

## Letters to the Editor

### Surgical treatment of T<sub>1</sub> carcinoma of the vocal cord

Dear Sir,

I was fascinated to read the report by Dr Daniilidis and his colleagues (Vol 104 pp. 222–224) on their results of cordectomy for glottic T<sub>1</sub> carcinoma. They had 74 patients who were treated more than five years ago, and of these 59 are alive and well, 10 are alive having undergone further treatment, and five patients died of their cancer. It would be most valuable to know why not a single patient in their series, who had an average over 60 years, died of second tumour or intercurrent disease. Their experience appears to be unique.

Yours faithfully,

Professor P. M. Stell, Ch.M., F.R.C.S.,  
Royal Liverpool Hospital,  
Prescot Street,  
PO Box 147,  
Liverpool L69 3BX.

### Author's Reply

Dear Sir,

Professor Stell's comment on our article is indeed interesting and we are happy to provide some explanations.

It is indeed a fact that 59 out of our 74 patients, who were followed-up for at least five years, survived with no signs of recurrence, development of second primary or other intercurrent disease. We've also mentioned in our article that two of our patients presented with a second laryngeal carcinoma eight and ten years respectively after chordectomy, which we considered as second primaries. So the development of second primaries in our patients population, although it was rather rare (approximately 2%), indeed existed and was mentioned.

What seems to be more or less strange is the fact that we did not mention any deaths from other causes, although the mean age of our patients was about 60 years. The explanation is the following:

1. Until 1980 our age limit for cordectomy was 70 years. Thus the group of patients that were eligible for five year survival included only three patients over 70 years of age, reducing considerably in this way the average age. Having also in mind that life expectancy in Greece is higher than in North Europe, it is not indeed peculiar that all our 59 free of disease patients survived for five years.

2. Another important factor is that due to the "Mediterranean mentality", which is different from the North European one, Greek patients tend to be very obedient (post-operatively only, unfortunately) following all doctor's instructions and mainly those regarding restraining from smoking and drinking.

We believe that the above reasons explain clearly enough why we did not mention any mortality from other causes when we calculated the five year survival of our patients.

Yours faithfully,

Professor J. Daniilidis and  
Dr. A. Nikolaou,

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42 Tsimiski Street,  
546 23 Thessaloniki,  
Greece.

### Prophylactic antibiotics and post-laryngectomy fistulae

Dear Sir,

We have read with interest the article "Prophylactic Antibiotics and Post-Laryngectomy Fistulae" by Violaris and Bridger (*JLO* March 1990). We disagree with their choice of antibiotic because they have failed to mention the fact that a significant proportion of oropharyngeal flora is gram-negative anaerobic bacteria. Cefuroxime is only moderately sensitive against some strains of *Bacteroides fragilis*; therefore, Cefuroxime alone fails to provide adequate prophylaxis against gram-negative anaerobes. Indeed, their second case had an anaerobe infection. We would also like to point out that Cefuroxime does not have any anti-pseudomonal activity.

We have performed 22 laryngectomies (total 21, supra-glottic 1) since 1987 and we have had no case of pharyngocutaneous fistula. An electro-surgical pencil is extensively used for dissection and haemostasis and T-closure was used in most cases. We believe that abolition of dead space is a very important factor which cannot be achieved by suction-drainage alone; we have effectively achieved this by a combination of low-grade suction and a crepe bandage around the neck. Suction is discontinued after 24 hours, but drains are left *in situ* for free-drainage for a further 48–72 hours; the bandage is removed on the seventh day.

We feel that the retention of a nasogastric tube for two weeks is unnecessary and feeding can be safely started on the eighth day; if anything early feeding should promote healing rather than adversely affecting it.

Yours faithfully,

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Dear Sir,

Many thanks for enclosing a copy of Dr Hussain's letter commenting on our paper on Prophylactic Antibiotics and Post-Laryngectomy Fistulae. I would like to congratulate them on their excellent success rate with laryngectomy and can only say that there is more than one way to perform an operation and in the end it is the results that matter!

Yours faithfully,

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