Lokal İleri Baş Boyun Kanserinde İndüksiyon Tedavisi mi? Eşzamanlı Kemoradyoterapi mi?

Dr. Deniz Tural
Bakırköy Dr. Sadi Konuk Eğitim ve Araştırma Hastanesi
Tıbbi Onkoloji

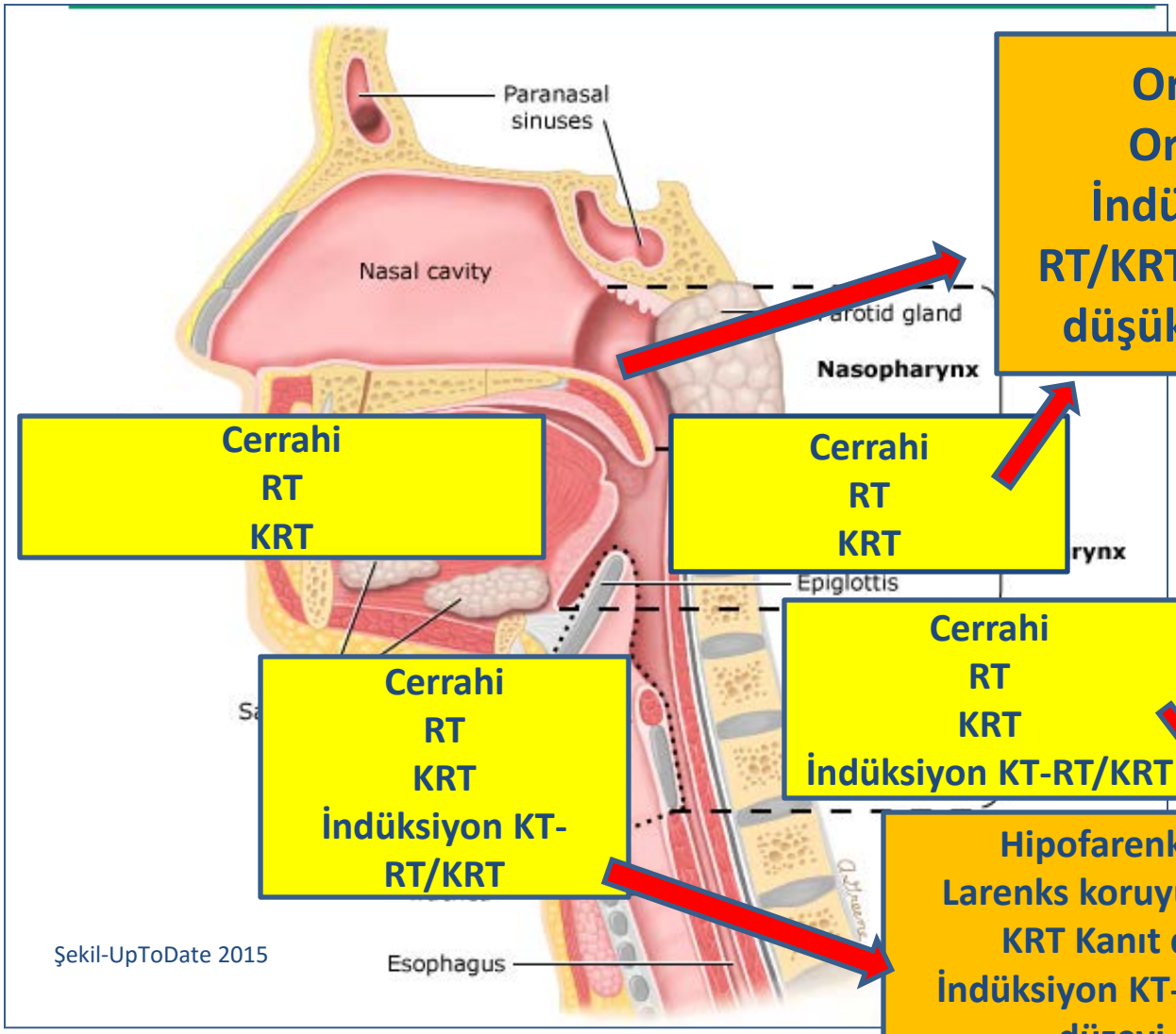
Sunum Akışı

- Giriş
- Lokal ileri baş boyun kanserlerinde tedavi seçenekleri
- Larenks koruyucu tedaviler
- Eş zamanlı Kemoradyoterapi (KRT)
- İndüksiyon Kemoterapi (KT) sonrası Radyoterapi, Kemoradyoterapi
- Sonuç

Lokal İleri Baş Boyun Kanserinde Tedavi Seçenekleri

- Heterojen grup
- Primer tümör bölgesi, evre, hastanın performansı, komorbidite tedavi seçeneğini belirler
- Erken evre (Evre I/II); Cerrahi, RT
- Lokal ileri evre (Evre III, IV)
  - Cerrahi–RT/KRT
  - Definitif KRT
  - İndüksiyon Kemoterapi- RT/KRT

Lokal-İleri Baş Boyun Kanserinde Tedavi Seçenekleri



Oral kavite
Orofarenks
İndüksiyon KT-RT/KRT kanıt düzeyi düşük(kategori 3)

Cerrahi
RT
KRT

Cerrahi
RT
KRT

Cerrahi
RT
KRT
İndüksiyon KT-RT/KRT

Cerrahi
RT
KRT
İndüksiyon KT-RT/KRT

Hipofarenks-larenks
Larenks koruyucu tedaviler
KRT Kanıt düzeyi 2A
İndüksiyon KT-RT/KRT kanıt düzeyi 2A-2B

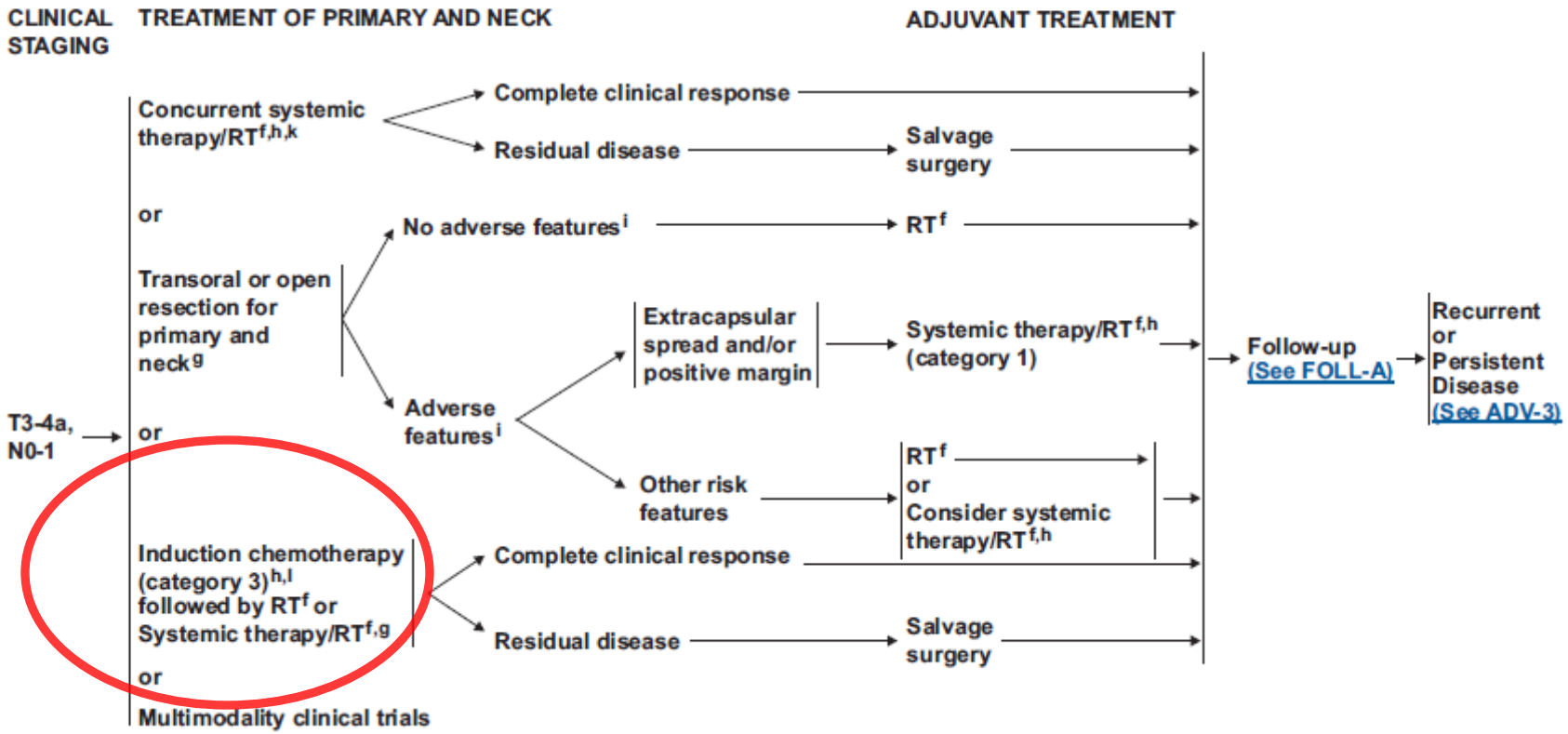
Lokal-İleri Baş Boyun Kanserinde Tedavi Seçenekleri

NCCN National Comprehensive Cancer Network®

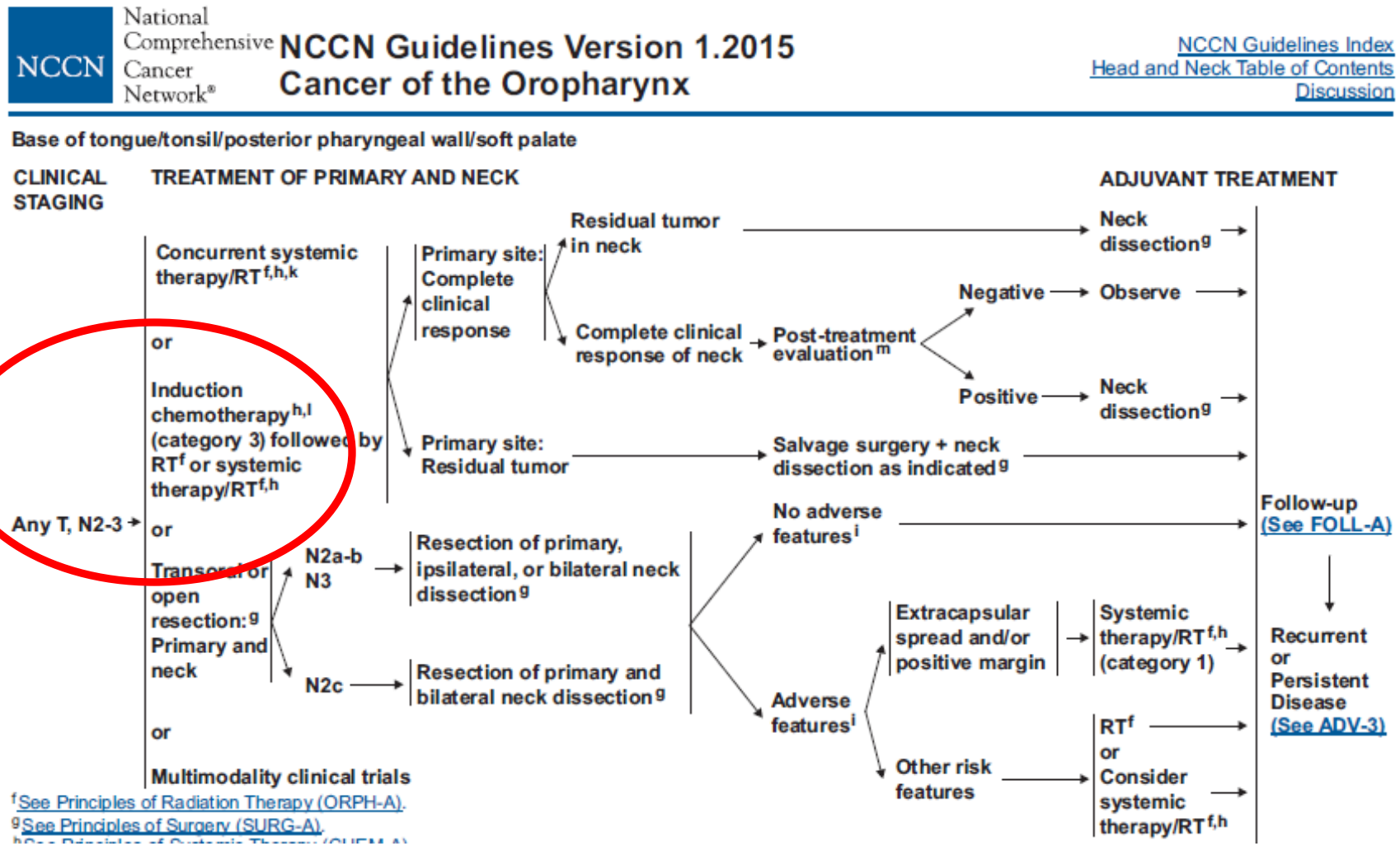
NCCN Guidelines Version 1.2015
Cancer of the Oropharynx

NCCN Guidelines Index
Head and Neck Table of Contents
Discussion

Base of tongue/tonsil/posterior pharyngeal wall/soft palate



Lokal İleri Baş Boyun Kanserinde Tedavi Seçenekleri



Lokal-ileri Hipofarenks-Larenks Tümörlerinde Larenks Koruyucu Tedavi

- **1990**
  Cerrahi ⟹ RT

- **2002 önce**
  Veterans Affairs Laryngeal Cancer Study Group-1991 NEJM
  EORTC çalışması
  İndüksiyon KT (Cisplatine+ 5-FU) ⟹ RT
  Definitive RT

- **2002 sonrası**
  RTOG 91-11 çalışması
  Eş zamanlı KRT(Cisplatine 100 mg/m2)

