



## Follow-up program in head and neck cancer



Francesca De Felice<sup>a,\*</sup>, Marco de Vincentiis<sup>b</sup>, Valentino Valentini<sup>c</sup>, Daniela Musio<sup>a</sup>,  
Silvia Mezi<sup>d</sup>, Luigi Lo Mele<sup>e</sup>, Valentina Terenzi<sup>c</sup>, Vittorio D'Aguanno<sup>b</sup>, Andrea Cassoni<sup>c</sup>,  
Martina Di Brino<sup>e</sup>, Gianluca Tenore<sup>f</sup>, Nadia Bulzonetti<sup>a</sup>, Andrea Battisti<sup>c</sup>, Antonio Greco<sup>b</sup>,  
Giorgio Pompa<sup>f</sup>, Antonio Minni<sup>b</sup>, Umberto Romeo<sup>f</sup>, Enrico Cortesi<sup>d</sup>, Antonella Polimeni<sup>f</sup>,  
Vincenzo Tombolini<sup>a</sup>

<sup>a</sup> Department of Radiotherapy, Policlinico Umberto I "Sapienza" University of Rome, Rome, Italy

<sup>b</sup> Department of Sense Organs, Policlinico Umberto I "Sapienza" University of Rome, Italy

<sup>c</sup> Department of Maxillofacial Surgery, Policlinico Umberto I "Sapienza" University of Rome, Italy

<sup>d</sup> Department of Medical Oncology, Policlinico Umberto I "Sapienza" University of Rome, Italy

<sup>e</sup> Department of Radiological Sciences, Oncology and Pathology, Policlinico Umberto I "Sapienza" University of Rome, Italy

<sup>f</sup> Department of Odontostomatological Science, Policlinico Umberto I "Sapienza" University of Rome, Italy

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### ABSTRACT

Follow-up program in head and neck cancer (HNC) is an important issue in patients management. It represents the major dilemma in daily practice clinic. Many guidelines have been published in order to better define the best clinical protocol, but a consensus has not been attained yet. We constructed a

\* Corresponding author at: Department of Radiotherapy, Policlinico Umberto I, "Sapienza" University of Rome, Viale del Policlinico 155, 00161 Rome, Italy.  
E-mail address: [fradefelice@hotmail.it](mailto:fradefelice@hotmail.it) (F. De Felice).

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follow-up program based on specific primary subsite, to standardize patients surveillance after treatment of HNC.

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## 1. Introduction

Head and neck cancer (HNC) is a relatively common cancer worldwide, resulting in approximately estimated 490,000 new cases and 200,000 deaths annually (Torre et al., 2015). Although this disease may be considered as unique, it is notable that incidence varies in relation to primary site onset, as well as geographic and ethnic populations. Over the past decades, independently of primary tumor, conservative treatments with curative intent have advanced significantly in the management of HNC, both in early and advanced stage disease (National Comprehensive Cancer Network, 2015). However, the overall risk of loco-regional recurrence and distant metastasis remains high, varying from less than 10% to more than 50%, based on primary site, stage and histological classification (De Felice et al., 2015a).

Therefore, a well-delineated post-treatment surveillance is paramount, but controversies remain regarding the selection of optimal follow-up strategies, especially for asymptomatic patients. The aim of a reasonable follow-up schedule after potentially curative management is mainly to evaluate therapeutic efficacy, manage late complications and offer a psychological support to the patient (Hambek, 2012). There is little evidence to suggest that early detection of recurrences adds significantly benefit to survival outcomes (Lester and Wight, 2009; Barker et al., 2001). The absence of an overall survival difference between early detection of loco-regional recurrence compared with self-referral new tumor manifestations only contrasts with the findings of a retrospective study in patients treated with curative intent for carcinoma of larynx, pharynx, and oral cavity that showed a survival benefit in early detection in asymptomatic patients (58 versus 32 months,  $p < 0.05$ ) (de Visscher and Manni, 1994). Considering that the vast majority of failures appears within 24 months, a closely follow-up is almost more important during the first 2 years to guarantee the better chance of cure, especially in term of curative salvage treatment (Haas et al., 2016). There are several general features of an appropriate surveillance program – including systematic follow-up visits with a complete physical examination, and baseline post-treatment radiologic investigations – but timing protocols as well as modalities used vary considerably among countries, due to diagnostic exams cost ineffectiveness (Barker et al., 2001).

The primary objective of this practice guideline is to provide an optimal follow-up program in HNC patients after curative treatment. We focused on the value of clinical and imaging follow-up in asymptomatic patients. We delineated how often the clinical examination and what kind of diagnostic investigations should be performed by the clinicians per year.

## 2. Methods

Head and Neck Unit of Policlinico Umberto I, Sapienza University of Rome conducted several group meetings in order to delineate the most appropriate follow-up strategy for patients with HNC. The combination information collected from cross-sectional imaging with clinical examination allows for the most accurate surveillance. Computed tomography (CT) and diffusion-weighted magnetic resonance imaging (DW-MRI) are part of the routine follow-up.

The consensus process was based on the available evidence from the international and national guidelines and the clinical experience of the Head and Neck Unit members.

The panel consisted of experts in HNC, including oral and maxillofacial surgeons (AC, VT, VV), otolaryngology head and neck surgeons (VDA, MDV), radiation oncologists (FDF, DM, VT), clinical oncologists (SM), radiologist (LL), pathologist (AB) and dentistry (UR).

In details, we firstly considered international and national HNC guidelines (National Comprehensive Cancer Network, 2015 Grégoire et al., 2010; AIOCC-AIRO-AIOM, 2012; British Association of Head and Neck Oncologists, 2001). We did not discuss diagnosis and treatment management in this manuscript, but we focused on a concise follow-up description of head neck region. Secondly, each member of the group delineated the follow-up program for each primary tumor subsite based on own daily clinical practice. To reach consensus on follow-up program, feedback from all parties was incorporated to create the final practice guideline. The resulting institutional recommendations were reviewed and approved by the Head and Neck Unit of the Policlinico Umberto I, Sapienza University of Rome.

## 3. Results

Although HNC shares many characteristics, yet also has unique features that are attributable to primary site. We presented follow-up program respective to HNC primary location.

### 3.1. Lip

The risk of lymph node metastases is principally related to the tumor location. Upper lip tumor and tumor that arose from commissural area have a higher risk of lymph node metastasis than lower lip cancer. Primary treatment depends on functional and cosmetic outcomes and generally surgery is preferred (de Visscher et al., 1999; de Visscher et al., 1998). Due to post-surgical anatomic distortion, especially in locally advanced disease, recommendation for surveillance includes both clinical and imaging examination. The optimal timing of clinical examination is every 3 months for the first 2 years and every 6 months thereafter. The imaging exam, including CT or MRI, is first done at 3 months, then 3 monthly for the first 2 years, and annually thereafter. Whereas, if radiation therapy is used as definitive treatment, it is recommended only within 3 and 9 months, due to overall low incidence of lymph node metastases and the accessible clinical location.

### 3.2. Oral cavity

The oral cavity consists of several anatomic subsites: buccal mucosa, upper and lower gingiva, retromolar trigone, hard palate, floor of mouth and anterior 2/3 of the mobile tongue. Surgical resection represents the treatment of choice and it is often accompanied by a neck dissection, because of rich lymphatic drainage in these areas (De Felice et al., 2014). Depending on pathologic stage, adjuvant radiotherapy is indicated to prevent loco-regional recurrence and optimize treatment outcomes. Adjuvant treatment

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