**ABSTRACTS**

**NEOPLASMS, MALIGNANT**


The authors examined the role of postchemoradiotherapy neck dissection in a group of 56 patients initially presenting with N2 neck disease (3 with N2a, 25 with N2b, and 28 with N2c). Nodes larger than 3 cm were seen in 77%, and 71% had central necrosis. All primary sites were included, but most (66%) were in the oropharynx. Follow-up ranged from 4 to 76 months. Recurrence or persistence was seen in 17 (30%) patients; 39 patients had a complete response (CR) and never had a recurrence. Only 11 of the 36 CR patients with CT–positron emission tomography (CT-PET) had a false-positive test that later became negative. Nine of the 11 that had recurrence and had a CT-PET had a positive study. The other 2 became positive at 3 and 9 months. It is not clear when the first false-negative scan was obtained; the second false-negative scan was obtained at 8 weeks. The disease-free interval was not affected by N classification, T classification, nodal size, or necrosis. As could have been predicted, patients with positive CT-PET scans had a reduced median disease-free interval compared with patients with a negative CT-PET scan (14 vs 32 months; p < .001). On multivariate analysis, the only predictor of neck recurrence was a positive PET (p = .02). The positive predictive value and negative predictive value of CT were 90% and 95%, respectively. The authors add more weight to the data supporting the use of CT-PET to determine the need for neck dissection after chemoradiotherapy for the treatment of N2 disease. A negative CT-PET obtained preferably 12 weeks after completion is highly predictive of the absence of persistent disease or later recurrence.

Pierre Lavertu, MD


The authors report on the neck management of 31 patients with oropharyngeal cancers treated with transoral robotic surgery (TORS) and selective neck dissection. The patients selected needed to be appropriate for this type of dissection. All had N0–2 disease. Neck dissection was performed between 1 and 3 weeks after the TORS. Two patients had bilateral dissections. The majority (77%) had levels I through IV dissected. Nine of 23 patients with pN+ disease were found to have extracapsular spread (ECS). The actual levels of nodal involvement were not reported. Seven patients did not receive adjuvant therapy; 12 had irradiation and 12 had chemoradiotherapy. Minimum follow-up was 18 months (range, 19–44 months). Only 1 patient had a contralateral neck recurrence 3 months after the management of a local recurrence 6 months after initial surgery. This recurrence was managed successfully with a radical neck dissection (RND). This patient and another patient with distant metastases were the only 2 patients with tumor recurrence. The overall neck control was 100%. No patient was pCNR. The overall endoscopic gastrostomy (PEG) tube dependent at 2 years. It is important to note that this approach has not only spared some patients from adjuvant therapy but also often resulted in de-escalation of therapy in the remaining patients. Chemotherapy was only used in 50% of patients, the dosage of radiation was lower than for primary therapy, and often the radiation fields were smaller and more appropriately tailored to the disease. Based on these results, it seems as though a proportion of patients treated initially by radiation or chemoradiotherapy may be overtreated. Prospective and larger studies are needed.

Pierre Lavertu, MD

**MEDICAL ONCOLOGY**


This study evaluated the experience of 35 patients with locally advanced squamous cell cancer of the head and neck who were treated with concurrent chemoradiotherapy consisting of cisplatin administered as a 120-hour continuous infusion beginning on days 1, 21, and 42 of a standard radiotherapy regimen. The median follow-up for these patients was 56.5 months, which was also the median survival with the median time to local recurrence not yet reached. There was significant toxicity, but most of this was mild to moderate. Fifteen (43%) developed hypothyroidism, and 11 of 33 patients who required percutaneous endoscopic gastrostomy tubes were tube dependent until their death or when last seen. Five patients (14%) required a tracheostomy, and 3 (9%) developed severe esophageal strictures. Twenty-four patients (69%) developed fibrosis in the radiation field.

This program of concurrent chemoradiotherapy with cisplatin administered as a 120-hour infusion for 3 cycles during radiotherapy appears to have significant activity in association with common toxicities that are, for the most part, mild to moderate, and it deserves further evaluation. A comparison with the usual 1- to 2-hour infusion regimen would be of interest.

Martin W. Oster, MD

The authors report 6 patients, treated over a 7-year period, who received an ipsilateral neurovascularized (long thoracic nerve) serratus anterior free flap. The soft tissue defects were related to cancer therapy (n = 2), trauma (n = 1), hemi-facial atrophy (n = 2), and noma (n = 1). Two patients had no VII n. palsy, and the rest had “asymmetric” motion of various parts of the face. Details of raising the flap, while preserving serratus function, and including the long thoracic nerve, are provided. This nerve is used for direct anastomosis to the VII n. The results included no flap loss, improvement in facial contour and, by 12 months, at least “degree 1 strength” in the mimetic muscles affected. Some examples of 12-month postoperative patients are presented; although motion cannot be specifically documented, the soft tissue restoration is obvious.

David Larson, MD