Interprofessional Insights: Advanced Care Coordination for Patients with Head and Neck Cancer

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DISCLOSURES

The following relevant financial relationships from the past 24 months have been identified and disclosed for the following faculty of this CE activity:

- Jaclyn V. Moore, MS, RD, C.S.O
  - Speaker for Alcresta Therapeutics and AbbVie Pharmaceuticals.

No relevant financial relationships from the past 24 months have been identified for the following planners of this CE activity:

- Jennifer Lewellyn, RN, OCN
- Mary Anderson, BSN, RN, OCN

OBJECTIVES

1. Describe the importance of interprofessional collaboration in head and neck oncology care

2. Analyze the impact prehabilitation, symptom management, and post-operative support can have on clinical outcomes

3. Identify the unique challenges faced by head and neck cancer patients in different geographical settings

4. Examine the long-term effects faced by head and neck cancer patients and strategies to support them into survivorship and beyond

QUESTION #1

How often are you taking care of head and neck cancer patients?

a. Daily

b. Monthly

c. Infrequently

d. Never

QUESTION #2

Where is your practice located?

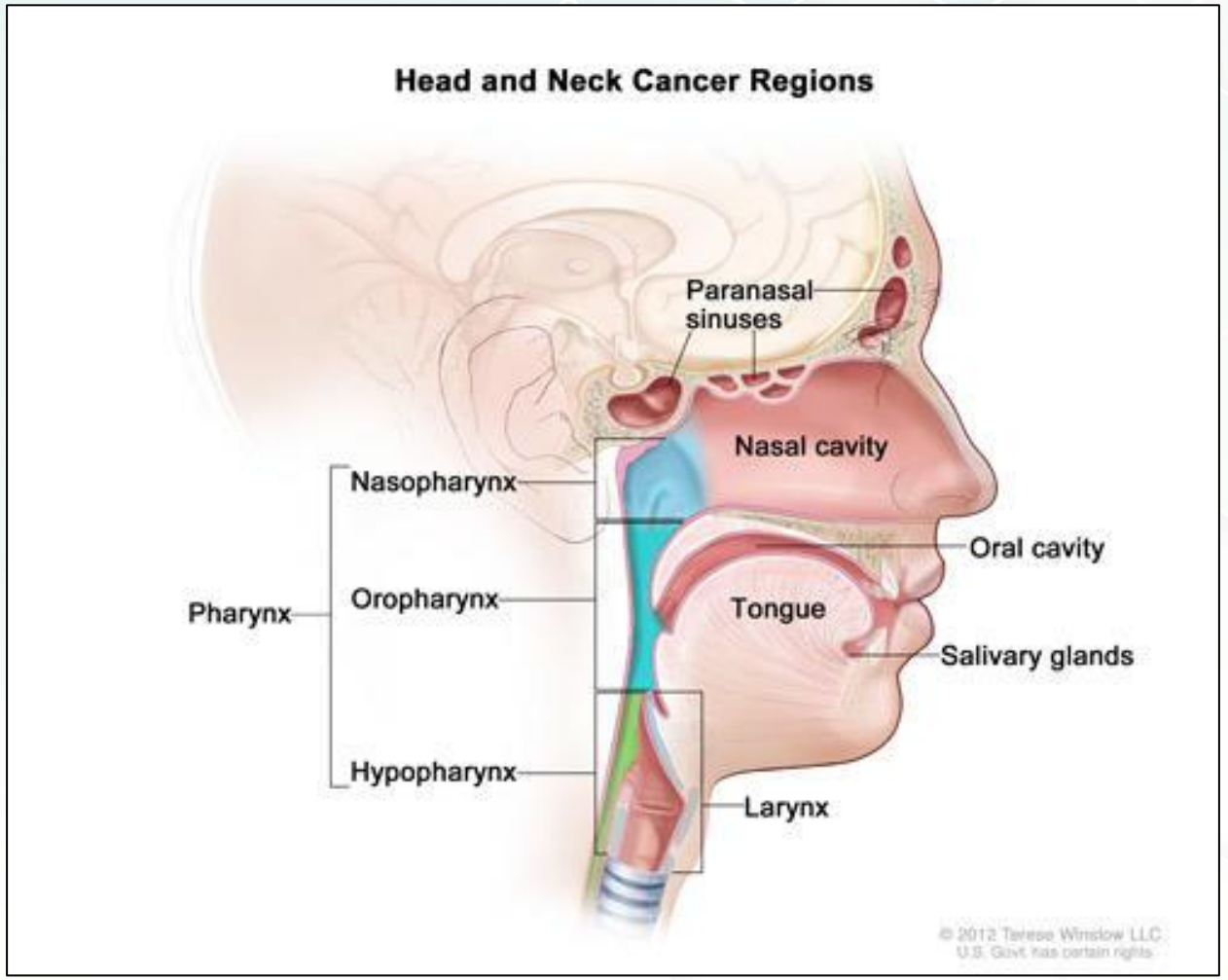
a. Rural Healthcare Setting

b. Urban Healthcare Setting

c. Suburban Healthcare Setting

d. Metropolitan Healthcare Setting

What is Head and Neck Cancer?



Source: https://www.cancer.gov/types/head-and-neck/head-neck-fact-sheet

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Stages of Head and Neck Cancer

Stage 0 (Cancer in Situ)

Tumor only in one spot. No cancer cells in deeper tissue, nearby lymph nodes, or distal sites.

