

REVIEW ARTICLE

**PARTICULAR ASPECTS OF TREATMENT IN MALIGNANT
LARYNGEAL TUMORS**

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ABSTRACT

Malignant tumors are a severe pathology structures that require a thorough, sustained therapy and long-lasting. In general, surgical approach is followed by radiation therapy and/or chemotherapy. The main therapeutic approach is surgical. Treatment success and ability but is given that surgical therapy is combined with the other two methods (radiotherapy and / or chemotherapy) . This paper critically considers the current strategies and their combination , and when one of them becomes predominant.

KEYWORDS: *malignant laryngeal tumor, therapeutical strategy.*

According to current data , cancer ranks second in the world for death after heart disease , statistics indicating that in the coming years, this disease will be the leading cause of mortality worldwide [1,2]. Among the risk factors that predispose to laryngeal cancer include: heredity, age, socio-economic conditions, lifestyle, inadequate diet, excessive consumption of tobacco and alcohol, immune depression, stress.

Cancer of the larynx is more common in males , but more recently, there was an increase in the number of cases and women. In Romania , laryngeal cancer ranks 7 at men and 27 at women [3].

The malignant transformation is a multi-stage process , requiring many changes in structure and gene expression . Although significant progress has been made in identifying the genetic structures that

predispose to cancer, but we know very little about the context of highly complex , favoring the disease [1,4,5].

Usually, the selected patients have a long history of smoking and drinking associated with other causes (messy lifestyle, poverty and work in a polluted area) [6].

Larynx cancer ranks first in the ENT neoplasias.

Deaths from laryngeal cancer is approximately 2.2 % of all deaths from respiratory cancer [2]. In Galati , laryngeal cancer incidence is 6.6 per 100,000 inhabitants .

Choosing the therapy is of great importance , and must therefore be ascertained. The factors that determine this choice are related tumors , the patient and the real possibility of being put into practice .

Surgery and radiation are the only major

methods of cure can be treated laryngeal neoplasms far. Chemotherapy and immunotherapy plays a role as an adjunct and palliative in the treatment of these cancers, remaining in discussion if present may be extended or may improve patients' lives through such means.

The problems the therapist faces are difficult because he has to decide if the patient needs primary surgery, choose the surgical method, if he has to be initially irradiated and which are the chances of surgery.

Surgical treatment of malignant laryngeal techniques include partial laryngectomy and total laryngectomy.

Corpectomy is the excision of vocal cord lesions used small medium third of the vocal cord .

Hemilaryngectomy is a vertical partial laryngectomy allowing excision lesions limited to the vocal cords and the preservation of the voice. The extension is for a vocal chord injury and 5 mm at the rope opposite vowel. It is forbidden to her vocal cords.

Alonso horizontal supraglottic laryngectomy type indicate the location of the tumor on the epiglottis and ventricular bands, respecting aritenozii . This procedure has the advantage of preserving and maintaining floor glottis voice and breathing.

Tumors located at the free edge of the epiglottis is extirpa epiglotectomie after Huet process (hio - tiro - epiglotectomie) . When tumor invades and lower half of the epiglottis and ventricular bands Alonso procedure is used (described above).

Frontal - lateral laryngectomy (Leroux - Robert) indicate the anterior commissure tumor localizations extending along a vocal cord mobility preserved. This technique includes resection angle triangular resection of part of the thyroid and arytenoid and local apophysis .

Anterior frontal laryngectomy indicate the location of the tumor in the anterior commissure

extending subcomisural . This practice is rarely but as a rule , the tumor is larger extension .

Hautant Delgado or Aubry hemilaryngectomy is indicated when the tumor has extended to a joint or arytenoid cricoaritenoidian. There is a vertical hemilaryngectomy because the cricoid and arytenoid with the back of his articulation remains intact .

In case of suspicion that the tumor is extensive subglottis is recommended laryngofissure (tirotoomie) that opens vertical midline thyroid cartilage as a book. In supraglottic laryngeal lesions can practice a subtotal laryngectomy with preservation cricoid and cricostomy . The cricoidian ring stiffness does not require the use of a tracheostomy cannula anymore.

The last alternative is total laryngectomy associated binding with evider radical lymph node. Can also be used as a rescue after the failure of early lesions. Remains the preferred surgery for advanced lesions. It consists in removing entirely the larynx, pharynx and tracheostomy full reconstruction.

In advanced carcinomas of the larynx , cobalt combination therapy improves outcomes distance. Paratracheal lymph removal is mandatory to prevent relapse subglottis lesions and mediastinal lymph invasion (Harrison 1971).

Another method is radiation therapy . It can be divided into two categories: teletherapy and brachytherapy , as the radiation source is placed at a distance or in contact with tumor volume . Response to irradiation is the result of several factors that belong body and tumor irradiation technique . The main parameters of radiotherapy are dose , volume and time which acts as a complex, so-called dose - time - volume report .

Cytostatic or chemotherapy agents are substances able to shrink the tumor volume , improve clinical status and to prolong survival and sometimes even the healing of patients with neoplastic disease . Their mode of action on protein biosynthesis disrupt cellular genetic apparatus , action aims not only

cancer cells but also reach all cellular systems of the body.

In vocal cord carcinoma, survival over 5 years exceeds 90%, while in the expanded is 70-75% for stage II and III and stage IV, only 21% [2].

Total laryngectomy is a physiological and psychological mutilation of the patient. Half the patients learn to use esophageal speech, which is the best method of voice rehabilitation after surgery [7-10].

Recently appeared modern techniques in reconstructive surgery after total laryngectomy, which meant progress in vocal rehabilitation or avoid tracheostomy [7,10,11]. They are another alternative that allows voice conservation partial laryngectomy in cases where it is not possible, creating a pseudolarynx. Have used numerous methods of reconstruction of the larynx after total laryngectomy, but few have given positive results. Such was described the creation of a trachea and esophagus between fistulas for short-circuiting of air towards the pharynx [8,9]. A method introduced by Serafini was suspension of the trachea to the hyoid. Another approach is the construction of a pseudolarynx. All techniques have advantages and disadvantages as imagined. Sometimes, failure can be corrected with radiotherapy and chemotherapy [12]. Not to be forgotten, however, as they may give complications, so it is a subtle indication of dosage and exposure time and treatment. These complications can be found in "radiation sickness", i.e. "citostatic" disease.

The treatment of laryngeal cancer is surgical, consisting of partial and total laryngectomy followed by radiotherapy.

When we applied surgical contraindication cases radiotherapy in usual doses, it is often the only therapeutic weapon.

Total laryngectomy performed after partial laryngectomy and radiation therapy do not benefit from postoperative radiotherapy.

Total laryngectomy performed after partial laryngectomy and radiotherapy requires maintaining food probe more (over 15 days) because of a history radiotherapy increases the risk of pharyngeal - cutaneous fistula

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