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Metastasis to the Lingual Lymph Node in Patients with Squamous Cell Carcinoma of the Floor of the Mouth: A Report of Two Cases

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Cancer of the tongue or the floor of the mouth sometimes metastasizes to the lingual lymph node. We present two patients with squamous cell carcinoma of the floor of the mouth who developed metastases to the lateral lingual lymph nodes.

Case 1, a 62-year old male, had squamous cell carcinoma of the floor of the mouth (T3N2cM0). He underwent tumor resection and bilateral neck dissection, and histological examination revealed five metastatic nodes including the lateral lingual node near the hyoid bone. No recurrent tumors were evident, but he died of pneumonia 10 months after the surgery.

Case 2, a 62-year old male, had squamous cell carcinoma of the floor of the mouth (T2N2cM0). He underwent tumor resection and bilateral neck dissection, and histological examination revealed three metastatic nodes including the lateral lingual node near the sublingual gland. No recurrence was found in the oral and neck regions, but he died of liver metastasis 18 months after the surgery.

Metastasis to the lingual lymph node may cause a recurrence of oral cancer in the neck, since conventional neck dissection cannot remove this node even in the case of en bloc resection of the primary tumor and the neck. When CT, MRI, or intra-operative palpation findings lead to a suspicion of metastasis to the lingual lymph node, the area of neck dissection should be extended to include this node.

Squamous cell carcinoma of the oral cavity often metastasizes to the cervical lymph nodes, and the prognosis depends upon the control of the metastatic rather than the primary tumor 3). Neck dissection, including functional, modified, and radical dissection, has been used for patients with oral cancer accompanied by lymph node metastasis, but in some cases it resulted in neck failure. It has been reported that tumor recurrence after neck dissection often occurs in patients with multiple positive nodes and extra-nodal invasion 2). However, recurrence near the hyoid bone was observed in some of our patients with tongue cancer accompanied by a single metastatic node but no extra-nodal invasion.

It is known that lymph nodes occasionally are located along some lymph vessels of the tongue and are known as lingual lymph nodes. The existence of lingual lymph nodes had
received little attention and no studies of metastasis of oral cancer to these lymph nodes had been reported until Ozeki et al. 4) first published their report on three patients with tongue cancer metastasizing to these lymph nodes. The lingual lymph node cannot be removed with usual neck dissection, so that metastasis to this node may cause neck recurrence of oral cancer. We present here two new patients of carcinoma of the floor of the mouth who had metastases to the lateral lingual lymph nodes.

**CLINICAL CASES**

**Case 1**

A 62-year old male was referred to our hospital because of pain in the floor of the mouth. Clinical examination revealed a 45 x 28mm tumor with ulceration in the anterior part of the left floor of the mouth (Fig. 1), and an enlarged submandibular lymph node. The diagnosis after histological examination of the biopsy specimen was well differentiated squamous cell carcinoma. CT and MRI images showed an enlarged left submandibular lymph node, and a right lateral lingual lymph node, which were located in the inner- and upper areas of the submandibular gland (Fig. 2). Because of the diagnosis of carcinoma of the floor of the mouth (T3N2cM0), he underwent bilateral functional neck dissection, resection of the tumor, and reconstruction using a free rectus abdominis myocutaneous flap. After resection of the mylohyoid muscle, an elastic hard, lateral lingual lymph node was found on the muscle near the hyoid bone. Histological examination showed that metastasis was evident in two left submandibular nodes, two left upper jugular nodes, and one right lateral lingual node.

There was no evidence of tumor recurrence, but he died of pneumonia 10 months after the surgery.

Figure 1  Intraoral findings of Case 1.

Figure 2  MRI image of Case 1 showing the lateral lingual lymph node.
Case 2

A 62-year old male was referred to our hospital because of swelling of the anterior floor of the mouth. Clinical examination revealed a tumor with ulceration in the median part of the floor of the mouth (Fig 3), and an enlarged left midjugular lymph node. The diagnosis after histological examination of the biopsy specimen was moderately differentiated squamous cell carcinoma. CT and MRI images showed an enlarger left midjugular lymph node, and a right lateral lingual lymph node which were located in the inner- and lower areas of the right sublingual gland (Fig. 4). Because of the diagnosis of carcinoma of the floor of the mouth (T2N2cM0), he underwent bilateral functional neck dissection, resection of the tumor, and reconstruction using a free forearm flap. When en bloc resection of the tumor and the neck was performed, an elastic hard, right lateral lingual lymph node was palpated near the sublingual gland. Histological examination showed that metastasis was evident in two left midjugular nodes and one right lateral lingual node. The patient obtained loco-regional control but died of liver metastasis 16 months after the surgery.

Approximate bounding box:

Figure 3  Intraoral findings of Case 2.

