

## 조기 구강설 편평세포암종의 잠재적 경부림프절 전이

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### Occult Lymph Node Metastasis in Early Oral Tongue Squamous Cell Carcinoma

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#### ABSTRACT

**Background and Objectives** : The most significant prognosticator of survival for patients with squamous cell carcinoma of the oral tongue has been the association of neck nodal metastasis. However, no consensus exists as to whether an elective neck dissection should be performed in patients with early oral tongue squamous cell carcinoma with a clinically negative neck. **Subjects and Method** : A retrospective analysis was performed on 54 early oral tongue squamous cell carcinoma patients (T1 = 26 and T2 = 28) with clinically negative necks who were treated between 1992 to 2003. All patients had an ipsilateral neck dissection and 29 patients had a contralateral neck dissection. Surgical treatment was followed by postoperative radiotherapy in 20 patients. The follow-up period ranged from 3 to 110 months (mean, 56 months). Data were analyzed using the Kaplan-Meier method, log-rank test, and the chi-square test. **Results** : Clinically occult, but pathologically positive ipsilateral lymph nodes were found in 26% (14/54) and contralateral lymph nodes in 3% (1/29). Based on the clinical staging of the tumor, 19% (5 of 26) of the cases showed lymph node metastases in T1 tumors, and 36% (10 of 28) in T2. All regional recurrences developed in the ipsilateral necks, there was no cases of contralateral neck recurrence. Patients with no evidence of occult nodal cancer have significantly improved disease-specific free survival rates over patients with any pathologically positive nodes (5 year disease specific survival rate, 90% vs 38%, p < 0.05). **Conclusion** : This study showed that ipsilateral elective neck dissection should be performed for early oral tongue cancers. On the other hand, our series suggests that it may not be harmful to observe the contralateral N0 neck in the treatment of early oral tongue cancer. (Korean J Otolaryngol 2006;49:407-10)

**KEY WORDS** : Tongue neoplasm · Lymphatic metastasis · Neck dissection.

가 .  
Fakih <sup>4)</sup> Franceschi <sup>5)</sup>  
가 , Yii <sup>6)</sup>  
가 Yuen <sup>7)</sup>  
가  
(T1/T2)

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IL)  
Kaplan - Meier  
Log - rank test  
p - value가 0.05

1992 2 2003 4  
104 54 26%(14/54)  
2 가 T1 19%  
(5/26), T2가 32%(9/28) 14  
54 (T1=26, T2=28) 7 (50%) level 7  
(37%) level level  
가  
22 79 53  
54  
2002 AJCC  
CT MRI Mancuso 1 level I III 3 , II 1  
level I & II, II & III, I & III 4 , 2 ,  
NO . Level IV, V 1  
29  
3%(1/29) , 1 가 T2  
Level II

rough  
가 12 , 20  
, 3 , 1  
, 2 , 28  
가 30 , pull th-  
가 (Table 1).

Table 1. The level of occult nodal metastasis

Level	Occult metastasis	
	Ipsilateral necks (n=54)	Contralateral necks (n=25)
I	3	
II	1	1
III	3	
I & II	4	
II & III	2	
I & III	1	
Total	14 (26%)	1 (4%)

Table 2. Sites of initial recurrence

Site	T1 (n=26)		T2 (n=28)	
	No.	(%)	No.	(%)
Primary	4	15	4	14
Ipsilateral neck	2	8	6	21
Primary/ipsilateral neck	0	0	1	4
Total	6	23	11	39

No. : number

54 (n=29) , 82 (n=54)  
1  
20  
34  
5,040 cGy 6,840 cGy  
5,964 cGy  
가  
3 110 56  
SPSS(V12, Chicago,

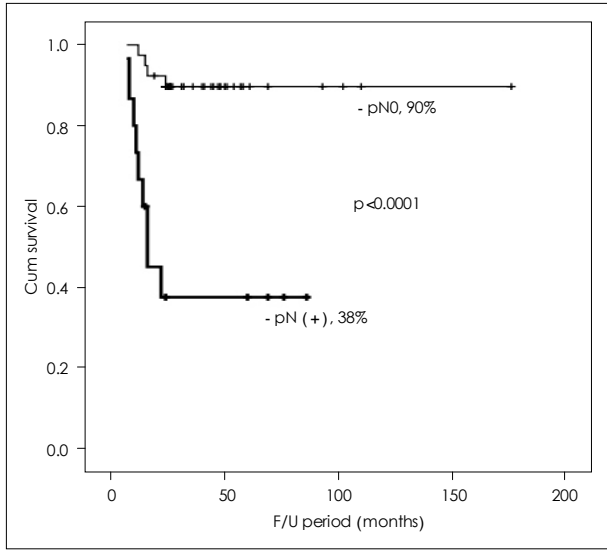


Fig. 1. Disease specific survival rate according to occult positive neck.

level V  
 가 (6/15), 5% (2/39)  
 가 40%  
 (p=0.009).  
 13% (1/8)  
 54, 36 (67%), 13  
 2, 3  
 Kaplan - Meier  
 가 가 38%, 가 90%  
 (p<0.0001) (Fig. 1).

(submandibular triangle)  
 (submental triangle)  
 가  
 가 (subsite)  
 가 30%  
 NO  
 23%  
 26% T1  
 15% 20% 16)  
 가  
 66% 54  
 (14/54)  
 19% (5/26), T2가 32% (9/28)

Yoshida<sup>17)</sup> cT2N0  
 24  
 가 14 (58%)  
 H & E  
 NO 가  
 가  
 T1  
 가  
 Decroix<sup>19)</sup> 244  
 25  
 6 (24%)<sup>20)</sup> Byers  
 33%

가<sup>5)</sup>

29 1 가 3%

1 25

가 가

54 26%

(14/54) T1

19%(5/26), T2가 32%(9/28)

가

29 1 (3%) 가

25 1

NO

가

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