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Locally advanced head and neck cancer in either the older or the vulnerable adult: Making the case for a team-based, "gero-centric" approach

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ABSTRACT

Multidisciplinary, team-based care goes hand in hand with geriatric oncology paradigms for caring for older adults with cancer. Team-based care was the central theme for the 2015 SIOG Annual Meeting. Team-based approaches to the evaluation and management of older adults with different cancer types, including head and neck cancer, were presented. This review aims to summarize the salient points of that presentation, including a synthesis of recent multidisciplinary, "gero-centric" research efforts to improve the care for older adults with more advanced stages of head and neck cancer.

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1. Introduction

The incidence of head and neck cancer is rising and currently is the sixth most common cancer worldwide.[1] A substantial proportion of these head and neck cancer will occur in patients younger than 65 years due to a commensurate rise in human papillomavirus (HPV)-related head and neck cancer, predominantly of the oropharynx.[2,3] In the U.S., the median age at diagnosis is 58 years for HPV-positive oropharynx cancers and 63 years for HPV-negative cancers.[3] However, at least 30% of head and neck cancer overall will still occur in patients older than 70 years, with a median age at diagnosis of 62 years for oral cavity/pharyngeal cancers (43% age ≥ 65 years) and 65 years for laryngeal cancers (51% age ≥ 65 years) in the U.S.[4,5] Many of these head and neck cancer in older adults will more likely be smoking-related and thus occur more commonly in the oral cavity, hypopharynx, and larynx, which will often warrant organ-preservation approaches incorporating chemotherapy and radiation into the treatment decision-making for these patients.

However, the evidence base for such combined modality therapy, particularly concurrent chemoradiation (CRT) with curative intent, for older adults with locally advanced head and neck cancer (LA-HNC) remains less robust than that of CRT for their younger counterparts.[6,7] The stigma of chronologic age may lead to frank exclusion or lack of adequate representation of older adults with cancer (including LA-HNC) in clinical trials.[8,9] This lack of an evidence base has led to difficulty in how best to approach individuals with LA-HNC with more advanced age, comorbidity, and/or impaired functional status.[6,7] It has also been reported that age >70 years may counteract the potential overall survival benefit of adding chemotherapy to definitive radiation therapy.[10] Furthermore, advanced age in and of itself may lead to suboptimal treatment decision-making for otherwise potentially curative disease in older adults with LA-HNC.[11,12]

Competing risks including comorbidity and impaired functional status may lead to increased non-cancer related morbidity and mortality, which has been seen in longer-term follow-up of older adults with LA-HNC undergoing CRT.[13,14] However, many single-institution studies have found that CRT utilized in select older adults with LA-HNC can still be beneficial in terms of feasibility, cancer control, and cancer-related survival.[15–18] However, older adults with LA-HNC treated with RT or CRT can demonstrate more impairment in self-reported functional outcomes such as physical performance, speech, swallowing, and functional status.[19–21] Furthermore, patient-reported outcomes for older adults with LA-HNC and how best to support them at the time of diagnosis, during treatment, and during survivorship where late-term complications of CRT or other therapies can still have significant impact on health-related quality of life and functional status remain critical knowledge gaps for clinical practice. In order to better shed light on these issues, this review, utilizing a clinical vignette, will (1) underscore the importance of implementing a team-based approach for evaluating and managing the older adults with LA-HNC; and (2) highlight ongoing research efforts incorporating geriatric assessments into the treatment decision-making paradigm for these patients.

2. Clinical Vignette

A 68-year-old homeless veteran with at least a forty-pack-year smoking history presented to the multidisciplinary head and neck cancer clinic at the Portland Veterans Affairs (VA) Healthcare System. He was residing outside an adoption agency center over one hundred miles away from Portland. He had persistent symptoms of dysphonia, weight loss, and at least two episodes of hemoptysis precipitating at least one emergency room visit. Direct laryngoscopy showed a friable lesion involving the left true vocal cord and biopsy confirmed invasive squamous cell carcinoma. He had CT imaging that did not reveal any distant metastatic disease. He had several enlarged left cervical lymph nodes all less than 3 cm in maximum dimension, ultimately staged as cT2 N2b M0 (clinical stage IVA), and thus could still be approached with curative intent. He had no significant functional or physical health problems in review with his primary care physician and the patient himself. He had undetermined mental health issues but was deemed to be of decision-making capacity by more than one of the team's physicians as well as a VA psychiatrist.

Based on the pivotal VA larynx and RTOG 91-11 studies, organ-preservation strategies were discussed with the patient in lieu of total laryngectomy and adjuvant RT.[13,22] He was deemed functionally a good CRT candidate provided sufficient supportive care including housing could be arranged in advance. As part of the multidisciplinary team, he was evaluated by at least one member from dentistry, head/neck surgery, medical oncology, radiation oncology, nutrition, speech/swallow therapy, audiology, and social work based on his medical and psychosocial needs. Based on the skilled nursing and rehabilitative needs, he was able to be placed into a skilled nursing facility under VA contract before his CRT with weekly cisplatin for a total RT dose of 70 Gy commenced. With frequent follow-up visits scheduled, he was able to complete all planned RT sessions without interruption or modification. He did not require gastrostomy tube placement during or immediately upon CRT completion. He did not require any hospitalization during CRT. He had a complete clinical and radiographic response with subsequent PET/CT re-staging with commensurate improvement in self-reported speech and swallowing function compared to baseline. He continues to follow with head/neck surgery alternating with radiation oncology for surveillance direct examinations and serial re-assessments by speech/swallow therapy (embedded in head/neck surgery follow-up clinics).

3. Discussion

The patient in the illustrative case lends support to a team-based approach to the evaluation and management of the older patient with LA-HNC since it was key to implementing a complex treatment plan and ensuring that the patient was followed closely to ameliorate acute CRT-related toxicities. The side effects can include mucositis, pain control, dermatitis, dehydration, weight loss/malnutrition, fatigue, asthenia, and nausea, which