

LA DISFAGIA NEI PAZIENTI CON TUMORI TESTA-COLLO: L' IMPORTANZA DELL' APPROCCIO MULTIDISCIPLINARE.

Risultati del Gruppo di lavoro AIOM-AIRO sulle terapie di supporto

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

Author	F-up	treatment	Unrelated cancer	Population	Percentage
Cooper					
<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>					
<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 2012</p>					
			27	99	19.2%
				103	26.2%



Disability in Patients With Head and Neck Cancer

Joseph C. Taylor, MD; Jeffrey E. Terrell, MD; David L. Ronis, PhD; Karen E. Fowler, MPH; Carol Bishop, MS, RN; Michael T. Lambert, MD; Larry L. Myers, MD; Sonia A. Duffy, PhD, RN; and The University of Michigan Head and Neck Cancer Team

- It is not unusual for head and neck cancer treatment that includes chemotherapy to take 4 to 6 months, during which time patients often develop **profound deconditioning or fatigue.**
- **Of the 384 patients who were working prior to their diagnosis of head and neck cancer, 52% (n=201) were disabled by their cancer treatment.**



SFIDA: GESTIONE TOSSICITA'

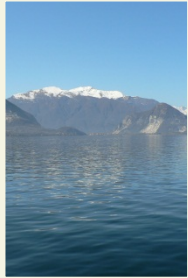


Gruppo di lavoro AIOM-AIRO sulle terapie di supporto

Coordinatori Numico-Bossi-Russi

I riunione Milano, 4 febbraio 2012

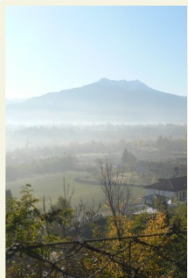
Quali obiettivi



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 degli studi clinici di trattamenti integrati



