UCCH Pathway

UCCH Guideline
Squamous Cell Carcinoma of the Lip

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Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Squamous Cell Carcinoma of the Lip

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according to TNM classification 8th edition

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Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

TB

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Pathway: Squamous Cell Carcinoma of the Lip

Work up

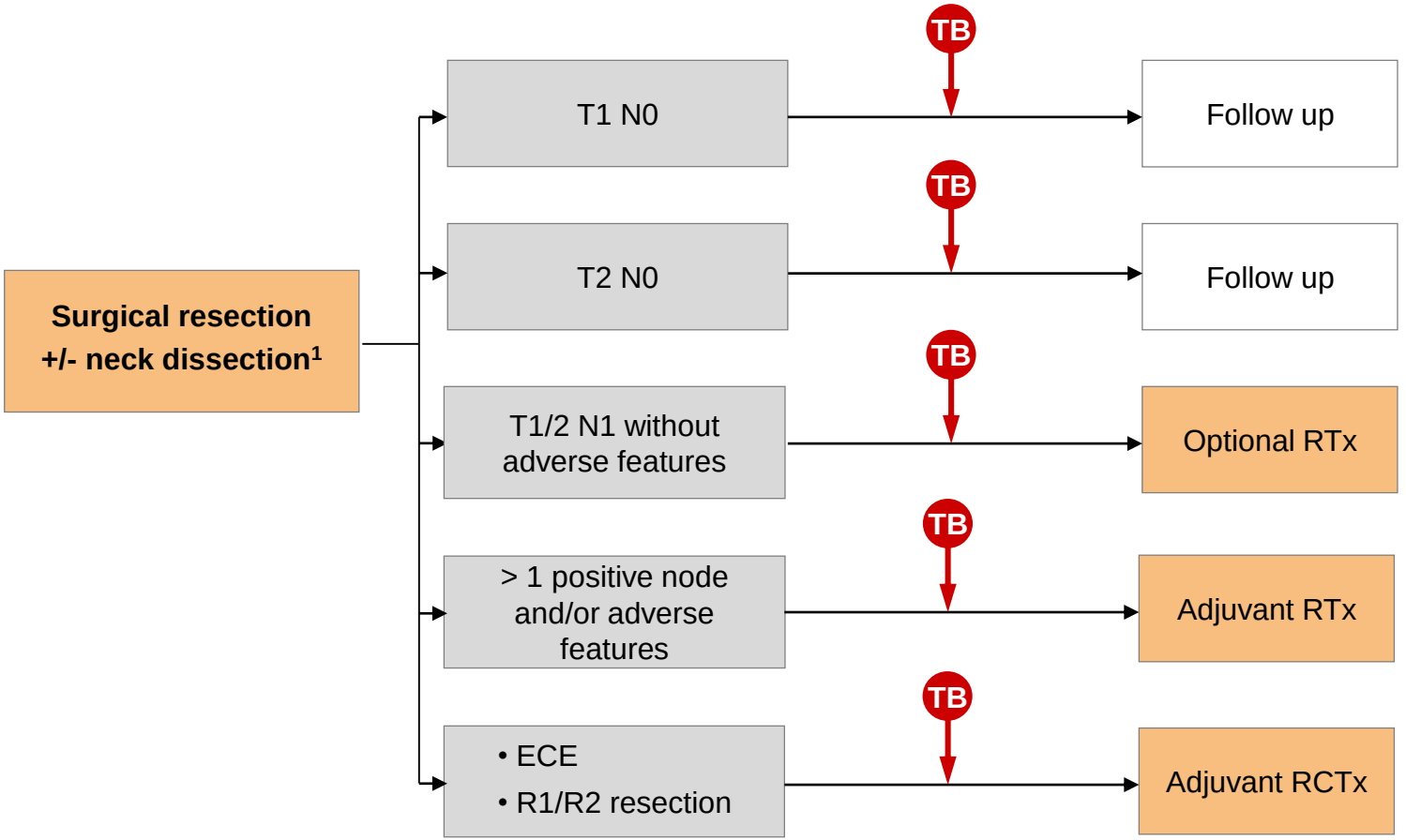
- Physical exam
- Biopsy
- T1/2: MRI head and neck or CT with contrast, chest x-ray, in case of N+: CT thorax/liver extension
- T3/4: MRI head and neck or CT with contrast, CT thorax/liver extension
- Dental evaluation and panoramic view
- Photodocumentation
- ORL examination
- Multidisciplinary consultation as indicated

