CovidSurg-Cancer

Examples of H&N patients that should be included:

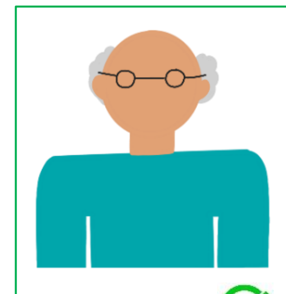
1

INCLUDED

67 year old male, type 2 diabetic. Presents with a T3N1M0 (3 nodes 3cm in size) SCC, p16 positive left tonsil cancer. Pre-Covid he would have been offered primary chemo-radiotherapy. Post-Covid aiming to avoid chemotherapy he is offered primary surgery, trans-oral laser and a neck dissection with planned adjuvant radiotherapy.

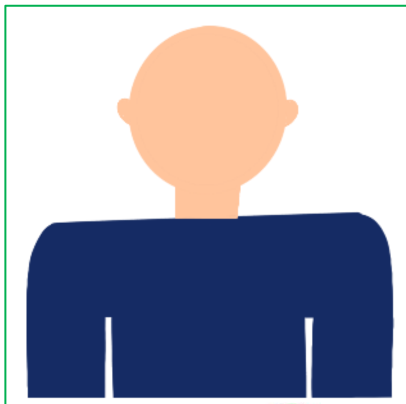
2

80 year old male presents with increasing hoarseness. Ex-smoker, stopping 3 years ago, COPD. Radiologically T4NOM0 laryngeal cancer tumour involving the strap muscles. Pre-Covd pt would have been offered expedient surgery. Post Covid surgery delayed due to reduced operating capacity and the aiming to avoid laryngectomy.



INCLUDED

3



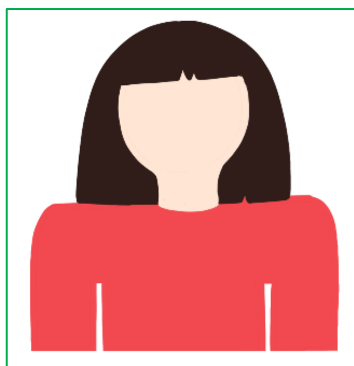
INCLUDED

A patient has a cT2N0 SCC floor of mouth abutting mandible in midline – the accepted treatment plan (beyond dispute internationally) would be primary surgery involving +/- tracheostomy, mandible rim resection, resection floor of mouth, bilateral neck dissection and a soft tissue fasciocutaneous free flap such as ALT, RFFF or MSAP. This usually entails a stay in ITU so several reasons why this is challenging in Covid era. 1. ITU, 2. Microsurgery, 3. Length of admission, 4. Tracheostomy a risk to surgeon and patient, 5. Length of procedure >8 hours. So these patients are being treated with radiotherapy in some centres which is suboptimal in terms of control rate, cure, and risk of osteoradionecrosis.

4

A patient has an HPV+ve cT2N2b oropharynx SCC – most centres would treat with concomitant chemoradiotherapy with cisplatin and 66Gy. This is challenging due to the chemotherapy and outcomes less good with radiotherapy alone. An alternative is primary surgery either with neck dissection _ robot / laser or neck dissection, mandibulotomy and free flap repair.

5



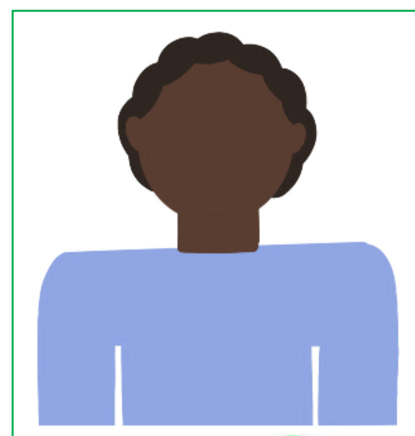
De-escalation or sub-optimal surgery ablation

Midline floor of mouth tumour cT1N0M0 should have had either sentinel node biopsy or neck dissection - owing to lack of theatre time received simple excision and observation of neck.

6

De-escalation or sub-optimal reconstruction

cT4aN1 orophaynx SCC invading mandible in retromolar region – should have had composite free flap repair but owing to lack of capacity received bridging plate as semi-permanent solution to the segmental mandible defect.



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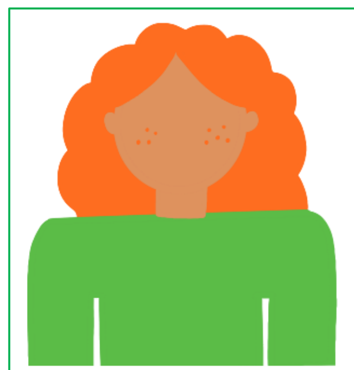

De-escalation or sub-optimal reconstruction

cT4aN0 SCC maxilla – should have had free flap and osseo-integrated implant based reconstruction but received simple ablation and prosthesis/ obturator due to lack of capacity.