SFORL Guidelines

French Society of ENT (SFORL) guidelines for care pathway organization in head and neck oncology (short version).

Early management of head and neck cancer


Keywords:
- Head and neck cancer
- Recurrence
- Screening
- Imaging

ABSTRACT

Early management in oncology is based on coordination and high-quality exchange between the various health-care partners. The present guidelines are based on a literature search with levels of evidence. Treatment waiting time can be optimized by performing assessment as early as possible (Expert opinion), to limit the interval (ideally, less than 4 weeks) between first consultation and data collection. In the first specialist consultation, diagnostic work-up should be scheduled and the data required for management should be determined (Grade B). Work-up may be conducted on a day-care basis or with conventional admission (Expert opinion). The patient’s medico-social context should be taken into account from the outset, with social work involvement whenever necessary (Expert opinion). Pain and nutritional management should be planned for (Grade A) and realistic therapeutic education be provided (Expert opinion). Community-hospital teamwork for supportive care should be optimized (Expert opinion). Management should be early and multidisciplinary, to shorten delay between diagnosis and treatment initiation.

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1. Introduction

Objective No. 2 of the French 2014–2019 Cancer Plan III [1] aims to optimize quality and safety in the management of cancerous disease (Expert opinion). This is to be achieved by improving the continuum between the various steps of the care pathway: i.e., improved coordination and exchange of high-quality information between the various health-care professionals involved.

Several points need working on to optimize early management of head and neck tumor: notably, treatment waiting time,
Table 1

<table>
<thead>
<tr>
<th>Text</th>
<th>Strength of recommendation</th>
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<tr>
<td>Level 1</td>
<td>High level of evidence</td>
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<tr>
<td>High-power randomized comparative trial</td>
<td>Grade A</td>
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<td>Meta-analysis of randomized comparative trials</td>
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<td>Decision analysis founded on well-conducted studies</td>
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<td>Level 2</td>
<td>Moderate level of evidence</td>
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<td>Low-power randomized comparative trial</td>
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<td>Cohort study</td>
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<td>Case-control study</td>
<td>Low level of evidence</td>
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<td>Retrospective comparative trial</td>
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<td>Comparative study with significant bias</td>
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<td>Retrospective study</td>
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<td>Case series</td>
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<td>Descriptive epidemiological study (transversal, longitudinal)</td>
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<td>Any other publication (case report, expert opinion, etc)</td>
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Adapted from the French National Health Accreditation and Assessment Agency guide (ANAES) literature assessment and guidelines grading guide (January 2000).

The present classification is intended to clarify the bases on which guidelines are drawn up. Absence of level of evidence should encourage further studies when possible. However, absence of level of evidence does not mean that the corresponding guideline is not relevant or useful (e.g., efficacy of mastectomy in breast cancer, of antibiotics in pharyngitis, etc).

* Unless otherwise stated, guidelines are based on expert opinion.

organization of the first consultation, and rapid initiation of supportive care so as not to delay treatment.

The present paper does not cover guidelines for the consultation communicating the diagnosis, multidisciplinary team meeting (MDTM), communication of the personalized treatment plan or setting up the therapy project.

2. Methodology

Guidelines were graded A, B or C according to decreasing level of evidence, in line with the guide to literature analysis and guidelines grading published by the French National Agency for Accreditation and Evaluation in Health (ANAES) (January 2000) (Table 1).

3. The issue of delays

The literature describes two relevant delays: “patient”, and “professional” [2] (level of evidence 4). The patient delay is the interval between symptom onset and first medical consultation; professional delay begins when the patient first sees a physician (specialist or general practitioner); but this varies between publications, some putting the starting point when the patient is admitted to a specialized center and terminating with the initiation of treatment [2] (level of evidence 4). Management delay may occur at all stages, especially before the first consultation, and is a major issue in head and neck oncology.

3.1. Patient delay and referral time

A meta-analysis of 18 studies of oral cavity cancer showed the patient delay to be the main factor of delay, with intervals ranging from 3.5 to 5.4 months. The professional delay comes on top of this [2] (level of evidence 4). Referral time (between when the patient is seen by a health-care professional who suspects cancer and when the patient is referred to an oncology specialist) can be shortened at several levels [1] (Expert opinion) by:

- improved awareness in community physicians and dental surgeons (or other health-care professionals) regarding head and neck cancer screening;
- information on centers managing head and neck cancer;
- facilitating the procedure (telephone, secretariat) for appointments with appropriate specialists.

