Neck Dissection Patient Information Sheet

How Do Cancers Spread?

Most cancers, which start in the head and neck region, have the ability to spread to other parts of the body; these are called metastases ("mets") or "secondaries". Cancers can spread in a number of different ways, most often by the blood to other distant organs like the liver, or by the lymph system to lymph nodes. In the head and neck region lymphatic spread is fairly common and distant spread occurs later.

Lymph nodes or "glands" are like sieves, which catch any bacteria, viruses or cancer cells in the body. Each node drains a particular area of the body. The nodes in the neck drain the skin of the head and neck and all the swallowing and breathing tubes. Once one cancer cell has been "caught" by a lymph node it can grow and multiply there, and in time can spread to the next node down the chain and so on.

What is a Neck Dissection?

There are 2 basic sorts of neck dissection:

Radical Neck Dissection:
A radical neck dissection is a surgical operation, which aims to remove all the lymph nodes in the neck between the jaw and the collarbones. This is usually planned if there is evidence that there are one or more affected nodes in the neck. Because the nodes are small and stuck to structures in the neck we usually remove some other tissues as well to ensure that we get a good clearance. We only remove structures which you can safely do without and those which do not leave serious long lasting effects.

Partial Neck Dissection:
A partial neck dissection is performed when although there is no strong evidence that there are affected nodes, we are suspicious that there may be microscopic amounts of cancer cells in nodes in the neck. In this case we tend to only remove those groups of nodes which experience has shown to be most often affected in your type of cancer.

In both sorts of operation we send all the tissues away to the laboratory to search for cancer cells and to see how extensive the spread has been.

What can I expect from the operation?

Most patients will be admitted 1 or 2 days before their operation. In many cases the neck dissection is only part of the surgery and some other procedure will also have been planned which is aimed at removing the primary or original tumour. The operation is performed under general anaesthesia, which means that you will be asleep throughout. There will usually be two long cuts made in the neck and the skin is turned backwards to allow the surgeons to get access to the underlying structures.

At the end of the operation you will have 1 or 2 drain tubes coming out through the skin and stitches or skin clips to the skin. When the skin is lifted up it looses its nerve supply and so is numb after the operation. This means that most patients do not have much pain after the operation. Because we remove one of the large muscles from the neck patients find that the neck looks a little flatter on the side of the operation and their neck can be stiff after the operation.

What are the risks?

Numb skin:
As mentioned above the skin of the neck will be numb after the surgery, this will improve to some extent, but you should not expect it to return to normal.

Stiff neck:
Some patients also find that their neck is stiffer after the operation.

Haematoma:
Sometimes the drain tubes which are put in at surgery block or fail to work, in which case blood can collect under the skin and form a clot (haematoma). If this occurs a return trip to the operating room may be required to remove the clot and replace the drains.

Chyle leak:
Chyle is the tissue fluid, which runs in lymph channels. Occasionally one of these called the thoracic duct is damaged during the operation, usually on the left side. This can be hard to spot during the operation. If this occurs, lymph fluid or chyle can collect under the skin, in which case we need to keep you in hospital longer and sometimes need to take you back to the theatre to fix the leak.

Accessory nerve:
This is the nerve to one of the muscles of the shoulder. We try hard to preserve this nerve but sometimes it needs to be removed, because it is too close to the tumour to leave behind. In this case you will find that your shoulder is a little stiff and that it can be difficult to lift your arm above the shoulder. Also lifting heavy weights, like shopping bags can be difficult.

Hypoglossal nerve:
Very rarely this nerve, which makes your tongue move also has to be removed due to involvement with the tumour. In this case you will find it difficult to clear food from that side of the mouth and it can interfere with your swallowing.

Marginal Mandibular Nerve:
This nerve is also at risk during the operation, but we also try hard to preserve it. If it is damaged you will find that the corner of your mouth will be a little weak. This is most obvious when smiling.

Will I need any other sort of treatment?

This will depend very much on what treatment you have had already, where your tumour is and what type of tumour it is. Sometimes we add radiotherapy to surgery to try to get a better cure rate.

What to do if you have any worries or concerns after the surgery

If it is within 48 hours or out of hours, phone the ward where you were admitted for surgery. During office hours phone our secretaries on 0118 9213160.

I have read this leaflet and had the chance to ask any questions to my surgeon.

Name: Signed: Date:

Surgeon: Signed Date: