Survivorship - Larynx/Hypopharynx Cancer

PATIENT PRESENTATION

Patient presents:

- A minimum of 30 months after completion of treatment for larynx/ hypopharynx cancer **and**
- Has one post-treatment CT neck (soft tissue) **and**
- No evidence of disease

HNSVC = Head and Neck Survivorship clinic

[1] Videostroboscopy allows documentation of altered function/anatomy and is recommended between 3 to 36 months after treatment; if not completed before the time of transition, order prior to the first survivorship consult. Patients who have undergone laryngectomy do not need videostroboscopy. Include Modified Barium Swallow study or Fiberoptic Endoscopic Evaluation of Swallowing with history of wide-field radiotherapy

[2] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

CONCURRENT COMPONENTS OF VISITS

SURVEILLANCE

- Physical exam within 6-12 months of transition to HNSVC to include:
  - Laryngoscopy
  - Chest x-ray
  - CT neck (soft tissue) with contrast if < 4 years from completion of treatment
  - Videostroboscopy[1] for patients receiving radiation with or without chemotherapy, if not performed
- Physical exam annually with:
  - Flexible fiberoptic laryngoscopy
  - Chest x-ray or chest CT when indicated, see Lung Cancer Screening algorithm
  - CT neck (soft tissue) with contrast if < 4 years from completion of treatment

MONITORING FOR LATE EFFECTS

Consider:

- Annual audiogram
- Xerostomia assessment
- Dental/osteoradionecrosis assessment
- Free T4 and TSH annually if treated with radiation therapy
- Peripheral neuropathy assessment
- Dysphagia assessment
- Speech pathology assessment
- Lymphedema assessment
- Sexual health/fertility assessment
- Carotid duplex study if none done in the 5 years post-radiation completion

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling and screening:

- Lifestyle risk assessment[3]
- Cancer screening[4]
- Vaccination[5] as appropriate
- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular risk reduction[6]

PSYCHOSOCIAL FUNCTIONING

Assess for:

- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Anxiety/depression
- Body image
- Financial stressors
- Social support
- Access to primary health care

New primary or recurrent cancer?

- Yes → Return to primary treating physician
  - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[2]
- No → Continue survivorship monitoring

DISPOSITION

Refer or consult as indicated

[3] See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

[4] Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate, and skin cancer screening

[5] Based on Centers for Disease Control and Prevention (CDC) guidelines

[6] Consider use of Vanderbilt's ABCDE's approach to cardiovascular health

Department of Clinical Effectiveness V8
Approved by the Executive Committee of the Medical Staff on 07/18/2023

SUGGESTED READINGS

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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DEVELOPMENT CREDITS

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