3.2. Management delay: work-up and treatment initiation

Time is needed to set up treatment once the patient has been admitted in a specialized center. Waiting time should be as short as possible so as not to delay treatment initiation, and comprises two periods: the time needed for assessment and discussion of the patient’s file in MDTM, and the time needed to set up treatment (surgery, radiation therapy and/or chemotherapy). Delay in assessment or treatment results in advanced tumor and worsened prognosis [3] (level of evidence 2), [4] (level of evidence 3). Each week of waiting time for radiation therapy reduces tumoral control by 1% [5] (level of evidence 4). Tumor volume doubling time ranges between 87 [6] (level of evidence 2) and 96 days [7] (level of evidence 4), with a 10% reduction in tumoral control per month to treatment [8] (level of evidence 4). Chen et al., in a meta-analysis of 8 studies of head and neck cancer, found a 1.15 increase in relative risk of local recurrence after radiation therapy per month between diagnosis and treatment initiation [9] (level of evidence 3). Huang et al. reported a 1.17 relative risk of local recurrence for waiting time exceeding 1 month before initiation of radiation therapy [10] (level of evidence 3).

Schlienger, like others [11–13] (level of evidence 4), reported more nuanced results, but still recommended a maximum 2 weeks’ waiting time for work-up [14] (level of evidence 4). Altogether, the literature points to a negative impact of increased time to treatment on local control and survival [3] (level of evidence 2), [4] (level of evidence 3).

In France, the National Cancer Institute (INCa) recommends an ideal maximum 4 weeks’ professional delay before treatment initiation [15] (Expert opinion). These intervals are difficult to respect, due to the number of imaging examinations required for assessment, the presence of comorbidities and the requirement for multidisciplinary management before treatment [16] (level of evidence 4).

Guideline 1
The objective is to facilitate the first consultation in the treatment center (Expert opinion).

Guideline 2
Work-up should be organized as quickly as possible so as to initiate treatment as soon as possible.

The delay between the first consultation with the treatment team and collection of the data needed for decision making, including MDTM and treatment organization, should be kept short: ideally 2 weeks and not more than 4 weeks (Grade B).

4. Organization of first consultation

Clinical head and neck examination is the first step in tumor assessment [17] (level of evidence 4). This first contact provides information, explaining the various necessary endoscopic examinations, imaging and biologic analyses. The patient is informed of the need for biopsies to reach definitive diagnosis. Initial work-up
should follow the guidelines of the French ENT Society (SFORL) on pre-treatment assessment in head and neck cancer. To avoid repeat examinations and delay, complementary examinations should follow the good practice criteria of the French-Language Society of Head and Head Imaging (Société Francophone d’Imagerie Tête et Cervix) [18] (Expert opinion).

Work-up scheduling should take account of the individual center’s organization so as to optimize examination [19] (Expert opinion).

4.1. Treatment anticipation

The first consultation should enable early initiation of supportive care [17] (Expert opinion), with an onco-geriatrician’s opinion if required by the patient’s age and general health status. General health status is assessed by the Karnofsky index and WHO Performance Status, present weight and healthy weight, weight loss and percentage weight loss with respect to healthy weight, and BMI. Ingesta are recorded [20] (level of evidence 4). Pain is assessed on a visual analog or numerical scale. Dental consultation is proposed, for dental assessment and panoramic dental X-ray if radiation therapy or chemotherapy is envisaged [17] (level of evidence 4). This initial exchange determines head and neck cancer risk factors (smoking, alcohol abuse, cannabis), with possible withdrawal supported by specialist consultations in nicotine and alcohol addiction. Analysis of occupational status, looking for occupational exposures, may lead to referral to an occupational physician for work-station adaptation. Social environment should also be assessed, to improve compliance and post-treatment quality of life. There are scores that help detect patients with social problems (EPICES). The consultation allows psychological assessment and quantification (Hospital Anxiety and Depression Scale [HADS] or MINI [psychiatric scale]) [21] (level of evidence 1) and possible dedicated consultation. The need for early referral to a social worker should be assessed.

**Guideline 3**
The first specialist consultation enables scheduling of the diagnostic work-up (biopsy and extension assessment) and to plan for the various data required for management: dental, nutritional, psychological and social status, etc. (Grade B).

4.2. Organizational aspects

Action 2.22 of the Cancer Plan consists in “providing first-line health-care workers with good practice tools for organizing the day-care pathway” [17] (Expert opinion).

