INTRODUCTION

Thyroid carcinoma forms about 1% of all cancers and causes 0.2% of cancer deaths. The majority of these tumors are of the papillary type which makes up about 80–85 percent of thyroid cancers. Papillary thyroid carcinoma (PTC), out of all thyroid cancers, has the highest incidence of cervical lymph node metastasis which is the most important prognostic factor for loco-regional recurrences in PTC patients. Cervical LN metastasis, however, does not always have a negative impact on overall survival in such patients. The ideal strategy for management of patients with PTC combines complete surgical resection of clinically and radiologically evident disease in the neck, use of radioactive iodine ablation (when indicated), and postoperative TSH suppression (when indicated). The optimal extent of surgery for cervical LN metastasis in PTC is still up for debate. The majority of researchers accept that pathologically negative neck nodes do not require prophylactic neck dissection. However, some physicians recommend modified radical neck dissection (MRND) for neck nodes that are pathologically positive, while others advise selective neck dissection with restrictions. In general, the extent of therapeutic postoralateral neck dissection includes level II–V. However, routine level V lymphadenectomy in patients with PTC with clinically lateral lymph node metastasis remains controversial. An increasing number of recent studies have shown that the incidence of level V lymph node metastasis is significantly lower than the incidence of level II–IV lymph node metastasis.

AIM OF THE WORK

The aim of this study was to assess involvement of level V cervical lymph nodes in patients with stage N1b papillary thyroid carcinoma.

PATIENTS AND METHODS

PATIENTS: The study included twenty patients with papillary thyroid cancer metastasizing to lateral cervical lymph nodes with no evidence clinically and radiologically of lymphadenopathy at level V. We excluded patients with previous thyroid or cervical lymph node surgery, patients with other head and neck malignancies and patients with history of neck irradiation. The study was conducted at Head, Neck and Endocrine surgery unit at Main Alexandria University Hospital.

Methods:
Preoperative assessment:
Thorough history taking, clinical examination, routine lab investigations and thyroid profile, Ultrasound neck and US guided fine needle biopsy from thyroid and suspicious lymph nodes.

Operative procedure:
Total thyroidectomy and posterolateral neck dissection was performed for all of our patients.

Postoperative assessment:
Histopathological examination of the specimens acquired. Clinical assessment of patients to exclude complications.

RESULTS

Table 1: Distribution of the affected lymph node levels according to postoperative histopathology (n = 20).

<table>
<thead>
<tr>
<th>Postoperative histopathology</th>
<th>No.</th>
<th>%</th>
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<tbody>
<tr>
<td>Affected Lymph Nodes (L.Ns)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td>III</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>IV</td>
<td>15</td>
<td>75.0</td>
</tr>
<tr>
<td>V</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>VI</td>
<td>19</td>
<td>95.0</td>
</tr>
</tbody>
</table>

CONCLUSION

- Incidence of cervical lymph node metastasis to level V in patients with N1b PTC is low compared to levels II, III and IV.
- There is clear evidence of postoperative morbidity from routine level V dissection in N1b PTC.
- Level V dissection in patients with N1b PTC may be reserved for patients with clinically or radiologically evident level V metastasis.