## Editorial Commentary

# Is Quality of Life "The Heart of The Issue" In Head and Neck Cancers?

Head and neck cancers distinctly differ from other cancers with regards to symptom burden, psychosocial issues, and quality of life. Physiological dysfunction and anatomical disfigurement are commonly seen in advanced head and neck cancer, which could be disease or treatment associated. Impairment of basic physiology of living such as eating, speaking, and breathing as well as issues associated with structural disfigurement like body image issues, social isolation, anxiety, and depression have a major impact on physical symptoms and quality of life.[1] Head and neck cancer is one of the most common cancers seen in India with around 80% patients presenting with advanced stage of illness with only 50% being amenable to curative/definitive intent treatment. Hence the prospective observational study conducted by All India Institute of Medical Sciences (AIIMS), New Delhi, is very pertinent in our setting and addresses important issues in patients with advanced head and neck cancer.

The study by Gandhi *et al.*, published in this issue reveals that most patients were middle aged, hailing from a low socio-economic strata, having only basic primary education and with history of substance abuse. Majority of the patients studied had T4, N2/N3 disease. Two-thirds of patients in the study had pain and required strong analgesics at initial presentation. The other symptoms noted were insomnia, fatigue, anorexia, dryness of mouth, and trismus. Anatomic disfigurement and physiologic dysfunction were assessed using EORTC-HN35 questionnaire and quality of life was assessed using EORTC QLQ-C15-PAL which is a 15 item abbreviated version derived from EORTC QLQ-C-30 specifically for use in the palliative care setting. QLQ-C15-PAL scores are directly comparable with scores derived from the parent instrument,

the QLQ-C30.[2] Quality of life assessment showed diminished emotional and physical functioning in the patients studied. This is important baseline data, from the Indian population which has several distinctive features which maybe different from Western studies.[3]

Terrel *et al.*, identified 13 demographic and clinical characteristics that are predictors of QOL in patients with advanced head and neck cancers of which advanced nature of disease, presence of comorbid conditions, presence of tracheostomy tube, chemotherapy and neck dissection were associated with significant decrement in QOL.[4] This is supported by studies by Pandey *et al.*, and Lewis *et al.*, who have correlated distress and quality of life in patients with advanced head and neck cancer.[5,6] Educational status, occupation, tumor, and nodal stage, pain scores and presence of physical symptoms were associated with higher distress and poor quality of life. Lopez-Jornet *et al.*, emphasized the use of EORTC-HN35 and EORTC QLQ-C-30 for assessment of quality of life in advanced cancer patients as it enables health practitioners to discover in which areas and to what extent patients find their lives affected by disease, the treatment they receive, its consequences and its impact on overall well being.[7] Study by So *et al.*, stressed the need for periodic monitoring for physical symptoms and QOL of life even in head and neck cancer survivors.[8]

Research on quality of life and symptom burden in head and neck cancers are extensively studied and published in the world literature. These studies use instruments like generic, disease specific, site specific and symptom specific instruments.[9,10] As QOL has multifactorial association, at times data correlating QOL with functional outcome and symptom burden fails to demonstrate a consistent relationship. This may be ascribed to methodological issues in study design or the patient's ability to adapt to functional and symptom control problems. Nevertheless considering the magnitude of head and neck cancer patients in India, this is an important area of research and the study from AIIMS is an important contribution to this knowledge base.

This study is particularly important as most of the patients studied were in the twilight zone in relation

to further disease modifying treatment and had poorly controlled symptoms and quality of life. Knowledge and anticipation of symptom burden and quality of life issues will help in developing disease specific symptom control algorithms and early introduction of palliative care. Integrated model and simultaneous and shared care model of palliative care delivery ensures assessment of symptoms early in the course of illness trajectory, continued input throughout treatment and after treatment phase and smooth transition towards palliative care when disease modifying treatment is no more relevant.[11,12]

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