



UCCH Pathway

UCCH Guideline

Squamous Cell Carcinoma of the Oropharynx

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Version Oct/2021

Guideline Squamous Cell Carcinoma of the Oropharynx

Version 08, Oct/2021

according to TNM classification 8th edition

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Implemented

Apr/2008

Revised

Dec/2010, Dec/2011, May/2015, May/2016, Jun/2017, Apr/2019, Oct/2021

Next planned review

Oct/2023

Legend of Colours



= Therapeutic procedure



= Clinical or diagnostic condition



= Diagnostic procedure



= Clinical trial



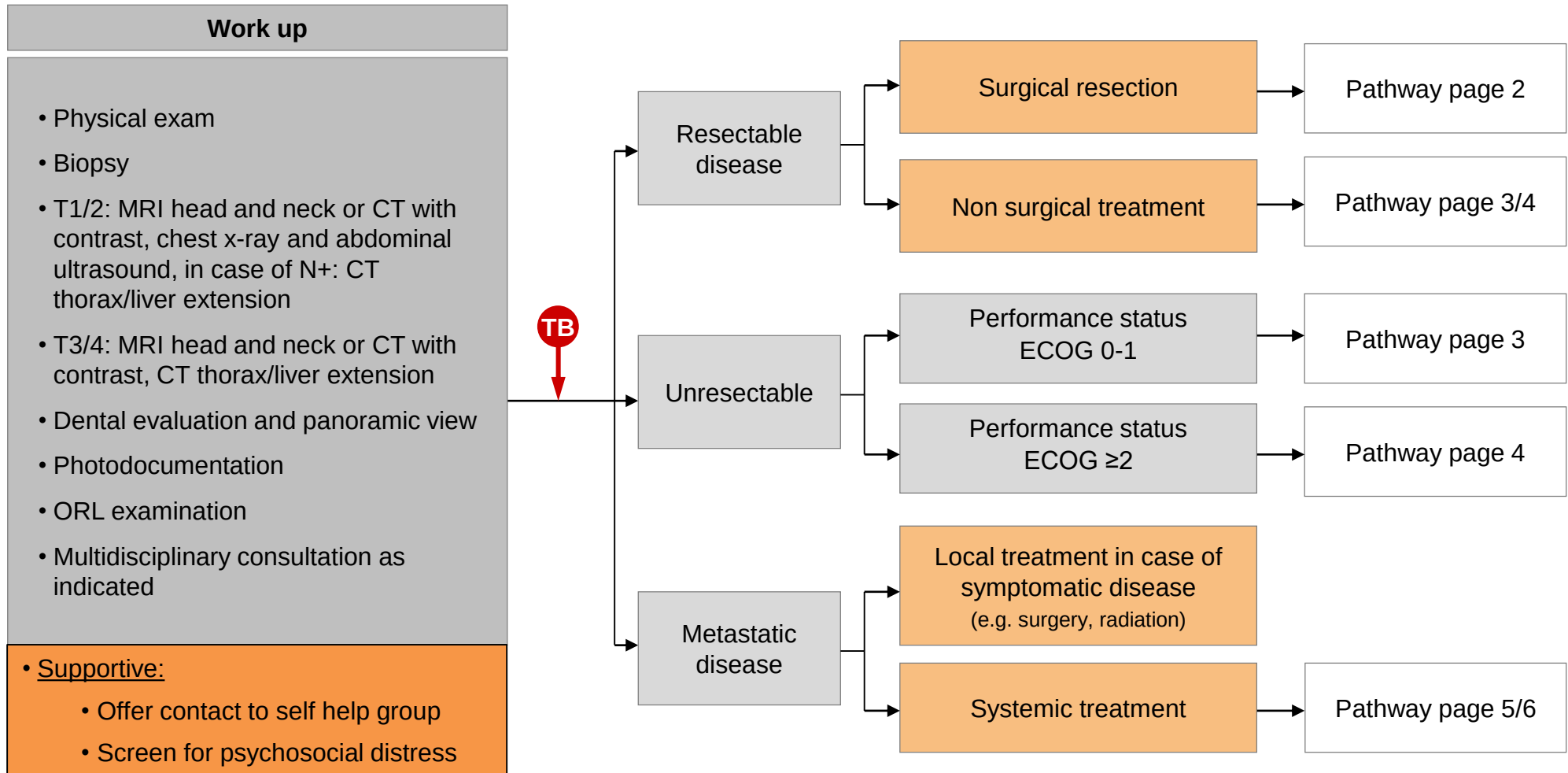
= Supportive measure



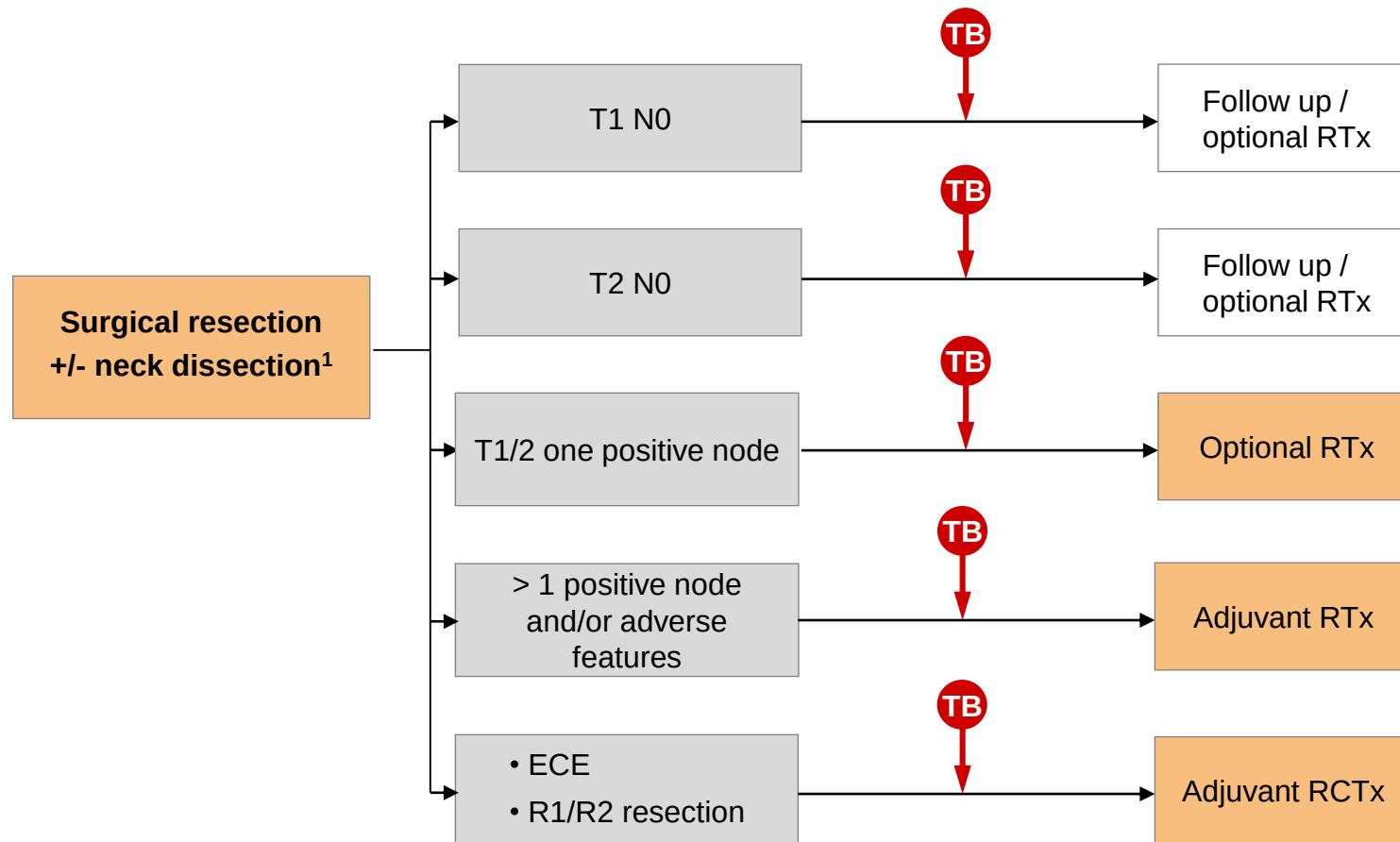
= Referral



