

Peer Review File

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Review Comments

Oral cancer is the 6th most common cancer worldwide. In the manuscript “Anaesthetic preoperative considerations for oral cancer surgery”, authors considered the principles of preoperative assessment, patient optimisation, risk stratification and strategies to minimise postoperative complications relating to surgery for oral cancer. Couple questions are required to be answered before it will be accepted.

Comment 1

Whether there were considerations to assess the nutrition status of patients with oral cancer?

Reply 1

There is a very clear section dedicated to nutrition in the manuscript (page 6) which I have copied below.

“Nutritional status

At the time of presentation, up to 60% of patients diagnosed with head and neck cancer are considered malnourished, or at high risk of malnutrition. (13) Nutritional deficits can result from the underlying factors relating to the disease (such as poor diet and excess alcohol intake), the detrimental impact of disease processes on oral intake, as well as the substantial side-effects associated with certain treatments, e.g., chemo-radiotherapy causing dysphagia, odynophagia, oral mucositis, xerostomia, trismus, taste changes and nausea. Preoperative malnutrition can have a negative impact on treatment tolerance and is an independent risk factor for infection, poor wound healing, increased risk of perioperative complications and increased mortality. (14) Interventions such as screening for malnutrition and early nutritional support can mitigate these effects, prevent significant weight loss and enable patients to better withstand the side-effects of treatment.

The head and neck cancer guidelines produced by the National Institute for Health and Care Excellence (NICE) in the UK recommend that all patients have nutritional screening by a clinician at presentation and input from a specialist dietitian throughout their care. (10) Nutritional prehabilitation is indicated if the body mass index (BMI) is less than 18.5 kg/m², if weight loss is greater than 10% of body weight, or if inadequate food intake is likely after surgery. Indeed, regular dietician input has been shown to improve outcomes. (15) Nutritional status can be optimised in several ways, including counselling/advice, high calorie supplements, and if required enteral feeding via nasogastric, nasojejunal or percutaneous feeding tubes. Each strategy must consider the individual patient’s current nutritional status, their social support, and likely issues with feeding postoperatively. International guidelines in oncology and head and neck cancer recommend estimating energy requirements of ≥ 30 kcal/kg/day and protein requirements of ≥ 1.2 -1.5g/kg/day of body weight. Some studies suggest that the energy and protein requirements of patients undergoing treatment is greater

due to the considerable loss of lean mass. (15)”

Comment 2

In the introduction, it was proposed to add related reference (DOI: 10.21037/fomm-21-13) about the oral cancer.

Reply 2

While we thank the reviewer for their suggestion. We struggle to see the relevance of this article with regards to preoperative optimisation for oral cancer. The article refers to the development of a protocol to detect metastatic disease; while the introduction mentions the early detection of oral cancer as it influences survival, the work up of disease burden and surgical management of the disease are not part of the scope of this article.

Comment 3 Whether there were specific considerations for old patients with oral cancer?

Reply 3

We thank the reviewer for bringing this to our attention. We did refer to the older population who present with oral cancer – both directly and indirectly

Directly:

Age of < 50 years is quoted as being associated with improved survival.

Advanced age was associated with increased pulmonary complications.

Indirectly:

There were specific considerations given to frailty rather than age. We would argue that frailty is a better indicator of peri-operative outcomes than age – although the two are directly linked and the older one is the more likely they are to be frail.

Scoring to predict morbidity and mortality which take age into account are referred to in the manuscript (NSQIP risk calculator link)

If the reviewer is asking for specific techniques to enact only for old people, then we would argue that if a patient is presenting for surgery the pre-habilitation suggested throughout the manuscript should be carried out as able for all patients - no specific interventions are suggested only for older people.

Comment 4

How to assess the psychology of patients before surgery?

Reply 4

Issues related to social isolation, fear, and depression are mentioned in the article but quite briefly. On further thought it we would like to increase the information in the article on psychological support. It is likely that a more motivated patient is more likely to comply with prehabilitation and possibly improve their outcome from surgery.

In response to the reviewers suggestion we have added the following:

“Psychological Assessment

Oral cancer can be particularly psychologically debilitating amongst other things due to potential disfigurement, loss of function and associated social isolation it can cause. Patients with the disease are also more likely to have dependence issues with alcohol and nicotine as discussed above; these might be mitigated by offering early engagement with these services.

It is important to assess patient psychology and identify patients with psychological difficulty. Indeed both the National Institute for Health and Care Excellence (NICE) and the United Kingdom National Multidisciplinary Guidelines for head and neck cancer (13) advocate early engagement with psychological services and indeed suggest improved outcomes if patients have a good psychological state.”

Comment 5

What were your good suggestions for the anaesthesia for oral cancer surgery?

Reply 5

This is part of a review series on oral cancer – the intraoperative considerations for anaesthesia are dealt with in a separate manuscript and we would therefore not comment on this aspect of patient care in this article. We have made this fact clearer in the introduction and abstract.