



NCG GUIDELINES- 2019

Head & Neck Cancer Management Guidelines

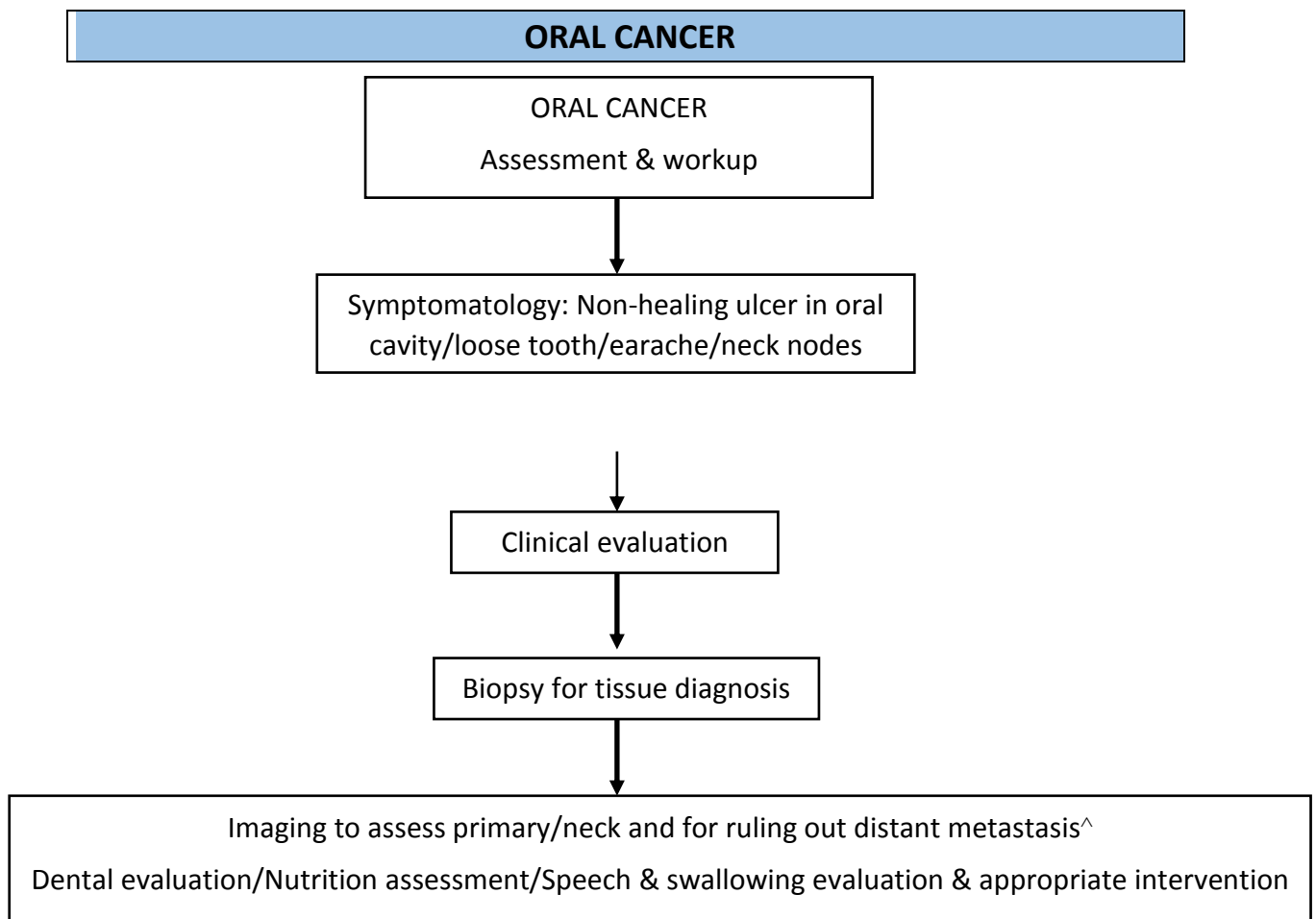
Categories of the guidelines

- a) Essential
- b) Optimal
- c) Optional

**Herewith essential will be referred as (a), optimal as (b) and optional as (c)*

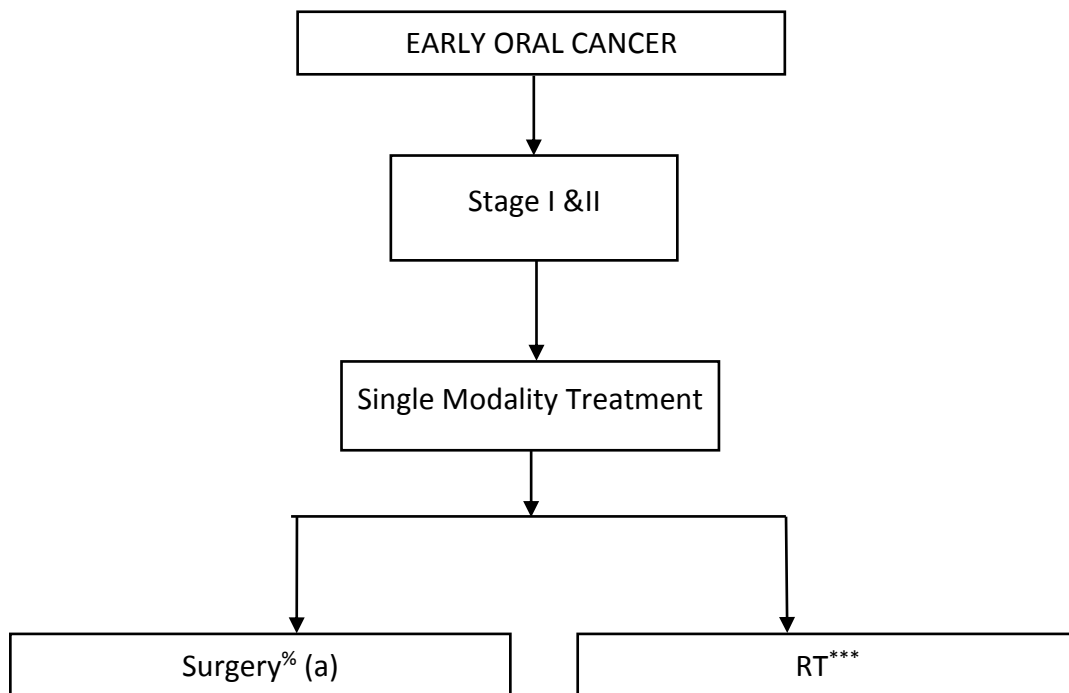
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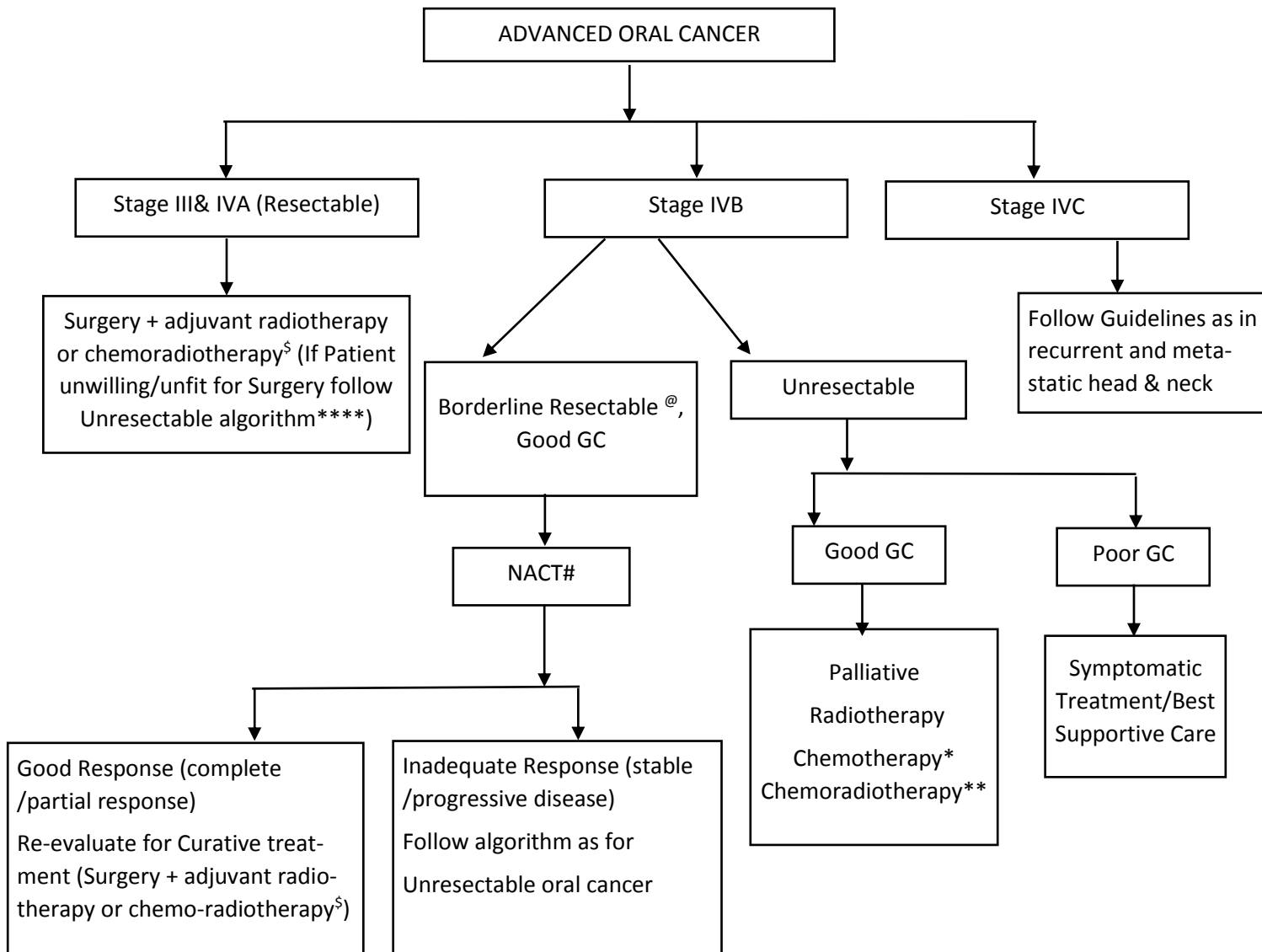
^Optimal Imaging modality for tongue lesion is an MRI(b) and for other sites a Contrast enhanced CT scan(b). Loco regional imaging is for assessment of the primary and the neck. Early-stage oral cavity that is amenable to adequate clinical evaluation may not warrant imaging studies of the primary and Ultrasound examination(c) of the neck is an optional alternative to CECT/MRI in this situation.

Chest X-ray(a) is an essential investigation for ruling out lung metastasis and possible aspiration. Either a PET CT(b) or CECT Thorax (c) should be optimal in patients being considered for curative therapy but with a high risk for distant metastasis (N3 node (size > 6 cm), multiple bilateral neck nodes, Lower cervical neck nodes, large primary (T4b) and in patients who have symptoms suggestive of distant metastasis.



%- Surgery - Primary tumor- Wide local excision (at least 1 cm gross margin so as to achieve > 5 mm histological tumor free margin) with appropriate Neck Dissection and appropriate reconstruction. For N0 Neck- Selective neck dissection addressing Level I-III (a)+/- Level IV. For N+ Neck – Modified neck dissection (Level I-V) with sparing of the XI nerve, IJV, SCM Muscle whenever oncologically feasible (a). The minimum optimal number of lymph nodes included in a SND should be >10 and in a MND >14.

***-The option of Radiation therapy for early oral cancers is optimal only for lip tumors and selected other sub sites. Tumors abutting the mandible risk osteoradionecrosis. The treatment should preferably include brachytherapy as a part of treatment. Either complete dose or partial dose should be delivered by brachytherapy.



****The option of Radiation Rx/ Chemo radiation Rx for advanced tumors is applicable only for patients who are unfit and unwilling for surgery, and target volumes that can be safely encompassed by a tumoricidal dose of 70 Gy. Patients with gross mandibular erosion risk osteoradionecrosis and are not suitable for this modality. Tumors abutting the mandible and tumors with gross skin ulceration are also at greater risk of complications.

\$- Indications for adjuvant post-op radiotherapy are T3-T4 primary, Node positivity, perineural invasion, lympho-vascular invasion, and poorly differentiated disease. IMRT may be considered (c) if affordable (employer insurance scheme, personal insurance schemes) and available. Adjuvant post-op concurrent chemo-radiation is indicated for positive margin and presence of extra nodal extension/extracapsular spread. and presence of nodal positivity of 2 or more lymph nodes. The options for adjuvant concurrent chemotherapy are- Cisplatin 100 mg/m² (optimal option) or weekly cisplatin 30-40 mg/m². Audiometry is preferred prior to administration of cisplatin.

@- Borderline Resectable - This is broadly a situation wherein the primary tumor is grossly resectable, but significant concern exists regarding the probability of a positive resection margin or excessive surgical morbidity. The decision regarding borderline resectability should be taken by a surgeon (preferably in a multidisciplinary tumor board). Situations which may be deemed as borderline resectable are-

1. Soft tissue swelling up to the zygoma in case of a BM-GBS primary.
2. Disease close to hyoid or valleculae in case of a Tongue primary.
3. Some situations with Extensive skin infiltration and Involvement of (Supra-notch) infratemporal fossa.

