

Podcast transcript – Cancer of the upper aerodigestive tract: interview with Martin Robinson

“I’m Martin Robinson. I was chairman of the CUADT guidance committee that looked into all the issues surrounding the management of patients with cancer of the upper area digestive tract.”

Q1: “So upper area digestive tract cancers are found at various sites in the airways of the head and neck. What does NICE recommend on the assessment of neck lumps?”

“Our recommendation is that clinicians should consider adding ultrasound guidance to fine-needle aspiration cytology or core biopsy for people with a neck lump that is suspected of being cancer of the upper areodigestive tract.

“We also recommend that the service should consider having a cytopathologist or biomedical scientist present to assess the cytology sample adequacy after the procedure has been carried out. That will ensure that the patient doesn’t go home having had an inadequate test.”

Q2: “And what is the current practice, would you say, in terms of assessment?”

“Of patients with occult primary cancer if suspected of originating in the head and neck but actually on examination and full assessment currently one to two per cent of patients will not have the primary determined. And the current practice is for the surgical team to take blind biopsies of a variety of sites to try and identify that primary site.”

Q3: “And what does NICE recommend?”

“Our recommendation is that we should consider a fluorodeoxyglucose PET-CT scan as the first investigation to help detect the primary site in these patients who usually present with a metastatic node in the neck and who it’s considered most likely they have a primary in the head/neck region.”

Q4: “And could you explain why NICE recommends this?”

“The use of a PET-CT would increase the chances that the surgical team will know where the primary site is most likely situated prior to doing those biopsies and save the patients the discomfort of having biopsies of all sorts of sites in the head and neck which are not involved.”

Q5: “And in terms of the treatment of early laryngeal cancer, what does NICE recommend in this area?”

“We’ve made one important recommendation on the management of TE1A, squamous cell carcinoma of the glottic larynx, in that we recommend that clinicians should offer transoral laser microsurgery to these people with this diagnosis.

“For the other early glottic and super-glottic laryngeal cancer patients, we’ve suggested that clinicians should offer a choice of transoral laser microsurgery or radiotherapy. Because they are of an equal effectiveness.”

Q6: “And in terms of management of neck cancer, what does NICE recommend ?”

“We’ve made recommendations on the management of the N0 neck in T1–T2 squamous cell carcinoma of the oral cavity. We recommended that patients should be offered surgical management when they have early oral cavity cancer, T1-T2-N0. We recommended that they should be offered sentinel lymph node biopsy instead of elective neck dissection for the same stages, unless they need cervical access at the same time as their operation on the primary site.”

Q7: “And why has NICE recommended that surgical management of the neck should be offered in all cases?”

“There is evidence that this improves the outcome for this group of patients, particularly a very recent large randomised trial.”

Q8: “And what are the treatment options that NICE recommends for people with T3 squamous cell carcinoma of the larynx?”

“There are two treatment options, which are radiotherapy with concomitant chemotherapy or surgery with adjuvant radiotherapy with or without concomitant chemotherapy. Our recommendation is that patients should be offered a choice of these two possibilities.

“And that there are a number of factors that should be taken into consideration when the choice is made between surgery and radiotherapy. These are the potential advantages of laryngeal preservation, the risk of needing a salvage laryngectomy with its complications, the benefits of primary surgery in people with poor compromised swallowing and airway function at presentation and what their likely voice and swallowing function of these patients is likely to be after treatment.

“We’ve also made a recommendation that patients with T4-A squamous cell carcinoma of the larynx, we should consider surgery without even radiotherapy with or without concomitant chemotherapy as the first choice treatment.”

Q9: “The guideline includes some recommendations on HPV related disease. Could you tell me a little bit about that?”

“HPV related squamous carcinoma has appeared as a serious clinical problem in the population over the last 10 years. This tends to appear in the oropharynx and these patients have a better prognosis than patients who do not have HPV related squamous cell cancers.

“We have made recommendations on the testing of all squamous cell carcinomas of the oropharynx using the p16 immunohistochemistry and that more complex high risk HPV DNA or RNA in situ hybridization techniques should be used to confirm the HPV status in this group of patients.

“We’ve also looked at the evidence for de-intensifying treatment. We recommend that clinicians do not offer de-intensification of curative treatment to this group of patients unless it is part of a clinical trial.”

Q10: “And the guideline contains some recommendations on rehabilitation and function, in particular it contains recommendations on nutrition support and speech and language therapy interventions. Why are these areas important?”

“These areas are extremely important in this group of patients because the disease itself can interfere with function of swallowing, speaking. And the treatment can interfere with this function, certainly in the short term and occasionally in the long term as well. So we felt that these were very important areas to evaluate and we made some

recommendations on enteral nutrition support. We recommended that patients' needs for enteral nutrition are assessed at diagnosis and their potential need for a prophylactic tube placement considered.

"The factors which should be taken into consideration by the multidisciplinary team include performance status and social factors of the patient. Nutritional status, which involves weight loss, their BMI and their ability to actually consume their nutritional needs. The tumour stage, tumour site. Whether they're having difficulty swallowing when they present and what the likely impact of the treatments, such as radiotherapy and chemotherapy, might have on these factors.

"Speech and language therapy interventions, we've recommended that clinicians should consider swallowing exercise programs for people having radiotherapy. Consider mouth opening exercises for people having radiotherapy who are at risk of reduced mouth opening. And consider voice therapy for people whose voices change because of their treatment.

"We also looked at the role of shoulder rehabilitation after neck dissection. We found clear evidence that clinicians should consider progressive resistance training for people with impaired shoulder function following surgery."

Q11: "So could you explain what osteoradionecrosis is and what does NICE say on the management of this?"

"Following the treatment of some patients with cancer of the upper aerodigestive tract, particularly those situated in the oral cavity, oropharynx, this use of radiotherapy can be associated with an increased risk of bone necrosis, which is called osteoradionecrosis. This is a troublesome but relatively rare consequence of radiotherapy treatment.

"We have recommended that clinicians consider surgery to remove necrotic bone and to establish soft tissue coverage in patients with osteoradionecrosis. And that they should only consider hyperbaric oxygen therapy or medical management for treating osteoradionecrosis as part of a clinical trial."

Q12: "And at the end of the guideline there are a number of areas that NICE has outlined for more research. What are those areas?"

“There were five areas which we identified where we felt that there was a need for further research. These were, firstly, the use of systemic imaging. Which patients would benefit from having systemic imaging? Who were actually at high risk of metastasis or a second primary cancer at presentation? We also would like HPV testing to be looked at to see whether a single step laboratory diagnostic test would be a most efficient way of making this diagnosis.

“There’s this group of patients with an unknown primary cancer which is presumed to be from the upper aerodigestive tract origin and we would like research to target the question of whether the radiotherapy volumes used can be selected by some clinical or pathological factors.

“We’d also like research into enteral nutrition support. We want to identify what specific clinical and non-clinical factors would allow risk stratification when selecting people with CUADT who’d benefit from short or long term enteral nutrition.

“And finally, follow-up, which is always a difficult area. We’d like work to help us identify the optimal method, frequency and duration of follow-up for people who are disease free after their treatment for this condition.”