Stage 1

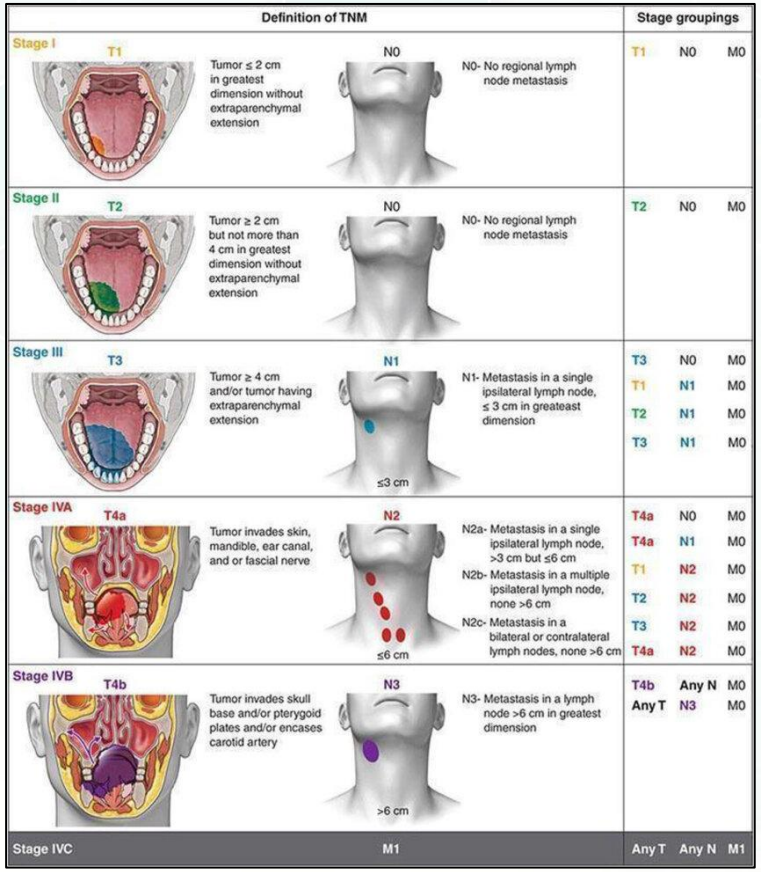
Primary tumor is 2cm or smaller with no other detectable cancer cells in other areas

Stage 2

Primary tumor is 2-4cm across and no other detectable cancer cells in other areas

Stage 3

Primary tumor is greater than 4cm across or any size, but has one positive lymph node on the same size as the primary tumor



https://www.researchgate.net/figure/Classification-and-Staging-of-Squamous-cell-carcinoma-of-Head-Neck-as-per-TNM-8th_fig2_370390384

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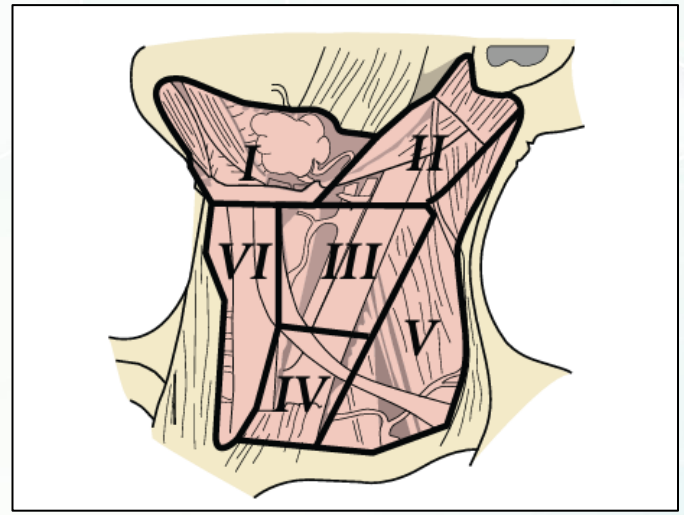
Stages of Head and Neck Cancer Cont..

Stage 4A

Primary tumor can be any size, but is growing into nearby structures and **either:**

- There is one lymph node on the same side that is 3-6cm across
- Cancer cells are present in one lymph node on the opposite side and less then 6cm across
- Cancer cells are present in 2 or more lymph nodes, but all are smaller than 6cm



www.entnet.org/academyU

Stage 4B

Primary tumor has invaded deeper tissue or it has spread to one or more lymph nodes and are larger than 6cm across, but has not spread to distance sites.

Stage 4C

Cancer calls have spread to distant sites

Diagnosis and Treatment Options

Diagnostics / Staging

- CT Head/Neck and Chest
- PET
- Biopsy

Treatment Options

- Chemotherapy (induction, curative intent, palliative intent)
- Radiation therapy
- Concurrent Chemoradiation therapy
- Surgery (resection, reconstruction)
- Immunotherapy
- Targeted therapy

Head and Neck Multidisciplinary Team

Primary H&N physician team

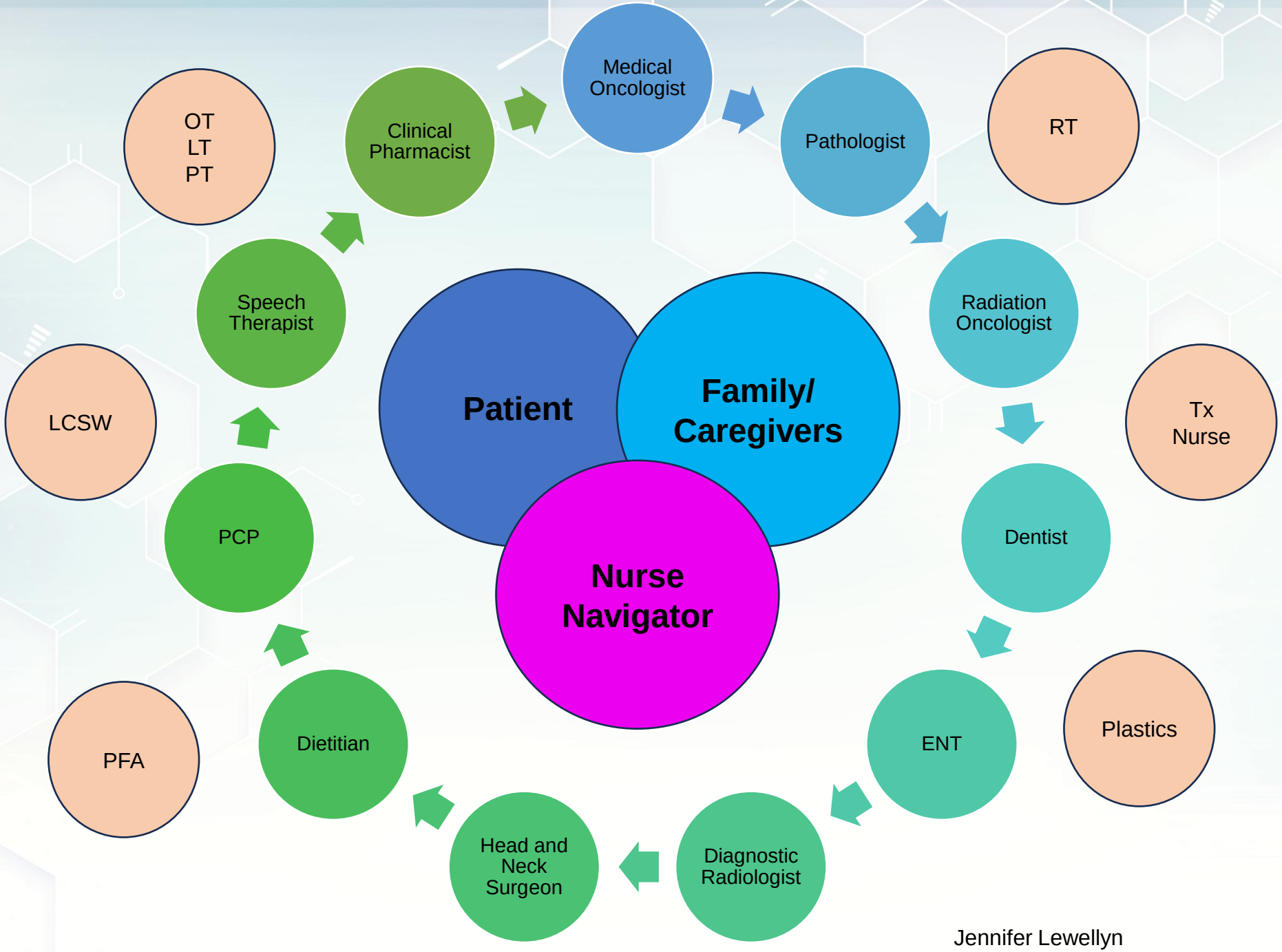
- Medical Oncologist
- Radiation Oncologist
- Ear, Nose and Throat Specialist (ENT)
- Head and Neck Surgeon/Otolaryngologist
- Dentist/Oral Surgeon