Radiological involvement of the infratemporal fossa which is inferior to the level of the mandibular notch is deemed as resectable by current surgical techniques.

If the treating team (surgeon) considers the lesion to be resectable then surgery should be offered as per the algorithm for operable oral cancers.

#NACT options

1. DCF- Docetaxel 75 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1, 5FU 750 mg/m² Continuous infusion of 24 hours D1-D5- 3 weekly
2. DC- Docetaxel 75 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly
3. TPE- Docetaxel 75 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly and Cetuximab (400 mg/m² first cycle and then 250 mg/m² subsequent weekly)
4. CF- Cisplatin 100 mg/m² D1 or Carboplatin AUC 5-6 on D1, 5FU 10000 mg/m² Continuous infusion of 24 hours D1-D4- 3 weekly
5. PC- Paclitaxel 175 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly
6. PC weekly—Paclitaxel v60-80 mg/m² D1-D5, Carboplatin AUC 1.5-2 on D1- weekly
7. Metronomic chemotherapy- Methotrexate 9 -15 mg/m² weekly, Celecoxib 200 mg twice daily with or without Erlotinib 150 mg daily

** In select patients who refuse surgery and are fit for chemoradiotherapy.

*1) Options for first line palliative chemotherapy include and need to be given

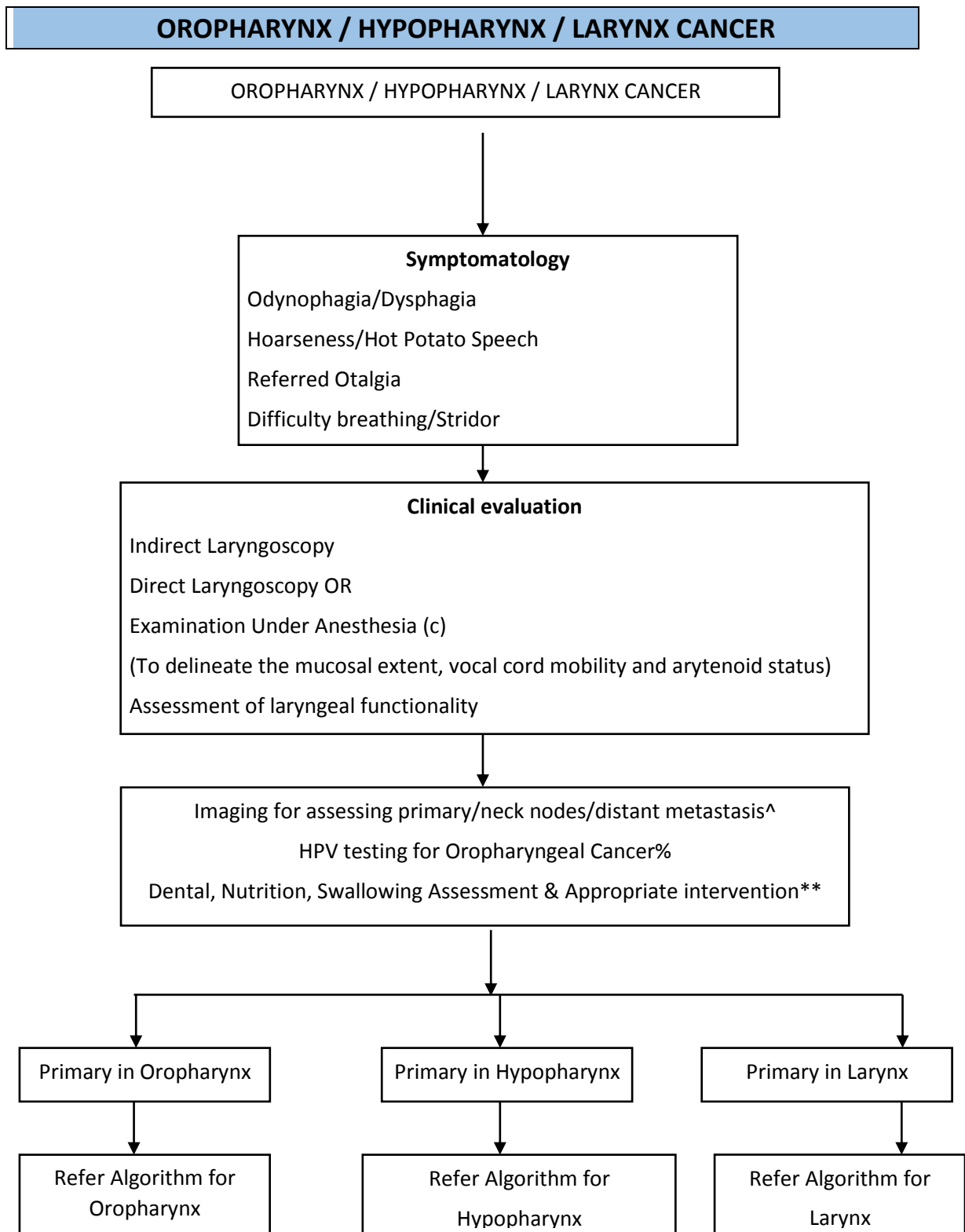
till progression or development of intolerable side effects-

- Cytotoxic chemotherapy (single agent or combination)- metronomic chemotherapy consisting of weekly methotrexate-celecoxib with or without erlotinib (Methotrexate 9 -15 mg/m² weekly, Celecoxib 200 mg twice daily with or without Erlotinib 150 mg daily); or combination Chemotherapy (Platinum, 5-FU, Taxane)
- 5FU– Platinum –Cetuximab or Paclitaxel -Platinum-Cetuximab (c);
- Pembrolizumab (if deemed appropriate with genetic testing for PDL1 and mutation load) (c)

2) Options for second line or beyond chemotherapy include- Triple metronomic chemotherapy (b) or single agent chemotherapy (b), or nivolumab or its altered schedules (c) or Pembrolizumab or its altered schedules (c)

Doses of palliative regimens- These are suggested doses and may need to be varied according to patient's condition.

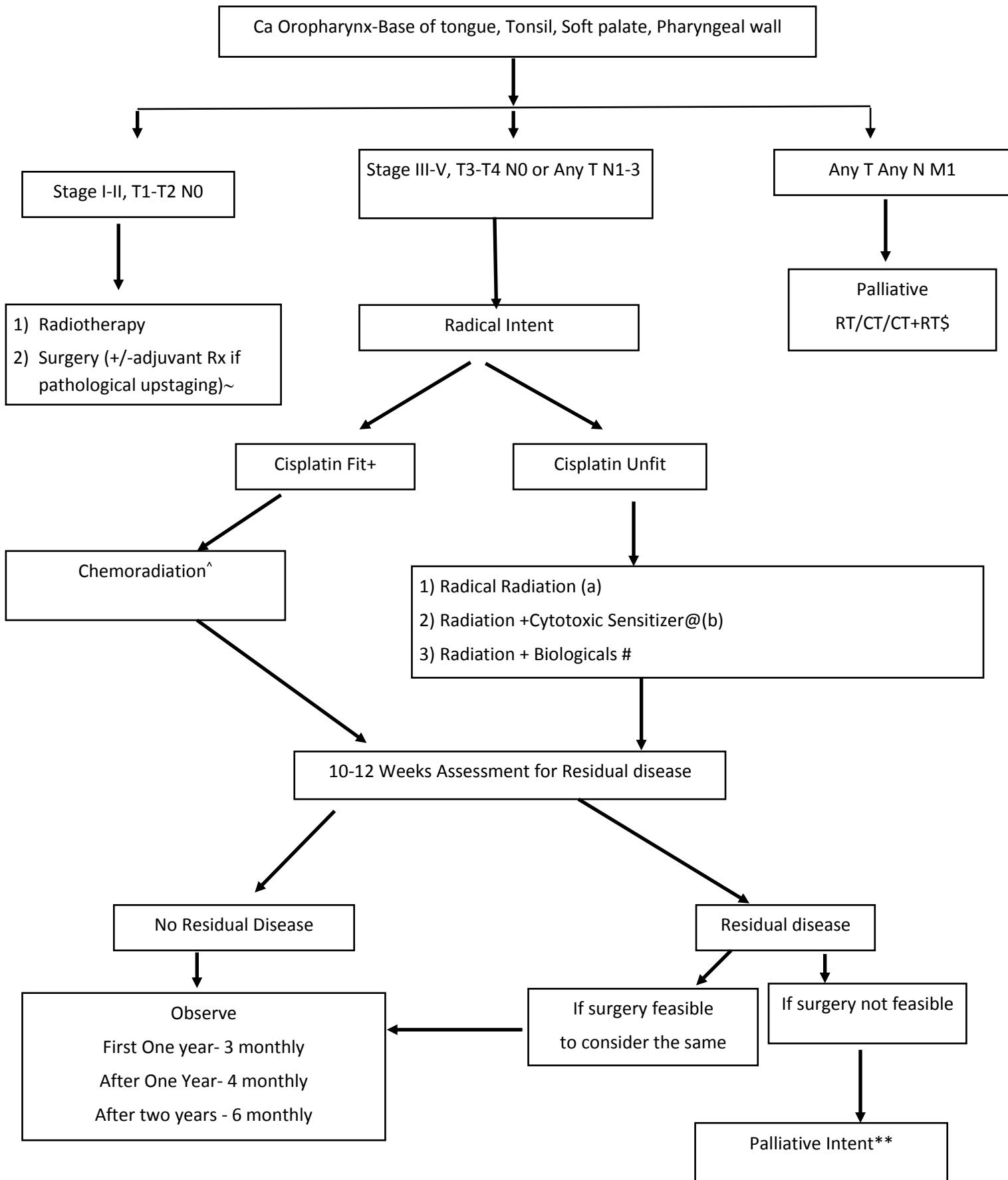
1. DC- Docetaxel 75 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly
2. TPE-Docetaxel 75 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly and Cetuximab (400 mg/m² first cycle and then 250 mg/m² subsequent weekly)
3. CF- Cisplatin 100 mg/m² D1 or Carboplatin AUC 5-6 on D1, 5FU 10000 mg/m² Continuous infusion of 24 hours D1-D4- 3 weekly
4. EXTREME- Cisplatin 100 mg/m² D1 or Carboplatin AUC 5-6 on D1, 5FU 10000 mg/m² Continuous infusion of 24 hours D1-D4- 3 weekly and Cetuximab (400 mg/m² first cycle and than 250 mg/m² subsequent weekly)
5. PC- Paclitaxel 175 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly
6. PCE- Paclitaxel 175 mg/m² D1-D5, Cisplatin 75 mg/m² D1 or Carboplatin AUC 5-6 on D1- 3 weekly and Cetuximab (400 mg/m² first cycle and then 250 mg/m² subsequent weekly)
7. PC weekly—Paclitaxel 60-80 mg/m² D1-D5, Carboplatin AUC 1.5-2 on D1- weekly
8. PCE weekly—Paclitaxel 60-80 mg/m² D1-D5, Carboplatin AUC 1.5-2 on D1- weekly and Cetuximab (400 mg/m² first cycle and then 250 mg/m² subsequent weekly)
9. Pembrolizumab- 200 mg 3 weekly or 400 mg 6 weekly or 2 mg/kg 3 weekly either alone or along with CF or PC
10. Nivolumab- 240 mg 3 weekly or 480 mg 6 weekly or 3 mg/kg 2 weekly alone. A lower dose of 20-40 mg may be used if clinical condition permits.
11. Metronomic chemotherapy- Methotrexate 9 -15 mg/m² weekly, Celecoxib 200 mg twice daily with or without Erlotinib 150 mg daily
12. Cisplatin-75 mg/m² 3 weekly
13. Carboplatin – AUC 5-6 3 weekly
14. Docetaxel 75 mg/m² D1 3 weekly
15. Paclitaxel 175 mg/m² D1 3 weekly
16. Paclitaxel 60-80 mg/m² D1 weekly



^- Optimal Imaging modality for the primary and the neck may be by a CECT(b) or MRI(b). A MRI may be optimal for the Oropharynx and a CECT for the larynx and hypopharynx. Chest X-ray(a) is an essential investigation for ruling out lung metastasis and possible aspiration. Either a PET CT(c) or CECT Thorax (b) should be optimal in patients being considered for curative therapy but with a high risk for distant metastasis (N3 node (size > 6 cm), multiple bilateral neck nodes, Lower cervical neck nodes, large primary (T4b), advanced hypopharyngeal cancer, and in patients who have symptoms suggestive of distant metastasis.

%- HPV testing(b) is Optimal for all Oropharyngeal Cancers. This may be by p16 (b). If expertise and facilities are available, then HPV mRNA testing is more specific (c). HPV+Ve Oropharyngeal Cancer is however currently noted in < 20% as per Indian studies and testing is not yet routine.

** - Assessment for speech(b) and swallowing to evaluate for aspiration(b) is considered Optimal. At least a 100 ml Bedside water swallowing test should be considered (b). If facility available, Fiber optic endoscopic evaluation of swallowing or Videofluoroscopy evaluation of swallowing to be undertaken (c)



~- Selected T1-2N0 lesions of tonsil – Base Tongue can be considered for minimally invasive Trans Oral Surgery (Laser/ Robotic) surgery (c) to achieve a margin negative resection of the primary (tumor free margin of 3-5 mm). This needs to be accompanied with selective neck dissection and appropriate adjuvant RT/ CTRT as indicated by surgical histology.

