**Survivorship - Unknown Primary (Head and Neck)**

**ELIGIBILITY**
- Cancer of unknown primary treated with radiation with or without chemotherapy and/or surgery
- A minimum of 30 months post-treatment
- NED

**CONCURRENT COMPONENTS OF VISIT**
- History and physical exam within 1 year of transition to HNSVC, then:
  - History and physical exam annually
  - Chest x-ray annually
  - Flexible fiberoptic laryngoscopy annually
  - CT (or MRI, per baseline imaging study) head and neck with contrast annually if < 4 years from completion of treatment

**SURVEILLANCE**
- Consider:
  - Annual audiogram
  - Xerostomia assessment
  - Dental/osteoradionecrosis assessment
  - Neurocognitive dysfunction assessment
  - Annual TSH (thyroid-stimulating hormone) and free T4 if treated with radiation therapy

**MONITORING FOR LATE EFFECTS**
- Dysphagia assessment
- Speech pathology assessment
- Lymphedema assessment
- Sexual health/fertility assessment
- Peripheral neuropathy assessment
- Carotid duplex study if not done within the 5 years post-radiation completion

**RISK REDUCTION/EARLY DETECTION**
- Patient education, counseling and screening:
  - Lifestyle risk assessment
  - Cancer screening
  - Vaccinations as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
  - Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
  - Consider cardiovascular risk reduction
  - Limit alcohol consumption

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

**DISPOSITION**
- Return to primary treating physician
- Primary Oncologist to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative

1 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).

2 See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

3 Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate, and skin cancer screening

4 Based on Centers for Disease Control and Prevention (CDC) guidelines

5 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health

NED = no evidence of disease
HNSVC = Head and Neck Survivorship clinic

**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.

Approved by the Executive Committee of the Medical Staff on 02/20/2024
SUGGESTED READINGS


Disclaimers: 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.

DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Head and Neck Survivorship workgroup 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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