Primary H&N support team

- Nurse Navigator (RN)
- Speech Language Pathologist (SLP)
- Registered Dietitian (RD)
- Physical Therapist (PT)
- Licensed Clinical Social Worker (LCSW)
- Clinical Pharmacist

Additional H&N team members

- Interventional Radiologist (IR)/Surgeon
- Plastic Surgeon
- Respiratory Therapist (RT)
- Occupational Therapist(OT)/Lymphedema (LT)
- Home Infusion Pharmacy/DME Company
- Treatment Nurse (Tx Nurse)
- Palliative Care/ Pain Management
- Wound Care
- Home Health/ Skilled Nursing
- Behavioral Oncology
- Patient Financial Advocate (PFA)
- Audiologist
- Primary Care Physician (PCP)
- Smoking/Alcohol Cessation Counselors



Jennifer Lewellyn

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Primary Head and Neck Physician Team

- **Medical Oncologist**
  - Meets the patient at diagnosis to discuss induction vs primary vs adjuvant systemic treatment options
- **Radiation Oncologist**
  - Meets the patient at diagnosis to discuss primary vs adjuvant options
  - Assesses oral cavity and determines need for dental eval/extractions
- **Ear, Nose and Throat Specialist (ENT)**
  - May provide initial diagnosis and/or surveillance
- **Head and Neck Surgeon/Otolaryngologist**
  - Meets the patient at diagnosis to discuss primary vs palliative resection
  - May assume the role of ENT for ongoing evaluation and surveillance
- **Dentist/Oral Surgeon**
  - Removes damaged or at-risk teeth prior to radiation treatment
  - Provides fluoride trays and long-term oral care recommendations

Additional Head and Neck Team Members

- **Interventional Radiologist (IR)/Surgeon**
  - Places gastrostomy tube for temporary nutrition access
  - Places implanted port for systemic therapy
  - May perform biopsy
- **Plastic Surgeon**
  - Participates in reconstruction following oncologic resection
  - May perform cosmetic surgery well after initial treatment
- **Occupational Therapist (OT)/Lymphedema Therapist (LT)**
  - Introduced to patient at the beginning of treatment
  - Follows patient during and after treatment for lymphedema therapy and long term eval of ADLs
- **Home Infusion Pharmacy/DME Company**
  - Provides necessary enteral nutrition and medical supplies

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At Diagnosis – What to Expect

- ENT

- Referrals to Oncology
  - Surgery
  - Medical oncology
  - Radiation oncology
  - Dentist

- New Patient consult appointments
  - Diagnosis and treatment recs
  - Imaging ordered: CT, PET
  - Biopsy

Photo: Diagnosis and treatment of ENT disease.
https://stock.adobe.com/search/images?k=ent&asset_id=407479294. Retrieved on March 11, 2025.

Case Study #1: Surgical Patient

52 y/o male, L tonsil SCC, -P16

PMHx: vertigo, smoker, homeless

Ht: 66”, Wt: 132#

STOCK PHOTO

6/14/24

ED: L tongue pain

1/13/25

ED: L cheek pain x 6 months and L neck lymphadenopathy

1/22/25

No showed to PET scan

1/27/25

Return ED worse pain

1/29/25

H&N surgery eval/ Multidisciplinary Clinic (MDC)

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Case Study #1: Initial Visit / Pre-operative Course

1/29/25: H&N MDC Visit

- H&N Surgery – pt not tolerating any PO, pain uncontrolled, social/transportation issues. Decision made to direct admit for prophylactic G tube, prehabilitation, and surgery.
- Radiation Oncology – introduction, plans to f/u after operation.
- H&N RN Navigator – introduction, review of treatment course, H&N MDC team and contacts, plans to f/u inpt.
- SLP – initial bedside eval, plans to f/u inpt.

1/29/25: Direct admission from H&N MDC (pedway).

Case Study #1: Initial Visit / Pre-operative Course

Patient presented to H&N MDC Clinic 1/29/2025

- H&N Surgery
  - Not tolerating anything by mouth
  - Uncontrolled Pain
  - Social and Transportation issues.
  - Decision made to direct admit for prophylactic G tube, prehabilitation, and surgery.

