

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.

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

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 head and neck with contrast¹ or MRI neck 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 assessment²

CONSULTATIONS

- Dental Oncology³
- Radiation Oncology
- Thoracic/Head and Neck Medical Oncology (THNMO)
- 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

Patient information presented at multidisciplinary planning conference

PRE-TREATMENT EVALUATION

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

See Page 2

AJCC = The American Joint Committee on Cancer

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 Treatment](#) 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

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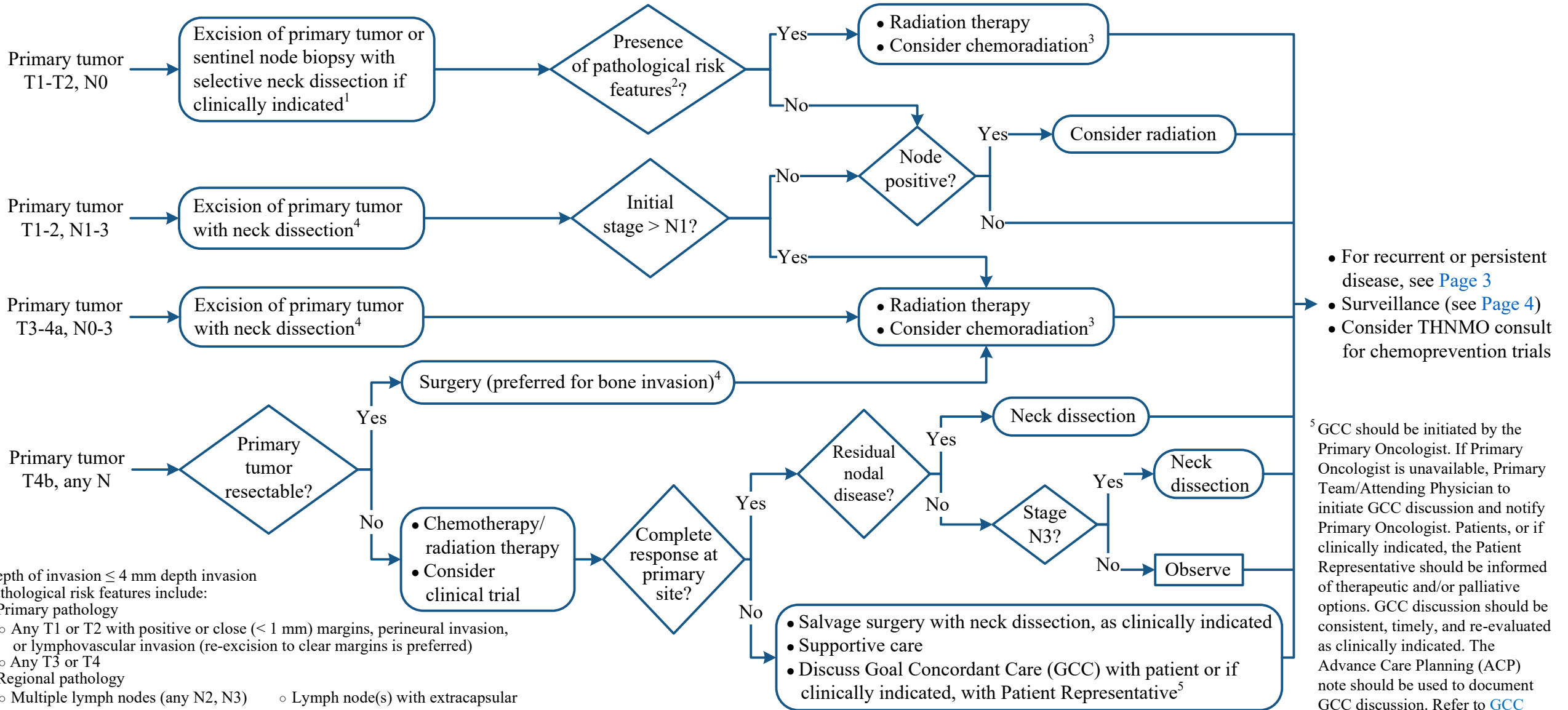
Note: Consider Clinical Trials as treatment options for eligible patients.

EVALUATION

PRIMARY TREATMENT

ADJUVANT TREATMENT

SURVEILLANCE



- For recurrent or persistent disease, see [Page 3](#)
- Surveillance (see [Page 4](#))
- Consider THNMO consult for chemoprevention trials

⁵ GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to [GCC home page](#) (for internal use only).

