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 contrast\(^1\) 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 assessment\(^2\)

CONSULTATIONS

- Dental Oncology\(^3\)
- 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

PRE-TREATMENT EVALUATION

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

Patient information presented at multidisciplinary planning conference

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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 tumor
T1-T2, N0

Excision of primary tumor or sentinel node biopsy with selective neck dissection if clinically indicated

Presence of pathological risk features?

Yes

No

No

Yes

Node positive?

Yes

Consider radiation

No

Yes

Initial stage > N1?

No

Radiation therapy

Consider chemoradiation

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?

No

Yes

Surgery (preferred for bone invasion)

Yes

No

ADJUVANT TREATMENT

Yes

Yes

No

No

Residual nodal disease?

Yes

Salvage surgery with neck dissection, as clinically indicated

Supportive care

Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative

Yes

No

Stage N3?

Yes

Neck dissection

No

Observation

SURVEILLANCE

Yes

No

Yes

Consider THNMO consult for chemoprevention trials

Yes

No

Yes

No

For recurrent or persistent disease, see Page 3

Surveillance (see Page 4)

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

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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Department of Clinical Effectiveness V9
Approved by the Executive Committee of the Medical Staff on 09/19/2023
**CLINICAL PRESENTATION**

- **Recurrence or persistent disease**
  - Restage
    - CT head and neck with contrast or MRI neck with contrast
    - CT chest with or without PET-CT to evaluate for metastatic disease
    - Discuss GCC with patient or if clinically indicated, with Patient Representative

- **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
        - Yes
          - Previous radiation therapy?
            - Yes
              - Consider re-irradiation, if clinically indicated
              - Palliative care
            - No
              - Consider chemotherapy and radiation therapy
        - No
          - Consider chemotherapy and radiation therapy

- **Surveillance** (see Page 4)

**RECURRENT TREATMENT**

- Yes
  - Consider systemic therapy/phase I clinical trial
  - Palliative care, as clinically indicated
- No
  - Consider salvage surgery, as clinically indicated
  - Palliative care, as clinically indicated
  - Salvage surgery, as clinically indicated
  - Consider post-operative radiation therapy, as clinically indicated
  - Consider re-irradiation, if clinically indicated
  - Palliative care
  - Consider chemotherapy and radiation therapy

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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. 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 ACP note should be used to document GCC discussion. Refer to GCC home page (for internal use only).
3. Pathological risk factors should be taken into consideration when making concurrent treatment decisions

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## Oral Cavity Cancer Surveillance

<table>
<thead>
<tr>
<th>Total years for surveillance</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of surveillance by month</td>
<td>2-3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Head and neck history and physical exam</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Baseline post-treatment CT or MRI neck with contrast</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider surveillance CT or MRI neck with contrast, if clinically indicated</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Thyroid function, if radiation therapy</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Chest x-ray yearly (CT chest if smoker)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Supportive care:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Speech and hearing evaluation
- Swallow evaluation
- Nutrition assessment
- Depression screening
- Smoking cessation
- Alcohol counseling
- Lymphedema evaluation
- Dental evaluation

As clinically indicated

Refer to Survivorship - Oral Cavity Cancer algorithm
SUGGESTED READINGS


MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)


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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