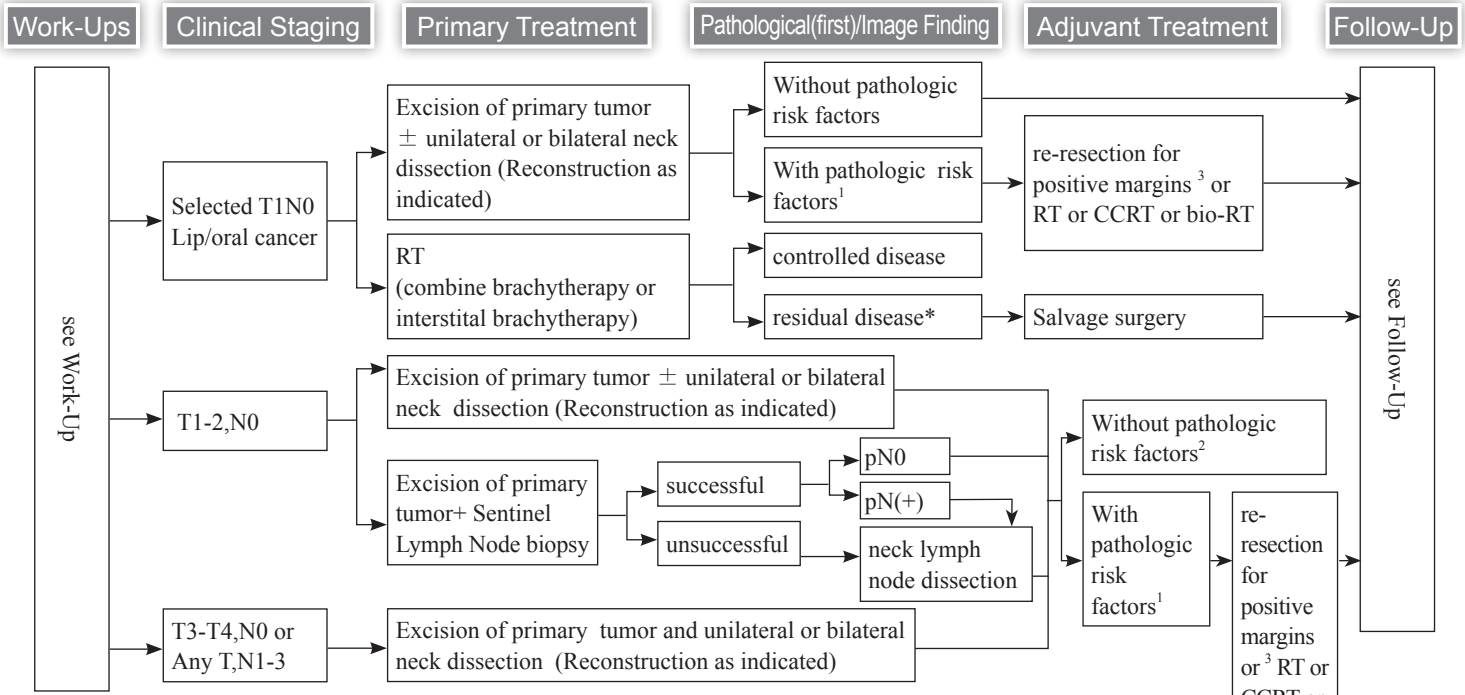
Head and Neck Cancers

《 Cancer of the oral cavity-1 》



*1 Pathologic risk factors: surgical margin with residual tumor,ECS(+),N2 or N3 node disease,pT3 or pT4 primary, node disease in Level IV or V、PNI(note)、LVI、Type V-WPOI

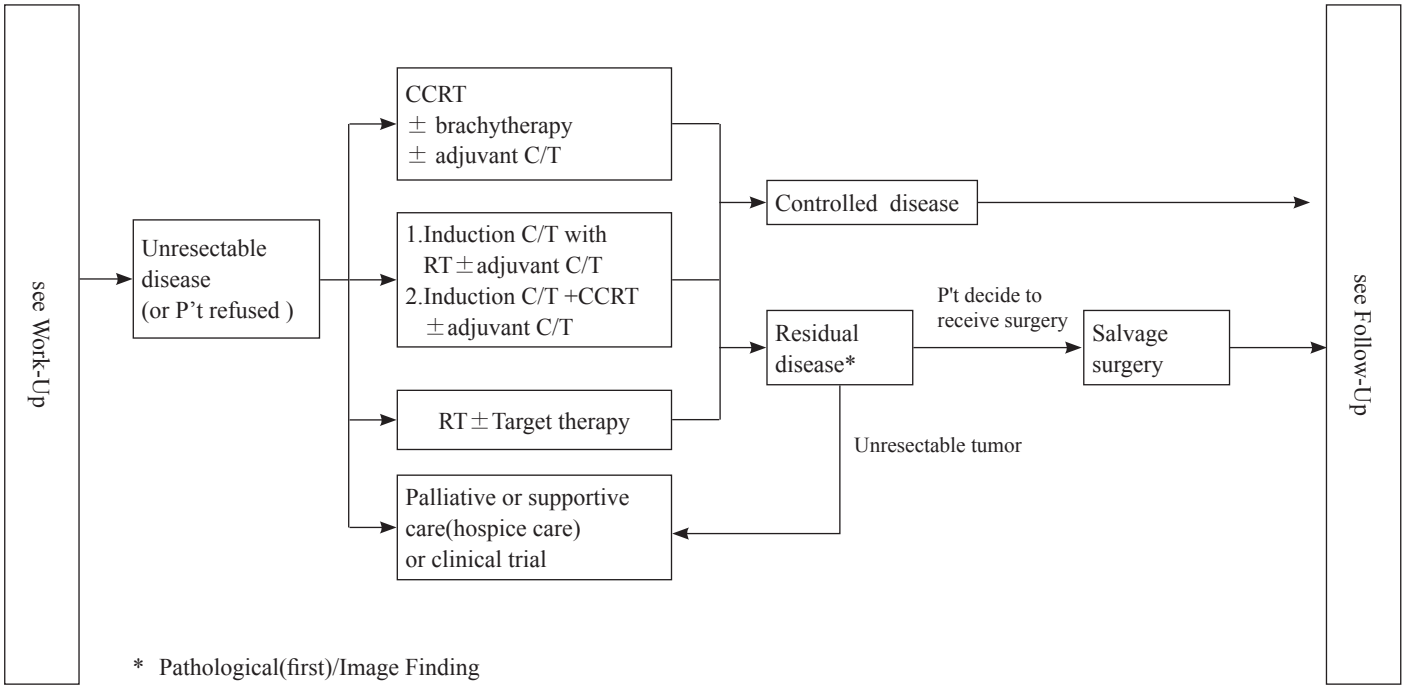
*2 no pathologic risk factor:T1-T2,N1 → OBS or RT note:PNI alone in early stage(stage I、II) selective treatment

