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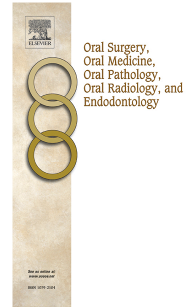

Head and neck surgeons at the vanguard of immunotherapy

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Head and neck surgeons at the vanguard of immunotherapy

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It has been said that the definition of insanity is doing the same thing over and over again and expecting to get a different result. So it has been with the treatment of head and neck cancer. For almost a century, we have prescribed for our patients various combinations of surgery, radiation therapy and chemotherapy and, while quality of life measurements have improved, due in part to advances in microvascular reconstruction and multidisciplinary care, overall survival at five years still hovers between 50-60% for HPV-unrelated (HPV-) head and neck squamous cell carcinoma (HNSCC). This is only marginally better than it was a century ago and is certainly not in keeping with improvements seen for some other solid cancers, most notably breast and colorectal cancer. While 2016 was a watershed year that witnessed the FDA approval of two new immunotherapies (nivolumab and pembrolizumab) for treatment of recurrent/metastatic HNSCC,[1,2] much work needs to be done if these agents are to be rationally integrated into standard of care. Surgery remains the primary modality of treatment for most patients with oral squamous cell carcinoma (OSCC) and T4 larynx cancer, and it is an increasingly popular therapeutic modality for T1/T2 oropharynx cancer. Thus the responsibility to ensure that patients are enrolled into practice changing clinical trials is paramount and rests squarely on the surgeon's shoulders.

Surgeons have been at the vanguard of immunotherapy for the treatment of cancer for a century. William Coley (1862–1936), a New York surgeon, is credited with being the

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