UCCH Pathway

UCCH Guideline
Salivary Gland Tumors

2.03.01 Anlage 25

Version Jun/2021

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Salivary Gland Tumors

Version 08, Jun/2021

according to TNM classification 8th edition

Salivary Gland Tumors board members

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

Responsible author	Böttcher/Freytag (ENT/CMF)
Implemented	Apr/2008
Revised	Dec/2010, Dec/2011, May/2015, May/2016, Jun/2017, Apr/2019, Jun/2021
Next planned review	Jun/2023

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

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

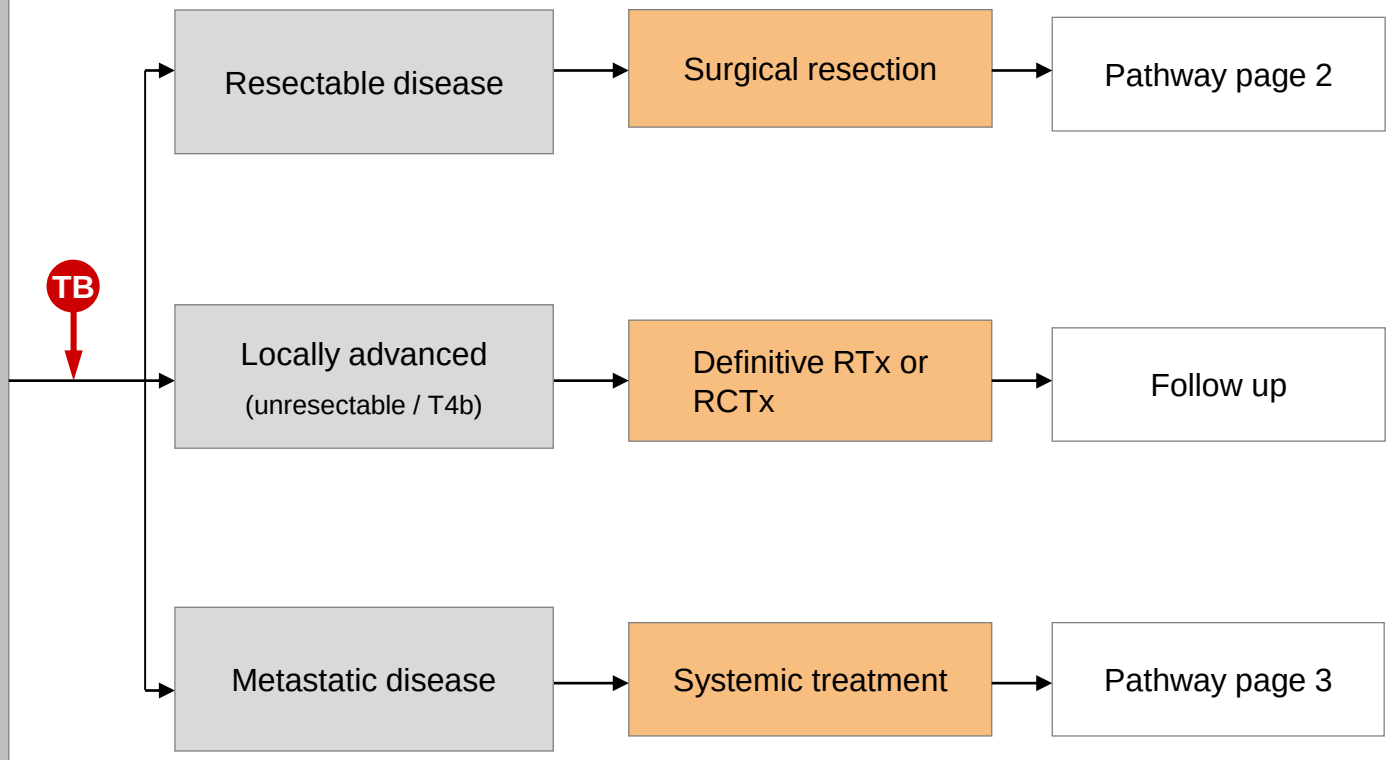
Version Jun/2021

Pathway: Salivary Gland Tumors

