In most institutions, a frequency of occult metastases exceeding 15%- 20% is considered to be sufficient to justify elective neck therapy. Therefore, prevention of regional relapse could significantly reduce mortality in the presence of intercurrent disease process.

The question of clinically negative N0 neck in squamous cell carcinoma of the larynx has not been resolved satisfactorily.

The aim of the current study was:

Review of different studies and recent trends in management patients with N0 neck status in laryngeal carcinoma.

By The current study, the following was concluded:

- The issue of the use of elective surgery versus elective radiation ends not at which treatment modality is more beneficial, but which one is less harmful. The patient's age, general health, family support, reliability and patient's own wishes are important. It is impossible to compare elective neck dissection and elective nodal irradiation efficacy because the status of neck disease is unknown when elective irradiation is used.
- The accurate histological information on micrometastases in neck nodes in patients with clinically negative neck nodes is probabaly one of the prime factors that tilts the argument towards nodal dissection, apart from the lesser associated morbidity.

• If the treatment planning for the primary tumor involves surgical excision through a neck approach, END is opted for when, indicated. If the primary tumor is being treated with irradiation, an elective irradiation of nodal area should be planned.

• Watchful waiting is an option while managing patients with N0 neck in laryngeal carcinoma. Patient factors are perhaps the most important consideration while deciding watchful waiting policy in patients with N0 neck in laryngeal carcinoma. For a patient who stays some distance from the surgical centre and who is not expected to come for regular follow-up (and for unreliable patients) an END would be a better option.

• The neck may be treated electively by either surgery or irradiation; both modalities can control the N0 neck effectively and nearly equally.

• Elective neck dissection (END) provides important information for prognostic purposes and therapeutic decisions, establishing the presence, number, location and nature of occult lymph node metastases.

• The selective lateral neck dissection (level II, III, and IV), unilateral or bilateral, is the procedure of choice for elective treatment. Paratracheal nodes (level VI) should be dissected in cases of advanced glottic and subglottic cancer.

• Radiation therapy of large field increases both the short-term morbidity (mucositis, pain) and the long-term morbidity (fibrosis, xetostomia). Radiation also increases the risk of

complication if salvage surgery is needed. It may also mask the recurrence in the neck, delaying salvage surgery until incurable disease is present.