Avoiding Errors in the Diagnosis and Management of Head and Neck Tumors

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Relevance and Purpose

- It is estimated that the average time from diagnosis to treatment of head and neck tumors is 56 days
- Head and neck tumors are typically present 6 months prior to diagnosis
- Reducing delays and common mistakes translates to better care and outcomes
Head and Neck Cancer: Key symptoms and findings

- Unilateral
- Persistent
- Progressive
Prolonged symptoms

- 54 yo Female- nonsmoker
- 6 months of tongue pain and earache
- Saw primary physician, oral surgeon, otolaryngologist
- Negative oral cavity and neck exam
- Treated with NSAID, antibiotics x 4 weeks
- Referred to psychiatrist

Delay in Diagnosis

- Developed 20 lbs weight loss
- Developed dysarthria
- Biopsy of tongue- negative
- Referred to neurologist for trigeminal neuralgia
Delay in Diagnosis

- Developed lump in neck
- FNA in office- purulent material
- Cultured and treated with IV antibiotics for abscess in neck

Persistent tongue pain
Head and Neck Symptoms

- Unilateral otalgia
- Sore throat
- Acidic food intolerance
- Dysphagia – odynophagia
- Persistent hoarseness or dysphonia
- Bleeding
- Non-healing sore
- Foreign body sensation
- Hearing loss
- Unilateral nasal symptoms

Nasal – Sinus Cancers

- Classic teaching:
  - Facial deformity
  - Orbital symptoms
  - Dental findings
  - Cranial nerve dysfunction
  - Bone destruction
- Above are too late!
Nasal – Sinus Cancers

- Early signs – unilateral!
  - Rhinorrhea
  - Obstruction
  - Epistaxis
Oral Carcinomas

- Persistent swelling
- Ulcerative lesion
- Pain or painless
- Non-specific irritation
- Blood-tinged saliva
- Otalgia
- Lump in the neck

Oral Cancer

- Late symptom
  - Difficulty swallowing
  - Altered speech
Pharynx Cancer

- Sore throat
  - Persistent
  - Localized
- Acidic food intolerance
- Otalgia
- Dysphagia
- Lump in the throat
Risk factors

- Tobacco
- EtOH
- Lichen planus
- Chronic dental disease
- Trauma
- HPV
- Immunodeficiency
- Radiation

Biopsy of lesion

- When is a negative biopsy really negative
- How to biopsy
  - small= excisional biopsy
  - Large- edge with normal
- If worried- repeat and go deeper
Avoidable Errors

1) Failure to inquire about head and neck symptoms in patients with a lump in the neck
2) Failure to perform a complete head and neck examination in a patient with a lump in the neck
3) Reliance on scans as a substitute for a complete (ENT) examination in the patient with a lump in the neck
4) Prolonged trial of antibiotics in the patient with a lump in the neck

Metastatic Cancer

- Hayes Martin 1952 – “Asymptomatic enlargement of one or more cervical nodes in an adult is almost always cancer and usually due to metastasis from a primary in the head and neck region.”
- M:F 4:1 60 = mean age
- Majority are squamous cell carcinoma
- Other = undifferentiated – adenocarcinomas - melanomas
Unknown primary

- Exam of the upper aerodigestive tract is normal- neck mass is positive for carcinoma
- Focus on: nasopharynx, oropharynx, supraglottic larynx, hypopharynx, skin

Unknown primary

- Palpate, then look for bleeding on endoscopy
- Retract tonsillar pillars
- Palpate the base of tongue
- Repeat exam
- Ask a colleague
Unknown primary- Imaging

- CT, PET/CT
- Surgery: Direct laryngoscopy, tonsillectomy, lingual tonsillectomy, opposite tonsillectomy
- Don’t forget nasopharynx

Avoidable Error

- Do not assume that a negative visual exam has eliminated the possibility of an OP primary
  - Induration
  - Bleeding
  - Asymmetry
Avoidable Errors

- Cystic neck mass = FNA
- Cystic neck mass is not often infectious or branchial cleft cyst
- Excisional biopsy should be avoided

Mass in Parotid Gland

- Anatomic Extent of Parotid Gland
- Superficial on exam is not always superficial
- Approach to parotid gland
Parotid Tumor

Rarely advise observation unless patient’s health contraindicates surgery

Parotid Region

- Paraparotid = parotid neoplasm
  - Anatomic extent of parotid not appreciated
  - Appear superficial or subcutaneous
  - Upper neck – tail of parotid
- Incisional biopsy
  - Tumor spillage – recurrence
  - Facial nerve damage
Avoidable Errors

1) Failure to inquire about head and neck symptoms in patients with a lump in the neck
2) Failure to perform a complete head and neck examination in a patient with a lump in the neck
3) Reliance on scans as a substitute for a complete (ENT) examination in the patient with a lump in the neck
4) Prolonged trial of antibiotics in the patient with a lump in the neck
5) Removal of a “parotid area” mass under local anesthesia
Pathology and Parotid Neoplasms

- Fine needle aspiration – FNA
  - False positive/negative – high
- FNA
  - Obvious malignancy
  - Possible lymphoma
  - Inflammatory node
  - Poor health
- Frozen section pathology
Case Report

- Football coach - excellent health
- Sudden onset - painful parotid mass
- Enlarging mass
- Lower pole of the parotid

Case Report

- FNA - suspicious for squamous cell carcinoma
- Trial antibiotics - swelling reduced but a firm parotid mass remains
- Repeat FNA read at Mayo Clinic - squamous cell carcinoma
**Warthin’s Tumor**

- Warthin’s tumor with metaplasia of the epithelial lining mimic SCC
- All physicians treating tumors of the head and neck must be aware of possible false-positive cytologic report

**Avoidable Errors**

6) Recommending that one observe a parotid mass since it is “usually” benign
7) Referral of a patient with a parotid mass to an inexperienced surgeon not trained in all aspects of head and neck surgery
My patient will best benefit by referral to whom?

- Experience
- Team management
- Availability of Frozen Section pathology
- Case Experience
- Specialty
Head and Neck Tumors

- Best chance to get well is with initial therapy
  - Knowledgeable – competent head and neck oncology team
  - Regular surgical experience
  - Frozen section pathology
  - Adjunctive therapy when indicated
  - Support personnel

Important Variables

- Patient’s health
- Tumor extent
- Surgical management
- Reconstruction
- Outcomes
  - Overall survival
  - Local/ regional recurrence
  - Quality of live
When should nothing be done and palliative care begin?

- When to operate, when not to operate?
- Patient/Family Desires
- Patient age and health
- Tumor Extent
- Recurrent tumors: What has been done before?

Summary: Avoidable Errors with Lump in Neck

- Failure to inquire about head and neck symptoms in patients with lump in neck
- Failure to perform a complete head and neck exam
- Reliance on scans as a substitute for a complete ENT exam
- Prolonged trial of abx
- Removal of a parotid mass under local anesthesia
Summary

Avoidable Errors with Lump in Neck

- Recommending observation of a “benign” parotid mass
- Referral of a patient with a parotid mass to an inexperienced surgeon not trained in all aspects of head and neck surgery
- Performing an open neck biopsy without preparation for proceeding with a neck dissection
- Referral of patients with head and neck tumors to the casual operator
Avoidable Errors - Bonus

➢ For HPV causative oropharyngeal cancer
  • Basing treatment on tobacco / alcohol
➢ Recognize the growing role of de-escalation of therapy to reduce treatment morbidity