
Pain in the tongue	21 (10)	20 (0.3)	52 (21)	5 (25)
Neck lump	14 (6)	8 (0.1)	23 (24)	4 (50)
Dysphagia	6 (3)	5 (< 0.1)	52 (12)	2 (40)
Dyspnea	5 (2)	69 (1.2)	55 (25)	29 (42)
Tussis or hemoptysis	4 (2)	275 (4.9)	34 (26)	114 (41)
General symptoms	2 (1)	62 (1.1)	56 (23)	25 (40)
Other local symptoms	7 (3)	—	—	—
Unrelated symptoms	32 (15)	—	—	—
Total	221 (100)	617 (11)	—	—

Note: SD = standard deviation.

*These symptoms were classified according to ref. 18 in the following categories (from top to bottom): R23 (voice symptoms); R21 (throat symptoms); D83 (disease of mouth/tongue/lip); D20 (mouth/tongue/lip symptoms); B02 (enlarged lymph nodes); D21 (difficulty in swallowing); R02 (dyspnea); R05 (cough); A04, A05, T08 (weakness/fatigue/decline in overall condition/weight loss).

†In 25 randomly selected primary health care centres.

LEARNING OBJECTIVES

- Epidemiology
- Most common types of head and neck cancer
- Most common presentation
- **Appropriate workup by primary care**
- When to send to a specialist
- Brief overview of how we treat