*3 consider re-resection to achieve negative margins for positive resection margins if feasible

* Pathological(first)/Image Finding

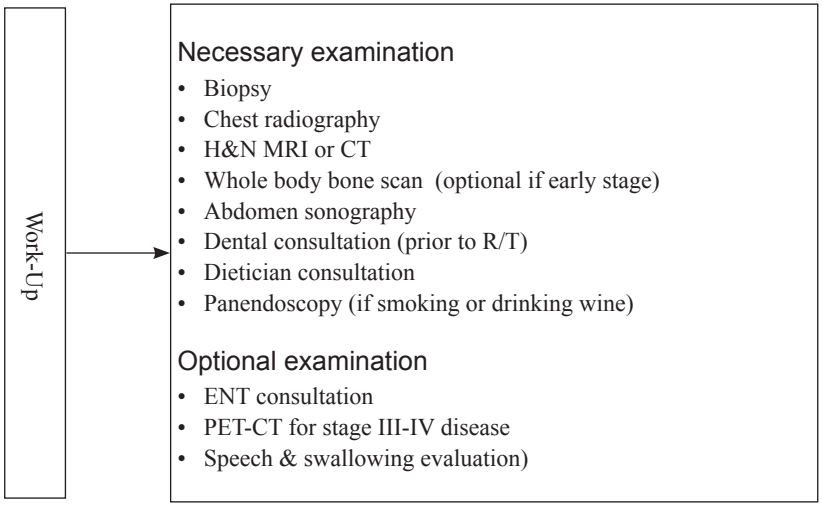
《 Cancer of the oral cavity-2 》

Work-Ups | Clinical Staging | Primary Treatment | Pathological(first)/Image Finding | Adjuvant Treatment | Follow-Up

