Readers' Forum-11

Q. How will you treat a case of carcinoma of the base of the tongue with bilateral metastatic nodes ?

A. Cancer of the base of the tongue with bilateral metastatic nodes in our country present in advanced stages T3/T4 lesions rarely they are in stages T1/T2. The strategy taken up for T3/T4 cases is palliative radiotherapy with bilateral parallel portals for radiation to the tumour including the neck area, usually 40-50 Gy in 10-20 fr over 2-4 weeks is given. In T1/T2 lesions a full dose of external beam radiation is given 60 Gy units in 28 fr over 4-5 weeks to tumour and neck area, if residual nodes persist with control of the primary, RND is considered with RND on the opposite side in selected cases.

Dr. Alok Bose Majumdar
Calcutta

A. Palliative Radiotherapy with Chemotherapy.

Dr. Farida H. Wadia
Surat

- A. 1) Radiotherapy to primary and entire neck on both sides.
2) Particular care of nutrition, including temporary Ryle's tube feeding during Radiotherapy.
3) Ongoing protocol trial of Anterior chemotherapy followed by R.T. response rate is over 50%. No conclusions can be drawn.
4) Curative surgery is almost never possible.
5) If after R.T. primary is controlled, RND may be considered, phased, if bilateral., (A rate occurrence).
6) Only 8 salvage surgeries of total glossectomy + Reconstruction + RND have been possible in this given situation,

considerable mobility and in all cases larynx had to be sacrificed.

7) 2 year cure rate : 11%.

Dr. Jatin Mody
Rajkot

A. The treatment protocol in our centre for such a case is to treat these with primary radiotherapy and reserve surgery in select patients with staged neck dissections. The latter is recommended if primary disease is cured and neck nodes are persisting.

Dr. Sudhir Bahadur
New Delhi

A. If the primary in the base of tongue is small (T1 or T2), the patient is first subjected to external RT to cover the primary and bilateral neck to a dose of 4500 cGy. Four weeks following this, a single stage bilateral neck dissection is performed preserving (if possible) at least one internal jugular vein. At the same time, interstitial implants are inserted at the primary site in the base of tongue to deliver about 2500 – 3000 cGy in the immediate post operative period.

If the primary is large (T3 or T4) it is unlikely to be controlled by radiation alone and the patient is subjected to excision of the base of tongue (either through a mandibulotomy or mandibulectomy approach) and bilateral neck dissection and post operative Radiotherapy is delivered after 4–6 weeks.

Dr Umanath K. Nayak
Hyderabad

A. A small lesion of base tongue, well localised, will be treated with surgery and (both) sides neck dissection.

Larger lesion treated with RT followed by surgery if required for residual disease.

Dr Girish Mishra
Karamsad

- A. I send such cases for radiotherapy because my experience with surgical management of such cases is disheartening

Dr. Gajendragadkar, V. N.

- A. Usually it has poor prognosis. RT C060 is the usual answer. Total glossectomy with bilateral radical neck dissection with reconstruction may be advantageous but is not accepted by most of the patients.

Dr. Hashmukh C. Shah

Nadiad

- A. Central lesions like the base of the tongue often metastasize to both sides of the neck. The deeply infiltrating and larger lesions respond better to surgery followed by radiotherapy. However due to the morbidity

of the surgery, it is not the first choice. Surgery is used to salvage operable radiotherapy failures. Surgery is invariably a total glossectomy. It is now possible in selected cases to excise the primary endoscopically with a CO2 LASER. A bilateral neck dissection is done at an interval. This is followed by radiation.

Dr. Pushkar Lece

Nashik

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Obituary

We deeply mourn the sudden demise of our life member Dr. K. L. Pathak, may his soul rest in peace.

Born : 29-2-1912

Died : 24-2-1997