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Operability After Modified Induction Docetaxel, Cisplatin, and Three-Day Fluorouracil in Locally Advanced Oral Cavity Cancer: A Retrospective Cohort Study

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Abstract

Introduction

Induction docetaxel, cisplatin, and fluorouracil (TPF) is used in locally advanced oral cavity cancer to facilitate resection, but its toxicity limits its use. Standard schedules deliver fluorouracil as a four- or five-day continuous infusion. Surgical and safety outcomes with a three-day, flat-dose fluorouracil schedule have not been described. We describe post-induction operability, surgery, pathological outcomes, and severe adverse events with this schedule.

Methods

This retrospective single-institution cohort included 156 consecutive patients with cT3-cT4b oral cavity squamous cell carcinoma who started docetaxel 75 mg/m² and cisplatin 75 mg/m² on day one, with fluorouracil 1000 mg/day by continuous infusion on days one to three, every 21 days, between January 2019 and December 2023. The principal outcome was operability recorded by the multidisciplinary team after induction. Analyses were descriptive, with Wilson 95% confidence intervals (CIs).

Results

The median age was 54 years, and 127/156 patients (81.4%) had cT4 disease. Three cycles were completed by 89 patients (57.1%). Objective response was recorded in 49/156 (31.4%; 95% CI 24.6-39.1). Post-induction operability was recorded in 67/156 (42.9%; 95% CI 35.4-50.8), and 58/156 (37.2%; 95% CI 30.0-45.0) underwent surgery. Among operated patients, 52/58 (89.7%) had R0 resection and 4/58 (6.9%) had a pathological complete response. Grade ⩾3 adverse events occurred in 124/156 (79.5%; 95% CI 72.5-85.1) and febrile neutropenia in 23/156 (14.7%), although prophylactic granulocyte colony-stimulating factor was recorded in 148/156 (94.9%). No deaths were recorded during induction; four of 58 operated patients (6.9%) died within 30 days of surgery, all after three cycles.

Conclusions

Fewer than half of the patients were recorded as operable after this schedule, and severe adverse events were frequent. Because baseline resectability was not recorded, operability cannot be interpreted as conversion to resectability. These data do not support a claim that the shortened schedule is better tolerated than standard TPF.

Categories: Oncology
Keywords: docetaxel, fluorouracil, induction chemotherapy, operability, oral cavity cancer, squamous cell carcinoma

Introduction

Induction docetaxel, cisplatin, and fluorouracil (TPF) improved outcomes compared with cisplatin and fluorouracil in the TAX 323 and TAX 324 trials, in which induction preceded radiotherapy or chemoradiotherapy [1,2]. These trials did not address whether induction improves outcomes before surgery. In resectable oral squamous cell carcinoma, a randomized phase III trial found no overall survival benefit from adding induction TPF before surgery [3].

The role of induction differs in borderline resectable oral cavity cancer, where it is used to make definitive resection possible; patients who become resectable proceed to surgery, and the remainder receive non-surgical treatment [4]. In an Indian institutional series of 3,266 such patients, 32.5% responded to neoadjuvant chemotherapy, although most did not receive a three-drug regimen [4]. In a randomized trial of

495 patients with borderline resectable oral cancer, TPF improved overall survival compared with docetaxel-platinum; 43.8% of all patients were deemed resectable after induction, and 34.5% underwent surgery [5]. Whether patients were resectable before induction is therefore central to interpreting any post-induction surgical outcome.

Toxicity is the main constraint on TPF. In the same randomized trial, grade ⩾3 adverse events occurred in 72.5% of patients receiving TPF, compared with 39.1% receiving docetaxel-platinum [5]. In the DeLOS-II trial in laryngeal and hypopharyngeal cancer, fluorouracil was omitted after four treatment-related deaths among the first 64 patients [6]. In Indian routine practice with five-day fluorouracil, cumulative febrile neutropenia occurred in 12 of 58 patients (20.7%) over two cycles [7]. Modified TPF schedules have been reported in patients unfit for standard TPF [8], but differences in dose, schedule, and patient selection prevent extrapolation between regimens.