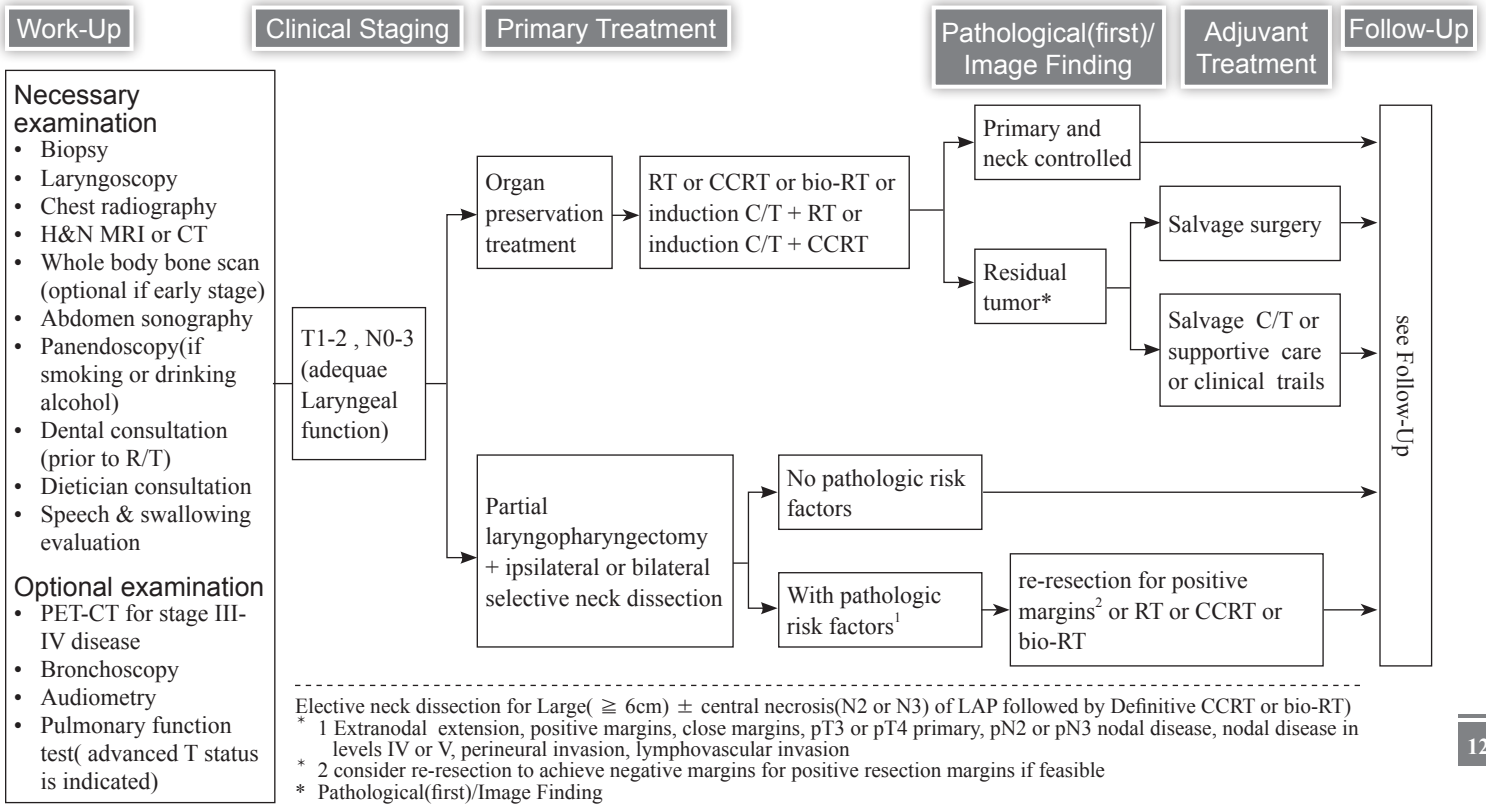


* Pathological(first)/Image Finding

《 Oral cavity 》


Work-Up
Necessary examination
• Biopsy
• Chest radiography
• H&N MRI or CT
• Whole body bone scan (optional if early stage)
• Abdomen sonography
• Dental consultation (prior to R/T)
• Dietician consultation
• Panendoscopy (if smoking or drinking wine)
Optional examination
• ENT consultation
• PET-CT for stage III-IV disease
• Speech & swallowing evaluation)

《 Cancer of the Hypopharynx -1 》



Elective neck dissection for Large(≧ 6cm) ± central necrosis(N2 or N3) of LAP followed by Definitive CCRT or bio-RT)

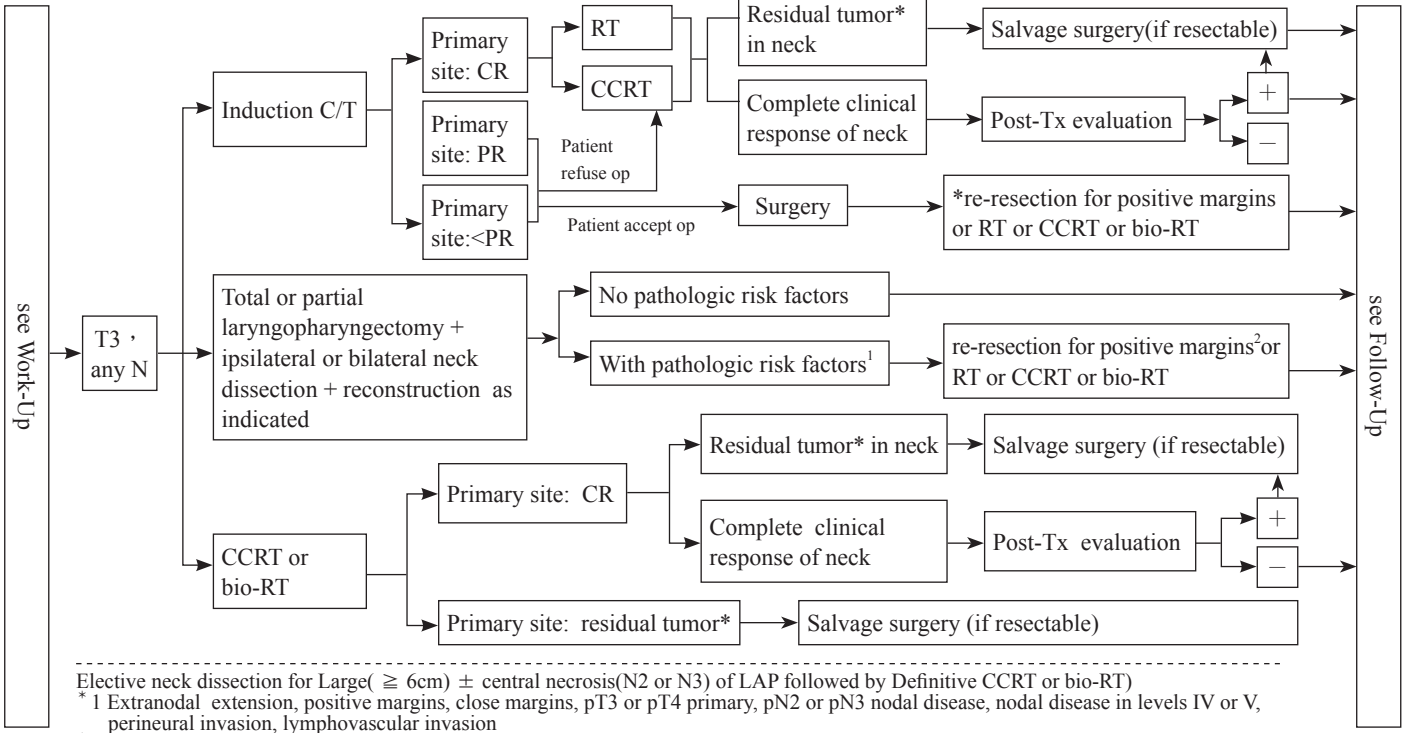
* 1 Extranodal extension, positive margins, close margins, pT3 or pT4 primary, pN2 or pN3 nodal disease, nodal disease in levels IV or V, perineural invasion, lymphovascular invasion

* 2 consider re-resection to achieve negative margins for positive resection margins if feasible

* Pathological(first)/Image Finding

《 Cancer of the Hypopharynx -2 》

Work-ups | Clinical staging | Primary treatment | Pathological(first)/Image Finding | Adjuvant treatment | Follow-Up