^ Options for chemoradiotherapy are as follows:

1. Radiation (70 Gy/35#) + Cisplatin 40mg/m² (weekly)(a),
2. Radiation (70Gy/35#) + Cisplatin 100 mg/m² once three weekly(b),
3. Radiation (70 Gy/35#) + Cisplatin 30-40 mg/m² + Nimotuzumab 200 mg weekly(b),
4. Other regimens such as carboplatin -5FU or 5FU-Hydroxyurea or paclitaxel-cisplatin(c) (These options were tested in platinum fit patients. Expertise in delivering chemotherapy is required for these regimens) and
5. NACT followed by Radiation or chemoradiation(c) Indications for neoadjuvant chemotherapy are N3 lymph nodes (> 6 cm) and extensive soft tissue extension, which is difficult to encompass safely in radiation portals. Post induction chemotherapy patients may be routed to Curative therapy or Palliative therapy as per clinical response and reassessment of General Condition.

@- The options in non-cisplatin fit are carboplatin -5FU or 5FU-Hydroxyurea. These options were tested in platinum fit patients and hence while administering them in cisplatin unfit patients caution is mandated. Expertise in delivering chemotherapy is required for these regimens.

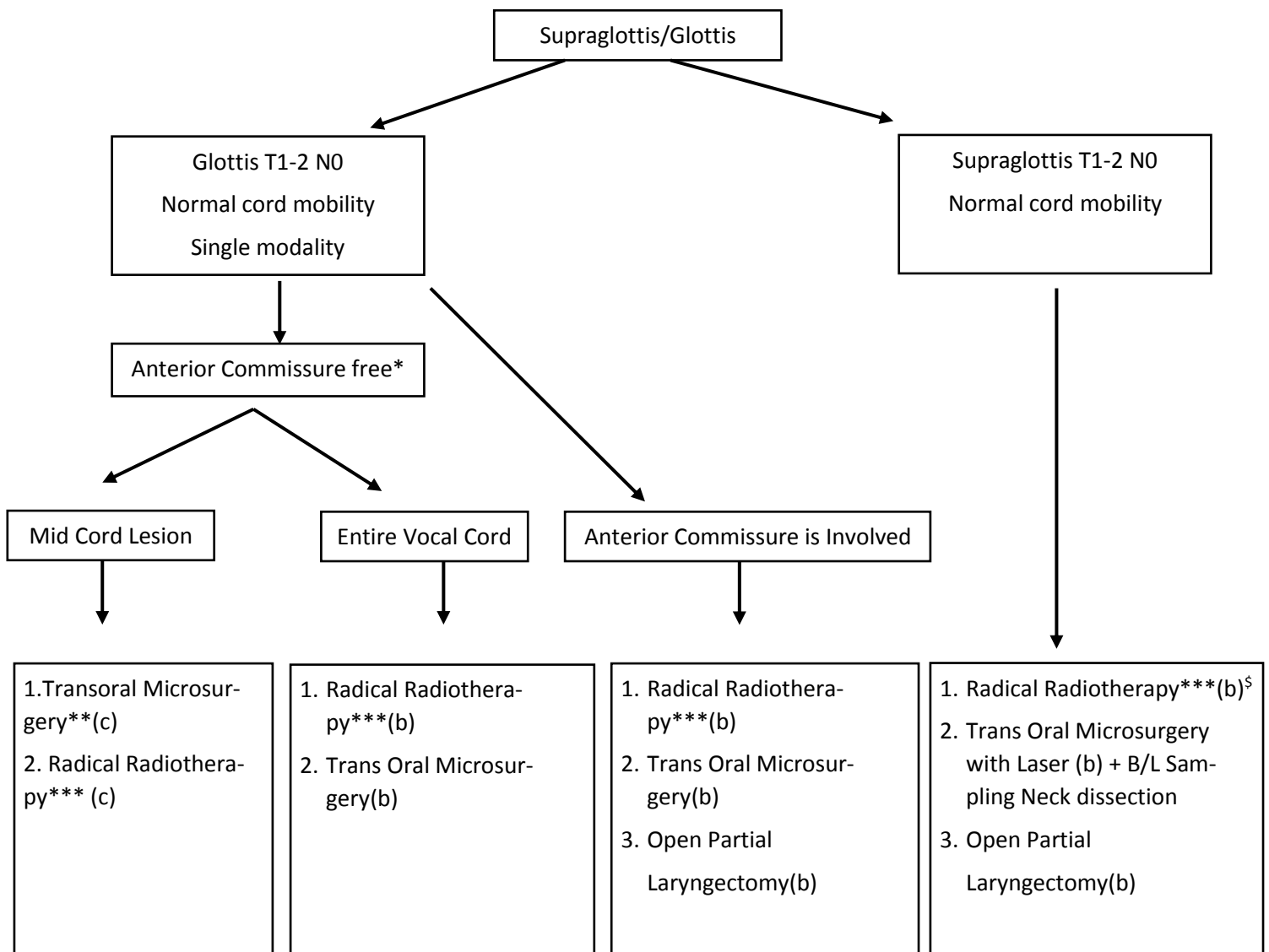
#- Either Cetuximab or Nimotuzumab can be used in this setting, Optimal if affordable (employer insurance scheme, personal insurance schemes) and available. However, these options were tested in platinum fit patients and hence while administering them in cisplatin unfit patients caution is mandated. Expertise in delivering chemotherapy is required for these regimens.

** - Large T4b lesions or large multiple N3 nodes (> 6 cm) could be considered for palliative therapy. In case of elderly patients or those with poor social support with very advanced disease this option can be considered.

+ - Standard criteria for cisplatin fitness to be followed

§Options for palliative chemotherapy -As listed in section for Oral Cancer

CARCINOMA LARYNX

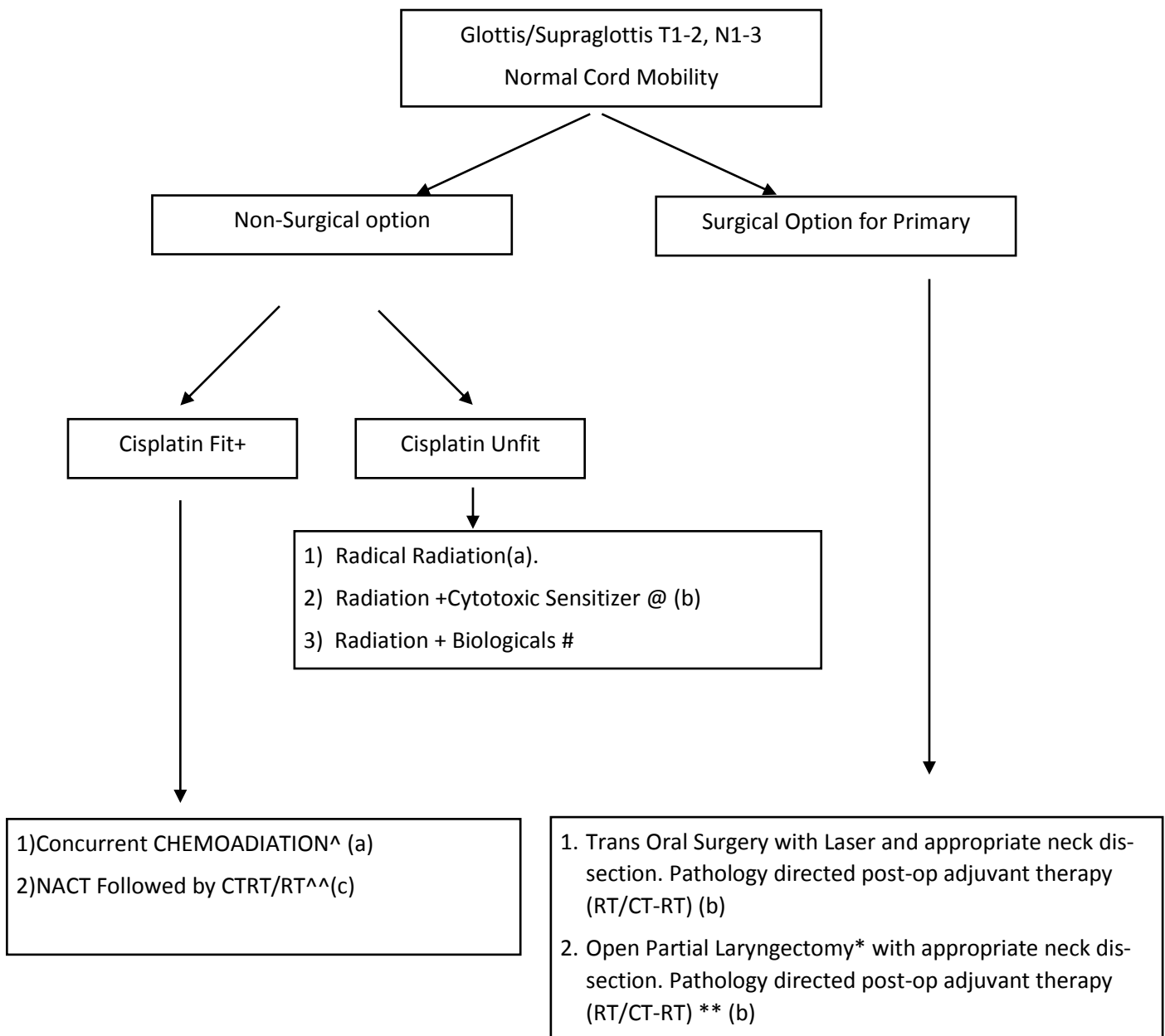


*At least a 16 slice CT scan with 3 mm cut should be preferred to evaluate involvement of cartilage.

**Tumor free margin of at least 1-2 mm should be achieved.

***The risk of occult metastasis to the neck needs to be addressed in all treatments for Supraglottic Cancer.

§ Primary 70Gy+ Prophylactic Neck Radiation. (b)



*Conservative laryngeal surgeries (Open partial laryngectomy) for Glottic growth / Supraglottic Laryngectomy for Supraglottic growth. Case selection should include considerations of anatomical spread to warrant a reasonable expectation of a R0 resection, and also physiological considerations with regard to pulmonary and swallowing function to minimize post-surgical swallowing dysfunction and aspiration.

** Indications for adjuvant post-op radiotherapy are T3-T4 primary, Node positivity, perineural invasion, lymphovascular invasion, and poorly differentiated disease. Adjuvant post-op concurrent chemoradiation is indicated for positive margin, and presence of extra nodal extension/extracapsular spread. The options for adjuvant concurrent

chemotherapy are- Cisplatin 100 mg/m² on day 1,22, 43 or weekly cisplatin 30-40 mg/m². Audiometry is preferred prior to administration of cisplatin.

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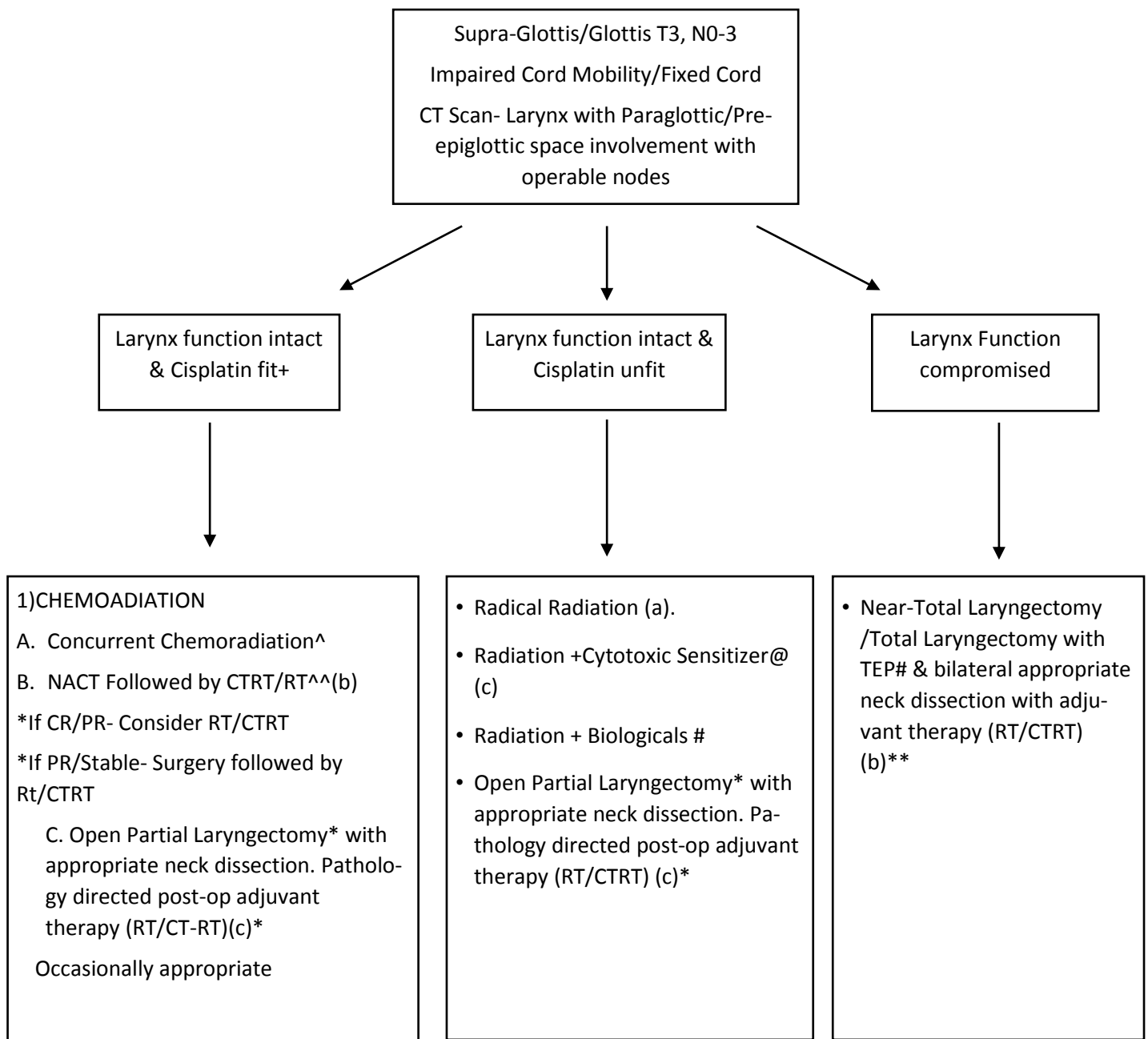
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*Conservative laryngeal surgery (Supracricoid Laryngectomy) for Glottic growth / Supraglottic Laryngectomy for Supraglottic growth is occasionally appropriate in the situation of mobile cords but T3 staging in view of paraglottic space/ pre-epiglottic space involvement.