Standard TPF delivers fluorouracil as 750 mg/m²/day for five days or 1000 mg/m²/day for four days [1,2]. At our institution, fluorouracil is given as a flat dose of 1000 mg/day for three days. This schedule was adopted as a pragmatic adaptation for a patient population with lower body weight and poorer nutritional status than trial populations. Surgical and safety outcomes with this schedule have not been reported. The objective of this study was to describe post-induction operability, surgery performed, pathological outcomes, and severe adverse events in patients with locally advanced (cT3-cT4b) oral cavity squamous cell carcinoma treated with this schedule, without inferring a comparative treatment effect.

Materials And Methods

Study design, setting, and ethics

This retrospective cohort study included consecutive patients who started modified induction TPF at the Gujarat Cancer and Research Institute, Ahmedabad, India, between 1 January 2019 and 31 December 2023. Data were analyzed in 2026. Reporting follows the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) recommendations for cohort studies [9]. The study protocol was approved by the Institutional Review Committee of the Gujarat Cancer and Research Institute, and the study was conducted in accordance with the Declaration of Helsinki. Because the study was a retrospective analysis of anonymized data from existing clinical records, the committee waived the requirement for individual informed consent.

Participants

Eligible patients had histologically confirmed oral cavity squamous cell carcinoma, were aged 18-75 years, had an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2, and received at least one cycle of modified TPF. Disease was staged using the American Joint Committee on Cancer eighth edition [10], and performance status was recorded on the ECOG scale [11]. Patients with distant metastasis, previous head and neck chemotherapy or radiotherapy, decompensated cirrhosis, or creatinine clearance <45 mL/min were excluded.

Treatment

Modified TPF comprised docetaxel 75 mg/m² and cisplatin 75 mg/m² intravenously on day one, and fluorouracil 1000 mg/day as a flat-dose continuous intravenous infusion on days one to three (3000 mg per cycle). Cycles were repeated every 21 days, with two to three cycles planned.

Treatment delivery was recorded as the number of cycles completed, prophylactic granulocyte colony-stimulating factor (G-CSF) use (yes/no), and a single dose-reduction percentage per patient. The dose-reduction field did not identify the drug or cycle affected.

Post-induction assessment and management

Operability was judged on the anatomical extent of disease and fitness for surgery, and was not determined by RECIST response category alone; predefined operability criteria were not recorded. After induction, operability was assessed by a multidisciplinary team (MDT).

Outcomes

The principal outcome was the proportion of patients recorded as operable after induction. Baseline (pre-induction) resectability was not recorded in the analytical dataset; therefore, this proportion is not a conversion rate. Secondary outcomes were surgery performed, tumor response, resection margin status, pathological complete response (pCR), and safety.

Tumor response was classified according to the Response Evaluation Criteria in Solid Tumours (RECIST), version 1.1 [12], as complete response, partial response, stable disease, or progressive disease. Objective response was defined as complete or partial response, and disease control as complete response, partial response, or stable disease. Among operated patients, margins were recorded as R0 or R1 and pCR as yes or

no. The imaging modality and the timing of response assessment were not recorded in the analytical dataset.

Safety outcomes were at least one grade ⩾3 adverse event, febrile neutropenia, grade 3-4 oral mucositis, and treatment-related death. Intensive care unit (ICU) admission was recorded as a healthcare-use outcome. Adverse events were graded according to the Common Terminology Criteria for Adverse Events (CTCAE), version 5.0 [13]. Grading, attribution of adverse events, and attribution of treatment-related deaths were abstracted retrospectively from clinical records covering the induction and perioperative periods; the analytical dataset did not preserve the identity of the original assessor, the exact observation window, or a formal cause-of-death adjudication. The composite grade ⩾3 adverse-event variable captured toxicities recorded during induction chemotherapy and was not derived automatically from ICU admission or death. Consequently, ICU admissions and treatment-related deaths, which would correspond to grade 4 and grade 5 events under CTCAE if attributed to treatment, are reported separately and are not necessarily counted within the composite.

Statistical analysis

All analyses were descriptive and included all 156 patients. Continuous variables are reported as medians with interquartile ranges (IQRs) and categorical variables as numbers and percentages. All 156 patients formed the denominator for response, operability, surgery, and safety outcomes. Margin status and pCR used the 58 operated patients as the denominator; all-treated R0 and pCR yields are reported separately. A secondary response summary was restricted to patients who received at least two cycles and is conditional on treatment continuation. Operability and surgery were also cross-classified by clinical T category and by response category.

