

cial. Use of sialagogues (eg, the cholinergic agonists pilocarpine hydrochloride and cevimeline hydrochloride) to maintain salivary function during curative XRT is a promising prophylactic therapy. The phase 3 study conducted by the Radiation Therapy Oncology Group (RTOG), which evaluated the concurrent use of oral pilocarpine to reduce hyposalivation and mucositis associated with radiation therapy in patients with head and neck cancer, was recently completed. This trial, RTOG 97-09, showed that the concomitant use of pilocarpine resulted in a significantly higher rate of unstimulated salivary flow. These results support the use of this agent to decrease radiation-associated xerostomia.¹ However, a similar pla-

cebo-controlled phase 3 trial with fewer subjects using oral pilocarpine concurrently with head and neck radiation therapy revealed no beneficial effect.² The use of antioxidants using free radical scavengers, such as amifostine or antioxidant vitamins, has proved beneficial to preserve irradiated salivary tissues.

I thoroughly enjoyed reviewing this manuscript and agree with the authors that prevention of radiation-induced salivary dysfunction will require a combination of the many potential therapies introduced in this article, with possible sequencing, during or after radiation therapy. The morbidity of xerostomia can be devastating, and clinicians' awareness of possible

treatment regimens can significantly improve patients' quality of life. Saliva is one of nature's miracles and is often taken for granted until it is lost.

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REFERENCES

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