UCCH Pathway

# UCCH Guideline
# Squamous Cell Carcinoma of the Hypopharynx

2.03.01 Anlage 23

Version Oct/2021

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Squamous Cell Carcinoma of the Hypopharynx

Version 08, Oct/2021

according to TNM classification 8th edition

Squamous Cell Carcinoma of the Hypopharynx board members

M. Freytag, M. Gosau (CMF)
J. Müller (Psychooncology)
A. Böttcher, C. Betz (ENT)
P. Schafhausen (Med. Oncology)
C. Petersen (Radiooncology)
U. Göbel (patient representative UCCH)
W. Wilczak (Pathology)
J. Salamon (Radiology)

| | |
|---|---|
| Responsible author | A. Böttcher (ENT) |
| 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 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)

Version Oct/2021

# Pathway: Squamous Cell Carcinoma of the Hypopharynx

2.03.01 Anlage 23

**Work up**

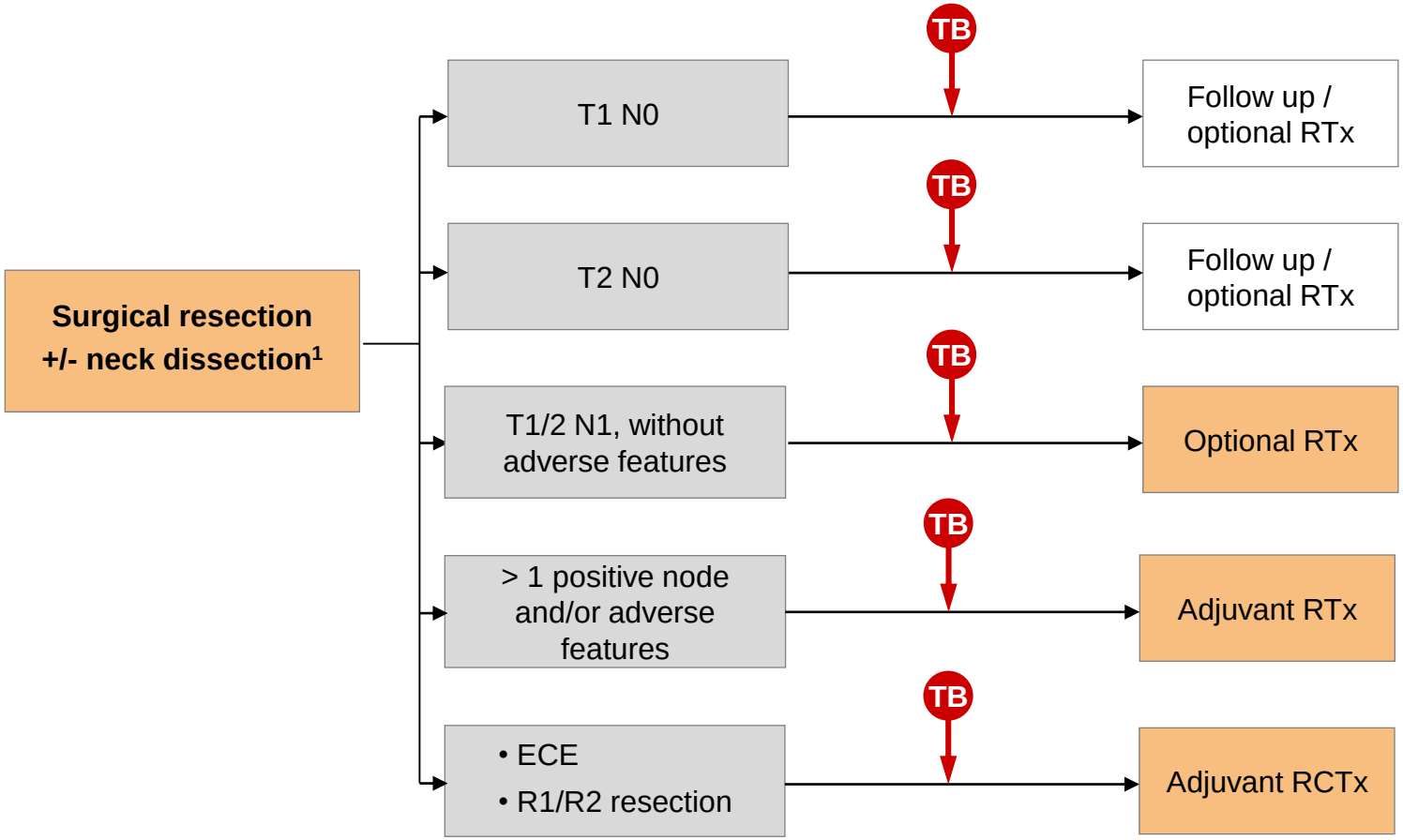
- Physical exam
- Biopsy
- T1/2: MRI head and neck or CT with contrast, chest x-ray and abdominal ultrasound, in case of N+: CT thorax/liver extension
- T3/4: MRI head and neck or CT with contrast, CT thorax/liver extension
- Dental evaluation and panoramic view
- Photodocumentation
- ORL examination
- 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
  - Non surgical treatment → Pathway page 3/4
- Unresectable
  - Performance status ECOG 0-1 → Pathway page 3
  - Performance status ECOG ≥2 → Pathway page 4
- Metastatic disease
  - Local treatment in case of symptomatic disease (e.g. surgery, radiation)
  - Systemic treatment → Pathway page 5/6

