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Letters to the Editors

Negative pathology following endoscopic resection of T_{1a} squamous carcinoma of the glottis. *J Laryngol Otol* 2005;**119**:592–4

Dear Sirs

Reading the article 'Negative pathology following endoscopic resection of T_{1a} squamous carcinoma of the glottis' by Nassif *et al*.[1] generated a number of questions.

A T_{1a} carcinoma of the glottis can represent a small mid-fold lesion or an exophytic lesion extending the whole length of the vocal fold. Tumour-node-metastasis staging mainly looks at the distribution of the tumour and does not differentiate between a superficial mucosal lesion and one that invades the underlying muscle. Pre-operative evaluation with stroboscopy and peri-operative evaluation using hydrodissection can do this.[2] It may then be possible to clinically differentiate between an incisional and excisional biopsy (many would now try to replace multiple random biopsies of a large lesion with complete enbloc resection when possible).

Carbon dioxide laser excision has been proven to be an excellent method for treating localized glottic carcinoma, but histological assessment of the charred specimen margins can lead to uncertainty as to the completeness of the excision. Repeat biopsies six weeks later or a frozen section of the remaining vocal fold at the time of resection can overcome this.

Many European centres now routinely carry out fat augmentation at the same time as the resection if this has involved the vocalis muscle (type 3 cordotomy or greater), with most patients achieving an excellent voice.[3] This raises the question of where and by whom this surgery should be done. Should it be the domain of the specialized laryngologist/head and neck surgeon, trained in the phonosurgical procedures mentioned above and with access to pre-operative stroboscopy and post-operative voice analysis, or will it be a 'non-specialized procedure' open to all trained ENT surgeons? This will probably be discussed by the Specialist Advisory Committee and training bodies, but we thank the authors for highlighting this area and confirming the efficiency of laser excision of early glottic carcinoma.

Yours faithfully,

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References

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3 Zeitels SM, Hullman RE, Franco RA, Bonting GW. Voice and treatment outcomes from phonosurgical management of early glottic carcinoma. *Ann Otorhinolaryngol* 2002; **111**(suppl 190):3–20

Author's reply

Dear Sirs

I am grateful to Dominic Bray and Meredydd Harries for raising more issues around the management of early laryngeal malignant lesions. The points they have raised are highly appropriate and summarize most of the current key areas in this disease and its management. Regarding post-excision reconstruction, questions exist over not only timing but also effectiveness. From our perspective, we addressed the question of orientation and analysis of the excised specimen by the use of an organic mount, in the form of dehydrated cucumber, which provided an excellent method of detailed pathological assessment. Clearly, the way to address many of these issues is to undertake well structured and co-ordinated research. It is hoped by all involved with this disease that clinical teams will carry out high quality research and publish their results accordingly.

Yours faithfully,

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