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EDITORIAL

Changing management of head and neck cancer

It is important to challenge established methods of disease management, in order for medical treatment to evolve. In this way, new, evidence-based treatment strategies can be introduced. This is particularly true in the field of head and neck cancer, where improvements in early diagnosis, treatment and survival often are made in small, incredibly slow increments. A number of articles in this issue of the JLO challenge established dogma in the assessment and treatment of this disease, and also in the training of specialist practitioners.

After treating patients with head and neck cancer, the normal duration of follow up seems to be arbitrarily set at five years. Kumar and colleagues[1] challenge this practice and suggest that a three-year post-treatment follow-up protocol is acceptable providing there is good patient education, and easy access to head and neck services for urgent referrals. Patients who have head and neck symptoms and a normal flexible nasoendoscopy examination are frequently subject to rigid endoscopy under general anaesthesia for further assessment. Fleming and colleagues[2] suggest that this practice does not benefit patients and that flexible endoscopy is sufficient. In another article, Dimbleby and colleagues[3] emphasise the importance of streamlining cervical node biopsy in reducing waiting times for the diagnosis and treatment of head and neck cancer and lymphoma presenting as neck masses.

Recent practice has seen a move towards primary chemoradiation treatment for head and neck patients, with salvage surgery for recurrence. This surgery is often debilitating and accompanied by complications. The experience of the surgical team in dealing with previously irradiated tissues is paramount in achieving good outcomes in this group of patients. Reynolds and colleagues[4] suggest that salvage surgery using transoral laser microsurgery can offer acceptable salvage rates, while at the same time avoiding the morbidity of open surgery, which includes long-term tracheostomy, enteral tube feeding and extended hospital stay.

How should we train modern laryngologists? It has always been assumed that training in head and neck cancer management is sufficient. This notion is challenged by De Zoysa and colleagues,[5] who suggest that in the UK there is a large variation in the laryngology-related skills of trainees. With the development of laryngology and voice as a separate sub-specialty, they advocate that each trainee should undergo at least six months of laryngology training within their individual programmes.

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