American Journal of Otolaryngology and Head and Neck Surgery

Research Article
Published: 27 Oct, 2026

One Year Audit of Head Neck Cancer Patients Discussed at Head and Neck MDT Meeting from ENT Department at Limerick University Hospital, Ireland

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Abstract

Objectives: To assess Head Neck cancer patients discussed at Head Neck MDT meeting seen and treated by different ENT Consultants at Limerick University Hospital, Ireland regarding source of referral, presentations, age & sex of patients, smoking and alcohol habit, site of lesions, imaging study, histopathology results, staging of cancer, reason for MDT discussion and outcome of MDT and post treatment CT/PET CT evaluation of patients to see residual/recurrence of cancer.

Study Design: A retrospective audit of all head neck cancer patients discussed at fortnightly Head Neck MDT meeting at Limerick University Hospital for one year from January 2024 to December 2024 seen and treated by different ENT Consultants.

Method: Head Neck MDT at Limerick University Hospital includes Maxillofacial patients and ENT patients. Total number of head neck cancer patients from ENT discussed at Head Neck MDT meeting were collected retrospectively from the printed Head Neck MDT meeting sheets prepared by the ENT team using audit pro forma sheet usually 2 days prior the date of MDT meeting. This data sheet clearly mentions patient's name, DOB, sex, symptoms, habit, site of lesions, recent imaging, pathology /cytology report, reason for MDT discussion. After discussion MDT outcome was recorded in MDT sheets and in patient's chart.

Results: Out of 333 patients discussed,139 patients from ENT (56.45%) seen and treated by different consultants. 27 patients were re discussed, so total number of ENT patients were 112. Patient's age ranged from 32-92 with mean age was 65.8. Male: female ratio was 2.7:1. Consultant A contributes 63.3% of patients as he is mostly involved taking care of head neck cancer patients. 65% of patients were moderate smoker and drinker. Most common sites of head neck cancer are oropharynx (tonsil & tongue base) contributes 32%, next is larynx 17.8% and 3rd site is skin cancer (13.39%). SCC is the most common head neck cancer (82.14%). Most common reason for MDT discussion was to analyse images and histopathology for final management plan (56.25% of cases). Next reason was to study post treatment PET scan to assess recurrence or residual disease (23.2% of cases). Regarding MDT outcome 54.46% of patients got concurrent chemoradiation and 16.07% of patients got primary surgery.

Conclusion: This retrospective one-year single center audit of head neck cancer patients discussed at Head Neck MDT meeting played an important role for analyzing images, histopathology, making final staging of cancer and deciding the best treatment option for any particular head neck cancer patients. Majority of max-face patients include oral cavity cancer and ENT patients include cancer of tonsil, tongue base and larynx. Most of these patients got concurrent chemoradiation as a modality of treatment from MDT discussion.

Keywords: Multidisciplinary team; Head neck cancer; Cancer management

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Received Date: *02 Oct 2026*
Accepted Date: *24 Oct 2026*
Published Date: *27 Oct 2026*

Citation:
Matin A, Attique S, Khanam M, Islam GT, Bassiouni ME, Almanassra A. One Year Audit of Head Neck Cancer Patients Discussed at Head and Neck MDT Meeting from ENT Department at Limerick University Hospital, Ireland. Am J Otolaryngol Head Neck Surg. 2026; 8(3): 1276.

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Introduction

Head and neck cancers mostly arise from upper aerodigestive tract and affecting voice, speech, swallowing and breathing. Head & Neck cancers are the sixth most common malignant tumor globally, and over 830 thousand cases are diagnosed each year with over 400 thousand patient death every year despite advancement in treatment in recent year [1]. In Ireland over 700 people are diagnosed with head neck cancer annually with 202 cases of mouth cancer, 162 of laryngeal cancer and 147 pharyngeal cancer [2]. The main risk factors for head neck cancer development are tobacco smoking, alcohol consumption and infection with Human Papilloma Virus (HPV) [3]. Approximately 75% of head neck cancers can be associated with the consumption of tobacco and alcohol [4]. There is clear causal relationship between HPV and development of oropharyngeal cancer [5]. Head and Neck cancer cases in Ireland are projected to increase by 2045 (+65% in males and by 67% in female [6]. Incidence of mouth cancer has recently increased by 3.3% per annum in women, while oropharyngeal cancer in men increased by 2.5% annually [7]. Head and Neck cancer is still more common in men particularly laryngeal cancer (7:1), followed by cancer of mouth and pharynx at 3:1.2 [8]. In Ireland, 4 patients die every week from head and neck cancer and over 2600 patients are living with the consequences [9]. So early detection of head and neck cancer improves outcomes and quality of life. Average 5-year survival rate in early-stage disease fall from 80% to 30% in advanced stage with regional or distant metastases [10]. General practitioners play a great role for early detection of head neck cancer patients by urgent referral to ENT consultants.