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



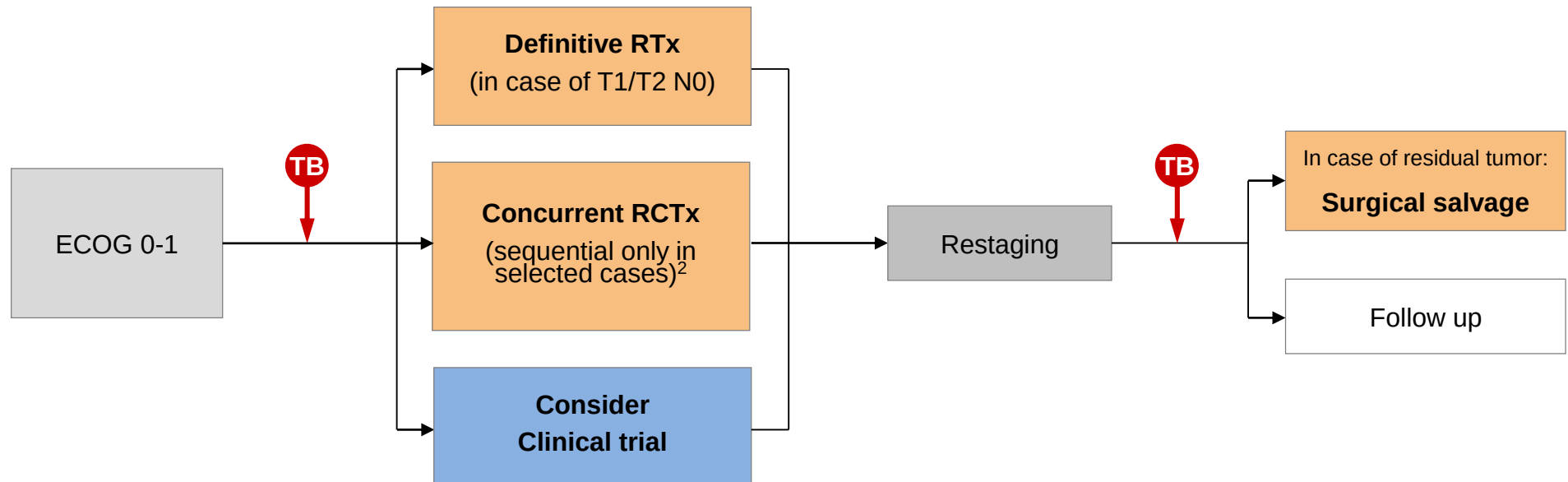
Pathway page 2: Surgical resection



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

¹ See indications for neck dissection in pathway page 8

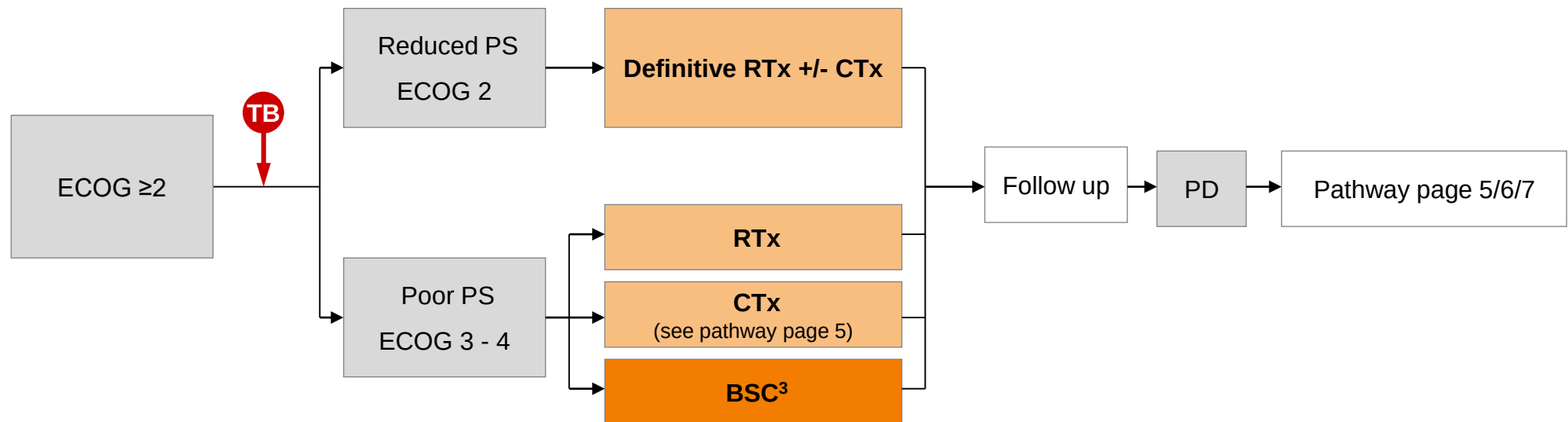
Pathway page 3: Non-surgical treatment and PS (ECOG) 0-1



