



**PRINCESS MARGARET CANCER CENTRE
CLINICAL PRACTICE GUIDELINES**

HEAD AND NECK

PALLIATIVE MANAGEMENT OF HEAD & NECK CANCER

Head & Neck Site Group – Palliative Management of Head and Neck Cancer

1. Introduction

- Patients with head and neck malignancy not suitable for curative treatment may include patients with metastatic disease at diagnosis, recurrent disease not suitable for a curative approach, as well as patients unfit for or declining curative treatment due to co-morbidities and/or extent of disease
- Treatment approaches for these patients should be individualized, taking into account the relevant patient, tumor and treatment factors that will influence management decisions
- A multidisciplinary approach is important involving the relevant members of the head and neck team to ensure optimal symptomatic and supportive management
- *These policies are the property of the Princess Margaret Hospital (PMH) Department of Radiation Oncology (DRO) Head and Neck Site Group. They should not be interpreted out of context. At all times the responsibility of the care of any individual patient remains that of the treating physician and prevails over the views of any group. Any formal use of these policies should only be undertaken under the direction of a member of the PMH DRO Head and Neck Site Group. The PMH Radiation Medicine Program accepts no responsibility for the care of any patient beyond these parameters.*

2. Management

2.1 Radiation Therapy

- Used in management of locoregional disease, where the goal of therapy may be:
 - to palliate existing symptoms
 - to delay progression of disease in order to delay onset of symptoms and provide longer symptom-free period / improved quality of life
- may also be used in palliation of symptomatic distant metastases (beyond the scope of this guideline)
- Target delineation:
 - Target volume will usually encompass gross tumor volume (GTV) only (i.e. no “elective” volume for subclinical disease)
 - In some instances regions of gross disease may be left untreated in order to focus on symptomatic disease and limit toxicity
- Choice of fractionation regimen will depend on patient and tumor factors. Suitable regimens include:
 - For pts with better performance status and able to tolerate longer treatment course, consider high-dose palliation, for local control:
 - 50Gy in 20 fractions, once daily (5 fractions/week)
 - Consider split-course schedule i.e 10 fractions, 5/week, 1-2 week break, then remaining 10 daily fractions, 5/week

- in certain situations (very good patient performance status with survival anticipated to be > 6 months) more aggressive dose regimes may be considered (60 Gy in 25 fractions or 70Gy in 35 fractions)
 - For pts with limited prognosis, but performance status sufficient to tolerate short course RT, appropriate standard palliative fractionation regimens include:
 - 20Gy in 5 fractions, daily over 1 week
 - 30Gy in 10 fractions, daily over 2 weeks
 - Very poor performance status (ECOG 3) and/or very limited prognosis, or by patient preference:
 - “0-7-21” schedule: 24Gy in 3 fractions, delivered day 0, day 7, day 21
 - Patients treated on “0-7-21” schedule should be reviewed prior to each fraction to assess patient tolerance and decision to proceed
 - single fraction 8Gy (for symptom control e.g. bleeding)
- Note that normal tissue tolerances for critical structures for hypofractionated regimens should be observed
 - e.g. for 0-7-21 regimen: 100% (total dose) exceeds spinal cord and brainstem tolerance for late effects therefore optic and neural structures must be excluded from the final fraction

2.2 Chemotherapy

- May be used in the palliative setting for patients with
 - Distant metastatic disease
 - Locoregional disease with symptoms unsuitable for / unable to be palliated with locoregional therapy (e.g. patients with recurrent/progressive disease that cannot receive further radiotherapy)
- The goals of treatment are similar to those stated above for radiation therapy, where the approach is to provide treatment in order to reduce, or delay onset of symptoms, without excessive treatment-related side-effects in order to provide overall improvement in quality of life (QOL) in patients with incurable disease
- Choice of regimen must be individualized, and depends on
 - patient factors (such as performance status, patient preference, QOL, tolerance of toxicity profile)
 - tumor factors (histology, extent and natural history of disease)
 - treatment factors (previous treatment, likely toxicities).
- Options for therapy include the following agents:
 - Platinum (cisplatin / carboplatin)
 - Fluoropyrimidines (5-FU or capecitabine)
 - Gemcitabine
 - Taxanes
 - Anti-EGFR targeted agents e.g cetuximab

- combination therapy (e.g platinum/5-FU/cetuximab, platinum/5-FU or platinum/gemcitabine) may be suitable for better performance status with reasonable life expectancy
- selected patients may be offered enrollment in phase I , II or III trials evaluating new agents based on tumor molecular characteristics and/or including immunotherapy agents.

2.3 Supportive Care

- Supportive care and symptom management only are appropriate for patients with poor performance status, significant co-morbidities and / or limited life expectancy, as well as by patient preference
- Early involvement of the specialist palliative care team is important, and need not preclude active therapy for patients with incurable disease
- Setting for palliative care team assessment and care delivery again depends on patient, tumor and treatment factors. Options include outpatient clinics, home-based care, as well as inpatient (hospice) care, with the latter usually reserved for patients with complex symptoms and care needs and/or end-of-life care.
- Goals are to aid in
 - Physical symptom management
 - Address psychosocial and spiritual needs
 - Advanced care planning

2.4 Surgical Care

- Surgical management of the palliative patient most often involves the placement of a tracheostomy tube for palliation of airway obstruction
- Surgery may play a role in the management of tumors with excessive bleeding that cannot be controlled by other means (radiation and/or embolization procedures)
- In rare instances non curative surgical resection of gross symptomatic tumor can be considered
- Gastrostomy tube placement may be considered to facilitate the administration of palliative medication, hydration or nutrition