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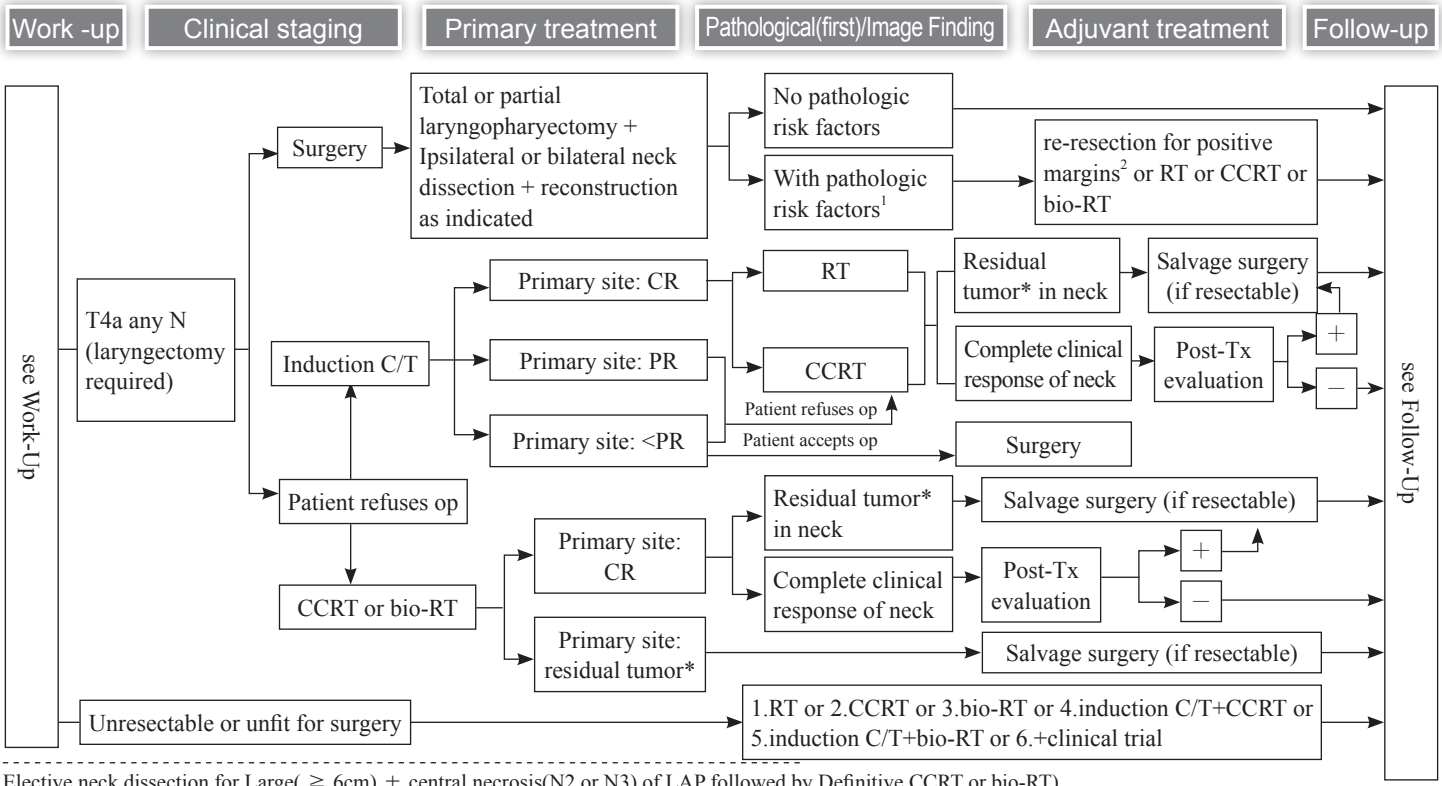
《 Cancer of the Hypopharynx -3 》



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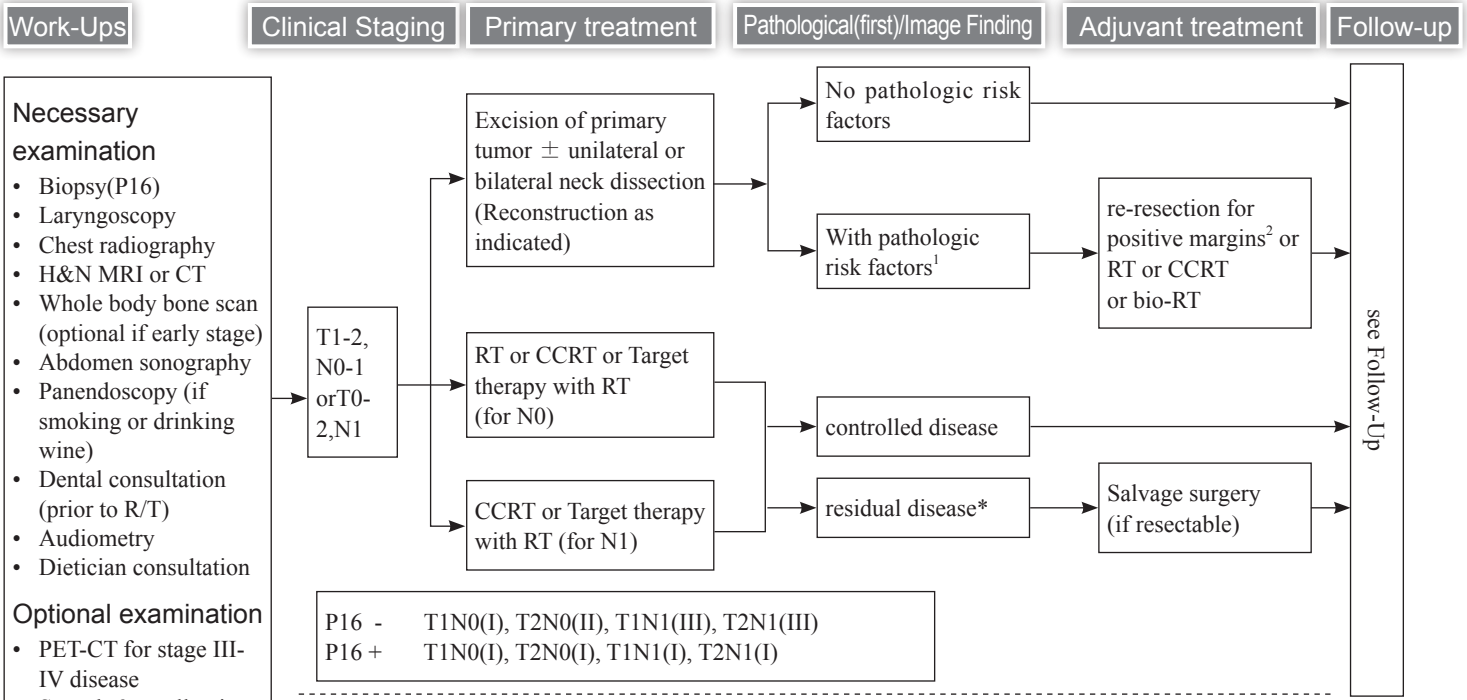
* Pathological(first)/Image Finding