2.03.01 Anlage 25

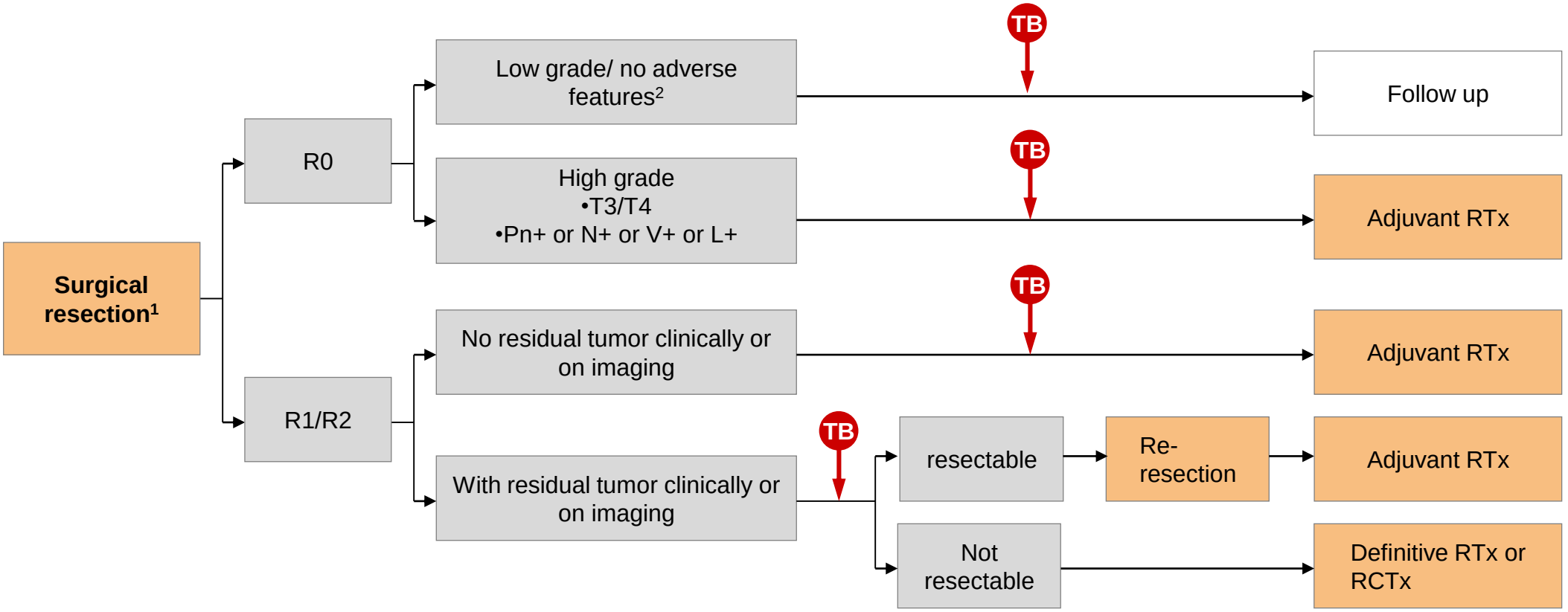
Work up

- Physical exam
- MRI head and neck (CT with contrast if contraindications against MRI)
- DWI-MRI of the salivary gland
- FNAC/ core biopsy or open biopsy if indicated
- Biopsy (if indicated e.g. locally advanced/ metastastic disease, exclusion of lymphoma)
- Chest x-ray and ultrasound abdomen **or**
- CT chest and upper abdomen (in case of T3+4, N+ and recurrent disease)
- Dental evaluation and panoramic view as indicated
- Voice, speech, swallowing and breathing evaluation as indicated
- Multidisciplinary consultation as indicated
- <u>Supportive:</u>
  - Screen for psychosocial distress
  - Offer psychooncological support



