

CONVEGNO AIRO LOMBARDA 

TUMORI DEL
DISTRETTO CERVICO-CEFALICO
DALLA DEFINIZIONE DEI VOLUMI DI TRATTAMENTO ALL'ADAPTIVE RADIOTHERAPY

22 Giugno 2013 ore 8:30
Via Francesco Nave 31, 20159 Milano

PRESENZA DEL CONVEGNO
Roberto Di Stefano
Fondazione IRI-C, Università
Stavros Constantinidis Milano

CON IL PO LORENZINO
Paola Basso (presso l'Area di
Ricerca Enrico Fermi)
Lorenzo Biondani (Università
Stavros Constantinidis Milano)
Paolo Di Marco (Università
Francesco Morosini Bergamo)
Giovanni Inchi (Pavia)
Alessandro Mariani (Università
Roberto Guzzoni Milano)

CON IL PO CASALECCHIO
Stavros Constantinidis
Maddalena Cristofari
Ester Colaninno
Marta Migliorini



**FONDAZIONE OPERA SAN CAMILLO
CASA DI CURA SAN PIO X**
Auditorium Michelangelo
Via Francesco Nave 31, 20159 Milano



U.O. di
RADIOTERAPIA
Osp. di Circolo e
Fondazione Macchi
VARESE

La terapia di supporto nei trattamenti integrati – M. Molteni

L'Autore dichiara assenza di conflitto di interessi in merito agli argomenti trattati in questa presentazione

Oral Complications of Cancer and Cancer Therapy

From Cancer Treatment to Survivorship

Joel B. Epstein, DMD, MSD, FRCD(C), FDS RCS (Edin)¹; Juliette Thariat, MD, PhD²; Rene-Jean Bensadoun, MD, HDR³; Andrei Barasch, DMD, MSc⁴; Barbara A. Murphy, MD⁵; Leanne Kolnick, MD⁶; Leslie Popplewell, MD⁷; Ellie Maghami, MD, FACS⁸

Cronic

Mucosal pain	Atrophy, neuropathy
Saliva	Viscosity, hyposalivation
Neurosensory	Taste alteration, taste loss, halitosis, mucosal neuropathy, trismus
Limited movement	Lip aperture, mucosa, muscle/TMJ, neck, shoulder, tongue, trismus
Infection	
Mucosal	Pain, halitosis
Dental	Demineralization, caries
Periodontal	Advanced attachment loss, mobility
Risk of mucosal injury	
Necrosis	Soft tissue, bone
Esthetic impact	Social withdrawal, low quality of life, depression
Speech	Social withdrawal, depression
Mastication/dysphagia	Impact on energy and nutrient intake

TMJ indicates temporomandibular joint.

TABLE 1. Oral Complications of Cancer Therapy

COMPLICATION	SYMPTOMS
Acute	
Mucosal	Mucositis, pain, dysphagia, limited oral function
Saliva change	Viscosity, volume
Neurosensory	Taste alteration, taste loss, neuropathic pain
Infection	
Dental/periodontal	Acute exacerbation of chronic infection
Mucosal	<i>Candida</i> , herpes, other
Limited movement	Opening of the jaw, tongue function

Author	F-up	treatment	Unrelated cancer Death	Population	Percentage
Cooper 2012	10 y	S->RT	50	208	24%
		S-CRT	72	202	35.6%

1 Long-Term Follow-Up of the RTOG 9501/Intergroup Phase III Trial: Postoperative Concurrent Radiation Therapy and Chemotherapy in High-Risk Squamous Cell Carcinoma of the Head and Neck

J. S. Cooper^{*1}, Q. Zhang^{*2}, A. A. Forastiere^{*3}, J. Jacobs^{*4}, S. B. Saxman^{*5}, J. A. Kish^{*6}, A. J. Cmelak^{*7}, J. F. Ensley^{*8}, C. J. Schultz^{*9}, S. S. Yom^{*10},
¹Maimonides Cancer Center, Brooklyn, NY, ²Radiation Therapy Oncology Group, Philadelphia, PA, ³Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD, ⁴Barbara Ann Karmanos Comprehensive Cancer Center, Detroit, MI, ⁵Lilly USA, Indianapolis, IN, ⁶H. Lee Moffitt Cancer Center, Tampa, FL, ⁷Vanderbilt Cancer Center, Nashville, TN, ⁸Harper-Grace Hospitals, Detroit, MI, ⁹Medical College of Wisconsin, Milwaukee, WI, ¹⁰University of California, San Francisco, San Francisco, CA

Purpose/Objectives: Previous analysis of this Intergroup trial demonstrated that with a median follow-up among surviving patients of 45.9 months, the concurrent postoperative administration of cisplatin and radiation therapy improved local-regional control and disease-free survival of patients who had high-risk resectable head and neck carcinomas. With a minimum of 10 years of follow-up potentially now available for all patients, these results are herein updated to examine long-term outcomes. **Material/Methods:** 410 analyzable patients who had high-risk resected head and neck cancers were prospectively randomized to receive either radiation therapy (RT: 60 Gy in 6 weeks) or identical RT plus cisplatin, 100 mg/m² i.v. on days 1, 22, and 43 (RT + CT). **Results:** At 10 years, the local-regional failure rates were 28.8% vs. 22.3% (p=0.10), disease-free survival was 19.1% vs. 20.1% (p=0.25) and overall survival was 27.0% vs. 29.1% (p=0.31) for patients treated by RT vs. RT + CT respectively. In the unplanned subset analysis limited to patients who had microscopically involved resection margins and/or extracapsular spread of disease, local-regional failure occurred in 33.1% vs. 21.0% (p=0.02), disease-free survival was 12.3% vs. 18.4% (p=0.05) and overall survival was 19.6% vs. 27.1% (p=0.07) respectively. Cause-specific survival trended towards improved outcome with RT + CT for patients whose death was due to the study cancer; however, more deaths not due to the study cancer were observed in patients treated with concurrent cisplatin. **Conclusion:** At a median follow-up of 9.4 years for surviving patients no significant differences in outcome were observed in the analysis of all randomized, eligible patients. Analysis of the subgroup of patients who had either microscopically involved resection margins and/or extracapsular spread of disease showed improved local-regional control with concurrent administration of chemotherapy. The subgroup of patients who were enrolled only because they had tumor in multiple lymph nodes did not benefit from RT + CT.

