UCCH Pathway

UCCH Guideline
Nose and Paranasal Sinus Tumors

2.03.01 Anlage 43

Version Feb/2022

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Nose and Paranasal Sinus Tumors

Version 01, Feb/2022

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

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

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Pathway: Nose and paranasal sinus tumors

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There are no randomized trials that define the optimal treatment for nose and paranasal sinus tumor because of the rarity of these tumors and because of their heterogeneity in both histology and site of origin.

Work up

- Physical exam, including a complete head and Neck exam and nasal endoscopy
- MRI with contrast or CT with contrast of skull base or both
- Biopsy (adequate tissue volume, correlate to clinical features, if incongruent re-biopsy)
- Chest x ray and ultrasound abdomen or
- CT chest and upper abdomen (in case of T3/4 or N+ or 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
  - Offer Contact to self help group

TB

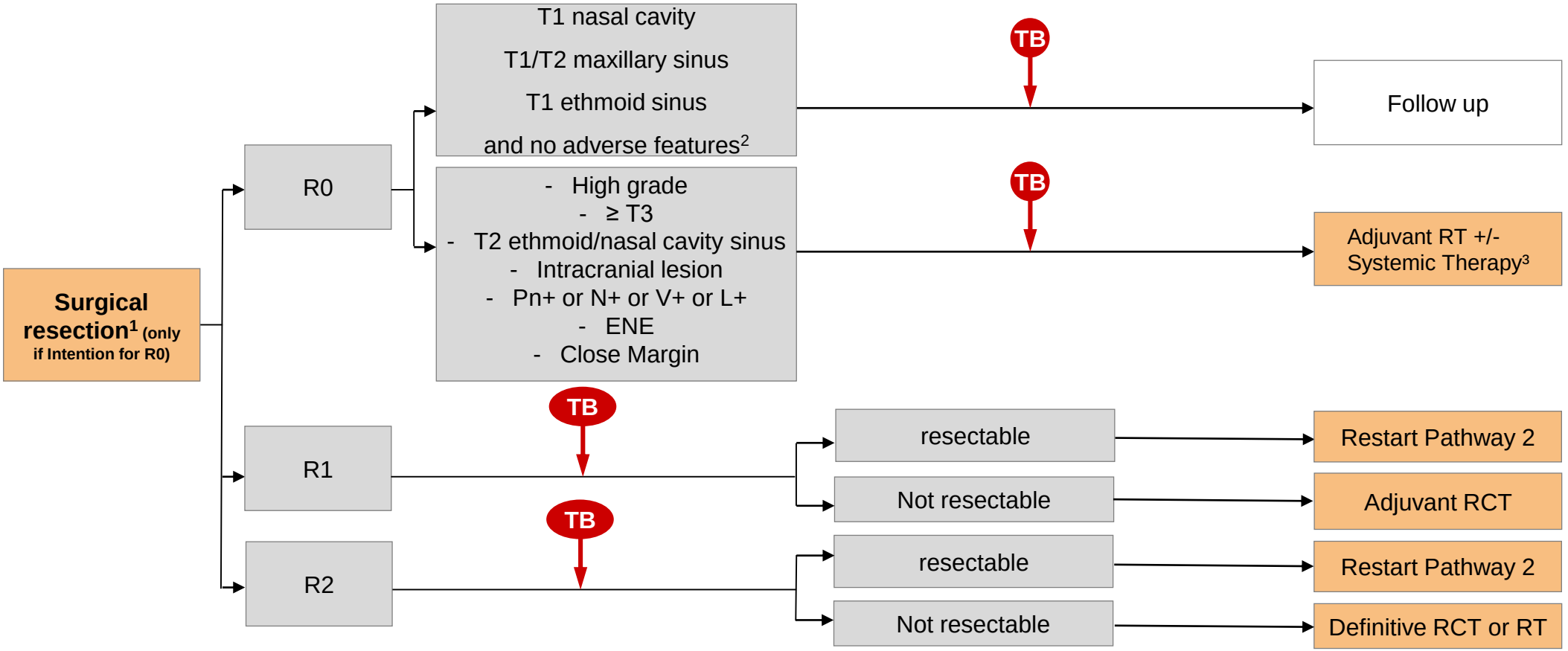
Resectable disease T1, T2, T3, T4a	Surgical resection (preferred)	Pathway page 2
cT3/4a (orbital invasion, high grade tumors)	Evaluation of Systemic Therapy followed by local treatment*	Follow up
Locally advanced (unresectable / T4b)	Definitive RCT or RT Palliative RT Best supportive care	Follow up
Metastatic disease	Systemic treatment	Pathway page 3