Wilson score 95% confidence intervals (CIs) were calculated for proportions [14]. No hypothesis tests or multivariable models were performed because the study was a single-arm descriptive cohort without a comparator. Survival was not analyzed because follow-up and event dates were not available. Pathology fields were coded as not applicable in non-operated patients and excluded from operated-patient summaries; no imputation was performed. Descriptive analyses were performed using SPSS version 21.0 (IBM Inc., Armonk, New York).

Results

Participants and baseline characteristics

A total of 156 patients were included (Figure *1*).

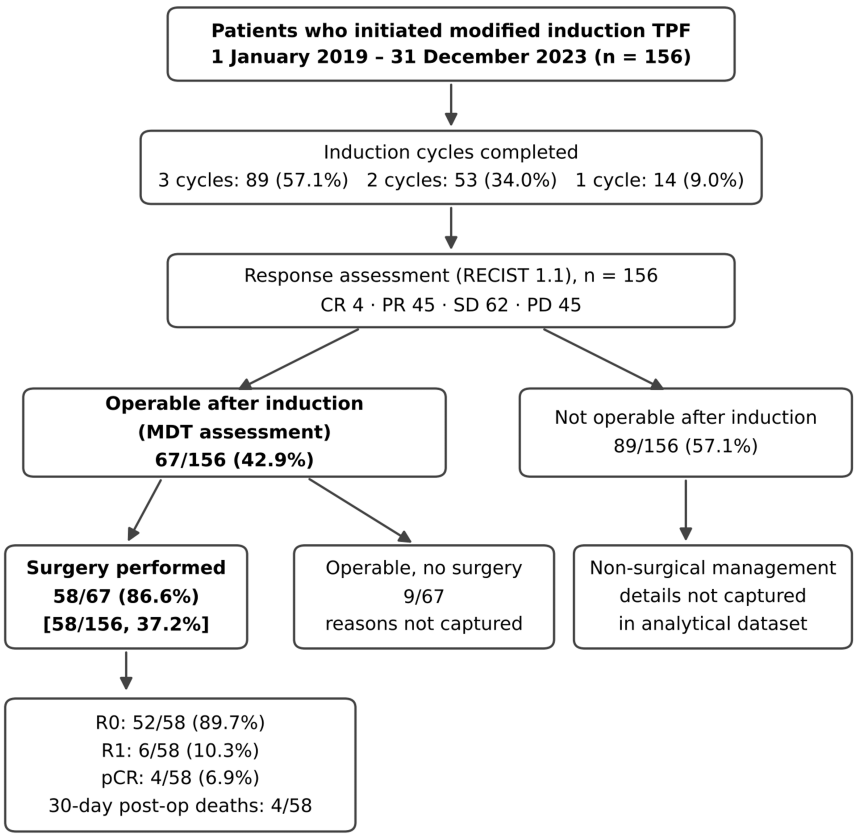


FIGURE 1: Treatment pathway of the 156 patients who initiated modified induction TPF

CR - complete response; PR - partial response; SD - stable disease; PD - progressive disease; pCR - pathological complete response; RECIST - Response Evaluation Criteria in Solid Tumors; TPF - docetaxel, cisplatin, and fluorouracil; MDT - multidisciplinary team

The median age was 54.0 years (IQR 49.0-58.0), and 139 patients (89.1%) were men. ECOG performance status was 0 in 31 (19.9%), 1 in 96 (61.5%), and 2 in 29 (18.6%). Buccal mucosa (76; 48.7%) and oral tongue (42; 26.9%) were the most frequent subsites. Clinical T category was cT3 in 29 (18.6%), cT4a in 77 (49.4%), and cT4b in 50 (32.1%). Weight <50 kg was recorded in 59 (37.8%), weight loss ⩾5% in 95 (60.9%), and albumin <3.5 g/dL in 48 (30.8%) (Table *1*).