Audit method

Audit organization and design / Study design:

Audit was designed with retrospective data collection, using audit proforma and Head Neck MDT meeting data sheet published 2 days before the MDT meeting.

Materials and Methods

Ethics

No ethical clearance was taken.

Study place: Limerick University Hospital, Ireland

Audit period /Study Period: From January 2024 to December 2024.

Patient selection and recruitment

Inclusion criteria

1. All known head and neck cancer patients who finished treatment, after 3 months for post treatment CT/PET scan discussion to evaluate recurrence/residual disease.

2. All new head and neck cancer patients with pathologically proven cancer for discussion of images, pathology and further management plan.

3. Any doubtful patients for discussion of images.

Exclusion criteria

1. Any head neck cancer patients who discussed once during this time period.

2. Any patient with suspected or known thyroid cancer, they are discussed at Thyroid MDT.

Data collection

During one year time from January 2024 to December 2024, 24 Head Neck MDT meetings were done at Limerick University Hospital under the department of ENT and Max-Fax. Total number of head neck cancer patients from ENT discussed at Head Neck MDT meeting were collected retrospectively from the printed Head Neck MDT meeting sheets prepared by the ENT team using audit pro forma sheet usually 2 days prior the date of MDT meeting. This data sheet clearly mentions patient's details, patient's habit, name of consultant, site of lesions, recent imaging, pathology /cytology report, reason for MDT discussion. After discussion MDT outcome was recorded in MDT sheets and in patient's chart.

Data analysis

The statistical analysis was performed using the SPSS-22 (Table 1).

Results

A total of 333 cases were discussed in Head Neck MDT meeting over one year period from Max-fax, ENT, medical oncology, radiation oncology and haematology department (Figure 1). 139 cases discussed from ENT and 27 cases re discussed and excluded from data analysis. So total number of ENT patients were 112.

Sex

Head neck cancer incidence was consistently higher in males with male female ratio 2.7:1.

Age

Age of patients ranged from 32-92, mean age 65.86. In our audit head neck cancer was recorded in 7.2% of people at or under 50 years, with 51.4%in the 51-70-year range group (Figure 2).

Consultant contribution

Following bar diagram shows distribution of patients under 4 different ENT consultants Figure 3. Majority of patients under Consultant A (63.39%) as he is mostly involved treating head neck cancer patients whereas only 4.46% patients treated under Consultant

Table 1: Audit proforma.

	Date of MDT
1. Patient's information	Name DOB/Age Sex- M/F MRN No
2. Source of referral	GP, ED, Consultant
3. Symbolic name of Surgeons	A B C D
4. Personal habit	Smoking/mild-mod-heavy, Drinking
5. Symptoms	Hoarseness Pain in throat / referred otalgia Dysphagia Neck lumps
6. FOL findings/Clinical Examination	Any growth in nasopharynx, oropharynx, vallecula, larynx, hypopharynx, salivary gland lumps/neck nodes
7. Investigations/ procedures & Final histopathology	CT neck & thorax/MRI/PET Scan/Panendoscopy & biopsy/FNAC
8. Reason for MDT discussion and outcome	Discussion of images/ histopathology/ post treatment scan Treatment: CRT/Radiotherapy/Palliative radiotherapy/Surgery only/Surgery plus post op radiotherapy

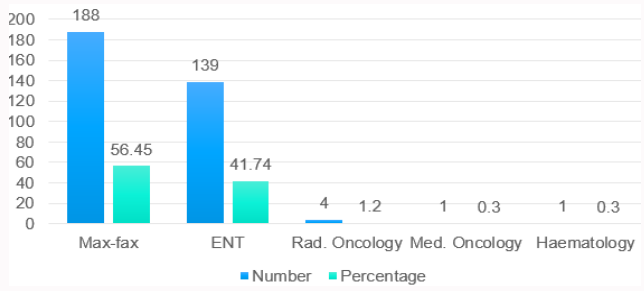


Figure 1: Cases discussed by departments (Total cases 333).

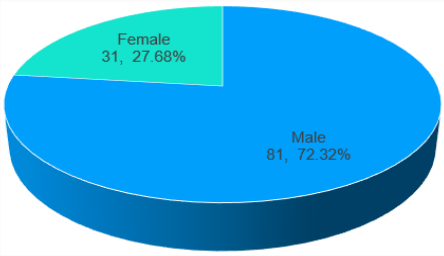


Figure 2: Pie chart showing sex distribution, total number of patients 112.