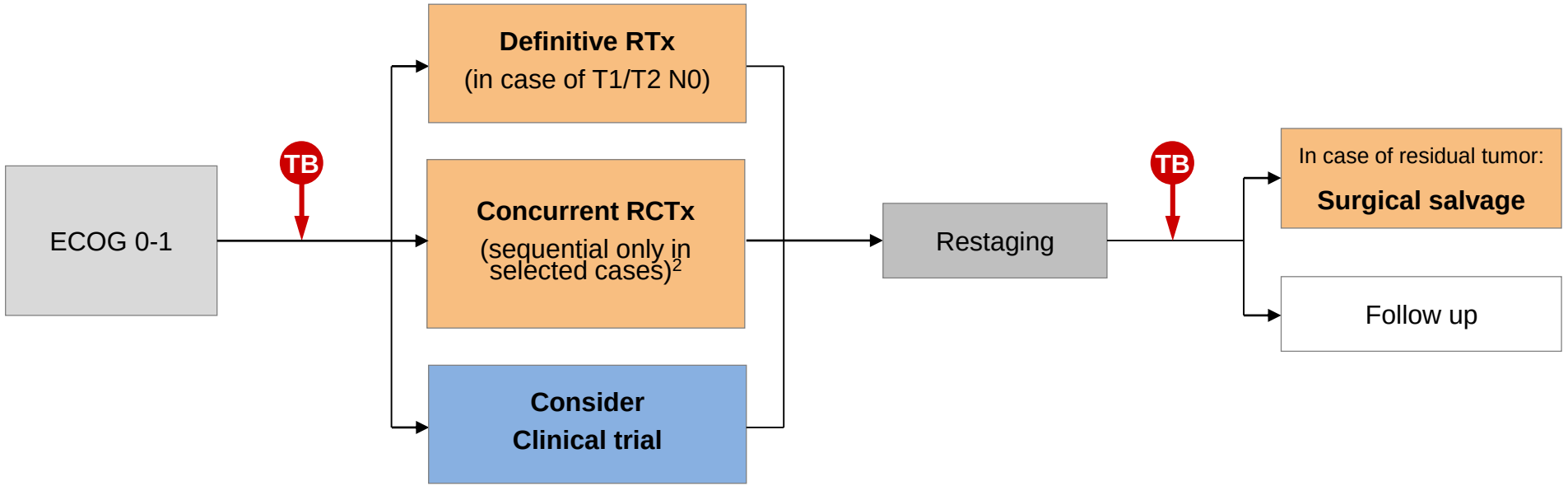
# Pathway page 2: Surgical resection




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

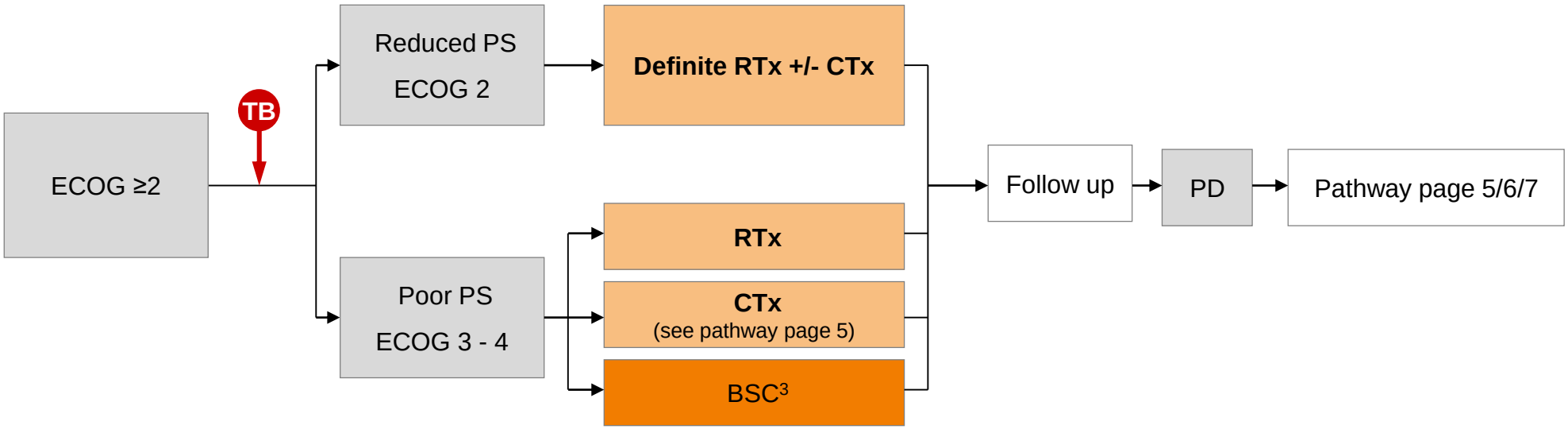
# Pathway page 3: Non-surgical treatment and PS (ECOG) 0-1




PS performance