- <u>Supportive:</u>
  - Offer contact to self help group
  - Screen for psychosocial distress

TB

- Resectable disease → Surgical resection → Pathway page 2
- Unresectable → Pathway page 3
- Metastatic disease → Local treatment in case of symptomatic disease (e.g. surgery, radiation)
- Metastatic disease → Systemic treatment → Pathway page 4/5

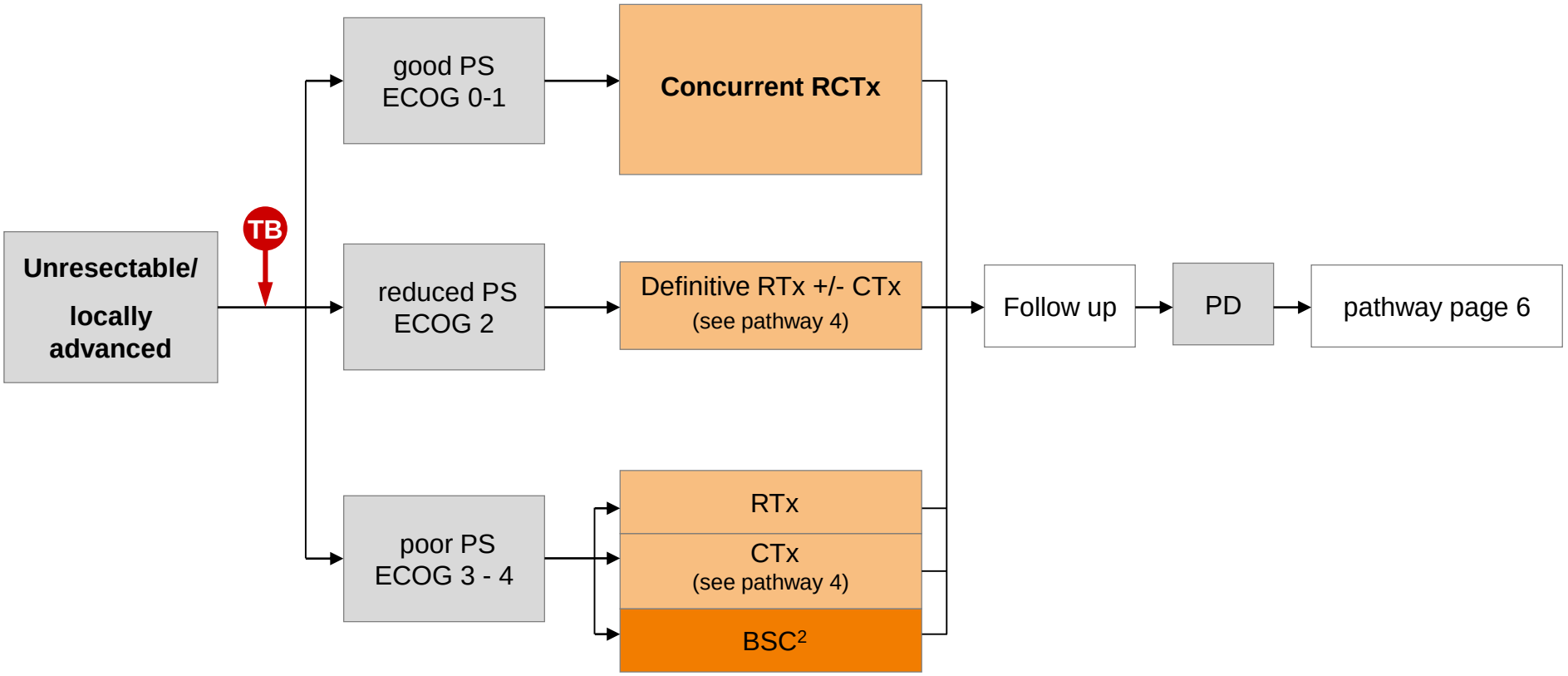
Pathway page 2: Surgical resection



ECE Extra Capsular Extension, RTx Radiotherapy, RCTx Radiochemotherapy, Adverse features: pT3/T4, Pn1, L1, V1

