Upper Airways Tract Cancer Guideline

Stakeholder Workshop: Group Notes

GROUP 1

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Proposed membership of the GDG

The group were happy with the proposed GDG membership. The following additional comments were made:

Adding a GP – the group agreed this was not necessary due to their limited role in the management of upper airways tract cancers. A GP would only contribute after treatment to deal with palliative care or psychological issues as a consequence of surgery.

Clinical Nurse Specialist – The group agreed that only one CNS would be needed for this guideline development group.

Scope

1 Guideline title

The majority of attendees recommended that the guideline title should be changes to 'Upper Aero-digestive tract cancers' as this is the term they are more familiar with in clinical practice. UAT is rarely used.

3 Clinical need for the guideline

3.1 Epidemiology

The group suggested that a table of incidence for all the UAT cancers covered by the scope would be easier to comprehend.

3.2 Current Practice

Section 3.2 d in relation to the treatment of laryngeal cancer. The group agreed this statement was too direct and that a better wording would be 'There has been a change in the treatment of laryngeal cancer over the last decade, with an increasing use of laser treatment.....'

Section 3.2g – change 'treatment' to 'investigation'.

4.1 Population

4.1.1 Groups that will be covered

The group noted that that the inclusion of 'lip' as a separate site for upper air ways tract cancer was not necessary as tumours in this site would be part of the oral cavity. They suggested lip was deleted.

An age cut-off of 16 years and over was agreed appropriate.

The group discussed and recommended the inclusion of salivary gland cancers within the scope and felt that due to the nature of the cancers that arise in this area (majority are non-squamous) then a different treatment pathway is usually necessary. The group also noted that there is substantial variation in practice in the treatment of salivary gland cancers, particularly surgery and non-adjuvant treatments.

It was also recommended that cancers of unknown primary (CUP) should also be included.

4.1.2 Groups that will not be covered

It was suggested that cancers of the middle ear be removed from this list as it was not relevant to the guideline remit.

4.2 Healthcare settings

The group were in agreement with this section**.**

4.3 Clinical Management

4.3.1 Key clinical issues that will be covered

Topic A

It was suggested that the information needs in this topic should look at the provision of psychological care and the disfiguring effects of surgery.

Topic B

The group discussed this topic and agreed that although there is known variation in practice in relation to the structure of neck lump clinics. The main area of concern was in relation to the type of diagnostics available and the appropriate clinical management of patients rather than the structure of the clinics.

Topic C

Core biopsy could be added as a staging tool.

Topic D – I

These topics are all about the appropriate treatment for each different UAT cancer site. The group agreed that in addition to the 6 sites a further two topics on salivary gland tumours and CUP tumours should be added. The group did query the inclusion of a treatment question for nasopharynx as there is less controversy for this cancer site, but decided it should stay in as there is variation in the use of non-surgical oncology.

Topic J - K

The two topics on HPV related cancers were discussed at length. The group felt that even though patients usually have better outcomes with these types of cancers the management and treatment are the same as with other UAT cancers. The group felt that as this is still a relatively new area there may be limited evidence as clinical trials have only just started recruiting.

Topic L

No comments on this topic.

Topic M

The group agreed that a topic on smoking cessation was probably unnecessary as there is a well established link between smoking cessation and better outcomes for patients with UAT.

Topic N

The group members agreed that this topic should be about the type of dietetic support for patients rather that the types of nutritional support given. It was noted that there is considerable variation in the provision and type of swallowing exercises offered to patients.

Additional topics

In addition to the inclusion of salivary gland cancers and CUP the group agreed that a topic on rehabilitation, specifically the setting and frequency, was an important topic.

4.3.2 Clinical issues that will not be covered

The group were happy with this section.

4.4 Main Outcomes

The group discussed and agreed the main outcomes but recommended the following changes. Remove 'psychological wellbeing', 'quality of life for those nearing the end of their life' and 'patient reported outcomes' as these would sit within the overall health related quality of life outcome. It was also agreed to remove 'disease related mortality'.

In addition to the listed outcomes it was noted that 'speech quality' and 'swallowing function' should be included as key outcomes as these are both key issues post surgery/ treatment.

