

From the Editor

An important priority for patients and treating physicians, as well as for the National Cancer Institute and the National Clinical Trials Network, is to minimize overtreatments and their short- and long-term consequences. This mission is somewhat complicated and fraught with challenges—after all, we have invested considerable resources to advance



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treatments and improve outcomes. But each step leaves open questions as to which population and specific subgroups should be included in the new treatment recommendations. The default criteria for treatment are typically the eligibility criteria used in the pivotal study, or if applicable, the FDA approval label. However, these may be overly inclusive (or not sufficiently so), and follow-up studies to refine these are felt to be less urgent than moving in altogether new directions. At the same time, our appreciation of real-world adverse effects that patients experience while on treatment, or many years later, is limited because of patient selection and the fact that most trials do not collect detailed long-term safety data.

In this issue of *The American Journal of Hematology/Oncology*[®], Dr Nagasaka and colleagues provide a refreshing review and perspective on the use of positron emission tomography (PET) scanning after combined modality therapy for head and neck cancer to determine the need for follow-up neck dissection. Key clinical trials exploring this approach for higher stage tumors (N2, N3) are nicely laid out. It is remarkable that residual disease seen with planned neck dissection following chemoradiation is common, around 40%.¹ However, in patients with radiographic responses that can be seen using modern imaging techniques, recurrence rates are under 10%.² This review covers trials that have examined imaging-guided decision making or outcomes, and one of the most important trials presented is a randomized trial designed to specifically evaluate, in patients with residual or equivocal residual nodal disease, image-guided decision making with those randomized to neck dissection versus PET/computed tomography scanning and neck dissection only in those with residual or equivocal residual nodal disease.³ In this trial, neck dissection rates were lower in the imaged group with no inferiority demonstrated in 2-year survival rates. Of course, longer-term follow-up is needed to evaluate both survival and late adverse effects, but we are now seeing more and more examples of “more is less”—a trend in the personalization of cancer care that can improve both quality of life and cost effectiveness.

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