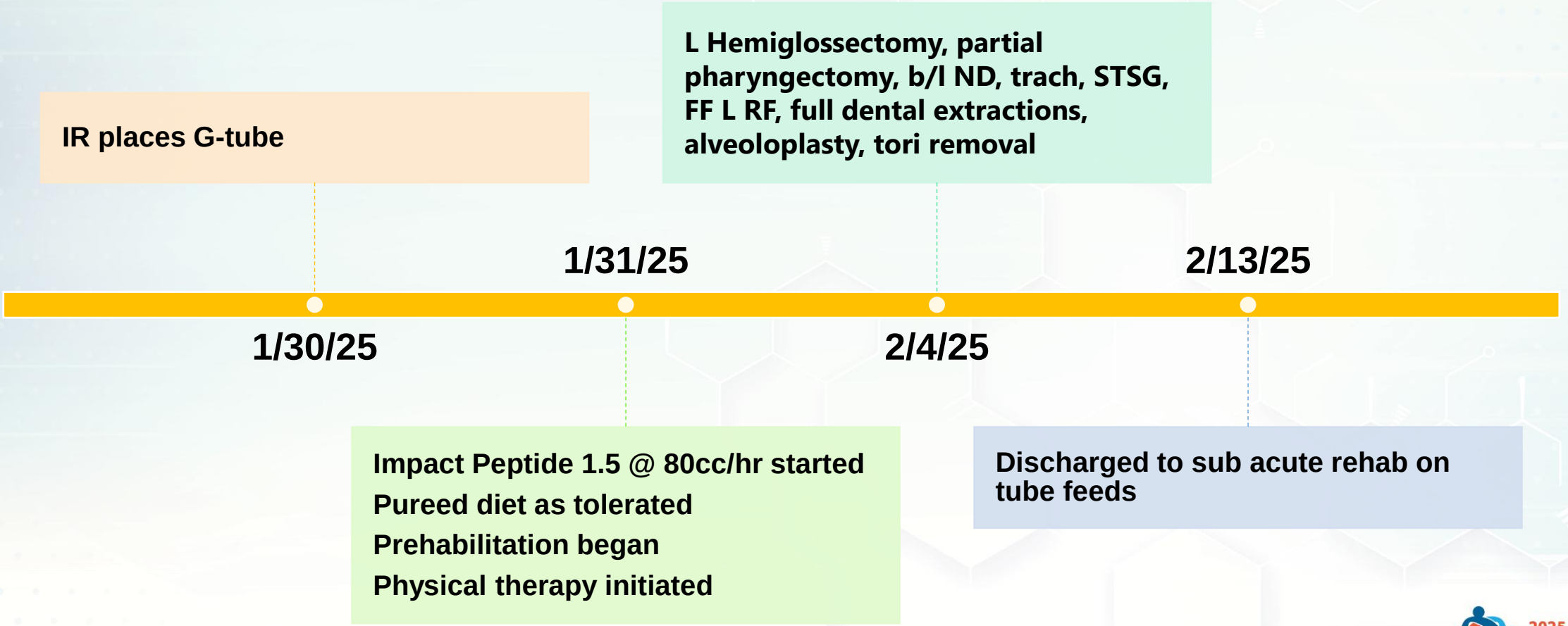
- Radiation Oncology
  - Introduction to services and treatment
  - Discussed Plans to f/u after operation

- H&N RN Navigator
  - Introduction
  - Provides information on H&N MDC team and how to contact
  - Reviews treatment plan and next steps
  - Plans to f/u inpatient

- SLP
  - Initial bedside evaluation
  - Plans to f/u inpatient

Direct admission to hospital from the MDC via pedway

Case Study #1: Hospital Course



Case Study #1: Pathology Result

- 4.5 cm primary tumor. 19 mm depth of invasion. Lymph-vascular space and perineural invasion present.
- Surgical margins negative, closest margin is the deep margin less than 1 mm. 1 of 8 right level 2 lymph nodes positive for metastatic carcinoma, metastatic deposit measuring 0.25 mm.
- All additional right neck nodes negative. 4 of 20 left level 2 nodes positive.
- Focally matted lymph nodes noted. Level 3 and 4 nodes are negative.
- Largest level 2 metastatic deposit 2.3 cm, extranodal extension present.
- Right level 1B nodes negative. 2/4 left level 1B nodes positive, largest metastatic deposit 1.8 cm, extranodal extension present.

Pathologic stage T4a N3b M0.

NCCN Guidelines for Adv Head and Neck Cancers

Surgical resection with neck dissection is the primary treatment for **T4a N3b M0** disease.

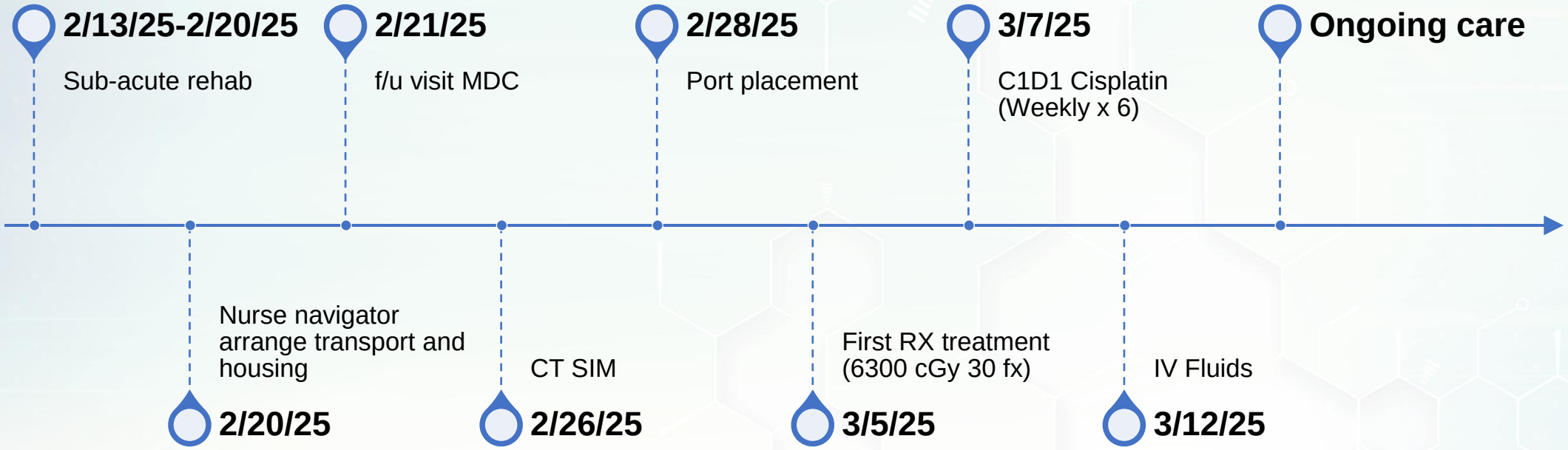
Adjuvant treatment recommendations are based on advanced pathological features:

- +PNI/ENE
- Close surgical margins
- +Nodal disease

Concurrent XRT with systemic therapy within 6 weeks of surgery

- XRT 60-66 Gy Monday - Friday over 6-6.5 weeks
- Chemotherapy with Cisplatin as preferred first line tx

Case Study #1: Adjuvant Course



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NCCN Guidelines for Management and Supportive Care

Nutritional Assessment

- Pre- and post- tx assessments
- Prophylactic feeding tube
  - Weight loss greater than 5% in 1 month of 10% in 6 months
  - Severe aspiration
  - Ongoing dehydration, dysphagia, anorexia, or pain that prohibits eating
  - Patients anticipated to have long-term swallowing disorder
  - Patients anticipated to receive large-field high-dose irradiation or bilateral neck irradiation

Speech Therapy

- Baseline evaluation
- Interval reassessments during and after tx into survivorship for late effects
- Regular follow-up if abnormal function

NCCN Guidelines for Management and Supportive Care cont...

