

# The Management of Head & Neck Cancer

## Pathway of Care

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## 1.0 Introduction and background

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Following the publication of Improving Outcomes Guidance (IOG) in Head and Neck Cancer (2004), the Kent and Medway Cancer Collaborative (KMCC) Head and Neck Tumour Site Specific Group (TSSG) reviewed the Pathway of Care for Head and Neck Cancer patients. This is a working document based on:

- IOG for Head & Neck Cancer (NICE 2004), accessible at: <https://www.nice.org.uk/guidance/ng36> and guidance published in February 2016, accessible at: <https://www.nice.org.uk/guidance/ng36>
- British Association of Otolaryngologists Head and Neck Surgeons (BAOHNS) Third Consensus Document “Effective Head and Neck Cancer Management” (2002)
- The Journal of Laryngology & Otology
- Guidelines agreed by the Kent & Medway Diagnostics Cross Cutting Advisory Group
- Outcomes from Head & Neck TSSG meetings
- Head & Neck TSSG Work Plan
- NICE referral criteria: <https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#head-and-neck-cancers>

This Pathway of Care document should be read in conjunction with the Head & Neck and Thyroid Cancer High Level Operational Policy. The focus of the Pathway of Care is on areas impacting directly on the care received by patients while the focus of the High Level Operational Policy is on the organisational aspects which underpin the delivery of care. The aim is, as far as possible, to avoid duplication and repetition between the two documents.

All Head & Neck TSSG documents are accessible at: <http://www.kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/head-and-neck-tssg/>

There is a separate Pathway of Care for patients with Thyroid Cancer, produced under the direction of the Thyroid Cancer TSSG, accessible at: <http://www.kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/thyroid-tssg/>

### 1.1 Head and Neck Cancer in Kent & Medway

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Within Kent and Medway, there are two multidisciplinary teams (MDTs), referred to as the East Kent and West Kent MDTs. Full details of the working arrangements within these hospitals are contained within the High Level Operational Policy. In outline:

- East Kent MDT based within East Kent Hospitals University NHS Foundation Trust (EKHUFT):
  - Kent and Canterbury Hospital (multidisciplinary clinic, radiotherapy and chemotherapy, short stay & day surgery)
  - William Harvey Hospital, Ashford (clinics, operating centre and chemotherapy)
  - Queen Elizabeth Queen Mother Hospital, Margate (clinics, day surgery and chemotherapy)
  - Buckland Hospital, Dover (clinics)
- West Kent MDT based across several Trusts and comprising:
  - Maidstone & Tunbridge Wells Hospital (multidisciplinary clinic, radiotherapy, chemotherapy, clinics and short-stay surgery)
  - Darent Valley Hospital (clinics)
  - Medway Maritime Hospital (clinics and short-stay surgery)
  - Queen Victoria Hospital, East Grinstead (clinics and operating centre)