《 Cancer of the Oropharynx -1 》



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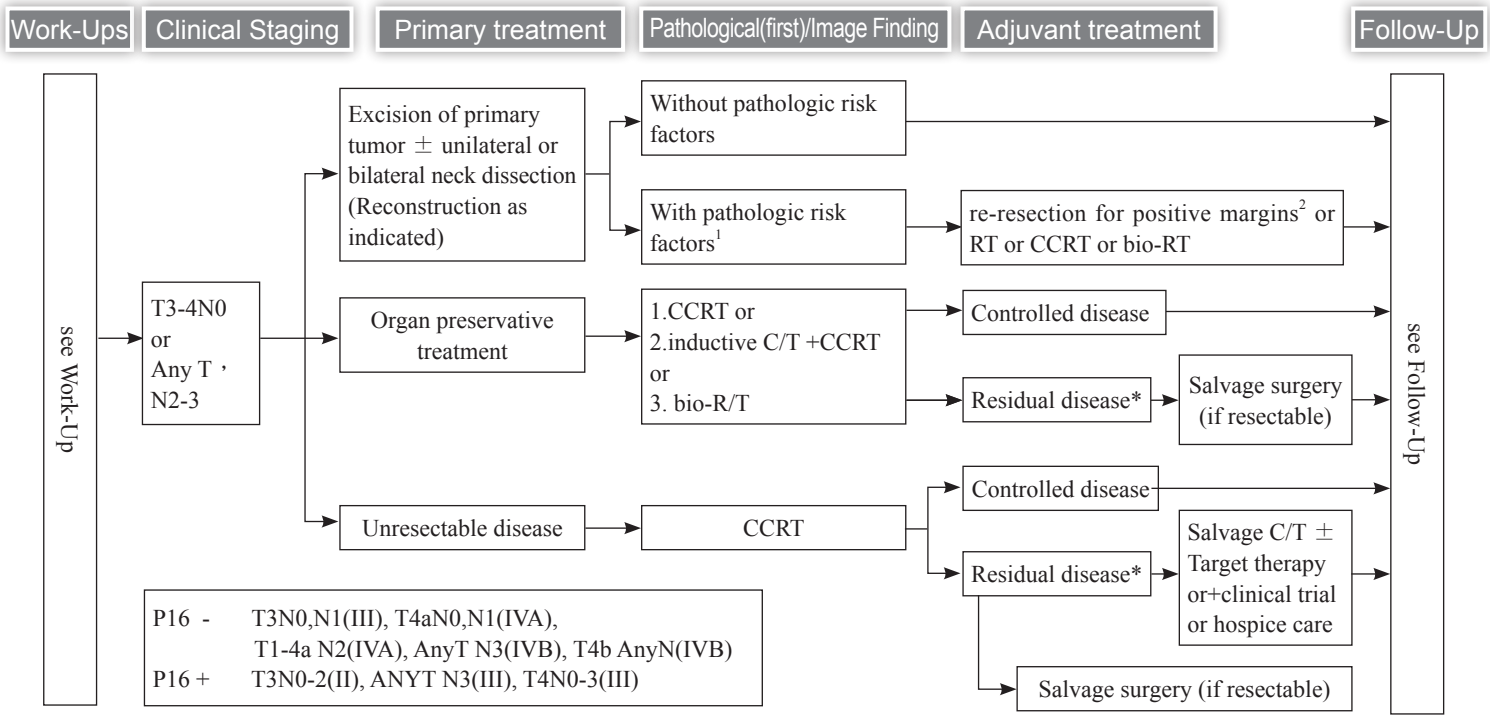
《 Cancer of the Oropharynx -2 》