Physical therapy

- Maintain range of motion
- Jaw exercises
- Lymphatic decompression therapy

Pain

- Assess for mucositis

Dental evaluation

- Evaluate and treat dental caries prior to start of treatment
- Extractions 2 weeks prior to RXT
- Manage xerostomia
- Prevent trismus
- Re-evaluation 6-12 weeks after xrt completion

Case Study #1 Surgical Pt Summary

Navigation Takeaways

- Delayed diagnosis, multiple ED visits without adequate f/u
- H&N MDC team efforts made to keep patient in-house from first MDC appointment vs lost to follow-up
- Free flap surgery with aggressive prehab and rehab support
- Prompt adjuvant tx
- Multiple resources leveraged including care coordination, financial support, transportation, lodging, medication access, nutrition, SLP services, PT
- Interprofessional collaboration is essential in H&N cancer management and key to successful patient outcomes

QUESTION #3

Which of the following is not a late stage effect related to head and neck cancer treatment?

a. Lymphedema
b. Mucositis
c. Xerostomia
d. Trismus

Case Study #2 Concurrent Chemoradiation (CCRT)

65 y/o male, Oropharyngeal Cancer
PMHx: HTN, CAD, GERD, CABG
Distant history of smoking for 15yrs, quit 15 yrs ago. ETOH use

https://lh6.googleusercontent.com/proxy/2XiTSAW5QLzWqbEmOGU_wLNaa_BjgeGOTFKqaMiRWSw9a6PhVAVEe_WI7hV55bdQood8vpOnvjhu60Tznjz-m0cB8aMbONqsSAXjE9ThcL-NNi0yVZhUkqVA-Pze5X27Knh1selamDPJ9Afmcr6m

7/5/24
Reports 5-month hx fullness, soreness, and bleeding of L throat
PCP place ENT referral

7/16/24
CT shows L oropharynx/ tongue bass mass. Enlarged LN

7/23/24
ENT visualizes 3cm
1B mass and 2cm level 2 mass on lt side
Ref to Med Onc

8/1/24
US guided FNA by IR

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Case Study #2: CCRT continued

- Diagnosis: oropharyngeal cancer 8/2/24
  - Core biopsy of L cervical level 2 LN
  - Reviewed by pathologist
    - SCC, P16+
  - **Staging: cT2N1**

- Recommended treatment:
  - Radiation 70 Gy in 35 fx
    - IMRT
  - Chemo weekly
    - Cisplatin

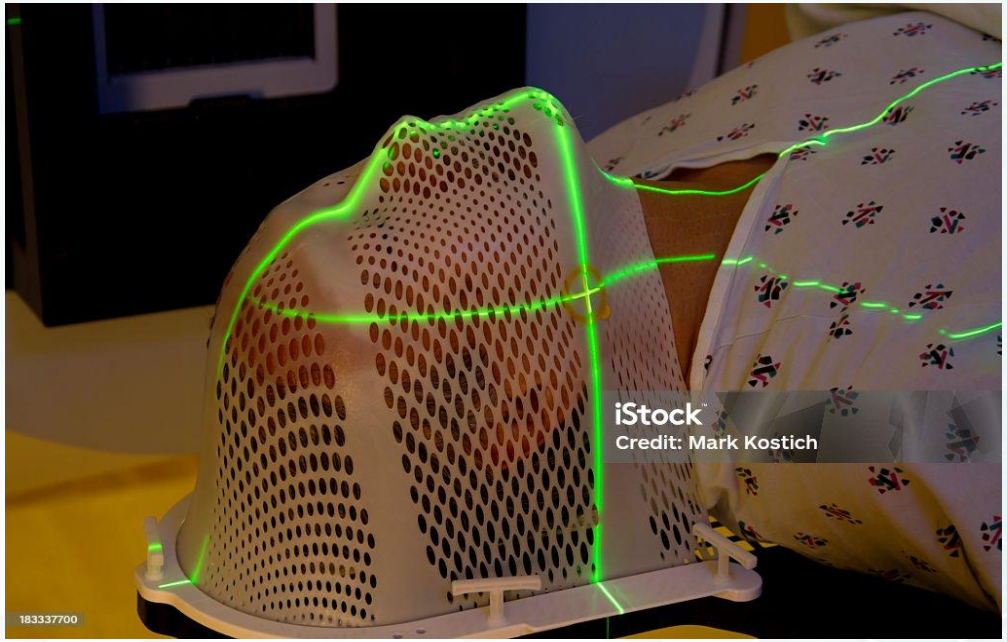
- Dental evaluation and treatment prior to start of Tx coordinated by nurse navigator

- Photo: https://fortune.com/img-assets/wp-content/uploads/2024/03/GettyImages-1501122979-e1711661547835.jpg?w=1440&q=75.

Yom SS, et al. Reduced-dose radiation therapy for HPV-associated oropharyngeal carcinoma (NRG Oncology HN002). *JCO* **39**, 956-965(2021).doi:10.1200/JCO.20.03128

Case Study #2: CCRT continued

- Phases of Treatment:
  - First day CCRT
  - Weekly labs (CBC, CMP, Mg), recheck, OTV (on treatment visit)
- Symptom Management
  - Radiation: radiodermatitis, dysphagia, odynophagia, fatigue, lymphedema
  - Chemo: N/V, neuropathy, tinnitus
  - Psychological/emotional distress
- Follow up: 1 month, 3-month, PET
  - Radiation Oncology
  - Medical Oncology
  - ENT repeat bx 1/10/25: negative