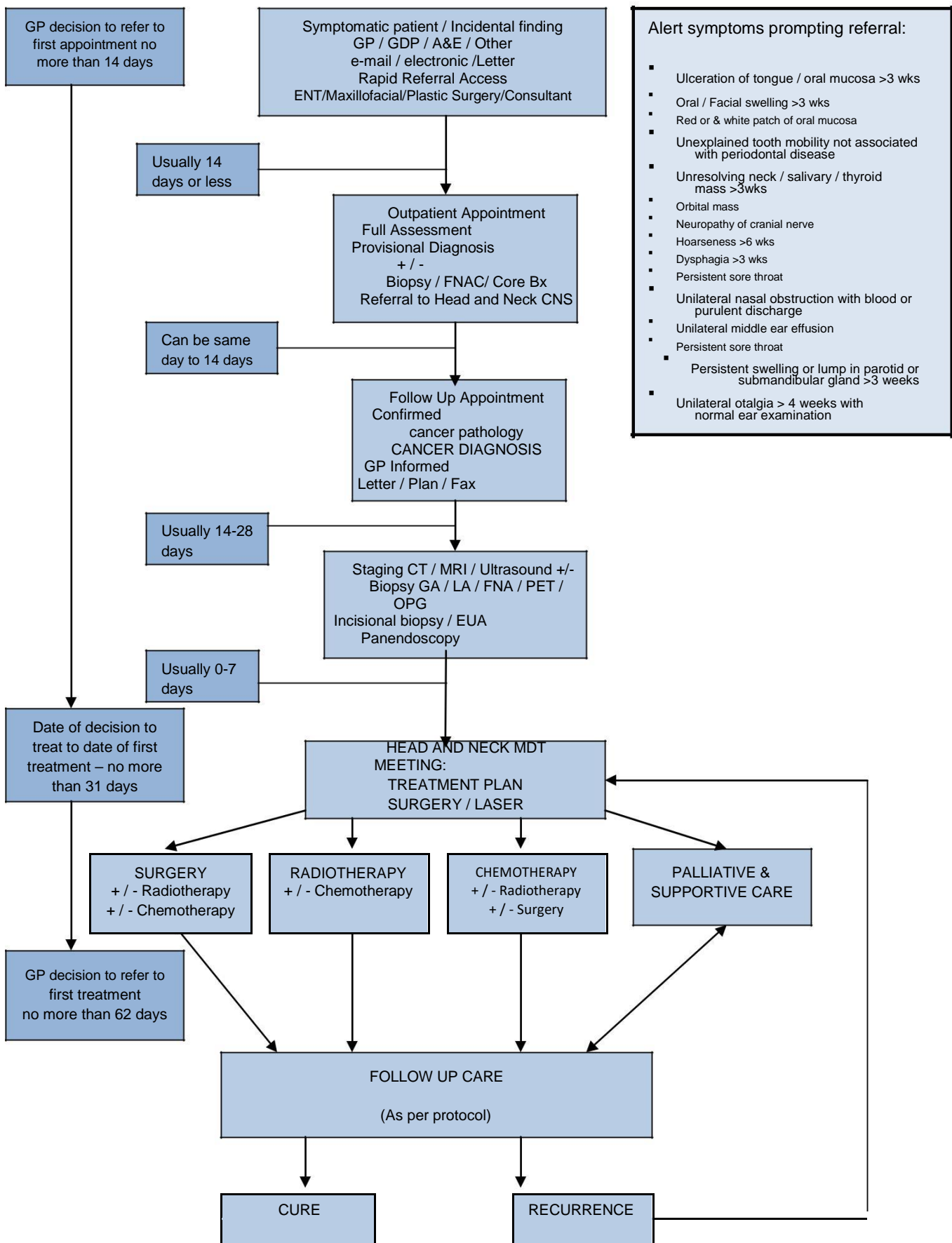
### 1.2 Terminology

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Cancers of the Head and Neck comprise:

- cancer of the upper aerodigestive tract (which includes cancers of the mouth, pharynx, larynx, sinuses, ears, nose and cervical oesophagus)
- cancers of the salivary glands
- complex skin cancers (particularly where reconstruction or neck dissection are required)
- malignant neck masses (regardless of tumour of origin).

## 2.0 Referral Pathway



## 2.1 Rapid Access

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General medical and dental practitioners are encouraged to refer patients with a high index of suspicion of cancer as a matter of urgency using the NG12 2-week wait (2WW) referral proforma (Appendix 1). Referrals should be made using e-referral, email (electronic referral) or faxed, details of which are shown on the 2ww proforma.

The NG12 guidance recommends the following:

For laryngeal cancer

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for laryngeal cancer in people aged 45 and over with:

- Persistent unexplained hoarseness or
- An unexplained lump in the neck.

For oral cancer

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with either:

- Unexplained ulceration in the oral cavity lasting for more than 3 weeks or
- A persistent and unexplained lump in the neck.

Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either:

- A lump on the lip or in the oral cavity or
- A red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia

Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) for oral cancer in people when assessed by a dentist as having either:

- A lump on the lip or in the oral cavity consistent with oral cancer or
- A red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia.