Characteristic	Value
Age, years, median (IQR)	54.0 (49.0–58.0)
Sex	
Male	139 (89.1)
Female	17 (10.9)
ECOG performance status	
0	31 (19.9)
1	96 (61.5)
2	29 (18.6)
Primary subsite	
Buccal mucosa	76 (48.7)
Oral tongue	42 (26.9)
Retromolar trigone	15 (9.6)
Gingivobuccal complex	14 (9.0)
Floor of mouth	9 (5.8)
Clinical T category	
cT3	29 (18.6)
cT4a	77 (49.4)
cT4b	50 (32.1)
Nutritional variables	
Weight, kg, median (IQR)	52.0 (46.9–57.0)
Weight <50 kg	59 (37.8)
Weight loss ≥5%	95 (60.9)
Albumin <3.5 g/dL	48 (30.8)

TABLE 1: Baseline characteristics (N = 156)

Values are n (%) unless otherwise specified.

ECOG - Eastern Cooperative Oncology Group; IQR - interquartile range

Treatment delivery and response

Three cycles were completed by 89 patients (57.1%), two by 53 (34.0%), and one by 14 (9.0%). Prophylactic G-CSF was recorded in 148 patients (94.9%). A dose reduction was recorded in 88 (56.4%): 15% in 39, 20% in 24, and 25% in 25 (Table *2*).

Measure	n/N	%	95% CI
Treatment delivery			
1 cycle completed	14/156	9	—
2 cycles completed	53/156	34	—
3 cycles completed	89/156	57.1	—
Prophylactic G-CSF recorded	148/156	94.9	—
Any dose reduction recorded	88/156	56.4	—
15% reduction	39/156	25	—
20% reduction	24/156	15.4	—
25% reduction	25/156	16	—
Tumor response (RECIST 1.1)			
Complete response	4/156	2.6	—
Partial response	45/156	28.8	—
Stable disease	62/156	39.7	—
Progressive disease	45/156	28.8	—
Objective response	49/156	31.4	24.6–39.1
Disease control	111/156	71.2	63.6-77.7
Objective response, ≥2 cycles	46/142	32.4	25.2-40.5

TABLE 2: Treatment delivery and tumor response (N = 156)

95% CIs are presented only for the prespecified response outcomes (objective response and disease control). Treatment-delivery variables and the individual RECIST categories describe the distribution of the cohort rather than estimate an outcome and are therefore reported without CIs. The dose-reduction field did not identify the drug or cycle. Percentages may not sum to 100 because of rounding.

CI - confidence interval (Wilson); G-CSF - granulocyte colony-stimulating factor; RECIST - Response Evaluation Criteria in Solid Tumors

Complete response was recorded in four patients (2.6%), partial response in 45 (28.8%), stable disease in 62 (39.7%), and progressive disease in 45 (28.8%). Objective response was 49/156 (31.4%; 95% CI 24.6-39.1) and disease control 111/156 (71.2%; 95% CI 63.6-77.7). Among the 142 patients who received at least two cycles, 46 (32.4%; 95% CI 25.2-40.5) had an objective response. Of the 14 patients who received one cycle, three had a partial response, six had stable disease, and five had progressive disease.

Operability and surgery

Post-induction operability was recorded in 67/156 patients (42.9%; 95% CI 35.4-50.8). Operability was 10/29 (34.5%) for cT3, 41/77 (53.2%) for cT4a, and 16/50 (32.0%) for cT4b tumors (Figure *2*, Table *3*). All 49 patients with a complete or partial response were recorded as operable, as were 11/62 (17.7%) with stable disease and 7/45 (15.6%) with progressive disease.

