

## Early Oral Cancer: Unsolved Debate

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### Commentary

Previously, results of a randomized controlled trial which investigated the efficacy of elective neck dissection (END) for early oral cancer by D'Cruz et al. had been reported [1,2]. It provides highly important information regarding the treatment strategy for early oral cancer patients, which had been controversial for long time. In this study, clinically T1/T2 N0 previously untreated oral cancer patients were randomly allocated to either END arm or therapeutic neck dissection (TND) arm. The patients in the END arm received END as well as primary tumor resection, and the patients in the TND arm received primary tumor resection followed by "watchful observation". They received TND when lymph node metastases were detected during follow-up. Primary endpoint was 3-year overall survival and was in favor of the END arm (80.0% vs. 67.5%, hazard ratio for death of 0.64,  $p=0.01$ ).

Although this study had an answer for the controversy whether END should be added to surgical resection for early oral cancer, we think that the results are not applicable to clinical practice. There are two points which have to be considered when interpret the results.

First, it seems that the "watchful observation" strategy in the TND arm did not work, negatively affecting the overall survival in the TND arm. Out of 253 patients assigned to the TND arm, 114 (45%) patients showed nodal relapse. Surprisingly, more than half of these patients had an advanced nodal stage (N2b/c, 45 cases; N3, 21 cases) and 20 (18%) had unresectable disease. In general, multiple neck nodes (i.e., N2b and N2c) and bulky mass (i.e. N3) are easily detected as palpable masses, even by the patients. Patients enrolled in this trial could have noticed such masses before the lymph node metastases grew to an advanced status, and the authors should have told the patients to visit the hospital before the nodes had enlarged to such an advanced nodal stage. Second, out of 243 patients assigned to the END arm, 72 patients, including 37 patients with extra capsular spread (ECS), had

positive lymph nodes, and almost all of them (69 patients) had received postoperative radiotherapy (PORT) for the neck after END. On the other hand, out of 253 patients assigned to the therapeutic neck dissection (TND) arm, 114 patients showed nodal relapse and only 86 patients received a TND. Although the majority of patients received neck dissection (80 patients) showed ECS, not all the patients were able to receive PORT (71 patients). The reasons for not receiving PORT were not described by the authors. Hence, it seems for us that this study compared END plus PORT with primary resection plus watchful observation with or without TND and PORT. In addition, evidence of postoperative treatment for head and neck squamous cell carcinoma was established [3-5] during the trial period. Although chemo-radiotherapy became the standard of care for patients with ECS, information on chemotherapy was not described in the article. In conclusion, we consider that these points might have affected the results, and another trial to resolve these points is warranted.

### References

1. D'Cruz A, Dandekar M, Vaish R (2015) Elective versus therapeutic neck dissection in the clinically node negative early oral cancer: A randomised control trial (RCT). ASCO Meet: LBA3.
2. D'Cruz AK, Vaish R, Kapre N, Dandekar M, Gupta S, et al. (2015) Elective versus Therapeutic Neck Dissection in Node-Negative Oral Cancer. See comment in PubMed Commons below *N Engl J Med* 373: 521-529.
3. Bernier J, Dommange C, Ozsahin M, Matuszewska K, Lefebvre JL, et al. (2004) Postoperative irradiation with or without concomitant chemotherapy for locally advanced head and neck cancer. See comment in PubMed Commons below *N Engl J Med* 350: 1945-1952.
4. Cooper JS, Pajak TF, Forastiere AA, Jacobs J, Campbell BH, et al. (2004) Postoperative concurrent radiotherapy and chemotherapy for high-risk squamous-cell carcinoma of the head and neck. See comment in PubMed Commons below *N Engl J Med* 350: 1937-1944.
5. Bernier J, Cooper JS, Pajak TF (2005) Defining risk levels in locally advanced head and neck cancers: a comparative analysis of concurrent postoperative radiation plus chemotherapy trials of the EORTC (#22931) and RTOG (# 9501). *Head Neck* 27: 843-850.