General Practitioners and General Dental Practitioners remain aware of the previously published NICE 'red flag' symptoms or signs which might suggest a Head & Neck cancer and include:

- ulceration of tongue / oral mucosa > 3 weeks
- oral / facial swelling > 3 weeks
- red or red and white patch of oral mucosa
- unexplained tooth mobility not associated with periodontal disease
- unresolving neck / salivary / thyroid lump > 3 weeks
- orbital mass
- neuropathy of cranial nerve
- hoarseness for more than 6 weeks
- dysphagia for more than 3 weeks
- persistent sore throat
- unilateral nasal obstruction with blood or purulent discharge
- unilateral middle ear effusion
- Persistent sore throat
- Persistent swelling or lump in parotid or submandibular gland > 3 weeks
- Unilateral otalgia > 4 weeks with normal ear examination

General practitioners are encouraged to:

- make referrals using the appropriate 2WW referral proforma (Appendix 1)
- include details of smoking and alcohol history
- provide information on all current medication
- provide results of all recent investigations

## 2.2 Patients with neck lumps

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80% of lateral neck lumps in adults aged over the age of 40 years are related to malignant disease. Any patient with a neck lump that has been present for more than three weeks and has not resolved after prescription of an appropriate antibiotic should be referred through the Rapid Access route, as above.

Features that should prompt an urgent referral include:

- size greater than 1cm
- fixed, rubbery or matted presenting as a mass in the parotid or thyroid gland or associated with a cranial nerve palsy
- a previously undiagnosed lump present for >3 weeks

## 2.3 Referrals with a low index of suspicion of cancer

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Patients presenting with other oral, nasal or pharyngeal conditions without the alarm symptoms described above should be referred to Maxillofacial or ENT clinics by letter or electronic referral.

## 2.4 Pathway for Hospital Clinicians who are not members of the Head & Neck MDT

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Patients diagnosed with Head and Neck cancer by other teams should be referred to the Head and Neck Cancer MDT at the earliest opportunity. Similarly, patients who are erroneously referred to other teams with symptoms or signs of head and neck cancer, particularly those with neck lumps, should be referred onto designated head and neck team members without delay.

The referral pathway for clinicians who are not part of a Head & Neck Cancer MDT is outlined in the Internal Referral Policy in Appendix 2. This ensures that patients investigated for other conditions and found to have a Possible Head & Neck cancer are fed into the Rapid Access pathway as quickly as possible.

Referrals should be made to one of the designated Head and Neck team members or via the Head and Neck Clinical Nurse Specialist who will arrange the immediate transfer of care to the Head and Neck Cancer MDT.

## 3.0 Local Specialist Clinics (incorporating Neck Lump Clinics)

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### 3.1 Local Specialist Head & Neck Clinics

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Patients referred as a 2WW referral (see Section 2.1) should be seen within two weeks of referral. Local Specialist Clinics should be staffed and run by members of a Head and Neck Cancer MDT.

Local Specialist Clinics also serve as Lump Clinics. Terms of Reference for Lump Clinics are included in Appendix 3.

### 3.2 Further investigations by Local Specialist Team

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To help reduce any delays in the diagnostic pathway, routine staging or preoperative investigations should be ordered by the local team as clinically indicated. These may include:

- Biopsy / FNAC with or without ultrasound guidance
- Panendoscopy
- CT

- MRI
- PET
- OPG

### 3.3 Imaging Guidance

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Full KMCC imaging guidelines are located on the website on the following link:

<http://www.kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/>

Ultrasound scans of the neck should have the following information contained within the report:

- A description of any abnormal masses / lumps
- The presence of cervical lymph nodes with details of internal echogenicity, and long and short axis dimensions for any abnormal lymph nodes.
- The appearances of parotid and submandibular salivary glands, including any abnormalities.
- Comment on left and right lobe of thyroid gland and the size and u grade of any nodules.

### 3.4 Pathology

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All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the website:-

<https://www.rcpath.org/uploads/assets/8f94d6b0-48d9-4ccc-93a966c705863e4c/g077-headnecktp-jan16.pdf>

### 3.5 Referrals to other MDTs

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Any lump in the neck or elsewhere within the head and neck region found to be involved by a haematological malignancy will be fast-tracked to the Haematology MDT.

Any neck lump found to be suggestive of thyroid malignancy will be fast-tracked to the Thyroid MDT.

Any lump in the neck or elsewhere within the head and neck region found to be involved by a solid tumour malignancy will be fast-tracked to the appropriate MDT.