Excluded histologic entities: Mucosal Melanoma, Sarcoma, Lymphoma

RT Radiotherapy, RCT Radiochemotherapy

* If CR (complete remission): Consider systemic therapy/RT or RT. If <CR: Resection (see Pathway 2), followed by systemic therapy/RT (if adverse features) or RT

Pathway page 2: Surgical resection



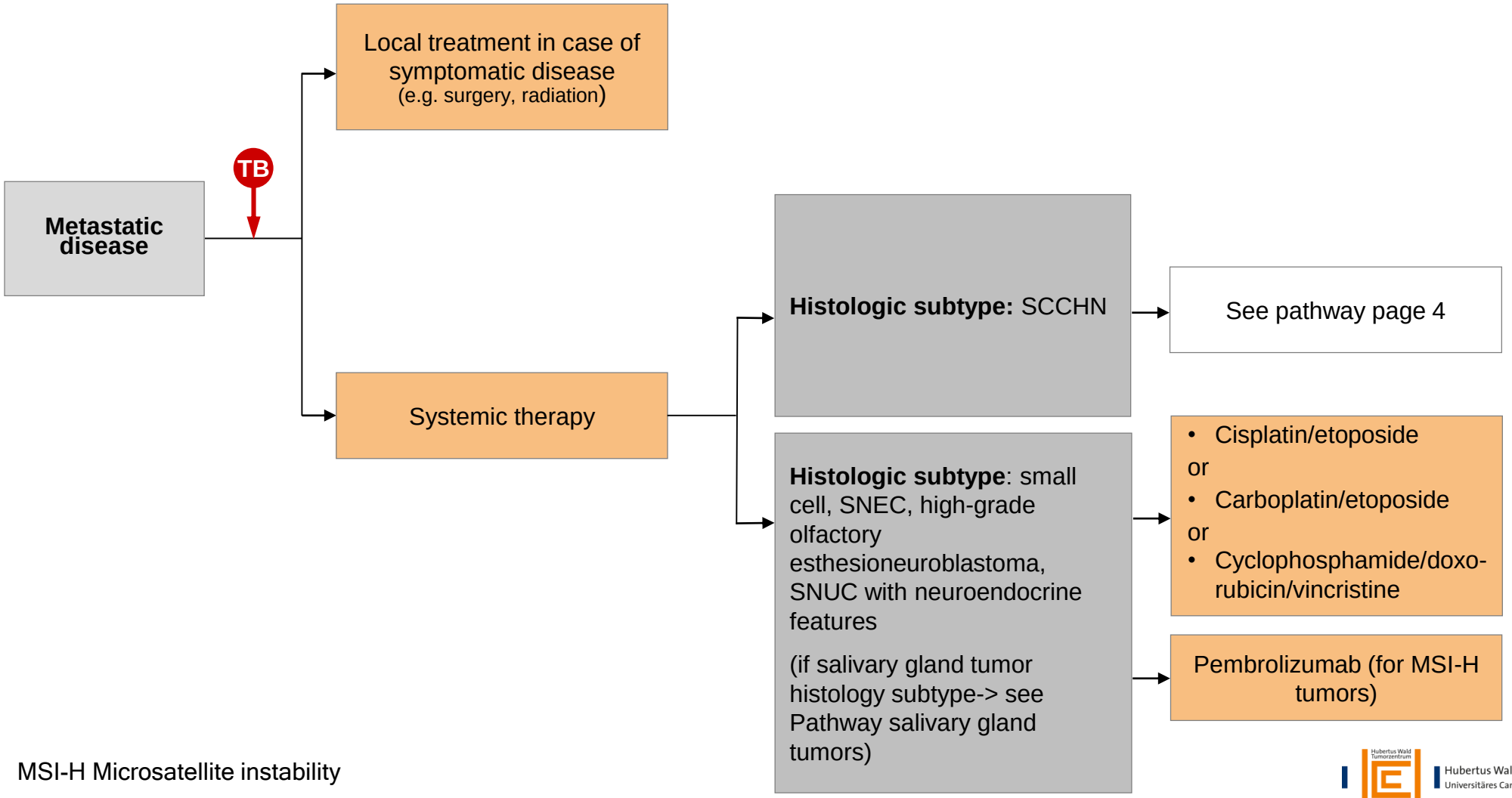
RT Radiotherapy, RCT Radiochemotherapy, L+= Lymphangioinvasion, Pn+= Perineural invasion, V+= Vascular invasion, N+= Positive nodes