A Tracheo-Esophageal Prosthesis (TEP) for speech rehabilitation is appropriate and optimal for most patients undergoing a Total Laryngectomy

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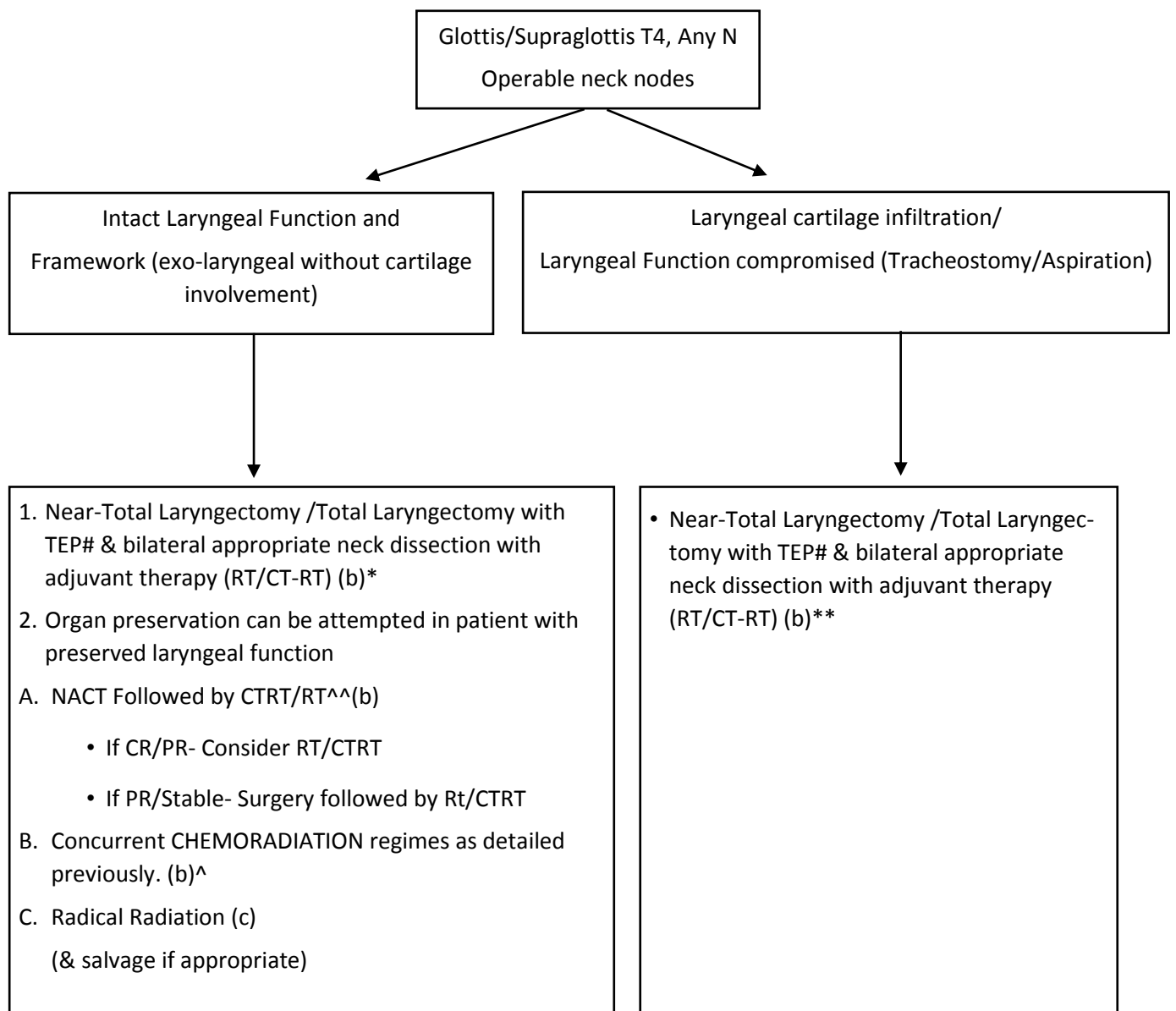
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^^ - Post induction chemotherapy the options for concurrent treatment are weekly cisplatin (30 mg/m²), weekly carboplatin or weekly Cetuximab or weekly Nimotuzumab.

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*- Surgery remains the optimal option. Non-surgical options are likely to compromise cure rates especially in the setting of cartilage erosion. Patients may however choose for a laryngeal preserving non-surgical option despite the risks towards cure.

Some situations with anterior commissure related Thyroid cartilage erosion with mobile cords may be appropriate for surgical organ preservation with partial laryngectomy rather than Total/Near-total laryngectomy.

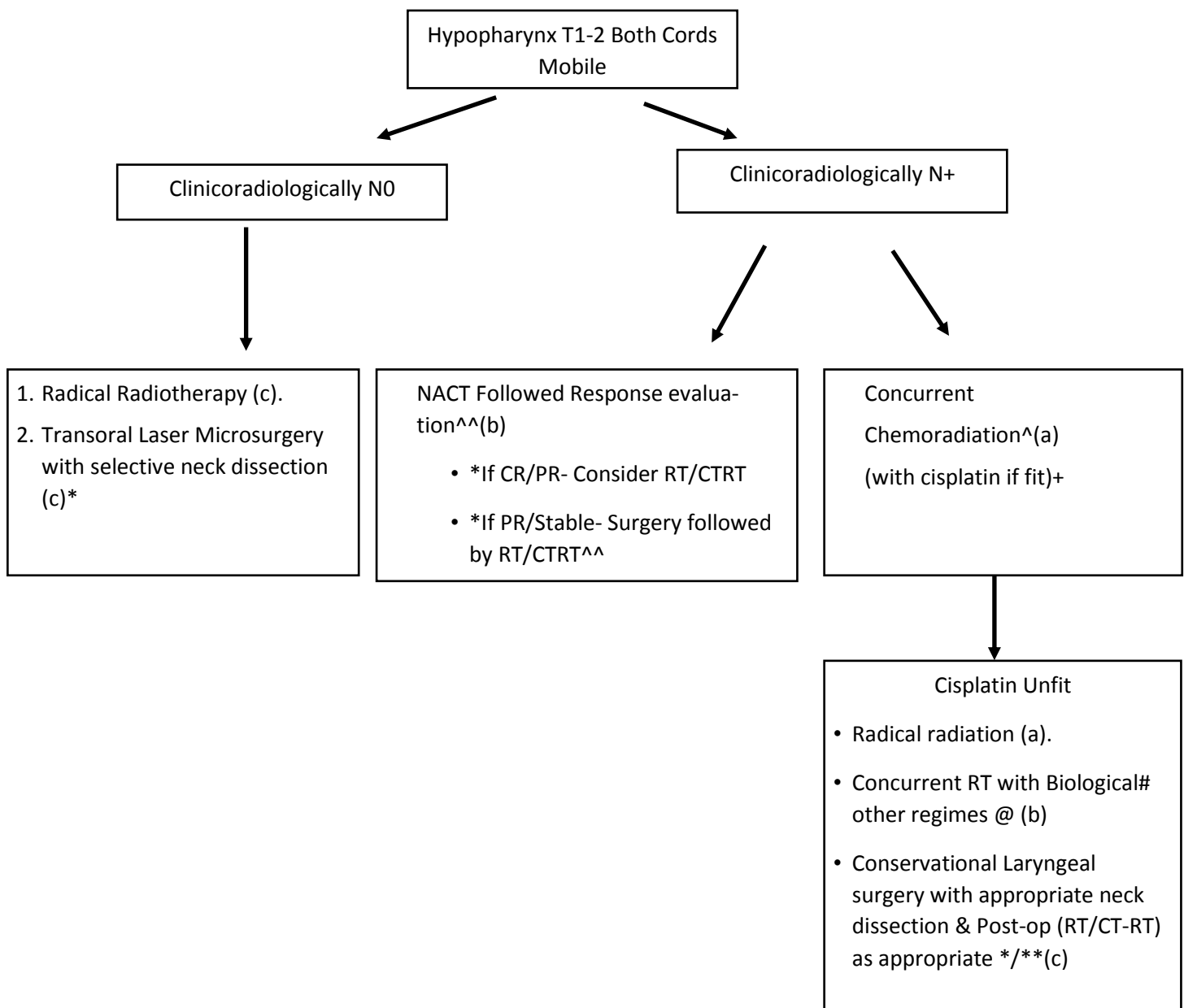
For patients undergoing Total Laryngectomy, a Tracheo-Esophageal Prosthesis (TEP) for speech rehabilitation is appropriate and optimal

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*Surgical Organ preservation should be considered in select cases as expertise for the same is not widely available.

Case selection should include considerations of anatomical spread to warrant a reasonable expectation of a R0 resection, and also physiological considerations with regard to pulmonary and swallowing function to minimize post-surgical swallowing dysfunction and aspiration.