## 4.0 Multidisciplinary Team Meeting

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### 4.1 MDT Meetings

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Head and Neck MDT meetings are held weekly:

- West Kent MDT at Maidstone Hospital, Tuesdays at 13:00
- East Kent MDT at Kent & Canterbury Hospital, Mondays at 14:00

Details of the core and extended membership of each MDT, together with their roles and responsibilities within the MDT, are contained within the High Level Operational Policy document.

Discussion of individual cases with all relevant clinical information will result in a range of treatment options to be discussed with patients when they attend the Head & Neck multidisciplinary clinic. Though a range of options may exist (at least in theory), in many cases there will be a single “best option” in terms of effectiveness and treatment morbidity which would be the MDT recommendation for treatment. There is a strong focus on organ preservation and functional outcome. Other options are also presented where these may be appropriate for individual patients.

## 4.2 MDT Clinics

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Multidisciplinary Head and Neck clinics are run in both Canterbury and Maidstone each week immediately following the MDT meeting. In these clinics, patients may be seen by Head & Neck surgeons, oncologists, clinical nurse specialists, speech and language therapists, consultant restorative dentist (EKHUFT only) and radiotherapy specialists.

Details of the structure and operation of multidisciplinary meetings and multidisciplinary clinics are contained within the High Level Operational Policy document.

Patients are allocated a key worker (for full policy, see High Level Operational Policy) who will be responsible for supporting them through that particular phase of the treatment and being available in the event of problems. Each MDT keeps a list of its key workers and the key worker allocated to each individual patient will be recorded in each patient's clinical notes.

## 5.0 Treatment with curative intent

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Site-specific treatment guidelines for Head & Neck Cancer can be found in Appendix 3. All patients are supported by a Head & Neck CNS. Those with particular needs are also referred for dietetic and speech and language support.

For some patients, it is essential that they stop smoking before curative treatment is undertaken as evidence indicates that smoking during treatment may reduce the effectiveness of treatment and is likely to increase the risk of post-operative and post-radiotherapy complications. Patients are given smoking cessation advice and given details of how to contact local smoking cessation services.

In all cases, MDTs should communicate promptly the plans for treatment to the patient's general practitioner (and others involved).

### 5.1 Surgery

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Following the discussions in the MDT meeting and multidisciplinary clinic, those patients for whom surgery is deemed the most appropriate treatment will be offered surgery in one of the designated operating centres, unless the highly specialised nature of the surgery requires referral to a tertiary centre.

All patients scheduled to undergo radical surgery are given a full verbal and written explanation of the planned procedure and possible side-effects before written informed consent is obtained by the consultant surgeon (or senior surgical trainee on behalf of the consultant). This process is supported by one of the Head & Neck CNS'. All Kent & Medway patients are referred to a Consultant in Restorative Dentistry.

### 5.2 Radiotherapy and Chemotherapy

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Following the discussions in the MDT meeting and multidisciplinary clinic, those patients for whom radiotherapy, with or without additional chemotherapy, is deemed the most appropriate treatment will be offered treatment within the Kent Oncology Centre with care coordinated by teams based on either the Maidstone or Canterbury site. Post-operative radiotherapy (with or without concurrent chemotherapy) will be considered for those patients considered to be at significant risk of recurrence, as detailed in Appendix 3.

All patients scheduled to receive radiotherapy are given a full verbal and written explanation of the planned treatment and its possible side-effects before written informed consent is obtained by the consultant clinical oncologist or specialist registrar, who will be planning the radiotherapy. A radiotherapy specialist gives a further



explanation to the patient and provides an information leaflet about radiotherapy before treatment commences. A dental assessment will be undertaken by a specialist Consultant in Restorative Dentistry prior to radiology.

For patients requiring chemotherapy, the same consent process applies and written information is given to supplement the verbal explanation. The chemotherapy nurses will arrange a pre-chemotherapy clinic appointment at which patients are given further written information containing a 24-hour helpline number. This enables patients or their carers to obtain rapid advice in the event of side-effects or complications of treatment. Copies of this information leaflet, with an additional booklet, are sent to the patients GP.

Detailed radiotherapy protocols are contained within the Quality Management System within the Oncology Centre.