Author Disclosure Block: J.S. Cooper: None. Q. Zhang: None. A.A. Forastiere: None. J. Jacobs: None. S.B. Saxman: A. Employment; Lilly, USA. J.A. Kish: None. A.J. Cmelak: None. J.F. Ensley: None. C.J. Schultz: None. S.S. Yom: None.

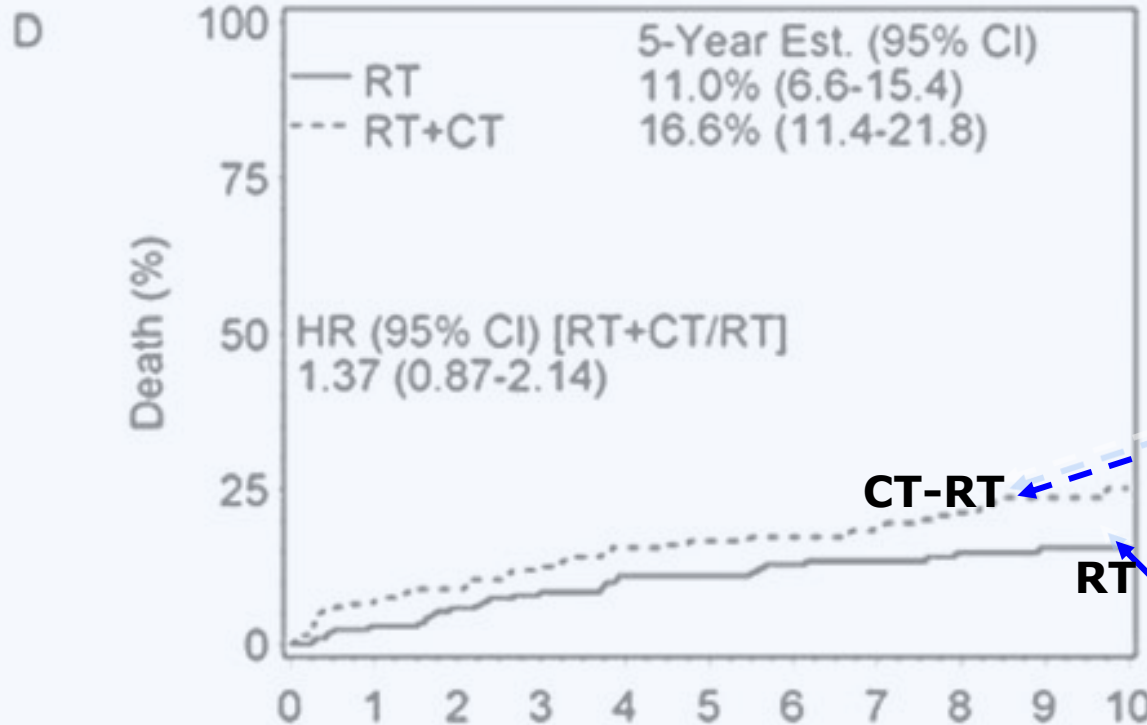
Death

Clinical Investigation: Head and Neck Cancer

Long-term Follow-up of the RTOG 9501/Intergroup Phase III Trial: Postoperative Concurrent Radiation Therapy and Chemotherapy in High-Risk Squamous Cell Carcinoma of the Head and Neck

Jay S. Cooper, MD,* Qiang Zhang, PhD,[†] Thomas F. Pajak, PhD,[†] Arlene A. Forastiere, MD,[‡] John Jacobs, MD,[§] Scott B. Saxman, MD,^{||} Julie A. Kish, MD,[¶] Harold E. Kim, MD,** Anthony J. Cmelak, MD,^{††} Marvin Rotman, MD,^{‡‡} Robert Lustig, MD,^{§§} John F. Ensley, MD,[§] Wade Thorstad, MD,^{|||} Christopher J. Schultz, MD,^{¶¶} Sue S. Yom, MD,^{***} and K. Kian Ang, MD, PhD^{†††}

Patients at Risk	Years after Randomization										
	0	1	2	3	4	5	6	7	8	9	10
RT	208	121	93	72	60	54	44	39	33	25	16
RT+CT	202	132	110	93	79	71	64	54	46	34	26



All patients	202
All Death	141 (69%)
Cancer related	69 (34%)
Cancer unrelated	72 (35%)

Patients at Risk	Years after Randomization										
	0	1	2	3	4	5	6	7	8	9	10
RT	208	121	93	72	60	54	44	39	33	25	16
RT+CT	202	132	110	93	79	71	64	54	46	34	26

All patients	208
All Death	148 (71.2%)
Cancer related	98 (47%)
Cancer unrelated	50 (24%)

Author	F-up	treatment	Unrelated cancer Death	Population	Percentage
Cooper 2012	10 y	S->RT	50	208	24%
		S-CRT	72	202	35.6%
Forastiere 2012	10.8y	RT	50	172	29%
		I-RT	60	174	34.5%
		CRT	74	174	42.5%

Long-Term Results of RTOG 91-11: A Comparison of Three Nonsurgical Treatment Strategies to Preserve the Larynx in Patients With Locally Advanced Larynx Cancer

Arlene A. Forastiere, Qiang Zhang, Randal S. Weber, Moshe H. Maor, Helmuth Goepfert, Thomas F. Pajak, William Morrison, Bonnie Glisson, Andy Teuri, John A. Ridge, Wade Thorstad, Henry Wagner, John F. Emley, and Jay S. Cooper