CASE PRESENTATION

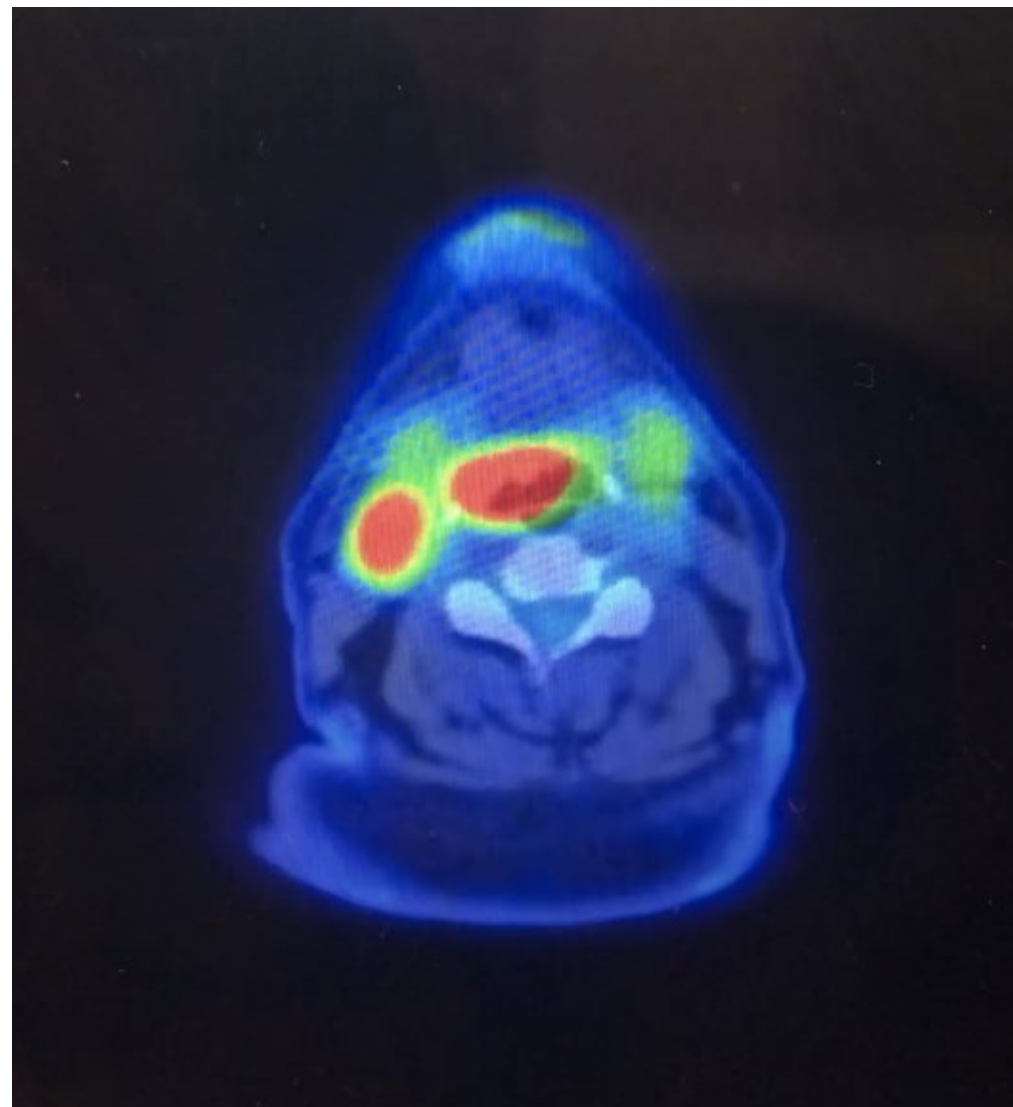
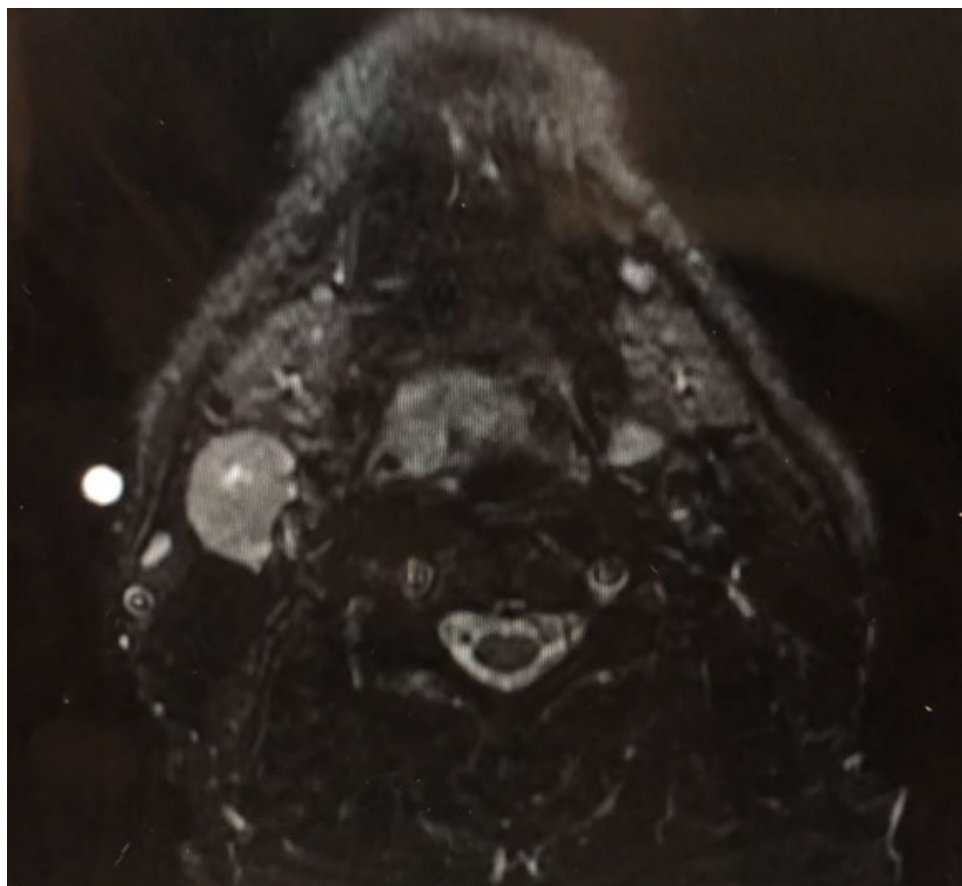
- 60yo Caucasian male
 - Intermittent sore throat x3 months
 - Few rounds of abx without relief
 - Neck mass appeared in right neck
- What are the next steps?