RTx Radiotherapy, RCTx Radiochemotherapy

Pathway page 2: Surgical resection

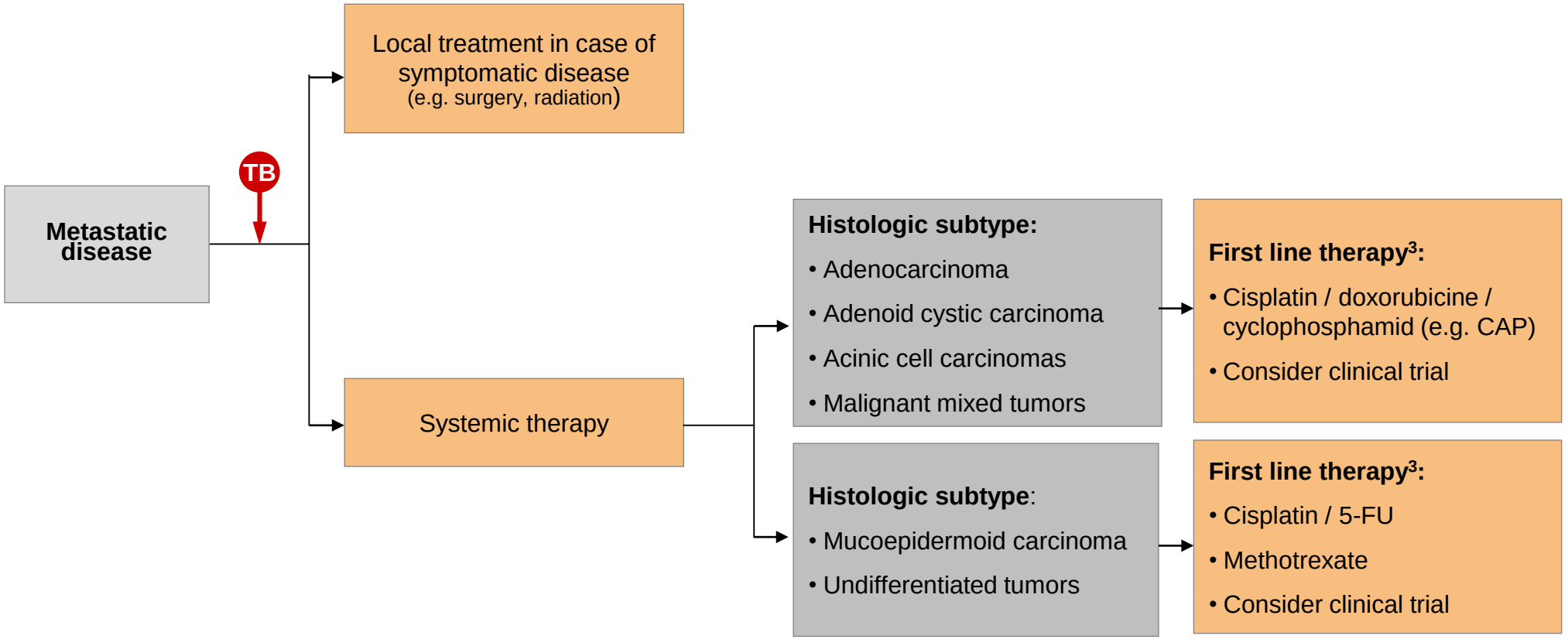


RTx Radiotherapy, RCTx Radiochemotherapy, L+= Lymphangioinvasion, Pn+= Perineural invasion, V+= Vascular invasion, N+= Positive nodes

1 Total parotidectomy + ND (in case of high grade or extensive disease) or partial parotidectomy (in case of low grade) +ND (in case of N+ or high grade)

2 V+, L+, Pn+, N+, ECS+

Pathway page 3: Metastatic disease, systemic treatment



[3] Consider treatment with trastuzumab in histologically proven positive Her-2 neu receptor status in all histologic subtype salivary gland tumors

Pathway Page 4: Restaging

6 weeks after completion of therapy

- Clinical examination
- Ultrasound neck
- 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.

Pathway Page 5: 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
- Thyroid function 1, 2 and 5 years after irradiation of the neck
- FNAC/ core needle biopsy/ open biopsy in case of suspicion of recurrence

- 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

Pathway Page 6: Therapy Protocols

Definitive Radiotherapy (RT):

- primary and gross adenopathy
  - 66 – 74 Gy; 1.8 – 2.0 Gy/fraction
- high risk nodal lymph regions
  - 44-64 Gy; 1.6 – 2.0 Gy/fraction

Adjuvant Radiotherapy (RT):

- Primary: 60 Gy, 1.8 – 2.0 Gy/fraction
- high risk neck: 44 – 64 Gy; 1,6-2.0 Gy/fraction

Radio-chemotherapy (RCT):

- 60 - 66 Gy, 2 Gy/die
- 100 mg/m^2 Cisplatin, d1, d22, d43 (optionally 40mg/m^2 weekly, in selected cases with increased risk profile reduction to 30mg / m^2 weekly) MMC and 5-FU week 1 and 5

Palliative chemotherapy (e.g. CAP):

- Cisplatin 50 mg/m^2 i.v. over 1h on d1
- Doxorubicin 50 mg/m^2 i.v. over 15 min on d1
- Cyclophosphamid 500 mg/m^2 i.v. over 1h on d1
- CAP every three weeks, max. 6 cycles