In Response to "Acute Oral Mucositis During Hypo-Fractionated Radiation in Squamous Cell Carcinoma of Oral Cavity"

Sir,

We read Hammad *et al.*[1] on their experience of acute oral mucositis (OM) during hypofractionated radiation in squamous cell carcinoma of the oral cavity with interest. Although this study contains a small number of patients (n = 11), it provides useful information, as hypofractionated radiotherapy is gaining popularity in head and neck cancer (HNC), especially in developing countries as it can be more cost-effective.[2]

Hammad *et al.*[1] reported 36% grade (G) III OM and 64% GII OM. After 1-month post-completion of treatment, the severity of OM was improved (9% GIII, 18% GII, and 46% GI). At 3-month follow-up, there is no GII/III OM and only 18% patients had G1 OM. None of the patients developed GIV OM. All patients who developed GIII OM had stage ≥ III (large radiotherapy volume including ipsilateral neck) and received concomitant weekly cisplatin. All patients had surgery and 3D conformal radiotherapy.

The authors report that 3 patients (27%) received this high dose, 55 Gy in 20 fractions with palliative intent. Can the authors shed light on their approach in using a higher, potentially more toxic dose in a palliative situation? We acknowledge that there is no standard palliative radiotherapy regimen for HNC.[3,4] However, life expectancy in such patients is limited, with a median survival of about 6 months[4] and therefore, is the use of radical radiotherapy appropriate? Although the use of "radical dose with palliative intent" has been a longstanding concept in HNC and may prove, especially useful where palliative systemic resources are limited.

Secondly, the authors reported that 73% patients had "addiction" but did not specify what type or whether having this addiction made the acute toxicity worse. There is evident that smoking during radiotherapy increases toxicity.

In general, the use of hypofractionated radiotherapy (>2.4 Gy/fraction) with concomitant chemotherapy in HNC is not recommended[5] although a recent large phase III trial shows similar 3-year survival and toxicity outcomes.[2] There remain concerns regarding late toxicity with hypofractionated radiotherapy in HNC and we would encourage the authors to consider publishing the long-term survival and toxicity outcomes in their particular patient population. Also, 55 Gy in 20 fractions can be considered radical dose, compatible with normo-fractionated (chemo)-radiotherapy regimens in HNC[6] and would the authors consider using slightly lower dose/fraction in adjuvant settings e.g. 50 - 52.5 Gy in 20 fractions? Such information and results would widen the HNC treatment world experience and be a useful addition to the present published literature.

COMPETING INTEREST:
The authors declared no conflict of interest.

AUTHORS' CONTRIBUTION:
MSI, JK, CK: Conception, design and drafting of the manuscript. All authors approved the final version of the manuscript to be published.

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AUTHOR'S REPLY:

Sir,

Our team is grateful to the authors of this letter for raising pertinent points and queries on our study published in this journal. All points raised in this letter are relevant and we are obliged to reply to all these queries. We shall quote our published experiences in our reply. Firstly, as rightly pointed out by the authors of the letter, we are practising in a developing country and we are facing workload and cost issues which were elaborated on our editorials narrating the complex relationship between cost and quality.[1] Clinicians' perspectives are important when it comes to the provision of healthcare in our environment of financial and service constraints.[2] Secondly, our site-specific team had made all treatment-related decisions through both quality processes which were executed in multidisciplinary[3] and intradisciplinary peer-reviewed settings.[4] As rightly pointed out in the letter, the selection of radiation dosages and fractionation is evidence-based and complies with clinical practice guidelines in all settings, *viz*, definitive, palliative, re-radiation, etc.[5] Aetiology of these tumours was found to be tobacco chewing in the form of betel nuts and supari. The radiation dose and fractionation of 50 to 52.5 Gy can be administered as suggested by the authors and our team is grateful to them for this recommendation. Lastly, our commitment towards reporting and showing our experiences will remain active as shown in our previously published manuscripts.[6,7] Our team wish to thank the authors of this letter to the editor of *Journal of College of Physicians and Surgeons, Pakistan (JCPSP*) for raising practical points related to radiation oncology clinical practice. Radiation treatment for HNC patients remains a clinical challenge and we all are compelled for achieve a one-hundred percent site-specific multi-disciplinary team (MDT) tumour board discussion rate.

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