Figure 4  MRI image of Case 2 showing the lateral lingual lymph node.

Surgical approach to the lingual lymph nodes

A neck dissection from levels II to V was performed with the usual method, and before the dissection of level I, the lingual lymph nodes were examined with the following method: after removal of the digastricus muscle from the hyoid bone (Fig. 5a) and resection of the mylohyoid muscle near the hyoid bone (Fig. 5b), the geniohyoid muscle was pulled to the median side (Fig. 5c). A finger was inserted along the hypoglossus nerve and fascia of the genioglossus muscle to palpate the lateral lingual lymph nodes (Fig. 5d), after which the finger was moved to the medial side of genioglossus muscle to palpate the median lingual lymph nodes. The superior part of the lingual lymph node is located near the sublingual salivary gland, and the inferior part near the hyoid bone. When metastasis to the lingual lymph node is suspected, the lymph node is included in the resection, but when no lymph nodes are detected, dissection of this area is terminated and proceeds to neck level I.
DISCUSSION

Some lymphatic vessels of the tongue run along the genioglossus muscle and flow out into the submandibular lymph nodes. The lingual lymph nodes are intermediate lymph nodes which occasionally are located outside a genioglossus muscle (lateral lingual lymph nodes) or between the bilateral genioglossus muscles (median lingual lymph nodes) (Fig. 6).

Rouviere 6) first noted the presence of the lingual lymph node and referred to them as the median and lateral lingual lymph node. Omura et al. 4) also identified the lingual lymph nodes as inconstant, interrupting nodules placed deeply above the suprahyoid region along the course of lymphatic vessels that drain the tongue and the floor of the mouth. However, according to the TNM classification, the lingual node is not classified as any level of necks, and there have been few reports of lingual node metastasis from oral cancer. Ozeki et al. 5) first reported three cases of tongue cancer metastasizing to the lingual lymph nodes in 1985. Dutton et al. 1) also reported on a patient with tongue cancer who had occult metastasis to the lingual lymph node, and stated that a traditional discontinuous neck dissection may not remove all of the lymph nodes at risk of metastasis from the oral cavity. However, the

![Image](image-url)
LINGUAL LYMPH NODE METASTASIS OF ORAL CANCER

significance of this lymph node for cancer of the tongue and floor of the mouth has not been fully documented.

We used to treat early tongue cancer patients with interstitial brachytherapy, but this was sometimes followed by local as well as neck recurrence of the cancer \(^7\). For the past 10 years, therefore, surgery has been the first choice of therapy for both early and advanced tongue cancer at our hospital, resulting in a substantial improvement in the local cure rate \(^8\). Currently, the main causes of death from tongue cancer are now neck failure and distant metastasis. Neck recurrence of tongue cancer has been reported in the level II neck, especially in patients with multiple neck metastases associated with extranodal invasion \(^2\). However, such neck recurrence has rarely been observed recently, probably because of adequate dissection of the upper- and posterior part of the level II neck combined with resection of the posterior belly of the digastricus muscle and for advanced cases parapharyngeal dissection of posterior invading tongue cancer \(^9,10\). However, some of our patients showed neck recurrence near the hyoid bone.

Of the 58 patients with carcinoma of the tongue or the floor of the mouth who underwent en bloc resection of the primary tumor and neck dissection between 1999 and 2004, we found three patients with neck recurrence probably caused by metastasis to the lingual lymph node. This lymph node may not be removed by normal neck dissection, even in cases of en bloc resection. Whether the lingual lymph node should be resected when it is detected by preoperative imaging or intraoperative palpation in patients with oral cancer who are undergoing neck dissection needs to be discussed. In order to remove the lingual lymph

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**Figure 6** Schematic representation of the median and lateral lymph nodes. The nodes are located along the genioglossus muscle and flow into the level I nodes. A: sublingual salivary gland, B: genioglossus muscle, C: geniohyoid muscle, D: anterior belly of digastric muscle, E: mylohyoid muscle, F: body of mandible, G: platysma muscle.
node, suprahyoid muscles including the mylohyoid, geniohyoid, and genioglossus muscles should be widely resected but this may cause major functional problems with swallowing and mastication. The frequency of metastasis to the lingual lymph nodes among oral cancer patients is relatively low, and we therefore believe that the area of the neck dissection should only be extended to these nodes when CT, MRI, or intraoperative findings lead to a suspicion of metastasis in lingual lymph nodes, or when pathological examination during surgery produces histological evidence of metastasis. Since ours is a report of a small number of patients with metastases to the lingual lymph nodes, further studies are needed to elucidate whether this surgical procedure results in reduced recurrence in the neck after surgery for tongue or floor of the mouth cancer.

REFERENCES