

Optimal care pathway for people with head and neck cancers

Quick reference guide



Please note that not all patients will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Prevention: The uptake of human papillomavirus (HPV) vaccination by Australian boys and girls 12–13 years of age should be encouraged. Strategies to curb alcohol intake and smoking and reduce to ultraviolet (UV) exposure will reduce future head and neck cancer burden.

Risk factors: Users of both tobacco and alcohol have a 50-fold (or greater) increased risk of developing head and neck cancer. Other risk factors include:

- age (over 40 years)
- sex (male)
- pre-existing oral lesions
- HPV exposure
- Epstein-Barr virus infection (for nasopharyngeal cancer)
- immunosuppressed patients
- ionising radiation exposure
- UV skin exposure (for skin cancer)
- inherited conditions.

Step 2

Presentation, initial investigations and referral

Signs and symptoms: The following symptoms should be investigated if they persist for more than three weeks, especially if there is more than one symptom:

- hoarseness or altered speech
- difficulty swallowing
- persistent sore throat (particularly with earache)
- unexplained neck or parotid lump
- mouth ulcer or mass
- leukoplakia (white or red patches) of oral mucosa
- unexplained tooth mobility and/or non-healing dental extraction site
- spitting or coughing up blood
- unilateral blockage of the nose or ear.

General/primary practitioner investigations: Ultrasound-guided fine needle aspiration cytology

(USgFNAC) of a node if there is suspicion of malignancy. Non-fine-needle aspiration (FNA) biopsies should not be carried out in a non-specialist setting.

Referral: All patients with a suspected head and neck cancer should be referred to a head and neck specialist with expertise in these cancers and who is affiliated with a multidisciplinary team within two weeks of identification by a general practitioner or dentist.

Communication – lead clinician to:¹

- offer smokers advice about smoking cessation
- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

Step 3

Diagnosis, staging and treatment planning

Diagnosis and staging: The following investigations should be undertaken:

- complete head and neck examination, including endoscopy
- scans to evaluate the primary site, preferably prior to biopsy to avoid the effect of upstaging from the oedema
- FNA for assessment of patients with neck or thyroid lumps inaccessible to biopsy
- biopsy (arranged by a specialist).

Staging:

- Computerised tomography (CT) and magnetic resonance imaging (MRI) of both the primary site and neck lymph nodes.
- MRI is for assessing tumours of the nasopharynx and paranasal sinuses and for cancers with skull base invasion, soft tissue intracranial extension and perineural tumour spread.

- Positron emission tomography (PET) CT is an important staging tool in locally advanced head and neck cancers.

Treatment planning: All newly diagnosed patients should be discussed in a multidisciplinary team meeting so that a treatment plan can be recommended.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/ or longevity without expectation of cure
- symptom palliation.

Having access to specialist nursing and allied health disciplines (in particular specialist speech pathology and dietetics) is important for managing the physical, psychological and social/ practical needs that may arise with head and neck cancer treatment.

Treatment options:

Surgery: This is a treatment option for the majority of head and neck cancer patients.

Radiation therapy: This can be delivered as primary treatment for organ conservation, usually concurrently with chemotherapy. It is also given following surgery (postoperatively) for patients at high risk of locoregional recurrence.

Chemotherapy or drug therapy:

Concurrent or adjuvant chemoradiation has now become the standard of care in locally advanced head and neck squamous cell carcinoma. There are selected clinical scenarios where neoadjuvant chemotherapy (prior to radiation therapy) is also appropriate.

Palliative care: Early referral can improve quality of life. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- discuss treatment options with the patient/carer including the intent of treatment as well as the risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

For detailed information see <<http://oralcancerfoundation.org/treatment/pdf/head-and-neck.pdf>>.

Step 5

Care after initial treatment and recovery

Treatment summary (provide a copy to the patient/carer and general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care plan (provide a copy to the patient/carer and general practitioner) outlining:

- medical follow-up required (tests, ongoing surveillance)

- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the patient's general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Most cases of recurrent head and neck cancers are identified through routine follow-up or when the patient presents with symptoms.

Treatment: Where possible, refer the patient to the original multidisciplinary team. Treatment will depend on the location and extent of disease, performance status, previous management and the patient's preferences.

Palliative care: Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the patient/carer
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.