

Optimal care pathway for people with head and neck cancer

Quick reference guide



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

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with head and neck cancer*.

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

- Stop smoking and avoid exposure to second-hand tobacco smoke.
- Avoid or reduce alcohol intake, ultraviolet exposure and occupational exposure to asbestos, wood dust, nickel alloy and silica dust.
- Vaccinate against human papillomavirus.
- Practise good oral hygiene.
- Eat healthily and maintain a healthy body weight.

Risk factors

People who frequently smoke and consume alcohol are at the highest risk of head and neck cancer.

Risk factors include:

- smoking, chewing tobacco or chewing betel quid
- alcohol consumption

- HPV exposure
- UV skin exposure (for skin cancer)
- pre-existing oral lesions
- poor oral hygiene
- age (over 40 years)
- sex (male)
- Epstein-Barr virus infection in genetically predisposed individuals (for nasopharyngeal cancer)
- immunosuppression
- ionising radiation exposure
- inherited conditions
- poor nutrition.

Screening recommendations

There are currently no formal screening programs in Australia for detecting head and neck cancer. Opportunistic screening should be conducted during general health examinations and dental check-ups.

Checklist

- ☐ HPV vaccination
- ☐ Recent weight changes discussed and the patient's weight recorded
- ☐ Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- ☐ Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- ☐ Physical activity recorded
- ☐ Referral to a dietitian considered
- ☐ Referral to a physiotherapist or exercise physiologist considered
- ☐ Education on being sun smart considered

Step 2: Presentation, initial investigations and referral

Signs and symptoms

The following signs and symptoms should be investigated if they persist for **more than 3 weeks**, especially if more than one symptom is present:

- mouth ulcer or mass
- unexplained tooth mobility and/or non-healing dental extraction site
- white or red patches of the oral mucosa – leukoplakia
- persisting lip ulcers or patches
- changes in the voice, such as hoarseness
- persistent sore throat (particularly together with earache) or cough
- difficulty or pain when swallowing or chewing
- coughing up blood (including spitting up blood)
- persistent unexplained neck or parotid lump or sore
- pain, pressure, unilateral ringing in the ear or hearing loss
- unilateral paralysis of the muscles in the face
- unilateral numbness, tingling, pins and needles or formication (feeling of insects crawling on the skin)

Checklist

- ☐ Signs and symptoms recorded
- ☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ☐ Patient notified of support services such as Cancer Council 13 11 20
- ☐ Referral options discussed with the patient and/or carer including cost implications

Step 2: Presentation, initial investigations and referral continued

- unilateral blockage of the nose, especially if associated with swelling or other problems with the eyes such as double vision
- trismus (lockjaw) or reduced jaw opening
- unexplained weight loss.

Initial investigations may include:

- structural imaging with ultrasound, CT and/or MRI
- ultrasound-guided fine-needle aspiration cytology (USgFNAC) of a node, if malignancy is suspected or a neck lump persists or grows (including lumps in the thyroid, salivary gland or lymph node).

Excisional biopsy of potentially malignant lesions should not be undertaken.

Appropriately trained practitioners can consider biopsy of a primary site, but this should not delay referral. Lymph nodes should not have incisional or excisional biopsy without specialist input.

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the

patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Patients with head and neck cancer should only be referred to specialists who regularly participate in subspecialty head and neck multidisciplinary meetings. The patient must be informed about the improved outcomes achieved at centres that treat higher numbers of complex head and neck cases.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Timeframe

Signs and symptoms should be investigated if they persist for **more than 3 weeks**, especially if more than one symptom is present.

The first specialist appointment should take place **within 2 weeks** of the initial referral from the general or dental practitioner.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging

The following investigations should be undertaken:

- complete head and neck examination, including endoscopy
- scans (ultrasound, CT, MRI or PET) to evaluate the primary site, regional lymph nodes and sites of possible distant metastases (scans should ideally be performed prior to biopsy to avoid the effect of upstaging from the oedema)
- biopsy (arranged by a practitioner with appropriate training and current experience).

Genetic testing

There is no established role for genetic testing for most head and neck cancers. Nasopharyngeal carcinoma has a higher incidence in people of Chinese or Southern European background, but there is currently no genetic test to identify specific individuals at risk.

Treatment planning

The multidisciplinary team should discuss all newly diagnosed patients with head and neck cancer so that a treatment plan can be recommended. The first multidisciplinary team meeting (MDM) should be **within 2 weeks** of receiving the diagnosis and staging results.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Communication

The lead clinician's¹ responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care

Checklist

- ☐ Diagnosis confirmed
- ☐ Full histology obtained
- ☐ Performance status and comorbidities measured and recorded
- ☐ Patient discussed at an MDM and decisions provided to the patient and/or carer
- ☐ Clinical trial enrolment considered
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ☐ Patient referred to support services (such as Cancer Council) as required
- ☐ Treatment costs discussed with the patient and/or carer

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 3: Diagnosis, staging and treatment planning continued

- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from MDMs.

Timeframe

Diagnostic investigations should be completed **within 2 weeks** of the specialist appointment.

Step 4: Treatment

Establish intent of treatment

- Curative
- Palliative, which may include anti-cancer therapy to improve quality of life or longevity (or both) without expectation of cure, or symptomatic treatment only

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

Surgery: Surgery can be used as the primary curative treatment modality in a number of head and neck cancers. It can be used to salvage residual or recurrent disease or as palliative treatment.

Radiation therapy: Radiation therapy can be used as the primary curative treatment in several head and neck cancers and may be given concurrently with systemic therapy. It can be given following surgery (postoperatively) for patients at high risk of locoregional recurrence. It can also be used as palliative treatment.

Systemic therapy: Systemic therapy, concurrent with radiation, can be used as the primary curative treatment or as an adjuvant treatment following surgery for several head and neck cancers. Neoadjuvant systemic therapy (before radiation therapy) is also appropriate in a small number of specific clinical scenarios. Targeted biological agents and immunotherapy are the standards of care for some recurrent head and neck cancers. Systemic therapy can also be used as palliative treatment.

Palliative care: Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- ☐ Intent of treatment established
- ☐ Risks and benefits of treatments discussed with the patient and/or carer
- ☐ Treatment plan discussed with the patient and/or carer
- ☐ Treatment plan provided to the patient's GP
- ☐ Treating specialist has adequate qualifications, experience and expertise
- ☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ☐ Early referral to palliative care considered
- ☐ Advance care planning discussed with the patient and/or carer

Timeframe

Surgery should be scheduled **within 4 weeks** of the MDM. Radiation therapy or systemic therapy as a primary treatment:

- for curative intent - start **within 4 weeks** of the MDM
- for palliative intent - start **within 2 weeks** of the MDM.

If systemic therapy is being used concurrently with radiation therapy, start **within 1 week** of radiation therapy.

Radiation therapy as an adjuvant treatment should start **within 6 weeks** after surgery.

Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing

- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

Checklist

- ☐ Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ☐ Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most cases of recurrent head and neck cancer will be detected at routine follow-up or by the patient presenting with symptoms before routine clinical follow-up.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values

and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

- ☐ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ☐ Advance care planning discussed with the patient and/or carer
- ☐ Patient referred to palliative care if appropriate
- ☐ Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient

- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- ☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ☐ Patient referred to palliative care
- ☐ Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.