

Skip metastasis: An Overview

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Clinically detectable metastatic disease at initial diagnosis is the most consistent adverse prognostic factor in osteosarcoma. Skip metastasis is rare in high-grade osteosarcoma and indicates a very poor prognosis. Skip metastases is a discontinuous spread of malignancy in which uninvolved contiguous regions are interspersed with foci of involvement. Skip metastases are defined according to Enneking and Kagan as synchronous smaller foci of tumor occurring in the same bone anatomically separated from the primary lesion or as synchronous smaller foci of tumor on the opposing side of a joint. The classic studies on skip metastases in osteosarcoma, which focused on patients who were treated with surgery only or included a considerable number of patients from the prechemotherapy era, reported high rates of local recurrence and distant metastases during course, resulting in poor outcomes. Oral cancer refers to cancer occurring between the vermilion border of the lips and the junction of the hard and soft palates or the posterior one third of the tongue. The chief risk factors for oral squamous cell carcinoma are smoking (especially > 2 packs/day) and alcohol use. Risk increases dramatically when alcohol use exceeds 6 oz of distilled liquor, 15 oz of wine, or 36 oz of beer/day. The combination of heavy smoking and alcohol abuse is estimated to raise the risk 100-fold in women and 38-fold in men. Squamous cell carcinoma of the tongue may also result from any chronic irritation, such as dental caries, overuse of mouthwash, chewing tobacco, or the use of betel quid. Oral human papillomavirus (HPV), typically acquired via oral-genital contact, may have a role in the etiology of some oral cancers; however, the role of HPV is not as clearly defined in oral cancer as it is in oropharyngeal cancer. Squamous cell carcinoma of the head and neck (SCCHN) frequently metastasizes to the regional lymph nodes and this is the strongest predictor of disease prognosis and outcome. The deleterious effect of cervical metastases on prognosis is so great that even a 20% chance of metastases in an otherwise clinically and radiographically negative neck pushes most clinicians toward its treatment. Tumor recurrence must reflect the presence of malignant cells which are not detected by current diagnostic procedures. This residual cancer may be present at the surgical margins, in lymph nodes or disseminated throughout the body. Histopathological examination of the neck dissection provides important information for staging and prognosis. The clinical significance of skip metastasis in head and neck cancer is not well established.

REFERENCES

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