THE NECK MASS

- Salivary gland tumors (80% benign)
- Thyroid
- Lymphomas
- Metastasis from head and neck primary
- Benign lymph node/inflammatory or infectious

NEXT STEPS

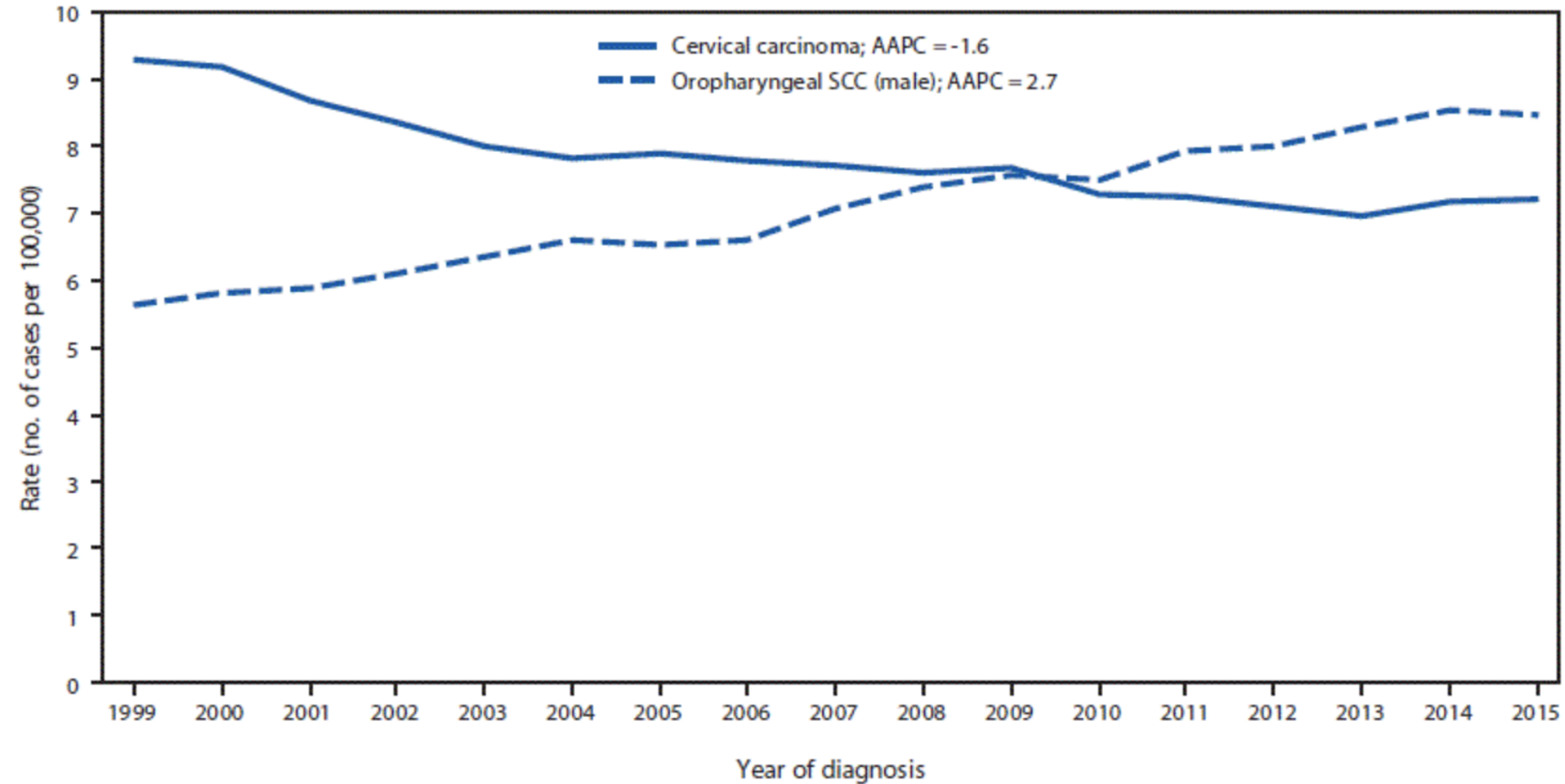
- Order imaging
- Order FNA
 - If nondiagnostic, repeat FNA
- Send to specialist



