Looking at Cancer

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January
There is steadily accumulating evidence that irradiation of clinically negative areas of the neck, in patients with head and neck cancers, to doses of 4,500 rads in five weeks to 6,000 rads in six weeks nearly eliminates subsequent nodal disease. This experience has been reported in patients with squamous cell carcinomas of the supraglottic larynx, the nasopharynx, the tonsillar fossa, the base of the tongue, the faucial arch and the oral cavity. M. Northrop and others (The University of Texas M.D. Anderson Hospital and Tumor Institute, Houston, Texas) report a series of 180 patients with squamous cell cancer of the oral tongue, floor of mouth and faucial arch, who had clinically positive neck nodes and in whom the primary tumor was controlled. Although the clinical material was not randomized and some reservations must be made for the possibility that selection factors might have influenced the results, certain conclusions appear justified. One is that the appearance of contralateral metastases is almost eliminated with radiation doses of 4,000-5,000 rads in five weeks. Another is that metastatic cervical cancer may be present only in both subdigastric areas, and irradiation to the whole neck is not warranted unless there are extensive cervical metastases. The authors state that a radical neck dissection is mandatory for any patient whose nodes have not received a minimum tumor dose of 6,000 rads in six weeks. Their recommendation, however, is that a radical neck dissection after moderate irradiation is preferred to radical irradiation, if large areas of the neck are to be included, because of subsequent fibrosis caused by irradiation.

A series of 1,467 Caucasian patients with nondisseminated lymphomas of extranodal origin was taken from data collected by the End Results Group of cancer registries in the years 1950-1964. Excluding Hodgkin's disease, about one fourth of the lymphomas reported arose in sites other than lymph nodes. C. Freeman and others (National Cancer Institute, Bethesda, Maryland) present survival rates and distributions according to site of origin, major histologic types, sex, age and extent of disease. When the prognosis of patients with extranodal lymphomas is compared with that for "all cancers" of the same site, the lymphoma patients appear to fare appreciably better when the site of origin is stomach, lung or tonsil.

February
R. T. Long and others (Ellis Fischel State Cancer Hospital, Columbia, Missouri) present data confirming the fact that failure of primary treatment of endometrial carcinoma is most often due to local recurrence in the vagina or cervical stump. They suggest modifications in the primary treatment which might reduce these local recurrences that appear to be due to seeding. One is an altered technique of hysterectomy which involves the use of a specially designed nonslipping occlusive clamp on the
vagina. Another is to increase the amount of preoperative radiotherapy in those patients with persistent disease at curttage after a standard course of preoperative therapy. These recommendations are logical; data are not available to confirm their effectiveness, although previous studies have shown that the use of preoperative irradiation is associated with a substantially reduced incidence of vaginal recurrence. Once recurrence has taken place, prognosis is poor. Transvaginal X-ray therapy or radium application, combined with external radiotherapy, is effective in prolonging survival. Pelvic exenteration may be elected if there is evidence of persistent disease following this procedure. As the initial procedure, it does not appear justified.

"Radiotherapy is of definite but limited value in the treatment of bronchogenic carcinoma," are the opening lines of a paper by D. T. Carr and others (Mayo Clinic, Rochester, Minnesota). In a carefully designed study, they investigated the effects of radiation therapy alone or in combination with 5-FU. Although their patients receiving combined therapy had slightly better survival rates, they concluded that the combination was not significantly more effective than radiotherapy alone. They similarly found no significant value in the use of split-course irradiation. The study is a model of sophisticated scientific approach to a decision pattern in clinical therapy; the authors' conclusions support the widely held opinion that the propensity of bronchogenic carcinoma to metastasize determines its poor prognosis, regardless of palliative effects of local radiation therapy, systemic chemotherapy or a combination of the two.

Persuasive evidence is offered by R. J. A. Aur and others (St. Jude Children's Research Hospital, Memphis, Tennessee) in favor of prophylactic central nervous system irradiation in children with acute lymphocytic leuke-

mia. In a well-designed study, they found that: (1) a one-week course of intensive intravenous chemotherapy early in remission does not prolong remission; (2) 2,400 rads cobalt-60 craniospinal irradiation prevents or delays the onset of CNS leukemia and thus prolongs continuous complete remission; (3) the same radiotherapy given after CNS leukemia develops is not sufficient to eradicate the disease, and (4) any therapeutic regimen for childhood ALL must include CNS therapy early during complete remission if its goal is permanent cure. They feel that childhood ALL is not an incurable disease. This paper is another very good example of the advances that can be made in the evaluation of therapeutic programs for cancer by concentration of cases in dedicated centers, and gives reason to suggest that patients with malignant disease, even of types traditionally considered incurable, should be managed by appropriately specialized groups, and not in general medical facilities.

It has long been known that the occurrence of herpes zoster is higher in cancer patients than in the general population. J. F. Wilson and others (National Cancer Institute, Bethesda, Maryland) found that herpes developed in 31 (19 percent) of 163 consecutively irradiated patients with Hodgkin's disease. Shingles occurred within six months of primary treatment in the majority, which the authors feel suggests immunosuppression by lymphoma and/or irradiation. It was not associated with a high incidence of relapse in this group, although it was in those whose zoster occurred later than six months. Examination of specific characteristics of patients exhibiting the disease combination is interesting, but fails to reveal an explanation for the association.