Guidelines for the use of chemotherapy are contained within the Kent & Medway - Cancer guidelines "Oncological Treatment of Head & Neck Cancer", accessible at:  
<http://www.kmcc.nhs.uk/tumour-sites/head-and-neck-tssg/>

### 5.3 Head and Neck Sarcoma

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Patients with head and neck sarcoma are referred for discussion to the Sarcoma MDT either at University College Hospital or the Royal Marsden Hospital. Where the tumour is suitable for surgical management this may be performed locally when the procedure is within the competence of the local team. The specimen will be sent to the sarcoma pathology laboratory for pathological investigation in line with the Improving Outcomes Guidance for Sarcomas: <https://www.nice.org.uk/guidance/csg9>

### 5.4 Cancer involving the skull base

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Cancers involving the skull base which cannot be treated locally will be referred to the Guy's / King's Skull Base MDT or the Brighton neurosurgical team.

### 5.5 Patients with tumours requiring craniofacial resection

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Patients with tumours requiring craniofacial resection will either be referred to the Guy's / King's Skull Base MDT, Charing Cross Hospital Skull Base MDT or treated collaboratively between the maxillofacial surgical team at Queen Victoria Hospital, East Grinstead and the neurosurgical team at Brighton.

All patients will be discussed by the MDT following resection and those for whom radiotherapy is felt to be beneficial will be offered post-operative radiotherapy (see Appendix 3).

### 5.6 Head & Neck cancers involving the eyes

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Periocular cancers referred to the Head & Neck MDTs may be managed by core members of the Head & Neck MDT with support from oculoplastic surgeons where necessary.

Periocular cancers may also be managed by core team members of a Specialist Skin Cancer MDT with support from oculoplastic surgeons where necessary.

More complex melanomas and other ocular tumours will be referred to Moorfields Hospital.

## 5.7 Minimal Access Surgery

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Minimal access surgery should be offered to all patients deemed suitable. Transoral Laser Microsurgery and Transoral Robotic surgery should be carried out in the appropriate designated centres (QVH for West Kent, WHH and K&C for East Kent and London tertiary centres).

## 5.8 Teenagers and Young Adults

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Whilst head & neck cancer is rare within the teenage and young adult population the Teenage and Young Adult (TYA) Improving Outcomes Guidance specify that patients aged 16 to 18 years should be admitted to a TYA Principal Treatment Centre (PTC) which should provide age-appropriate facilities. Patients aged 19 to 24 years should be offered a choice of access to a TYA PTC unhindered access to age-appropriate facilities. Should TYAs of 19 to the end of their 24<sup>th</sup> year choose not to be treated in the TYA PTC they may be treated at the surgical centre of the respective H&N MDT. However, in the latter circumstance they must be given access to the services and resources offered by the TYA MDT at the PTC, either remotely or through specified clinical services. The CYP Principal Treatment Centre for Kent & Medway is based at the Royal Marsden Hospital.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre and Referred to their local Teenage and Young Person Clinical Nurse Specialist. There is one located for West Kent and one for East Kent based at the relevant Oncology Centres.

The CNS' for H&N    QVH - Addy Katandika  
                             MMH - Debbie Hannant/Debbie Owen  
                             MTW – Eve Bateta  
                             Maidstone Oncology – Ruth Casey

## 6.0 Patients with Cancer beyond the scope of radical treatment

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### 6.1 Aims of treatment

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Following MDT discussion, there will be a proportion of patients for whom, either because of stage of disease or their general level of fitness, curative treatment is not a realistic option. The aim of treatment in these circumstances is both to improve and maintain quality of life, and so far as this is possible, to extend life.

Palliative interventions to improve and maintain quality of life and to extend life may include radiotherapy, chemotherapy or limited surgery. All patients will receive appropriate attention to relief of pain and other symptoms.

Open and frank discussions with patients should take place with patients at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them. Relatives and carers will need to be appropriately supported and given appropriate information. However, in accordance with the recommendations set out in the revised Improving Outcomes Guidance in Head and Neck Cancer, avoiding, as far as possible, situations in which relatives and carers receive information different to that given to the patient.

All patients will be supported by a Head & Neck Clinical Nurse Specialist (CNS) who will discuss with patients and their carers, ways in which support (physical, emotional and spiritual) can be provided for them at home or close to home. In many cases, this will involve referral to a Community-based Palliative care team.