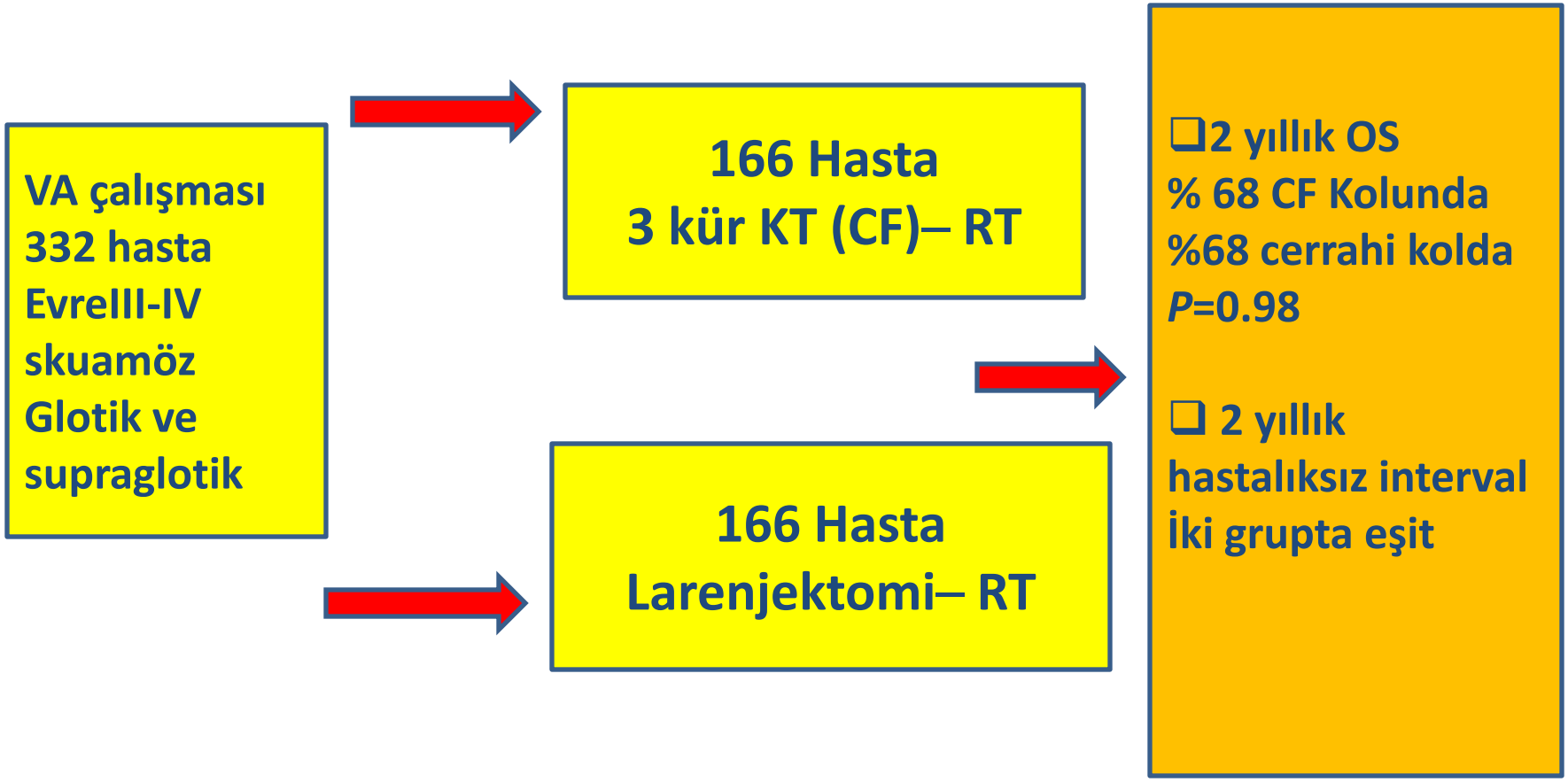
- **2005 sonrası**
  Docitaksel+ Cisplatin+5-FU indüksiyon KT ⟹ KRT/RT

Neden İndüksiyon Kemoterapi?

- Larenjektominin psikososyal ve yaşam kalitesi yönünde hasta üzerinde çok önemli bir etkisi var
- Organ koruyucu cerrahi yapabilmek
- Cerrahi komplikasyonlarını azaltmak
- Yaşam kalitesini artırmak
- Mikrometastaz ve uzak metastaz engellemek ya da geciktirmek

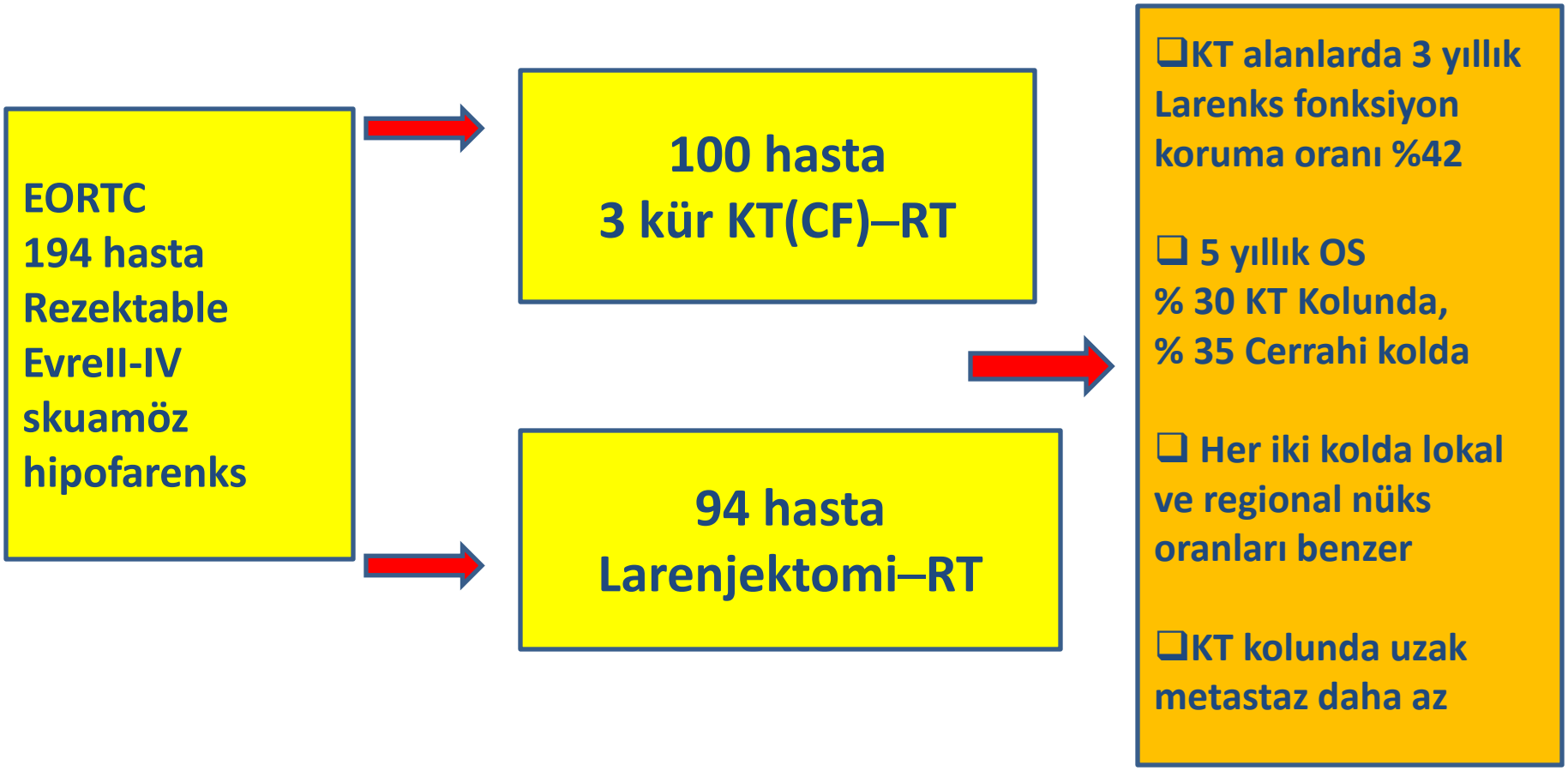
Pointreau Y, et al. Induction chemotherapy in head and neck cancer: A new paradigm. Anticancer Drugs 2011

Larenks Koruyucu Tedavi



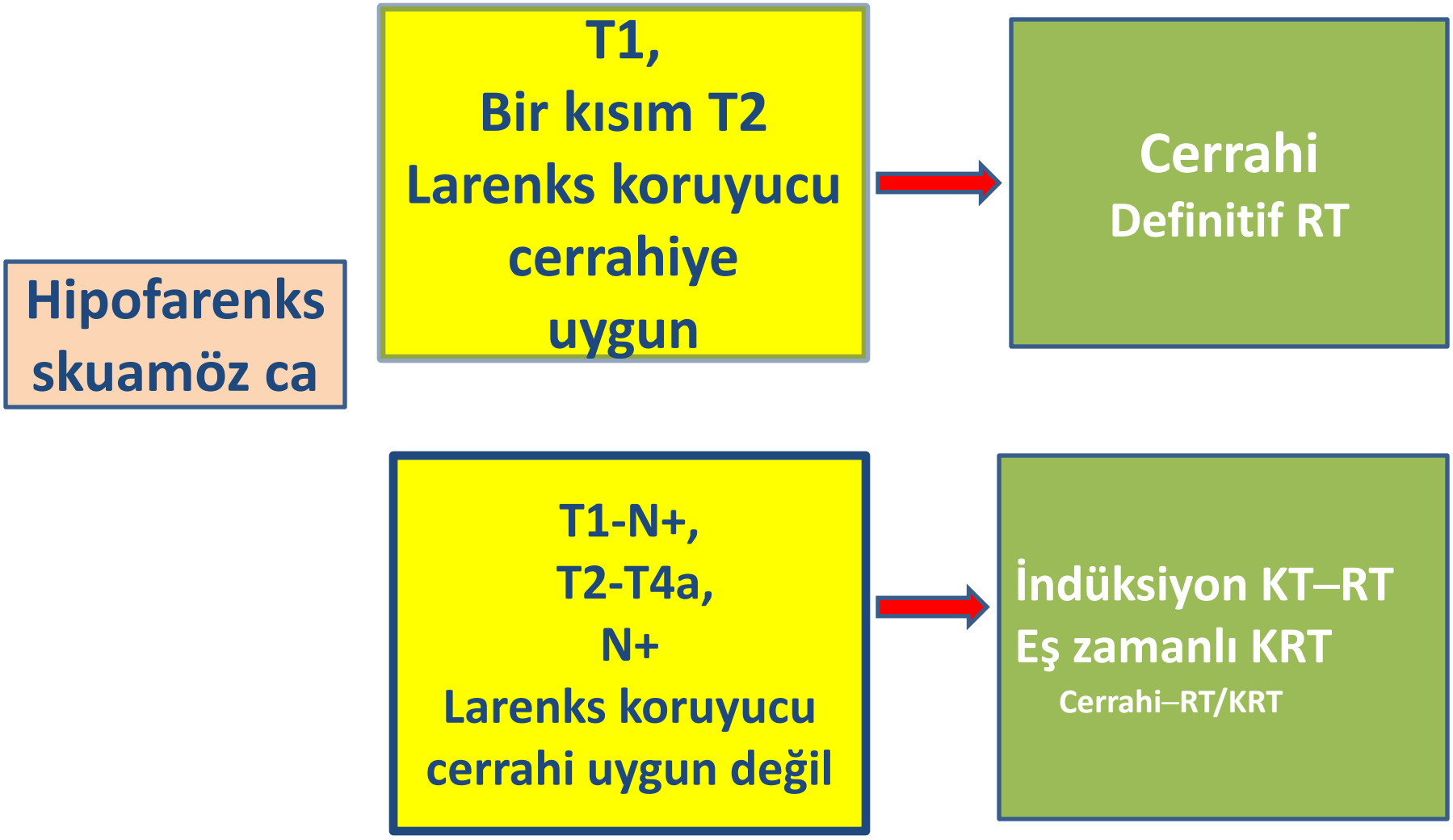
The Department of Veterans Affairs Laryngeal Cancer Study Group. NEJM, 1991