Unmet need: mancanza di linee guida fondate su evidenza

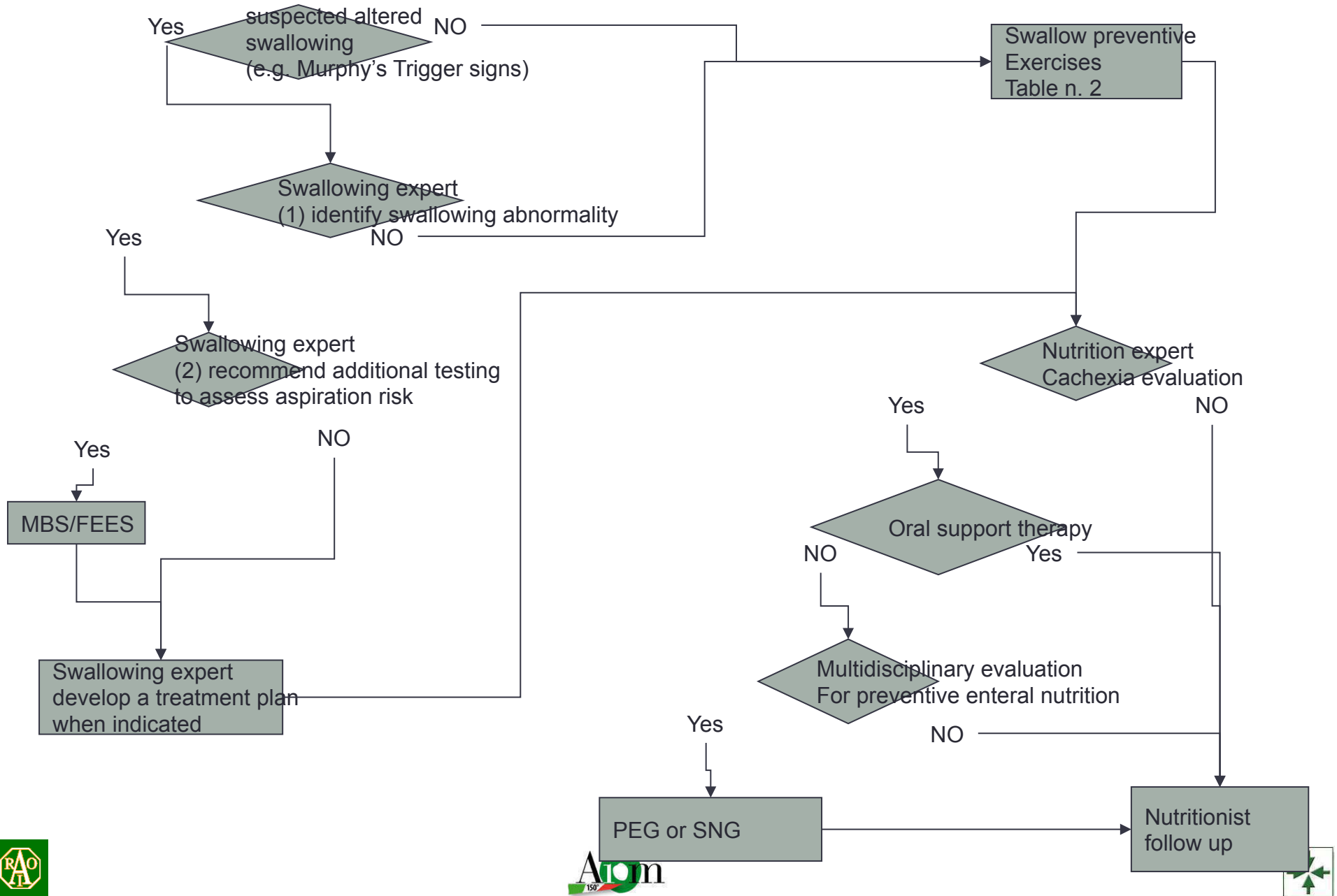
- In the absence of high-quality evidence, recommendation development becomes complex.
- In 2010, the ASCO Board of Directors approved development of guideline recommendations using [consensus methodology](#). (*JCO September 1, 2012 vol. 30 no. 25 3136-3140*)
- A modified **Delphi** approach to recommendation development is based on a systematic Literature review by a Steering Committee.
- Recommendations are drawn by the Steering Committee.
- Consensus is achieved through the rating of recommendations by a large group of clinicians in a first round of votation. Consensus is defined as high agreement by $\geq 75\%$ of raters.
- The Steering Committee revise remaining recommendations for which the threshold for consensus was not met or define consensus not reached.
- If revisions are made, another round of consensus is undertaken. If consensus is not reached, this is reported in the guideline, and no recommendation is provided.



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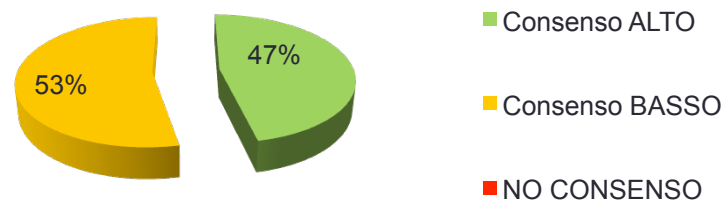


HNCP CT/RT
Dysphagia nutrition evaluation

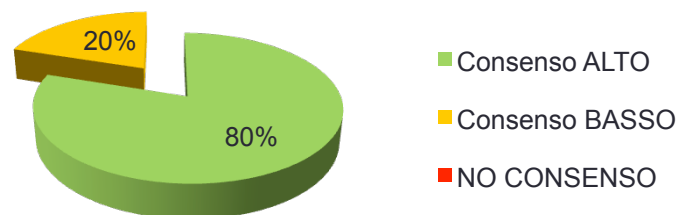


CONSENSUS NOT ACHIEVED

10) A multimetric model (more than one parameter: e.g. Dmean, different DVHs) should be considered in order to evaluate DARS dose constraints



10)) In order to compare the predictable patients' risk of acute and late dysphagia with those reported in Literature, Simulation Computed Tomography (S-CT)-based delineation of organs in the head and neck at risk for radiation-induced swallowing dysfunction (SWOARs) and collection of dosimetric parameters are suggested and encouraged, although available data are not yet consolidated for the routine use in clinical practice.



