Clinical Indicators: Neck Dissection

**Procedure**

<table>
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<tr>
<th>Procedure</th>
<th>CPT</th>
<th>Days</th>
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<tbody>
<tr>
<td>Suprahyoid</td>
<td>38700</td>
<td>090</td>
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<tr>
<td>Radical Neck Dissection (RND) (lymphadenectomy)*</td>
<td>38720</td>
<td>090</td>
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<tr>
<td>Modified RND</td>
<td>38724</td>
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*Note: Radical neck dissection performed in conjunction with removal of a primary malignancy is coded with the primary; in some instances a single CPT codes describes both, eg CPT 31365 for total laryngectomy with radical neck dissection whereas in others, each must be coded separately.*

**Indications**

1. **History** (one or more required)

   a) Primary head and neck malignancy proven by biopsy or prior surgery (required).

   b) Enlarging or persisting neck mass with history of regional primary malignancy. (May require needle or open biopsy or imaging supportive of neoplasm.)

   c) Neck mass malignancy proven by biopsy or fine-needle aspiration but no primary site identified.

2. **Physical Examination** (required)

   Comprehensive examination of the head and neck with emphasis on:

   a) Description of neck mass (Levels) and clinical staging (N0-N3, M0-M1, Staging I-V).

   b) Description of head and neck primary site and stage, if known.

3. **Tests** (required)

   a) Pathologic confirmation of primary site or in case of unknown primary, confirmation of neck mass malignancy.

   b) CT Scan, PET, ultrasound, or MRI of head and neck

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\(^1\) RBRVS Global Days
c) Metastatic work-up rule out distal metastasis before performing the Neck Dissection

**Postoperative Observations**

a) Wound infection or breakdown.
b) Bleeding.
c) Facial edema
d) Chylous leak.
f) Electrolyte balance and blood volume determination.
g) Adequate airway management and deglutition
h) Drains--document if functional or removed.
i) Pneumothorax.

**Outcome Review**

1) **One Week**
   a) Review chart for topics listed above, under "postoperative observations."
   b) Is patient able to return to normal daily activity? Assess need for physical therapy
   c) Recommendations made following review of pathological findings including need for adjuvant therapy. (Positive margins, extracapsular spread, perineural invasion, soft tissue invasion.

2) **Beyond One Month**
   a) Tumor status--Any evidence for residual or recurrent tumor? This likely will include endoscopy and “re-staging” imaging post treatment.
   b) Functional assessment--Is patient able to return to work? Are there any restrictions? Assess need for physical therapy.
   c) Cancer registry---Is case being followed by local tumor registry, institution or surgeon for long-term survival studies?
   d) Long-term follow-up by surgical oncologist.
Associated ICD-9 Diagnostic Codes (Representative, but not all-inclusive, codes)

196.0  Secondary and unspecified malignancy of lymph node (primary unknown)
198.89 Secondary malignant neoplasm of other specified sites, other
199.0  Malignant neoplasm without specification of site, disseminated
199.1  Malignant neoplasm without specification of site, other

Additional Information
Assistant Surgeon -- Y

Patient Information

Neck dissection is performed in order to remove known or suspected lymph nodes containing cancer. Its purpose is to assess the extent of disease spread and aggressiveness (extranodal extension), to prevent regional disease progression with involvement of cranial nerves, skin and major vessels. Over the past 50 years it has proven to be an effective method of head and neck cancer control. Complications of this surgery include wound infection and breakdown, bleeding, leakage of lymph fluid, injury to nerves (controlling the lower face, throat, shoulder, tongue, diaphragm), and skin sensation under ear and jaw. Undesired effects can include shoulder weakness and chronic pain in the neck and shoulder. Most patients who have only a neck dissection are able to return to normal daily activities after healing.

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