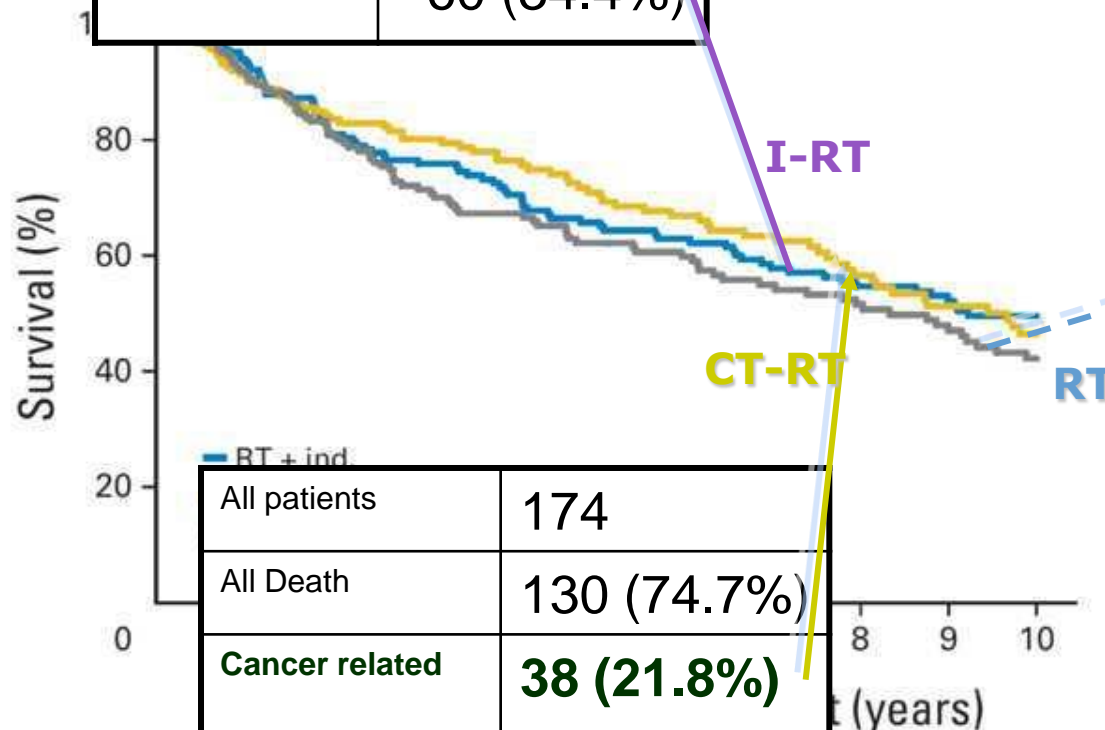
Listen to the podcast by Dr Harari at www.jco.org/podcasts

All patients	174
All Death	120 (68.9%)
Cancer related	45 (25.9%)
2° tumour	15 (8.6%)
Cancer unrelated	60 (34.4%)

Cancer Related

All patients	172
All Death	124 (72%)
Cancer related	60 (34.8%)
2° tumour	15 (8.7%)
Cancer unrelated	49 (28.4%)

A



All patients	174
All Death	130 (74.7%)
Cancer related	38 (21.8%)
2 tumour	18 (10.3%)
Cancer unrelated	74 (42.5%)

No. at risk	
RT + ind.	174
RT + conc.	174
RT only	172

	8	9	10
	69	61	52
	56	46	36
	59	51	43

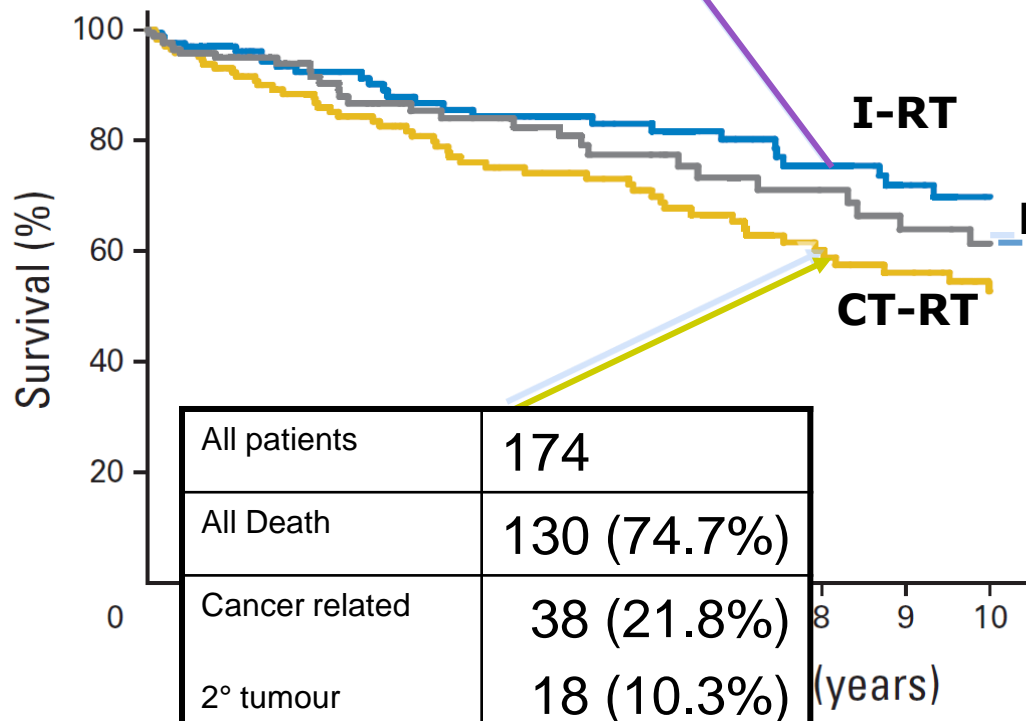
Long-Term Results of RTOG 91-11: A Comparison of Three Nonsurgical Treatment Strategies to Preserve the Larynx in Patients With Locally Advanced Larynx Cancer

Arlene A. Forastiere, Qiang Zhang, Randal S. Weber, Moshe H. Maor, Helmut Goeppfer, Thomas F. Pajak, William Morrison, Bonnie Glisson, Andy Teuri, John A. Ridge, Wade Thorstad, Henry Wagner, John F. Emley, and Jay S. Cooper

Listen to the podcast by Dr Harari at www.jco.org/podcasts

All patients	174
All Death	120 (68.9%)
Cancer related	45 (25.9%)
2 tumour	15 (8.6%)
Cancer unrelated	60 (34.4%)

B



All patients	174
All Death	130 (74.7%)
Cancer related	38 (21.8%)
2° tumour	18 (10.3%)
Cancer unrelated	74 (42.5%)