## 6.2 Specialist Palliative Care

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Specialist palliative care services are provided in line with:

- The Network Supportive and Palliative Care Strategy (2006).
- NICE guidance “Improving Supportive and Palliative Care for Adults with Cancer” (2004), accessible at: <https://www.nice.org.uk/guidance/csg4>
- NICE QS13 End of Life Care for Adults: <https://www.nice.org.uk/guidance/qs13>

All patients with Head and Neck cancer will be given access to specialist palliative care support. Referral is encouraged for all those with:

- metastatic disease
- complex or difficult symptom management issues
- psychological and family issues
- spiritual issues

Decisions to refer to specialist palliative care services should be reviewed:

- at relapse
- when other lines of treatment have been exhausted
- during hospital admission for complications of cancer or its treatment

## 6.3 Communication with Primary Care and Community-based services

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General Practitioners and all community-based teams should be kept informed of:

- changes in treatment plan
- changes in prognosis
- changes in medication
- outcome following admission for surgery
- completion of courses of radiotherapy / chemotherapy
- follow-up arrangements

## 7.0 Patient Information

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Written information is provided to patients and their carers at the time of clinic visits and is always available to patients through their CNS or Macmillan Radiotherapy Specialist (see also sections 5.1 and 5.2).

Patients are directed to local smoking cessation and drug and alcohol services as necessary.

## 8.0 Clinical Trials

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Patients are considered for entry in clinical trials wherever possible. Where suitable trials exist, trial entry should form part of the MDM discussion.

Current and potential future clinical trials are discussed in the Head & Neck Cancer TSSG on a regular basis (currently approximately every six months).

## 9.0 Follow-Up

In the early years, the key purpose of follow-up is to detect recurrence. In the later years of follow-up, the emphasis is also on recognising late treatment complications.

Upon completion of radical treatment, patients will be followed up in the appropriate Joint Head & Neck or local clinic using the following protocol:

### East Kent

Interval in weeks	Year 1	Year 2	Year 3	Year 4	Year 5
T <sub>1-2</sub> N <sub>0</sub> ; surgery only	8 – H	12 – L	12 – L	26 – L	26 – L
T <sub>1-2</sub> N <sub>0</sub> ; radiotherapy or combined Modality	8 – H	12 – A	12 – L	26 – L	26 – L
T <sub>3-4</sub> or N <sub>1-3</sub>	6 – H	8-12 - A	12 – A	26 – L	26 – L

### West Kent

	Year 1	Year 2	Year 3	Years 4-5
Early stage (T <sub>1-2</sub> N <sub>0</sub> ) surgery or RT Only	8 - H for first 6/12 then L if no concerns	12 – L	12 – L	26 – L
Combined modality	6 - H until PEG removed / PET-CT or 6 months (whichever is latest) then 8 - L	12 – L	12 – L	26 – L
Advanced stage (T <sub>3-4</sub> or N <sub>3</sub> )	6 - H until PEG removed / PET-CT or 6 months (whichever is latest) then 6 - L	8-12 L	12 – L	26 – L

H = H&N clinic Maidstone; L = local follow-up

In addition **all** patients to have Maidstone (H) follow up at 1, 2 and 5 years from end of treatment, or if there are any unresolved or new concerns

H = Head and Neck Clinic

L = Local ENT / Maxillofacial / Plastic clinic

A = Alternating H&N and Local clinic

Patients (and their relatives and carers) have access to their key worker or other between visits, primarily by telephone. In the event of symptoms which might indicate a recurrence or complication of treatment, an urgent appointment is arranged in either the local clinic or the Head & Neck clinic, as appropriate.

## 10.0 Data

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset (COSD). The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable. Details of the COSD are available from: [http://www.ncin.org.uk/collecting\\_and\\_using\\_data/data\\_collection/cosd.aspx](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx)

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, Systemic Anti-Cancer Therapy (SACT), diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

## **11.0 Personnel and Contact Information**

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A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://www.kmcc.nhs.uk/tumour-sites/terms-of-reference/>

## 12.0 Glossary

Acronyms in common usage throughout KMCC documentation

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
COSD	Cancer Outcomes and Services Dataset
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)
KMCA KMCC	Kent & Medway Cancer Alliance Kent & Medway Cancer Collaborative
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non Surgical Oncology Group <i>(Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs)</i>
PoC	Pathway of Care <i>(KMCC agreed disease site specific clinical guidelines)</i>
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
RAT	Research and Trial Group <i>(Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda)</i>
RNOH	Royal National Orthopaedic Hospital
TSSG	Tumour Site Specific Group (TSSG)
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