ECOG The Eastern Cooperative Oncology Group, ICT Induction Chemotherapy, RTx Radiotherapy, RCTx Radiochemotherapy

² See preconditions for Protocol Sequential Therapy on page 20/21

Pathway page 4: Non-surgical treatment and PS (ECOG) ≥ 2

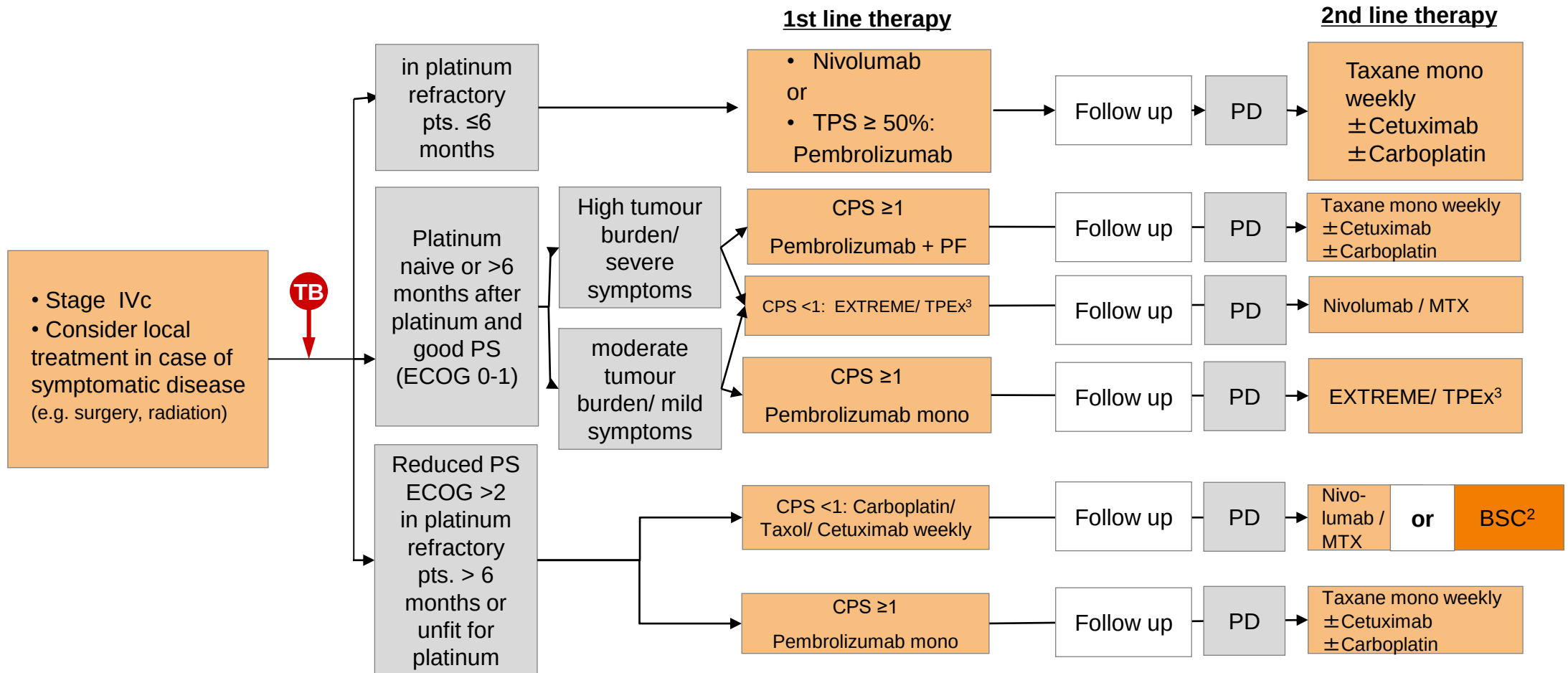


PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC best supportive care

RTx Radiotherapy, CTx Chemotherapy, PD Progressive Disease

³ See palliative care screening tool on page 12

Pathway page 5: Metastatic disease (systemic treatment)



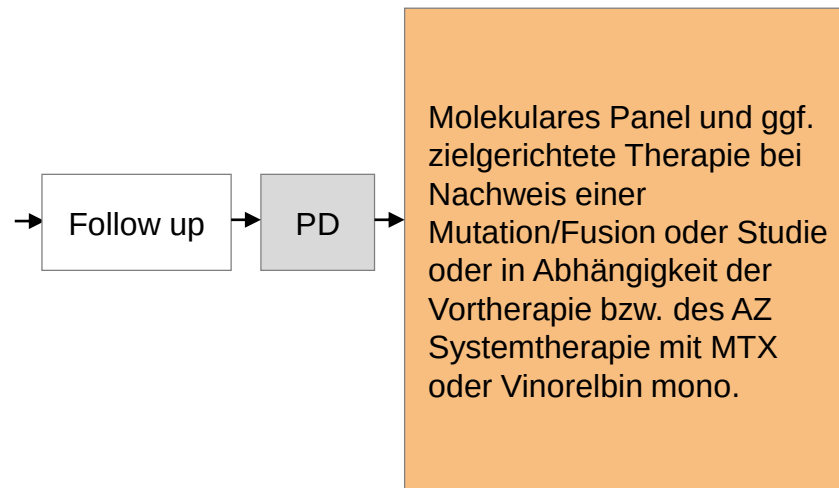
PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC Best supportive care, PD Progressive Disease, CPS combined proportion score