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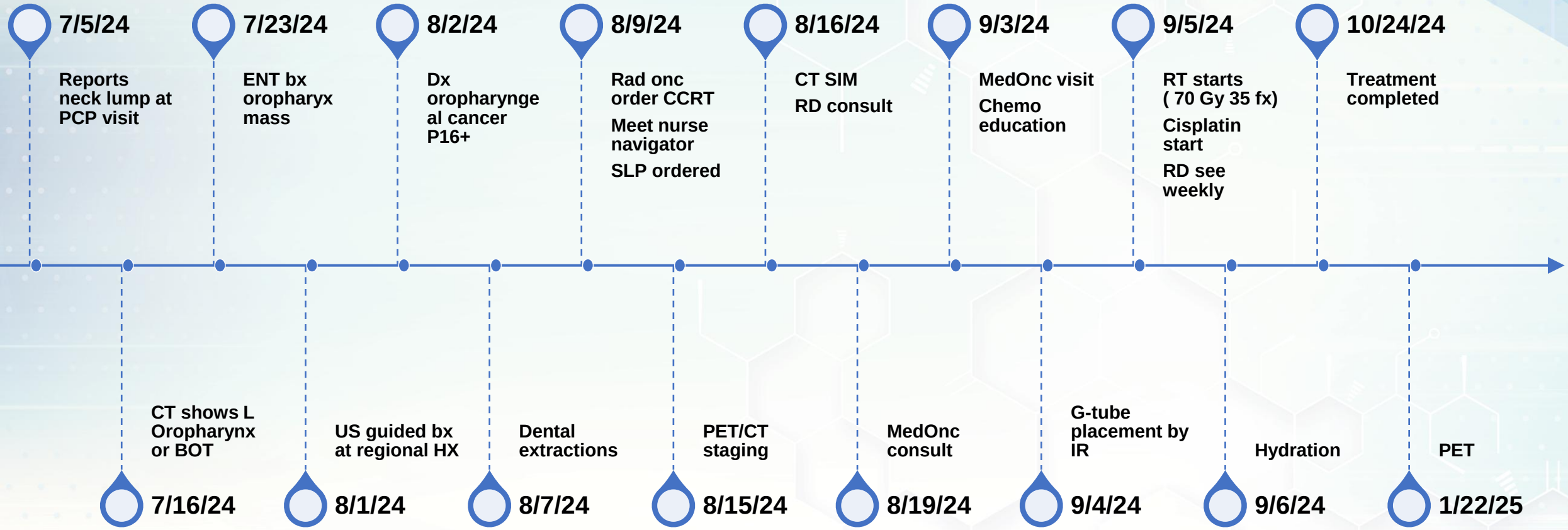
Case Study #2: CCRT continued



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Case #2: CCRT Survivorship

- Survivorship planning (within 1 yr) and evaluation for long term side effects that impact quality of life.
- Ongoing assessments for psychological distress
- Long term surveillance: consider tumor site, stage, prognostic factors, symptoms and changes based on clinical exam
- Radiation: Clinical evaluations with scope
  - Lymphedema, Fibrosis
  - Dysphagia, Dysgeusia, Trismus
  - Hypothyroid
  - Carotid Artery
  - Dental evaluation and follow up
- Medical Oncology/Cisplatin: Clinical evaluations
  - Audiology test
  - Lab work, renal function

NCCN® Guidelines for P16 HPV+ Oropharynx Cancer

Concurrent systemic therapy and XRT is the primary treatment for **T2 N1 M0** disease.

Primary therapy for high-risk

- Weekly Cisplatin 40mg/m2
- Concurrent XRT 66-70 Gy Monday - Friday over 6-7 weeks
- IMRT preferred to minimize dose to critical structures

*P16 is a cyclin-dependent kinase inhibitor that blocks cell cycle progression at G1 to S check point. Associated with HPV infection.

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Stephen S et al. Significance of p16 in site-specific HPV positive and HPV negative HNSCC. doi:10.5539/cco.v2n1p51

NCCN® Guidelines: Follow-Up Recommendations Post Systemic Therapy/RT

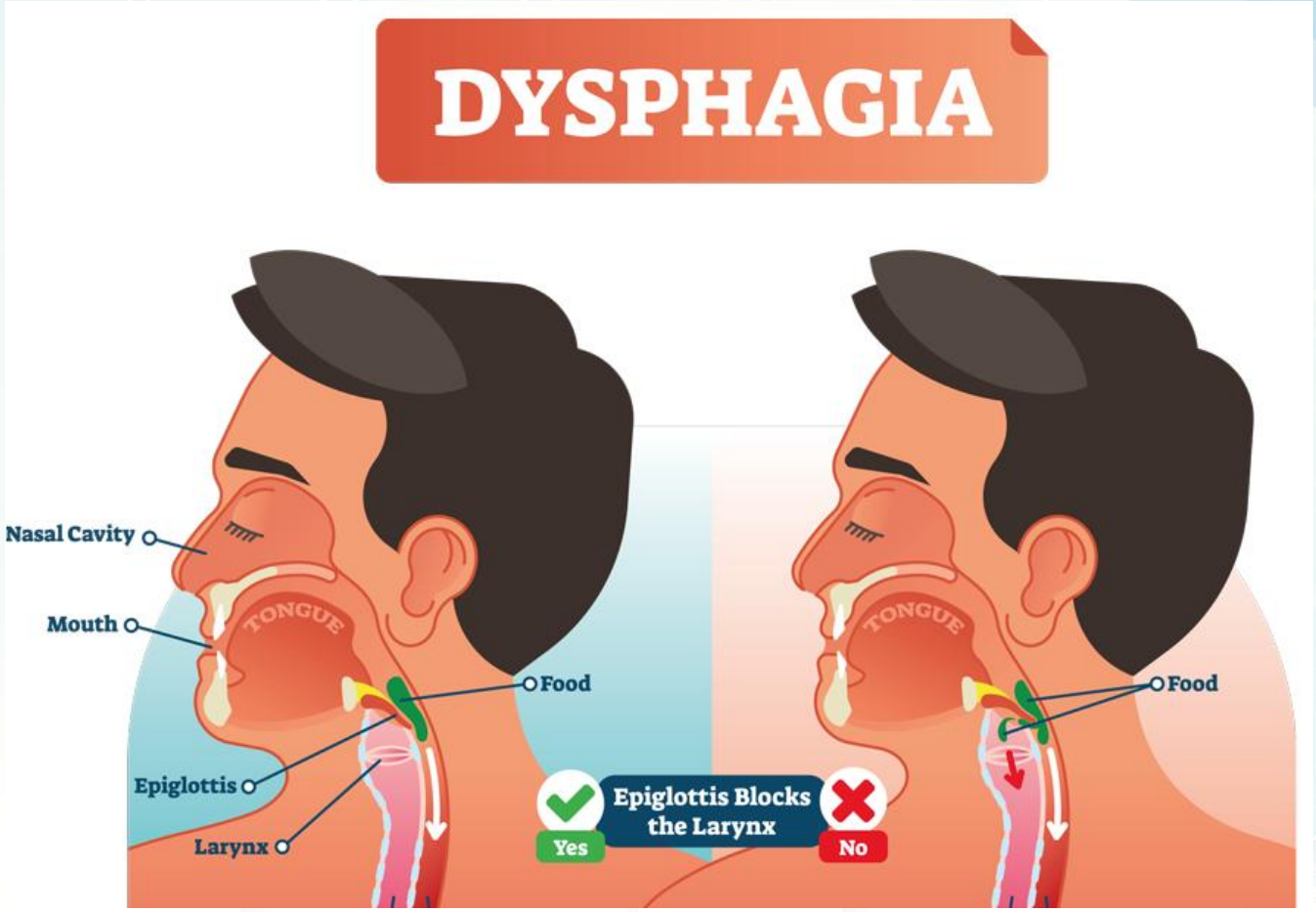
- Clinical assessment 4-8 weeks after TX completion
- CT with contrast of primary and neck in 8-12 weeks
- Head and neck exam with mirror and fiberoptic exam every
  - 1-3 months on year 1
  - 2-4 months on year 2
  - 4-8 months on years 3-5
  - Annually after year 5
- TSH every 6-12 months if neck irradiation
- Ongoing SLP, PT, and nutritional assessment until stable
- Dental evaluation and lymphedema management as indicated
- Ongoing surveillance for depression
- Survivorship care planning within one year

