Patients with lateralized oropharyngeal carcinoma who are being treated with upfront curative surgery should undergo ipsilateral neck dissection of levels II–IV. The multidisciplinary team should discuss with patients the potential functional impact of bilateral neck dissection and postoperative adjuvant radiation therapy with or without chemotherapy. Patients with tumors extending to the midline tongue-base or palate or involving the posterior oropharyngeal wall are candidates for bilateral neck dissections unless bilateral adjuvant radiotherapy is planned. Patients with cN+ disease, who have either unequivocal extranodal extension into surrounding soft tissues or carotid artery or cranial nerve involvement, should undergo bilateral neck dissections. Patients with biopsy-proven distant metastases should not undergo routine surgical resection of metastatic cervical lymph nodes. Adequate dissection should include at least 18 lymph nodes.

Patients with biopsy-proven distant metastases who have neck dissection concurrently or before transoral endoscopic head and neck surgery should have ligation of at-risk feeding blood vessels to reduce the severity and incidence of postoperative bleeding.

The multidisciplinary team should discuss with patients the potential functional impact of bilateral neck dissection and postoperative adjuvant radiation therapy with or without chemotherapy. Patients with tumors extending to the midline tongue-base or palate or involving the posterior oropharyngeal wall should undergo bilateral neck dissections unless bilateral adjuvant radiotherapy is planned. Patients with biopsy-proven distant metastases should not undergo routine surgical resection of metastatic cervical lymph nodes.

PET/CT scan at ≥ 12 weeks after completion of radiation/chemoradiation

Intense FDG uptake in any node

No nodal FDG uptake, and no abnormally enlarged lymph nodes

Mild FDG uptake in a node ≤ 1 cm or a persistently enlarged node ≥ 1 cm without either mild or intense FDG uptake

Patients who complete radiation/chemoradiation and have anatomic cross-sectional imaging (CT or MRI scans) at ≥ 12 weeks post therapy showing resolution of previously abnormal lymph nodes may be followed closely with serial cross-sectional imaging or PET/CT, with neck dissection reserved for clinical or radiographic concern for progressive disease.

These algorithms are derived from recommendations in Management of the Neck in Squamous Cell Carcinoma of the Oral Cavity and Oropharynx: ASCO Clinical Practice Guideline. This is a tool based on an ASCO guideline and is not intended to substitute for the independent professional judgment of the treating physician. Practice guidelines do not account for individual variation among patients. This tool does not purport to suggest any particular course of medical treatment. Use of the guideline and this tool are voluntary.