status, ECOG The Eastern Cooperative Oncology Group, RTx Radiotherapy, RCTx Radiochemotherapy

[2] See preconditions for Protocoll Sequential Therapy on page 17-19

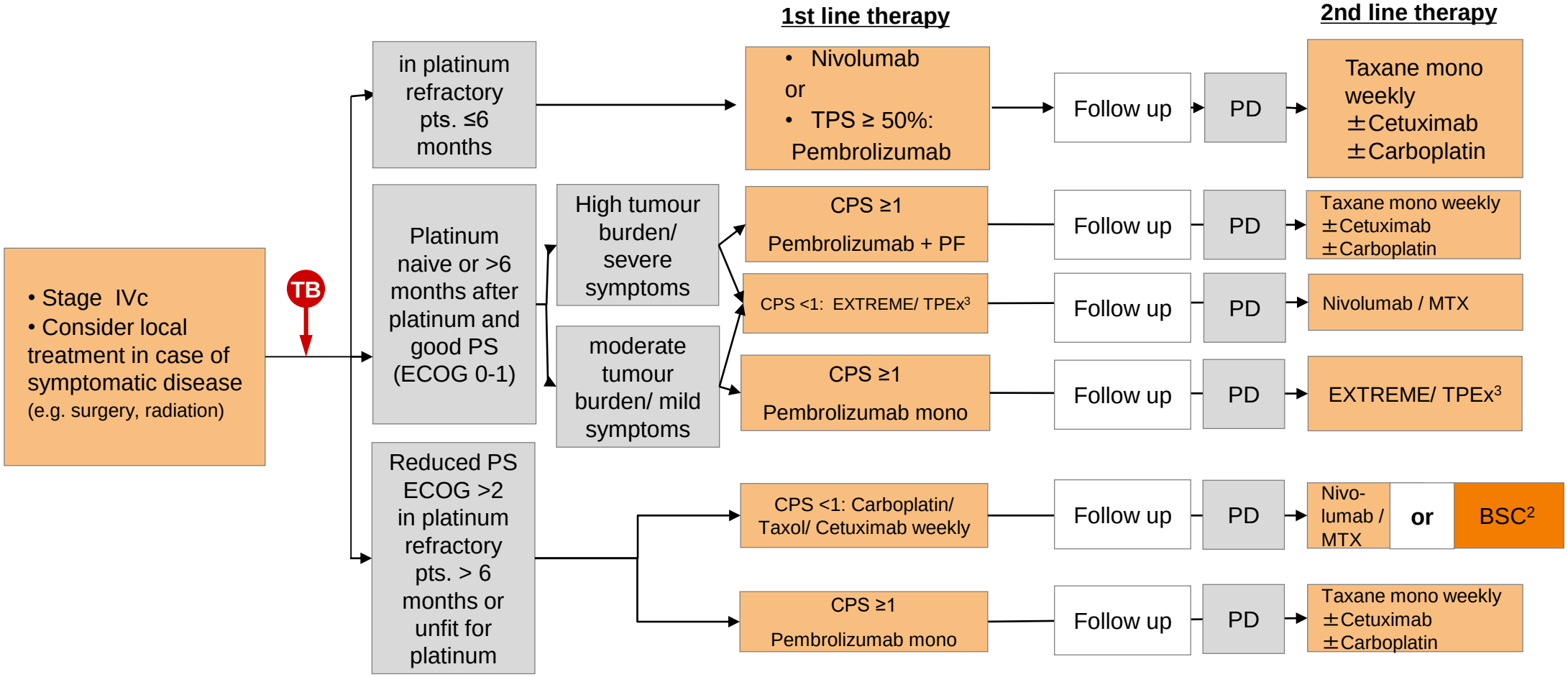
# Pathway page 4: Non-surgical treatment and PS (ECOG) ≥ 2




