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Letter to Editor

Letter to “Medial lingual lymph node metastasis in carcinoma of the tongue”

To the Editor,

We have read with interest the paper from Eguchi et al. [1] describing a case of metastasis in a lingual lymph node located in the medial compartment. The case presentation is detailed, and the iconography is excellent.

The reported case was properly treated with upfront surgery, and the lingual metastasis was identified and effectively addressed even if it disclosed as an intraoperative unexpected finding.

The definitive pathological analysis demonstrated a radically resected tumor showing minor vascular invasion, with a lingual mass within the T-N tract confirmed as a metastasis in a lingual lymph node of the medial compartment and not an isolated second localization of the primary tumor. Furthermore, 2 adjunctive occult neck metastases were identified in the ipsilateral neck specimen.

The Authors claimed that the absence of extranodal extension and the negative margins justified the omission of postoperative adjuvant treatment.

Being aware that retrospective evaluations are always biased by the uncovered clinical evolution, the reader should take advantage of this peculiar case to reflect on the importance of adjuvant treatment in Stage IV oral cancer, and on its indications, that are not always straightforward.

In the discussion, the authors correctly acknowledge that the presence of a lingual lymph node metastasis has to be considered a negative prognostic factor warranting aggressive treatment, but this factor was not deemed sufficient to consider postoperative treatment.

Following the 7th TNM edition [2] (the one applied in this report) the pathological staging of this tumor was pT4a because of the infiltration of the extrinsic tongue musculature, and N2b because of the 2 lymph node metastases in the neck (Stage IVA). Furthermore, additional negative elements not impacting on the pTNM were the presence of a metastasis in a lingual lymph node and the presence of minor vascular invasion.

Also following the 8th TNM edition, [3] pathological staging would have been IVA, given the pN2b nodal sta-

tus. Furthermore, the authors reported a tumor thickness of 15.9 mm and it is most likely to assume that the depth of infiltration of this tumor exceeded 10 mm, making it a pT3.

Adjuvant therapy should be considered for head and neck squamous cell carcinomas pathologically staged as Stage III and IV [4]. However, we agree that NCCN guidelines do not provide definitive guidance in this setting.

Following the TNM staging used by the authors, postoperative radiotherapy should have not been excluded even for a radically resected pT4a tumor, regardless of the lymph node status, especially when displaying vascular invasion. The presence of 2 neck node metastases should also be considered a significant risk factor to be taken into account when considering postoperative radiotherapy. In fact, the recent ASCO Clinical Practice Guideline [5] suggest that adjuvant neck radiotherapy should be administered to patients with oral cavity cancer and pathologic N2 or N3 disease.

The presence of 2 or more lymph node metastases was considered the cutoff lymph node burden for postoperative chemoradiation in the RTOG 9501 trial by Cooper et al. [6]. However, when these findings were combined with the results of the other pivotal adjuvant EORTC 22931 trial by Bernier et al, the absence of ENE and positive margins justified to omit postoperative chemotherapy, delivering only adjuvant radiotherapy [7].

Finally, the presence of multiple ipsilateral neck metastases is a significant risk factor for the presence of occult contralateral lymph node metastasis/disease in oral cavity squamous cell carcinomas [8,9].

In our opinion, the take-home message to be underlined is that, in the presence of an ipsilateral N2b neck and a further lymph node metastasis in the medial lingual compartment, postoperative radiotherapy targeting the ipsilateral and contralateral neck should be strongly considered.

In light of the contralateral neck recurrence only 6 months after primary surgery, the case reported by Eguchi et al. suggests that contralateral neck dissection should be warranted after the intraoperative discovery of a suspicious medial lingual lymph node.

In conclusion, we agree with the authors on the severity of the reported clinical condition, being the task of the multidisciplinary team to analyze all available elements, to plan a

complete therapeutic program, even more in rare occurrences as the one herein described.

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