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increased pain control, and decreased narcotic usage in patients receiving CRT for oropharyngeal cancer. This modality can be considered as an adjunct in the management of OM where dental and technical expertise is available.

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Longitudinal Assessment of Quality of Life Following Intensity Modulated Radiation Therapy for Cervical Cancer: Preliminary Analysis of the INTERTECC Phase 2 Clinical Trial

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Purpose/Objective(s): To measure quality of life (QOL) associated with intensity modulated radiation therapy (IMRT) and concurrent cisplatin for patients with locoregionally advanced cervix cancer.

Materials/Methods: This study was a prospective aim of the INTERTECC Phase II trial, which enrolled 83 patients with stage IB-IVA cervical carcinoma. Patients received IMRT (45-50.4 Gy in 25-28 daily fractions) with concurrent cisplatin (40 mg/m²) followed by HDR brachytherapy as indicated. Patients completed the EORTC QLQ-C30 and QLQ-CX24 questionnaires at baseline and 1, 4, 12, 24, and 36 months post-treatment. Raw scores were scaled per EORTC instructions. We assessed internal consistency with Cronbach's α and changes from baseline with paired t-tests.

Results: Response rates at baseline and 1, 4, and 12 months post-treatment were 100%, 89%, 80%, and 61%, respectively. Internal consistency was high for all assessed multi-item domains ($\alpha > 0.70$) at baseline except for nausea/vomiting (N/V) ($\alpha = 0.48$). At 1 month, global QOL and constipation were significantly improved, while N/V was significantly worse compared to baseline (Table). At 4 months, global QOL and overall symptom experience were significantly improved, while N/V returned to baseline. At 12 months, global QOL and symptom experience remained improved. Global QOL was similar between treatment sites. There were no significant differences in physical function, pain, fatigue, appetite loss, or diarrhea.

Conclusion: Cervix cancer patients treated with IMRT and cisplatin reported improved overall QOL with fewer bothersome symptoms during 1 year of follow-up when compared to baseline, albeit with a transient increase in nausea/vomiting. Further analysis is needed to assess effects of missing data. The effect of IMRT on QOL should be evaluated in phase III clinical trials.

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What to Ask/When to Act—Patient-Reported Trismus and Mouth-Opening Distances in Head and Neck Cancer Radiation Therapy

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Purpose/Objective(s): To investigate the association between temporally robust domains of patient-reported trismus symptoms and mouth-opening ability as assessed by the maximal interincisal opening distance (MIO) in head and neck cancer (HNC) patients treated with primary radiotherapy (RT).

Materials/Methods: The study included 196 patients previously treated with state-of-the-art RT for HNC in 2007-2012, who had been assessed for trismus pre-RT, and at 3, 6, and 12 months post-RT with a 22-item patient-reported trismus questionnaire (Gothenburg Trismus Questionnaire, GTQ) and MIO-measurements. The GTQ-items are reported on a 5-point Likert scale with a 1-week recall period. At each follow-up, symptom domains were generated by means of factor analysis and relative risk ratios (RR) were calculated for the temporally robust symptoms within the identified domains, which were ultimately correlated with MIO (categorized into five intervals [mm]: 1: >50 ; 2: $>40 \leq 50$; 3: $>35 \leq 40$; 4: $>25 \leq 35$; 5: ≤ 25) using Pearson's correlation coefficient (Pr).

Results: Four symptom domains were identified at each follow-up and included items related to jaw function (*Jaw*), eating ability (*Eating*), pain (*Pain*), and quality of life (*QOL*), and involved 2/3/2/2 temporally robust symptoms, respectively. The median RR for these symptoms for an answering category >2 at 3/6/12 months was 3.0/2.5/2.4 for *Jaw*, 3.8/2.7/2.1 for *Eating*, 1.6/1.1/1.0 for *Pain*, and 3.5/3.2/2.6 for *QOL*. Correlations between MIO and the temporally robust symptoms post-RT were weak to modest (Pr = 0.19-0.55) with the overall stronger correlations for the 2 *QOL* items "interference with private activities" and "interference with professional activities" (3/6/12 months post RT: 0.34/0.46/0.55 and 0.34/0.40/0.45, respectively).

Conclusion: Translating patients' experiences into objective measurements and vice versa widen possibilities to monitor RT-induced injuries. Mouth-opening distances in HNC patients following RT can be understood in terms of associated patient-reported symptom severities on jaw-related difficulties. To prevent progression of RT-induced trismus, actions to monitor MIO and to begin/intensify mouth-opening exercises may need to be taken as patients communicate their mouth-opening status to interfere with private or social life.

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Abstract 3299; Table 1.

Subscale	Baseline (mean, 95% CI)	Δ at 1 month (mean difference, 95% CI)	Δ at 4 months (mean difference, 95% CI)	Δ at 12 months (mean difference, 95% CI)
Global QOL	64.2 (58.8, 69.6)	9.4 (3.0, 15.7)	10.5 (3.2, 17.8)	10.0 (2.6, 17.4)
Symptom Experience	16.1 (12.8, 19.3)	-3.1 (-6.9, 0.8)	-4.8 (-8.6, -1.0)	-3.7 (-7.0, -0.3)
Physical Function	85.8 (82.0, 89.6)	-1.4 (-5.0, 2.1)	-0.10 (-3.8, 3.6)	0.9 (-3.6, 5.4)
Pain	19.5 (13.6, 25.5)	-5.7 (-12.0, 0.6)	-3.4 (-10.1, 3.6)	-1.1 (-8.4, 6.2)
Fatigue	26.5 (21.2, 31.8)	1.7 (-3.4, 6.8)	0.9 (-5.0, 6.8)	0.5 (-6.8, 7.8)
N/V	3.9 (1.9, 6.0)	4.5 (0.8, 8.1)	1.6 (-1.9, 5.0)	0.4 (-3.0, 3.7)
Appetite Loss	13.0 (7.2, 18.8)	0.5 (-6.6, 7.5)	-4.1 (-10.4, 2.2)	-2.0 (-9.3, 5.3)
Constipation	16.5 (10.3, 22.6)	-8.0 (-14.2, -1.8)	-5.7 (-13.1, 1.6)	-7.8 (-13.6, -2.0)
Diarrhea	8.0 (4.2, 11.9)	-0.5 (-5.1, 4.2)	6.8 (-0.5, 14.1)	2.8 (-4.4, 9.9)