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Head and neck cancer

RCR consensus statements

H&N CAG January 2025

Dr Georgina Casswell

Clinical Oncology Consultant UHBW

4.0 Adjuvant contralateral neck irradiation following surgery for oral tongue cancer for patients planned for postoperative ipsilateral radiotherapy

Published 2022

Statement	Voting outcome
4.1 Offer contralateral neck radiotherapy for patients having adjuvant ipsilateral radiotherapy for oral tongue squamous cell carcinoma who have had surgery to the primary site and an ipsilateral neck dissection if any of the following apply: – T3 or T4 tumour – Primary is within 10 mm of the midline – Two or more pathological lymph nodes in the ipsilateral neck – Extranodal extension (ENE) is present in the ipsilateral neck.	Strongly supported

Key points from consensus meeting

- General agreement that many oral tongue cancers are inherently aggressive and difficult to salvage following recurrence.
- Compelling evidence for high rates of contralateral recurrence if N2b (TNM7). DAHANCA suggests oral tongue cancer should be viewed as a midline structure.
- MDTs should consider the option of bilateral neck dissections in patients with oral tongue tumours, particularly for cancers approaching the midline.

Full background notes

- Vergeer et al carried out a retrospective review of well-lateralised oral tongue cancers receiving surgery with ipsilateral radiotherapy.
- Increasing volume of ipsilateral nodal disease predicted the risk of CLNR at five years; risk of contralateral recurrence
  - PN0 1%
  - pN1/pN2a 12%
  - pN2b 27%

Vergeer M. Ipsilateral irradiation for oral and oropharyngeal carcinoma treated with primary surgery and postoperative radiotherapy. *Int J Radiat Oncol Biol Phys* 2010; **78:** 682–688.

4.2	Consider contralateral neck radiotherapy for patients having ipsilateral adjuvant radiotherapy for oral tongue squamous cell carcinoma who have had surgery to the primary site and an ipsilateral neck dissection if there is a single involved lymph node with no ENE in the ipsilateral neck.	Strongly supported

Key points from consensus meeting

- If the primary is well lateralised, resected with good margins and there is no ENE in lymph nodes some would not offer contralateral radiotherapy.
- There was discussion as to the strength of the statement between 'offer' and 'consider'. The wording was changed from offer to consider to allow for clinical assessment of individual cases. Using consider would give the freedom to discuss with patients the balance between treatment-related morbidity and risk of contralateral relapse.

Full background notes

- When considering N1 (single lymph node disease), contralateral failure rates of up to 12% have been reported.
- This raises the possibility that patients with any ipsilateral nodal disease may benefit from bilateral PORT. The risk of CLNR is due to the bilateral lymph drainage of oral cancers, which was reported by the Sentinel European Node Trial (SENT) as 12% in early (T1–2) lateralised disease

Waldram R, Taylor AE, Whittam S *et al*. Prestwich evaluation of locoregional recurrence patterns following adjuvant (chemo)radiotherapy for oral cavity carcinoma. *Clin Oncol* 2020; **32:** 228e237.

Schilling C, Stoeckli SJ, Haerle SK *et al*. Sentinel European Node Trial (SENT): 3-year results of sentinel node biopsy in oral cancer. *Eur J Cancer* 2015; **51:** 2777e2784.

Full background notes

- rcr-publications_head-and-neck-cancer-rcr-consensus-statements__february-2022.pdf