³ See palliative care screening tool on page 12

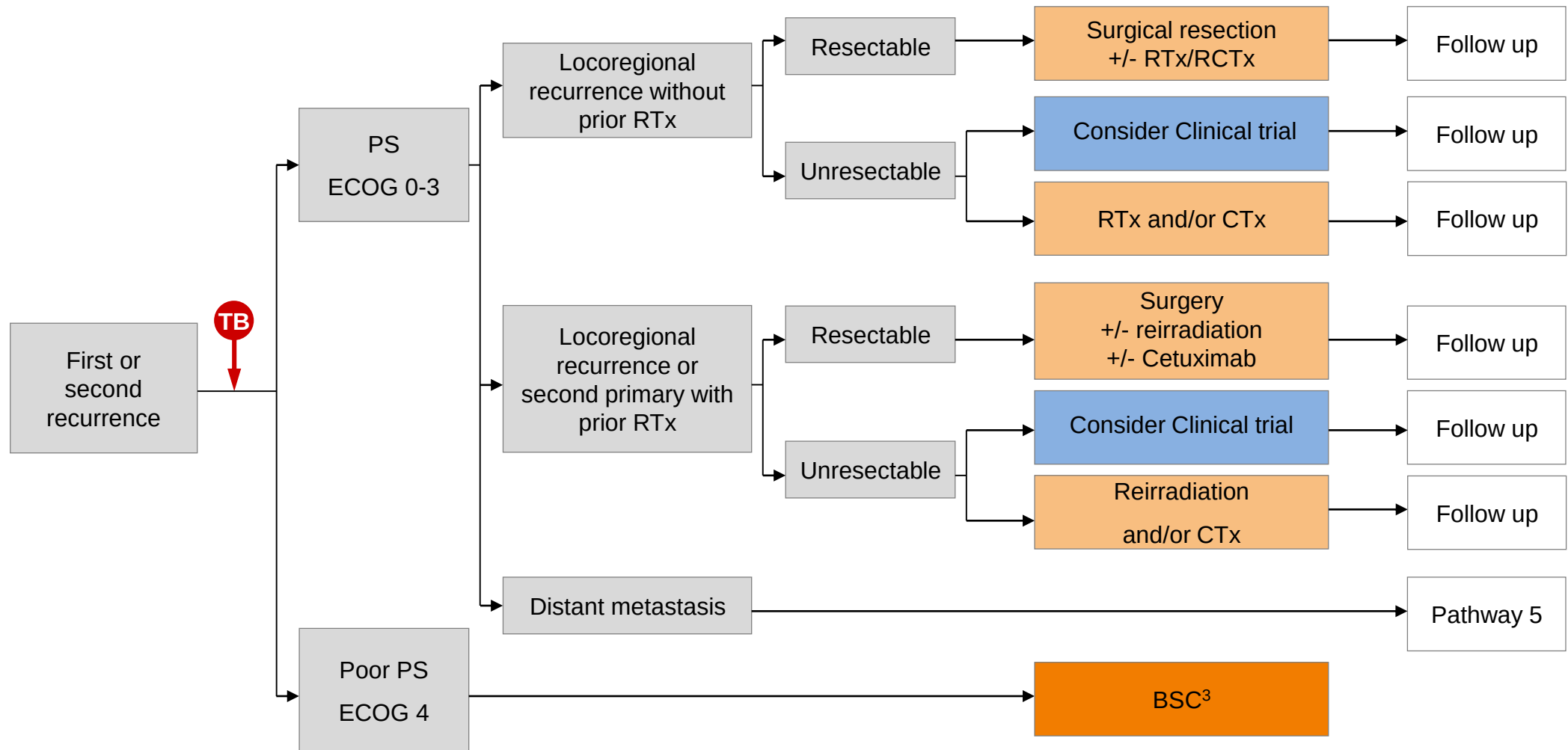
⁴ See therapy protocols SCCHN on pages 14-16

Pathway page 6: Metastatic disease (systemic treatment)