HPV-RELATED OROPHARYNGEAL CANCER

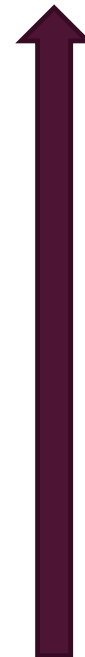
- Incidence is increasing
 - 3-fold increase in the last few decades
- Surpassed cervical cancer as most common site of HPV-related cancer
 - Currently, no screening tool
- Male to female ratio 4:1
- Younger (median age 54), higher socio-economic status, higher education level

FIGURE 1. Trends* in age-adjusted incidence of cervical carcinoma among females and oropharyngeal SCC among men,[†] — United States,[§] 1999–2015



CYSTIC NECK MASS IN 50YO M

- HPV related cancer
- HPV related cancer
- HPV related cancer
- Thyroid cancer
- Branchial cleft cyst



Most likely

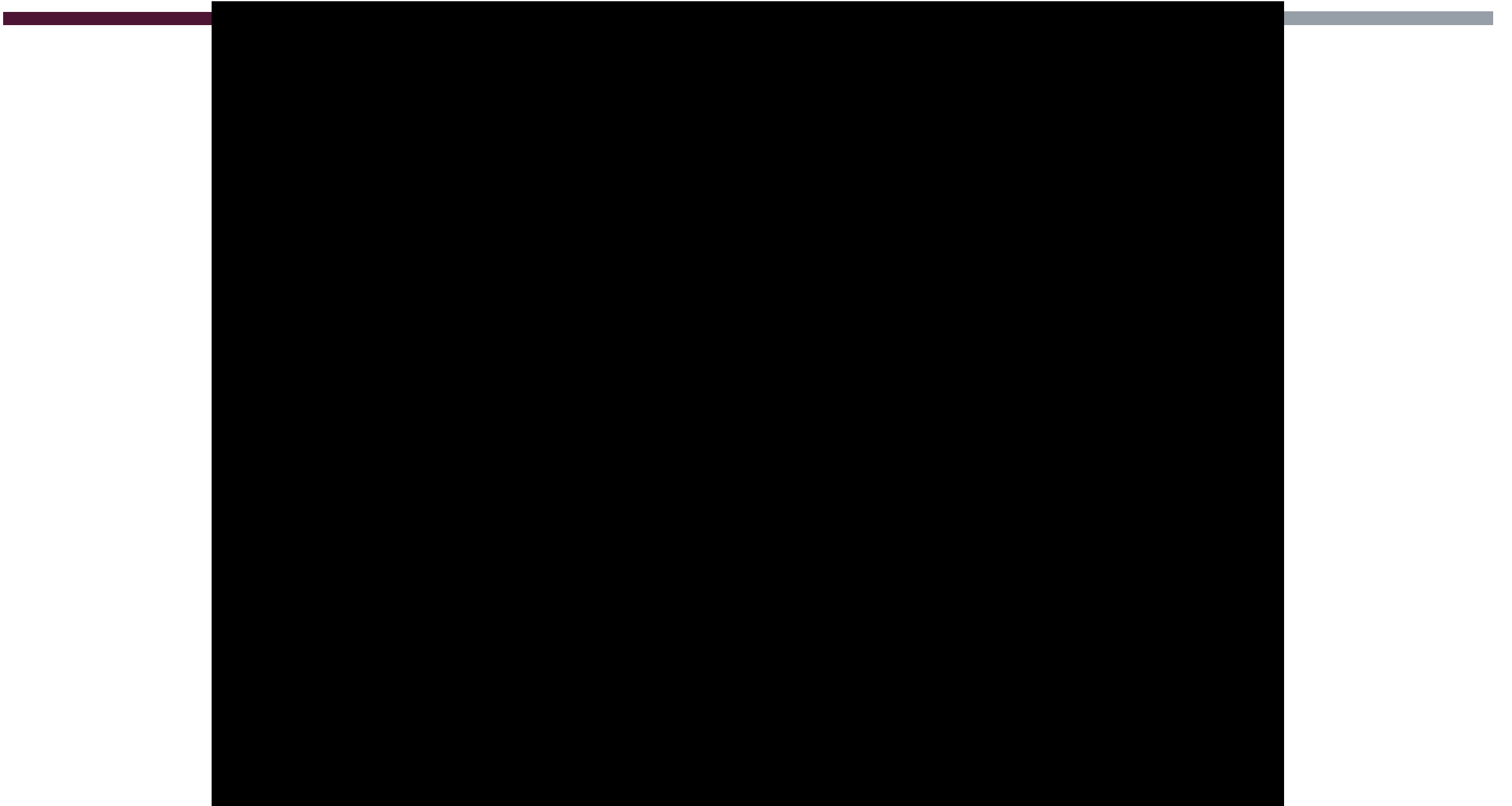
Least likely

LEARNING OBJECTIVES

- Epidemiology
- Most common types of head and neck cancer
- Most common presentation
- Appropriate workup by primary care
- When to send to a specialist
- Brief overview of how we treat

BRIEF OVERVIEW OF TREATMENT

- Surgery is primary treatment modality for most of these tumors
 - Exceptions: nasopharyngeal cancer, some laryngeal and hypopharyngeal cancer
- For HPV-related tumors
