To the Editor:

Your interview with Dr. LaSalle D. Leffall, Jr., of Howard University, appearing in the September/October 1971 issue of Ca—A Cancer Journal for Clinicians is a disappointment to me as a practicing head and neck surgeon. Dr. Leffall's criteria for neck dissection are based on the presence of palpable lymph nodes or the presence of a primary lesion having a high incidence of histologically positive nodes.

Many well conducted surveys have established an incidence of 25-60 percent of histologically positive nodes in clinically negative neck examinations (I refer to studies of Lyall and Schetlin, Kremin, Southwick, Sako, Ward, etc.). Palpable nodes are at least 0.5 cm. -1.0 cm. in size. To quote Dr. Harry Southwick, "With such inaccuracy in clinical evaluation, there would seem to be little justification for relying on such evaluation to determine when the regional lymph nodes should be removed."

In my opinion, $T_3$ lesions indicate an elective neck dissection regardless of the location of the primary tumor, histology of the primary tumor, presence or absence of clinical nodes or preoperative radiation. Surgery is a poor therapeutic cancer modality at best, and it appalls me that a Chief of Surgery chooses to ignore 25-60 percent of subclinical cancer.

A second point of disappointment in Dr. Leffall’s surgical criteria is the reliance on radiological evidence of bone involvement for a mandibular resection. The intraoral lymphatics and their relation to the inner table of the mandible are well known; to wait until radiographic involvement occurs compromises the surgical procedure.

I would welcome Dr. Leffall’s statistics for his position taken in your article. Both the ear, nose and throat literature and the general surgical literature favor stronger surgical criteria.

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To the Editor:

In response to Dr. Appleton’s criticisms, I think that although there has been some difference of opinion concerning the place of elective neck dissections in the management of patients with cancer of the head and neck, most recent statistical data from large centers support our point of view. I shall quote from two recent articles.
The first is entitled "Management of Cancer of the Floor of the Month," by Dr. Charles C. Harrold, Jr., from the Head and Neck Service, Memorial Cancer Center, New York, New York (American Journal of Surgery 121: 487-493, October 1971). His study reveals that elective neck dissection, although beneficial under special indications in about 35 percent of patients with clinically negative cervical nodes, would have yielded no increased survival rates if it had been used more frequently. Further, their indications at Memorial Center for performing regional lymph node dissections in combination with excision of the primary lesion has been the clinical presence of metastatic nodes or the presence of a primary lesion whose excision required a surgical approach that entered the neck. These indications are similar to ours.

The second reference is an article by Dr. Richard Jesse, et al., from the Head and Neck Service, The M. D. Anderson Hospital and Tumor Institute, Houston, Texas, on "Cancer of the Oral Cavity—Is Elective Neck Dissection Beneficial?" (American Journal of Surgery 120: 507-508, October 1970). After reviewing the charts of 521 patients with cancer of the oral cavity and clinically negative necks, Jesse and his group concluded that complete elective treatment of the neck is not advocated. In 27 percent of the patients, the neck was partially irradiated in conjunction with treatment of the primary lesion.

Dr. Appleton states that in his opinion T3 lesions should have an elective neck dissection and lists various criteria. The majority of these lesions would be treated by neck dissection in our hands also, because they would meet one of the three criteria which we have established for the performance of neck dissection, that is: (1) presence of clinically positive nodes, (2) the primary having a high incidence of histologically positive nodes and (3) the planes of the upper neck having been entered. Obviously, some patients who meet the second and third criteria for neck dissection will also have clinically negative cervical nodes.

Dr. Appleton further states that we rely on a radiological evidence of bone involvement for a mandibular resection, but he fails to mention that we combine this with the primary tumor being at least three to four millimeters from the mandible. I agree if one were to rely solely on X-ray evidence of bone involvement as the criterion for mandibular resection, he would be performing a disservice to his patients. We have been influenced by the work of Dr. Frank C. Marchetta and his associates at the Roswell Park Memorial Institute. I refer to their article, "Periosteal Lymphatics of the Mandible and Intraoral Carcinoma" (American Journal of Surgery 108: 505-507, October 1964). They performed serial sections of the mandibular periosteum removed from surgical specimens of patients with intraoral carcinoma. They came to the following conclusions: (1) the periosteum was involved only in those patients in which the tumor rested against the mandible; (2) in instances in which there were only a few millimeters of normal tissue between the lesion and the mandible, there was no periosteal involvement; (3) no relationship existed between the size of the lesion and the presence of periosteal involvement; (4) there was no relationship between periosteal involvement and the presence or absence of cervical metastases; and (5) the distance between the lesion and the mandible appeared to be the decisive factor relative to involvement of the periosteum by tumor. As reported at the recent meeting of The Society of Head and Neck Surgeons in Vancouver, B.C., May 1971, we have used this technique in 21 patients over the past four years—11 of whom were operated on more than three years ago with the remainder being operated on during the past three years. There was one local re-
currence in each group which may or may not be related to nonresection of the mandible. It must be noted that the use of nonresection would be applied to a selected group of patients.

The majority of our patients with operable lesions who have indications for neck dissections are treated by combined incontinuity en bloc resection of the intraoral primary, the mandible and the regional cervical nodes (neck dissection). In selected cases, modifications are employed according to the criteria listed in the interview. We believe that our indications for neck dissection are sound and that careful follow-up will allow us to perform a secondary neck dissection if clinically positive nodes arise.

Thus, in summary, neck dissections are performed at the time of original surgery if one of the listed criteria exists. Further, according to recent reports from most large centers, the trend is against the use of elective or so-called prophylactic neck dissections. With regards to our approach to the mandible, we have been pleased with the results to this date and currently plan to continue its use under the conditions as outlined.

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A Constituency of Millions

Another portion of the blame rests with the public itself, which insists on being poisoned. Somebody buys all the quack medicines that build palaces for the mushroom, say rather, the toadstool millionaires. Who is it? These people have a constituency of millions. The popular belief is all but universal that sick persons should feed on noxious substances. One of our members was called not long since to a man with a terribly sore mouth. On inquiry he found that the man had picked up a box of unknown pills, in Howard Street, and had proceeded to take them, on general principles, pills being good for people. They happened to contain mercury, and hence the trouble for which he consulted our associate.—O. W. Holmes, Currents and Counter-currents in Medical Science. In: Medical Essays. Boston: Ticknor and Fields, 1860. P. 186.