4.3 Cancer of the Larynx

Introduction

For purposes of this clinical stage classification, the larynx is divided into three regions: supraglottis, glottis, and subglottis and is summarized as follows¹:

<table>
<thead>
<tr>
<th>Site</th>
<th>Subsite</th>
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<tbody>
<tr>
<td>Supraglottis</td>
<td>Suprahypoid epiglottis, Infrahypoid epiglottis, Aryepiglottic folds (laryngeal aspect), Arytenoids, Ventricular bands (false cords)</td>
</tr>
<tr>
<td>Glottis</td>
<td>True vocal cords, including anterior and posterior commissures</td>
</tr>
<tr>
<td>Subglottis</td>
<td>Subglottis</td>
</tr>
</tbody>
</table>

Regional Lymph Nodes. The incidence and distribution of cervical nodal metastases from cancer of the larynx vary with the site of origin and the T classification of the primary tumour².

Metastatic Sites. Distant spread is common only for patients who have bulky regional lymphadenopathy. When distant metastases occur, spread to the lungs is most common; skeletal or hepatic metastases occur less often. Mediastinal lymph node metastases are considered distant metastases.³

Staging

Clinical Staging. The assessment of the larynx is accomplished primarily by inspection, using indirect mirror and direct endoscopic examination with a fiber optic nasolaryngoscope. The tumour must be confirmed histologically, and any other data obtained by biopsies may be included.⁴

Pathologic Staging. Pathologic staging requires the use of all information obtained in clinical staging and in histologic study of the surgically resected specimen. The surgeon's evaluation of gross unresected residual tumour must also be included. Specimens that are resected after radiation or chemotherapy need to be identified and considered in context. The pathologic description of any lymphadenectomy specimen should describe the size, number, and position of the involved node(s) and the presence or absence of extracapsular extension.⁵

² Cancer Staging Manual p62
³ Cancer Staging Manual p62
⁴ Cancer Staging Manual p62
⁵ Cancer Staging Manual p63
Practice Pathway for the Management of Cancer of the Supraglottic Larynx

**Presenting symptoms**
- Dysphagia
- Dyspnea
- Stridor
- Lump in neck
- Voice change
- Otalgia
- Odynophagia

**Initial Workup**
- History and Physical
- Biopsy
- Chest x-ray
- CT (Head & Neck, skull base to clavicles)
- MRI as indicated

Consultation by expert pathologists in case of an unclear diagnosis strongly recommended.

Referral should not be delayed while waiting for test results.

**Referral to:**
- Speech Language Pathologist
- Dietitian for nutritional assessment
- Dental assessment

**T stage?**
- T1
- T2-T4
- T4

**Management of the Neck**
- T1- N0 OR T2-T4 N0-N1

**Follow Up and Surveillance**
- to be conducted by oncologist or otolaryngologist

- History and Physical Exam (including laryngoscopy)
  - Year 1 and 2 every 2-4 months
  - Years 3-5 every 6 months
  - > 5 years every 12 months

**If recurrence detected, refer to Management of Recurrence (p 34)**

Information and Supportive/Psychosocial Care services need to be appropriate and available to patients throughout the continuum of care (see Part 5 p 48)
Presenting symptoms

Initial Workup

- History
- Physical examination

Endoscopy

- CO₂ laser
- Radiotherapy

If T3, consider concurrent chemo

- Total laryngectomy
- Thyroidectomy
- Radiation therapy
- Chemotherapy

- Surgery not desirable

Larynx

Referral should not be delayed while waiting for test results.

strongly recommended.
Presenting symptoms → Initial Workup → Treatment of the Primary Tumor

- History
- Biopsy
- Chemotherapy based on pathologists in case of an unclear diagnosis: strongly recommended.
- Referral should not be to RT¹ to oral cavity
- Dietitian for nutritional assessment
- Dental assessment
- Speech Language Pathology
- Maxillofacial prosthodontist prior to RT¹ to oral cavity

¹Radiotherapy