Societies' proceedings

ROYAL SOCIETY OF MEDICINE — SECTION OF LARYNGOLOGY

7 May 1971

Discussion of Papers—H. J. SHAW (London)

Mr. PRESIDENT,

It is a rare privilege to be asked to open the discussion following two such important papers by Dr. Farr and Dr. Lewis. Both are personal friends and past colleagues. So much the greater, therefore, is my pleasure in adding my welcome to our Society today. We will surely look forward to many future visits from them both.

They are distinguished representatives of one of the most important centres for the treatment of cancer in the U.S.A., with much personal experience in treating head and neck tumours and with access to statistical data which is unique.

Firstly, I would offer them my congratulations on the content and presentation of their papers. Indeed, if I may, for a moment, include some of this mornings papers to the section of Otology we have had an impressive Oncological feast today. With so much of rare quality and interest to digest there will be wide areas of agreement but also plenty of points of detail and conclusion to arouse our discussion.

In Dr. Farr's paper he has ably traced the gradual change in treatment emphasis at Memorial Centre for mouth and pharynx cancer since 1935. He has given us statistical evidence for not adopting a policy of preliminary irradiation before resection in many tumours, but I would suggest that a total dose of 2000 rads. before surgery may be insufficient to affect survival rates. At present, our policy at the Royal Marsden Hospital is to give up to 4000 rads. in three to four weeks with a similar interval before surgery. Again, the method admittedly requires further evidence to be convincing.

I am glad that he feels that mouth and pharynx cancer is really one disease process with widespread mucosal degeneration and subsequent multicentric origin of tumours throughout the air and upper food passages. This may partly explain the high local recurrence rate which he quotes. Again, this has not been so noticeable in our experience, most early recurrences being of metastatic nature.

He is right to emphasize the high and often tragic degree of 'doctor delay' in referring these patients to hospital and, also, the mismanagement that still regrettably occurs at some hospitals in relation to endoscopic examination and investigation of 'lumps in the neck'.

With regard to aspiration biopsy, I agree that it is of great diagnostic value, but this is always in direct proportion to its frequency of use. The occasional aspiration will usually give disappointing results.

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I was much interested in his evidence that there is a gradual rise in this type of cancer in women of recent years. In this context we also find a slightly better prognosis for cancer in females at most sites in this area. Consideration of the epidemiology of mouth and pharynx cancer today indicates that more research is urgently needed into hormonal and nutritional factors involved.

Regarding points of surgical technique: where large resections are necessary I would suggest that soft tissue replacement and resurfacing by using anterior chest or forehead flaps will give better functional results in irradiated patients than neck flaps. There is the added advantage that a later neck dissection is not compromised.

Underflap suction drainage is a useful technique but I feel there is still virtue in the older, bulky dressings for extensive neck wounds. Early immobility and firm adherence of irradiated neck flaps are essential to good healing and this may be in doubt with light dressings.

I would finally like to ask Dr. Farr if he will give us his view of elective neck dissection for cancer in this area, and if he will advise us on the use of pharyngo-oesophageal replacement by gut transplant?

In Dr. Lewis's paper, we have heard him present a remarkable consecutive series of 772 cases of cancer of the nasal cavity and sinuses extending back thirty years in which an overall survival rate of 28 per cent was obtained mainly by surgical resection alone or, at times, using irradiation post-operatively. This is a considerable achievement, especially when it comprises the work of a number of surgeons over the years. There are very few series approaching this in size and scope and in this country, as in other U.S. centres, disappointment at the results of irradiation or surgery alone has led to the use of a combined sequence of treatment by a full course of irradiation followed at an interval by radical surgery. It is of interest that the results of whatever treatment, method or sequence, excepting irradiation alone, give very similar survival figures. This suggests a common factor such as involvement of skull base structures which defeats any method of ablation in a large proportion of tumours.

It is certainly news that he finds chronic sinusitis to be a possible factor in causation despite negative evidence in the past. It would be interesting to know whether any aetiological associations were found in wood workers or those exposed to chemical dust and fumes.

In his table on pathology no mention is made of transitional cell carcinoma or of its synonyms. Since it accounts for a substantial number of tumours in records from centres in this country and Scandinavia there must be a simple explanation for the omission.

Regarding surgical technique, in my experience there is seldom any need to ligate the external carotid artery no matter how wide the resection even after irradiation; a moderate degree of controlled hypotension during anaesthesia gives an excellent surgical advantage, but I agree that all blood loss should be promptly replaced. I was also most interested to learn that he feels that cryo-surgery is of value in palliating locally recurrent disease. It should be more effective than diathermy.

Finally, I would like to ask Dr. Lewis whether he feels that cytotoxic chemotherapy has any place as a preliminary to conventional treatment, at least in advanced cases?

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