













Head and neck cancer - patient information guide

The development of reconstructive surgical techniques in the last 20 years has led to major advances in the treatment of patients with head and neck cancer.

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1. Introduction

Modern techniques mean that surgeons can remove a tumour and immediately reconstruct the deficit, or repair the damage, caused by the initial surgery.

Reconstructive surgery in this area also goes hand-in-hand with cosmetic surgery, whereby surgeons look to achieve the best functional and aesthetic results. The aim is to enable patients to chew, swallow, speak and perform other core functions to the best of their ability, while also minimising the visual impact of the surgery and the cancer.

2. What conditions might affect a patient in this area?

Cancers can appear in the following locations around the head and neck:

- Skin cancers of the face, including - ears, eyelids, nose and lips
- Cancers of the upper aerodigestive tract - mouth, tongue, palate, throat, nose and sinuses, pharynx, larynx
- Salivary gland tumours
- Skull base tumours

Some tumours in these regions will be benign, in particular most salivary gland tumours. The most common cancers in this region are skin cancers, followed by cancer of the mouth and related structures.

Head and neck cancers can present in a number of ways but important symptoms are:

- an ulcer or sore area that does not heal within a few weeks
- difficulty in swallowing, or pain when chewing or swallowing
- white or red patches inside the mouth

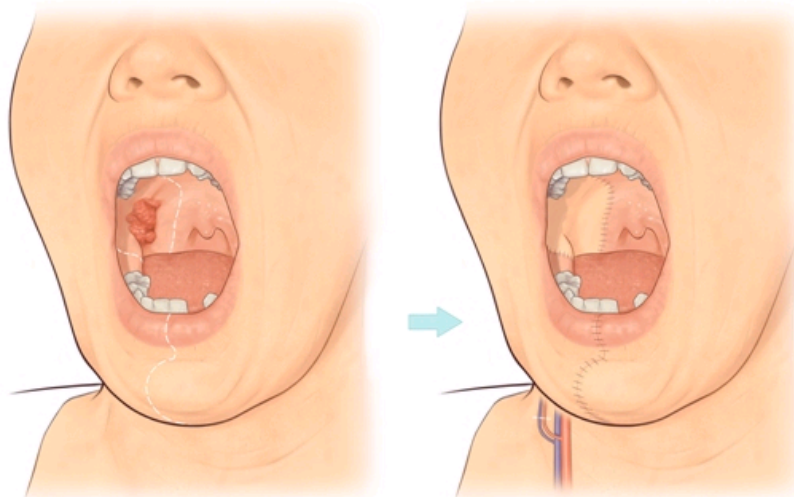
- a loose tooth
- a persistent blocked nose, or nose bleeds
- a constant sore throat and earache on one side
- a swelling or lump in the face, mouth or neck
- pain or numbness in the face or upper jaw

Some of these symptoms are things that we all might experience temporarily. If these symptoms are persistent and progressive you should consult your doctor about them. As with many cancers if diagnosed early cure is usually possible.

Many cancers of the upper aerodigestive tract are associated with smoking. Other risk factors include excessive drinking and poor diet.

3. What surgery is available, and what techniques are involved?

In view of the wide variety of head and neck tumours the nature of the operations involved vary widely from simple local anaesthetic procedures for skin cancers to complex resections and reconstructions for the more advanced or inaccessible tumours. Each operation involves a resection or removal of the tumour followed by an appropriate reconstruction to repair the defect. Some tumours require division of the bones of the facial skeleton and reconstruction of bone defects. In view of the complexity of some of the defects resulting from the resection of head and neck tumours, flaps are often the most appropriate reconstructive technique.



This shows a cancer in the mouth in the region of the tonsil. When it is removed the defect is repaired using a microvascular free flap.

A flap is a piece of living tissue that is transferred from one part of the body to another, along with the blood vessels that keep it alive. Often a free flap is used where the blood vessels are disconnected at the site from where the flap is taken and then reattached microsurgically in the head and neck. The main benefit of flap surgery is that surgeons can tailor the reconstruction very precisely to a patient's needs. Depending on the nature of the defect caused by the surgical excision, surgeons can make free flaps either thin and pliable, or bulky and padded. Skin, oral lining, muscle, cartilage and bone can all be reconstructed. The flap technique also enables surgeons to reduce what is called donor site morbidity – which means reducing the damage caused to the area from where the flap tissue has been taken.

The cancer itself is removed and because we know these cancers can spread to the lymph glands in the neck, we sometimes remove these glands as part of the operation to treat the primary tumour.

4. Is this surgery available on the NHS?

The surgical treatment of all forms of head and neck cancer is available on the NHS.

5. Who will I see as a patient?

Most patients with head and neck cancer will initially present to their GP or dentist. A referral will be made to the hospital and the patient will be seen by an appropriate specialist and, where appropriate, in a Combined Head and Neck clinic. If there is a high suspicion of cancer the first appointment will usually be within 2 weeks of referral.

In a combined clinic patients are seen by a multi-disciplinary team (MDT). This team will be made up of specialists working together to make sure that the best possible treatment is given. These specialists may include the following:

- Plastic and Reconstructive Surgeon
- Ear Nose and Throat Surgeon
- Oral and Maxillofacial Surgeon
- Clinical Oncologist
- Clinical nurse specialist
- Dietician
- Speech therapist
- Radiologist
- Pathologist

Patients are best dealt with in combined clinics where Plastic, Maxillofacial and Ear, Nose and Throat (ENT) surgeons work together with cancer specialists (oncologists). Combined operations, involving more than one surgical specialty, are often in the patient's best interests and some patients also require combined forms of treatment including radiotherapy and/or chemotherapy.

