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Editorial

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Some characteristics of head and neck cancer surgery

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An editorial note

As the founder of the weekly Head and Neck Tumor Clinic at Ghaem Hospital in the city of Mashhad, I had the privilege of leading it for thirty years. With the invaluable support of our oncologist radiotherapists and fellow residents, our interdisciplinary approach to treating head and neck cancer proved to be a fulfilling and rewarding career for me.

This multidisciplinary approach began in 1979 and persisted until my retirement in 2010. The clinic is still operational and has gained increased acceptance, benefiting from new manpower and professionals. Depending on the referred patients, we had the opportunity to consult with related specialists such as general surgeons, thoracic surgeons, and pathologists. Our pathologists were highly regarded, and in their absence, their detailed notes and descriptions proved immensely helpful in our decision-making process.

This clinic was not a research based clinic, while several papers were reported by the clinic activists, mostly in domestic journals as well as few papers in international journals. According to the high volume of cancer cases that we were involved in their treatment I have a chance to have an overview and look at the head and neck cancer treatment.

We acknowledge that the body of our work constituted no more than 9% of the total number of oncologic patients. However, these cases possessed certain characteristics that allowed us to provide treatment in collaboration with our colleague oncologic radiotherapists.

Our oncologic cases have the following characteristics:

a) The majority of these cases involved well-differentiated tumors. Additionally, our head and neck oncologic cases often have a prolonged disease course, providing clinicians with an opportunity to engage in diagnostic surgical interventions, as well as surgical or radiotherapeutic treatments.

b) Head and neck cancer exhibits a distinct geometric pattern of distribution in its regional lymphatics, offering a valuable opportunity to utilize neck dissection as an effective method for enhancing their prognosis.

c) Tumors originating from salivary glands and thyroid often exhibit a propensity for perineural invasion. This necessitates a heightened level of otolaryngic attention to address the challenges associated with facial and recurrent nerve involvement.[1] To mitigate neural complications arising from the disease process or surgical interventions, various considerations must be considered, encompassing pre-operative, intra-operative, and postoperative surgical techniques. These interventions may encompass facial nerve decompression, nerve grafting, cosmetic facial surgeries, and rehabilitative procedures to address laryngeal functions, such as voice rehabilitation or surgeries to alleviate aspiration and dysphonia.[2]

In general, squamous cell carcinomas constituted the vast majority of these lessons. As surgeons, this necessitated close collaboration with our oncologist radiotherapists, who could administer preoperative or postoperative treatments, as well as adjuvant chemotherapy, to enhance the prognosis of our patients.

The requirement for performing ablative surgeries to address the disease process highlights the importance of surgical reconstructive techniques such as chest flaps, regional flaps,[3,4] and microvascular surgery for free flaps. Successfully managing the extensive task of treating head and neck cancer cases demands a higher level of expertise or a collaborative team effort.

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Conflicts of interest

Author declares that there is no conflict of interest.

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