Letter by G. Studer, U. M. Luetolf, C. Glanzmann1 on the Comment by H. Christiansen C. F. Hess

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Letter by G. Studer, U.M. Luetolf, C. Glanzmann[1] on the Comment by H. Christiansen & C.F. Hess

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We would like to reply on the comment by Christiansen & Hess [1] on our article "Locoregional failure analysis in head and neck cancer patients treated with IMRT" [3] in Strahlenther Onkol 2007;183:417–25 (No. 8).

The authors state that our study results do considerably modify the widely accepted clinical target volume (CTV) definitions for head and neck cancer (HNC) published by Gregoire et al. [2]. This statement requires some precision, as Gregoire et al. did not recommend CTVs related to specific HNC situations, but offered a highly appreciated anatomic image atlas of the relevant lymph node regions in HNC, which per se are well known for decades (original article, p. 234, under "6. Discussion": "These guidelines do not intend to give any recommendations for the optimal treatment strategy for node negative patients with a head neck primary, or the selection of various levels that require treatment").

As described in our methods, we are somewhat more restrictive in the elective irradiation of node negative neck sides, compared to the recommendations of many RTOG protocols, e.g., with respect to the upper level II (often not going up to the skull base on the noninvolved neck side), or the medial retropharyngeal node groups, or regarding the submandibular groups in many patients with other than oral cavity tumors, respectively. However, results of a recent update of our intensity modulated radiotherapy (IMRT) cohort of meanwhile 410 curatively irradiated patients (01/2002–04/2007) confirm the appropriateness of chosen planning target volumes (PTVs), as no nodal relapses developed in initially noninvolved lymphatic areas, and no additional failures out of boost areas developed in the meantime.

Unfortunately, the authors do not give any information about their own practice of IMRT PTV/CTV and treatment schedules.

The authors state, that the follow-up time of 2 years is too short. In concordance with many published reports in the literature, our updated results again confirm a 2 year follow-up time being long enough to draw reliable conclusions in HNC, as only two out of 89 events occurred later than 2 years post IMRT (Figure 1).

Concerning the other points issued by Christiansen & Hess, combined chemotherapy should be considered the standard treatment in HNC today. Slight dose escalation using simultaneously integrated boost (SIB) IMRT is recently under investigation in a prospective study set up at our institution (started spring 2007). Dose escalation and variation of the fractionation regimen have to be performed very carefully:

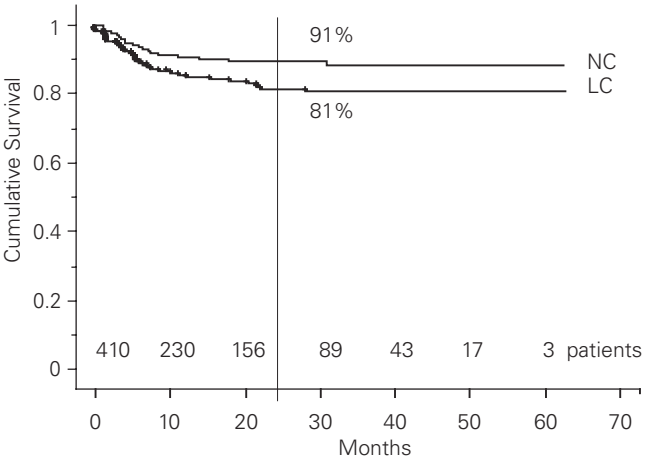

Figure 1. 2-year locoregional control rates in 410 patients. LC: local control; NC: nodal control.

Abbildung 1. 2-Jahres-Lokalkontrollraten bei 410 Patienten. LC: lokale Kontrolle; NC: nodale Kontrolle.

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based on the generally accepted treatment regimens as well as considering the already high locoregional control rate in small and intermediate sized tumors, we regard the margin for a dose escalation in HNC as rather limited. Additionally, we think the radiooncologic community may obtain more important advances in the treatment of HNC by increasing research activities on molecular profiling, basic mechanisms of radiosensitivity, combined treatment targeting agents, etc. Radiation oncologic research seems too much focused on the dose and volume paradigms, compared with the research activities on molecular mechanisms and combined treatment of medical oncology.

References

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