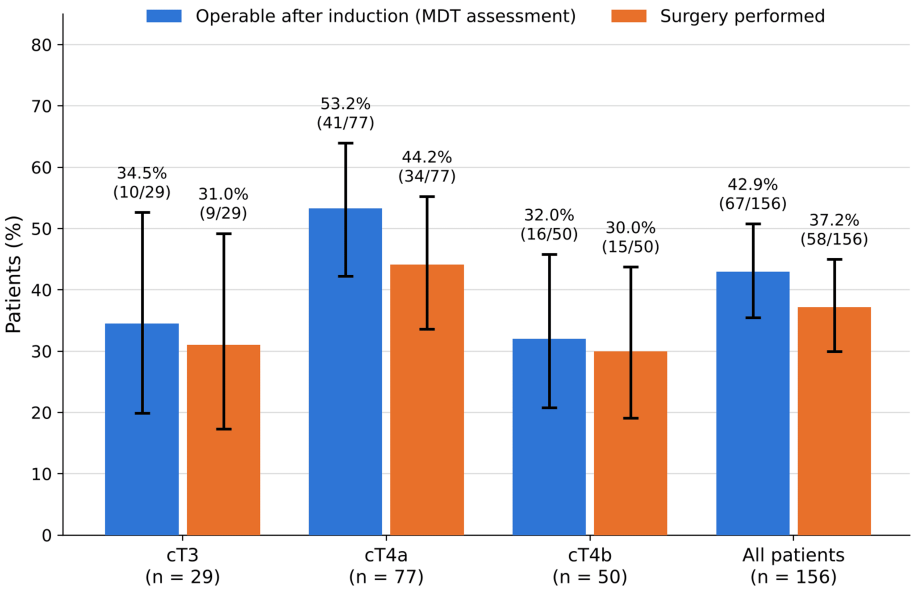


FIGURE 2: Post-induction operability and surgery by clinical T category

Bars show percentages; error bars show Wilson 95% confidence intervals; labels give n/N.

Measure	n/N	%	95% CI
Post-induction operability			
All patients	67/156	42.9	35.4–50.8
cT3	29-Oct	34.5	19.9–52.7
cT4a	41/77	53.2	42.2–64.0
cT4b	16/50	32	20.8–45.8
Complete or partial response	49/49	100	—
Stable disease	Nov-62	17.7	10.2–29.0
Progressive disease	Jul-45	15.6	7.7–28.8
Surgery performed			
All patients	58/156	37.2	30.0–45.0
Among operable patients	58/67	86.6	76.4–92.8
cT3	29-Sep	31	17.3–49.2
cT4a	34/77	44.2	33.6–55.3
cT4b	15/50	30	19.1–43.8
Complete response	4-Mar	75	—
Partial response	40/45	88.9	76.5–95.2
Stable disease	Sep-62	14.5	7.8–25.3
Progressive disease	Jun-45	13.3	6.3–26.2
Pathology among operated patients			
R0 resection	52/58	89.7	79.2–95.2
R1 resection	Jun-58	10.3	—
Pathological complete response	Apr-58	6.9	2.7–16.4
All-treated yields			
R0 resection	52/156	33.3	26.4–41.1
Pathological complete response	4/156	2.6	1.0–6.4

TABLE 3: Operability, surgery, and pathological outcomes

95% CIs are omitted where the proportion is the complement of a row already presented (R1 resection is the complement of R0 resection), where every patient in the category had the outcome (49/49 patients with complete or partial response judged operable), and where the denominator was too small for a meaningful interval (3/4 patients with complete response operated). Nine of 67 operable patients did not undergo surgery. All-treated yields do not assign pathological response to non-operated patients.

CI, confidence interval (Wilson); MDT, multidisciplinary team.

Surgery was performed in 58/156 patients (37.2%; 95% CI 30.0-45.0), representing 58/67 (86.6%) of those recorded as operable. By response category, surgery was performed in 3/4 patients with complete response, 40/45 with partial response, 9/62 with stable disease, and 6/45 with progressive disease (Figure 3). Of the 98 patients (62.8%) who did not undergo surgery, one (1.0%) had a complete response, five (5.1%) a partial response, 53 (54.1%) stable disease, and 39 (39.8%) progressive disease; seven (7.1%) required ICU admission. Details of their subsequent management were not captured.

