The Fraternity of Strangers

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I greet you on the occasion of the 30th anniversary of the founding of The Society of Head and Neck Surgeons. Over the past 30 years, we have united in a bond of kinship as we have faced the peril of cancer of the head and neck as our common foe. It was this feeling of kinship that struck me when I first attended a meeting of this Society. I found myself surrounded by a diverse group who shared a similar heritage and was actively combating this common peril. I never failed to gain strength from the enrichment and affirmation that I found there. All the while, I was reminded of a passage from Victor Hugo's *Les Miserables*: "Great perils have this beauty, that they bring to light the fraternity of strangers." We are duty bound to honor these men of foresight who first conceived of this Society and brought us together for the purpose of organizing the battle against head and neck cancer. Let us now reminisce in our mature years on how we understand it all began.

The undisputed father of head and neck surgery is Dr. Hayes Martin of the Memorial Hospital for Cancer and Allied Diseases in New York. It is not Dr. Theodore Kocher, who did the first upper neck dissection in the 1880s; it is not Dr. George Crile of Cleveland, who systematically planned and performed the first radical neck dissection in the early part of this century; nor is it Dr. Grant Ward of Baltimore, who did the first composite resection for cancer in 1932 and wrote the first comprehensive textbook of head and neck surgery in 1950. Hayes Martin is the father of head and neck surgery because he developed the discipline and produced the disciples who went out to teach and develop their own succeeding generations. And all the while, they were refining the management of the head and neck tumor patient. Along the way, it became apparent to Dr. Martin that there was a need to form a society of head and neck surgeons. To this end, he gathered together a group of his former pupils and asked Dr. Grant Ward, a respected colleague, to do the same. This nucleus formed our Society in 1954, and it flourished from its very beginning. The glue that held it together was the need of those surgeons who battled cancer of the head and neck daily. That need was intense indeed because it was so vital that they share ideas and experiences to sustain them in the fight. Cancer of the head and neck is rather uncommon and the problems are so immense, the impact on the patient is so severe, and the stakes for success or failure are so high that only a select few surgeons prevail. The cases, therefore, tend to cluster in easily identifiable centers and are in the hands of only a select few. These surgeons are a breed set apart, for they must be very aggressive with the cancer and very innovative in their reconstructive and rehabilitative techniques, yet all the while very compassionate toward the victims. These patients require surgeons who are well-grounded in knowledge, judgment, and techniques. The discipline crosses over and borrows from so many specialties that the only common denominator is the anatomic area and the disease itself.

Although we are justifiably proud of our heritage, it is not enough. For in spite of great efforts by many members of this Society, much remains unsettled. Permit me to recite but a few of the unsettled issues. (1) Are all cancer sites in the upper aerodigestive tract different or do they really act identically if stage and mode of treatment are held constant as one evaluates various sites? If they are in fact the same, we can stop subdividing by site and thus arrive at statistically significant numbers more rapidly, as we compare modes of treatment. (2) Should our staging systems be revised once again to incorporate better methods of measurement and assessment, such as computerized tomographic scanning, examination and measurement under anesthesia, and the incorporation of the pathologic findings after resection whenever possible? (3) What is the minimum safe

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margin of resection around the cancer, and how might it vary depending on type and location? Is the proper margin 2 cm, or can it be 1 cm or even 0.5 cm? (4) In spite of all that has been published on the subject, we have yet to prove in large, prospectively randomized series that combination radiation and surgery is significantly better than surgery alone or even radiation alone. (5) We have never fully settled the issue of prophylactic antibiotics in head and neck surgery. We believe they are essential, but we cannot point to more than one or two small, prospectively randomized studies that address the question of their efficacy. We are not certain which antibiotics should be used or for how long. (6) Does chemotherapy really make a difference in tumor-free survival or cure rates? An affirmative answer eludes us in spite of a vast number of clinical trials. (7) What is the role of mandibular replacement? Should it be immediate, short delayed, or long delayed? What is the influence of radiation on replacement success? When should it not even be considered? What material should be used? Should it be a vascularized free graft or simply avascular bone? Should a tray with particulate bone be used and, if so, of what material? Can hyperbaric oxygen increase the success of mandibular replacement? (8) What is the role of lesser operations? Can a modified or functional neck dissection be as good as a standard radical neck dissection, and if so, when can it safely be used? (9) What is the real difference between the two common forms of single modality treatment, radiation and surgery, in terms of success? And which cases are best treated by each? (10) What is the true incidence of radiation complications, such as prolonged soft tissue induration, necrosis of bone, loss of teeth, xerostomia, and radiation myelitis with paralysis? What is the true incidence of radiation induced cancer? Is radiation necessarily a less disabling modality than surgery? (11) What is the perception of our medical colleagues from the same or ancillary professions of what we do for cancer of the head and neck? Is the condition and its treatment viewed as "nasty business," best shunned and avoided whenever possible? (12) Finally, who should be given the responsibility and privilege of treating these patients? What should their education, training, and experience be to have this privilege? How many cases should a physician manage per year to keep his expertise? Does it really make any difference in results who manages them? We think it does, but we must document our perceptions.

Those are but a few of the unsettled issues in head and neck cancer management. Thus, we have even more reason to cling together to fight this great peril as a fraternity of strangers. For that was the formula that brought us together, and it is the bond that will keep us together.