Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/CAD/ID 3000

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20 November 2015

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to head and neck cancer.

Within your health trust how many patients are currently [within the past 6 months] being treated for head and neck cancer (Squamous cell carcinoma)?

April to September 2015 – 26 patients

Of these how many are treated with the following therapies;
Carboplatin
Cetuximab
Cisplatin
Docetaxel
5-Fluorouracil (5FU)
Radiotherapy Only

Please see the table below:

If your health trust has a protocol or pathway for the treatment of head and neck cancer patients [including referral pathway to other trusts], please could you provide details?

Please see the attached document.

Within your health trust how many patients are currently [within the past 6 months] being treated for Colorectal Cancer?

April to September 2015 – 136 patients

Of these how many are treated with the following therapies;
Bevacizumab

Cetuximab
Panitumumab
Aflibercept
Oxaliplatin
Irinotecan
5-Fluorouracil
Irinotecan with 5-fluorouracil (5FU) and folinic acid [FOLFIRI]
Oxaliplatin with 5-fluorouracil (5FU) and folinic acid [FOLFOX]
Capecitabine and oxalipatin (CAPOX / XELOX)
Capecitabine and irinitecan (CAPIRI)

Please see the table below: please note that patients may be having multiple treatment regimes

EAS regimes	**Number of patients**
Carboplatin & Paclitaxel	1
Carboplatin with radiotherapy	7
Cetuximab weekly	4
Cisplatin & 5-Fluorouracil with radiotherapy	16
Cisplatin & 5-Fluorouracil without radiotherapy	5
Cisplatin every 3 weeks with radiotherapy	20
Gemcitabine & Carboplatin	1
Paclitaxel	2
TP	2
TPF	10
NB a single patient may have more than 1 regime	

Patients with Chemotherapy or RT appointments in period 1/14/2015-30/09/2015 at Maidstone and Tunbridge Wells NHS Trust, can be subsequent treatment and can have been seen first at another hospital
Patients with H&N diagnosis, where histology contains squamous or SCC = 80
Patients having RT Only = 24

Oncological Treatment of Head & Neck Cancer

Pathway of Care

Kent & Medway Cancer Collaborative

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Table of Contents

1.0 Introduction

1.1 Overview

This document has been written to provide guidance on the treatment of head and neck cancer in the Kent & Medway Cancer Network.

Radiotherapy schedules are as defined in the Kent Oncology Centre Quality System Clinical Protocols (Disease Management and Radiotherapy Protocols).

See network chemotherapy prescribing proformas for details of chemotherapy / anti-cancer regimens.

All patients will be considered for entry into a clinical trial (see appendix A).

All patients should be discussed within a multidisciplinary team meeting before commencing initial treatment.

For skin cancers and sarcomas arising in the head and neck area, reference should be made to skin cancer and sarcoma treatment guidelines.

Please note, some of the drugs/doses recommended within this document are outside of the U.K. licensed marketing authorisation.

2.0 Squamous carcinomas of the lip and oral cavity

This group includes cancers of the lip, anterior two-thirds of the tongue, floor of mouth, gum (alveolus) and hard palate.

2.1 Radical Treatment

Surgery is the preferred initial treatment.

Those with disease beyond the scope of surgery or those not sufficiently fit for surgery may be considered for radical radiotherapy.

2.2 Adjuvant Treatment

Histology is reviewed in the H&N Multidisciplinary Meeting with emphasis on risk stratification. On this basis, patients may be grouped into those at high, intermediate or low risk of locoregional recurrence.

High risk features are:

- the presence of primary tumour at the resection margin
- nodal involvement with extracapsular spread.

Intermediate risk features are:

- resection margins <5mm
- perineural infiltration
- discohesive invasion front
- vascular invasion
- nodal involvement without extracapsular spread
- adenoid cystic carcinoma

Those in the high risk category are considered for postoperative chemoradiotherapy.

- cisplatin 100mg/m_2 every 3 weeks during radiotherapy (2-3 cycles)
  or
- cisplatin 40mg/m_2 weekly during radiotherapy

Those in the intermediate risk category may be considered for postoperative radiotherapy (or occasionally chemoradiotherapy) depending on the number of risk features which are present.

2.3 Palliative Treatment

Palliative radiotherapy may be considered as initial treatment for those with locally advanced disease and poor performance status.

Radiotherapy may be beneficial to those with metastatic disease, particularly in bones or brain.

Chemotherapy may be considered for selected patients with metastatic disease and/or locally advanced locoregional disease beyond the scope of surgery and radiotherapy.

- cisplatin 100mg/m_2 *plus*
  5-fluorouracil 1000mg/m_2/day for 4 days every 3 weeks (up to 6 cycles)

Carboplatin should be substituted for cisplatin in those unlikely to tolerate a large fluid load or those with borderline renal function, borderline performance status or ototoxicity from cisplatin:

- carboplatin AUC=5 *plus*
  5-fluorouracil 1000mg/m_2/day for 4 days every 3 weeks (up to 6 cycles)

Cetuximab in combination with platinum based chemotherapy (funding approval required) followed by cetuximab as maintenance therapy until disease progression(funding approval required), may be considered for selected patients who have not received previous treatment with cetuximab. This group may include younger patients with WHO PS 0-1 with well or moderately differentiated primary tumours.