Larenks Koruyucu Tedavi

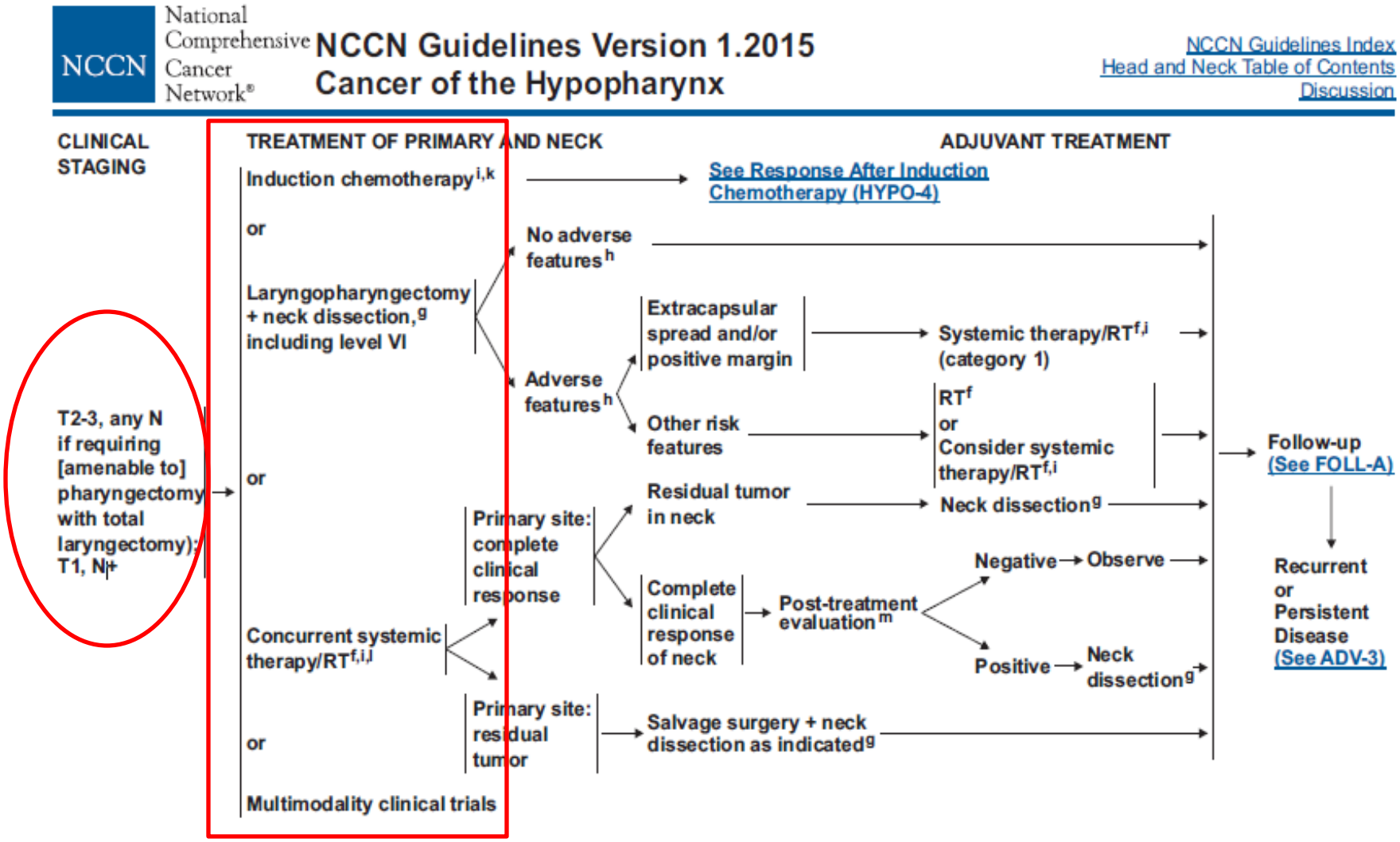


L. Lefebvre et al, Journal of the National Cancer Institute, 1996

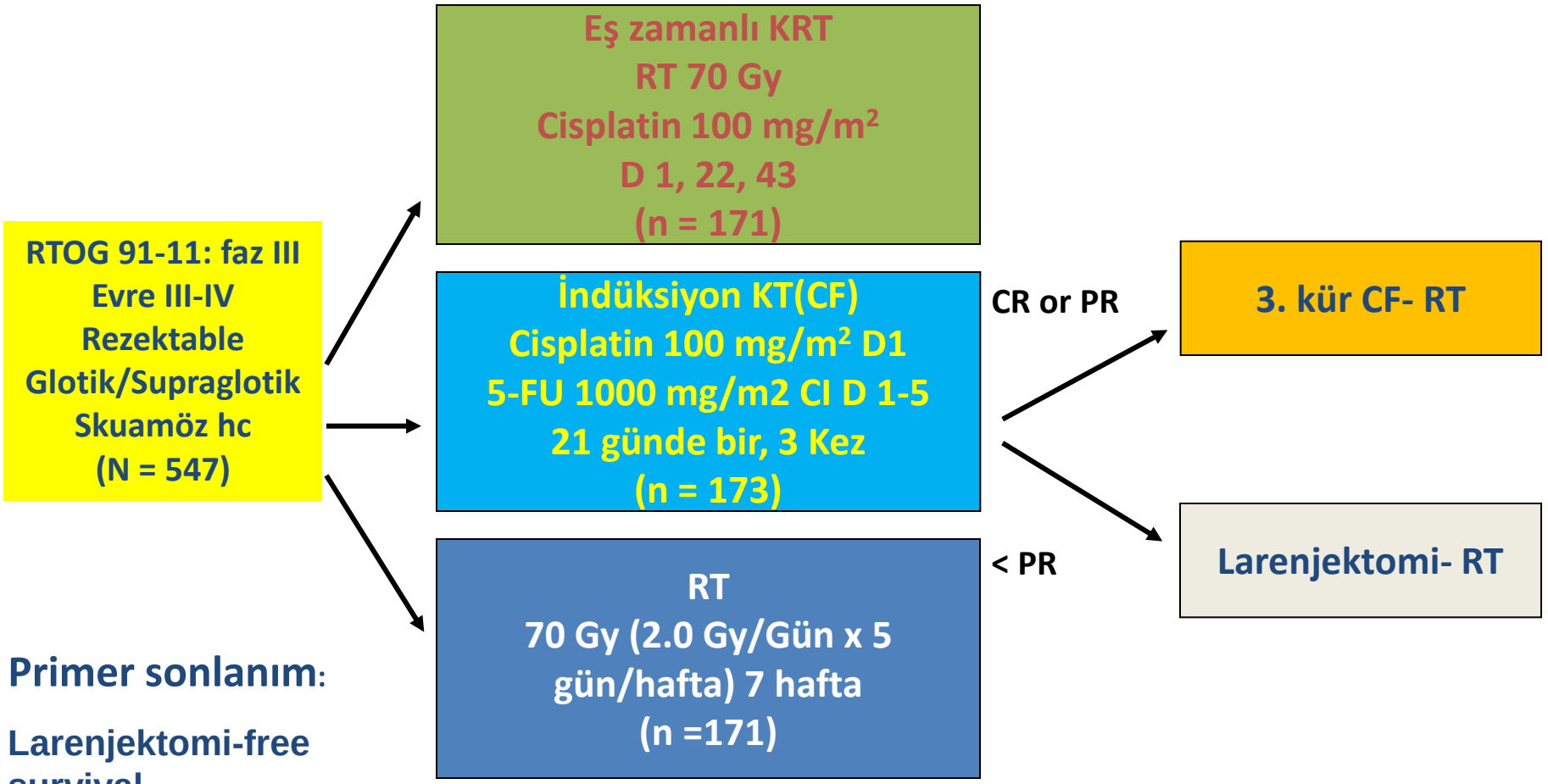
Hipofarenks Ca Tedavi Seçenekleri



Lokal İleri Hipofarenks Ca Tedavi Seçenekleri



Larenks Koruyucu Tedavi



Primer sonlanım:

Larenjektomi-free survival

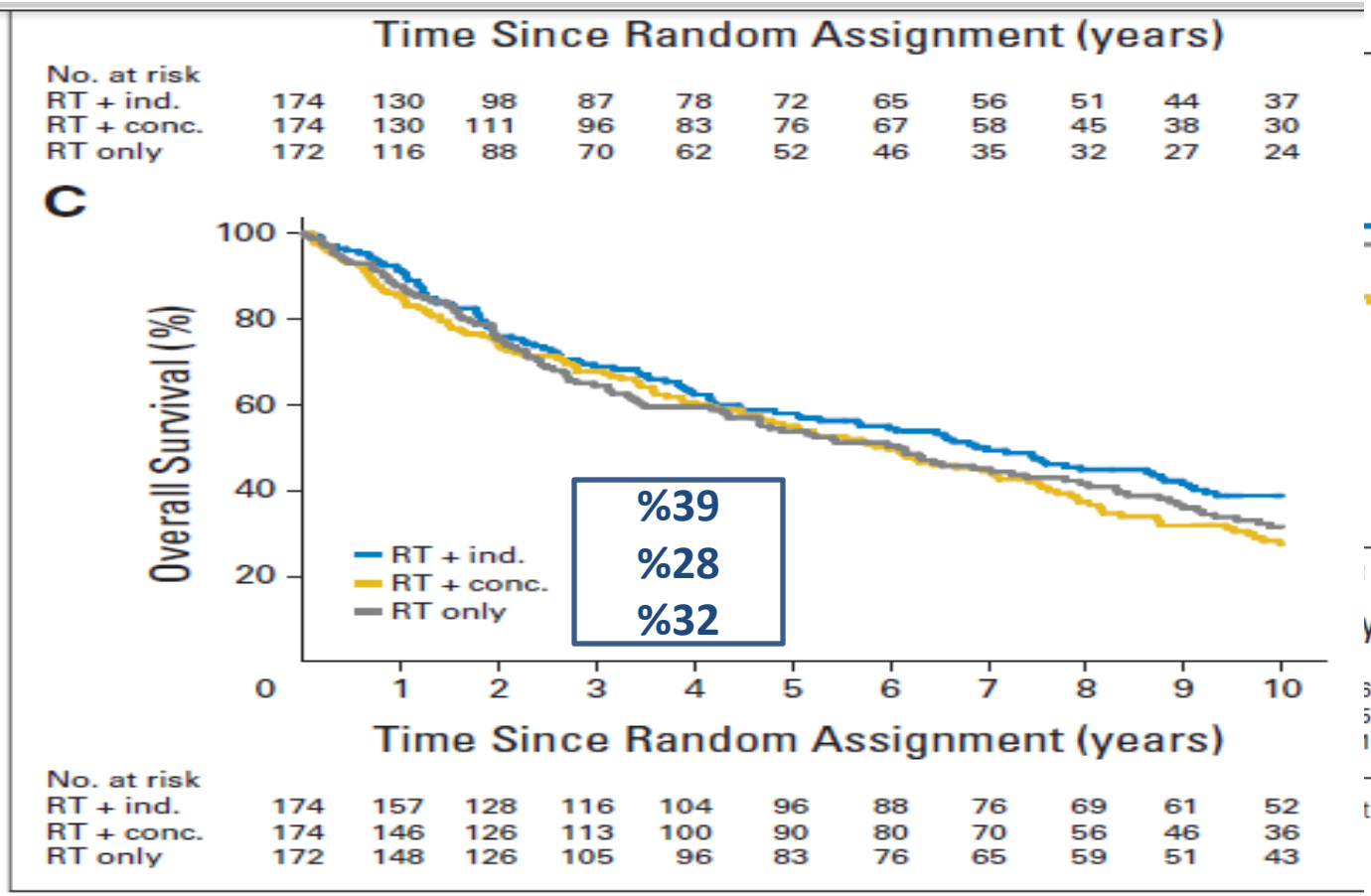
Forastiere AA, JCO 2013.

RTOG 91-11: 5 yılık Sonuçları

- Eş zamanlı KRT , İndüksiyon KT-RT ve RT göre daha iyi Larenks koruma
- İndüksiyon KT-RT RT göre daha iyi larenjektomi-free survival

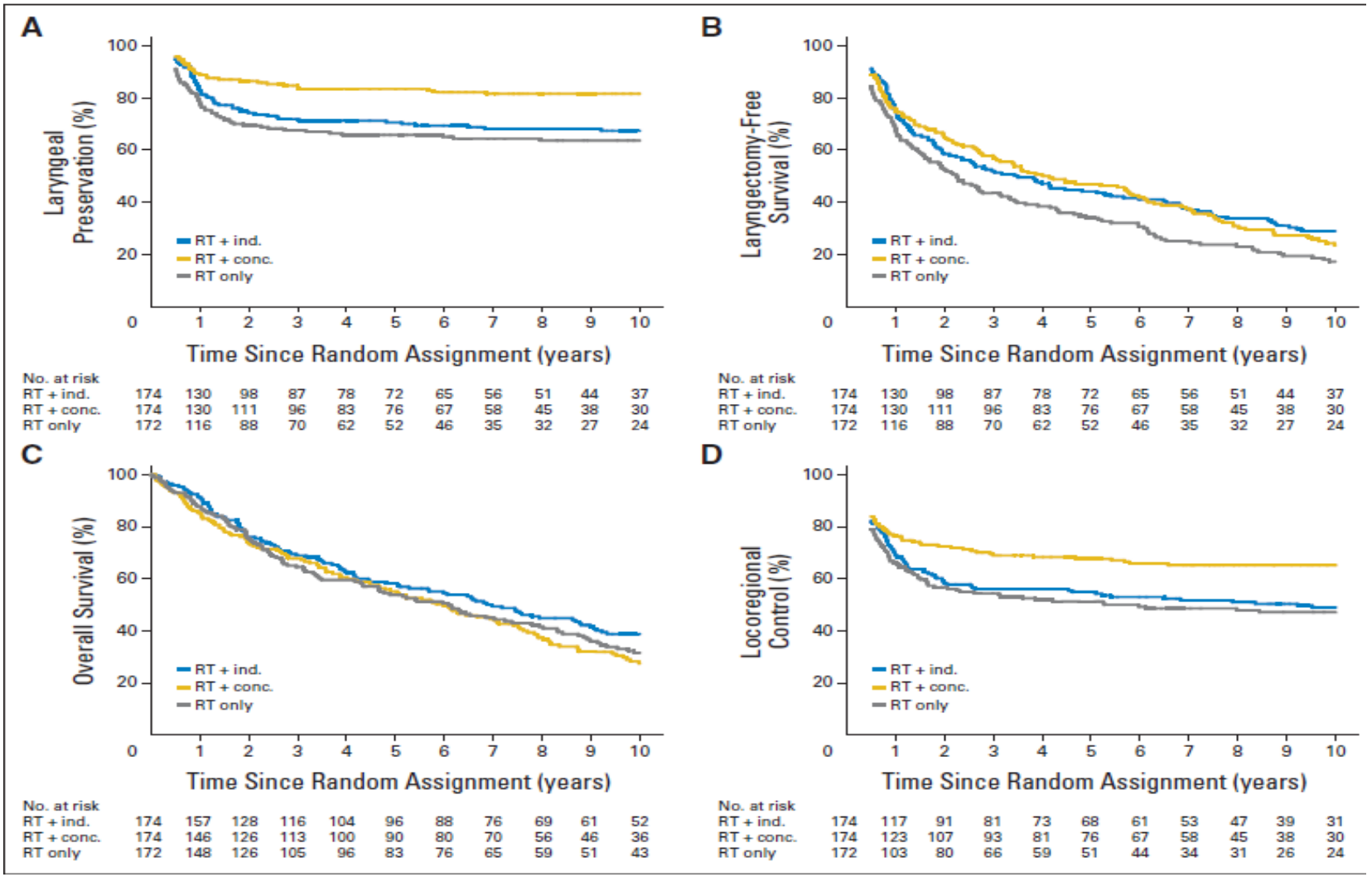
	Eş zamanlı KRT, %	İndüksiyon KT-RT,%	RT , %
Larenjektomi-free survival	**47** ***P* = .98 vs induction** ***P* = .011 vs RT**	**45** ***P* = .011 vs RT**	**34**
Larenks koruyucu	**84** ***P* = .0029 vs induction** ***P* = .00017 vs RT**	**70** ***P* = .37 vs RT**	**66**

RTOG 91-11: Uzun Dönem Sonuçları



Forastiere AA, JCO 2013

RTOG 91-11: Uzun Dönem Sonuçları



Forastiere AA, JCO 2013

KRT /RT Lokal ileri Baş boyun ca

Meta-analysis of chemotherapy in head and neck cancer (MACH-NC): An update on 93 randomized trials and 17,346 patients

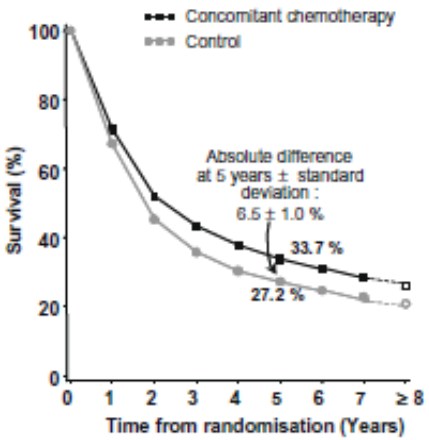
Yaş	MACH-NS KRT vs RT	
	HR: 0.76 (95% CI: 0.66-0.86) n = 2584	*P* = .003
51-60	HR: 0.78 (95% CI: 0.70-0.87) n = 3306	
61-70	HR: 0.88 (95% CI: 0.78-1.00) n = 2698	
> 71	HR: 0.97 (95% CI: 0.76-1.23) n = 692	

Jean-Pierre Pignon, et al, Radiotherapy and Oncology 2009

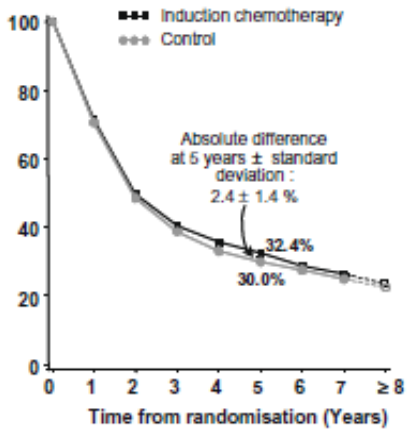
Meta-analysis of chemotherapy in head and neck cancer (MACH-NC): An update on 93 randomized trials and 17,346 patients

Jean-Pierre Pignon et al,
Radiotherapy and Oncology 2009

(a) Concomitant chemotherapy.