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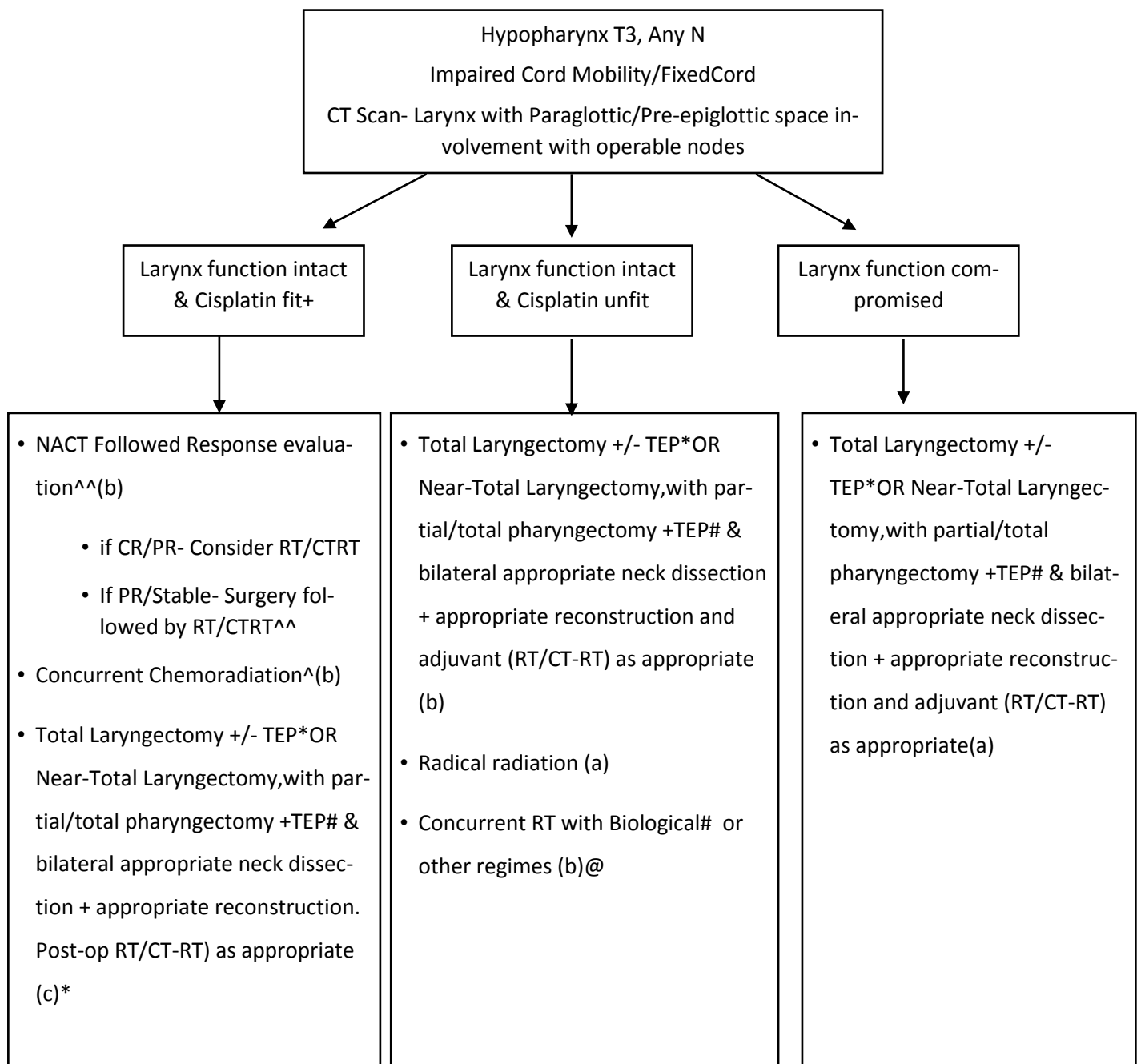
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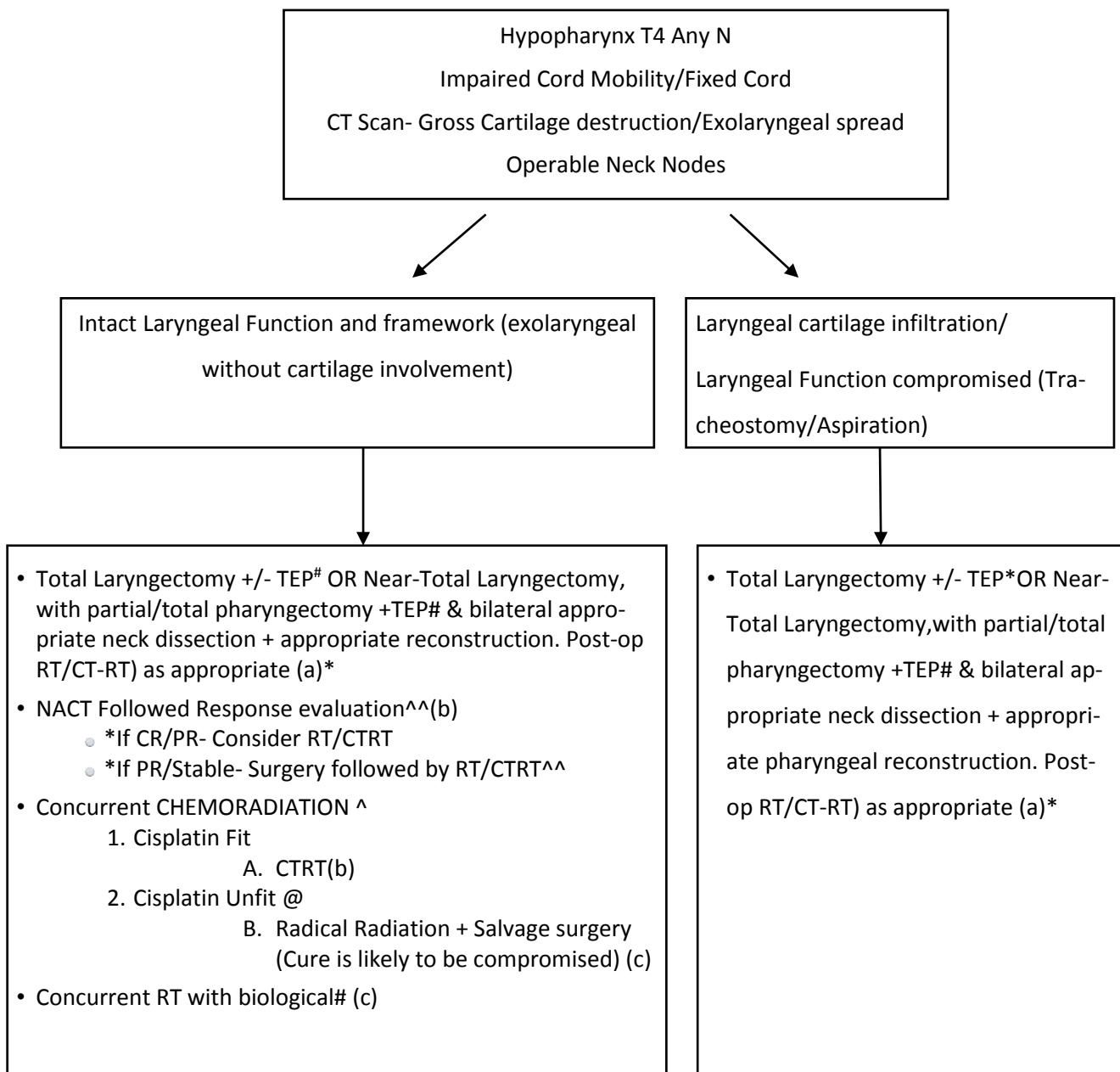
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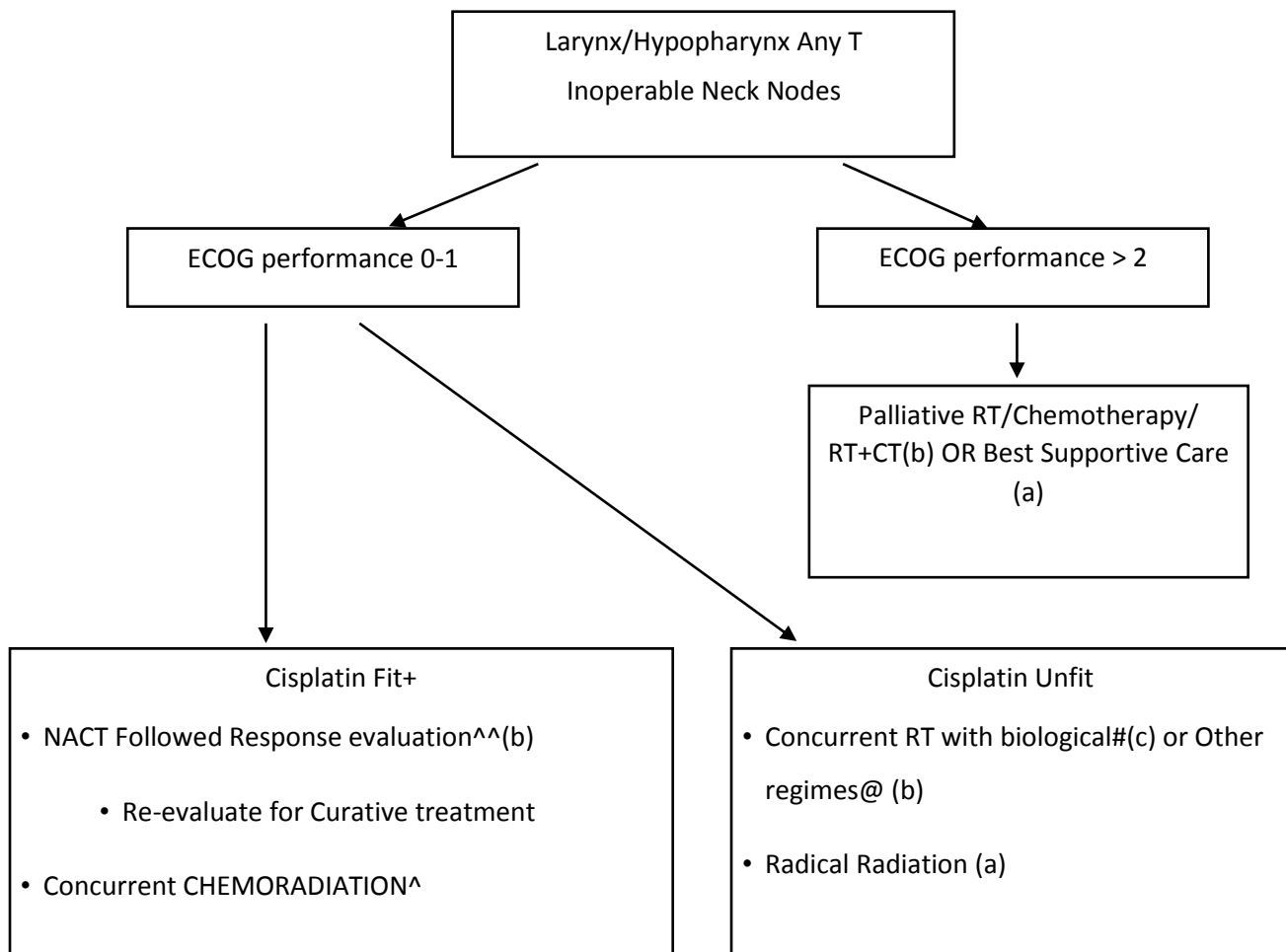
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+ cisplatin fitness as per standard practice/guidelines