[1] See indications for neck dissection in pathway page 7

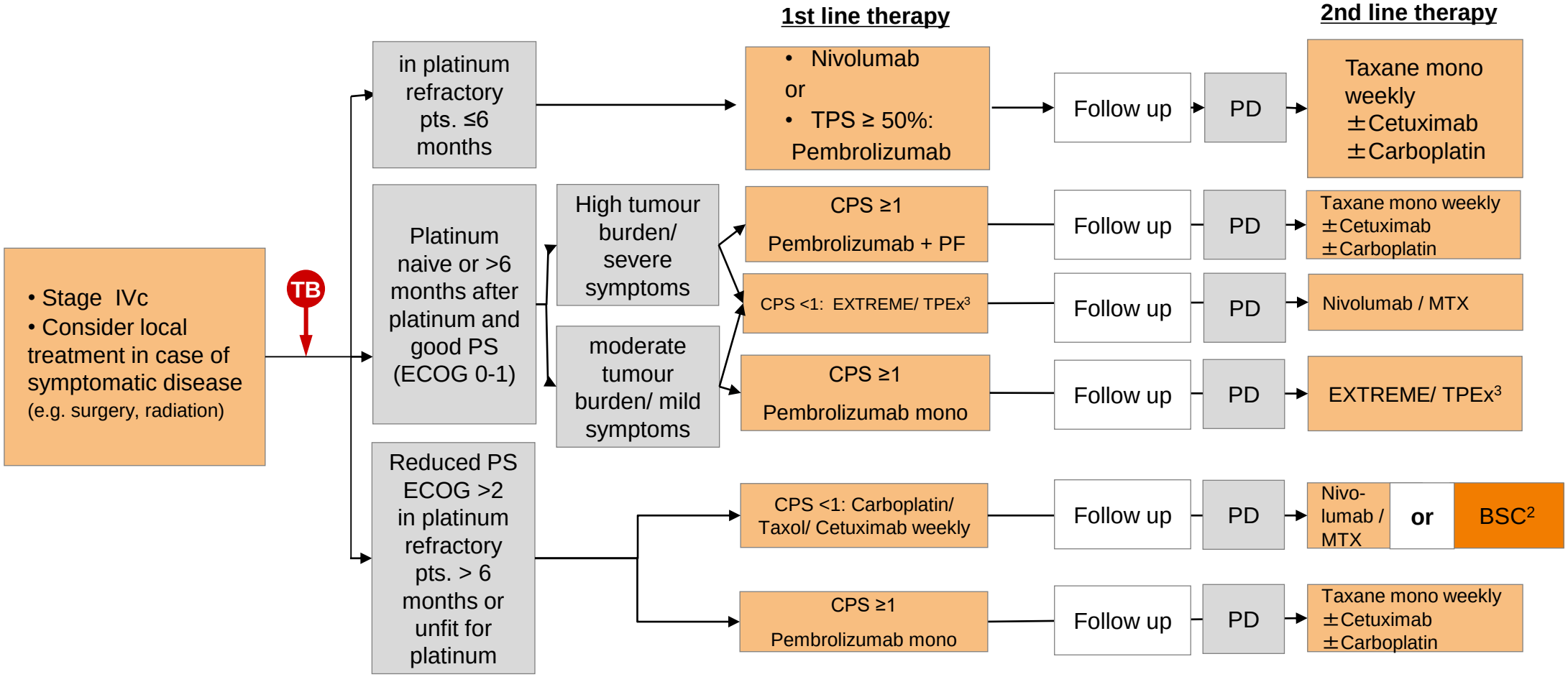
Pathway page 3: Unresectable (locally advanced)



PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC Best supportive care, PD Progressive Disease, RTx Radiotherapy, RCTx Radiochemotherapy, CTx Chemotherapy

[2] See palliative care screening tool on page 11

Pathway page 4: Metastatic disease (systemic treatment)



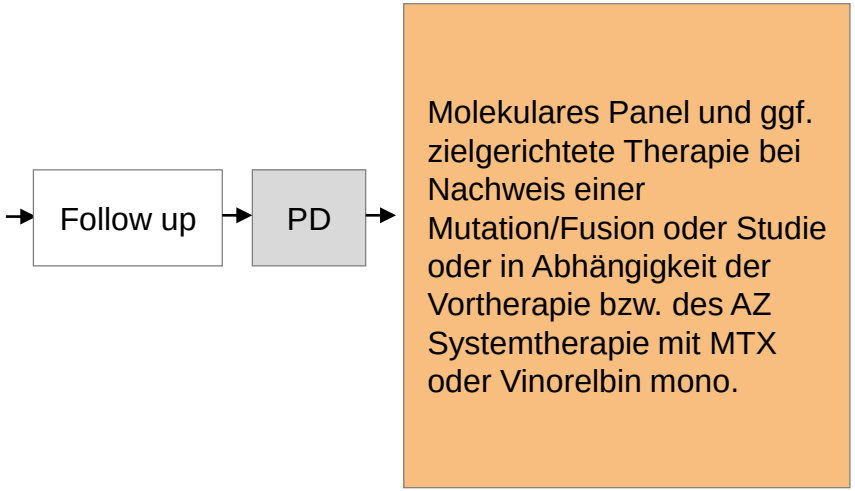
PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC Best supportive care, PD Progressive Disease, CPS combined proportion score

[2] See palliative care screening tool on page 11

[3] See therapy protocols SCCHN on pages 13-15

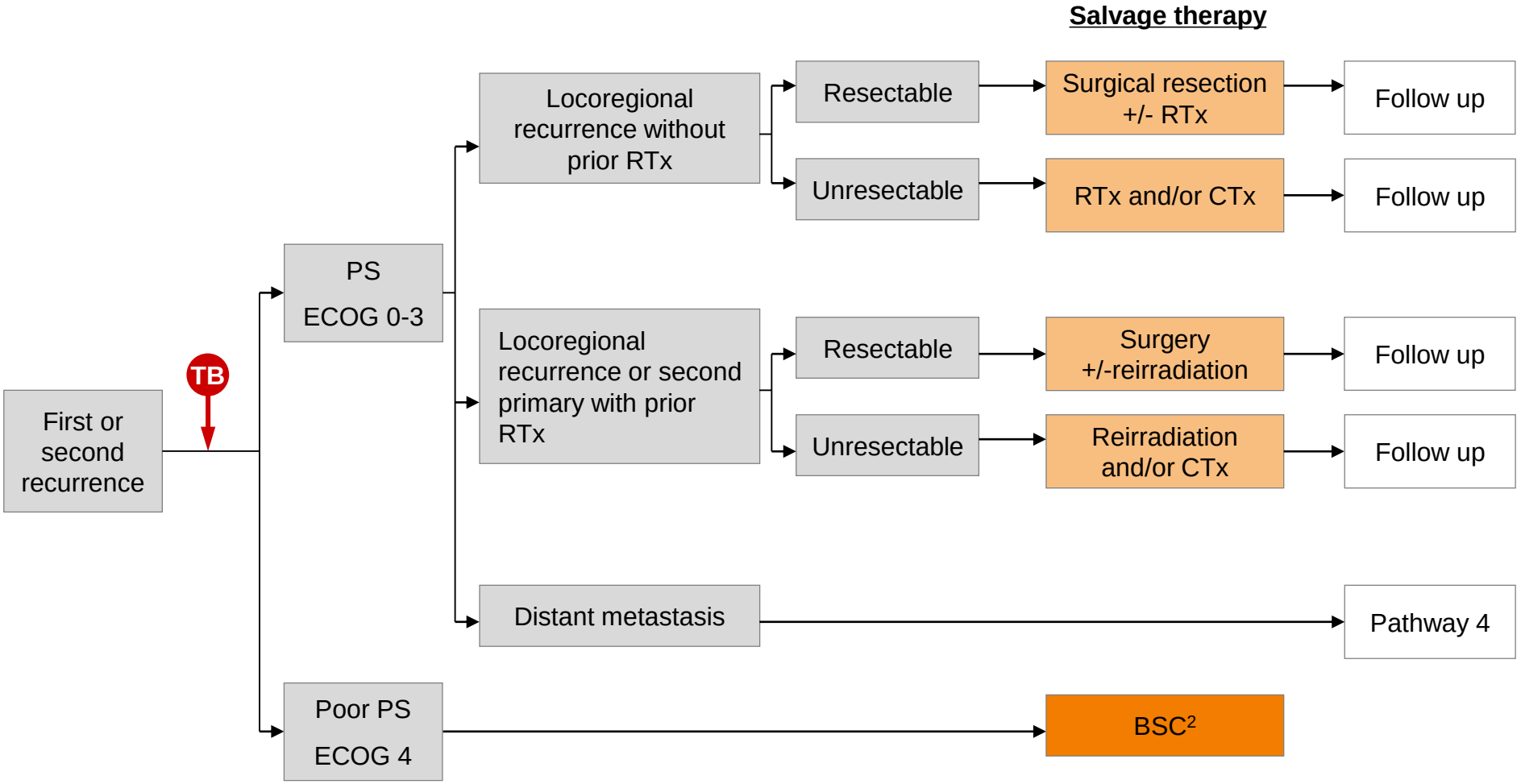
Pathway page 5: Metastatic disease (systemic treatment)