(b) Induction chemotherapy



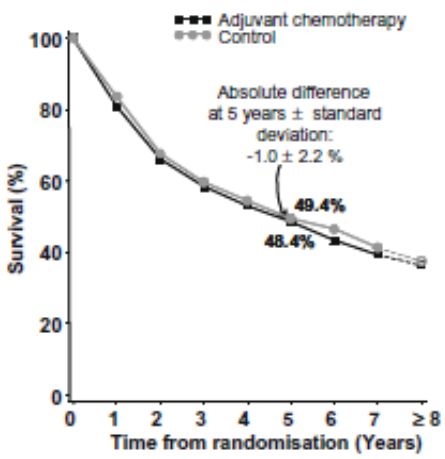
Death/person-years by period

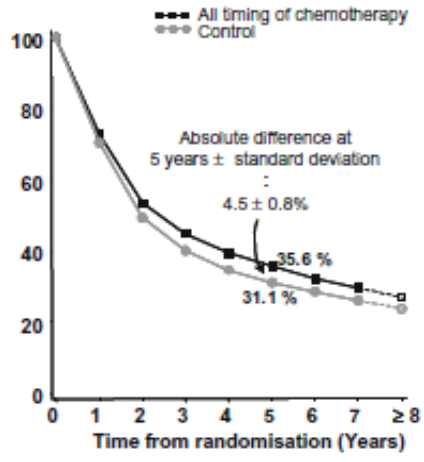
	Years 0-2	Years 3-5	Years ≥ 6
Control	2500/6298	672/3658	217/2487
Chemotherapy	2187/6647	706/4576	278/3194

Death/person-years by period

	Years 0-2	Years 3-5	Years ≥ 6
	1283/3535	393/2276	137/1417
	1318/3820	392/2608	167/1530

(c) Adjuvant chemotherapy





Trial category	*n* of trials (patients)	Hazard ratio (95% confidence interval)	*p*-value	5-yr SR
All trials	108 (17,493)[a]			
Adjuvant	12 (1,244)	1.06 (0.95–1.18)	.31	
Induction	34 (5,311)	0.96 (0.90–1.02)	.18	+2.4%
Concomitant	62 (9,615)	0.81 (0.78–0.86)	<.0001	+6.5%

[a]Some trials had strata that corresponded to different locoregional treatments or chemotherapies, and some trials had three arms or a 2 × 2 design, which led to some arms being used twice in the analysis such that the number of comparisons in the meta-analysis was 108.

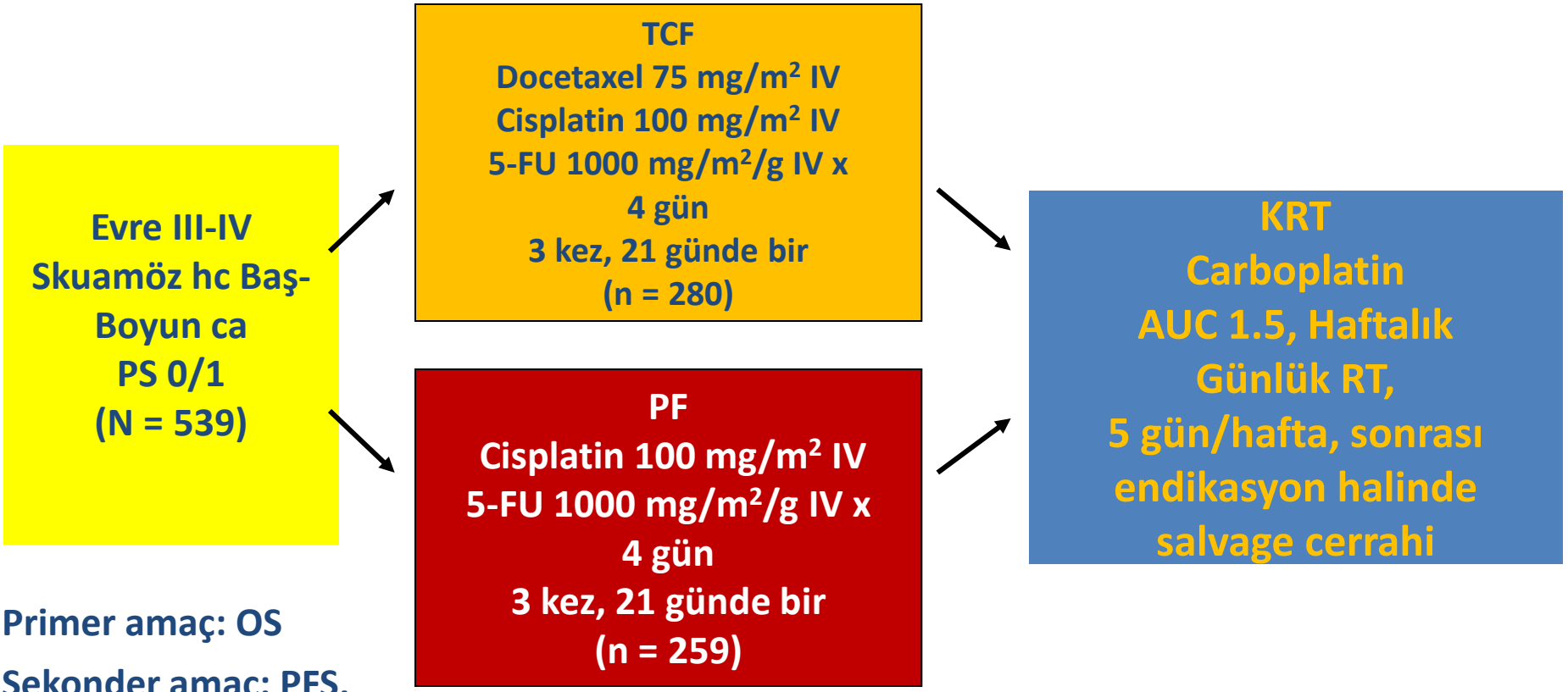
Yeni İndüksiyon KT Tedavi Seçenekleri

Üçlü KT İndüksiyon (TCF)-KRT/RT > İkili KT (CF)-KRT/RT?

