Letter to the Editor “Stage II Oral Tongue Cancer: Survival Impact of Adjuvant Radiation Based on Depth of Invasion”

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Rubin et al1 recently concluded that postoperative radiation therapy (PORT) has no benefit to patients with pathological stage T2N0 oral tongue cancer regardless of depth of invasion >5 mm or <5 mm. We believe that the conclusions of this article must be interpreted with an abundance of caution.

First and foremost, this study was retrospective, limiting the assessment of why included patients received (or did not receive) PORT. It is possible that patients who received PORT may have had a worse clinical and pathologic picture, explaining the similarity in outcomes between the cohorts. An alternative conclusion from these data is that patients who received PORT (presumably due to increased risk factors not available in the National Cancer Database, such as perineural and lymphovascular invasion and the need to revise margins to obtain clear margins) had similar overall survival (OS) to those who did not receive PORT. One could argue that PORT resulted in equal outcomes between the high- and low-risk groups and therefore was beneficial for patients with negative clinical/pathologic features. In addition, mean follow-up was limited to 28.4 ± 10 months, far shorter than the accepted standard of 5 years, especially for assessment of OS.

Second, the primary end point of this study was OS, further hampering its conclusions. The more critical end point, particularly with such short follow-up, is the ability to control disease locally and regionally. The authors note that the lack of disease-specific survival was a “limitation” of their study—we believe that this is too great a limitation to make meaningful conclusions. Indeed, disease-free or local recurrence-free survival should have been primary end points in this analysis.

Finally, our greatest concern is that the conclusions contained in this article may result in withholding needed care/adjuvant PORT from patients who need it most. Until a prospective randomized trial is completed with appropriately matched cohorts, conclusions about withholding radiation from this group of patients with intermediate risk of local and regional recurrence and death from disease simply cannot be made. If this was the authors’ intent, the current study falls short of this goal, and we implore caution in using these findings to withhold adjuvant therapy from patients with intermediate-stage oral cavity with adverse features such as depth of invasion >5 mm, who may benefit from adjuvant radiation therapy.

Mark A. Varvares, MD
Department of Otolaryngology–Head and Neck Surgery, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts, USA

Department of Otolaryngology, Harvard Medical School, Boston, Massachusetts, USA
James McIntyre, MD
Department of Radiation Oncology, Massachusetts General Hospital, Harvard Medical School, Boston, Massachusetts, USA

Mustafa G. Bulbul, MD
Department of Otolaryngology–Head and Neck Surgery, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts, USA

Department of Otolaryngology, Harvard Medical School, Boston, Massachusetts, USA

Sidharth V. Puram, MD, PhD
Department of Otolaryngology–Head and Neck Surgery and Department of Genetics, Washington University School of Medicine, St Louis, Missouri, USA

Disclosures

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Reference