Survivorship - Unknown Primary (Head and Neck)

History and physical exam within 1 year of transition to HNSVC, then:
- Physical exam annually
- Chest x-ray annually
- Flexible fiberoptic laryngoscopy annually
- CT head and neck with contrast annually if less than 4 years from completion of treatment (or MRI if previous imaging was MRI)

Consider:
- Annual audiogram
- Xerostomia assessment
- Dental/osteoradionecrosis assessment
- T4 and TSH annually if treated with radiation therapy
- Dysphagia assessment
- Speech assessment
- Lymphedema assessment

Patient education, counseling and screening:
- Lifestyle risk assessment
- Cancer screening
- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis Screening and Management – HBV and HCV algorithm)
- Consider cardiovascular risk reduction
- Limit alcohol consumption

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Anxiety/depression
- Body image
- Financial stressors
- Social support

Cancer of unknown primary treated with radiation with or without chemotherapy and/or surgery and 2 years post-treatment and NED

SURVEILLANCE

MONITORING FOR LATE EFFECTS

RISK REDUCTION/EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

DISPOSITION

New primary or recurrent cancer?
Yes
Return to primary treating physician
No
Continue survivorship monitoring

Refer or consult as indicated

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

NED = no evidence of disease
HNSVC = Head and Neck Survivorship clinic
1See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
2Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate and skin cancer screening
3Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health

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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Approved by the Executive Committee of the Medical Staff on 12/18/2018
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SUGGESTED READINGS


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DEVELOPMENT CREDITS

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