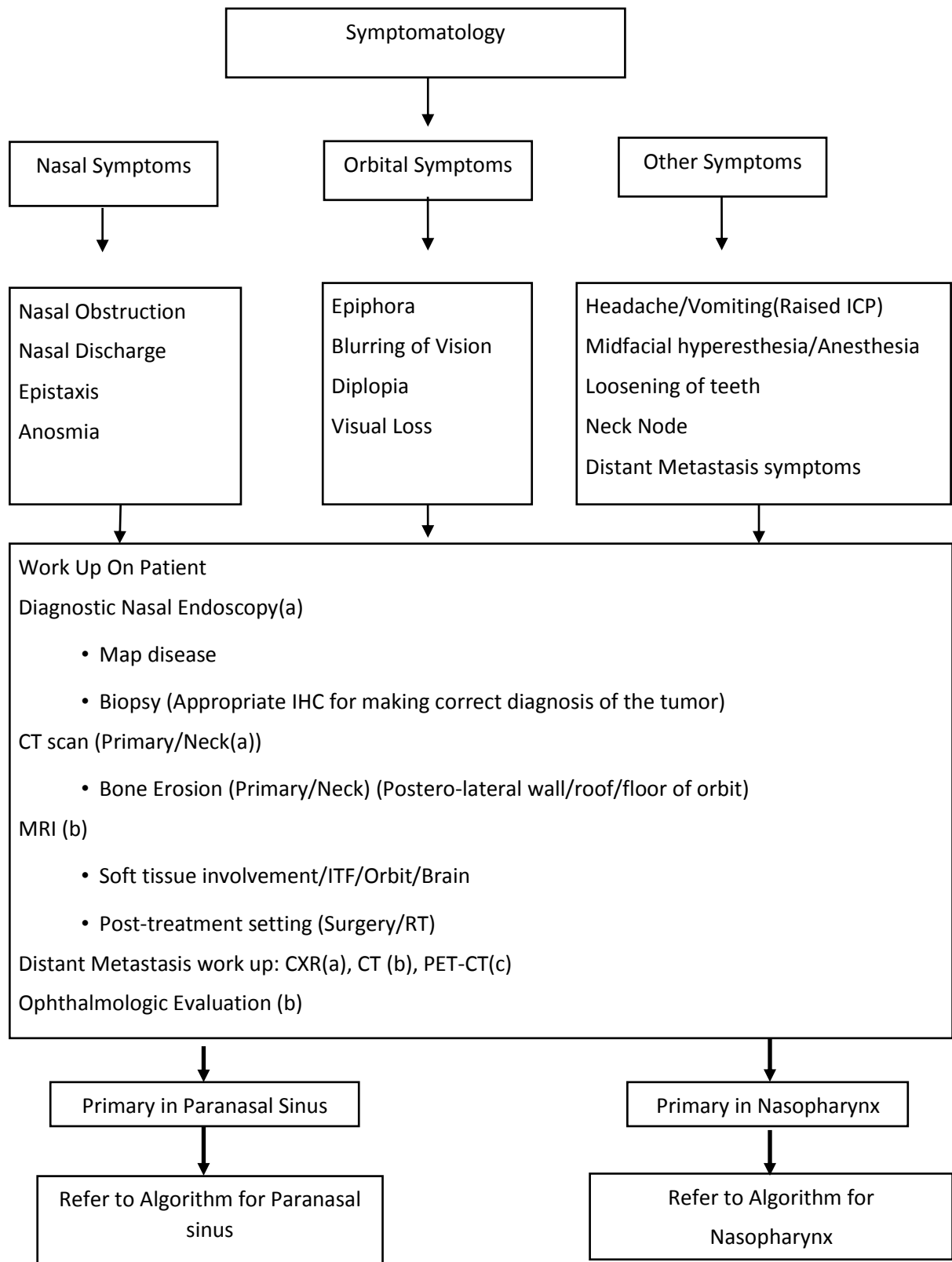
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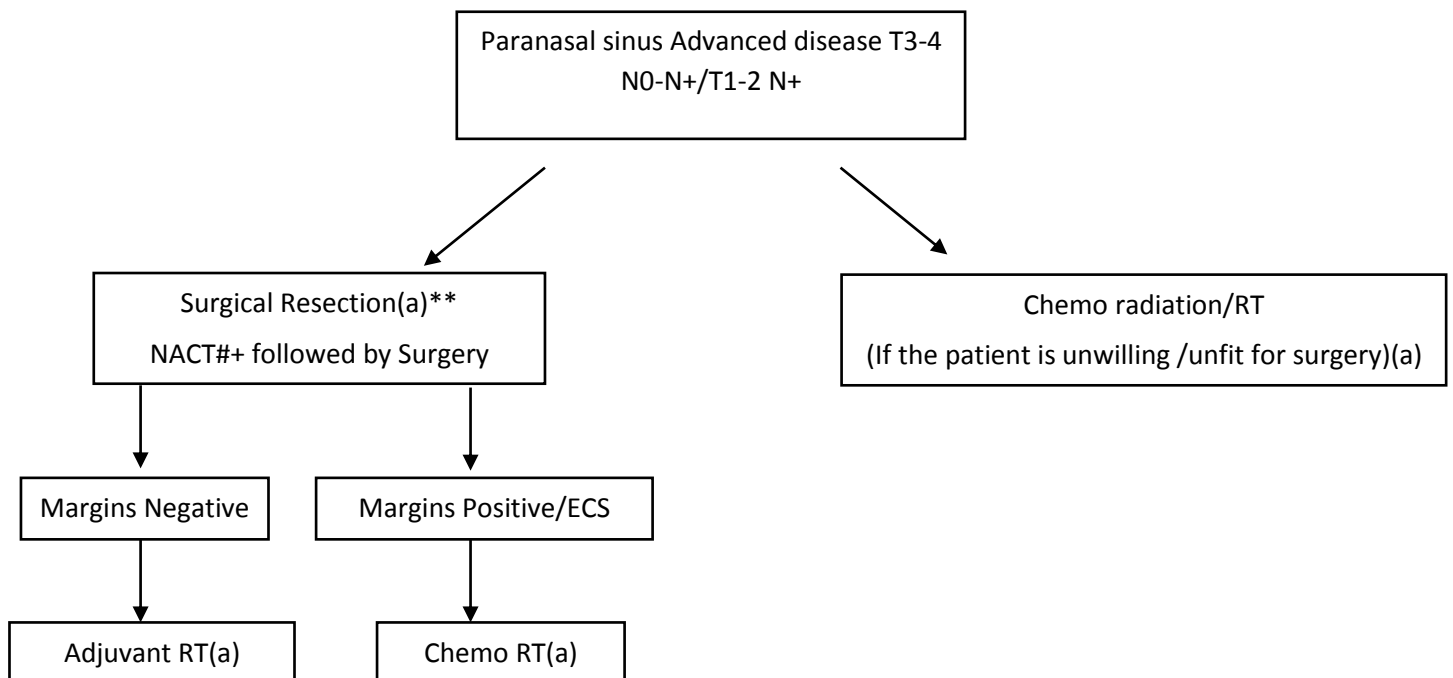
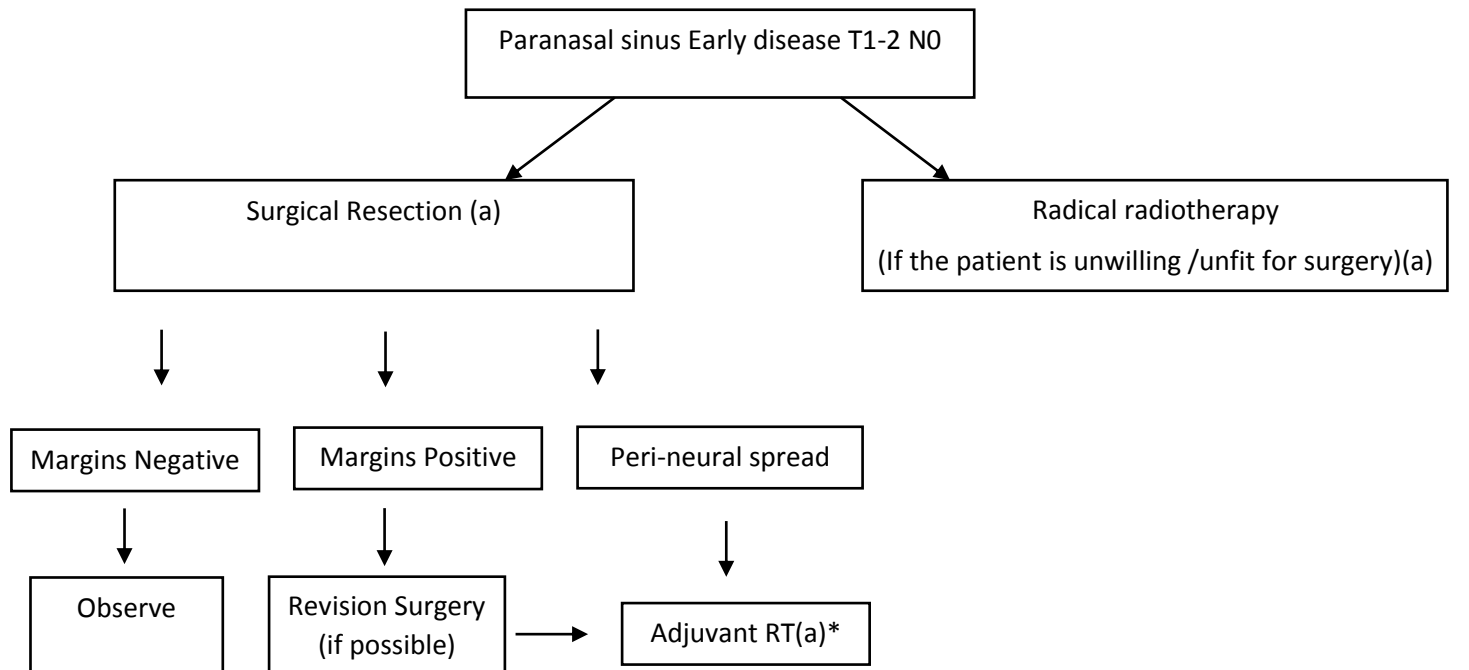
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2. Radiation (70Gy/35#) + Cisplatin 100 mg/m² once three weekly(b),
3. Radiation (70 Gy/35#) + Cisplatin 30-40 mg/m² + Nimotuzumab 200 mg weekly(b),
4. Other regimens such as carboplatin -5FU or 5FU-Hydroxyurea or paclitaxel-cisplatin(c) (These options were tested in platinum fit patients. Expertise in delivering chemotherapy is required for these regimens) and
5. NACT followed by Radiation or chemoradiation(c) Indications for neoadjuvant chemotherapy are N3 lymph nodes (> 6 cm) and extensive soft tissue extension, which is difficult to encompass safely in radiation portals. Post induction chemotherapy patients may be routed to Curative therapy or Palliative therapy as per clinical response and reassessment of General Condition.

PARANASAL SINUS AND NASAL CAVITY MANAGEMENT ALGORITHM



NASAL CAVITY & PNS

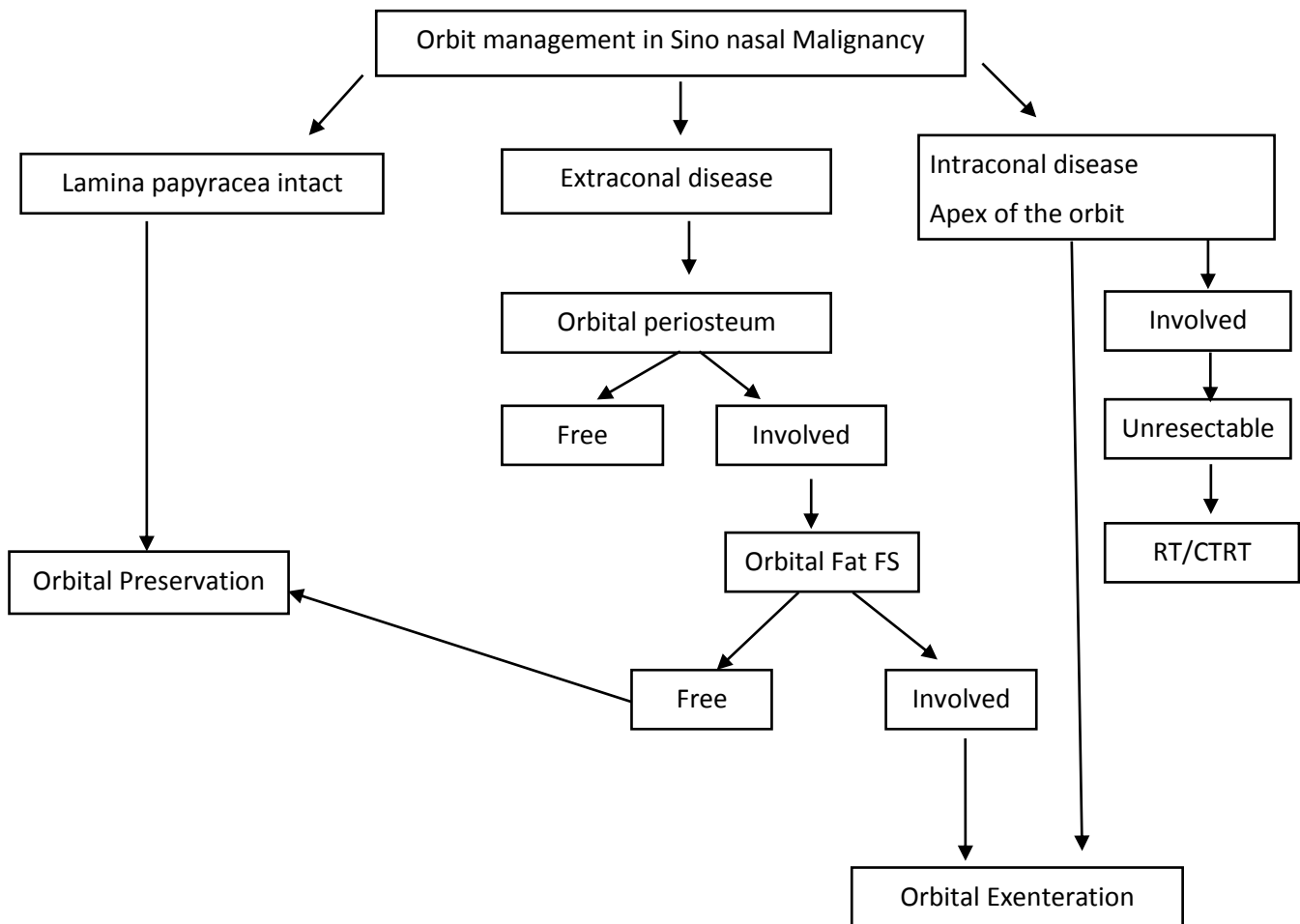


*Radiation in the PNS is optimally delivered with IMRT due to the vicinity of cranial nerves, intracranial contents and orbit. **(IMRT (b))**. For advanced tumors and posteriorly positioned tumors radiation therapy should include coverage for the retropharyngeal node.

** - Surgery should achieve a R0 Resection. The appropriate surgical technique may be accordingly selected (endoscopic, partial, total or extended maxillectomy, orbital exenteration, craniofacial resection). Neck Dissection is undertaken for a N+ neck. Prognosis is however very guarded for N+ disease except in the situation of Level I nodes related to anterior PNS Tumour/ Skin involvement.

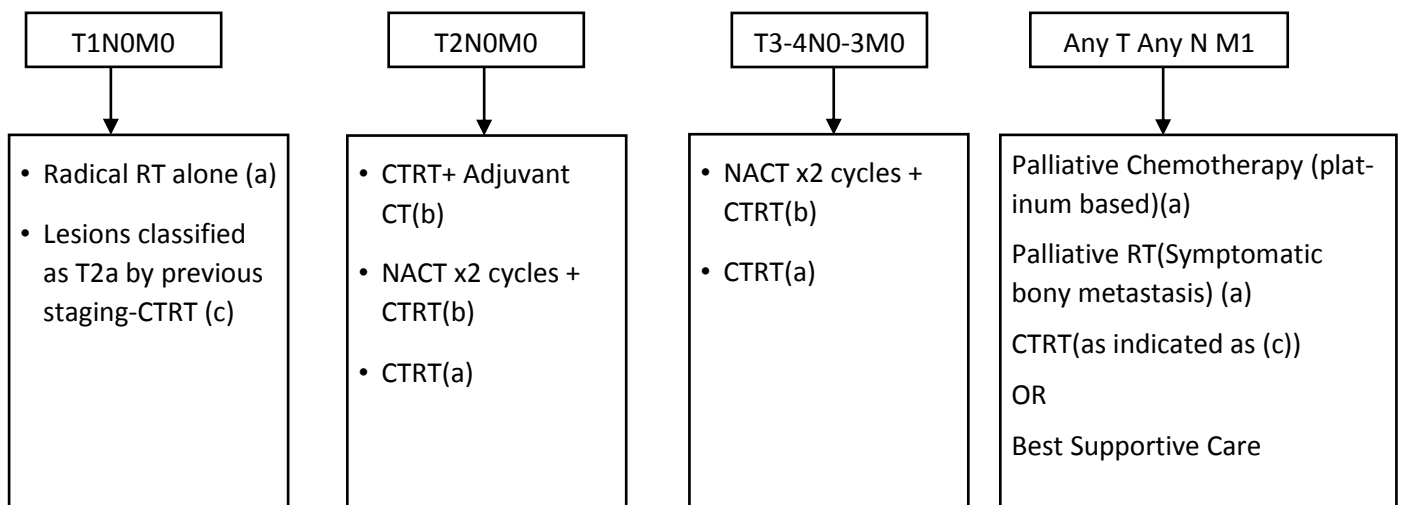
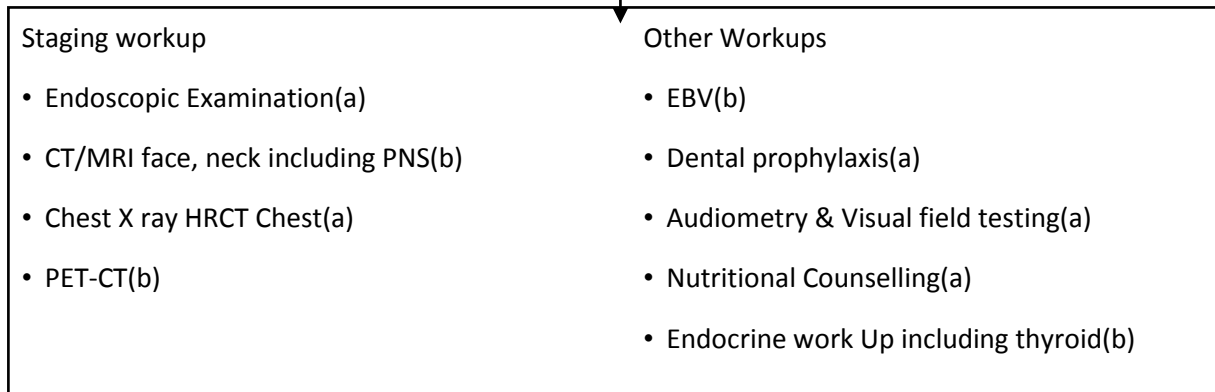
#NACT indication- should be considered optimal for advanced tumors with non-squamous high-grade histology {ENB (Gr3,4)/SNUC/SNEC/NUT/Small cell/Others}. (b)