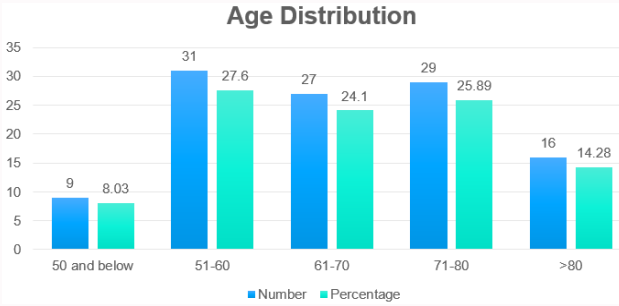


Figure 3: Age Distribution (Total No. 112) with mean age 65.86.

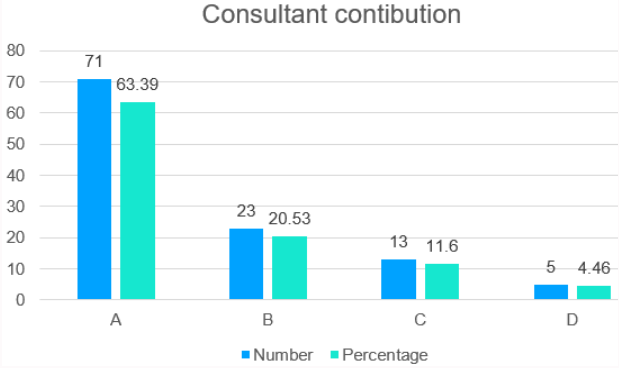


Figure 4: Consultant Contribution (Total no. 112).

D (Figure 4).

Source of referral

Majority of head neck cancer patients (82.14%) were referred from GP (Figure 5). Other patient's referral source was from ED and from inter hospital Consultant.

Presenting complaint

Main presenting complaints were discussed in following diagram.

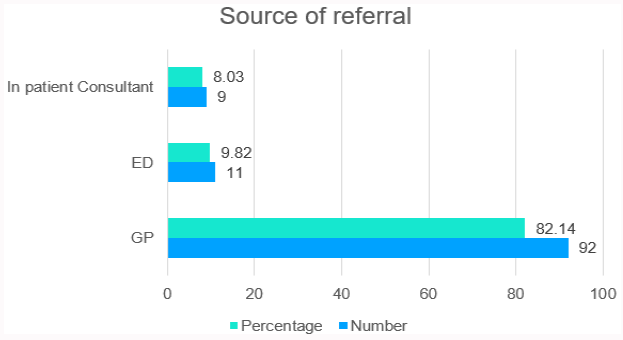


Figure 5: Referral source of head neck cancer patients (Total No. 112).

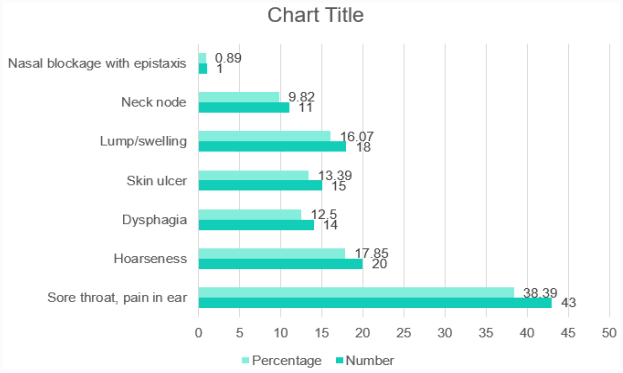


Figure 6: Showing chief complaint (Total No.112).

Table 2: Showing reason for MDT discussion.

Reason	Number	Percentage
Discussion of images, histopathology, stages and management plan	63	56.25
Discussion of 3 months post treatment PET scan/CT scan to see recurrence/residual cancer	26	23.21
Discussion of histopathology only	13	11.6
Discussion of images only	10	8.92

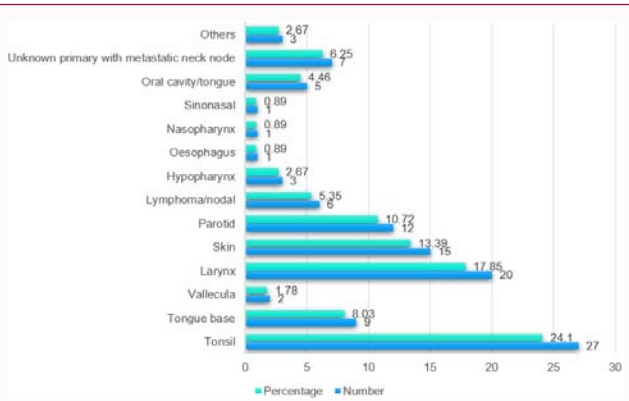


Figure 7: Shows sites of cancer (Total No. 112).

Main complaints were sore throat, hoarseness of voice, dysphagia and neck lumps (Figure 6).

Site of lesions

Following diagram showed site of lesions. Main sites were tonsil (24.1%), larynx (17.85%), skin (13.39%), Tongue base (9.85%) salivary gland (10.7%) (Figure 7).