3rd line therapy



PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC Best supportive care, PD Progressive Disease

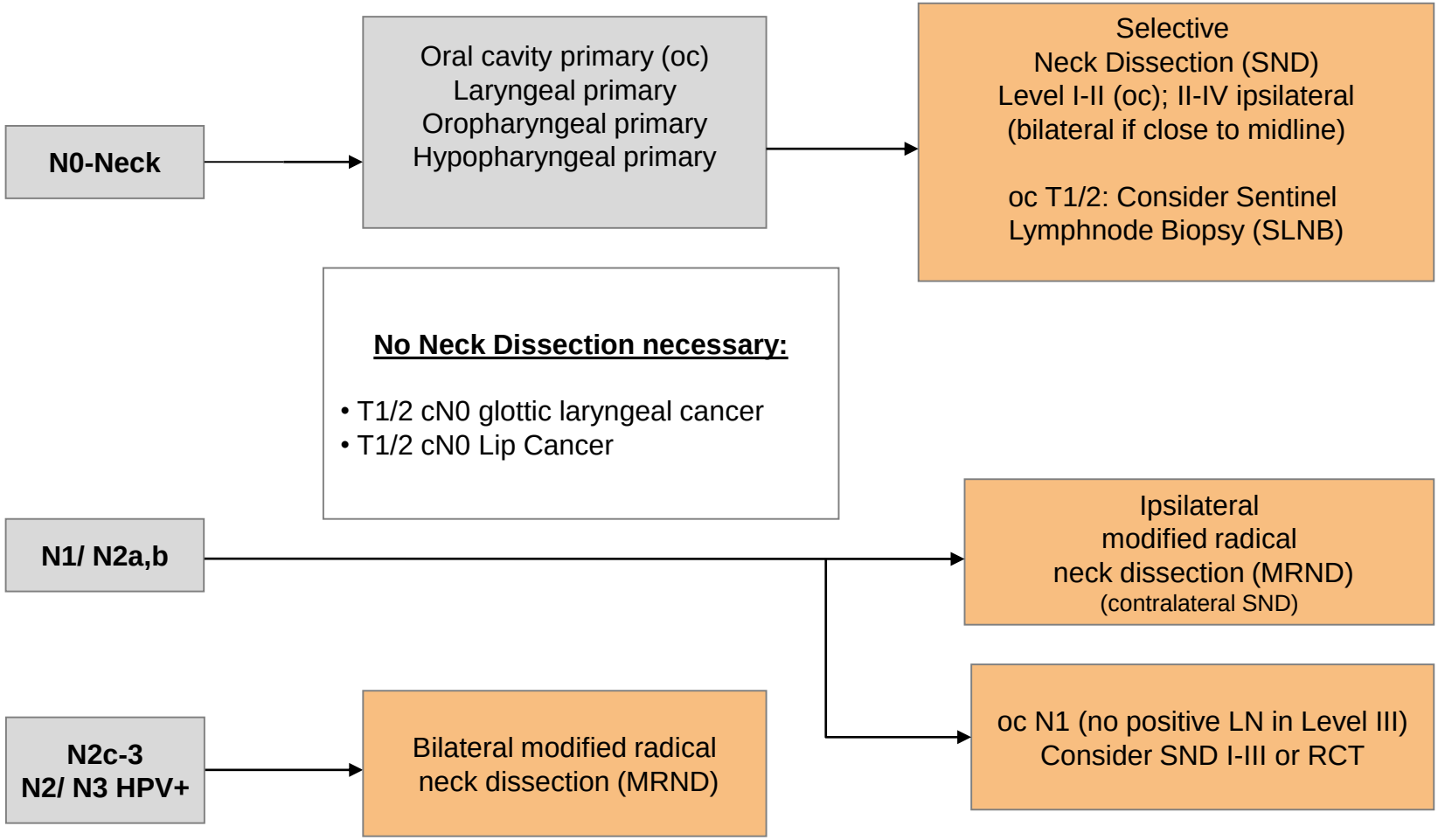
Pathway page 6: Salvage therapy



PS Performance Status, ECOG The Eastern Cooperative Oncology Group, RTx Radiotherapy, CTx Chemotherapy, BSC Best supportive care

[2] See palliative care screening tool on page 11

Pathway page 7: Indications for Neck Dissection



oc Oral Cavity Primary, RCTx Radiochemotherapy, SND Selective Neck Dissection

Pathway page 8: Restaging

3 months after completion of therapy

- Clinical examination
- Ultrasound neck
- ORL examination
- MRI neck (including primary lesion), if contraindication CT neck
- In case of unclear or suspicious lesion in thorax or abdomen: CT chest, CT/ultrasound abdomen

Pathway page 9: Follow up

Every 3 months up to 30 months, afterwards every 6 months (5-year follow up)
Offer contact to self help group and psychooncological support whenever necessary
TSH every 6-12 months if neck irradiated, dental +oral evaluation exposed to intraoral radiation treatment

First 30 months:

every 3 months: Clinical examination, Ultrasound neck
every 6 months: Clinical examination, Ultrasound neck, chest x-ray, Panoramic view, Photodocumentation

In high risk patients:

Year 1: every 6 weeks

Month 30 – 60:

every sixth month: Clinical examination, Ultrasound neck, chest x-ray, Panoramic view, Photodocumentation

CT/MRI with contrast Head+Neck:

Months: 3-6 (Restaging), 6-9, 18, 30, 60

CT with contrast Chest in pN+ situations:

Months: 6-9, 18, 30, 60

High risk patients: <45y old, 2 years after recurrence, >pN2, ECE+, constant risk factors

Pathway page 10: Best supportive care

Best supportive care / palliative treatment
Consider nutritional counseling, psychological counseling, offer contact to self-help group

Upper airway obstruction:
PEG tube
Tracheostomy

Tumor associated pain:
analgetics (WHO)
palliative (chemo)radiation

Pathway page 11: Palliative care screening tool

Screening items			Points
1.	• Presence of metastatic or locally advanced cancer		**2**
2.	• ECOG score (functional status score, performance status)		**0-4**
3.	• Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)		**1**
4.	• Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)		**1**
5.	• Presence of palliative care problems		**1**
	a.	• Symptoms uncontrolled by standard approaches	**1**
	b.	• Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	• Patient/family requests palliative care consult	**1**
	d.	• Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	• Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015

