

Chemo re-irradiation in recurrent head and neck cancer: a single institution experience

Dear Editor,

Treatment of recurrent head and neck squamous cell carcinoma (HNSCC) in previously irradiated areas is a great therapeutic challenge. The prognosis of these patients is very poor and the therapeutic options are limited. A few patients with locoregional recurrence can be salvaged by surgery or re-irradiation (re-RT) [1]. Surgical resection is the treatment of choice. Re-RT is an alternative treatment option for patients who are not candidates for surgical salvage [2]. Although survival rates of selected patients treated with concurrent chemotherapy and re-RT cannot exceed 25% at 2 years, they are still higher than the outcome of matched historical controls treated with chemotherapy alone (10%) [3]. More than 50% of recurrent HNSCC patients who undergo salvage treatment, will not survive because of the local-regional recurrent disease [4]. We studied the medical records of 15 patients with recurrent HNSCC in previously irradiated areas who were retreated with concurrent chemoradiation or RT alone in our institution between September 1998 and May 2010. All patients had a histological or cytological confirmation of a recurrent squamous cell carcinoma. Thirteen patients (86.6%) were treated with combined chemotherapy and re-RT. Two patients received only RT due to impaired renal function. Four out of 15 (33.3%) underwent incomplete tumor resection after the initial surgical evaluation and decision about possible resectability of the recurrent disease. Chemotherapy was given concurrently with RT once a week. The chemotherapeutic regimens used were cisplatin 35-40 mg/m² weekly (11 patients) and cetuximab at an initial dose of 400 mg/m², followed by 250 mg/m² weekly (2 patients). The median courses of chemotherapy were 3 (range 2-5). Eleven patients (73.3%) received total RT dose of 30.6 Gy in 17 fractions, 1 patient received 24 Gy and 3 a dose higher than 30.6 Gy. All patients underwent external beam radiation therapy (EBRT) daily, 5 days per week. The dose per fraction to target volume was 1.8 Gy. A 3-D conformal planning technique was used. The spinal cord was routinely excluded from the treatment beams because of the previously received RT. The planning target volume (PTV) included the tumor with a 2-cm margin. Overall survival was calculated from the date of the first re-treatment to the date of death. The median initial RT dose was 65.2 Gy (range 59.4-70.2). The median re-RT dose was 32.77 Gy (range 24-50) and the median cumulative RT dose was 97.9 Gy (range 89.7-116.4). Overall response rate (complete response/CR

and partial response/PR), was seen in 86.6% of the patients, with CR in 26.6% of them. Half of the complete responders had received a cumulative RT dose of ≥ 100 Gy. The median time interval between initial radiotherapy and re-RT was 39.8 months. The median post-salvage overall survival was 8.9 months with 1- and 2-year survival rates of 26.6% and 13.3%, respectively. The median post-salvage local control was 4 months (range 1-9). According to the literature a higher cumulative RT dose seems to be more effective [5]. We could conclude that in patients with recurrent HNSCC in previously irradiated areas, who are not candidates for surgical salvage, re-RT is an alternative therapeutic option. Patients should receive at least a re-RT dose of 50 Gy, with a cumulative RT dose of ≥ 100 Gy, concurrently with chemotherapy. Concurrent chemo-re-RT in this group of patients seems to be feasible and safe with satisfactory results in response rate, locoregional control and overall survival.

References

1. Specenier PM, Vermorken JB. Recurrent head and neck cancer: current treatment and future prospects. *Expert Rev Anticancer Ther* 2008; 8: 375-391.
2. Vermorken JB, Specenier P. Optimal treatment for recurrent/metastatic head and neck cancer. *Ann Oncol* 2010; 21: 252-261.
3. Wong SJ, Machtay M, Li Y. Locally Recurrent, Previously Irradiated Head and Neck Cancer: Concurrent Re-Irradiation and Chemotherapy, or Chemotherapy Alone? *J Clin Oncol* 2006; 24: 2653-2658.
4. Studer G, Graetz K, Glanzmann C. Outcome in recurrent head neck cancer treated with salvage-IMRT. *Radiat Oncol* 2008; 3: 43.
5. Schaefer U, Micke O, Schueller P, Willich N. Recurrent head and neck cancer: retreatment of previously irradiated areas with combined chemotherapy and radiation therapy-results of a prospective study. *Radiology* 2000; 216: 371-376.

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Clinical and pathological characteristics of patients 80 years and older with breast cancer

Dear Editor

The number of older cancer patients has increased in recent years [1]. Since older patients are more likely to have comorbidities, standard therapy of these patients is more difficult than patients of younger age. There is limited information in the literature about clinicopathological characteristics of very old women with breast cancer. Guidelines for their care are often lacking. The aim of this

communication was to define the clinicopathological characteristics of breast cancer patients aged 80 years and over.

One thousand seven hundred five consecutive breast cancer patients presented at Hacettepe University Institute of Oncology between 1977 and 2010 were evaluated. In all, 10 (0.58%) patients were >80 years of age at the time of diagnosis. There was no history of oral contraceptive use and hormone replacement therapy. Nine (90%) patients had different comorbidities such as hypertension and heart fail-