Hyperkeratosis of the Larynx

Since histologically benign hyperkeratosis of the vocal cord frequently recurs and since cancer may supervene after a few years, should cord excision be performed even when the lesion is benign?

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Hyperkeratosis of the larynx is a troublesome lesion since recurrences are common, but it does not seem to be a precancerous lesion. However, if the histologic report shows hyperkeratosis with atypism, there is cause to suspect that the lesion may be precancerous. If the keratotic area involves only one cord or segments of both cords, but not the anterior commissure, removal of the keratotic area and stripping the cord, if necessary, is usually adequate treatment. Of course, any material stripped should be carefully examined for areas of in situ carcinoma associated with the keratosis. If the keratotic area recurs and all irritating factors, such as smoking, are eliminated, repeated removals of the keratotic area can be done without harm to the patient.

Occasionally, if a hyperkeratotic area is extensive and involves the whole cord and if there is a question of malignancy, a cordectomy can be performed with careful subsectioning to rule out cancer. The real problems are those rare cases in which the hyperkeratotic areas involve not only the true vocal cords but also all of the interior larynx. These patients are extremely difficult to treat because the keratoses tend to recur following excision. If atypia is found in the keratotic areas, invasive carcinoma may be diagnosed eventually. In such a case, radiation therapy can be employed with expectation of good results. However, if radiation therapy fails, either a limited procedure or laryngectomy may be indicated.

In summary, the diagnosis of hyperkeratosis, per se, without carcinoma in situ or atypia, is not cause for alarm and conservative treatment is entirely justified.

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Estrogen and Breast Cancer

A woman taking estrogen for surgical or normal menopause develops breast cancer and has a mastectomy at which time there is no evidence of metastases. Should estrogen therapy be stopped?

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Current literature does not correlate administration of female hormones for benign clinical situations with an increase in the incidence of breast cancer. In patients with recurrent mammary carcinoma, however, there is little doubt that estrogen may have the effect of exacerbating the disease.

The response to large-dose estrogen as a primary treatment for patients with advanced mammary carcinoma who are five or more years postmenopausal is 33 percent. No data are available regarding the response to therapeutic doses in patients with recurrent disease who developed tumors while receiving replacement estrogen.

Since the patient described above developed a tumor on replacement therapy, it should be discontinued. The therapeutic use of large-dose estrogen would be questionable were she to continue on the agent and the tumor recurred. In this situation the patient could be denied a potentially effective agent.

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Rx of Liposarcoma

What is the treatment of choice for a 50-year-old woman with a large liposarcoma of the pleomorphic type in her right anterior thigh?

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I assume that the diagnosis has been established by biopsy which is, of course, the first step in treatment. Since liposarcomas frequently vary in appearance from one area to another, a random biopsy may not reveal the true nature of a tumor and biopsy of multiple areas may be necessary.

In my opinion, the treatment of choice is surgical, although some authorities feel that irradiation or a combination of surgery and radiation therapy constitutes adequate treatment for at least some liposarcomas, as opposed to sarcomas of other histogenesis. Since the tumor in the above case is large, adequate surgical treatment probably involves amputation. However, this decision can not be soundly made without a great deal more information on the anatomic relationships of the lesion. If wide excision can be carried out with preservation of a useful extremity, such treatment should suffice. Since the tumor usually extends beyond its grossly apparent limits, excision must be wide, including the entire biopsy site and a good margin of uninvolved surrounding tissue. This is true for all soft tissue sarcomas but is of utmost importance in this case for two reasons. First, the tumor is pleomorphic, indicating a high degree of malignancy and a real potential for distant metastasis; and second, a proportion of liposarcomas are multicentric and one or more multiple centers may be missed by conservative surgery. If amputation or radical surgery is performed, postoperative irradiation should not be necessary.

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