CONSENSUS NOT ACHIEVED

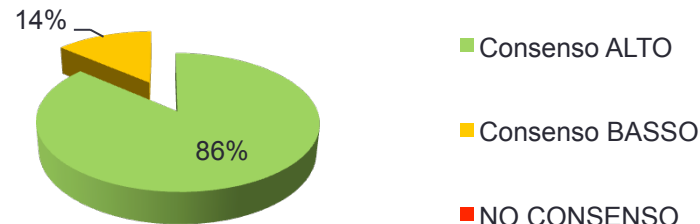
14) **All patients** need to be evaluated by a nutrition expert before starting the treatment.

14) For asymptomatic and not at risk patients, the evaluation of nutrition and swallowing experts before starting treatment **is not needed but advisable**

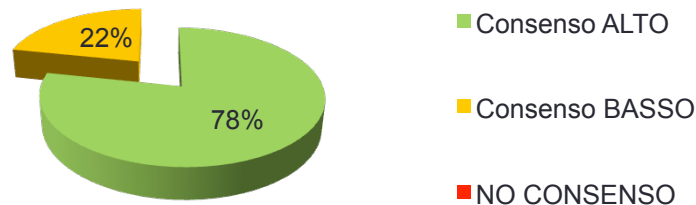


CONSENSUS

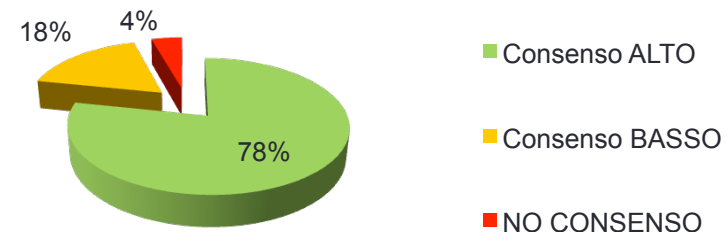
- 1) H&N cancer patients should be treated with curative chemo-radiotherapy in centres supported also by nutrition and swallowing experts.



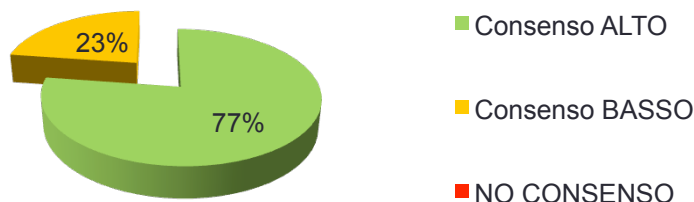
- 2) A patient-rated scale evaluating subjective dysphagia and its impact should be administered to all patients before treatment and regularly during f-up (EORTC QLQ H&N35, FACT-H&N, EAT-10, SWAL-QOL or MDADI).



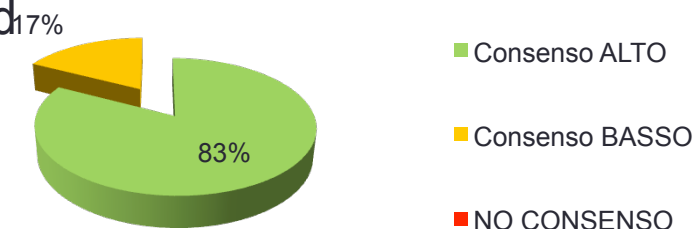
- 3) All patients need to be clinically evaluated in order to search for signs and symptoms that herald dysphagia and/or inhalation and/or aspiration (e.g. Murphy's trigger signs, 3-ounce water swallow test, recent history of recurrent pneumonia...) at baseline, during and after treatment.