Therapy Protocols RTx/ RCTx

Definitive Radiotherapy (definitive RTx)[5]:

high risk:

- ≥ 70-72 Gy (2.0 Gy/day) or equivalent or moderately accelerated in an integrated dose concept
- External-beam RT ≥ 50 Gy +/- brachytherapy

Medium risk:

- ≥ 60 Gy (2,0/die) or equivalent or moderately accelerated in an integrated dose concept

Low risk:

- ≥ 50 Gy (2,0/die) or equivalent or moderately accelerated in an integrated dose concept

Postoperative (adjuvant) Radiotherapy (RTx)[5]:

Primary:

- ≥ 60 Gy (2.0 Gy/die) or equivalent or moderately accelerated in an integrated dose concept

Neck:

- Involved nodal stations: 60 Gy (2 Gy/day) or equivalent or moderately accelerated in an integrated dose concept
- Uninvolved nodal stations: 50 GY (2 Gy/day) or equivalent or moderately accelerated in an integrated dose concept

Palliative Radiotherapy (RTx)[5]:

- Moderate Hyperfraction or moderately accelerated in an integrated dose concept

Radio-chemotherapy (RCTx)[5]:

- Definitive or high risk adjuvant 70-72 Gy, 2 Gy/die or equivalent or moderately accelerated in an integrated dose concept
- Adjuvant 66 Gy or equivalent or moderately accelerated in an integrated dose concept
- Cisplatin 40 mg/m2 every week (max. 7 cycles)

or

- Mitomycin 10 mg/m2 day 5 and day 36 and
- 5-FU 600 mg/m2 during 120 h infusion day 1-5

5 SIB (simultane integrated boost possible**)**

Therapy protocols SCCHN (1)

TPEx

- Cisplatin 75 mg/m^2 every 3 weeks
- Docetaxel 75 mg/m^2 every 3 weeks
- Cetuximab 250 mg/m^2 weekly (400 mg/m^2 loading dose)
- + G-CSF after each cycle
- Maintenance after 4 cycles TPEx: Cetuximab 500 mg/m^2 biweekly

EXTREME

- Cisplatin 100 mg/m^2 every 3 weeks (max. 6 cycles)
- 5-FU 4000 mg/m^2 during 96h infusion every 3 weeks (max. 6 cycles)
- Cetuximab 250 mg/m^2 weekly (400 mg/m^2 loading dose)
- + G-CSF after each cycle
- Maintenance after 4-6 cycles EXTREME: Cetuximab 500 mg/m^2 biweekly

Therapy protocols SCCHN (2)

Carboplatin/Paclitaxel/Cetuximab weekly (R/M-SCCHN)

- Paclitaxel 80 mg/m^2 weekly
- Carboplatin AUC2 weekly
- Cetuximab 250 mg/m^2 weekly (400 mg loading dose)
- Maintenance after 18 weeks: Cetuximab 500 mg/m^2 biweekly

TPF (Induction) (max. 3 cycles)

- Cisplatin 80-100 mg/m^2 every 3 weeks
- 5-FU 4000 mg/m^2 during 96h infusion every 3 weeks
- Docetaxel 75 mg/m^2 every 3 weeks
- + G-CSF after each cycle

Therapy protocols SCCHN (3)

Nivolumab Mono

- Nivolumab 240 mg every 2 weeks or 480 mg every 4 weeks

Pembrolizumab Mono

- Pembrolizumab 200 mg every 3 weeks or 400 mg every 6 weeks

Pembrolizumab + PF

- Pembrolizumab 200 mg every 3 weeks
- Cisplatin 100 mg/m^2 every 3 weeks (max. 6 cycles)
- 5-FU 4000 mg/m^2 during 96h infusion every 3 weeks (max. 6 cycles)
- After PF-cycles Pembrolizumab Mono maintanance