Case Study #2: CCRT Summary

- Time from diagnosis to evaluate effectiveness of treatment: 5+ mos
- Medical Providers involved: 7
- Supportive staff: Nurse, radiation therapists, clinical staff, social worker, dietitian, SLP, RN Navigator
- Complex psychosocial challenges (depression, substance abuse, body image disturbance, broken support systems, social isolation)
- Survivorship plan and continued surveillance for 5 years
- Possibility of osteoradionecrosis or residual malignancy

Long-Term Side Effects

- Dysphagia
- Dysgeusia
- Trismus
- Lymphedema
- Hypothyroid
- Carotid
- Trauma



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QUESTION #4

What percentage of patients with locally advanced squamous cell carcinoma head and neck cancer will reoccur?

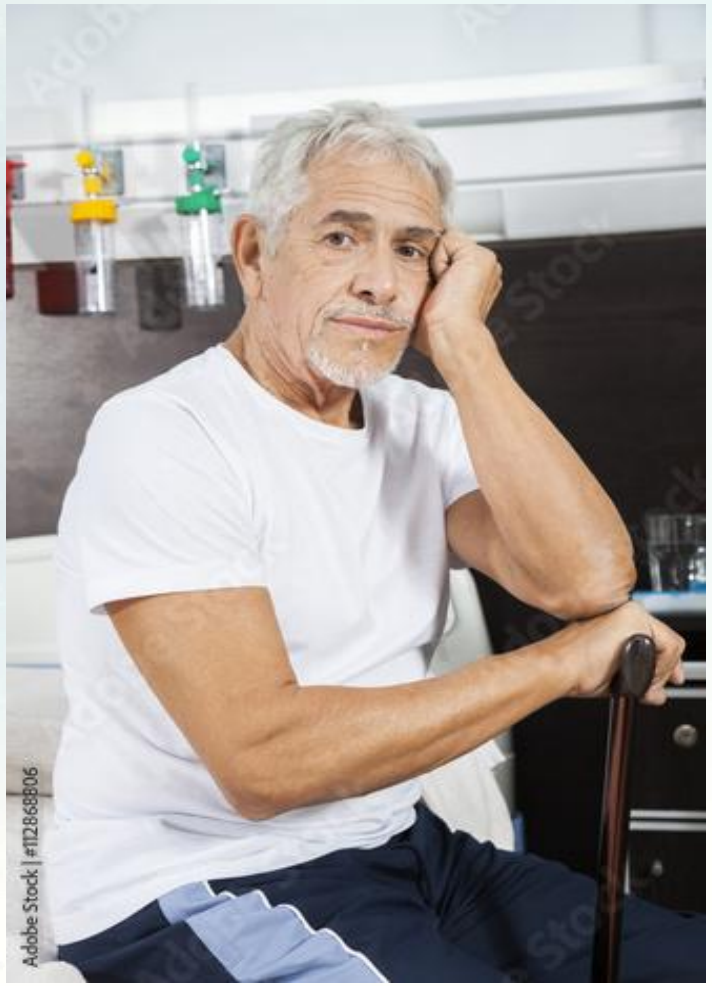
a. 25%

b. 33%

c. 50%

d. 75%

Case Study #3: Recurrent H&N Cancer



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71 y/o male, recurrent R vocal cord SCC, -P16

PMHx: Smoker. GERD, HTN, OSA, Appendectomy.

Cancer Hx: prostate cancer s/p XRT (2021), colorectal cancer s/p colectomy (2022), R vocal cord squamous cell carcinoma s/p definitive XRT (2023), L forehead/back basal cell carcinoma s/p wide local excision (11/2024).

Ht: 67”, Wt: 190#

Presentation:

1/27/25: Referred to H&N MDC 2/2 persistent sore throat and hoarseness. Prior oncology care at OSH.