- TAX 324
- EORTC 24971,
- GORTEC 2000-01
- TTCC 2002
- İtalyan Faz II çalışması

Yeni İndüksiyon KT Tedavi Seçenekleri

TAX 324: Faz III İndüksiyon Çalışması

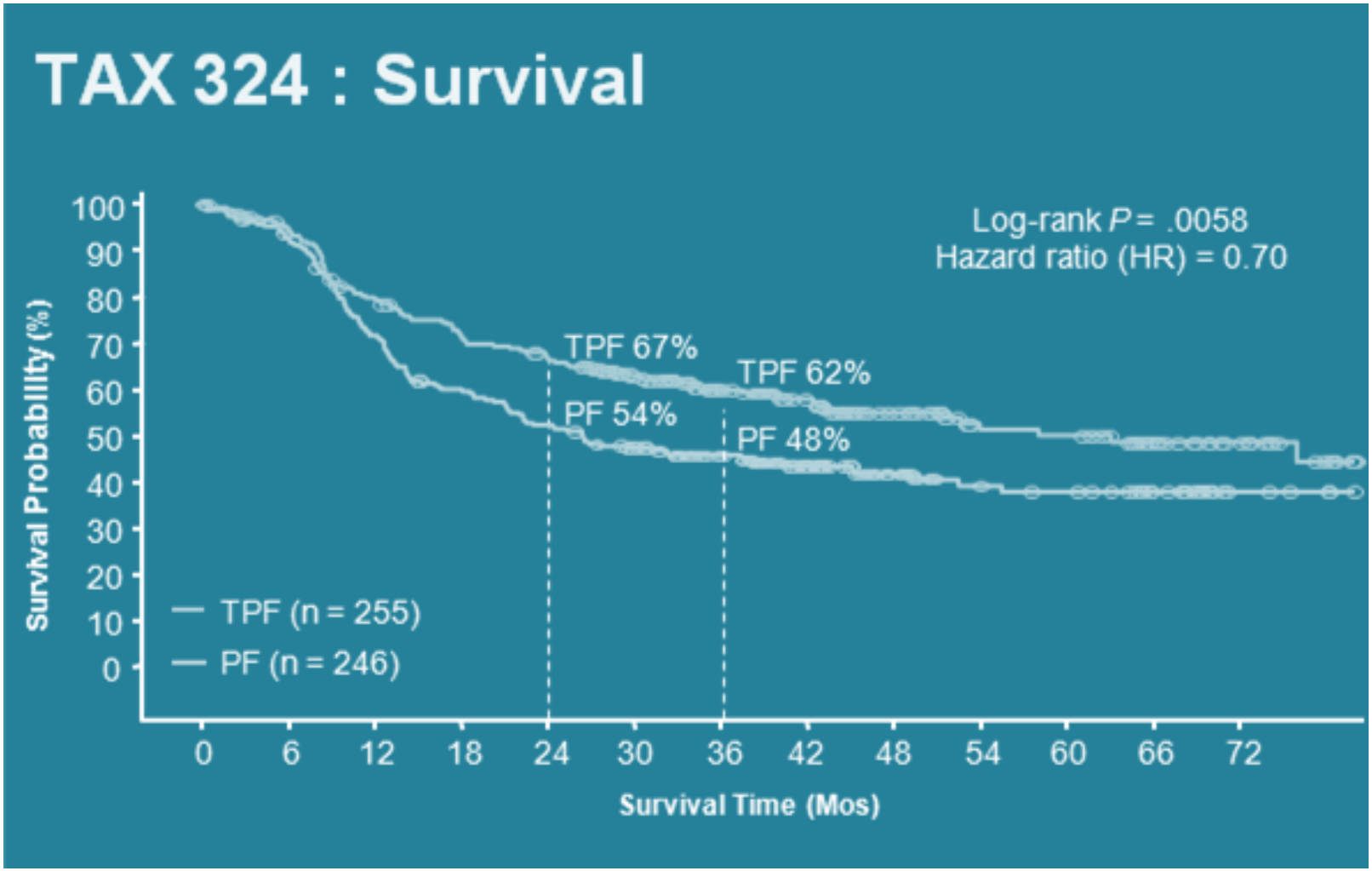


Primer amaç: OS

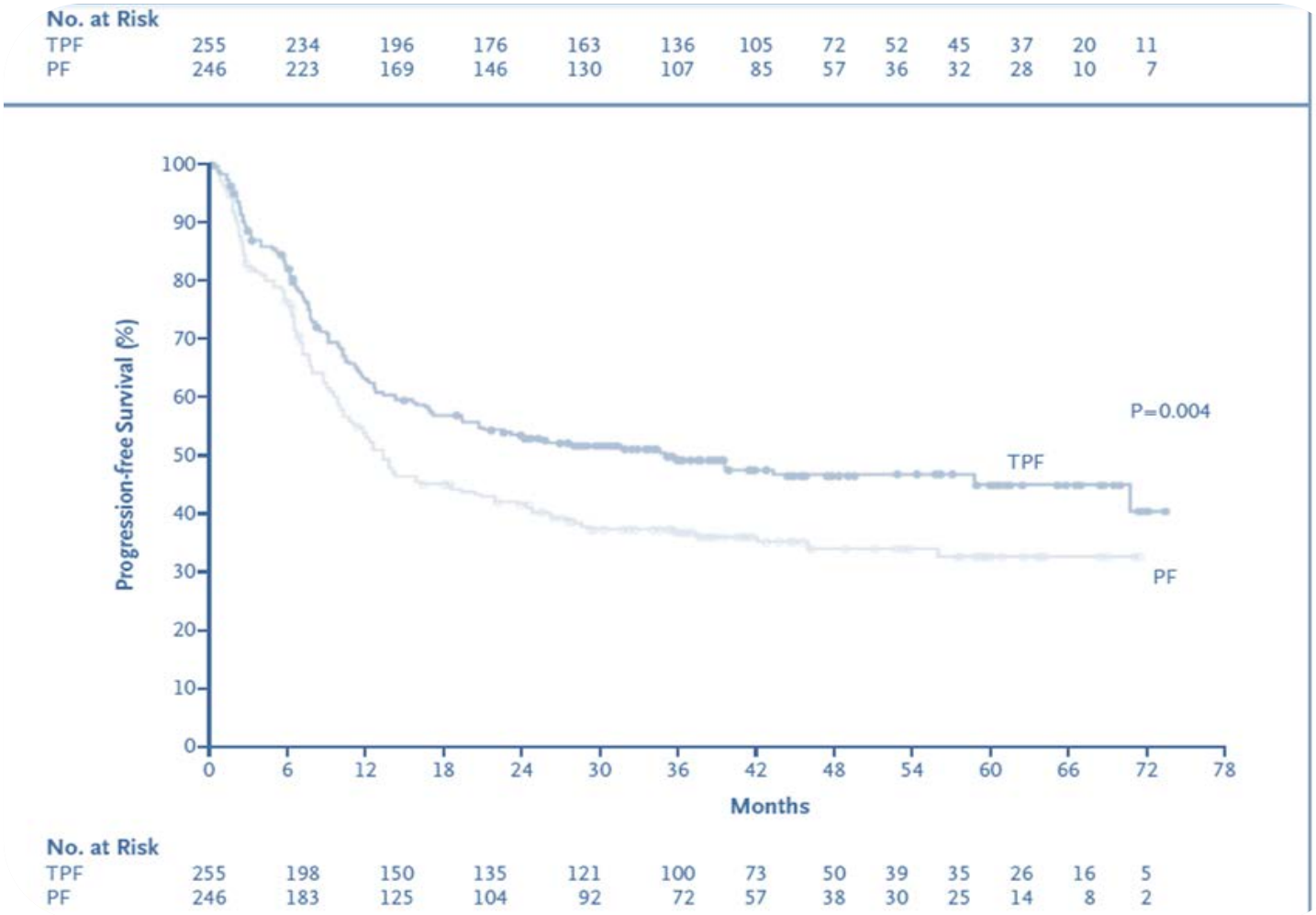
Sekonder amaç: PFS, güvenlik

Jochen H Lorch, et al. Lancet Oncol 2011

Yeni İndüksiyon Tedavi Seçenekleri



Yeni İndüksiyon KT Tedavi Seçenekleri

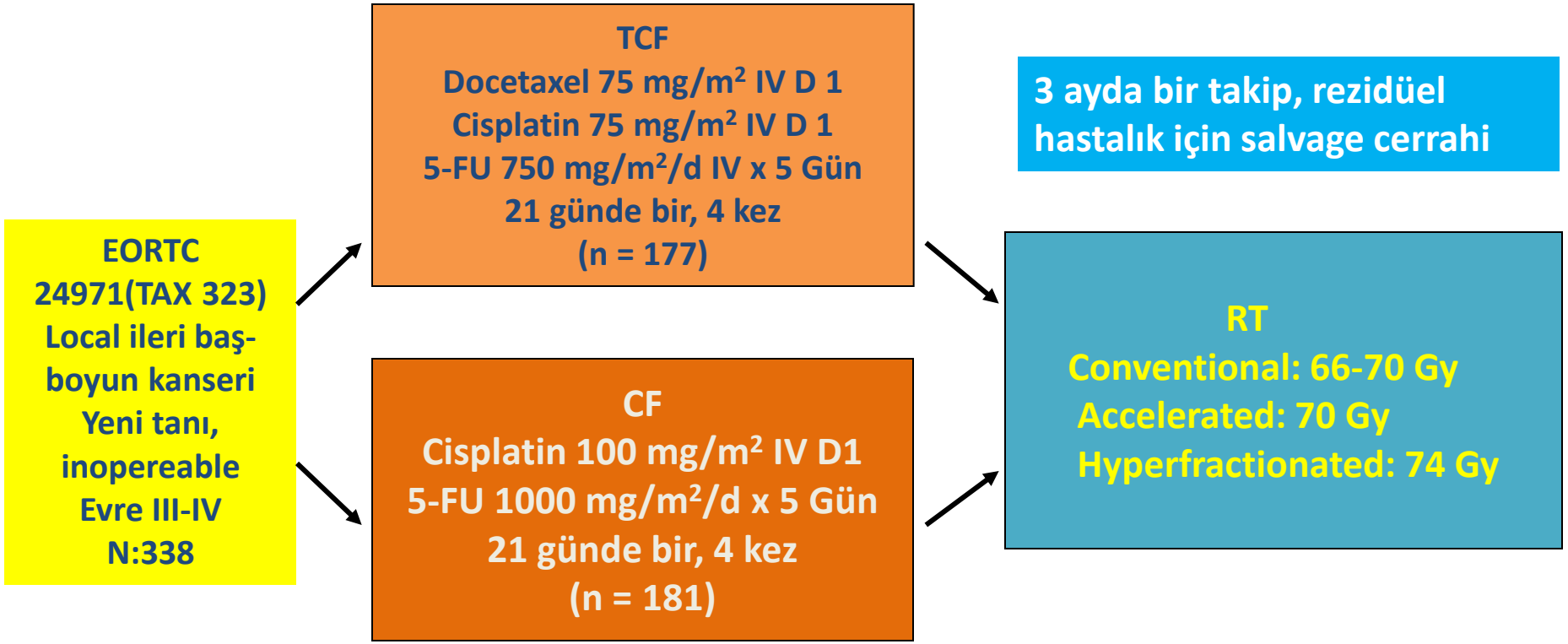


TAX 324 Yan Etki: Yönetilebilir

TCF ve CF benzer toksisite ve yan etkiler

Variable	TPF	PF	P Value†
Adverse events during induction chemotherapy			
No. of patients	251	243	
Hematologic — %			
Anemia grade 3 or 4	12	9	0.32
Thrombocytopenia grade 3 or 4	4	11	0.005
Neutropenia grade 3 or 4‡	83	56	<0.001
Febrile neutropenia‡§	12	7	0.04
Neutropenic infection¶	12	8	0.23
Nonhematologic grade 3 or 4 — %			
Stomatitis (mucositis)	21	27	0.14
Nausea	14	14	1.00
Esophagitis, dysphagia, or odynophagia	13	9	0.26
Anorexia	12	12	0.78
Vomiting	8	10	0.54
Diarrhea	7	3	0.07
Infection	6	5	0.70
Lethargy	5	10	0.03
Treatment delays during induction chemotherapy‖			
No. of patients	251	243	
Patients who had delays — no. (%)	73 (29)	157 (65)	<0.001
Reason for delay			
Hematologic			
Any adverse event	11 (4)	108 (44)	<0.001
Neutropenia	2 (1)	95 (39)	
Nonhematologic	25 (10)	22 (9)	0.76
Other**	38 (15)	40 (16)	0.71
Adverse events during chemoradiotherapy			
No. treated with chemoradiotherapy	202	184	
Nonhematologic grade 3 or 4 — %			
Stomatitis (mucositis)	37	38	1.00
Esophagitis, dysphagia, or odynophagia	23	24	0.81
Anorexia	11	15	0.29
Infection	9	7	0.45
Lethargy	6	6	1.00
Nausea	6	6	1.00
Vomiting	3	5	0.46
Diarrhea	0	2	0.11

Yeni İndüksiyon KT Tedavi Seçenekleri



Primer sonlanım: PFS

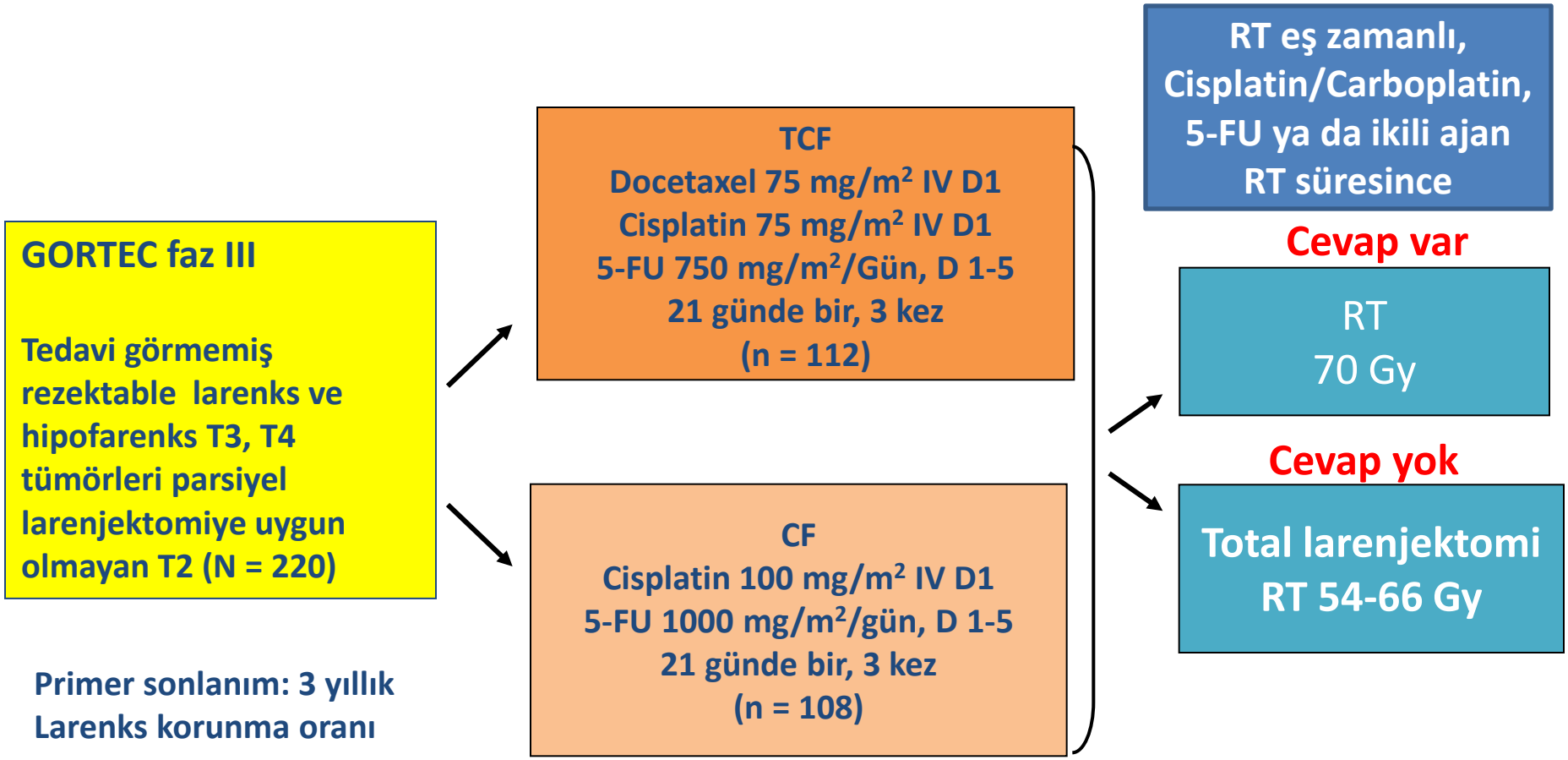
Sekonder sonlanım: RR, OS, toksite, yaşam kalitesi

Jan B. Vermorken, et al. N Engl J Med 2007

EORTC 24971 Sonuçları

- TCF tedavisi alanlarda PFS daha uzun
  - Medyan PFS: 11 ay – 8.2 ay (*P* = 0.015)
  - HR: 0.74 (95% CI: 0.59-0.95)
- TCF tedavisi alanlarda OS CF göre daha uzun
  - Medyan OS: 18.6 ay –14.2 ay (*P* = .0052)
  - HR: 0.73 (95% CI: 0.56-0.90)
- Yaşam kalitesi (konuşma, yeme, PS kötüleşme) TCF, CF göre daha iyi

Larenks Koruyucu Tedavi



Primer sonlanım: 3 yıllık Larenks korunma oranı

Pointreau Y , J Natl Cancer Inst 2009

GORTEC 2000-01:Sonuçları

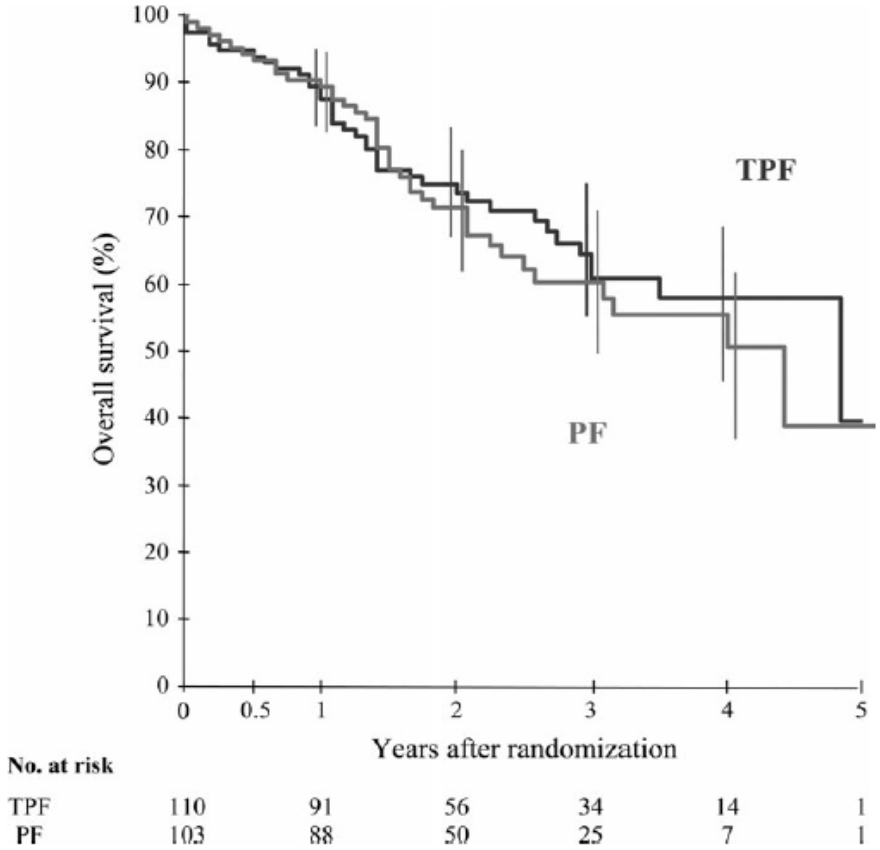


Figure 4. Overall survival among patients who were randomly assigned to docetaxel, cisplatin, plus 5-fluorouracil (TPF) vs cisplatin plus 5-fluorouracil (PF). At 3 years, overall survival rates were not statistically different ($P = .57$, two-sided log-rank test).

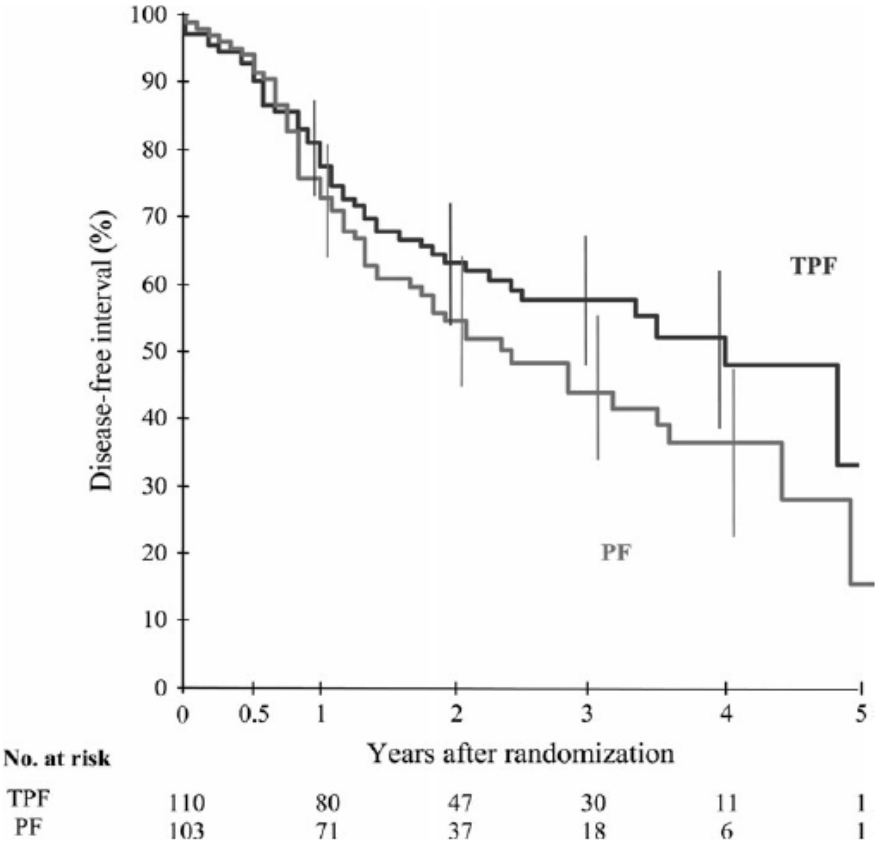


Figure 5. Disease-free interval among patients who were randomly assigned to docetaxel, cisplatin, plus 5-fluorouracil (TPF) vs cisplatin plus 5-fluorouracil (PF). At 3 years, disease-free intervals were not statistically different ($P = .11$, two-sided log-rank test).