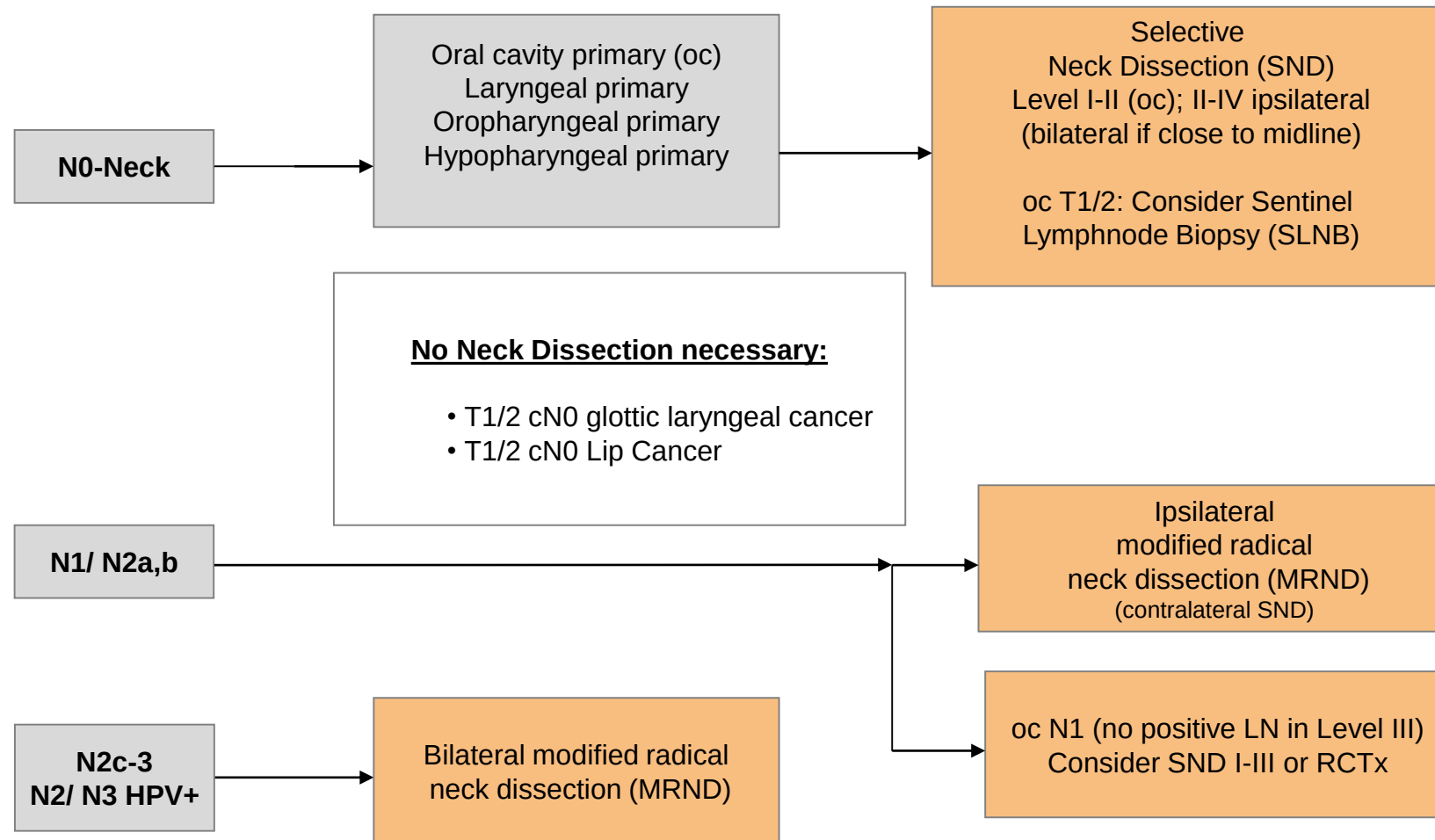
3rd line therapy



Pathway page 7: Salvage therapy



Pathway page 8: Indications for Neck Dissection



Page 9: Restaging

6 weeks after completion of therapy

- Clinical examination
- Ultrasound neck
- Examination (endoscopy) under anesthesia
- 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

Palliative setting

- CT imaging after 6-8/9 weeks, depending on clinical outcome. No imaging in clinically measurable manifestation.

Page 10: 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

- Clinical examination
- Ultrasound of the neck
- Examination (panendoscopy) under anesthesia in case of suspicion of recurrence
- Thyroid function 1, 2 and 5 years after irradiation of the neck
- AJCC I/ II:
 - Chest x-ray every 12 months and in case of suspicion of recurrence
 - MRI of the neck every 12 months and in case of suspicion of recurrence
- AJCC III/ IV:
 - MRI of the neck and CT of the thorax every 12 months and in case of suspicion of recurrence
 - Abdominal ultrasound

Page 11: 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

Page 12: 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 determining 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 signals 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)⁶:

high risk:

- $\geq 70-72$ Gy (2.0 Gy/day) or equivalent or moderately accelerated in an integrated dose concept

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)⁶:

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)⁶:

- Moderate Hyperfraction or moderately accelerated in an integrated dose concept

Radio-chemotherapy (RCTx)⁶:

- 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

⁶ SIB (simultane integrated boost possible)

Therapy protocols SCCHN (1)

TPEX

- Cisplatin 75 mg/m² every 3 weeks
- Docetaxel 75 mg/m² every 3 weeks
- Cetuximab 250 mg/m² weekly (400 mg/m² loading dose)
- + G-CSF after each cycle
- Maintenance after 4 cycles TPEX: Cetuximab 500 mg/m² biweekly