No. at risk
 RT + ind. 174
 RT + conc. 174
 RT only 172

	46	38	30
	45	38	30
	31	26	24

Cancer Unrelated

All patients	172
All Death	124 (72%)
Cancer related	60 (34.8%)
2 tumour	15 (8.7%)
Cancer unrelated	49 (28.4%)

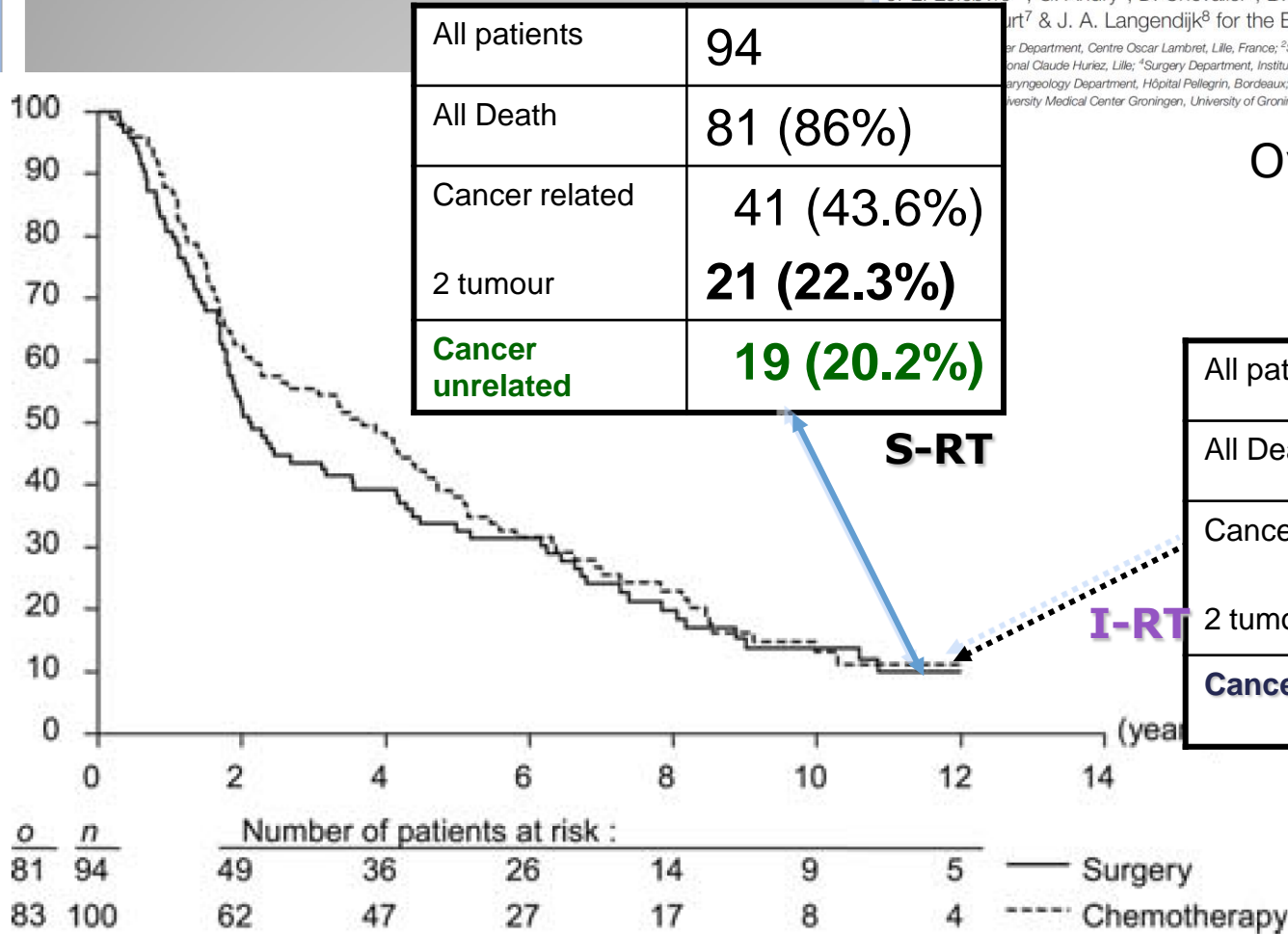
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		S-CRT	72	202	35.6%
Forastiere 2012	10.8y	RT	50	172	29%
		I-RT	60	174	34.5%
		CRT	74	174	42.5%
Lefebvre 2012	10.4y	S->RT	19	94	20.2%
		CRT	27	100	27.0%

Mortalità non cancro correlata a 10 anni di follow up nei trattamenti combinati

Laryngeal preservation with induction chemotherapy for hypopharyngeal squamous cell carcinoma: 10-year results of EORTC trial 24891

J.-L. Lefebvre^{1*}, G. Andry², D. Chevalier³, B. Lubinski⁴, L. Collette⁵, L. Traissac^{6,†}, J. A. Langendijk⁸ for the EORTC Head and Neck Cancer Group

¹Department, Centre Oscar Lambret, Lille, France; ²Surgery Department, Institut Jules Bordet, Brussels, Belgium; ³Otolaryngology Department, Centre Oscar Lambret, Lille, France; ⁴Surgery Department, Institut Gustave Roussy, Villejuif, France; ⁵Statistics Department, EORTC Headquarters, Brussels, Belgium; ⁶Department of Otolaryngology, Hôpital Pellegrin, Bordeaux; ⁷Facial Surgery Department, Centre François Baclesse, Caen, France; ⁸Department of Radiation Oncology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands



Overall Survival

Figure 3. Overall survival. *o* is the number of events; *n* is the number of patients.

