

LETTER TO THE EDITOR**In reply to McDowell et al**

To the Editor,

We thank McDowell and colleagues for their valuable comments and interpretation of our data. We absolutely agree that minimizing treatment volumes is key to reducing long-term toxicity from radiation and is an underutilized deintensification method. Although there is international consensus in the definition of lymph node levels, the selection of nodal levels to be treated still often has its basis in very old studies describing patterns of recurrence in patients who were not staged with MRI or PET-CT.

We acknowledge that 14% risk of nodal involvement is below the commonly accepted threshold (15%-20%) for treating nodal areas in head and neck cancer, but this limit is arbitrary, non-site-specific, and at least three decades old. In that period, neck treatments (both surgery and radiotherapy [RT]) have significantly advanced and now offer less toxicity. We appreciate the uncertainty in whether cancer-related deaths can be prevented with bilateral neck RT, but we argue that a 7% cancer-related risk of death in a disease that is usually curable is not insignificant.

Contralateral neck recurrences (CNRs) are not always salvageable, and although Lynch et al had 100% success in their series,¹ this rate has not been demonstrated by others (25%-50%).^{2,3} CNRs are not easy to detect. Perhaps there is a role for routine imaging as part of follow-up in patients with N2b treated with unilateral RT—a strategy not currently used in the United Kingdom. Of interest, plasma circulating human papillomavirus (HPV) DNA post-treatment has been found to correlate with clinical response,⁴ so in future, this might prove to be an effective method to detect CNRs early, in an effort to improve salvage treatment rates.

A middle-ground solution of offering patients contralateral neck RT to a limited nodal area might be another option to consider. One of our patients developed an isolated contralateral retropharyngeal node recurrence, but other series have suggested that omitting the contralateral upper level 2 and retropharyngeal nodes is safe and improves quality of life.^{5,6} Sparing the contralateral neck is not the only volume deintensification approach in oropharyngeal cancer: efforts have also been made to spare the ipsilateral uninvolved levels 1b⁷ and 5,⁸ and perhaps the time for a prospective clinical trial to investigate limited nodal RT in tonsillar tumors has come.

The key to using ipsilateral neck RT appropriately is patient selection. The Norwich and Royal Marsden series suggest an increased risk for CNR in the unselected N2b population, and although it can be argued that the evidence is not yet strong to suggest bilateral neck RT in all patients in this group, we advocate caution when considering ipsilateral RT. Patients should be informed of the CNR risk and followed-up carefully so that recurrence can be detected when salvage is still possible.

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