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

[3] See palliative care screening tool on page 12

# Pathway page 5: Metastatic disease (systemic treatment)



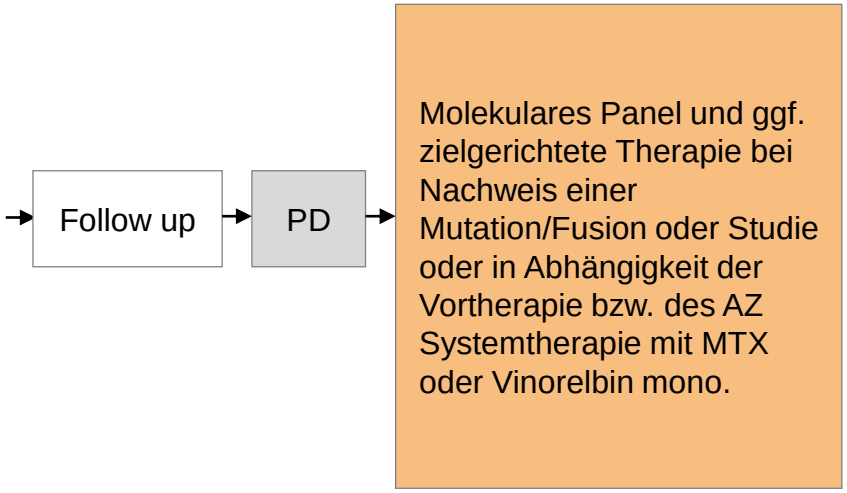

PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC Best supportive care, PD Progressive Disease, CPS combined proportion score