NACT can be considered for SCC (c) in situations wherein surgical resection may not yield a R0 Resection or lead to unacceptable morbidity (Intracranial extension; High ITF involvement; orbital preservation in intraocular extension)

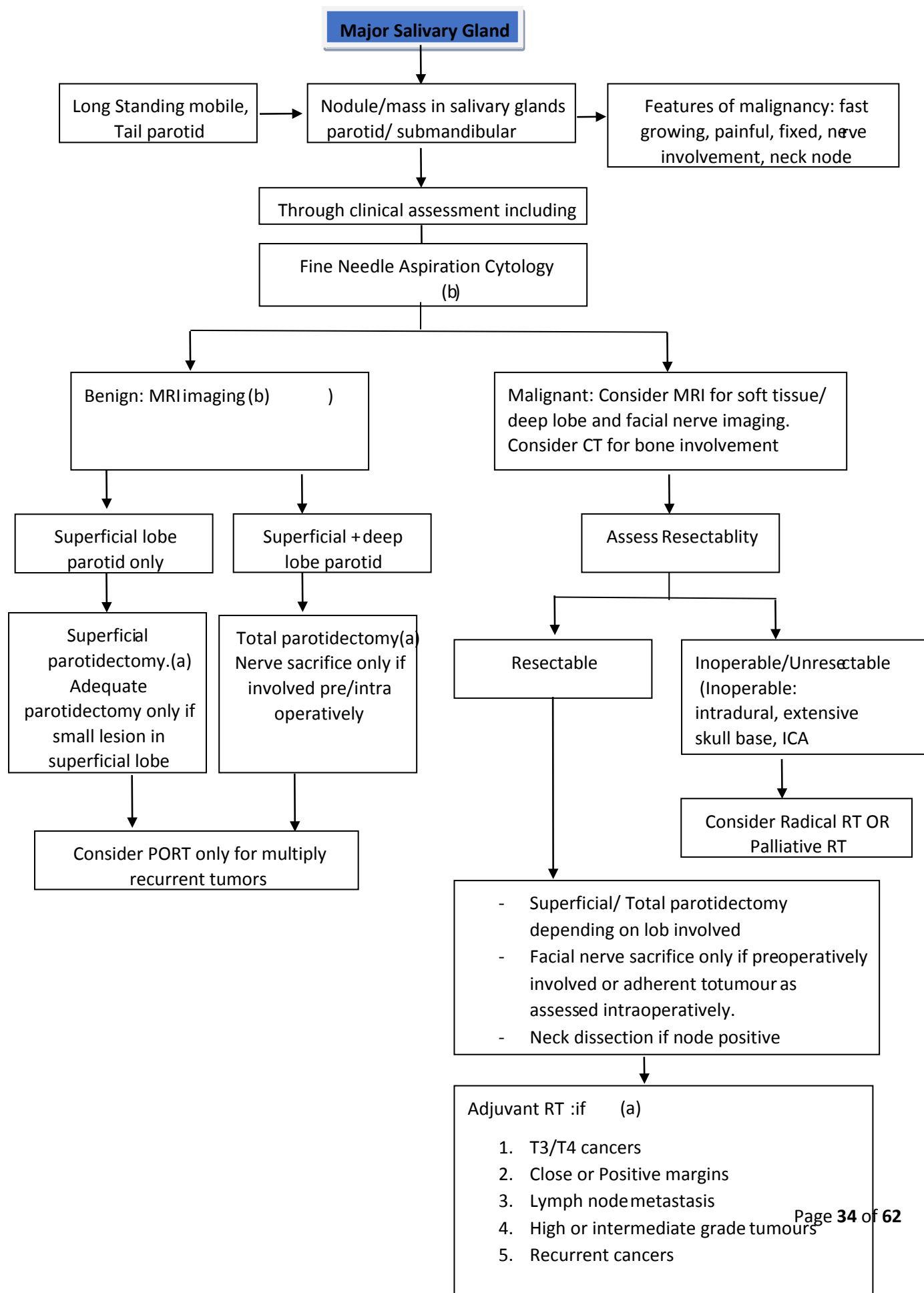


NASOPHARYNX

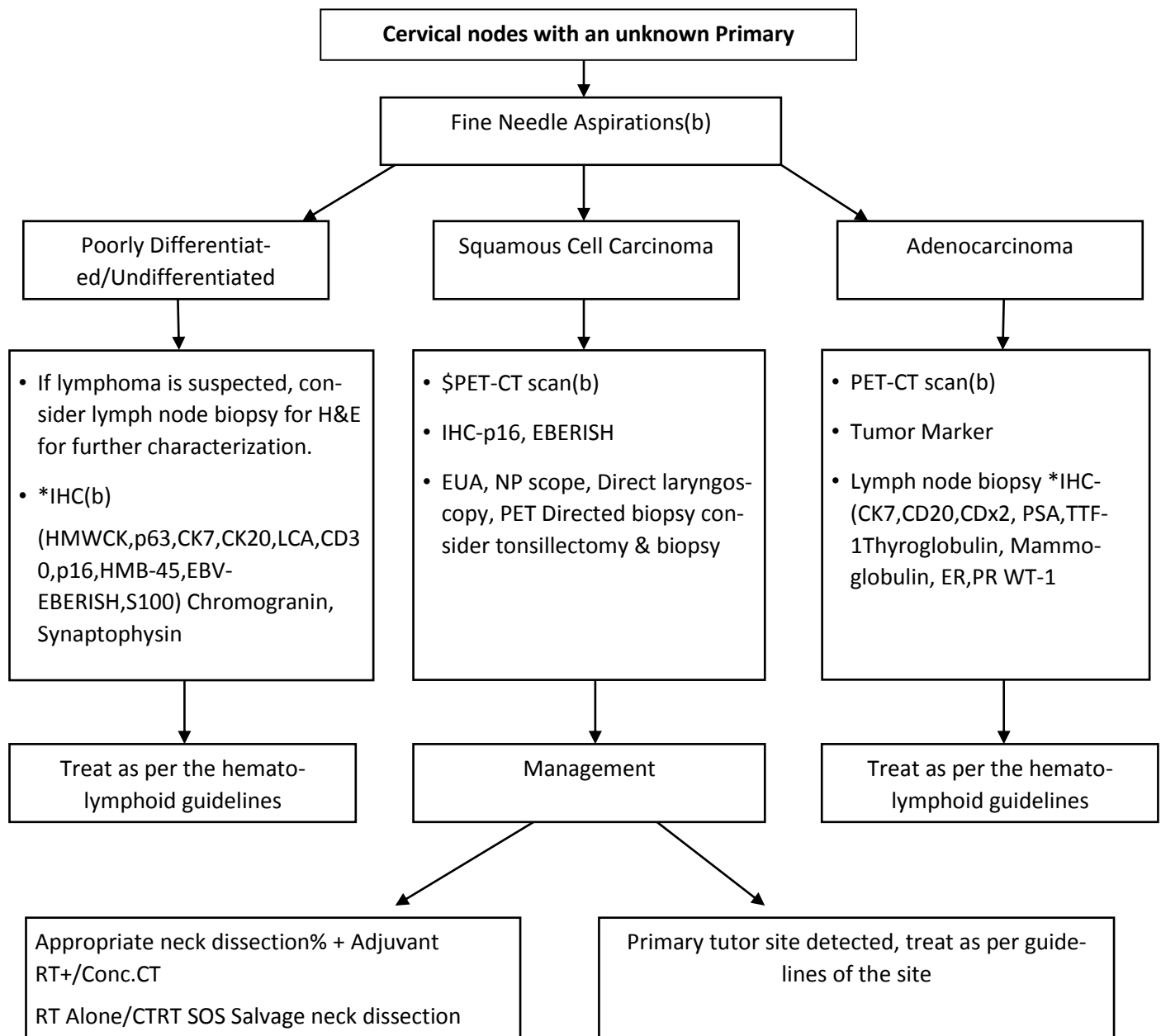
NASOPHARYNX



- FOLLOW-UP
- PET-CT/MRI for response evaluation(b)
- Examination of nasopharynx, neck and cranial nerves(a)
- For T3and T4 tumors, PETCT/MRI might be done annually for 5 years(b)
- Audiometry(a)
- EBV(b)
- IMRT or 3DCRT are the optimal modalities of Radiotherapy for Nasopharyngeal Cancer(b)
- All treatments have titrated as per patient's general condition and tolerability



CERVICAL NODES WITH AN UNKNOWN PRIMARY

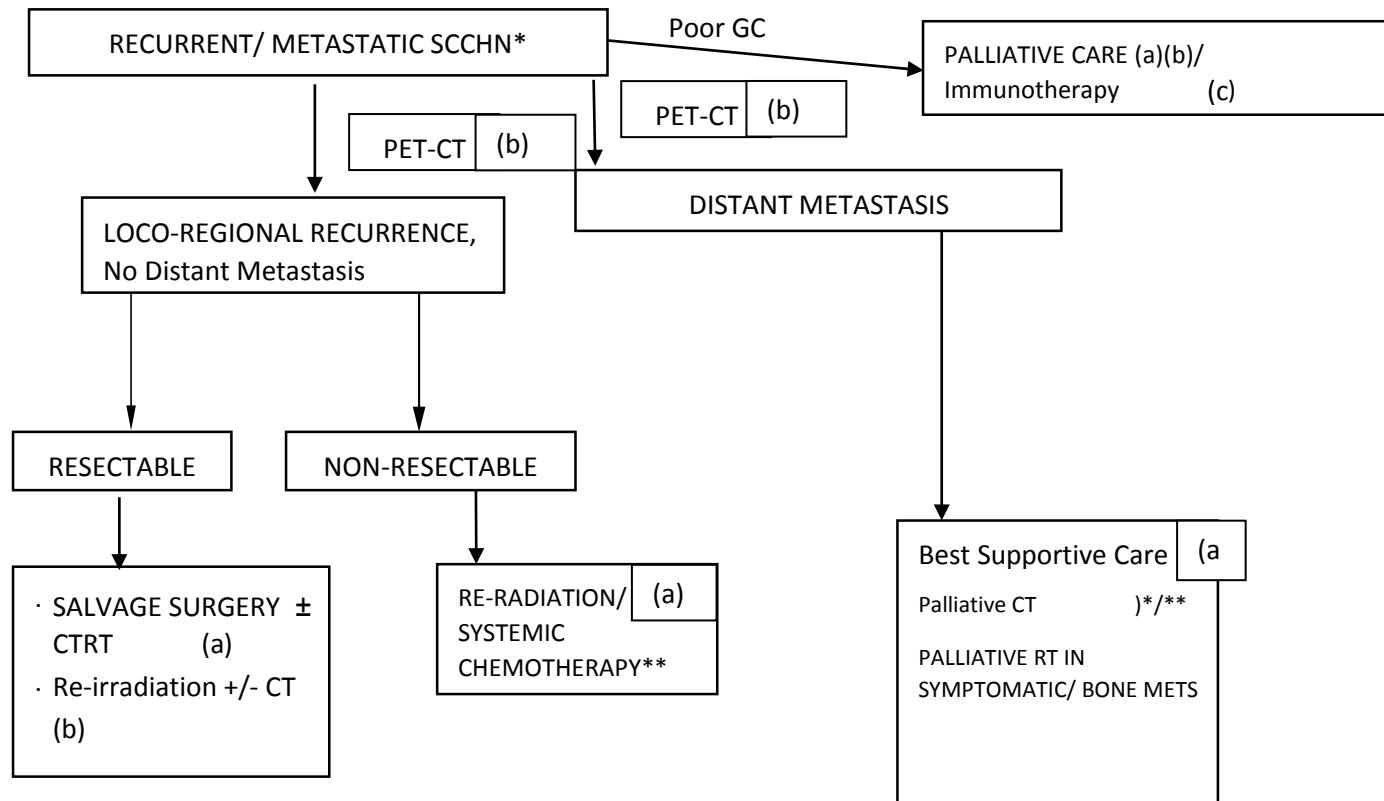


*Optimal

§ PET-CT where not available (a) → CECT of the Face & Neck
 CECT thorax
 USG (Abdomen)

%Depending on nodal stage and institutional policy

MANAGEMENT ALGORITHM FOR RECURRENT / METASTATIC SCCHN



*Consider early palliative care.