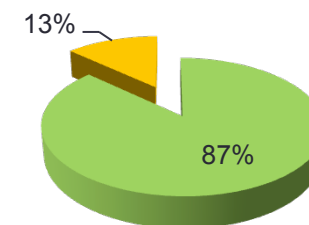
4) For asymptomatic and not at risk patients, the evaluation of nutrition and swallowing experts before starting treatment is not needed but advisable



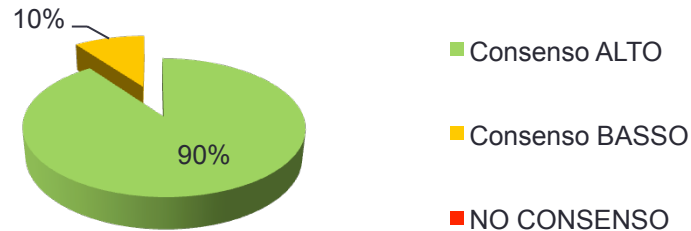
5) In patients with swallow impairment a co-evaluation between nutrition and swallowing experts is recommended



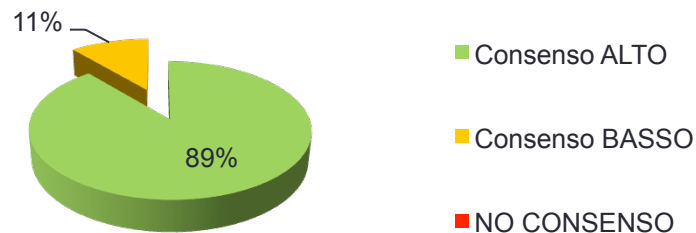
6) All patients with signs or symptoms heralding dysphagia should be referred for a detailed swallowing evaluation to a swallowing expert as soon as possible in order to (1) identify swallowing abnormalities, (2) recommend additional testing (clinical/radiological exams) to assess inhalation/aspiration risks, and (3) develop a treatment plan (correction of the swallowing mechanism by patient's education and exercises) when appropriate and offer indications to the nutrition expert.



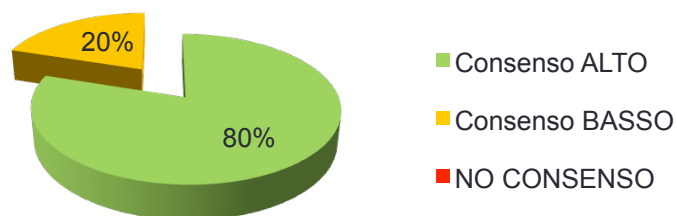
7) In order to identify swallowing abnormalities, instrumental testing such as FEES (Fiberoptic Endoscopic Evaluation of Swallowing) and/or VFS (Swallowing Videofluoroscopy) can be recommended on the basis of swallowing expert's prescription.



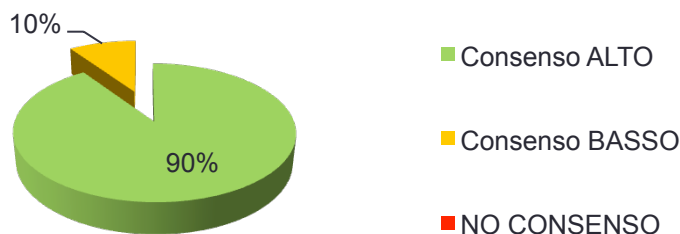
8) Even if FEES is less expensive than VFS, the choice can be guided by the opinion of the swallowing expert and by test availability/accessibility



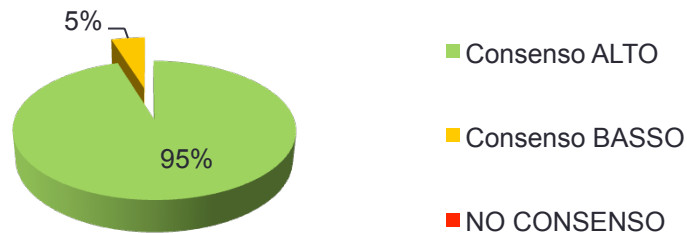
9) In order to compare the predictable patients' risk of acute and late dysphagia with those reported in Literature, Simulation Computed Tomography (S-CT)-based delineation of organs in the head and neck at risk for radiation-induced swallowing dysfunction (SWOARs) and collection of dosimetric parameters are suggested and encouraged, although available data are not yet consolidated for the routine use in clinical practice.