First line treatment for frail or elderly patients:

- carboplatin AUC=5 *plus*
  gemcitabine 1200mg/m_2 days 1and 8 on a 3 week cycle (up to 6 cycles)

Second line treatment for all other patients:

- gemcitabine 1250mg/m_2 days 1 and day 8 on a 3-week cycle (up to 6 cycles)
- paclitaxel 80mg/m_2 days 1,8 & 15 every 28 days

3.0 Squamous carcinomas of the pharynx, larynx

This group includes cancers of the nasopharynx, oropharynx (soft palate, tonsil and tongue base), hypopharynx (pharyngeal wall, pyriform fossa and postcricoid) and larynx (including epiglottis).

3.1 Radical Treatment

Radiotherapy with concurrent chemotherapy in selected cases, according to tumour site, stage and performance status. In general, chemoradiotherapy is recommended for those with cancers which are T_3, T_4 or node-positive and those of good performance status (WHO PS 0-1) and age 75 or less. A selected subset of T_2 cancers of the larynx (those exhibiting reduced cord movement or with subglottic extension) should also be considered for chemoradiotherapy.

- cisplatin 100mg/m_2 every 3 weeks during radiotherapy (2-3 cycles)
  or
- cisplatin 40mg/m_2 weekly during radiotherapy

Patients of borderline performance status or age may be treated with cisplatin at a reduced dose.

As an alternative, patients receiving chemoradiotherapy for oropharynx cancer may be treated with:

- cisplatin 75mg/m_2 *plus*
  5-fluorouracil 750mg/m_2/day for 4 days every 3 weeks (weeks 1 and 5 of radiotherapy).

Carboplatin should be substituted for cisplatin in those unlikely to tolerate a large fluid load or those with borderline renal function, borderline performance status or ototoxicity from cisplatin:

- carboplatin AUC=5-6 every 3 weeks during radiotherapy (2-3 cycles)
  or
- carboplatin AUC=5 *plus*
  5-fluorouracil 750mg/m_2/day for 4 days (weeks 1 and 5 of radiotherapy).
  or
- carboplatin AUC 1.5-2 every week during radiotherapy

Cetuximab given concurrently with radiotherapy may be considered for those of good performance status (WHO PS 0-1) for whom platinum-based therapy is not appropriate. Cetuximab commences two weeks prior to the start of radiotherapy.

- cetuximab 400mg/m_2 loading dose followed by 250mg/m_2 weekly (8-9 weeks)

Surgery may be preferable for a selected group of advanced (T_4) cancers of the larynx and hypopharynx, including those with a poor response to induction chemotherapy (see below).

3.2 Neo-adjuvant treatment

Induction (neo-adjuvant) chemotherapy (TPF) is recommended for locally advanced squamous cancers of the oropharynx, larynx and hypopharynx (T_4, bulky T_3 or bulky nodal disease) prior to chemoradiotherapy. Patients should generally be of good performance status (WHO PS 0) and aged 70 or less.

- docetaxel 75mg/m_2 *plus*
  cisplatin 75mg/m_2 *plus*
  5-fluorouracil 750mg/m_2/day for 5 days every 3 weeks (2-4 cycles)

Induction (neo-adjuvant) chemotherapy (TP) is recommended for locally advanced cancers of the nasopharynx and paranasal sinuses (T_4, bulky T_3 or bulky nodal disease) prior to chemoradiotherapy. Patients should generally be of good performance status (WHO PS 0) and aged 70 or less.

- docetaxel 75mg/m_2 *plus*
  cisplatin 75mg/m_2 every 3 weeks (2-4 cycles)

Those not sufficiently fit for TPF or TP (WHO PS 1 or age over 70) may be considered for neo-adjuvant cisplatin and 5FU.

- cisplatin 100mg/m_2 *plus*
  5-fluorouracil 1000mg/m_2/day for 4 days every 3 weeks (up to 6 cycles)

3.3 Adjuvant Treatment

Postoperative radiotherapy or chemoradiotherapy may be considered for patients with carcinomas of the larynx or hypopharynx undergoing primary surgery.

- cisplatin 100mg/m_2 every 3 weeks during radiotherapy (2-3 cycles)
  or
- cisplatin 40mg/m_2 weekly during radiotherapy

3.4 Palliative Treatment

As section 2.3.

4.0 Malignant salivary gland tumours

This group includes cancers of the parotid and submandibular glands and of minor salivary glands located within the oral cavity and pharynx.

4.1 Radical Treatment

Surgery is the preferred initial treatment.

Those with disease beyond the scope of surgery or those not sufficiently fit for surgery may be considered for radical radiotherapy. There is no established role for concurrent chemoradiotherapy.

4.2 Adjuvant Treatment

Postoperative radiotherapy should be considered for those with high grade tumours or with tumour present at or close to resection margins.