6. What should I expect in terms of treatment, procedures and outcomes?

In the first place a precise diagnosis needs to be established. Sometimes this can be done just by examination or with a simple needle test, or biopsy done in clinic. It might be necessary to have a biopsy done under a short general anaesthetic combined with an endoscope examination of the tumour and surrounding areas. For some tumours scans are particularly helpful in showing the nature and extent of the growth. Both MRI and CT scans are used. This process will establish the diagnosis and stage the disease. Staging is important in establishing the best treatment and to let the patient know the chances of cure.

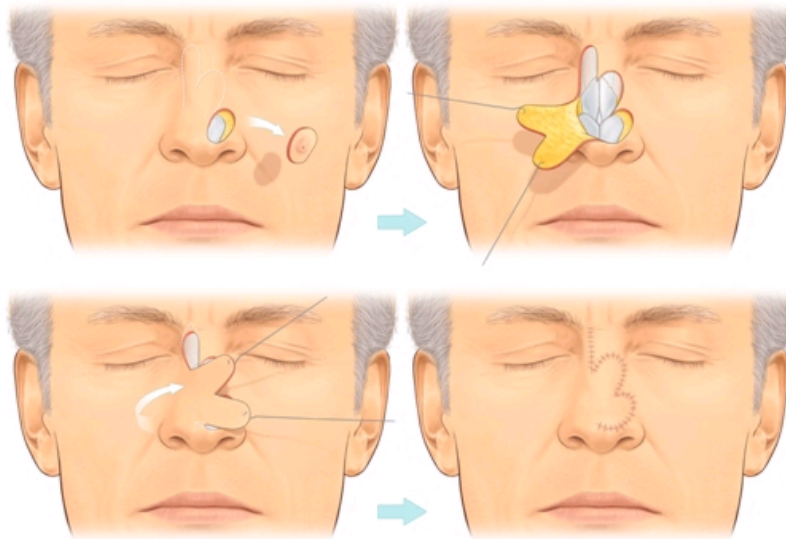
Once the results of these tests are known patients are seen again by the MDT (see above) who will discuss with you what treatment is required, and what you can expect.

For some head and neck cancers radiotherapy alone is the most appropriate treatment. For some patients surgery alone is used. Some patients will benefit from a combination of treatments. Sometimes there may a choice to be made between two possible lines of treatment, you will be given advice and support in making this decision.

If you are having an operation the type of procedure varies considerably depending on the site of the tumour.

7. Face and lips

Small skin cancers and lip cancers are often treated under local anaesthetic as day cases. Larger tumours may need a general anaesthetic and a day or so in hospital. There will be some swelling and bruising that should settle in a week or so. Usually there will be some stitches to be removed. Scarring on the face whilst lumpy and red at first tends to settle down well. In most cases the operation will result in cure and no further treatment is needed. For some tumours a period of follow up as an outpatient will be recommended to check for any evidence of recurrence.



In this case a skin cancer has been removed from the nose leaving a defect that cannot simply be stitched up. A local flap, called a bilobed flap is used to close the defect. The flap consists of skin along with the underlying soft tissue and its blood supply. A local flap like this relies on the fact that the skin has some natural elasticity and uses the lax skin in the bridge of the nose to close a defect near the tip of the nose where the skin is naturally tight.

8. Salivary gland

Most salivary gland tumours are benign and arise in the parotid gland. This is a salivary gland that sits in the cheek just in front of and below the ear. The facial nerve (the nerve that supplies the muscles that move the face) runs through the parotid gland. Tumours are treated by an operation called superficial parotidectomy. This is a general anaesthetic procedure where that part of the parotid gland that contains the tumour is removed. A cut is made in front of and below the ear. The affected part of the gland is carefully removed preserving the facial nerve. The incision is stitched up and a drain (a plastic tube leading to a suction device) inserted. You will be up and about soon after the operation, and can usually go home after one or two days. There may be some stitches to be removed a week or so later. Scarring is usually inconspicuous after this operation. Some patients will have some temporary weakness of the muscles of the face, this generally recovers within a few weeks. For more serious parotid tumours the facial nerve has to be removed along with the tumour. This will result in permanent weakness of the facial muscles, known as [facial palsy](#). Benign parotid tumours are cured by complete removal. Cancer of the parotid gland is sometimes also treated by radiotherapy, such patients will also require outpatient follow up.

9. Mouth, jaws, sinuses, pharynx, larynx and skull base

Again small tumours, particularly of the tongue and larynx, can be treated by relatively simple operations with brief hospital stay and quick recovery. However, many tumours of the upper aerodigestive tract require major surgery. Incisions used and the exact nature of what is involved varies according to the site of the tumour. The team treating you will be able to give more accurate details of what is likely to happen in your situation.

If you are undergoing major surgery you can expect to be in hospital for about two weeks. If a tumour has been removed and the deficit repaired in the mouth or throat area, patients may need to have a temporary feeding tube inserted down the nose into the stomach. Some patients will need a temporary tracheostomy (an opening into the trachea to help with breathing). If the larynx (voice box) is removed the tracheostomy will be permanent. Patients may need to be re-taught how to chew, swallow and speak – a gradual procedure that can take several weeks. Once you are discharged from hospital, you will need to return to the clinic after a few weeks for a post-operative assessment.

Using the new techniques available to them, surgeons work to achieve the best functional

outcomes, enabling patients to speak and swallow properly. Increasingly, surgeons can enable head and neck cancer patients to have a good quality of life.

10. Where should I go for further information or support?

[Cancer Backup](#) is an excellent source of information about all cancer-related conditions. The head and neck cancer section is particularly comprehensive.

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