¹ Depth of invasion ≤ 4 mm depth invasion

² Pathological risk features include:

- Primary pathology
 - Any T1 or T2 with positive or close (< 1 mm) margins, perineural invasion, or lymphovascular invasion (re-excision to clear margins is preferred)
 - Any T3 or T4
- Regional pathology
 - Multiple lymph nodes (any N2, N3)
 - Lymph node(s) with extracapsular
 - Lymph node(s) in level IV or V extension

³ Pathological risk factors for addition of chemotherapy include positive margins (re-excision to clear margins is preferred) or extracapsular extension

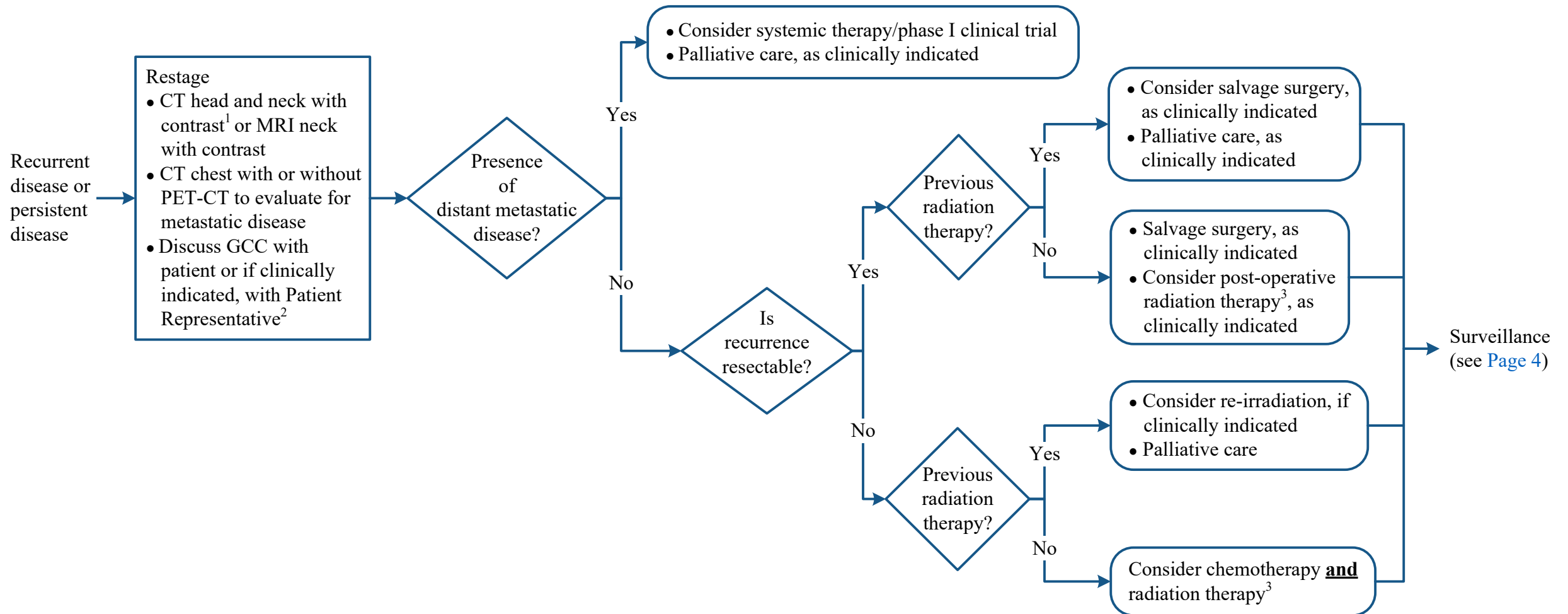
⁴ Bilateral neck dissection for N2c neck disease. Consider bilateral neck dissection for midline lesion.

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CLINICAL PRESENTATION

RECURRENT TREATMENT



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

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³ Pathological risk factors should be taken into consideration when making concurrent treatment decisions

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Oral Cavity Cancer Surveillance

| Total years for surveillance | | | | Year 1 | | | Year 2 | | Year 3 |
|--|-------------------------|---|---|--------|----|----|--------|----|--|
| Frequency of surveillance by month | 2-3 | 6 | 9 | 12 | 16 | 20 | 24 | 30 | Refer to Survivorship - Oral Cavity Cancer algorithm |
| Head and neck history and physical exam | x | x | x | x | x | x | x | x | |
| Baseline post-treatment CT or MRI neck with contrast | x | | | | | | | | |
| Consider surveillance CT or MRI neck with contrast, if clinically indicated | | x | x | x | x | x | x | x | |
| Thyroid function, if radiation therapy | x | | | x | | x | | x | |
| Chest x-ray yearly (CT chest if smoker) | | | | x | | | x | x | |
| Supportive care: <ul style="list-style-type: none"> • Speech and hearing evaluation • Swallow evaluation • Nutrition assessment • Depression screening • Smoking cessation • Alcohol counseling • Lymphedema evaluation • Dental evaluation | As clinically indicated | | | | | | | | |

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

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