[3] See palliative care screening tool on page 12

[4] See therapy protocols SCCHN on pages 14-16

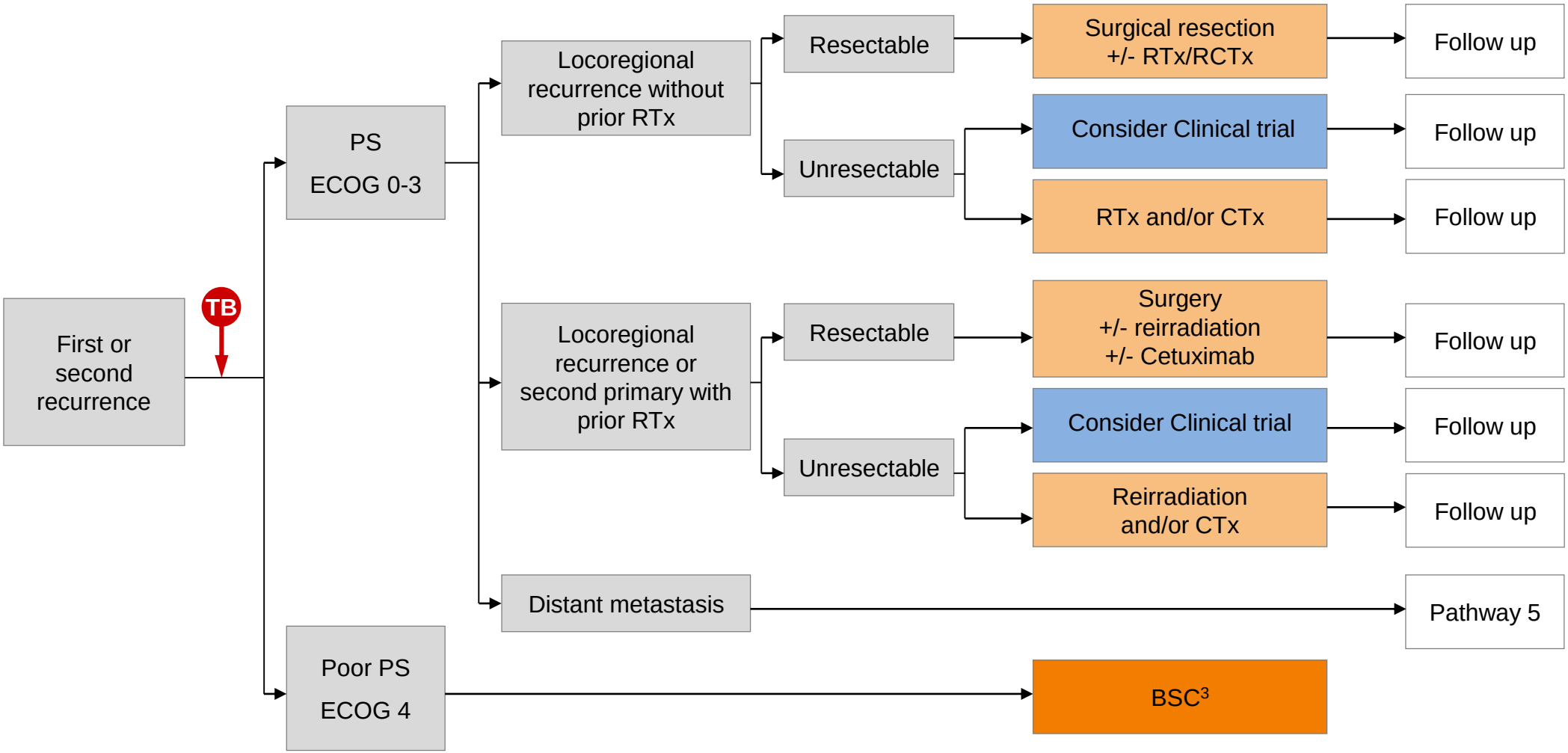
# Pathway page 6: Metastatic disease (systemic treatment)

