

response in these poor prognosis patients and may facilitate definitive local surgery or radiotherapy. Further follow up will be performed for survival rates.

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PUBLICATION

Postoperative radiotherapy after the partial laryngectomy in supraglottic cancer: an analysis of 79 patients

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Background: To evaluate treatment results and complication rates of postoperative radiotherapy after the partial laryngectomy for squamous cell carcinoma of supraglottic larynx.

Materials and Methods: Between January 1980 and July 2003, 79 patients with squamous cell carcinoma of supraglottic larynx who were treated with radiotherapy after the partial laryngectomy were evaluated. There were 77 (97.5%) male and 2 (2.5%) female with median age of 55 years (37–75 years). According to the 1998 TNM staging system of AJCC, the disease was T1 in 7 (8.9%), T2 in 35 (44.3%), T3 in 15 (19%), T4 in 20 (25.3%), Tx 2 (2.5%), N0 in 58 (74.7%), N1 in 10 (12.7%) and N2 in 11 (12.7%) patients. Bilateral neck dissection was performed in 13 (16.5%) and unilateral neck dissection in 18 (22.8%) patients. 48 (60.8%) patients did not undergo a neck dissection. The surgical margins were positive in 24 patients and close in 8 patients. The treatment field was confined only the larynx in 4 patients, neck lymphatics and the larynx in another patients. The median radiation dose was 50 Gy (48–70 Gy). Survival rates were calculated using the Kaplan–Meier method. Univariate analysis was performed using log-rank test. The median follow up time was 62 months for the surviving patients (17–260 months).

Results: 53 patients (67.1%) were still alive at last follow-up. 16 (20.3%) died of larynx cancer and 10 (12.7%) died of reasons not related to larynx cancer. Locoregional recurrence rate was 13.9%. The 5-year locoregional progression free rate, disease-free survival and overall survival rates were 84%, 77%, 72% respectively. On univariate analysis, histologically positive neck disease and grade II edema decrease the regional and local control respectively (79% $p = 0.01$ and 64% $p = 0.0001$). 67 (84.8%) patients had larynx edema and 18 (22.8%) had neck fibrosis. Tracheostomy could not be closed in 3 cases due to edema. Severe complication led to total laryngectomy in 1 patient. Cerebrovascular disease was seen in one patient.

Conclusion: Postoperative radiotherapy can safely be performed after the partial laryngectomy. Recurrence of tumor should be suspected in patients with continuous severe edema. The determination of radiotherapy treatment volumes according to high risk recurrence areas might reduce complication rates.

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PUBLICATION

Cryosurgery of larynx cancer T3N0M0 as a part of combined treatment

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Aim: To determine ability of using cryogenic method for treating larynx cancer T3N0M0 as an organ-preserving method.

Materials and methods: 36 patients with primary larynx cancer T3N0M0, who had a radiation therapy (40 Gy) in first phase of combined treatment, with poor effect – reduction of tumor dimensions less than 50%. All patients had squamous cell carcinoma confirmed by cytological and histological examination. Low efficacy of radiation therapy was an indication to cryogenic treatment as an organ-preserving method. The zone of cryodestruction involved healthy tissue also. Cryosurgery was performed after making a laryngofissure with temporary tracheostomy. It was performed in minimum 3 cycles of freezing/warming. The laryngofissure was closed after cryodestruction.

Results: The follow-up ranged from 3 to 7 years. Recurrent disease was detected in 2 cases, these patients underwent laryngectomy. Metastases were revealed in 5 patients during follow-up and they had functional neck dissection of II–VI levels. Overall 3-years survival – 88.8% (32 patients), overall 5-years survival – 80.5% (29 patients). Satisfactory voice function was preserved in 32 (88.8%) patients. 29 (80.5%) patients continued to work at their previously jobs.

Conclusion: Cryogenic treatment of larynx cancer is an effective method for treatment of patients with locally-advanced larynx cancer T3N0M0, with poor effect after 40Gy radiation therapy. The obtained data show that cryogenic treatment is a perspective method on the final phase of combined therapy of larynx cancer, that allow us to improve complete response and to save larynx and its function.

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PUBLICATION

Assessing the feasibility of a randomized study of smoking cessation following active intervention in patients with squamous carcinoma of the Head and Neck: Results of a pilot study

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Introduction: Smoking is a major risk factor in the aetiology of squamous cell carcinoma of the head and neck (SCCHN) region. It also leads to many co-morbid conditions which are a common cause of death in patients who survive head and neck cancer. In addition, it compromises the tolerance to treatment of SCCHN. It is thought that those who continue to smoke have an increased risk of second primary or recurrent cancer. Many patients continue to smoke following their diagnosis. It is not clear whether active intervention could lead to better prognosis. A prospective randomized trial can possibly answer that question.

Aim: We set out to conduct out a population based pilot study in 2 Canadian centers with the aim of obtaining data on the number of patients who continue to smoke following diagnosis of SCCHN as well as interaction with other factors. The purpose of this study was to assess the feasibility of a phase III smoking intervention study in patients following treatment of SCCHN.

Materials and Methods: All newly diagnosed patients with head and neck cancer for a period of six months were asked to consent to the pilot study. There has been no refusal. A study questionnaire was completed with the aid of a trial nurse. No serum cotinin levels were done based on our previous experience which showed a good correlation between serum analysis and patient information.

Results: Demographics were typical for SCCHN patients the majority being males (75%), Caucasian (86%). Having high school or less education (80%), average age 64 years, 25% were employed and the majority also consumed alcohol.

Many significant differences were seen between the 3 groups of patients who are smokers, non smokers and the patients who are quitters. 32% of patients indicated that they continue to smoke at the time of diagnosis.

Summary and Conclusions: Based on the results of that population based study, a prospective Randomized study was not planned. Taking into consideration the small percentage who continue to smoke following diagnosis and the likely small benefit of smoking intervention in these patients such a trial would require a large sample size of 1200–1500 patients with long-term follow-up.

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PUBLICATION

Delay in referral of oropharyngeal squamous cell carcinoma to secondary care is associated with more advanced stage at presentation and poorer survival

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Squamous carcinoma of the oropharynx presents with symptoms common to many benign diseases, and this can cause delay in referral. We investigate delay in referral, and the effect of that delay, from symptom onset to the decision to refer from primary care, using a retrospective case notes based study of patients presenting at our institution with oropharyngeal squamous carcinoma over the last 10 years. Of 69 patients suitable for evaluation, 54 were male, 15 female (M: F 3.6:1). Stage grouping was II, III, IVA and IVB 9%, 24%, 52% and 15% respectively. Frequencies of presenting symptoms were: neck mass 49.3%, sore throat 33.3%, other 17.4%.

Using correlation analysis and ordinal regression, we examined the relationship between increased referral delay, clinical stage at presentation and survival.

Increasing delay in referral from primary to secondary care was positively correlated with more advanced disease stage at presentation ($r_s = +0.346$, $p = 0.004$). This was confirmed with ordinal regression modeling (delay estimate=0.045, $p = 0.042$). For every one-week increase in delay in referral, presenting stage increases by 0.045 of “a stage”. Patients with delay of less than 6 weeks had significantly improved survival compared to those with a delay of greater than 6 weeks ($p = 0.032$) as illustrated in Fig 1.

Our results indicate that a prolonged delay before referral to secondary care is positively correlated with an advance in clinical stage at presentation to secondary care, also that the delay in referral can affect survival. Also, although sore throat is a symptom which is not referred to in the UK Dept. of Health urgent referral guidelines for Head and Neck cancer, since one third of patients presented with this symptom, we recommend that it should be so included.