INITIAL EVALUATION

- Confirm outside pathology
- History
  - Chief complaint
  - History of present illness and previous treatment
- Past medical history including but not limited to:
  - Social history (including tobacco and alcohol use)
- Physical examination
  - Full head and neck exam
  - General medical examination
- Stage T and N (AJCC)
- Imaging studies
  - CT neck with contrast or MRI with contrast
  - CT chest, as clinically indicated (if smoking history of > 30 pack-year, consider CT chest)
  - Consider PET/CT scan for stage III or IV
- Lifestyle risk assessment

CONSULTATIONS

- Dental Oncology
- Radiation Oncology
- Thoracic/Head and Neck Medical Oncology (THNMO) for patients with stage III or IV
- Speech Pathology for patients whose treatment may impact swallowing and/or speech
- Plastic Surgery for patients who will require major reconstruction (pharyngeal or bony reconstruction)
- Nutritional assessment
- Smoking cessation for active smokers only
- Perioperative Evaluation and Management (POEM)
- Audiogram, if receiving chemotherapy

PRE-TREATMENT EVALUATION

Primary tumor
- T1-T2, N0
- T1-2, N1-3
- T3-4a, N0-3
- T4b, any N

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

1 CT is tailored to oncologic imaging: high-resolution, bone and soft tissue window, 90-100s contrast delay for optimal opacification of mucosa and soft tissues
2 See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
3 Consider dental extraction based on results of dental evaluation prior to initiation of primary treatment
EVALUATION

Primary tumor T1-T2, N0
- Excision of primary tumor or sentinel node biopsy with selective neck dissection if clinically indicated

Primary tumor T1-2, N1-3
- Excision of primary tumor with neck dissection

Primary tumor T3-4a, N0-3
- Excision of primary tumor with neck dissection

Primary tumor T4b, any N
- Primary tumor resectable?

ADJUVANT TREATMENT

Presence of pathological risk features?
- Yes
  - Radiation therapy
  - Consider chemoradiation
- No

Initial stage > N1?
- Yes
  - Node positive?
    - Yes
      - Consider radiation
    - No
- No

SURVEILLANCE

Complete response at primary site?
- Yes
  - Neck dissection
- No

Residual nodal disease?
- Yes
  - Neck dissection
- No

Stage N3?
- Yes
  - Neck dissection
- No
  - Observe

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

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

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Department of Clinical Effectiveness V8
Approved by the Executive Committee of the Medical Staff on 09/21/2021
CLINICAL PRESENTATION

Recurrent disease or persistent disease

Restage
- CT head and neck with contrast
- CT chest with or without PET-CT to evaluate for metastatic disease

Presence of distant metastatic disease?

Yes

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

No

Is recurrence resectable?

Yes

Previous radiation therapy?

Yes

- Consider salvage surgery, as clinically indicated
- Palliative care, as clinically indicated

No

- Salvage surgery, as clinically indicated
- Consider post-operative radiation therapy, as clinically indicated

No

Previous radiation therapy?

Yes

- Consider re-irradiation, if clinically indicated
- Palliative care

No

Consider chemotherapy and radiation therapy

No

Surveillance (see Page 4)

1 CT is tailored to oncologic imaging: high-resolution, bone and soft tissue window, 90-100s contrast delay for optimal opacification of mucosa and soft tissues

2 Pathological risk factors should be taken into consideration when making concurrent treatment decisions
Oral Cavity Cancer Surveillance

<table>
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<th>Total years for surveillance</th>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<td>Frequency of surveillance by month</td>
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<td>Consider surveillance CT neck with contrast, if clinically indicated</td>
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<td>Thyroid function, if radiation therapy</td>
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<tr>
<td>Chest x-ray yearly (CT chest if smoker)</td>
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<td>x</td>
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SUGGESTED READINGS


This practice algorithm is based on majority expert opinion of the Head and Neck Center Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

- Gregory Chronowski, MD (Radiation Oncology)
- Ed Diaz, Jr., MD (Head and Neck Surgery)
- Renata Ferrarotto, MD (Thoracic/Head and Neck Medical Oncology)
- Steven J. Frank, MD (Radiation Oncology)
- Clifton Fuller, MD, PhD (Radiation Oncology)
- Wendy Garcia, BS*
- Adam S. Garden, MD (Radiation Oncology)
- Paul W. Gidley, MD (Head and Neck Surgery)
- Ann M. Gillenwater, MD (Head and Neck Surgery)
- Maura Gillison, MD, PhD (Thoracic/Head and Neck Medical Oncology)
- Lawrence E. Ginsberg, MD (Neuroradiology)
- Bonnie S. Glisson, MD (Thoracic/Head and Neck Medical Oncology)
- Ryan P. Goepfert, MD (Head and Neck Surgery)
- Neil Gross, MD (Head and Neck Surgery)
- Brandon Gunn, MD (Radiation Oncology)
- Ehab Y. Hanna, MD (Head and Neck Surgery)
- Amy C. Hessel, MD (Head and Neck Surgery)
- Jason Michael Johnson, MD (Neuroradiology)
- Stephen Y. Lai, MD, PhD (Head and Neck Surgery)

- Carol M. Lewis, MD (Head and Neck Surgery)†
- Charles Lu, MD (Thoracic/Head and Neck Medical Oncology)
- Amy Moreno, MD (Radiation Oncology)
- William H. Morrison, MD (Radiation Oncology)
- Frank E. Mott, MD (Thoracic/Head and Neck Medical Oncology)
- Jeffrey N. Myers, MD, PhD (Head and Neck Surgery)
- Marc-Elie Nader, MD (Head and Neck Surgery)
- Jack Phan, MD, PhD (Radiation Oncology)
- Kristen B. Pytynia, MD (Head and Neck Surgery)
- David Rosenthal, MD (Radiation Oncology)
- Komal Shah, MD (Neuroradiology)
- Shalin J. Shah, MD (Radiation Oncology)
- Michael Spiotto, MD, PhD (Radiation Oncology)
- Shirley Y. Su, MBBS (Head and Neck Surgery)
- Molly K. Tate, MSN, APRN (Radiation Oncology)
- Rui Jennifer Wang, MD (Head and Neck Surgery)
- Mary Lou Warren, DNP, APRN, CNS-CC*
- Mark Zafereo, MD (Head and Neck Surgery)†

* Clinical Effectiveness Development Team
† Core Development Team

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