<table>
<thead>
<tr>
<th>CLINICAL EVALUATION</th>
<th>PRIMARY TREATMENT</th>
<th>ADJUVANT TREATMENT</th>
<th>SURVEILLANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe dysplasia/ carcinoma in situ</td>
<td>Endoscopic removal (stripping/laser)</td>
<td>● Radiation to primary tumor or ● Endoscopic partial laryngectomy or ● Open partial laryngectomy</td>
<td>● Radiation therapy or ● Neck dissection(s)</td>
</tr>
<tr>
<td>Primary tumor most T1-2, any N</td>
<td></td>
<td>Is nodal status positive?</td>
<td>Yes</td>
</tr>
<tr>
<td>Glottic</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Primary tumor most T3, N0-N1</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Concurrent chemoradiation</td>
<td>Complete response at primary site?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residual nodal disease?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
| | | Total laryngectomy1,2 and neck dissection(s), as clinically indicated | |}

3 Pathological risk features include:
- Primary pathology:
  - Any T1 or T2 with perineural invasion or lymphovascular invasion
  - Any T3 or T4
- Regional pathology:
  - Multiple lymph nodes (any N2, N3)

4 Pathological risk factors for addition of chemotherapy include:
- Positive margins (re-excision to clear margins is preferred)
- Extracapsular extension

1 Primary tumors requiring total laryngectomy not amenable to partial surgery
2 Total laryngectomy to be considered for patients with significant pretreatment laryngopharyngeal dysfunction or are medically unable to tolerate organ preservation therapy

Note: Consider Clinical Trials as treatment options for eligible patients.
Larynx Cancer

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**Note:** Consider Clinical Trials as treatment options for eligible patients.

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<th>ADJUVANT TREATMENT</th>
<th>SURVEILLANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary tumor most T1-2, N0</td>
<td>Surgery: • Endoscopic resection with neck dissection(s) or • Open partial laryngeal surgery with neck dissection(s)</td>
<td>Pathologic N1?</td>
<td>Pathologic N1?</td>
</tr>
<tr>
<td></td>
<td>Definitive radiation</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Partial laryngectomy &amp; neck dissection(s) as indicated, and ipsilateral thyroidectomy</td>
<td>Yes</td>
<td>Consider radiation therapy</td>
</tr>
<tr>
<td></td>
<td>Concurrent chemoradiation</td>
<td>Yes</td>
<td>Radiation or chemoradiation</td>
</tr>
<tr>
<td></td>
<td>Complete response at primary site?</td>
<td>No</td>
<td>Pathologic N1?</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Radiation therapy</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Observe</td>
</tr>
<tr>
<td>Primary tumor T4, N0</td>
<td>Surgery: • Total laryngectomy and neck dissection(s), as indicated, and ipsilateral thyroidectomy • Consider primary TEP</td>
<td>Pathologic N1?</td>
<td>Residual nodal disease?</td>
</tr>
<tr>
<td></td>
<td>Definitive radiation</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Concurrent chemoradiation</td>
<td>Yes</td>
<td>Neck dissection(s)</td>
</tr>
<tr>
<td></td>
<td>Complete response at primary site?</td>
<td>No</td>
<td>Observe</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Radiation therapy</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>Consider chemotherapy</td>
</tr>
<tr>
<td></td>
<td>Laryngectomy and neck dissection(s), as clinically indicated</td>
<td>Yes</td>
<td>Surveillance (see Page 6)</td>
</tr>
<tr>
<td>Supraglottic node negative</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Low-volume base-of-tongue involvement
2. Primary tumors requiring total laryngectomy not amenable to partial surgery
3. Total laryngectomy to be considered for patients with significant pretreatment laryngopharyngeal dysfunction or are medically unable to tolerate organ preservation therapy

Pathological risk features include:
- Primary pathology
  - Any T1 or T2, with perineural invasion
  - Any T3 or T4
  - Regional pathology
  - Multiple lymph nodes (any N2, N3)

Pathological risk factors for addition of chemotherapy include:
- Positive margins (re-excision to clear margins is preferred)
- Extracapsular extension

Department of Clinical Effectiveness V6
Approved by the Executive Committee of the Medical Staff on 07/25/2017
**Larynx Cancer**

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Note: Consider Clinical Trials as treatment options for eligible patients.

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**CLINICAL EVALUATION**

- **Primary tumor**
  - T1-2, N+ and
  - Selected T3 (not requiring total laryngectomy)

- **Supraglottic node positive**
  - T4, N+

**TREATMENT**

- **Concurrent chemoradiation**
  - Complete response at primary site?
    - Yes
      - Complete response of nodal disease?
        - Yes
          - N1 (initial stage)
            - Observe
        - No
          - N2-3
            - Neck dissection
    - No
      - Salvage surgery as clinically indicated

- **Total laryngectomy and neck dissection(s) as indicated, and ipsilateral thyroidectomy**
  - Consider primary TEP

**SURVEILLANCE**

- **Radiation therapy**
  - Consider chemoradiation

- **Neck dissection**

---

3 Pathological risk features include:

- Primary pathology
  - Any T1 or T2 with perineural invasion or lymphovascular invasion
- Any T3 or T4 Regional pathology
- Multiple lymph nodes (any N2, N3)

4 Pathological risk factors for addition of chemotherapy include:

- Positive margins (re-section to clear margins is preferred)
- Extracapsular extension

---

1 Low-volume base-of-tongue involvement

2 Total laryngectomy to be considered for patients with significant pretreatment laryngopharyngeal dysfunction or are medically unable to tolerate organ preservation therapy

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Clinical Presentation

Recurrence of disease

- Restage
  - CT head and neck
  - CT chest or PET to evaluate for distant metastatic disease

Presence of distant metastatic disease?

- Yes
  - Consider systemic therapy/phase I clinical trial
  - Palliative care as clinically indicated

- No
  - Primary treatment chemoradiation?

Is recurrence resectable?

- Yes
  - Consider salvage surgery, as clinically indicated

- No
  - Is recurrence resectable?

- Yes
  - Consider systemic therapy
  - Clinical trial
  - Palliative care, as clinically indicated

- No
  - Consider chemotherapy and radiation therapy

Notes:
- Consider Clinical Trials as treatment options for eligible patients.

\[^1\] Pathological risk factors should be taken into consideration when making concurrent treatment decisions.
LARYNX CANCER SURVEILLANCE

<table>
<thead>
<tr>
<th>Total years for surveillance</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of surveillance</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>by month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head and neck history and</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>physical exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline CT</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Chest x-ray (CT chest, if</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>smoker)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid function</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Larynx Cancer

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SUGGESTED READINGS


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