Author	F-up	treatment	Unrelated cancer	Population	Non-cancer
Conner					
<p>RTOG 91-11 " ...but there was an unexplained increase in deaths unrelated to cancer in patients who received concomitant cisplatin/RT.</p> <p>Forastiere JCO 2012</p>					
Lefebvre					
<p>EORTC trial 24891 "The excess of cancer-unrelated/unknown deaths observed in the experimental arm is another matter of concern..."</p> <p>Lefebvre Annals of Oncology</p>					
			27	103	19.2%
					26.2%

Mortalità non cancro correlata a 10 anni di follow up nei trattamenti combinati

Causes of death of patients with laryngeal cancer

Alfio Ferlito · Missak Haigentz Jr. · Patrick J. Bradley · Carlos Suárez · Primož Strojan · Gregory T. Wolf · Kerry D. Olsen · William M. Mendenhall · Vanni Mondin · Juan P. Rodrigo · Carsten C. Boedeker · Marc Hamoir · Dana M. Hartl · Jennifer L. Hunt · Kenneth O. Devaney · Lester D. R. Thompson · Alessandra Rinaldo · Robert P. Takes

In the setting of non-surgical treatment protocols implemented in patients with advanced stage laryngeal cancers, the proportion of those dying during therapy due to acute complications of protocol treatment ranges from 4 to 7.5 % of all registered deaths or between 2 and 6 % of treated patients [8, 32].

Comorbidities and late toxicity of therapy

As mentioned above, the most important risk factors for laryngeal cancer are alcohol and tobacco consumption. These risk factors are also the cause of significant and potentially lethal comorbidity in these patients. Smoking in particular, with all its associated diseases, significantly degrades life expectancy [14]. The adverse impact of smoking on survival is most pronounced in those with early stage disease (stage I–II) with an otherwise favorable prognosis who may live long enough to develop other fatal conditions [15]. In addition to long-term comorbidities,

there is evidence that active smoking impairs efficacy of head and neck cancer therapy [67].

Given aggressive and often multidisciplinary, curative-intent approaches for most patients with laryngeal cancer, treatment-associated mortality may occur from disease-related and therapy-related causes. In those with associated comorbidities, the risk of dying during the follow-up period is significantly increased. Chronic adverse effects of non-surgical treatment for advanced laryngeal cancer can also result in death reported as from “other causes” [23]. Mortality can occur from aspiration and pneumonia resulting from compromised laryngeal function and sequelae of pharyngeal/esophageal stenosis and from stroke related to atherosclerosis of the carotid artery.

Causes of death of patients with laryngeal cancer

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apparent. Among the most common long-term morbidities associated with surgical and non-surgical therapy for laryngeal cancer is hypothyroidism. Thyroid tissue is anatomically anterior to the larynx and is, therefore, included in RT treatment fields; the gland is also removed in the setting of salvage resection. Although symptomatic disease can contribute to quality of life issues, including risk of depression and suicide (see below), subclinical disease contributes to cardiovascular disease risk and resulting early mortality [68]. Renal failure from cisplatin-based chemotherapy can also contribute to long-term comorbidities that may impact survival [69].

The question, already raised in the introduction, is whether it is possible to influence the identified causes of death in patients with laryngeal cancer. Some factors will be difficult to influence. However, prevention, including discouraging the continuation of smoking and alcohol abuse and more concern for late effects of treatment, such as swallowing problems with silent aspiration, could be relevant measures in this respect.

Competing Roads to Larynx Preservation

Everett E. Vokes, *University of Chicago Medical Center, Chicago, IL*

See accompanying articles on pages 845 and 853

However, for larynx cancer, tobacco and alcohol exposure remain the dominant risk factors that lead to frequent significant comorbidities and competing mortality risks. In addition, laryngeal cancer can predispose patients to swallowing problems with associated malnutrition and aspiration. Similarly, acute and long-term effects of surgery and radiation can contribute to these complications, especially in older patients and patients with advanced stage disease.⁹

Intriguingly, however, long-term survival beyond 4.5 years showed a separation of survival curves in favor of induction chemotherapy. This trend was caused by a higher number of deaths unrelated to larynx cancer despite the absence of a documented increase in late toxicities in the concomitant group. Although not statistically significant or otherwise well explained by the data, this finding is of considerable concern because long-term survival is likely of greater importance to most patients than the avoidance of a laryngectomy.¹² As the authors point out, it is possible that the decreased long-term survival in the concomitant arm was a random occurrence or was associated with risk-factor-associated comorbidities that were not specific to the treatment delivered. Alternatively, these deaths could have been due to a latent increase of delayed functional decline that led to chronic toxicities including aspiration pneumonia and associated cardiopulmonary compromise. It is clearly recognized that, in this 20-year old trial, older radiation techniques were used, and current radiation techniques such as intensity-modulated radiation therapy (IMRT) might lead to a lower incidence of late toxicities.

Studio	Schedula	RT	Mortalità
Adelstein	P+RT	C	4%
Forastiere	P+RT	C	5%
Corvò	PF+RT	ALT	7%
Lefebvre	PF+RT	ALT	6%
Bonner	C+RT	C/HF	5%
Posner	TPF→CTRT	C+Cb	2%
Vermorken	TPF→RT	C	2%

La mortalità dei trattamenti integrati
dati dagli studi randomizzati

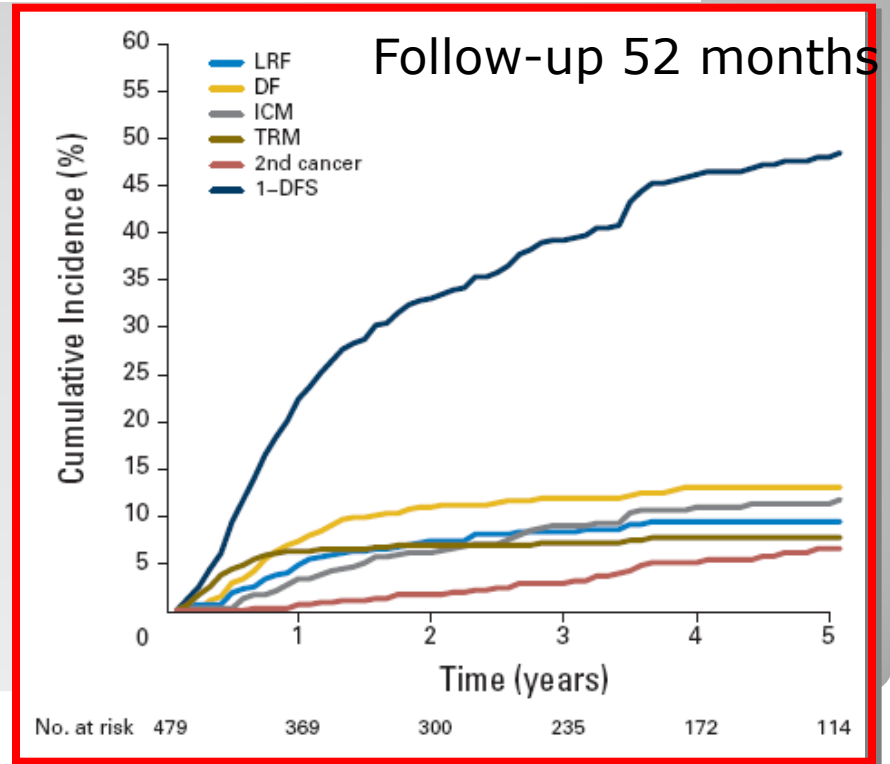
Studio	Centro	#	Mortalità
Argiris 2002	Chicago	324	9.2%
Nguyen 2004	Dallas	55	9,1%
Merlano 2008	Cuneo	155	6.4%
Adelstein 2006	Cleveland	222	14%
Mell 2010	San Diego	479	7,8%