1/27/25: Direct laryngoscopy endoscopy with biopsy

Case Study #3: Initial Visit / Pre-operative Course

2/5/25: Pt canceled CT scans and MDC visit due to acute illness

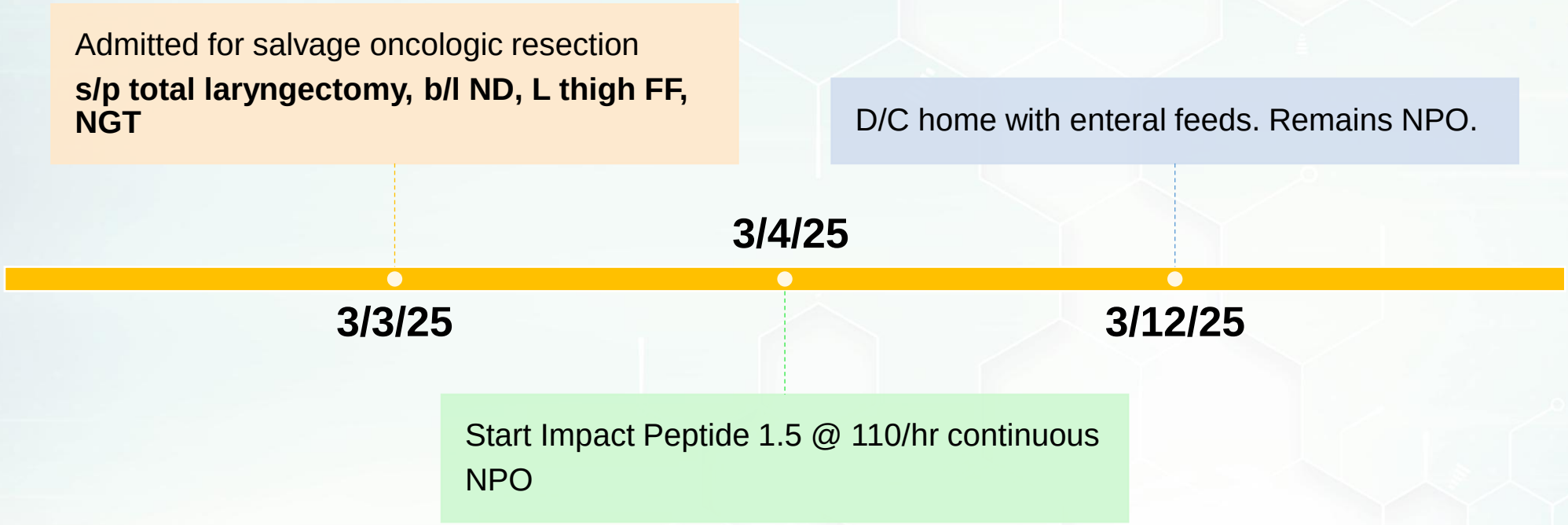
2/14/25: CT head, neck, and chest performed (recurrent larynx SCC, cervical lymph nodes, no distant mets)

2/19/25: Pt canceled MDC visit due to weather/transportation

2/21/25: Initial H&N MDC Visit

- H&N Surgery – recommended TL, b/l ND, L R forearm FF
- Radiation Oncology – discouraged re-irradiation 2/2 risk for non-functional larynx
- H&N RN Navigator – follow-up, review of treatment course, H&N MDC team and contacts, plans to f/u inpt
- SLP – initial bedside eval, plans to f/u inpt
- RD – initial eval, prehab

Case Study #3: Hospital Course



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Case Study #3: Pathology Result

- 2.6 cm primary tumor. Transglottic extension present.
- Tumor laterality: right; left: midline. Histologic type squamous cell carcinoma, conventional (keratinizing).
- Histologic grade 2, moderately differentiated. Tumor extends into the paraglottic space. Lymph-vascular space not identified.
- **Perineural invasion present.** Surgical margins negative, closest margin is the radial margin greater than 9 mm.
- All regional lymph nodes negative for tumor (75).

Pathologic stage T3 N0.

NCCN® Guidelines for Recurrent Head and Neck Cancers

Surgical resection is recommended primary treatment for locoregional reoccurrence with prior XRT

T3 N0 M0 disease.

- Reirradiation should be used in a highly select subset of patients due to risk of irreversible toxicities.
- Weekly carboplatin or cisplatin with concurrent XRT may also be considered.
- Research trials should be considered when reirradiation is not recommended.

Case Study #3: Adjuvant Course

3/14/25: Follow-up H&N MDC Visit

- H&N Surgery follow-up
- RD follow-up: Cont G tube feeds, PO per SLP, aggressive replacement
- SLP follow-up: MBSS scheduled 3/19/25, TEP consult
- RN Navigator follow-up: Coordination of care

3/19/25: Follow-up H&N MDC Visit

- H&N Surgery follow-up
- Radiation Oncology follow-up: rec consolidative re-RT 2/2 +PNI
- Behavioral Oncology follow-up
- SLP follow-up: post-MBSS review
- RD follow-up: cont G tube feeds, PO per SLP, aggressive replacement
- RN Navigator follow-up: coordination of care

Tx ongoing.

Case Study #3 Recurrent H & N Cancer Takeaways

Navigation Takeaways

- Delayed diagnosis, patient canceled multiple appointments
- H&N Nurse Navigator provided support for both patient and caregiver
- Free flap surgery with aggressive prehabilitation and rehabilitation support
- Multidisciplinary review proved critical in determining the best treatment recommendations for the patient. I.e., plan for salvage surgery vs re-irradiation following DLE with biopsy proven recurrence.

Barriers to care

Patient Related:

- Rural locations lack cancer treatment centers and supportive care, i.e.:
  - Dental surgeon
  - SLP
  - OT
  - PET
- Behaviors/Choices
- Lack of follow up with recommendations

Social Determinants of Health

https://marcus-daly-site-390.siteassist.biz/patients-and-visitors/social-determinants-of-health/

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Barriers to Care Cont.

Provider Related:

- Lack multidisciplinary clinic for H&N cancer
- Communication challenges
- Care not well coordinated
- Education; not providing information in ways patients can understand
- Mental health and emotional concerns are not addressed

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Barriers to Care Cont.

- System Related:
  - Multiple EMRs
  - Various sites where care is provided
  - Inadequate health insurance coverage
  - Lack of dental insurance
  - Travel logistics to various sites in and out of area

- Optimal Care:
  - High volume centers
  - Dedicated H&N RN navigators
  - Multidisciplinary meetings for care coordination

Stock Photo

- Ascopub.org. Downloaded February 10, 2025, from 204.010.247.001 ASCO Meeting Abstract from the 2024 ASCO annual meeting. Evaluating perceived barriers to optimal care in head and neck cancer: A mixed-methods study. Powell., F, et al.
- Powell et al. Evaluating perceived barriers to optimal care in head and neck cancer: A mixed-methods study. *JCO* **42**, 6079-6079(2024).
- doi:10.1200/JCO.2024.42.16_suppl.6079

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Supportive Resources in Survivorship

Psychosocial

- Support Groups
  - SPOHNC.org
  - WebWhispers.org

Counseling/Therapy

- Psychologytoday.com
- PCP
- LCSW

Organizations

- Head and Neck Cancer Alliance
- American Cancer Society
- The Laryngectomy Site

Providers

- Oncologists
- Pain Specialists
- RD
- SLP, OT
- Survivorship Plan APP
- RN Navigator

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QUESTION & ANSWER

Interprofessional Insights: Advanced Care Coordination for Patients with Head and Neck Cancer

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CE CODES

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