[1] N+ uncommon, if present neck dissection ; T3/T4 (size > 4 cm) maxillary sinus: selective ND (ipsilateral levels I-III) possible + adjuvant therapy

[2] no positive margins, no ENE (extranodal extension)

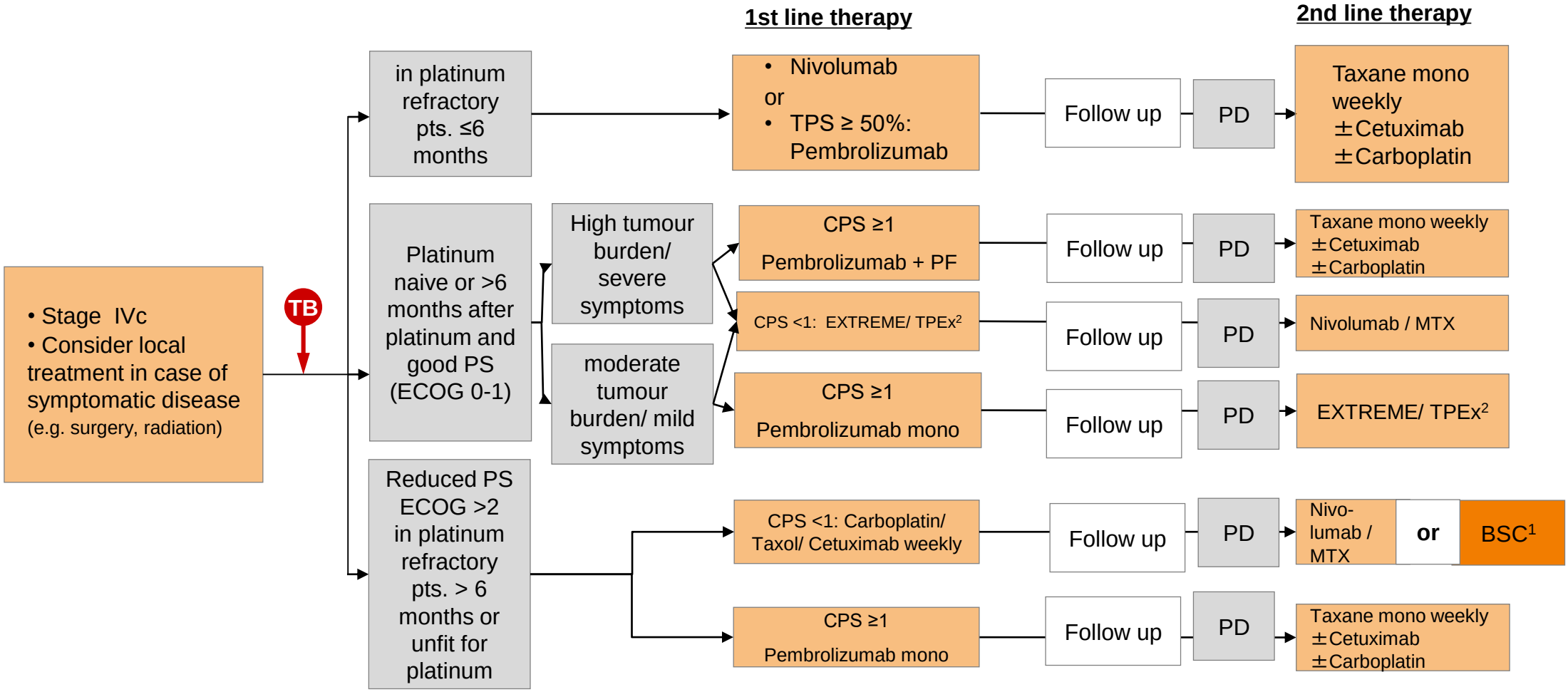
[3] If SNUC with neuroendocrine features, small cell, high-grade olfactory neuroblastoma, SNEC histologies, ENE and/or close margin, systemic therapy should be part of the overall treatment

Pathway page 3: Metastatic disease, systemic treatment



MSI-H Microsatellite instability

Pathway page 4: Metastatic disease, systemic treatment (SCCHN)