La mortalità dei trattamenti integrati
dati dalle casistiche istituzionali

Predictors of Competing Mortality in Advanced Head and Neck Cancer

Loren K. Mell, James J. Dignam, Joseph K. Salama, Ezra E.W. Cohen, Blase N. Polite, Virag Dandekar, Amit D. Bhate, Mary Ellyn Witt, Daniel J. Haraf, Bharat B. Mittal, Everett E. Vokes, and Ralph R. Weichselbaum

Loco-regional failure	9,4%
Distant failure	13,1%
Second cancer	6,6%
Treatment-related	7,8%
Intercurrent mortality	11,8%
Non cancer mortality	19,6%





Novità e Progressi nelle terapie di supporto nei tumori della testa collo
(a cura di Dott. Rampino e dott. Russi)



Raccomandazioni AIRO sulla valutazione e gestione della DISFAGIA
Prof. Maria Grazia Ruoreda

SWALLOWING DYSFUNCTION IN HEAD AND NECK CANCER PATIENTS TREATED BY RADIOTHERAPY: REVIEW AND RECOMMENDATIONS OF THE SUPPORTIVE TASK GROUP OF THE ITALIAN Association of Radiation Oncology

Elvio G. Russi a, □, Renzo Corvò b, Anna Merlotti c, et Al.

Low level of evidence

Cancer Treatment Reviews. <http://www.sciencedirect.com/science/article/pii/S0305737212000795> (Accessed April 29, 2012)

Conclusions: In HNCPS treatment, disease control has to be considered in tandem with functional impact on swallowing function. SLPs should be included in a multidisciplinary approach to head and neck cancer.

All patients need to be clinically evaluated for researching signs and symptoms that herald dysphagia.

Table 1 Murphy's trigger for dysphagia evaluation (Murphy and Gilbert 2009)

● Inability to control food, liquids, or saliva in the oral cavity
● Pocketing of food in cheek
● Excessive chewing
● Drooling
● Coughing, choking, or throat clearing before, during, or after swallowing
● Abnormal vocal quality after swallowing; “wet” or “gurgly” voice
● Build-up or congestion after a meal
● Complaint of difficulty swallowing
● Complaint of food “sticking” in throat
● Nasal regurgitation

**Consenso sulla terapia di supporto
nel paziente con neoplasie testa-
collo sottoposto a trattamenti
integrati chemio-radioterapici.**

**Gruppo di lavoro AIOM-AIRO
sulle terapie di supporto**

Milano, 4 febbraio 2012

Table 1 Suggestion from AIOM-AIRO Dysphagia supportive care group

Nutrition and swallowing experts evaluation
Clinical evaluation for signs and symptoms that herald dysphagia - inhalation - aspiration (advisable also in asymptomatic HNCPs)
Administration of a pts-rated scale evaluating subjective dysphagia and its impact on QOL pre-during and post CRT
All patients with dysphagia signs or symptoms should be referred to a swallowing expert
Swallowing abnormalities should be evaluated with instrumental testing such as FEES (Fiberoptic Endoscopic Evaluation of Swallowing) and/or VFS (Swallowing Videofluoroscopy)
Simulation Computed tomography (S-CT)based delineation guidelines for DARS (dysphagia aspiration-related structures) and collection odosimetric parameters are suggested
Acute mucositis can worsen dysphagia and increase the risk of polmunary complication. When possible the lowest dose to oral mucosa is advisable
Patients may benefit from strategies aimed at the prevention of swallowing dysfunction after curative (CH) RT such as preventive swallowing exercises during treatment
All patients with dysphagia need to be evaluated by a nutrition expert. Institutional guidelines to standardize the criteria for artificial nutrition (patient selection, timing and methods) are advisable.

Is Speech Language Pathologist Evaluation Necessary in the Nonoperative Treatment of Head and Neck Cancer?

Heather M. Starmer, MA, CCC-SLP; Christine G. Gourin, MD, MPH

BEST PRACTICE

The best evidence strongly supports an active role for SLPs in the nonoperative management of HNCA patients that begins at the point of cancer diagnosis. Pretreatment instrumental swallowing assessments are indicated to identify silent dysphagia to optimize safe and efficient oral intake during treatment and to tailor interventional strategies. Based upon the available evidence, SLP evaluation and prophylactic swallowing intervention should be considered standard of care in the pretreatment setting for patients undergoing organ preservation treatment for HNCA to prevent dysphagia and optimize functional outcomes. Further, long-term follow-up appears appropriate given the potential for long-term sequelae following treatment.



Novità e Progressi nelle terapie di supporto nei tumori della testa collo
(a cura di Dott. Rampino e dott. Russi)

Raccomandazioni AIRO sulla valutazione e gestione della DISFAGIA
Prof. Maria Grazia Ruoredda



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Elvio G. Russi a, □, Renzo Corvò b, Anna Merlotti c, et Al.