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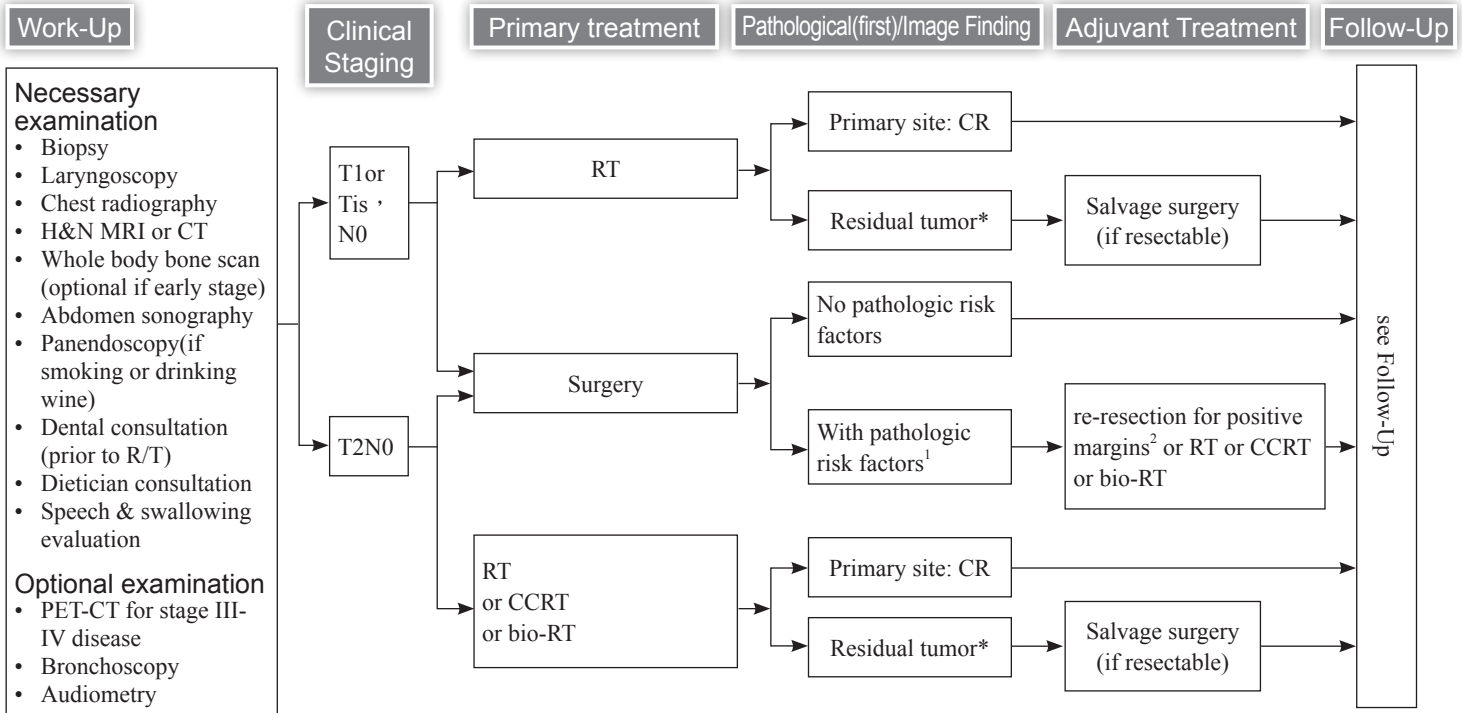
《 Cancer of the Glottic Larynx-1 》



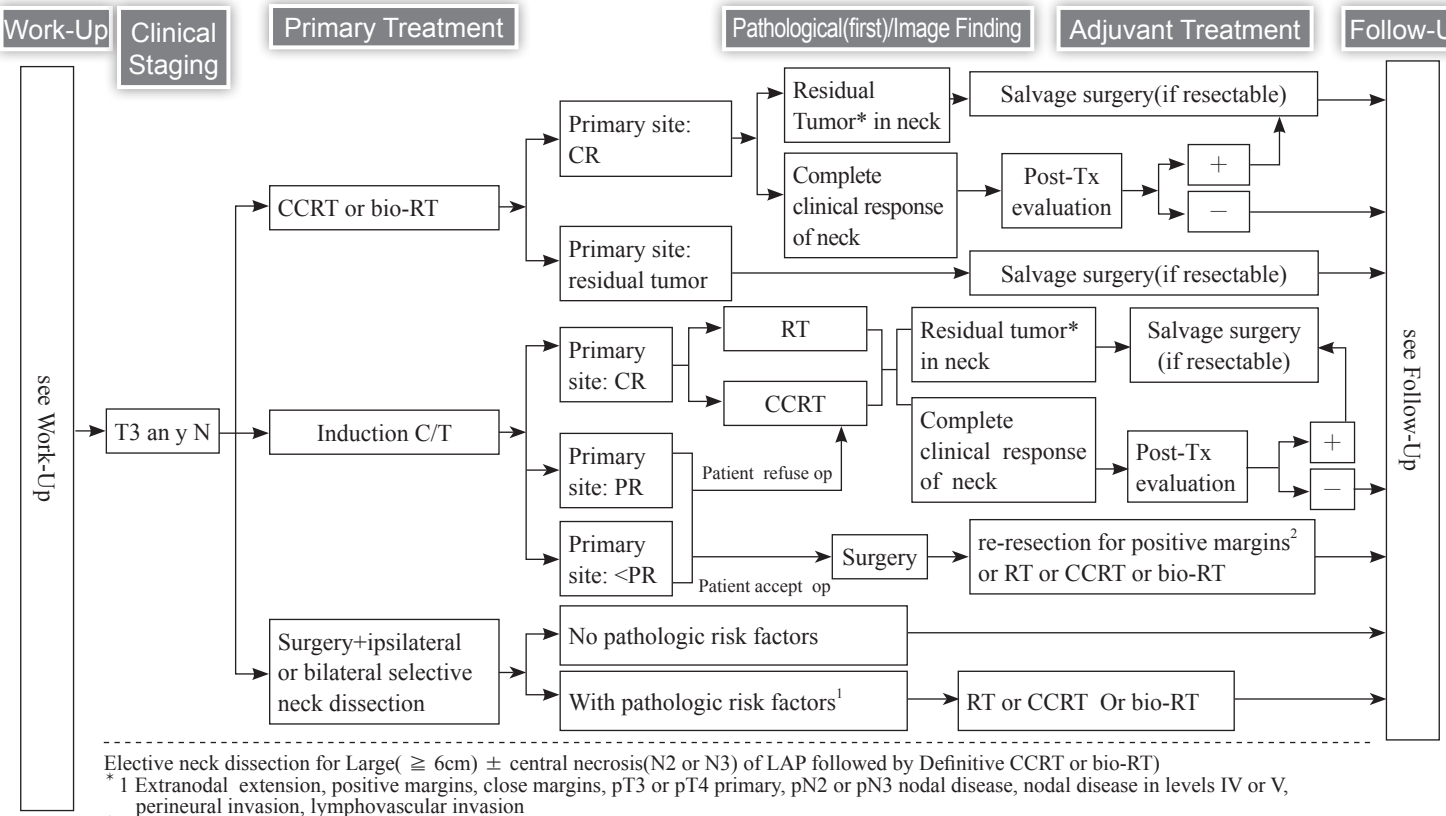
Elective neck dissection for Large(≧ 6cm) ± central necrosis(N2 or N3) of LAP followed by Definitive CCRT or bio-RT)