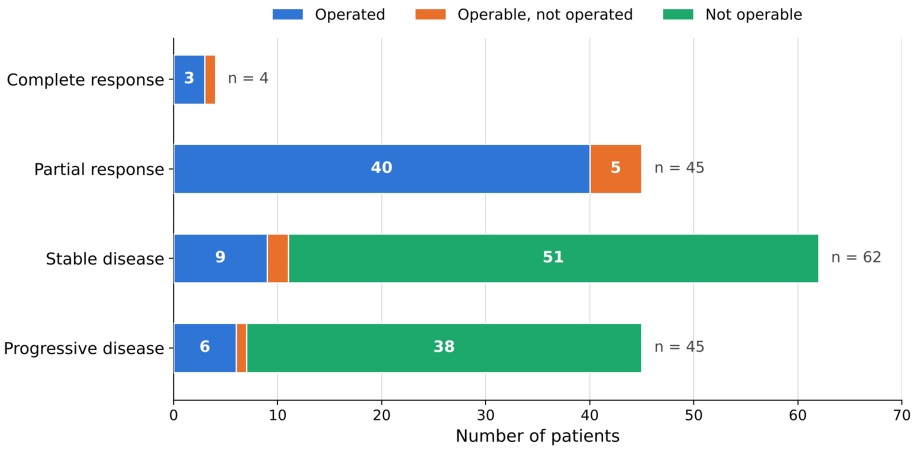


FIGURE 3: Operability and surgery by RECIST response category

Segments show the number of patients operated on, recorded as operable but not operated on, and not recorded as operable. Unlabelled segments contain one or two patients

RECIST - Response Evaluation Criteria in Solid Tumors

The nine operable patients who did not undergo surgery comprised one with complete response, five with partial response, two with stable disease, and one with progressive disease.

Pathological outcomes

Among the 58 operated patients, 52 (89.7%; 95% CI 79.2-95.2) had R0 and six (10.3%) had R1 resection, giving an all-treated R0 yield of 52/156 (33.3%; 95% CI 26.4-41.1). A pCR was recorded in 4/58 operated patients (6.9%; 95% CI 2.7-16.4), an all-treated yield of 4/156 (2.6%). Of the four patients with pCR, two had a recorded clinical complete response, one a partial response, and one progressive disease.

Adverse events and healthcare use

Acute toxicity during induction, ICU admission, and 30-day all-cause post-operative mortality are summarised in Table 4.

Outcome	n/N	%	95% CI
At least one grade ≥3 adverse event	124/156	79.5	72.5-85.1
Grade 3–4 oral mucositis	66/156	42.3	34.8-50.2
Febrile neutropenia	23/156	14.7	10.0-21.2
ICU admission	8/156	5.1	2.6-9.8
Death during induction chemotherapy	0/156	0	0.0-2.4
30-day postoperative death	Apr-58	6.9	2.7-16.4

TABLE 4: Adverse events, healthcare use, and mortality

The denominator is all 156 treated patients, except for 30-day postoperative death, where it is the 58 operated patients. Events are not mutually exclusive. Febrile neutropenia and grade 3-4 mucositis are components of the grade ≥3 composite. Causes of the four postoperative deaths were not available.

CI - confidence interval (Wilson); ICU - intensive care unit

Grade ⩾3 adverse events during induction were frequent, and grade 3-4 oral mucositis was the most common severe event captured; febrile neutropenia occurred despite prophylactic G-CSF in most patients. Of the eight patients who required ICU admission, seven were not operated on, and two had no grade ⩾3 adverse event documented during induction.

All four post-operative deaths occurred in patients who had completed three cycles of induction and undergone definitive resection. None had febrile neutropenia during induction, and none had an ICU admission documented.

Eight patients (5.1%; 95% CI 2.6-9.8) were admitted to the ICU; seven of these were not operated on, and two had no grade ⩾3 adverse event recorded.

Four patients (2.6%; 95% CI 1.0-6.4) had a recorded treatment-related death. All four had completed three cycles and undergone surgery, and none had febrile neutropenia or ICU admission recorded.

Discussion

In this cohort treated with docetaxel, cisplatin, and three-day flat-dose fluorouracil, 42.9% of patients were recorded as operable after induction, and 37.2% underwent surgery. Objective response was 31.4%. Among operated patients, 89.7% had R0 resection and 6.9% had pCR. Grade ⩾3 adverse events were recorded in 79.5% of patients.

Interpretation of the principal outcome depends on baseline resectability, which was not recorded. A patient who was resectable before induction and remained so afterward follows a different pathway from one whose tumor became resectable, and clinical T category alone cannot distinguish them. The observed pattern by T category illustrates this: operability was higher in cT4a (53.2%) than in cT3 tumours (34.5%), which is unlikely to reflect tumor extent alone and may instead reflect the reasons for which patients with cT3 disease were selected for induction. Similarly, the recording of 18 patients with stable or progressive disease as operable, 15 of whom underwent surgery, indicates that operability decisions were not determined by RECIST response alone; the operability criteria and the anatomical sites of progression are needed to interpret this.

