ESMO Minimum Clinical Recommendations for diagnosis, treatment and follow-up of squamous cell carcinoma of the head and neck

Incidence
- The crude incidence of squamous cell carcinoma of the head and neck in the European Union is 48.9 cases/100000 per year; the mortality is 30.8 cases/100000 per year.

Diagnosis
- Pathological diagnosis should be made according to the WHO classification from a surgical biopsy.

Staging and risk assessment
- Routine staging should include physical examination, head and neck endoscopy, and head and neck CT scan.
- Thoracic CT scan to rule out metastatic disease could be useful.
- Routine esophagoscopy and bronchoscopy is not recommended [III, B].
- Staging should use the TNM system.
- Tumors should be staged according to the UICC/AJCC system and be grouped into the categories shown in Figure 1.

Treatment plan
- A multidisciplinary treatment schedule should be established in all cases. Treatment should take into account the patient’s performance status. The patient’s nutritional status must be corrected and maintained.

Resectable tumor
- The standard treatment depends on primary tumor location and extension. It could be surgery with or without postoperative radiotherapy or radiotherapy alone [I, A].
- Adjuvant chemotherapy has demonstrated no benefit [I, A]. Concomitant chemo-radiotherapy with single-agent platinum following surgery has shown a benefit for disease-free and overall survival in comparison with postoperative radiotherapy alone [II, B].
- Induction chemotherapy has demonstrated no benefit on disease-free survival and overall survival [I, A]. The pattern of relapse with a reduction of distant metastasis is its only possible impact [II, C].
- Induction chemotherapy allows organ preservation for advanced larynx cancer and hypopharynx cancer requiring total laryngectomy. This organ preservation has no unfavorable impact on disease-free survival and overall survival [I, A]. The standard chemotherapy in this indication combines cisplatin and 5-fluorouracil [I, A]. The decision to avoid surgery and to give radiotherapy alone is based on response to induction chemotherapy. The level of response allowing organ preservation is debatable.

Unresectable tumor
- Concurrent chemo-radiotherapy, concomitant or alternated treatment is recommended [I, A]. This modality is superior to radiotherapy alone for response rate, disease-free survival and overall survival [I, A], but associated with increased toxicity. For patients with poor performance status standard radiotherapy alone should be considered.
- A platinum-based regimen remains the standard chemotherapy for concurrent chemo-radiotherapy [I, A].
- Induction chemotherapy followed by radiotherapy alone or by surgery in case the primary tumor becomes resectable has demonstrated no benefit in comparison with radiotherapy alone [I, A]. Induction chemotherapy followed by a concomitant chemo-radiotherapy should still be viewed as investigational.

Local regional and metastatic recurrence
- Surgery and/or radiotherapy is rarely curative. For most patients palliative chemotherapy is the standard option.
- Weekly methotrexate is considered to be a standard treatment [I, B].
- Combination chemotherapy with cisplatin has a significantly higher response rate than methotrexate alone, but without any benefit in terms of survival [II, B].

Follow-up
- The optimal approach to the post-treatment surveillance of patients is controversial. The aim of the follow-up is the early
detection of local regional recurrence and potentially curable second primary tumors. The results of physical examination will determine further investigations: CT scan, MRI, ultrasonography, endoscopy with biopsy fine-needle aspiration and head and neck endoscopy.

• Evaluation of thyroid function should be carried out in patients with irradiation to the neck at 1, 2 and 5 years.

Note

Levels of Evidence [I–V] and Grades of Recommendation [A–D] as used by the American Society of Clinical Oncology are given in square brackets. Statements without grading were considered justified standard clinical practice by the expert authors and the ESMO faculty.

Literature


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