* 1 Extranodal extension, positive margins, close margins, pT3 or pT4 primary, pN2 or pN3 nodal disease, nodal disease in levels IV or V, perineural invasion, lymphovascular invasion

* 2 consider re-resection to achieve negative margins for positive resection margins if feasible

* Pathological(first)/Image Finding

《 Cancer of the Glottic Larynx -2 》



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* 1 Extranodal extension, positive margins, close margins, pT3 or pT4 primary, pN2 or pN3 nodal disease, nodal disease in levels IV or V, perineural invasion, lymphovascular invasion

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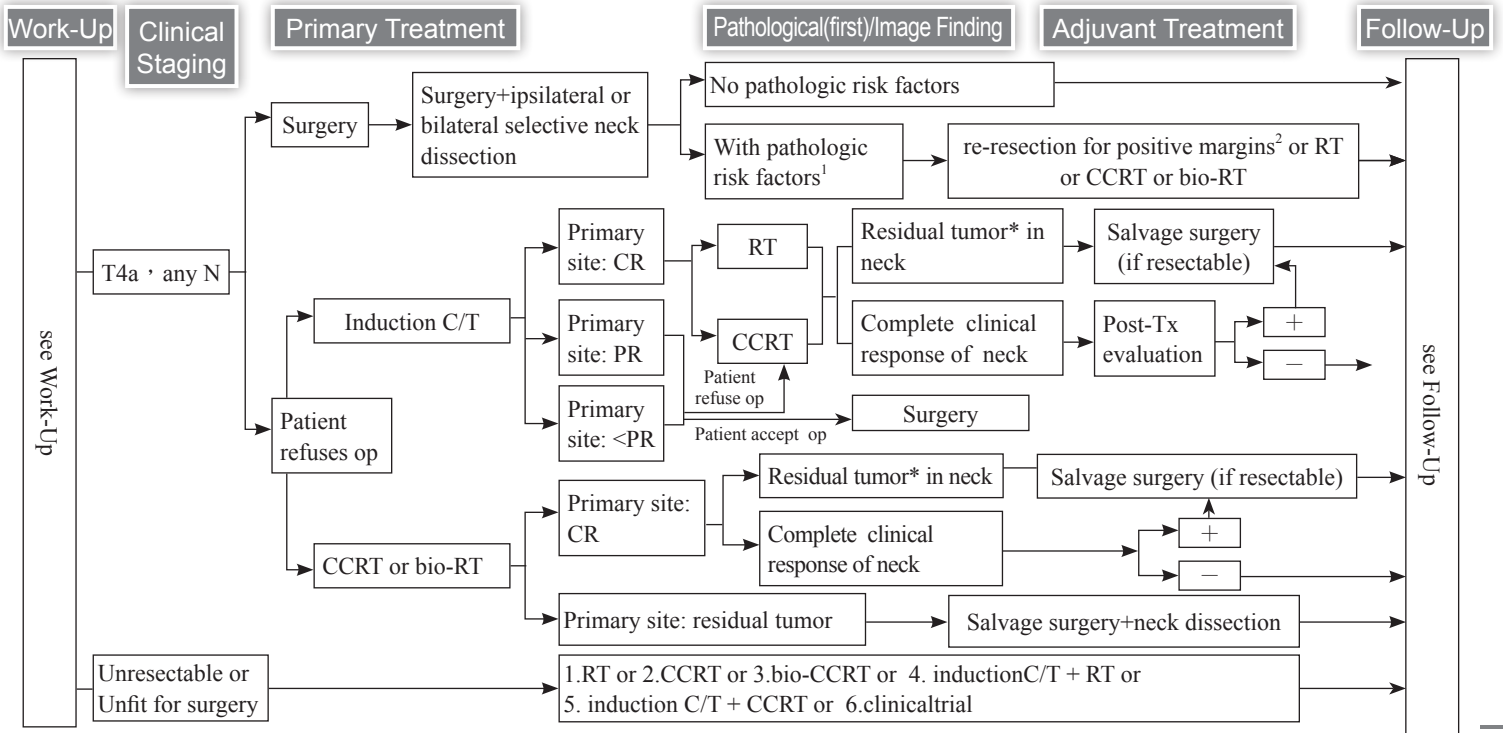
《 Cancer of the Glottic Larynx -3 》