The objective response rate of 31.4% is similar to the 32.5% reported in the Indian series of 3266 patients [4], but most patients in that series received two-drug regimens, and eligibility and response assessment differed. In the randomized trial comparing TPF with docetaxel-platinum, 43.8% of the pooled trial population was deemed resectable after two cycles and 34.5% underwent surgery [5]. These figures are numerically close to ours, but they pool both trial arms and a defined borderline resectable population, so they neither isolate the effect of TPF nor validate the present schedule.

The high R0 proportion among operated patients should be read alongside the all-treated R0 yield of 33.3%. Patients reaching surgery are selected by response, MDT assessment, fitness, and treatment completion, so operated-patient proportions describe a selected subgroup. Likewise, the pCR proportion does not describe pathological response in the 98 patients who were not operated. One of the four patients with pCR had been recorded as having progressive disease after induction. This discordance may reflect apparent radiological or clinical progression caused by tumor necrosis, edema, or local inflammation rather than viable tumor growth, or unverified coding in the retrospective record; it could not be resolved from the analytical dataset.

The three-day flat-dose schedule was adopted institutionally as a pragmatic adaptation to a patient population that differs substantially from those in which TPF was established, rather than as a formal dose-finding exercise. TAX 323 restricted enrolment to patients aged 18-70 years, and both TAX 323 and TAX 324 required a performance status of 0-1 and a creatinine clearance ⩾60 mL/min; TAX 324 additionally excluded patients with >20% weight loss in the preceding three months or those requiring parenteral nutrition, and neither trial permitted primary G-CSF prophylaxis [1,2]. Approximately half of the patients in those trials had a performance status of 0 (50.8% in TAX 323 and 56% in TAX 324), and oral cavity primaries constituted only 13-18% of each population [1,2]. Even the Indian series that used five-day fluorouracil enrolled a highly selected cohort with a median age of 43.5 years, ECOG performance status 0 in 82.8%, a median body-mass index of 23.2 kg/m², and a median albumin of 4.15 g/dL [7]. By contrast, 18.6% of our patients had an ECOG performance status of 2, 37.8% weighed <50 kg, 60.9% had lost ⩾5% of body weight, 30.8% had an albumin <3.5 g/dL, all had oral cavity primaries, and eligibility extended to 75 years of age and a creatinine clearance of 45 mL/min. For illustration, in an adult of 52 kg (the median weight in this cohort) and average height, with a body-surface area of approximately 1.5 m², the standard schedules deliver about 5600-6000 mg of fluorouracil per cycle, whereas the modified schedule delivers 3000 mg: roughly half the cumulative dose per cycle, at a daily dose (approximately 670 mg/m²) only modestly below that of TAX 323. The intention was to limit the mucosal and myelosuppressive toxicity of protracted fluorouracil infusion in undernourished patients whose oral intake was already compromised by the primary tumor, while retaining the docetaxel-cisplatin backbone and adding routine G-CSF prophylaxis. Whether this adaptation achieved its purpose cannot be determined from an uncontrolled cohort: the toxicity observed despite reduced fluorouracil exposure is as consistent with the frailty of the population as with any property of the schedule, and a direct comparison with standard TPF in the same population has not been performed. Docetaxel and cisplatin were retained at standard starting doses, and this may have contributed to the frequency of severe adverse events and dose reductions; reducing fluorouracil alone may be insufficient to improve tolerability in a frail population, and the contribution of each agent could not be assessed because the dose-reduction field did not identify the drug affected.

The toxicity profile does not support describing this schedule as well tolerated or safer than standard TPF. The 79.5% grade ⩾3 adverse-event proportion is not lower than the 72.5% reported in the TPF arm of the randomized trial [5], although grading, ascertainment, and monitoring differed. Febrile neutropenia occurred in 14.7% of patients despite recorded G-CSF use in 94.9%; primary G-CSF prophylaxis is recommended when the expected febrile neutropenia risk is approximately 20% or higher [15], but without cycle-level data on G-CSF timing and dose delivery, these figures cannot be compared with the 20.7% reported with five-day fluorouracil in Indian routine practice [7]. All four treatment-related deaths occurred after surgery; until their timing and attribution are established, they cannot be assigned to induction rather than to the perioperative period. Because the composite grade ⩾3 variable captured toxicities recorded during induction and was not derived from ICU admission or death, two of the eight ICU admissions and all four deaths fall outside it; the composite should therefore be read as a measure of recorded induction toxicity rather than of all CTCAE grade 4-5 events [13].