Pointreau Y , J Natl Cancer Inst 2009

Yeni İndüksiyon KT Tedavi Seçenekleri

original article

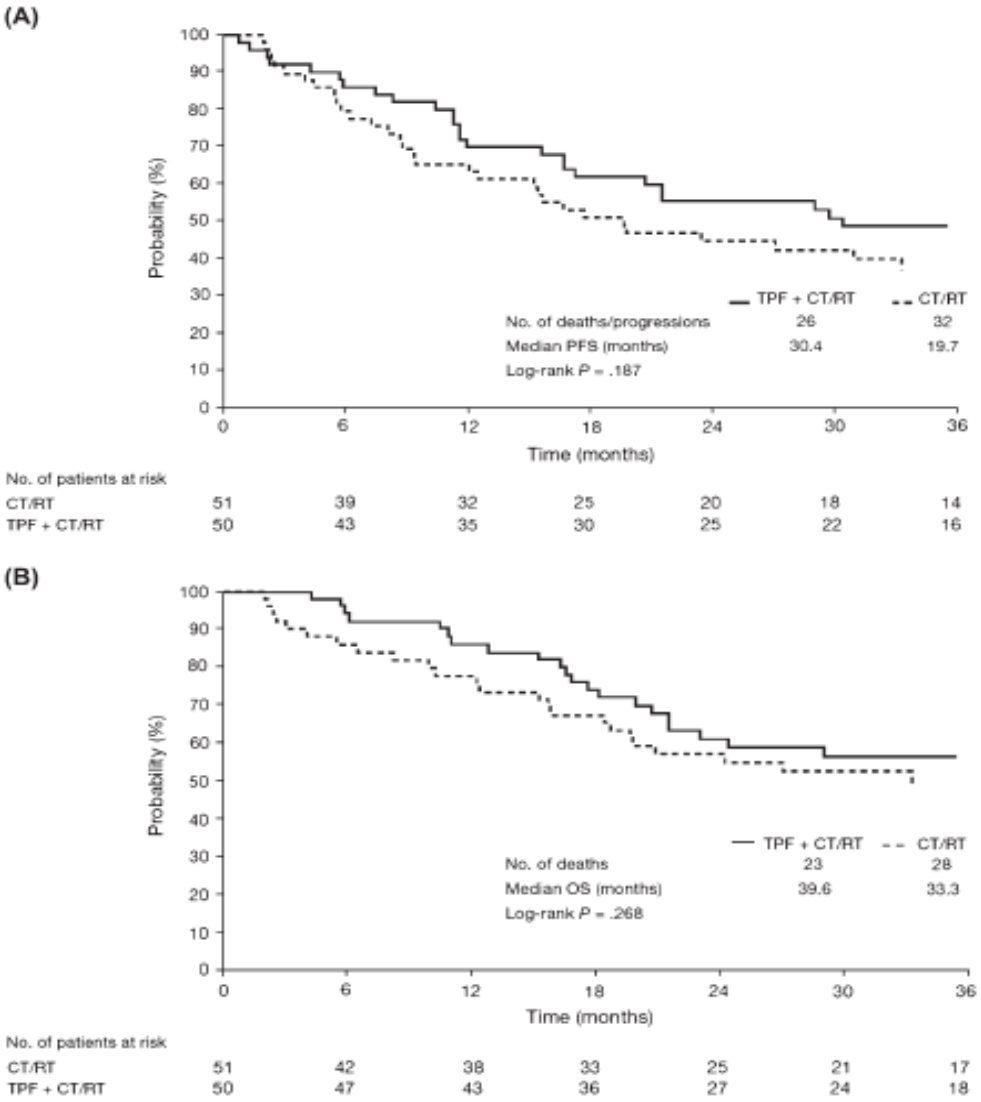


Figure 3. Kaplan–Meier plots of (A) progression-free survival (PFS) and (B) overall survival (OS) for all patients treated with concomitant chemoradiotherapy (CT/RT) versus docetaxel, cisplatin plus 5-fluorouracil (TPF) induction therapy followed by CT/RT.

TCF-TF Karşılaştırma meta-analiz

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Taxane-Cisplatin-Fluorouracil As Induction Chemotherapy in Locally Advanced Head and Neck Cancers: An Individual Patient Data Meta-Analysis of the Meta-Analysis of Chemotherapy in Head and Neck Cancer Group

Pierre Blanchard, Jean Bourhis, Benjamin Lacas, Marshall R. Posner, Jan B. Vermorken, Juan J. Cruz Hernandez, Abderrahmane Bourredjem, Gilles Calais, Adriano Paccagnella, Ricardo Hitt, and Jean-Pierre Pignon on behalf of the Meta-Analysis of Chemotherapy in Head and Neck Cancer, Induction Project, Collaborative Group

5 ÇALIŞMANIN METAANALİZ SONUÇLARI;

TCF, CF GÖRE; DAHA AZ PROGRESYON, LOKAL-REGİONAL , UZAK METASTAZ SONUÇLARINA SAHİP

unrestricted research grant from Sanofi-aventis.

Presented in part at the Third International Conference on Innovative Approaches in Head and Neck Oncology, February 24-26, 2011, Barcelona, Spain.

The sponsors of this study had no role in the study design, data collection, data analysis, data interpretation, or the writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to

There was no interaction between treatment effect and the following patient covariates: age, sex, performance status, tumor stage, or site. Tax-PF was associated with significant reductions of progression, locoregional failure, and distant failure compared with PF, with HRs of 0.78 (95% CI, 0.69 to 0.87; $P < .001$), 0.79 (95% CI, 0.66 to 0.94; $P = .007$), and 0.63 (95% CI, 0.45 to 0.89; $P = .009$) respectively.

Conclusion

This IPD meta-analysis shows the superiority of Tax-PF over PF as induction chemotherapy. Its precise role in the management of LAHNC remains to be determined.

J Clin Oncol 31.

TCF-TF Karşılaştırma metaanliz

JOURNAL OF CLINICAL ONCOLOGY JOURNAL OF CLINICAL ONCOLOGY

Is Taxane-Cisplatin-Fluorouracil Superior to Cisplatin-Fluorouracil As Induction Chemotherapy in Outcome in Locally Advanced Head and Neck Cancers?

Deniz Tural and Saadetin Kilickap

Sonuç:

Orofarenks ve dışı olanların oranı (HPV+, daha iyi yanıt)

TAX324, TAX 325 Orofarenks tm oranı fazla

GORTEC larenks, hipofarenks (OS, p; 0.96)

TAX324, TAX 325 cisplatin dozları (75 mg/m2 vs 100 mg/m2)

İndüksiyon sonrası RT ile verilen kemoterapi farklı

Pointreau at al[2] demonstrated that a three-drug regimen was effective for larynx preservation. But, four other trials demonstrated that induction chemotherapy was effective in locally advanced head and neck (including oral cavity, hypopharynx, oropharynx, and larynx) carcinoma.[3–6] Tumors were dominantly localized in the oropharynx in the TAX-323 and TAX-324 trials.[3,4] But, it is well-known that oropharynx squamous cancers have good prognosis depending on the high rate of human

İndüksiyon KT+KRT – Eş zamanlı KRT?

#5500: Docetaxel-Based Chemoradiotherapy Plus or Minus Induction Chemotherapy to Decrease Events in Head and Neck Cancer (DeCIDE)

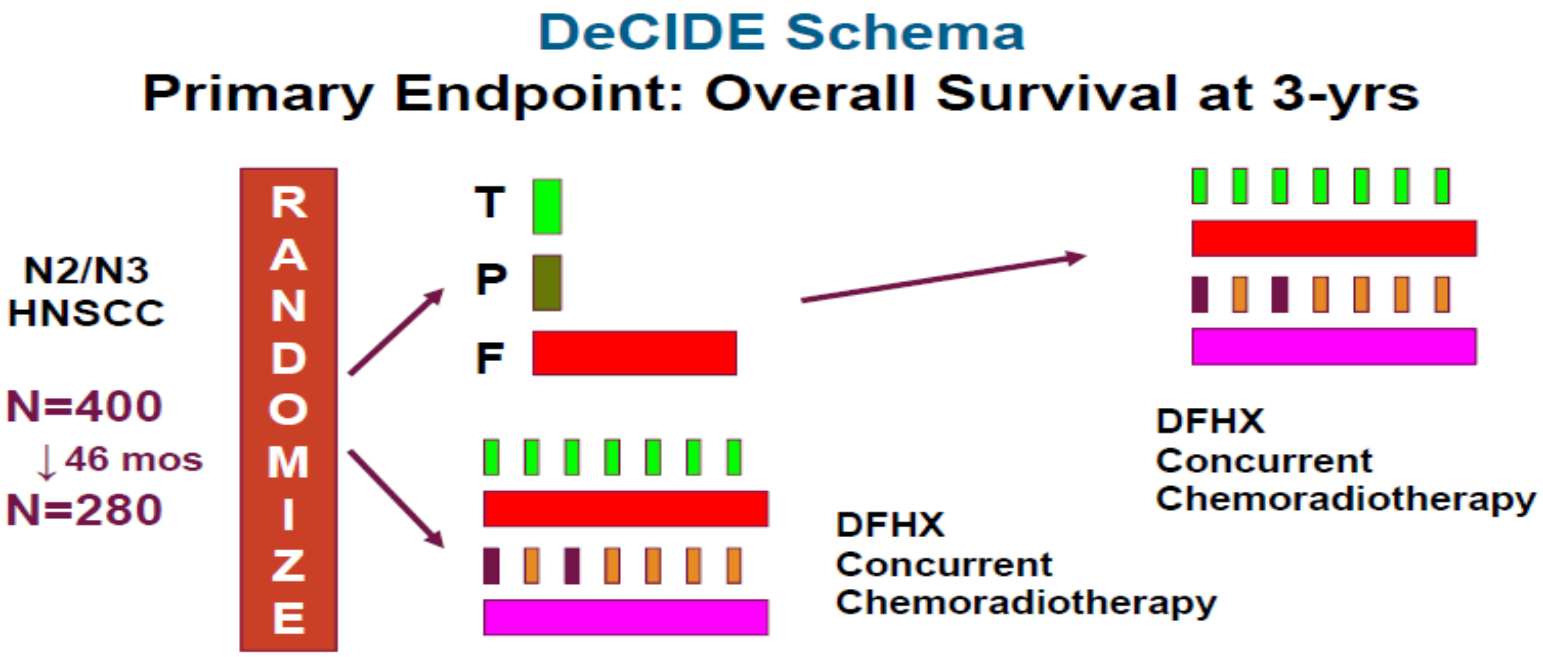
Results of a Phase III Multicenter, International Study

E. Cohen, T. Karrison, M. Kocherginsky, C. Huang, M. Agulnik, B. Mittal, F. Yunus, S. Samant, B. Brockstein, L. Raez, R. Mehra, P. Kumar, F. Ondrey, T. Seiwert, V. Villaflor, D. Haraf, E. Vokes

PRESENTED BY: Ezra Cohen

PRESENTED AT: ASCO Annual '12 Meeting

İndüksiyon KT+KRT – Eş zamanlı KRT



TPF: Docetaxel + Cisplatin + 5-FU Q3 weeks X2

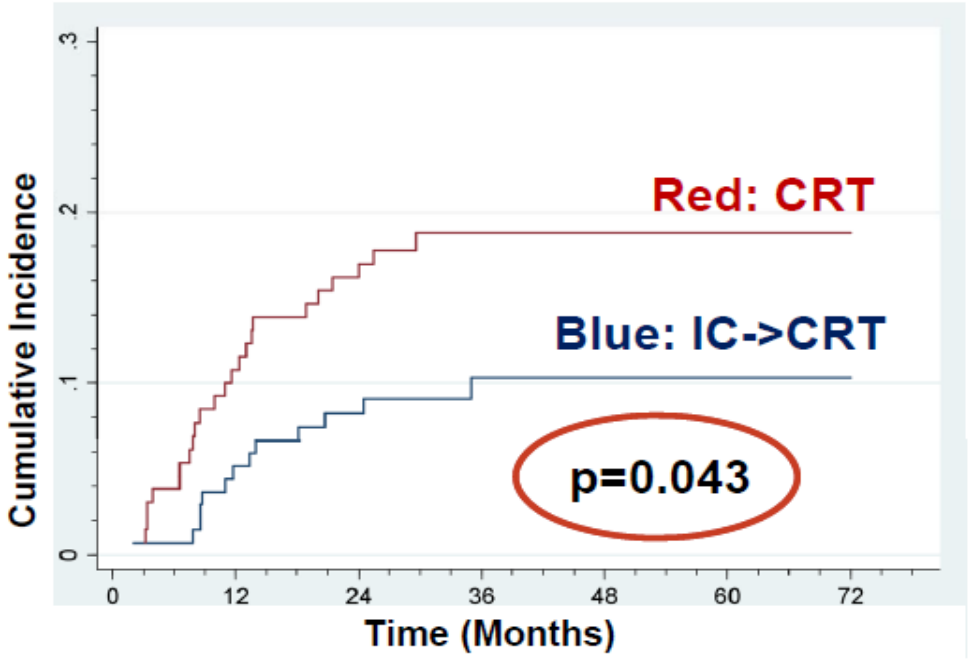
DFHX: Docetaxel + Hydroxyurea + FU + Hyperfractionated RT