4.3 Palliative Treatment

Palliative radiotherapy may be considered as initial treatment for those with locally advanced disease and poor performance status.

Radiotherapy may be beneficial to those with metastatic disease, particularly in bones or brain.

Chemotherapy may be considered for selected patients with metastatic disease and/or locally advanced locoregional disease beyond the scope of surgery and radiotherapy (excluding those with adenoid cystic carcinoma).

- carboplatin AUC=5 *plus*
- paclitaxel 175mg/m_2 every 3 weeks (up to 6 cycles).

Adenoid cystic carcinomas:

- cisplatin 75mg/m_2 day 1 with the option of giving as a split dose (25mg/m_2) on days 1,8, and 15 of a 3 week cycle
  plus
- vinorelbine 25mg/m_2 IV days 1 and 8 of a 3-week cycle (funding approval required) (up to 6 cycles)

5.0 Sinonasal and ear cancers

This group includes cancers of the nasal cavity, maxillary or ethmoid sinuses (rarely frontal or sphenoidal sinuses), auditory canal and middle ear. Cancers of the pinna and nasal ala are considered as skin cancers (see skin cancer treatment guidelines).

5.1 Radical Treatment

Surgery is the preferred initial treatment.

Those with disease beyond the scope of surgery or those not sufficiently fit for surgery may be considered for radical radiotherapy.

Concurrent chemoradiotherapy may be considered for those with locally advanced squamous sinonasal cancer and a good response to induction chemotherapy.

- cisplatin 100mg/m_2 every 3 weeks during radiotherapy (2-3 cycles)
  or
- cisplatin 40mg/m_2 weekly during radiotherapy

5.2 Neo-adjuvant Treatment

Induction (neo-adjuvant) chemotherapy (TP) is recommended for locally advanced cancers of the nasopharynx and paranasal sinuses (T_4, bulky T_3 or bulky nodal disease) prior to chemoradiotherapy. Patients should generally be of good performance status (WHO PS 0) and aged 70 or less.

- docetaxel 75mg/m_2 *plus*
  cisplatin 75mg/m_2 every 3 weeks (2-4 cycles)

Those not sufficiently fit for TP (WHO PS 1 or age over 70) may be considered for neo-adjuvant cisplatin & 5FU.

- cisplatin 100mg/m_2 *plus*
- 5-fluorouracil 1000mg/m_2/day for 4 days every 3 weeks (2-4 cycles)

Induction (neo-adjuvant) chemotherapy may be considered for those of good performance status with neuroendocrine carcinoma or extrapulmonary small cell carcinoma:

- carboplatin AUC=5 *plus*
- etoposide 100mg/m_2 iv day 1 and 200mg/m2 orally days 2 & 3 of a 3-week cycle (2-4 cycles)

Carboplatin should be substituted for cisplatin in those unlikely to tolerate a large fluid load or those with borderline renal function, borderline performance status or ototoxicity from cisplatin:

- carboplatin AUC=5 *plus*
- 5-fluorouracil 1000mg/m_2/day for 4 days every 3 weeks (2-4 cycles)

5.3 Adjuvant Treatment

Postoperative radiotherapy should be considered for those with high grade tumours or with tumour present at or close to resection margins.

5.4 Palliative Treatment

As section 2.3 (except for adenoid cystic carcinomas, see section 4.3).

6.0 Appendix A: Clinical Trials

Refer to the local research team who will provide on request an orientation handbook, list of current trials and associated trial protocols and summaries.

Contact numbers

MTW – Clinical Trials Office	01622 225 033
Darent Valley Hospital – Clinical Trials Office	01322 428 100 ext 4810
Medway Hospital – Clinical Trials Office	01634 825 094
East Kent Hospitals – Clinical Trials Office:	
Solid Tumours (excluding Gynae)	01227 866 393

7.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the KMCN website via the following link: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/

8.0 Glossary

Acronyms in common usage throughout KMCN documentation

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCN	Kent & Medway Cancer Network
KMCRN	Kent & Medway Cancer Research Network
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non Surgical Oncology Group *(Permanent oncologist sub group of the DOGs with a specific responsibility for chemo/rad pathways and advice to the DOG, Network and GEOGRAPHICAL LOCATIONs on new drugs)*
PoC	Pathway of Care *(Network agreed disease site specific clinical guidelines)*
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RAT	Research and Trial Group *(Permanent sub-group of the DOGs with a specific responsibility for taking forward the clinical trials agenda)*
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

9.0 Document Administration

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Co-author(s)	Caroline Waters
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Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
September 09	0.1	Document created	N Rowell
October 09	0.2	Minor format changes	C Waters
December 09	0.3	Paragraph added around cetuximab in palliative treatment of squamous carcinoma of the lip and oral cavity.	C Waters
February 10		Final version agreed	N Rowell
April 2010		Changes to palliative treatment gemcitabine regimens in section 2 Changes to radical treatment regimens in section 3. (removal of carboplatin AUC 1.5 weekly and addition of carboplatin AUC 5 plus 5-fluorouracil 750mg/m_2)	Head and Neck NOG

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