## **13.0 Appendix 1 - Rapid Access Referral Proforma**

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The most up to date version of the Head & Neck Rapid Access Referral Proforma can be found on the Kent & Medway Cancer Collaborative website on the following link:-

<http://www.kmcc.nhs.uk/tumour-sites/gp-referral-proformas-new-ng12-2ww/>

## **14.0 Appendix 2 - Treatment with curative intent by site and stage**

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### **a) Purpose**

To provide current guidelines for the radical treatment of Head & Neck Cancer, according to tumour site and stage. See also Sections 5.1 and 5.2.

### **b) Information at referral**

At referral the following information is essential:

- histology
- results of staging investigations and where they have been performed
- history of any previous cancer and treatment
- the presence of any comorbidity
- WHO and Adult Co-morbidity Evaluation (ACE) 27 status

### **c) Initial treatment following diagnosis**

The MDT teams will aim to follow national guidance as published. Head & Neck cancer UK National Multidisciplinary Guidance 2016.

Guidance on Oncological and (Radiotherapy and chemotherapy) JLO/130 SL Nice Guidance NG36 link.

<http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/head-and-neck-tssg/>

<http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/thyroid-tssg/>

## 15.0 Document Administration

Document Title	The Management of Head and Neck Cancer – A Pathway of Care
Principle author	Nick Rowell
Co-author(s)	Sue Honour/Ian Vousden/Jeremy Davis/Natalie Aluwalia/L.Newman
Current version number	17.0
Current status	FINAL
Original publication date	Spring 2005
Expected review date by	November 2023

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Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
Spring 2005	1	Initial draft	N.Goodger
Autumn 2005	2	Draft – amendments as per DOG meeting	N.Goodger
August 2006	3/4/5	Draft – amendments as per DOG meeting	N.Goodger
August 2006	6	Draft – Network format and update	A.Jackson/C.Evans
January 2007	7	Draft – contacts update	A.Jackson/S.Coltart/N.Rowell/H.Smedley
January 2007	8	Final draft – updated + insertion of oncology details	A.Jackson/N.Goodger
February 2007	8	Published – reviewed for final corrections	A.Jackson/N.Goodger
October 2008	9.1	Review draft – complete review	D.Mitchell/A.Jackson
2010	10	Final – complete changes/updates made	A.Jackson
September 2011	11	Final – complete review	N.Rowell
December 2011	12	Final – Contact detail update	C.Tsatsaklas
April 2012	13	Final/Published	N.Rowell
June 2012	13.1	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	S.Stanley/C.Tsatsaklas
November 2012	13.2	Draft – data collection section updated	A.Brittle/C.Tsatsaklas
April 2013	14	Published	N.Rowell/H&N DOG
March 2014	15	Final – H&N TSSG agreed update to appendix 3 – insert selected T1/T2 laser resection text + general admin text updates	C.Tsatsaklas/N.Rowell/H&N TSSG
June 2014	15	FINAL/PUBLISHED – ratified by the Operational & Quality Group (25/6/14)	Operational & Quality Group
June 2016	15.1	Review of content and addition of NICE guidance	J.Davis/L.Newman/N.Aluwalia
July 2016	15.2	Amended with consideration of comments made by the H&N TSSG. To be ratified by Operational & Quality Group	J.Davis
August 2016	15.3	Comments added from Operational & Quality Group. Ratification complete	N.Aluwalia
November 2016	16.0	Final Published version	N.Aluwalia/J.Davis
September 2020 – Feb 2021	16.1	Draft - updates to document from the new lead	N. Goodger/A. Wiltshire



July 2021	16.2	Draft – update on weblinks	N. Goodger / A. Wiltshire
August 2021 September 2021	16.3 16.4	Draft – update on MDT guidance Teenagers and Young Adults updates and amendments	N. Goodger / A. Wiltshire
<b>November 2021</b>	<b>17.0</b>	<b>Final – ratified by Head &amp; Neck TSSG following meeting on 20.09.2021.</b>	<b>N. Goodger / A. Wiltshire</b>