**3rd line therapy**




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

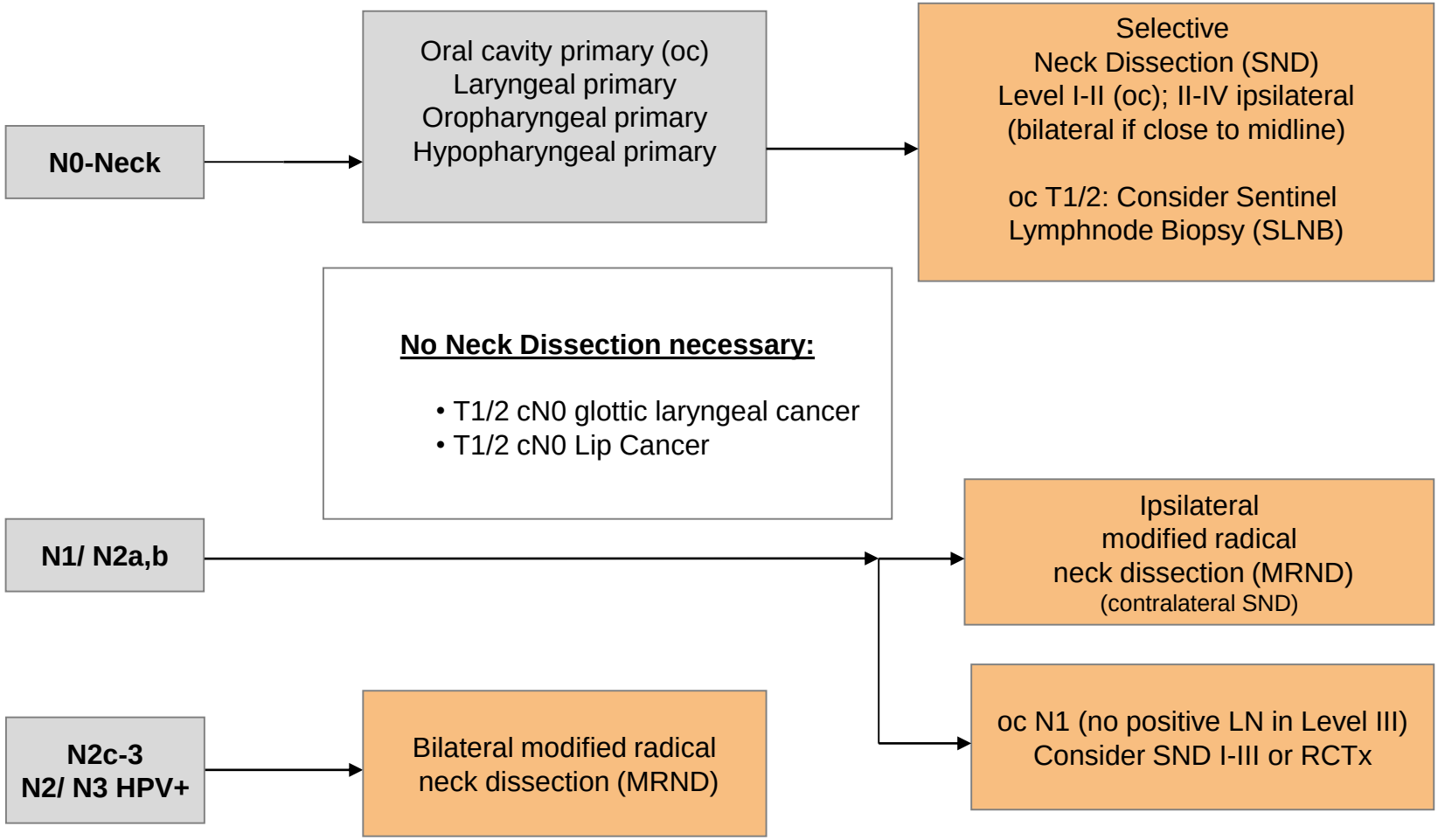
# Pathway page 7: Salvage therapy




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

[3] See palliative care screening tool on page 12

# Pathway page 8: Indications for Neck Dissection




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

# Page 9: 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

## 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

- UICC 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

- UICC 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, offering 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 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 RT)[4]:**

**high risk**:

- ≥ 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 (RT) [4]:**

**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 (RT) [4]:**

- Moderate Hyperfraction or moderately accelerated in an integrated dose concept

**Radio-chemotherapy (RCT) [4]:**

- 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

[4] 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

# 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 x $10^9$/L, neutrophils > 1 x $10^9$/L, platelets > 80 x $10^9$/L, hemoglobin > 9.0 g/dL
  - Adequate liver function: Bilirubin < 2.0 g/dL, SGOT, SGPT, AP, G-GT < 3 x ULN
  - Adequate renal function: serum creatinine <1.5 mg/dL, or if creatinin between 1.5 mg/dL and 1.8 mg/dL, creatinine clearance > 60ml
  - 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 g/dl, bilirubine >2mg/ml) or kidney insufficiency)
- Docetaxel 75 mg/m2 d1, Cisplatin 100 mg/m2 d1, 5-FU 1000 mg/m2 d1-4 (In case of dip in hearing sensitivity Cisplatin may be splitted into 50 mg/m2 on d1+2)
- Supportive therapie: GCSF (e.g. Neulasta) d6, Ciprobay 500 mg 1-0-1 in case of neutropenia < 1000/µl

# 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)

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**Follow up: Interdisciplinary tumor consultation**