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Editorial
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The End Results of the Treatments, Depend on the Total Therapy and Effectiveness of the Planned and the Given Such Treatments

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Editorial

In the news, that even the treatment options for laryngeal cancer patients seemed to be improved, but survival rates did not. This was written by senior author, surgeon(s) from the department of Head and Neck of very respected University [1].

They even included Surgery alone as one of these options that did not improve survival of these patients. Their real objectives are trying to say or prove that alternative none surgical treatments(s), also failed to improve survival of these patients.

Laryngeal cancers patients were the earliest randomized conducted research to preserve the organ, for obvious reason. Single arm study from Wayne State University (WSU) suggested the feasibility and the effective of our initial trial. The first of such trial was conducted by the VA hospitals, by Dr K Hong of VA hospital in Boston, MA. Based, on our findings and results of our single arm trial with induction chemotherapy with Cisplatin and 5FU infusion ((PF) given for two courses. At that time the CT arm was followed by total RT only. Dr. Hong was recruited by MD Anderson Cancer Center in Houston, TX, so he recruited a surgeon from the same above Institute to chair such trial. Important, the VA Hospital of Ann Arbor affliate of UM did not activate the study or registered patient on the study because of their bias.

Even, not the best and total CT was given, and only total RT alone was given after so called induction two courses of CT, the trial proved it's objective, laryngeal preservation and similar survival in both arms.

Since then, the induction combination CT is much improved in results and avoidance of acute, sub acute and delayed side effects.

Instead, of total RT given after the induction CT, a much more effective and very important safer CT concurrent with RT where recommended and given.

The end results is very effective up to 100% complete response, up to 100% voice and organ preservation, and up to 100% 5-years survival.

What this recent article suggest, is to give one single course of induction CT, what ever types and effectives, and then responders (partial or better) to continue the course of CT and recieve a second course only, and followed by RT only. But the non responders, send them to their mutilating knives, and have total laryngectomy and complete lost of voice, and a hole in the neck called tracheostomy. We are still wondering of bioselectivity of admisterating one course, of much less effective CT at the 21st century.

It have been proven that TPF is more effective than PF, in response and overall survival.

No difference, trying to cut half or less of the cancerous growth, for the purpose of cure, are actually malpractice.

What is missing from such article, that surgeon(s) of that time, will decide the CT agent(s) number of combination, and the number of courses. Because they do not want more time to pass and they may be unable to put their hands of the laryngeal organ and take it all out, for the so called concerned to cure the patients.

At the present time, our best, effective and most safe treatment for all stages III and IV head and neck cancers, is induction CT with modified TPF (Taxeter, Platinol, FU), for total of three courses.

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Followed by concurrent weekly Carboplatin (C) (AUC 1.5) with total RT.

The Carboplatin given on day one of the RT, then weekly for additional 2-3 weekly doses post RT. This is because, the effectiveness of RT is on for the same period of time.

Taxotere 75 mg/m^2 IV day one.

Carboplatin AUC 5.0 IV day one.

5FU 2,600 mg/m^2 24 hours infusion daily for five days.

To repeat the same combination every 21 days for a total of three courses.

To repeat imaging at the end of the second course.

Dental evaluation and care during the induction chemotherapy and before RT.

Total RT to start at the end of the third week of the third cycle.

Carboplatin AUC 1.5 day one of RT, and then weekly during RT, for additional 2-3 cycles after the end of RT. the later because the RT effects are still on, during that period of time.

Imaging three weeks after the total treatments where completed. And then every three months for two years, then every six months, for three yeas, and then annually or as indicated clinically.

This, total treatments resulted in 100% local control, disease free survival, and over all survival at 5 years, and beyond.

As important with the minimum, acute, subacute and delayed side effects, if any, especially the two.

No electrolytes or fluid imbalanced, no renal toxicities, minimum nausea and no vomiting, no hearing or peripheral neuropathy.

True and effective organ preservation have to be done with intelligent planning, precision and well thoughts of total initial CT, proper number of courses, and as important even may be more is a total concurrent CT+RT.

Absolutely, no different than precise surgeon planning to remove a total and localized malignant cancer for the purpose of negative margins, and eventually cure these patients.

The end results have to be measured is overall survival and then organ preservation.

References

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