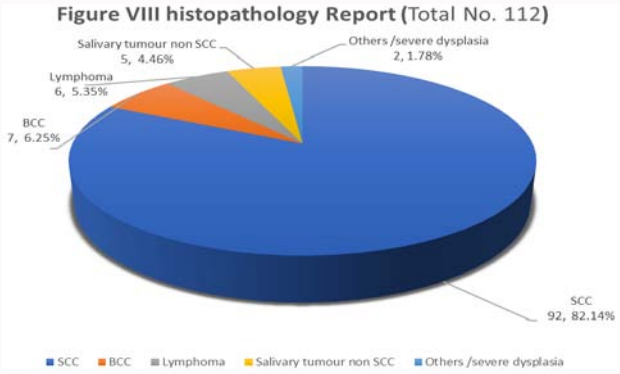


Figure 8: Histopathology Report (Total No. 112).

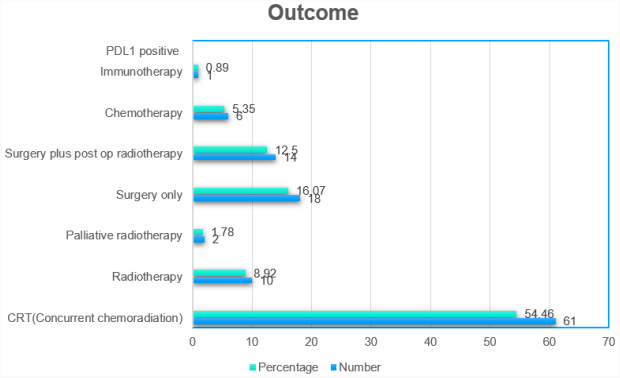


Figure 9: Showing MDT outcome (Total No. 112).

Histopathology report

Figure 8 showed pathology report of 112 patients. Most of the head and neck cancer are SCC (82.14%).

Reason for MDT discussion

Out of 112 cases 63 cases (56.25%) were discussed images, histopathology and for further management (Table 2), 26 cases (23.2%) were discussed post treatment PET/CT scan to see any recurrence/ residual disease.

MDT outcome

Figure 9 shows MDT outcome. 61 cases (54.46%) got concurrent chemoradiation for tonsil, tongue base, vallecula, larynx cancer. All skin cancer had wide local excision plus/minus reconstruction.

Discussion

Head and Neck cancer treatment requires a wide range of specialist, thereby treatment is usually discussed and agreed by Multidisciplinary Team (MDT). The aim of this audit was to produce meaningful results and also to discuss limitations so that further audit can be done to improve patients care and cancer outcome. This one-year audit of Head Neck MDT at Limerick University Hospital provides an overview of head neck cancer patients regarding referral pathway, age, sex, symptoms at presentation, site of cancer, reasons for MDT discussion and outcome of MDT discussion for best management plan. GPs are generally the first point of contact for head neck cancer patients internationally, ranging from 91% in USA to 70% in Canada, 50% in the UK [11,12]. In our audit 82% patients were referred from GP which is similar to these studies. Head neck cancers are more common in male with male female ratio 2.7:1 in this audit. Mean age of patients was 65.8 with 51.4% in age group 51-70. SCC was the dominant histopathology in head neck cancer (82.14%) in our audit which is similar to Dr O' Sullivan 's audit in Ireland [7]. Oral cavity, oropharynx, larynx is almost exclusively SCC. In our fortnightly Head Neck MDT meeting, 24 meetings were taken place over one year time, the meetings were attended by ENT surgeons and team, Max-fax Surgeons and team, Radiologist, Pathologist, Medical Oncologist and Radiation Oncologist. From ENT, 133 cases were discussed and 27 cases were re-discussed, so total 112 patients were included for this audit. Most of the max-fax patients have oral cavity/tongue cancers and they went for surgery with post op radiotherapy. We did include only our ENT patients. Majority of our cancer patients got concurrent chemoradiation (54.46%). Despite worldwide implementation of MDT in cancer management, robust evidence to suggest improvement in outcomes in patients with head neck cancer is lacking. The study suggest that MDT time delays is important factor. We believe that early-stage head and neck cancers can be successfully managed without MDT. But on the other hand, apart from influencing treatment decision in advanced cancer, MDT have also been shown to improve cancer staging and subsequently patient outcome [13].

Study Limitation and Future Audit Plan

This is a single center, short duration (one year) study with limited sample size (112). Maxillofacial patients are not included in this audit. Their patients are mostly oral cavity cancers and contributed a great number in Head Neck MDT. During the time of seen in outpatient clinic, time to put on MDT from seen in OPD and to start treatment after seen or after MDT was not included which is very important to influence treatment outcome as there might be delay starting treatment. All these issues should be included in future audit.

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