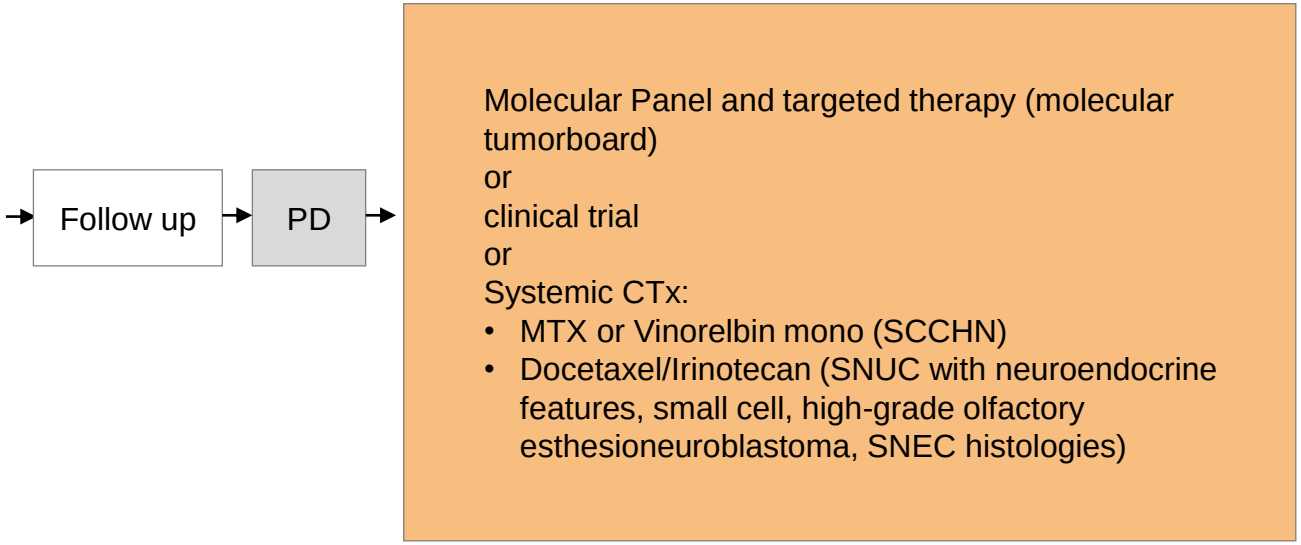
PS Performance Status, ECOG The Eastern Cooperative Oncology Group, BSC Best supportive care, PD Progressive Disease, CPS combined proportion score

[1] See palliative care screening tool on page 9

[2] See therapy protocols SCCHN on pages 11-13

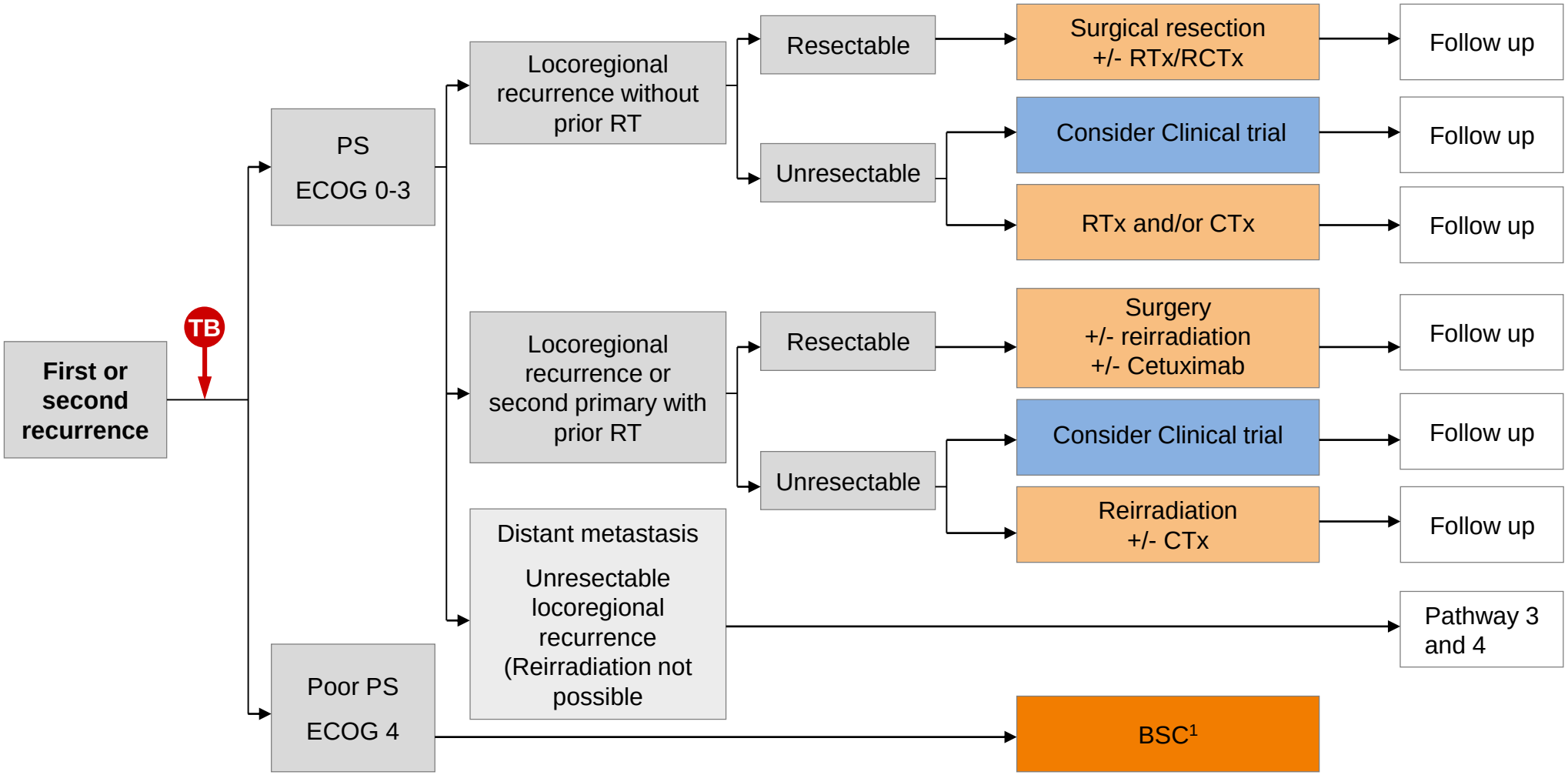
Pathway page 5: Metastatic disease, systemic treatment (SCCHN)