Day surgery should be developed, mainly for economic reasons. The priority remains, however, to do all possible to achieve rapid diagnosis and treatment, including extension assessment (notably imaging), endoscopy with biopsies, and general assessment (cardiac, nutritional, comorbidity) as part of the pre-treatment work-up (before surgery or radiation/chemotherapy). Assessment may be performed on a day-care basis or under conventional admission according to patient-related criteria, place of residence (distance from reference center) and the time needed for the work-up.

**Guideline 4**
Initial work-up may be performed on a day-care basis or under conventional admission according to technical possibilities, type of patient and respect of recommended treatment waiting times (Expert opinion).

5. Supportive care

Supportive care should be envisaged and planned from the start. It is an integral part of Cancer Plan II (2009–2013) and is defined as “all care and support necessary for patients throughout their illness, conjointly with specific treatment” [1] (Expert opinion). The main lines comprise nutritional treatment, pain management, addiction cessation, psychological care, social support and the development of therapeutic education programs. Integrating supportive care early on in management of head and neck lesions enables treatment initiation to be optimized without delay. It also enhances the patient’s tolerance of treatment.

Nutritional management should involve specialists (nutritionists, dieticians) and be implemented as soon as cancer is suspected. Denutrition worsens postoperative morbidity and mortality, increases infection risk and reduces treatment efficacy.

Early pain management and anticipation of pain is primordial. Fifty percent of patients experience pain before treatment, 80% during treatment and 70% after treatment [22] (level of evidence 4). Pain management may be medical or use complementary techniques such as physiotherapy, auriculotherapy, acupuncture, homeopathy, etc.

In head and neck oncology, continuing intoxication by, for example, nicotine or alcohol, increases the risk of recurrence or onset of second cancer [23] (level of evidence 2). A survey performed 2 years after diagnosis of cancer found that 18% of head and neck cancer victims continued to smoke and 25% consumed alcohol 4 times a week [24] (Expert opinion). Early and rapid management of addiction is therefore essential [25] (level of evidence 4). This may consist in systematic anti-smoking consultation. Nicotine replacement may be prescribed, depending of the patient’s degree of dependence [26] (level of evidence 1). Alcoholism assessment may be suggested for patients who consume alcohol 4 or more times a week. Other addictions involved in head and neck cancer should also be taken into account. Referral to a psychologist or psychiatrist may be considered, according to the situation [27] (Expert opinion).

In head and neck cancer patients, the prevalence of depressive symptoms is between 6% and 15% [28] (Expert opinion) and the risk of suicide is elevated (3.7-fold in women) [29] (level of evidence 2). Support or medical treatment should be offered when the diagnosis is communicated, to provide accompaniment during the illness.

An optimal care pathway also includes adapted social management. Support for head and neck cancer patients is essential, as many are socially disadvantaged [30] (Expert opinion). Screening for personal, familial or occupational difficulties (EPICES score) enables the patient and family to be referred to social services [27,28] (Expert opinion). This aspect also allows links to be made between hospital and community physicians [31] (Expert opinion). Externally, the social worker optimizes networking (home hospitalization, home nursing care, community nurses, personal services, etc.) and the setting up of assistance (social and family intervention technician, social life auxiliary, etc.) and financial help (local personalized autonomy allowance [Allocation Départementale Personnalisée d’Autonomie], national health and social action for palliative care fund [Fonds National d’Action Sanitaire et Sociale de Soins Palliatifs], etc.).

Finally, therapeutic education improves autonomy in the patient’s management of disease and treatment and enhances quality of life [32] (Expert opinion). Some teams have launched therapeutic education programs, but none have yet been validated by the French Health Authority, although they promote hospital-community links and improve management.
6. Conclusion

Management of head and neck cancer in specialist centers should be early. It should optimize diagnostic work-up and shorten waiting times between diagnosis and treatment initiation.

Organizing the care pathway as of the first consultation promises improved survival and quality of life. The hospital-community network is essential, to promote home management and reduce fatigue in patients and family.

Early management of head and neck cancer thus requires a multidisciplinary approach, and should be provided by approved centers.

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Guideline 5

The patient’s medico-social context should systematically be taken into account, with the help of social services whenever required (Expert opinion).

Pain detection and management should be early (Grade A).

Realistic therapeutic education should be offered (Expert opinion).

Community-hospital collaboration should be promoted for supportive care (Expert opinion).

References