

# “COMMANDO” Procedures in Cancer of the Head & Neck: Short Communication

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## ABSTRACT

The “COMMANDO” procedure has been regarded as an intrepid surgical technique in the field of otolaryngology. The procedure involves resecting a portion of the mandible along with neck dissection and removal of the primary intra-oral tumor. Herein, the authors narrated on the indications of composite resection, the various approaches from the aspect of soft tissue and osseous, as well as complications.

**Keywords:** Otolaryngology, Mandible, Neck Dissection, Composite, Resection, Neoplasm.

## 1. INTRODUCTION

The “COMMANDO” procedure, also known as the composite resection, represents a bold and intriguing operation schedule that includes resection of a portion of the mandible in continuity with the neck dissection and resection of the primary intra-oral lesion. George Washington Crile set forth such a concept in 1906, while Hayes Martin popularized the surgery during World War 2 [2]. The “COMMANDO” operation is often utilized for unilateral malignant lesions involving or adjacent to the mandible. It includes tumours of the mandible, buccal mucosa, gingiva, alveolar ridge, the floor of mouth, tongue, retromolar trigone, and tonsil [1] [2]. A temporary tracheotomy is routinely performed at the operation in anticipation of post-operative soft tissue swelling with the risk of obstructing the airway [2][3]. Feeding can be established either through a nasogastric feeding tube which may be passed during the procedure, or a planned percutaneous gastrostomy feeding tube.

## 2. RESULTS AND DISCUSSION

A variety of surgical approaches, broadly categorized into soft tissue with sequential bony techniques, are available for the “COMMANDO” procedure. The confounding variables on the surgical choice may include: (1) Location and size of the lesion (2) Tumor approximation to the mandible (3) Degree of surgical field exposure (4) The vertical height of the mandible (5) Previous mandible irradiation (6)

Existence of dentition (7) Local expertise. A small lesion that is anteriorly located can be easily accessible through the peroral approach. Under the circumstances where adequate exposure is hampered by the location of the tumor or trismus, either a visor flap approach or cheek flap with lower lip split may be considered to facilitate the surgery. Visor flap obviates the unsightly facial scar while incorporating the incision along with neck dissection. Conversely, the lower lip splitting approach offers a more comprehensive surgical access and potentially preserves the function of the marginal mandibular nerve.

A thorough evaluation encompasses clinical assessment, radio-imaging appraisal, gross surgical field inspection, and intraoperative frozen section is indispensable to determine the bony approaches. Gross invasion of the mandible necessitates en bloc resection with an adequate surgical margin. Undoubtedly, segmental resections often result in functional and cosmesis defects that may benefit from reconstruction. On the other hand, marginal mandibulectomy can be considered in tumors close to or abutting a nonirradiated mandible [4].

During the early phase, recovery may be hindered by wound infection, wound dehiscence, oro-cutaneous fistula, flap necrosis, and chyle leak. Long term surgical complications include residual tumour, disruption of swallowing, mastication and articulation function, neurological complications, pathological fracture or

osteoradionecrosis of the mandible, and cosmetic concerns [5].

### 3. CONCLUSION

COMMANDO procedures could be as an alternative on managing the head and neck cancer, especially on the mandible tumor. However, several confounding variables should be considered.

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