Opinion

Head & neck carcinomas: where supportive care is a tool to overcome sequelae beyond remission

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Locally advanced, non-metastatic head and neck squamous cell carcinomas (HNSCC) require an optimal local control: radical surgery and mainly concomitant chemo-radiation therapy (CCRT). The patients may enter long term remission and cure if they are adequately managed; especially that local recurrence is more common than distant metastases. In this perspective, both surgery and CCRT are the mainstay of the treatment despite being mutilating, heavy and tough procedures in a population more prone to suffer from complications: high prevalence of alcohol and tobacco consumptions. Once they are successfully done with their anti-neoplastic treatment, they will start facing a new life style and they will find themselves abandoned, weak, without any reserves to fight. Consequently, the supportive care is a must in association with the multi-disciplinary team management of these cancers. It doesn't mean a withdrawal of care, but it is the only way to overcome the treatment related sequelae. Thereafter, the disease curability won't be at the expense of the quality of life.

Patients diagnosed and treated for HNSCC are often frail. They have multiple comorbidities, added to their addiction problems (smoking, alcoholism) and the toxicities from the oncologic treatment. The first and cornerstone step is the nutritional evaluation and support. Beside the cancer related cachexia and catabolic syndrome, these patients are unable to eat: obstruction due to tumoral growth, dysgeusia and mucositis secondary to CCRT as well as the chemotherapy induced emesis. They are at a high risk of anorexia leading to weight loss, sarcopenia and toxicity accumulation. So, the early nutritional support by restoring enteral feeding using nasogastric or gastrostomy tubes may reverse this vicious circle. This will result in a stabilization of the weight with the ability to achieve the planned oncologic treatment.

Moreover, the anti-neoplastic treatments (surgery or CCRT) are painful. Patients should be regularly seen by the palliative team in order to evaluate their symptoms (mucositis, radiation dermatitis, post-operative rehabilitation) and to adapt their analgesic treatment. Furthermore, they are at risk of withdrawal symptoms after being addicted many years to alcohol consumption and smoking. Accordingly, the onco-psychiatry department should assist them before, during and mostly after their treatment. They should also intervene to help them to accept their situation, their difficult re-integration in the society knowing that they will suffer from many esthetic and behavioral changes. Likewise, a dental care is mandatory in this anatomic area that will be affected by all the surgical and radiation therapy toxicities. Most of the radical oncologic surgeries in HNSCC are debilitating, and the patients need a special post-operative, paramedical logopedic rehabilitation program: speech therapy including the phonation, the sound resonance, the intonation and the aeromechanical components of respiration. The physical therapy, either motor or respiratory, is also essential to enhance the patients' functional abilities. Along with all the previous problems, these patients have to afford difficult social and financial conditions with many familial conflicts; there is a major role of the supportive care team during this period of loss of autonomy and frailty.

Conclusion

In conclusion, oncologists should be aware of this hard post therapeutic period in every patient treated for HNSCC. ''*Curing without Caring*'' must be avoided. Head and neck oncology is one of the specialties where supportive care has a place to overcome all the inevitable sequelae, improve the patients' quality of life.

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Conflict of interest

The author declares no conflict of interest.