EXTREME

- Cisplatin 100 mg/m² every 3 weeks (max. 6 cycles)
- 5-FU 4000 mg/m² during 96h infusion every 3 weeks (max. 6 cycles)
- Cetuximab 250 mg/m² weekly (400 mg/m² loading dose)
- + G-CSF after each cycle
- Maintenance after 4-6 cycles EXTREME: Cetuximab 500 mg/m² biweekly

Therapy protocols SCCHN (2)

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

- Paclitaxel 80 mg/m² weekly
- Carboplatin AUC2 weekly
- Cetuximab 250 mg/m² weekly (400 mg loading dose)
- Maintenance after 18 weeks: Cetuximab 500 mg/m² biweekly

TPF (Induction) (max. 3 cycles)

- Cisplatin 80-100 mg/m² every 3 weeks
- 5-FU 4000 mg/m² during 96h infusion every 3 weeks
- Docetaxel 75 mg/m² 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/m² every 3 weeks (max. 6 cycles)
- 5-FU 4000 mg/m² during 96h infusion every 3 weeks (max. 6 cycles)
- After PF-cycles Pembrolizumab Mono maintenance

Protocol Sequential Therapy - page 1

Staging: ENT-clinic

- Physical exam
- Ultrasound neck
- Biopsy (including HPV p16 analysis)
- MRI for primary and neck (CT with contrast if contraindications against MRI)
- Chest x-ray and ultrasound abdomen **or**
- CT chest and abdomen (UICC stage III or IV and recurrent disease)
- Panendoscopy under anesthesia
- Preanesthesia studies
- Dental evaluation and panoramic view as indicated
- Voice, speech, swallowing and breathing evaluation as indicated
- Multidisciplinary consultation as indicated
- Portacath (Department of radiology, registration in angiographie phone: 54022)
- Creatinine clearance
- Audiometry
- PEG tube



Protocol Sequential Therapy - page 2

Induction chemotherapy: Medical Oncology

- 3 cycles TPF on d1, d22 and d43 (Precondition:
 - ECOG 0-1
 - Adequate bone marrow function: leucocytes $> 3.0 \times 10^9/L$, neutrophils $> 1 \times 10^9/L$, platelets $> 80 \times 10^9/L$, hemoglobin $> 9.0 \text{ g/dL}$
 - Adequate liver function: Bilirubin $< 2.0 \text{ g/dL}$, SGOT, SGPT, AP, G-GT $< 3 \times \text{ULN}$
 - Adequate renal function: serum creatinine $< 1.5 \text{ mg/dL}$, or if creatinin between 1.5 mg/dL and 1.8 mg/dL, creatinine clearance $> 60\text{ml}$
 - No serious co-morbidity, e.g. arterosclerosis + apoplexy, recent MI, high-grade carotic stenoses, unstable cardiac disease despite treatment, congestive heart failure NYHA grade 3/4, Insulin-dependent diabetes mellitus, uncontrolled hypertension, liver cirrhosis (Quick $< 75\%$, total protein $< 3.0 \text{ g/dl}$, bilirubine $> 2\text{mg/ml}$) or kidney insufficiency)
- Docetaxel 75 mg/m^2 d1, Cisplatin 100 mg/m^2 d1, 5-FU 1000 mg/m^2 d1-4 (In case of dip in hearing sensitivity Cisplatin may be splitted into 50 mg/m^2 on d1+2)
- Supportive therapie: GCSF (e.g. Neulasta) d6, Ciprobay 500 mg 1-0-1 in case of neutropenia $< 1000/\mu\text{l}$



Protocol Sequential Therapy - page 3

Restaging after 3 cycles TPF has to be organized by Medical Oncology within 3 weeks after 3. cycle TPF so that radiation can start on d 64-71!!

- Panendoscopie (ENT-clinic)
- MRI-neck (or CT if contraindications against MRI)
- Audiometry and Creatinine Clearance if necessary
- In case of CR/PR: combined radiochemotherapy beginning d63 (=>PEG-tube necessary)
- In case of SD/PD: salvage-resection with adjuvant radiation



**Radiotherapy:
Department for radiotherapy**

- Radiatio: 70Gy, 2 Gy/d (five fractions per week until week seven)



Follow up: Interdisciplinary tumor consultation