



Royal Berkshire
NHS Foundation Trust

Neck dissection (lymph node removal)

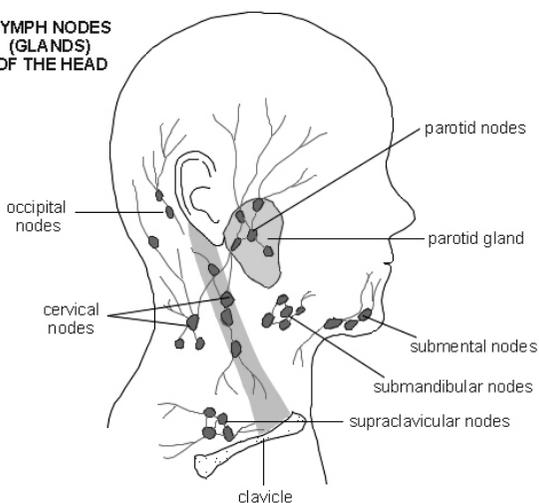
Information for patients,
relatives and carers

This booklet has been written by experienced staff and patients as a guide for anyone having surgery to remove the lymph glands in their neck. It answers those questions most frequently asked. The information is only a guide and your healthcare team will give you more detailed information as you need and want it. We hope you and your family will find the information both reassuring and supportive.

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 different ways. In the head and neck region lymphatic spread is fairly common and distant spread may

LYMPH NODES
(GLANDS)
OF THE HEAD



occur. Lymph nodes or 'glands' are like sieves, which catch any bacteria, viruses or cancer cells in the body. The nodes in the neck drain the skin of the head 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 in the chain and so on.

Lymph node removal is carried out by an operation called a neck dissection.

What is a neck dissection?

There are two basic sorts of neck dissection:

1. A radical neck dissection is a surgical operation, which aims to remove all the lymph nodes in the neck between the jaw and the collar bones. This is actually planned if there is evidence that there is one or more affected lymph nodes in the neck. Because the nodes are small and stuck to other structures in the neck, they are usually removed with some surrounding tissues as well, to ensure all disease is removed. The only structures that are removed are those which you can safely do without, and those which do not leave you with long lasting effects.
2. A partial neck dissection is performed when there is a suspicion that there may be microscopic (tiny) amounts of cancer cells in your neck. In this case only those groups of lymph nodes that experience has shown to be most often affected in your type of cancer are removed.

In both operations the tissues are sent to the laboratory to search for cancer cells and see how extensive the spread has been

What can I expect from the operation?

In many cases the neck dissection is part of the surgery and another procedure will also have been planned, which is aimed at removing the primary or original tumour. The operation is performed under a general anaesthetic, which means you will sleep throughout. There will usually be two long cuts made in the neck allowing the surgeons to get access to the underlying structures. At the end of the operation you will have one or two drain tubes coming out through the skin and clips or stitches to the skin. The scar will run along the natural creases in your neck.

When the skin is lifted up it loses some nerve supply and so is numb after the operation. This means that most people do not have much pain afterwards. Pain killers will be prescribed and can be administered as needed. If removal of one of the large neck muscles is necessary, the neck will always look a little flatter where the surgery was performed.

What are the problems that may occur?

Numb skin

The neck will be numb after surgery. This will improve to some extent, but you should not expect it to return to normal.

Stiff neck

You may find your neck is stiffer after the operation. You may require physiotherapy for your neck / shoulder. Your team will arrange this if necessary.

Haematoma

Sometimes drains put in at the time of surgery can block or fail to work. Blood can collect under the skin and form a blood clot (haematoma). If this occurs further surgery may be required to remove the clot and replace the drains.

Chyle leak

Chyle is the tissue fluid that runs in lymph channels. Occasionally, one of these channels called the thoracic duct can be damaged during the operation. This can be hard to spot during the surgery. If this occurs, lymph fluid or chyle can collect under the skin. You will usually be placed on a fat-free diet until the leak has healed. Occasionally, you

may need to return to theatre for further surgery. We may therefore need to keep you in hospital a little longer than planned.

Accessory nerve damage / injury

This is the nerve to one of the muscles of the shoulder. Surgeons 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 your shoulder. Again, physiotherapy can be arranged for you to maximise your shoulder movements.

Hypoglossal nerve damage

Very rarely this nerve, which makes your tongue move, has to be removed due to the spread of 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. Speech can sometimes be less clear. The speech and language therapists and dietitian will be able to support you and offer advice.

Marginal mandibular nerve damage / injury

This nerve is also at risk during the operation, but the surgeons will try hard to preserve it. If damaged you will find that the corner of your mouth will be weak and lip closure may be weaker on that side. The speech and language therapists will be able to suggest exercise and strategies that may help improve this function.

Will I need any other sort of treatment?

This will depend very much on the treatment you have already had, where your tumour is and what type of tumour it is. Sometimes, you may need to have radiotherapy or chemoradiotherapy.

Useful contact details

Head and Neck Cancer Clinical Nurse Specialists (CNS)

Amy Raynor, Annabel Jacob and Jo Hand 0118 322 8827

Macmillan Cancer Support

0808 808 0000

Mon-Fri 9am-8pm

www.macmillan.org.uk

Notes

This document can be made available in other languages and formats upon request.

Royal Berkshire NHS Foundation Trust
London Road
Reading RG1 5AN
Telephone 0118 322 5111
www.royalberkshire.nhs.uk

Heidi Waite/Amy Raynor
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