 - Primary Chemo/Radiation
 - Primary transoral robotic surgery (improved QOL, lower long-term side effects)

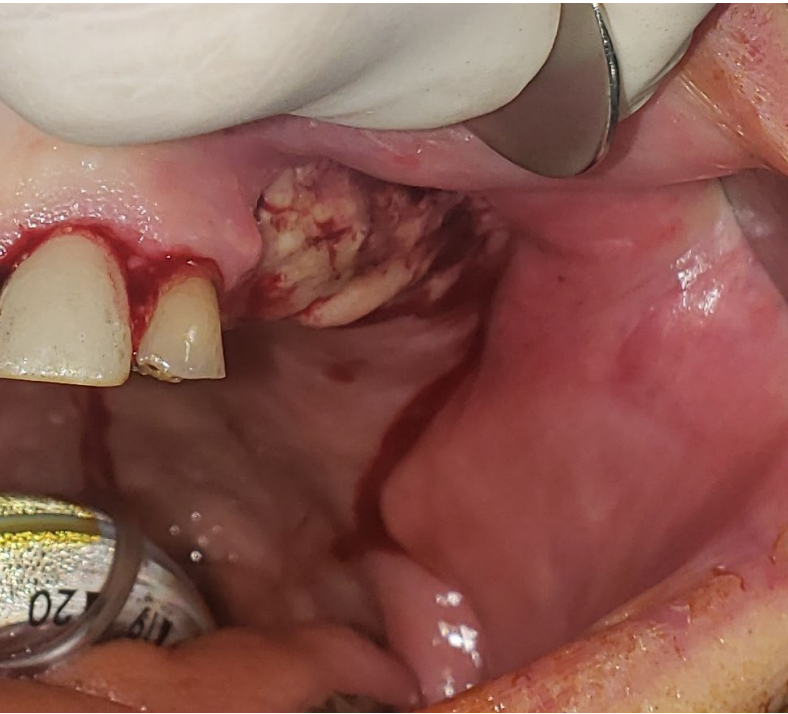


Transoral Robotic Surgery for Oropharyngeal Cancer: Long Term Quality of Life and Functional Outcomes

Peter T. Dziegielewski, MD, FRCSC^{1,2,*}, Theodoros N. Teknos, MD^{1,2}, Kasim Durmus, MD^{1,2}, Matthew Old, MD^{1,2}, Amit Agrawalm, MD^{1,2}, Kiran Kakarala, MD^{1,2,3}, Anna Marcinow, MD^{1,2}, and Enver Ozer, MD^{1,2}

- Improved oral diet
 - Decreased gtube dependence
 - Fewer cases of ORN
 - No xerostomia
-
- Associated with Increased QOL
 - These findings have been re-validated across multiple studies, including systematic review

FREE FLAP SURGERY



Pre-op tumor



Immediate post-op



3 mo post op

TAKE HOME POINTS

- Head and neck cancer is relatively rare
 - Persistent pain >2 weeks, dietary changes, neck mass
- 50-60 year old male with a persistent neck mass should raise suspicion
- CT scan, FNA, referral
- When in doubt, call a friend
 - 619-810-1265

THANK YOU

FOR QUESTIONS OR COMMENTS,
PLEASE EMAIL
BRIANNA.HARRIS.MD@GMAIL.COM