DeCIDE Faz III Çalışmanın Sonuçları

3- Yıllık Sonuçları					
	KT-KRT (%)	KRT (%)	HR	95% CI	P
OS	75	73	0.92	0.59-4.42	0.70
DFS	69	64	0.84	0.56-1.26	0.39
RFS	67	5	0.76	0.52-1.13	0.18
Uzak metastaz oranı	10	19	0.46	0.23-0.92	0.025
Lokoregional nüks oranı	9	12	0.79	0.37-1.68	0.55

İndüksiyon KT+KRT, Eş zamanlı KRT

Cumulative Incidence of Distant Recurrence without Prior Local/Regional Recurrence



İndüksiyon KT+KRT, Eş zamanlı KRT

#5501: The PARADIGM Study: A phase III study comparing sequential therapy (ST) to concurrent chemoradiotherapy (CRT) in locally advanced head and neck cancer

Robert I. Haddad, Guilherme Rabinowits, Roy B. Tishler, Douglas Adkins, Fadlo Raja Khuri, Joseph Clark, Jochen H. Lorch, Sewanti Atul Limaye, Lori J. Wirth, Anne O'Neill, Sarah Riley, Marshall R. Posner

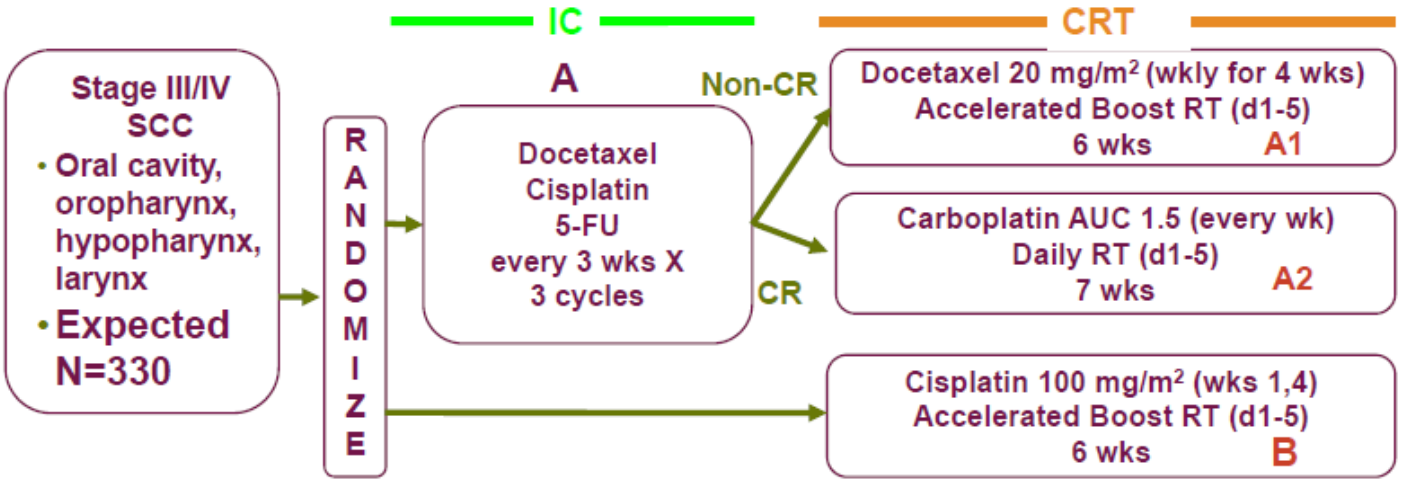
PRESENTED BY: Robert Haddad

PRESENTED AT: ASCO Annual '12 Meeting

İndüksiyon KT+KRT, Eş zamanlı KRT

PARADIGM: Study Design

Primary Endpoint: Overall survival at 3 yrs



Accrual: 145 patients
08/'04 - 12/'08
Halted 12/08 for Poor Accrual

PARADIGM Faz III Sonuçları

Induction chemotherapy followed by concurrent chemoradiotherapy (sequential chemoradiotherapy) versus concurrent chemoradiotherapy alone in locally advanced head and neck cancer (PARADIGM): a randomised phase 3 trial

Robert Haddad, Anne O'Neill, Guilherme Rabinowits, Roy Tishler, Fadlo Khuri, Douglas Adkins, Joseph Clark, Nicholas Sarlis, Jochen Lorch, Jonathan J Beitler, Sewanti Limaye, Sarah Riley, Marshall Posner

Summary

Background The relative efficacy of the addition of induction chemotherapy to chemoradiotherapy compared with chemoradiotherapy alone for patients with head and neck cancer is unclear. The PARADIGM study is a multicentre open-label phase 3 study comparing the use of docetaxel, cisplatin, and fluorouracil (TPF) induction chemotherapy followed by concurrent chemoradiotherapy with cisplatin-based concurrent chemoradiotherapy alone in patients with locally advanced head and neck cancer.

Methods Adult patients with previously untreated, non-metastatic, newly diagnosed head and neck cancer were eligible. Patients were eligible if their tumour was either unresectable or of low surgical curability on the basis of advanced tumour stage (3 or 4) or regional-node stage (2 or 3, except T1N2), or if they were a candidate for organ preservation. Patients were randomly assigned (in a 1:1 ratio) to receive either induction chemotherapy with three cycles of TPF followed by concurrent chemoradiotherapy with either docetaxel or carboplatin or concurrent chemoradiotherapy alone with two cycles of bolus cisplatin. A computer-generated randomisation schedule using minimisation was prepared and the treatment assignment was done centrally at one of the study sites. Patients, study staff, and investigators were not masked to group assignment. Stratification factors were WHO performance status, primary disease site, and stage. The primary endpoint was overall survival. Analysis was by intention to treat. Patient accrual was terminated in December, 2008, because of slow enrolment. The trial is registered with ClinicalTrials.gov, number NCT00095875.

Findings Between Aug 24, 2004, and Dec 29, 2008, we enrolled 145 patients across 16 sites. After a median follow-up of 49 months (IQR 39–63), 41 patients had died—20 in the induction chemotherapy followed by chemoradiotherapy group and 21 in the chemoradiotherapy alone group. 3-year overall survival was 73% (95% CI 60–82) in the induction therapy followed by chemoradiotherapy group and 78% (66–86) in the chemoradiotherapy alone group (hazard ratio 1·09, 95% CI 0·59–2·03; p=0·77). More patients had febrile neutropenia in the induction chemotherapy followed by chemoradiotherapy group (16 patients) than in the chemoradiotherapy alone group (one patient).

Interpretation Although survival results were good in both groups there was no difference noted between those patients treated with induction chemotherapy followed by chemoradiotherapy and those who received chemoradiotherapy alone. We cannot rule out the possibility of a difference in survival going undetected due to early termination of the trial. Clinicians should still use their best judgment, based on the available data, in the decision of how to best treat patients. The addition of induction chemotherapy remains an appropriate approach for advanced disease with high risk for local or distant failure.

Funding Sanofi-Aventis.

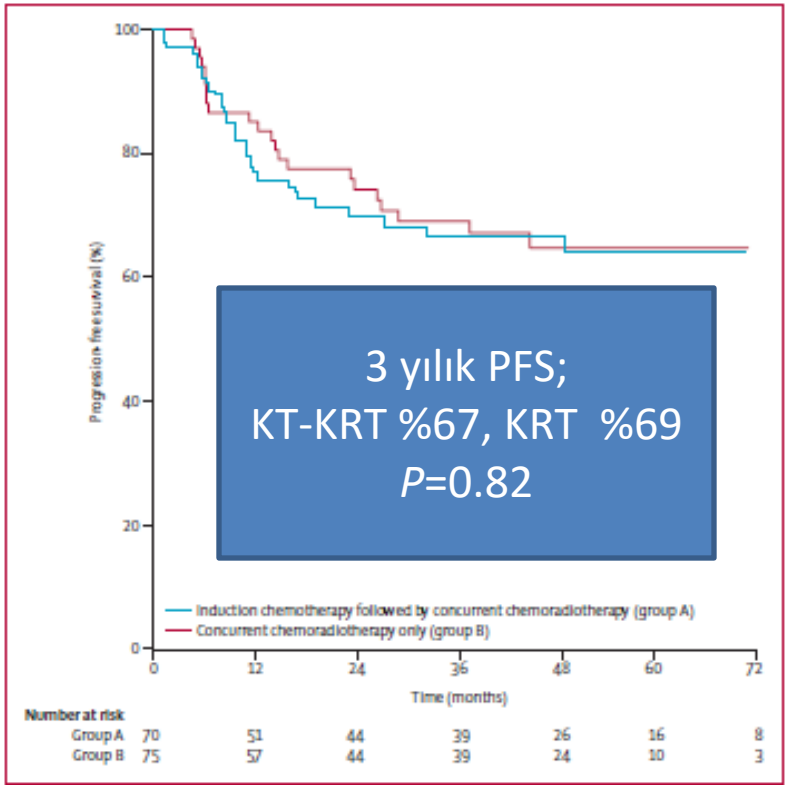
Lancet Oncol 2013; 14: 257–64

Published Online February 13, 2013 http://dx.doi.org/10.1016/S1470-2045(13)70011-1

See Comment page 188

Department of Medicine, Brigham and Women's Hospital, and Department of Medicine, Harvard Medical School, Boston, MA, USA (R Haddad MD); Department of Medical Oncology (R Haddad, G Rabinowits MD, J Lorch MD, S Limaye MD), Department of Biostatistics and Computational Biology (A O'Neill MS), Department of Radiation Oncology (R Tishler MD), and Department of Medical Oncology (S Riley), Dana-Farber Cancer Institute, Boston, MA, USA; Division of Hematology/Medical Oncology (Prof F Khuri MD), and Department of Radiation Oncology (Prof J J Beitler MD), Winship Cancer Institute at Emory University School of Medicine, Atlanta, GA, USA; Department of Medical Oncology, Washington University School of Medicine, St Louis, MO, USA (D Adkins MD); Stritch School of Medicine, Loyola University Chicago, Maywood, IL, USA (Prof J Clark MD); Sanofi-Aventis US, Bridgewater, NJ, USA (N Sarlis MD); and Division of Hematology/Medical

Eş zamanlı KRT – İndüksiyon KT+KRT



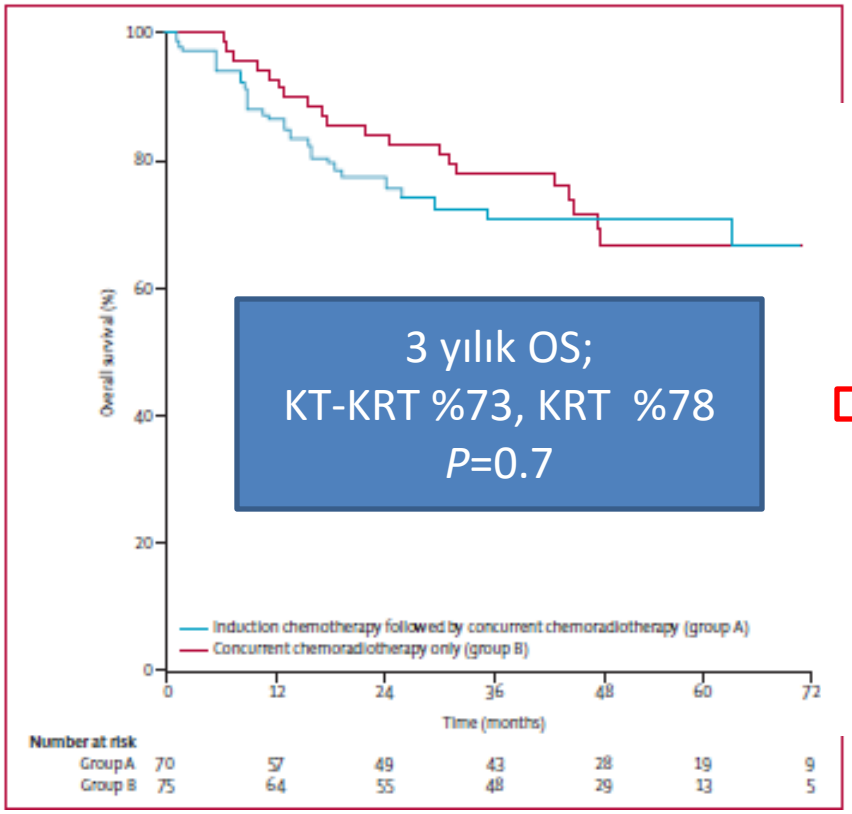
3 yılık PFS;
KT-KRT %67, KRT %69
P=0.82

	Induction chemotherapy followed by concurrent chemoradiotherapy (n=70)	Concurrent chemoradiotherapy only (n=75)
Mucositis		
Grade 1–2	29 (41%)	44 (59%)
Grade 3–4	33 (47%)	12 (16%)
Febrile neutropenia		
Grade 3–4	16 (23%)	1 (1%)
Pain		
Grade 1–2	41 (59%)	35 (47%)
Grade 3–4	2 (3%)	9 (12%)
Xerostomia		
Grade 1–2	42 (60%)	46 (61%)
Grade 3–4	5 (7%)	5 (7%)
Neuropathy		
Grade 1–2	22 (31%)	18 (24%)
Grade 3–4	0	2 (3%)
PEG tube placed	55 (79%)	64 (85%)

Data are number of patients with events (%). PEG=percutaneous endoscopic gastrostomy.

Table 4: Toxic effects (frequencies shown)

İndüksiyon KT+KRT – Eş zamanlı KRT



3 yılık OS;
KT-KRT %73, KRT %78
P=0.7

	HR (95% CI)*	p value	3-year rates (95% CI)	
			Induction chemotherapy followed by concurrent chemoradiotherapy	Concurrent chemoradiotherapy only
Progression-free survival				
Number of events			23	22
Progression-free survival	1·07 (0·59–1·92)	0·82	67% (54–76)	69% (56–79)
Oropharynx	1·79 (0·71–4·56)	0·22	67% (49–80)	83% (66–92)
Non-oropharynx	0·72 (0·33–1·58)	0·42	66% (45–80)	55% (35–70)
Number of deaths				
Number of events			20	21
Overall survival	1·09 (0·59–2·03)	0·77	73% (60–82)	78% (66–86)
Oropharynx	1·40 (0·55–3·55)	0·47	73% (55–84)	83% (67–92)
Non-oropharynx	0·86 (0·36–1·99)	0·72	73% (52–85)	72% (52–84)

HR=hazard ratio. *Based on log-rank test for group A vs group B.

Table 3: Summary of outcomes

İndüksiyon KT sonrası RT?, KRT?