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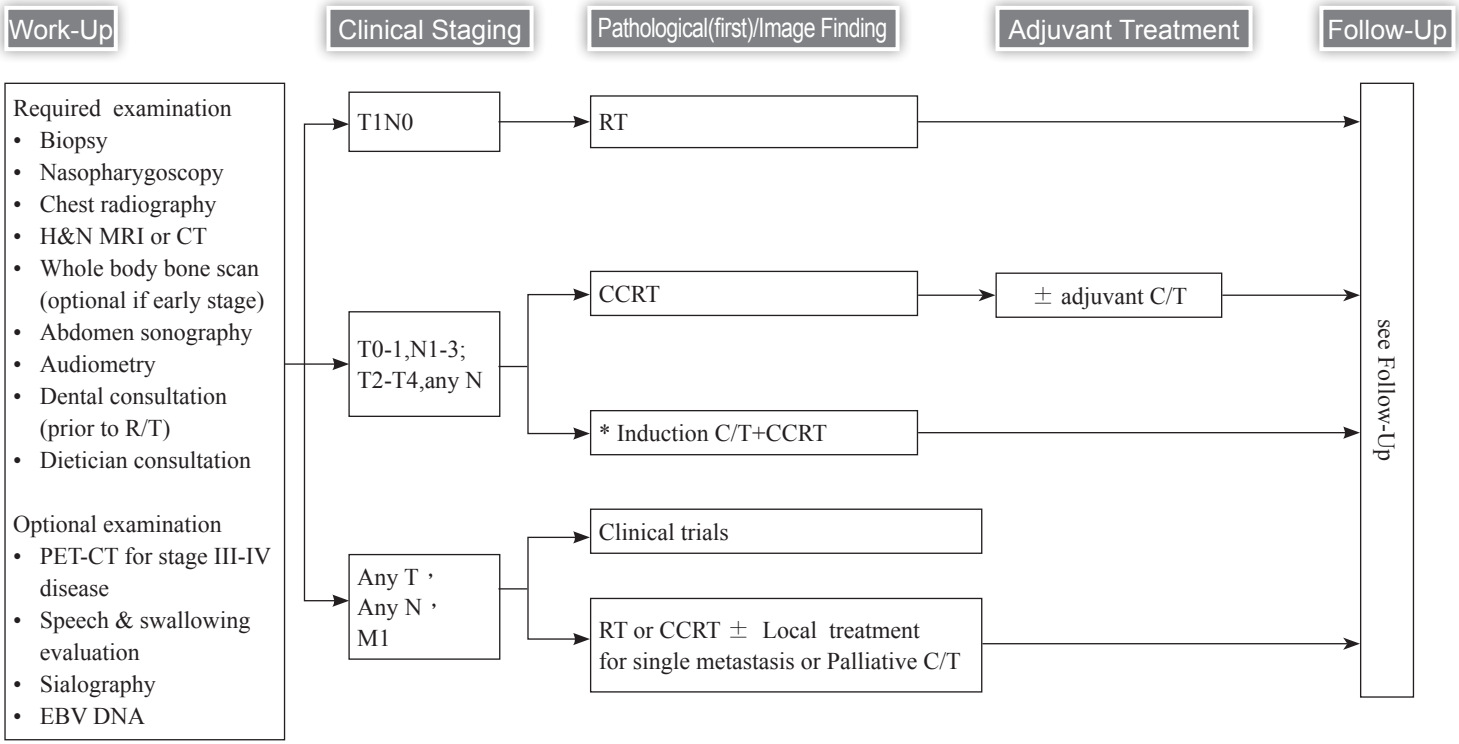
* 2 consider re-resection to achieve negative margins for positive resection margins if feasible

*Pathological(first)/Image Finding

《 Cancer of the Nasopharynx -1 》



* Induction chemotherapy can be used in selective patients (T4 or N3)

《 follow up recommendation 》

Follow-up frequency
- Every month in the 1st year after treatment
- Every 2-3 months in the 2nd year after treatment
- Every 3 months in the 3rd year after treatment
- Every 6 months in the 4th-5th year after treatment

H&N MRI or CT
- Every 3-6 months within the first 3 years after treatment
- Every 6-12 months beyond 3 years after treatment

Whole body bone scan
- Every 3-6 months within the first 3 years after treatment
- Every 6-12 months beyond 3 years after treatment

Abdomen sonography
- Every 3-6 months within the first 3 years after treatment
- Every 6-12 months beyond 3 years after treatment

PET and Whole body bone scan and Panendoscopy
- If indicated clinically

《 Reference 》

1. Al-Sarrf M, LeBlanc M, Giri PG, et al. Chemotherapy versus radiotherapy in patients with advanced nasopharyngeal cancer : phase III randomized Intergroup study 0099. J Clin Oncol 1998; 16:1310-1317.Wee J, Tan EH, Tai BC, et al. Randomized trial of radiotherapy versus concurrent chemoradiotherapy followed by adjuvant chemotherapy in patients with American Joint Committee on Cancer/International Union against cancer stage III and IV nasopharyngeal cancer of the endemic variety.J Clin Oncol 2005; 23 : 6730-6738.
2. Bernier J, Cooper JS, Pajuk TF, et al. Defining risk levels in locally advanced head and neck cancers : A comparative analysis of concurrent postoperative radiation plus chemotherapy trials of the EORTC (#22931) and RTOG (#9501).Head Neck 2005; 27: 843-850.
3. Bernier J, Domenge C, Ozsahin M et al. Postoperative irradiation with or without concomitant chemotherapy for locally advanced head and neck cancer.N Engl J Med 2004; 350:1945-1952.
4. Budach W, Hehr T, Budach V, et al. A meta-analysis of hyperfractionated and accelerated radiotherapy and combined chemotherapy and radiotherapy regimens in unresected locally advanced squamous cell carcinoma of the head and neck. BMC Cancer 2006; 6 : 28-38.
5. Chan AT, Leung SF, Ngan RK, et al. Overall survival after concurrent cisplatin-radiotherapy comparedwith radiotherapy alone in locoregionally advanced nasopharyngeal carcinoma.J Natl Cancer Inst 2005; 97: 536-539.
6. Chan ATC, Hsu M-M, Goh BC, et al. Multicenter, phase II study of cetuximab in combination with carboplatin in patients with recurrent or meta tatic nasopharyngeal carcinoma.J Clin Oncol 2005; 23: 3568-3576.
7. Cooper JS, Pajak TF, Forastiere AA et al. Postoperative concurrent radiotherapy and chemotherapy for high-risk squamous-cell carcfinoma of the head and neck.N Engl J Med 2004; 350(19) : 1937-1944.
8. Hartford AC, Palosca MG, Eichler TJ, et al. American Society for Therapeutic Radiology and Oncology (ASTRO)and American College of Radiology (ACR) Practice Guidelines for Intensity-Modulated Radiation Therapy (IMRT).Int J Radiat Oncol Biol Phys 2009; 73: 9-14.
9. NCCN Head abd Neck Cancer Guidelines Version 3, 2021.

10. Machtay M, Moughan J, Trotti A, et al. Factors associated with severe late toxicity after concurrent chemoradiation for locally advanced head and neck cancer : an RTOG analysis.J Clin Oncol 2008; 26 : 3582-3589.
11. Sanguineti G, Geara FB, Garden AS, et al. Carcinoma of the nasopharynx treated by radiotherapy alone : determinants of local and regional control.Int J Radiat Oncol Biol Phys 1997; 37: 985-996.