These findings should also be viewed alongside evidence from resectable disease. Besides the randomized oral cavity trial [3], a meta-analysis of randomized trials of neoadjuvant chemotherapy before surgery in head and neck squamous cell carcinoma found no overall survival or disease-free survival benefit overall, although the subgroup receiving cisplatin and fluorouracil with or without docetaxel showed a disease-free survival benefit [16]. Another meta-analysis rated the certainty of evidence for surgical and pathological outcomes as very low for chemotherapy, in trials using cisplatin and fluorouracil, and low for immunotherapy [17]. This evidence supports keeping resectable and borderline resectable populations distinct and does not establish efficacy for a shortened fluorouracil schedule.

Strengths and limitations

The strengths of this study are the inclusion of consecutive patients, the use of all treated patients as the denominator for the principal outcomes, and a transparent descriptive analysis with confidence intervals.

The study also has important limitations. It is a single-institution, uncontrolled, retrospective cohort and is therefore subject to selection and ascertainment bias. The number of patients screened or excluded before inclusion was not recorded, so the participant flow begins with the 156 treated patients (Figure *1*). Baseline resectability was not recorded, and operability after induction was a multidisciplinary team judgment made without predefined criteria; post-induction operability therefore cannot be interpreted as conversion to resectability, and patient selection cannot be replicated exactly by other centers. The dataset also did not include clinical N category, comorbidities, organ-function measurements, body-surface area, treatment dates, or drug-specific delivered doses. The dose-reduction field did not identify the drug or cycle affected, so the contribution of each agent to toxicity could not be assessed.

The imaging modality and timing of response assessment were not recorded, and the definitions of margin status and pathological complete response and the attribution of adverse events could not be verified. Safety data comprised selected indicators rather than a complete event-level record, and the absence of a recorded event does not exclude incomplete documentation. The causes of the four postoperative deaths were not available. The subsequent management and outcomes of non-operated patients were not captured, and survival could not be analyzed. The schedule was adopted on pragmatic grounds rather than derived from a dose-finding study, and the relation of baseline nutritional variables to toxicity was not analyzed. The findings may not apply to populations with different baseline resectability or supportive care.

Future studies should record baseline resectability, use prespecified operability and response criteria, collect cycle-level toxicity and dose data, document causes of death, and report survival.

Conclusions

After induction docetaxel, cisplatin, and three-day flat-dose fluorouracil, fewer than half of the patients with cT3-cT4b oral cavity cancer were recorded as operable, and severe adverse events were frequent. Without baseline resectability, these findings describe the treatment pathway rather than conversion to resectability, and they do not establish comparative efficacy or improved tolerability. Baseline surgical assessment, adjudicated outcomes, and survival data are needed before this schedule can be evaluated.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Rajan Yadav, Arya Pradhan, Devarshi Panchal, Harsha P. Panchal, Apurva Patel, Sonia K. Parikh, Kajal Shah

Acquisition, analysis, or interpretation of data: Rajan Yadav, Arya Pradhan, Devarshi Panchal, Harsha P. Panchal, Apurva Patel, Sonia K. Parikh, Kajal Shah

Drafting of the manuscript: Rajan Yadav, Arya Pradhan, Devarshi Panchal, Harsha P. Panchal, Apurva Patel, Sonia K. Parikh, Kajal Shah

Critical review of the manuscript for important intellectual content: Rajan Yadav, Arya Pradhan, Devarshi Panchal, Harsha P. Panchal, Apurva Patel, Sonia K. Parikh, Kajal Shah

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Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. Institutional Review Committee of the Gujarat Cancer and Research Institute issued approval IRC/2026/P-83. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **AI use statement:** The authors have declared that no AI tools were used during the work or in the drafting of this article. The authors take full responsibility for the work. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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