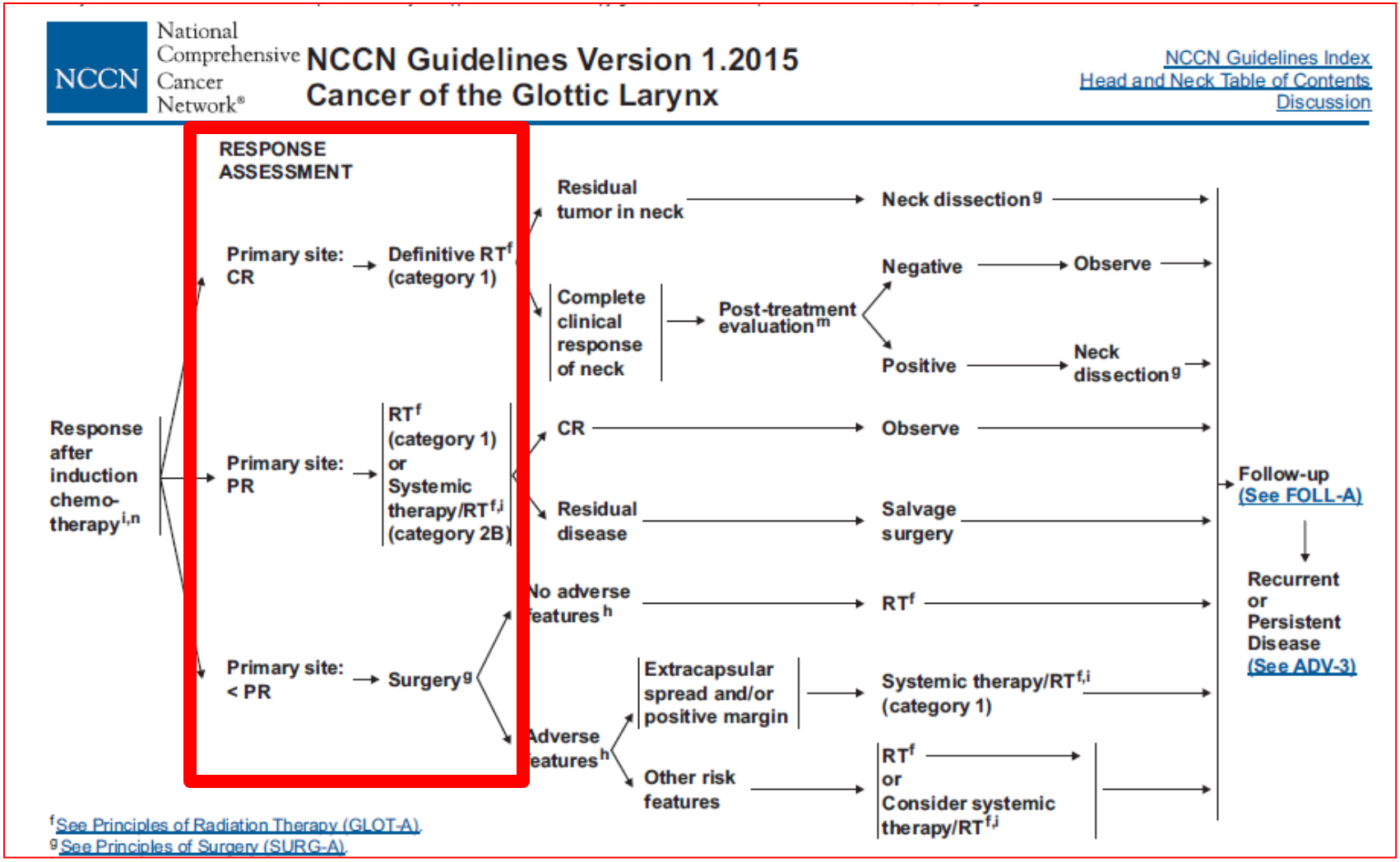
- İndüksiyon KT sonrası parsiyel ve tam yanıt olan hastalarda RT kanıt düzeyi 1 (RTG0 91-11)[1]

- İndüksiyon KT sonrası parsiyel ve tam yanıt olan hastalarda eş zamanlı KRT kanıt düzeyi 2B (GORTEC)[2]

- NCCN 2015; İndüksiyon KT sonrası eş zamanlı KRT, KT olarak Carboplatin, Cetuximab önerilir[3,4,5]

[1]Forastiere AA, JCO 2013, [2]Pointreau Y ,J Natl Cancer Inst 2009 , [3]Haddad R Lancet Oncology 2013, [4]Buiret G, Int J Radiat Oncol Biol Phys 2010, [5]Lefebvre JL, J Clin Oncol 2013

İndüksiyon KT sonrası RT?, KRT?



Eş zamanlı KRT – İndüksiyon KT+KRT

PubMed.gov
US National Library of Medicine
National Institutes of Health

PubMed | Search | Advanced

Abstract | Send to:

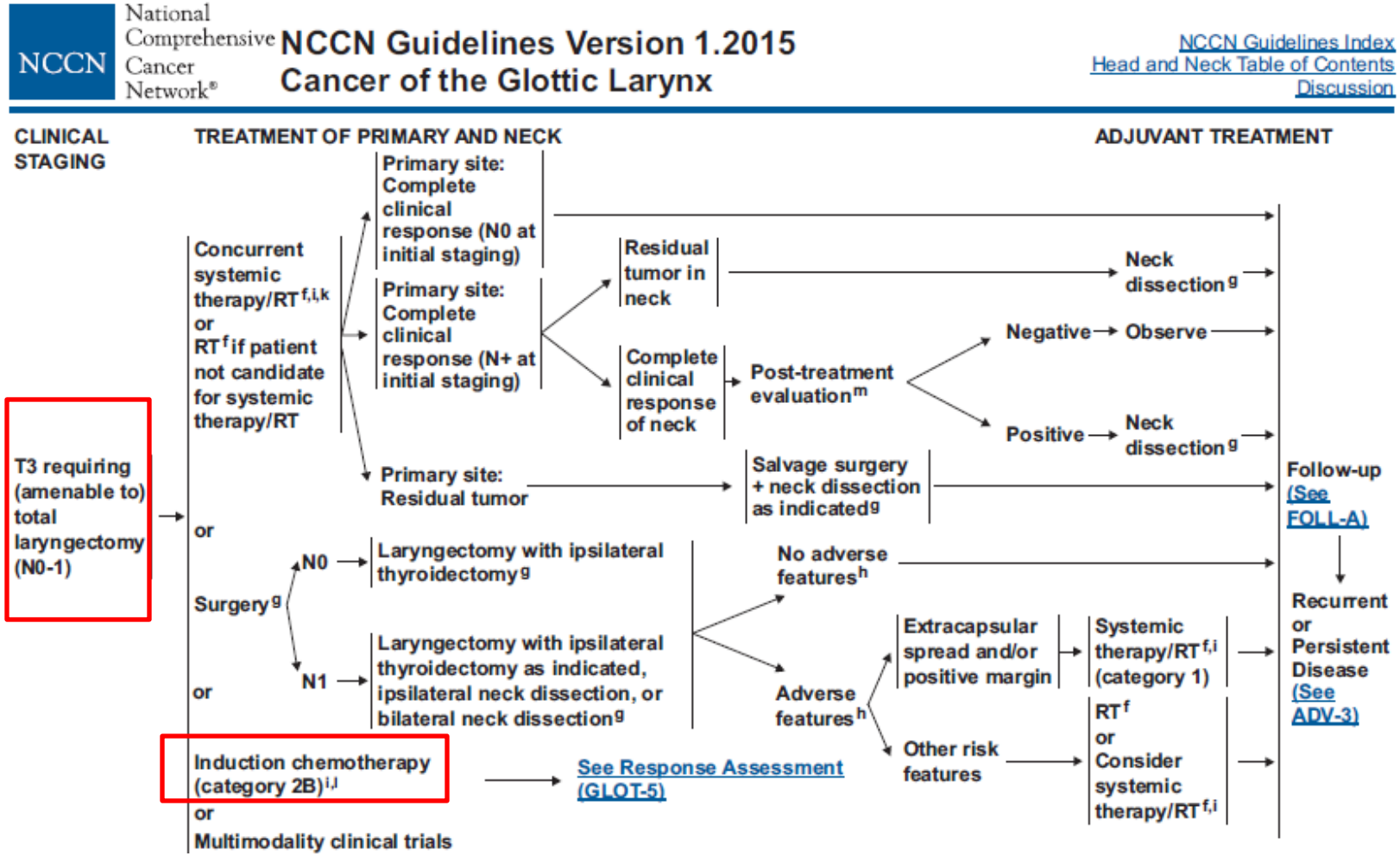
Oncol Rep. 2012 Feb;27(2):467-74. doi: 10.3892/or.2011.1512. Epub 2011 Oct 21.

Toxicity profile and clinical outcomes in locally advanced head and neck cancer patients treated with induction

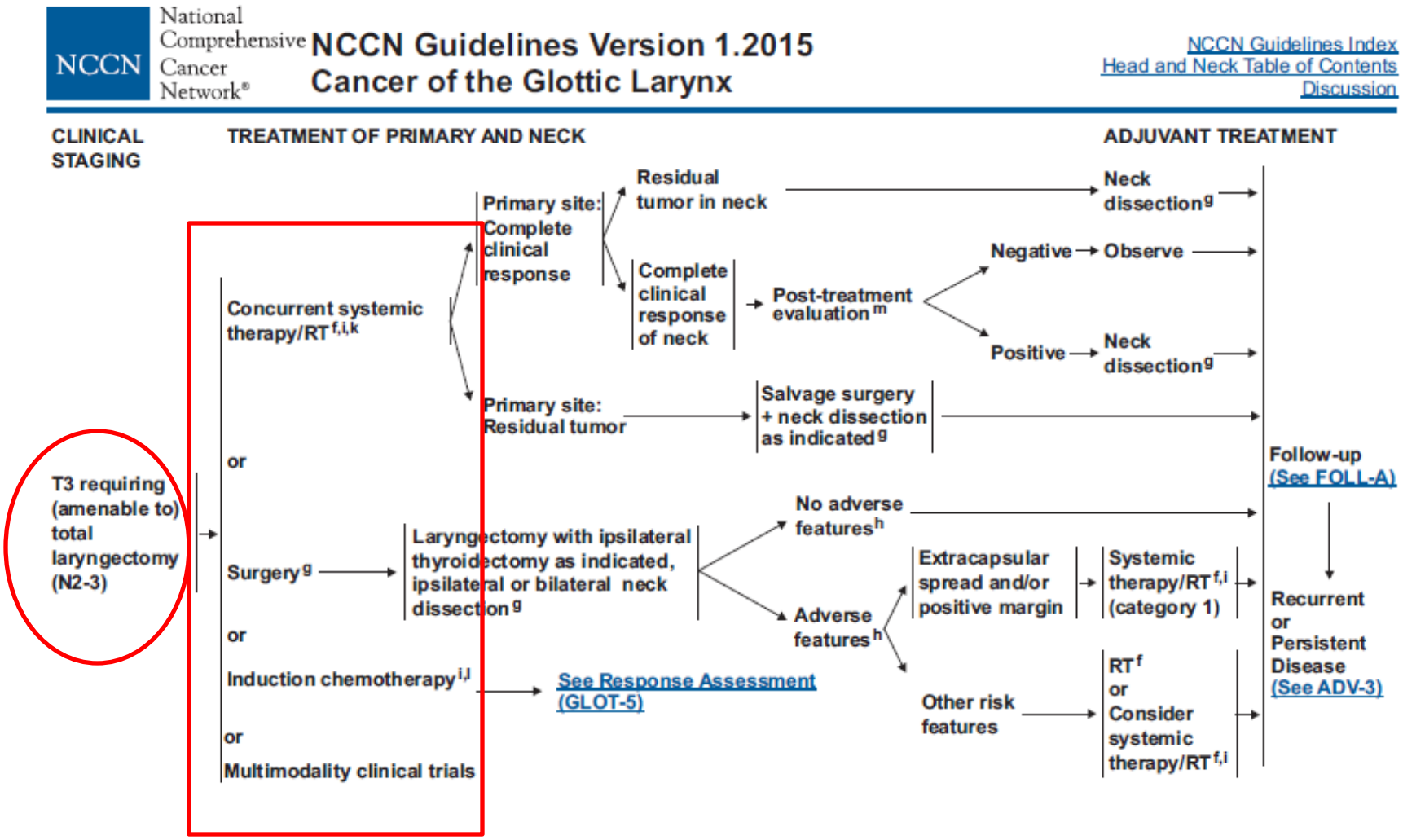
KT-KRT grup ile KRT karşılaştırıldğında,
DFS ve OS benzer bulunmuş.
Fakat indüksiyon ve sonrası eş zamanlı KRT planladığı gibi tedavisi tamamlanan hasta grubu tamamlamayanlara göre
2 yılık DFS daha iyi (%83 vs %27, p=< 0.001)

hospitalization for adverse events, including 5% needing intensive care. The most common high grade adverse events were grade 4 neutropenia (21%) and neutropenic fever (17%). Six percent of patients were unable to tolerate concurrent chemotherapy. The 2-year disease-free survival was significantly higher in patients able to complete induction and concurrent chemoradiation as planned (83 vs. 27%, p<0.001). Induction chemotherapy followed by concurrent chemoradiation results in promising survival rates in our cohort of advanced head and neck carcinoma patients. Due to severe toxicities in a subset of patients, this strategy is only recommended in selected high-risk patients who are carefully followed by an experienced multidisciplinary team.

KRT? İndüksiyon KT-RT/KRT?



KRT? İndüksiyon KT-RT/KRT



Sonuç

- **İndüksiyon KT;**
  - **Tedavi süresi uzun, toksite daha fazla, sağkalım farkı yok**
  - **DeCIDE, EORTC çalışmaları, lokal ileri baş-boyun kanserlerinde uzak metastazı azaltıyor**
  - **Metastaz riski yüksek (Larenks, Hipofarenks) N2B, N2C, N3 hastalarda düşünülebilir**
  - **Radyolojik olarak metastaz şüphesi olan, bx alma olanağı olmayan hastalarda düşünülebilir**
  - **Deneyimli, toksite yönetimi iyi yapılan merkezlerde uygulanmalı**
  - **Üçlü kombinasyon (TCF) seçilmelidir**
- **Eş zamanlı KRT**
  - **Lokal ileri baş boyun kanserlerinde KRT (Cisplatine 100 mg/m2)**
  - **İndüksiyon sonrası KRT uygulanacaksa, eş zamanlı carboplatin AUC 1.5-2 haftalık ya da cetuximab tercih edilmelidir.**