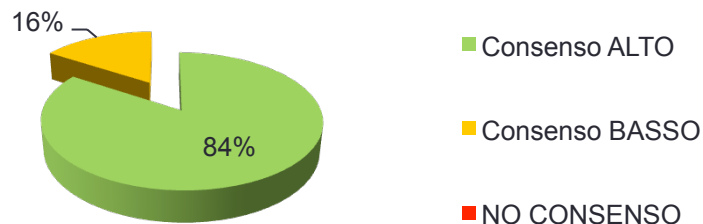
11) Acute mucositis can worsen dysphagia, therefore also dose distribution through oral mucosa need to be kept as low as possible.



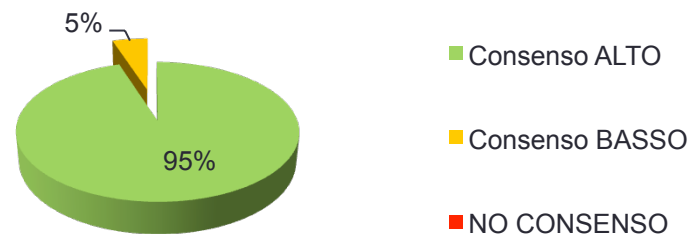
12) Patients may benefit from strategies aimed at the prevention of swallowing dysfunction after curative (CH) RT such as preventive swallowing exercises during treatment. Swallowing exercises should be prescribed and supervised by a speech and language



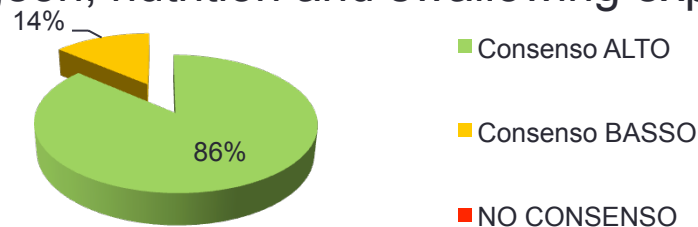
13) Two types of exercises can be recommended for patients with dysphagia both at the beginning, during and after treatment: indirect (e.g. exercises to strengthen swallowing muscles) and direct (e.g. exercises to be performed while swallowing).



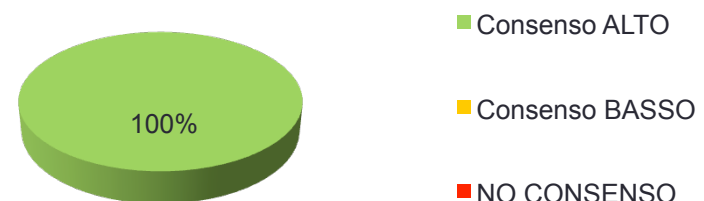
15) At present time is no sufficient literature evidence to define the optimal timing and methods of artificial nutrition (nasogastric tube, percutaneous gastrostomy, parenteral nutrition) for HNCPs receiving chemo-radiotherapy. Regardless of when enteral nutrition is started, patients should be encouraged to continue to swallow and to wean from artificial nutrition as quickly as it is safe and feasible to do so.



16) If it is decided to use preventive enteral feeding, a co-evaluation among radiation and oncologists , ENT surgeon, nutrition and swallowing experts is needed.



17) Institutional guidelines to standardize the criteria for artificial nutrition (patient selection, timing and methods) are advisable.



CONCLUSIONE

DOCUMENTO CONDIVISO AIRO-AIOM
PREVENZIONE E GESTIONE DELLA DISFAGIA
PRATICA CLINICA





— GRAZIE PER L'ATTENZIONE —