Cancer Treatment Reviews. <http://www.sciencedirect.com/science/article/pii/S0305737212000795> (Accessed April 29, 2012)

(5) Recommendations for chemo radio-treated patients



Patients submitted to chemo-radiotherapy need to be monitored for aspiration, history of recurrent pneumonia, and pulmonary function tests both during therapy and during follow up. (Recommendation C; extrapolation from level 2 and 3)

If pneumonia or sepsis is suspected the search for Systemic inflammatory Reaction Syndrome (SIRS) is recommended (Recommendation D; level 5) (expert opinion based on physiology and bench research)

Innate Immune Responses to Danger Signals in Systemic Inflammatory Response Syndrome and Sepsis

A. Castellheim*, O.-L. Brekke†, ‡, T. Espevik§, M. Harboe* & T. E. Mollnes*,†, ‡

Table 3 Critical illnesses which are induced by systemic inflammation.

Genesis	Condition	Definition
Non-infectious	Systemic inflammatory response syndrome ¹	Two or more of: → Core temperature >38 °C or <36 °C → Heart rate > 90 beats/min ² → Respiratory rate > 20 breaths/min or PaCO ₂ < 4.26 kPa or mechanically ventilated → Leukocyte count > 12,000/μl or <4000/μl

Caused by conditions like multiple trauma, haemorrhage, burn, pancreatitis, ischaemia / reperfusion conditions like resuscitation after cardiac arrest

Symptom Control Issues and Supportive Care of Patients With Head and Neck Cancers

Clin Adv Hem Oncol 2007

Barbara A. Murphy, MD, Jill Gilbert, MD, Anthony Cmelak, MD, and Sheila H. Ridner, RN, PhD

Cumulative Weight Loss and Time Course

Time Course	Significant Weight Loss	Severe Weight Loss
1 week	$\leq 2\%$	$> 2\%$
1 month	$\leq 5\%$	$> 5\%$
3 months	$\leq 7.5\%$	$> 7.5\%$
6 months	$\leq 10\%$	$> 10\%$

Patients with a critical weight loss should be seen quickly by a dietician to formulate an aggressive intervention strategy. Nutritional assessments should continue on a frequent basis throughout the treatment and periodically to ensure adequate nutritional intake. This generally requires **the expertise of a dietician versed in facing patients with head and neck cancer.**



available at www.sciencedirect.com



<http://intl.elsevierhealth.com/journals/clnu>



OPINION PAPER

Cachexia: A new definition

Weight loss of at least 5%* in 3-6 months in cancer patients
(or BMI <20 kg/m²)**

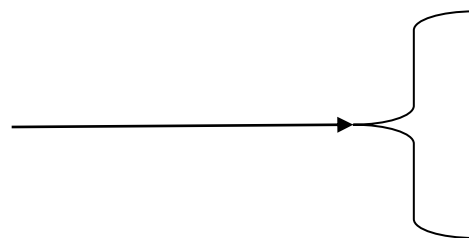
Decreased muscle strength

Fatigue ***

Anorexia ****

Low fat-free mass index

Abnormal biochemistry:





C. Bergamini

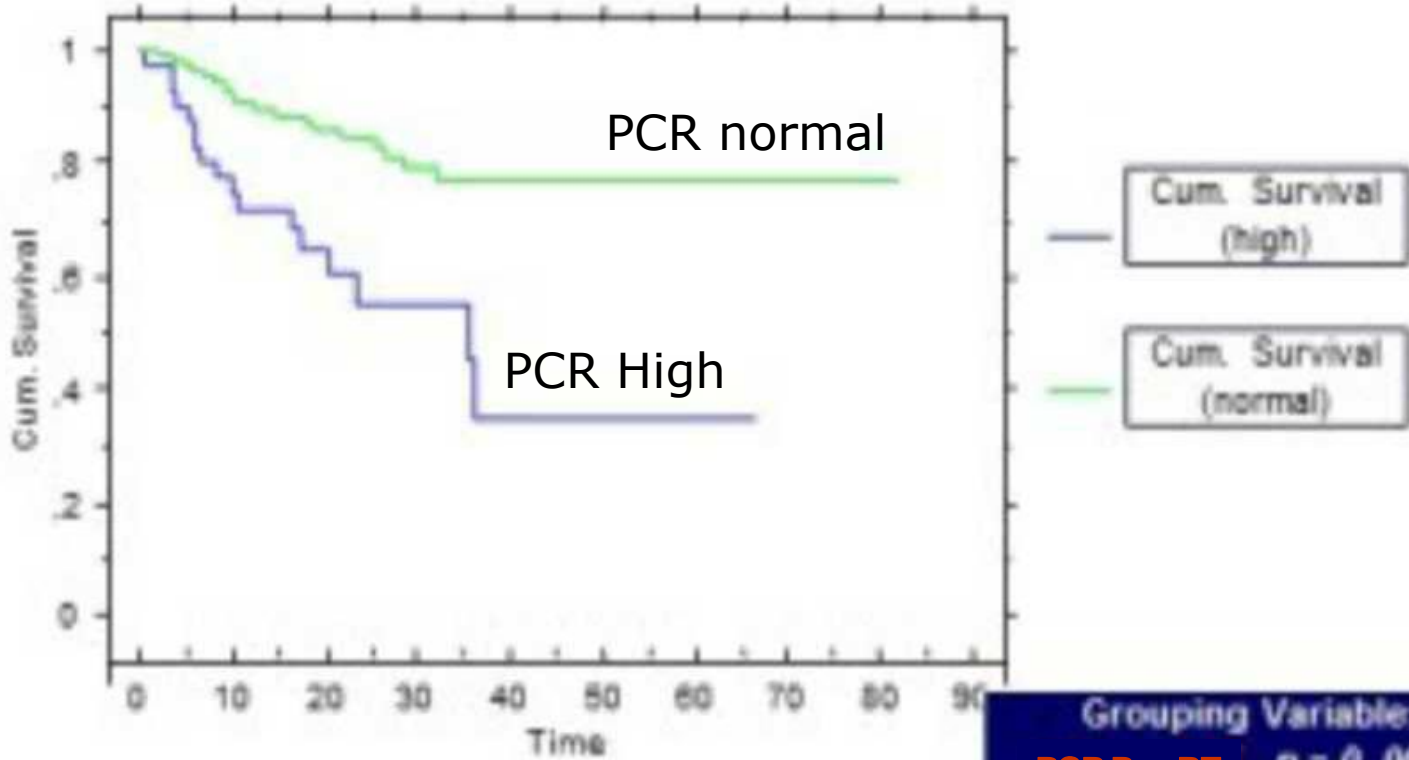
Prognostic correlation of nutritional factors and C-reactive protein (CRP) in locally advanced head and neck carcinoma