4.5 Review Questions

Question b. The group agreed that this question was appropriate to ask – however the topic (4.3.1b) needs to be re-worded as it doesn't currently match.

Questions c-h. The review questions on investigations are appropriate however an additional two questions should be added to include salivary gland cancer and unknown primary.

Questions i-n. The questions on treatment should consider the outcomes of radiotherapy. The group felt this was an important outcome to capture. In addition to this an additional two questions on salivary gland cancer and CUP should written.

Questions q-r. The group felt these questions should be removed due to the lack of evidence in this emerging area and for the reason that patients with HPV related cancer would not be treated differently.

Questions t, u and v. The group felt these three questions could be rationalised into one overarching question. They suggested the following question was used instead 'What is the most effective management of palliative symptoms, for example compromised airways and pain'.

Questions x-y. The dietician on the group advised a more appropriate review question would be around the optimal timing, frequency and duration of dietetic support. The group agreed.

GROUP 2

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Hisham Mehanna
Julia Woolgar
Sarah Willett
Terence Lacey
Wai Lup Wong

Proposed membership of the GDG

The group agreed that the proposed GDG membership was sensible. The following additional comments were made:

ENT and maxilla-facial surgeons would be more relevant than plastic surgeons.

It would be good to get input from both clinical and medical oncologists.

There was also some discussion about the time commitment of GDG membership.

Scope

1 Guideline title

No comments on this topic.

3 Clinical need for the guideline

3.1 Epidemiology

No comments on this topic.

3.2 Current Practice

No comments on this topic.

4.1 Population

4.1.1 Groups that will be covered

The group discussed and recommended that the population be limited to mucosal tumours only (melanoma and squamous cell carcinoma).

4.1.2 Groups that will not be covered

It was suggested that all salivary gland cancers (including sublingual) and sarcomas be excluded from the scope.

4.2 Healthcare settings

No comments on this topic.

4.3 Clinical Management

4.3.1 Key clinical issues that will be covered

Topic A

The group agreed that complicated treatment decisions might require extra time which could affect the current ‘waiting time to treatment’ target. Consequently patients might be rushed into making decisions. They also discussed that HPV+ patients have particular information needs. No change needed to scope however.

Topic B

The group recommended changing “effective structure” to “effective investigative pathway”.

Topic C

The group recommended changing “effective investigations” to “effective investigative pathway”. The group also recommended adding sentinel node biopsy to the list of example investigations and adding unknown primary cancers of presumed UAT origin.

Topic D – I

The group discussed making sure treatment for both recurrent and newly diagnosed disease is covered.

The group recommended adding a topic for treatment of unknown primary cancers of presumed UAT origin.

The group also discussed whether we should refer to new technologies (such as IGRT, PET-CT planning for radiotherapy and robotic surgery) in this topic and its related clinical questions. They decided that the wording of the topics did not exclude new technologies and no change was needed.

Topic J – N

No comments on these topics.

Additional topics

The group discussed the long term complications of treatment in patients who might have been cured and interventions to improve quality of life. The group agreed that the topic of survivorship was important. They suggested that smoking cessation, speech and language therapy and nutritional support could potentially be combined into this topic.

4.3.2 Clinical issues that will not be covered

No comments on this topic.

4.4 Main Outcomes

No comments on this section.

4.5 Review Questions

Question a. The group agreed that timeliness of information should be considered but no change to wording was required.

Question b. The group recommended changing “most effective methods” to “most effective investigative pathway” to match (4.3.1b). They also discussed included adequacy checks in the list of tests.

Questions c-h. The group felt that these questions should be combined into 3 questions covering newly diagnosed, recurrent and unknown primary disease respectively

Questions i-n. The group discussed whether new technologies would be included here and decided they would. Some of the group wanted to include issues about service configuration and specialist centres (for example for laser treatment or robotic surgery).

Question p. The group recommended changing “method” to “algorithm” as there is no single test.

Questions t, u and v. The group felt these questions do not quite match the palliative care topic. There should be separate questions for end-of-life palliative care and (extra) questions about survivorship with long term complications of treatment (xerostomia, dysphagia and fatigue).