3rd line therapy



PD Progressive Disease, CTx Chemotherapy, MTX Methotrexate

Pathway page 6: Salvage therapy



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

[1] See palliative care screening tool on page 9

Page 7: Restaging after completion of therapy

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 / Systemic therapy

- CT imaging every 6-12 weeks, depending on clinical outcome and therapy protocol.

Page 8: 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

- MRI of the neck and CT of the thorax/abdomen every 12 months and in case of suspicion of recurrence

Page 9: 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 RT/RCT

Definitive Radiotherapy (RT):

- High-risk: 70 Gy (2 Gy)
- Median risk: 60 Gy (2 Gy)
- Low-risk: 50 Gy (2 Gy)
- Or equivalent integrated dose concept

Adjuvant Radiotherapy (RT):

- R0: 60 Gy (2 Gy), low-risk 50 Gy (2 Gy)
- R1, close margin or ECE (if age <=70y consider RCT): high-risk: 66 Gy (2 Gy), median risk: 60 Gy (2 Gy), low-risk: 50 Gy (2 Gy)
- Or equivalent integrated dose concept

Radio-chemotherapy (RCT):

- If SCC: Cisplatin 40mg/m² weekly (6x) or Cisplatin 100mg/m² d1, 22, 43
- If small cell, SNEC, high-grade olfactory esthesioneuroblastoma, SNUC with neuroendocrine features: Cisplatin 33 mg/m² day 1-3 or Carboplatin AUC5-6 day 1 every 3 weeks (max. 3 cycles) and Etoposid 100 mg/m² day 1-3 every 3 weeks (max. 3 cycles)

Therapy protocols systemic therapy, 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 systemic therapy, 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 systemic therapy, 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

Therapy protocols systemic therapy: small cell, SNEC, high-grade olfactory neuroblastoma, SNUC with neuroendocrine features

Cisplatin or Carboplatin/Etoposide

- Cisplatin 80 mg/m^2 day 1-3 or Carboplatin AUC5 day 1 every 3 weeks
- Etoposid 120 mg/m^2 day 1-3 every 3 weeks

Cyclophosphamid/Doxorubicin/Vincristine

- Cyclophosphamid 600 mg/m^2 day 1 every 3 weeks
- Docxorubicin 60 mg/m^2 day 1 every 3 weeks
- Optional: Vincristine 2 mg abs. day 1 every 3 weeks

Docetaxel/Irinotecan

- Docetaxel 35 mg/m^2 day 1, 8, 15 every 3 weeks
- Irinotecan 80 mg/m^2 day 1, 8 every 3 weeks

Pembrolizumab Mono (MSI-H tumors)

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