PROGNOSTIC CORRELATION OF NUTRITIONAL FACTORS AND C-REACTIVE PROTEIN (CRP) IN LOCALLY ADVANCED HEAD AND NECK CARCINOMA (LAHNC) TREATED WITH CHEMORADIATION (CRT)

Cristiana Bergamini ¹, Paolo Bossi ¹, Ester Orlandi ², Simona Barlera ³, Cecilia Gavazzi ⁴, Lisa Licitra ¹

¹Head and Neck Medical Oncology, ²Radiotherapy, ⁴Nutrition Unit, Fondazione IRCCS, Istituto Nazionale Tumori, Milan, Italy
³Biostatistics, Istituto Mario Negri, Milan, Italy

OS



Grouping Variable:
PCR Pre RT , $p = 0,0004$



2011
Review

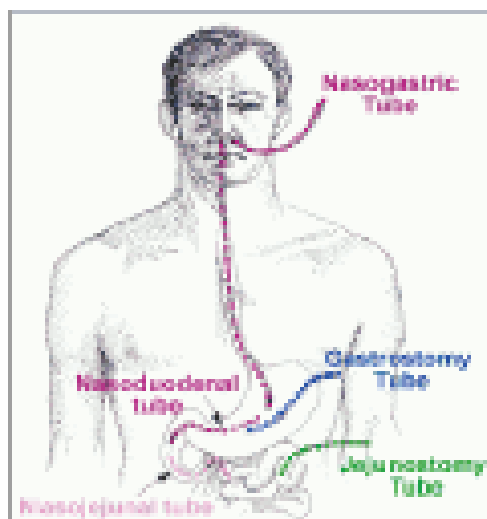
Prophylactic feeding tubes for patients with locally advanced head-and-neck cancer undergoing combined chemotherapy and radiotherapy—systematic review and recommendations for clinical practice

C. Orphanidou MSc, K. Biggs BSc MHSc,†
M.E. Johnston BSc,‡ J.R. Wright MD MSc,†
A. Bowman BSc,§ S.J. Hotte MD MSc,† A. Escau BHE,||
C. Myers BSc BEd MSc,# V. Blunt BSc RD,** M. Lafleur RN,†
B. Sheehan MD,§ and M.A. Griffin BSc RD††*

- No randomized controlled trials have directly addressed this question. Evidence from studies in the target population was limited to seven descriptive studies.
- The available evidence was insufficient to draw definitive conclusions about the effectiveness of prophylactic feeding tubes in the target patient population or to support an evidence-based practice guideline.
- The recommendations are based on the expert opinion

Prophylactic PEG placement in head and neck cancer: How many feeding tubes are unused (and unnecessary)?

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COMMENTS

Background

Impairment of oral intake occurs in the majority of patients with head and neck cancer (HNC) receiving chemoradiotherapy. Placement of prophylactic percutaneous endoscopic gastrostomy (PEG) tube in asymptomatic newly diagnosed HNC before chemoradiation is a common practice in some centers. In some studies PEG has been associated with a decrease in treatment related weight loss in patients with HNC, but no studies have examined the utilization rate. PEG placement is an invasive procedure, with possible complications. The authors anecdotally noticed a finite rate of non use of prophylactic PEG tubes among those patients.

Research frontiers

This study aimed to determine the prevalence of non use or limited use of prophylactically placed PEG tubes in HNC patients and to evaluate any possible factors that might predict the non use or limited use of prophylactic PEGs.

Innovations and breakthroughs

This is the first study that addressed the issue of use of prophylactic PEG in HNC patients. The result of this study showed that a significant number of patients (47%) with prophylactic PEG tubes never used their PEG or used it for less than 2 wk. No association with PEG use vs non-use was observed for cancer diagnosis, stage, or specific cancer treatment.

Applications

Prophylactic PEG placement may be unwarranted in some patients but the selection of patients needs to be better defined to prevent unnecessary risk exposure.

Peer review

This is a well-written retrospective study, and it is important to realize that prophylactic PEG placement has its side effects.

To PEG or not to PEG ?

- Nasogastric and percutaneous endoscopic gastrostomy feeding in head and neck cancer patients receiving radiotherapy treatment at a regional oncology unit: a two year study

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- Enteral Nutrition during the Treatment of Head and Neck Carcinoma Is a Percutaneous Endoscopic Gastrostomy Tube Preferable to a Nasogastric Tube?

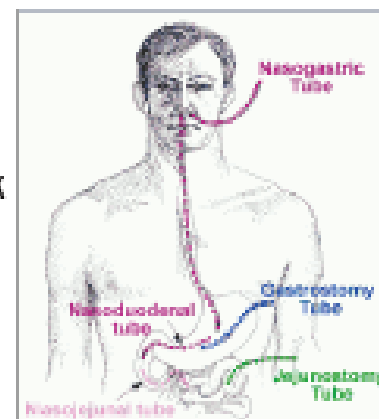
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- Complications following gastrostomy tube insertion in patients with head and neck cancer: a prospective multi-institution study, systematic review and meta-analysis

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- Nasogastric tube feeding and percutaneous endoscopic gastrostomy tube feeding in patients with head and neck cancer

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Meta analysis

Meta-analysis of chemotherapy in head and neck cancer (MACH-NC): A
on 93 randomised trials and 17,346 patients

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Collaborative Group¹

2009



Prevenire e contenere la tossicità dei trattamenti integrati nella pratica clinica



Creare un modello riproducibile di terapia di supporto, che consenta di pianificare la gestione dei pazienti e influenzare l'organizzazione dell'assistenza



Costituire una base di consenso adeguata per la costruzione di studi clinici sui trattamenti integrati

Conclusioni



GRAZIE PER L'ATTENZIONE