**Options for first line palliative chemotherapy include-

- Cytotoxic chemotherapy (single agent or combination)- metronomic chemotherapy consisting of weekly methotrexate-celecoxib with or without erlotinib; or combination Chemotherapy (Platinum, 5-FU, Taxane)
- 5FU– Platinum –Cetuximab or Paclitaxel -Platinum-Cetuximab (c);
- Pembrolizumab (if deemed appropriate with genetic testing for PDL1 and mutation load) (c)

**Options for second line or beyond chemotherapy include- Triple metronomic chemotherapy (b) or single agent chemotherapy (b), or nivolumab or its altered schedules (c) or pembrolizumab or its altered schedules (c)

ANNEXURE -1. RADIOLOGY SYNOPTIC REPORTING FORMATS

ORAL CAVITY:

CT/ MR legend:

CT scan/ MR scan of the neck dated:

Oral cavity (Buccal, Lip, alveolus, palate and RMT)

T stage:

Laterality:

Location/ epicenter: Buccal mucosa/ Retromolar trigone/ Alveolus/ Lip

If buccal mucosa: gingivobuccal sulcus (GBS) involvement: upper/ lower/ both

If Retromolar trigone: upper/ lower/ both

If lip: upper/ lower/ angle

Alveolus: upper/ lower

Whether Measurable/ Nonmeasurable.

If measurable

Size:X X ... cm. (<2 cm, 2-4 cm,> 4 cm)

Depth of invasion: (Previous Depth of invasion:)

Primary Disease extent:

Retromolar trigone: Not involved/ Involved

Floor of mouth: Not involved/ Involved

Gingivolingual sulcus: Not involved/ Involved

Tongue: Not involved/ Involved

Masseter muscle involvement: Not involved/ Involved

Masticator space involvement: Not involved/ Involved

Infratemporal fossa: Not involved/ Involved

If yes Extension to High Infratemporal fossa: Present/ Absent

Retroantral space extension: Not involved/ Involved

Medial pterygoid muscles involvement: Not involved/ Involved

Lateral pterygoid muscles involvement: Not involved/ Involved

Pterygoid plates: Not involved/ Involved
Pterygopalatine fossa: Not involved/ Involved
Pterygomaxillary fissure: Not involved/ Involved
Temporalis Muscle: Not involved/ Involved
Condylar fossa: Not involved/ Involved

Maxillary sinus involvement: Not involved/ Involved
Hard palate involvement: Not involved/ Involved

Skin involvement: Not involved/ Involved
Specific comments, if any:

Perineural spread: Absent/ Present/ cannot be commented*
If present:
Nerve involved (V1, V2, V3 etc):

Cranial extent of perineural:
Extension up to skull base: Absent/ Present/ Suspicious or cannot be commented*
If yes: foramen ovale, foramen rotundum, vidian canal, greater palatine foramen

Intracranial extension: Present/ Absent/ Suspicious or cannot be commented*
If yes: cavernous sinus involvement: Present/ Absent

Vascular involvement: Absent/ Present (with CCA and ICA)
If present angle of contact: <90, 90 – 179, 180 – 269; >270
IJV status:

Bone status

Dentition: Absent/ Present
Bony Erosion: Absent/ Present: if present: maxillary/ mandibular

If absent:
Height of the mandible free from Para mandibular soft tissue: mm

If present:
Bone invasion absent or limited to cortical bone: Absent/ Present
Medullary/ marrow invasion: Absent/ Present
Mandibular canal (MC) involvement: Absent/ Present
Mandibular foramen (MF) involvement: Absent/ Present
If yes, Superior extent: foramen ovale/ cavernous sinus

The height of the intact mandible at the site of erosion:

N stage

Presence of nodal disease: Metastatic/ Benign (reactive) / Indeterminate

If indeterminate/ suspicious: need for additional imaging

Laterality- Ipsilateral / contralateral / Bilateral

Right levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal

Left levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal

Necrosis: Absent/ Present

Perinodal extension/extracapsular spread: Absent/ Present

Vascular involvement:

IJV: involved/ compressed/ cannot be commented upon

CCA abutment: Absent/ Present

ICA abutment: Absent/ Present

ECA abutment: Absent/ Present

If present angle of contact for CCA and ICA: <90, 90 – 179, 180 – 269; >270

Strap muscles involvement: Absent/ Present

Prevertebral fascia invasion: Absent/ Present

Size of the largest node:

Right side: mm and level

Left side: mm and level

M Stage

Lung nodules: Absent / Present

If present:

solitary/ multiple

location:

Size:

suspicious/ TSTC@/ Benign

Any other metastatic lesion (hepatic, adrenal, skeletal): Absent / Present

If yes, specify location and size:

Impression:

T stage

N stage

M stage

Specific comments, if any:

* Needs additional imaging.

Needs additional imaging/ FNAC correlation.

@ Follow-up/ image guided FNAC correlation.

LARYNX AND HYPOPHARYNX

CT/ MR legend:

CT scan/ MR scan of the neck dated:

Primary:

Laterality:

Larynx/ Hypopharynx:

If Larynx: epicentre of disease: Glottic/ Supraglottic/ Sub glottic

If hypopharynx: epicentre of disease: Pyriform sinus/ post-cricoid

Whether Measurable/ Nonmeasurable. If measurable

Tumor Volume/Transverse dimensions: (AP x transverse x CC)Volume:.....cc

T stage:

Epiglottis: Not involved/ Involved: If Involved: Free edge (ipsilateral / both sides)/ Base

Pre-epiglottic space: Not involved/ Involved: If Involved: Less than 25 % / Less than 50%/ More than 50%

Valleculae: Not involved/ Involved: If Involved: ipsilateral/ both sides

Hyoid bone: Not Involved/ Involved: If Involved: (erosion/ sclerosis)/ cannot be commented

Medial wall of pyriform & AE fold: Not Involved/ Involved: If Involved: (Ipsilateral/Contralateral)

Lateral wall of pyriform sinus: Not Involved/ Involved

Apex of pyriform sinus: Not Involved/ Involved

Para Glottic Space: Not Involved/ Involved (a) at false cord level b) true cord level) both

False vocal cord: Not Involved/ Involved

True vocal cord: Not Involved/ Involved

Anterior commissure: Not Involved/ Involved

Posterior commissure: Not Involved/ Involved

Sub-Glottis: Not Involved/ Involved (if involved inferior extent in mm)

Post cricoid: Not Involved/ Involved

Trachea: Not Involved/ Involved

Thyroid gland: Not Involved/ Involved

Pre-vertebral fascia: Not Involved/ Involved/ Indeterminate

Cartilage erosion:

Thyroid cartilage: Not Involved/ Involved: If Involved: (sclerosis/ erosion-lysis/ encased & displaced)

If Eroded: Unilateral/Bilateral laminae, Outer/ Inner cortex/both

Arytenoid cartilage: Not Involved/ Involved: If Involved: (sclerosis/ erosion-lysis/ encased & displaced).

Cricoid cartilage: Not Involved/ Involved: If Involved: (sclerosis/ erosion/ lysis/ marrow invasion)

Crico-arytenoid joint: Not Involved/ Involved

Exolaryngeal Spread: absent/ Present,

If present mode of spread-through eroded thyroid cartilage/ through thyrohyoid membrane/ along the posterior aspect of the thyroid cartilage.

N stage:

Presence of nodal disease: Metastatic/ Benign (reactive) / Indeterminate

If indeterminate/ suspicious: need for additional imaging

Laterality- Ipsilateral / contralateral / Bilateral

Right levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal

Left levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal

Necrosis: Absent / Present

Perinodal extension/extracapsular spread: Absent / Present

Vascular involvement:

IJV: involved/ compressed/ cannot be commented upon

CCA abutment: Absent / Present

ICA abutment: Absent / Present

ECA abutment: Absent / Present

If present angle of contact for CCA and ICA: <90, 90 – 179, 180 – 269; >270

Strap muscles involvement: Absent / Present

Prevertebral fascia invasion: Absent / Present

Size of the largest node:

Right side: mm and level

Left side: mm and level

M Stage

Lung nodules: Absent / Present

If present:

solitary/ multiple

location:

Size:

suspicious/ TSTC@/ Benign

Any other metastatic lesion (hepatic, adrenal, skeletal): Absent / Present

If yes, specify location and size:

Impression:

T stage

N stage

M stage

Specific comments, if any:

Needs additional imaging/ FNAC correlation

@ Follow-up/ image guided FNAC correlation

CARCINOMA TONGUE

Laterality:

Tumour size (AP x transverse x CC) MM:

Depth of invasion MM:

T stage:

Crosses the midline: No/ abuts lingual raphe/ yes.

Extrinsic muscles: Not involved/ Involved

Genioglossus: Not involved/ Involved (origin/ insertion)

Hyoglossus: Not involved/ Involved (origin/ insertion)

Geniohyoid: Not involved/ Involved (origin/ insertion)

Lingual neurovascular bundle: Not involved/ Involved (grade:0/I/II/III)

If involved: Unilateral/bilateral

Sublingual space: Not involved/ Involved

Submandibular space: Not involved/ Involved

Mylohyoid: Not involved/ Involved (origin/ insertion)

Floor of mouth: Not involved/ Involved

Masticator space: Not involved/ Involved

ITF: Not involved/ Involved.

If yes Extension to High Infratemporal fossa: Present/ Absent

Posterior one-third of the tongue (BOT):Not involved/ Involved

RMT: Not involved/ Involved

Tonsillo-lingual sulcus: Not involved/ Involved

Tonsil: Not involved/ Involved

Inferior extent: up to vallecular/ epiglottis / PFS

Hyoid: Not involved/ Involved (Distance from hyoid bone)

Valleculae- Not involved/ Involved

Epiglottis: Not involved/ Involved

PFS: Not involved/ Involved

Mandibular involvement:

Cortical breach: Present/ absent

Marrow signal abnormality: Present/ absent

Need for additional imaging: yes (CT bone window)

N stage

Presence of nodal disease: Metastatic/ Benign (reactive) / Indeterminate

If indeterminate/ suspicious: need for additional imaging.

Laterality- Ipsilateral / contralateral / Bilateral.

Right levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal.

Left levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal.

Necrosis: Present/ Absent.

Perinodal extension/extracapsular spread: Present/ Absent.

Vascular involvement:

IJV: involved/ compressed/ cannot be commented upon.

CCA: Present/ Absent

ICA: Present/ Absent

ECA: Present/ Absent

If present angle of contact for CCA and ICA: <90, 90 – 179, 180 – 269; >270

Strap muscles involvement: Present/ Absent
Prevertebral fascia invasion: Present/ Absent

Size of the largest node:
Right side: mm and level.
Left side: mm and level.

Impression:

T stage

N stage

Specific comments, if any:

Needs additional imaging/ FNAC correlation

@ Follow-up/ image guided FNAC correlation

CARCINOMA NASOPHARYNX

CT/ MR legend:

CT scan/ MR scan of the neck dated:

Laterality: Right/ Left/ Both

Crossing midline: No/ Yes

Tumour size (AP x transverse x CC)

Primary tumor extent:

Fossa of Rosenmuller: Not involved/ Involved

Eustachian tube opening: Not involved/ Involved

Pharyngobasillar fascia: Not involved/ Involved

Levator VeliPalatini: Not involved/ Involved

Tensor Velipalatini: Not involved/ Involved

Parapharyngeal space: Not involved/ Involved

Carotid space: Not involved/ Involved

Pterygoid muscles: Not involved/ Involved

If present: medial/ lateral/ both

Infratemporal fossa: Not involved/ Involved

Pterygoid plates: Not involved/ Involved

Pterygopalatine fossa: Not involved/ Involved

Pterygomaxillary fissure: Not involved/ Involved

Masseter muscle: Not involved/ Involved

Masticator space: Not involved/ Involved

Intra-nasal extension: Not involved/ Involved
Pre-vertebral muscles: Not involved/ Involved
Clivus (altered marrow signal): Not involved/ Involved
Intra-cranial extension: absent/ Present
If present: extent
Dural enhancement: Not involved/ Involved
Parenchymal involvement: Not involved/ Involved
Oropharynx: Not involved/ Involved

Perineural spread:

Absent/ Present/ cannot be commented*

If present:

Nerve involved (V1, V2, V3 etc):

Cranial extent of perineural:

Extension up to skull base: Present/ Absent/ Suspicious or cannot be commented*

If yes: foramen ovale, foramen rotundum, vidian canal, greater palatine foramen

Intracranial extension: Present/ Absent/ Suspicious or cannot be commented*

If yes: cavernous sinus involvement: Present/ Absent

N stage:

Presence of nodal disease: Metastatic/ Benign (reactive) / Indeterminate

If indeterminate/ suspicious: need for additional imaging

Laterality- Ipsilateral / contralateral / Bilateral

Right levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal

Left levels: Levels IA & IB/II, III, IV, V, VI & retropharyngeal

Necrosis: Absent / Present

Perinodal extension/extracapsular spread: Absent / Present

Vascular involvement:

IJV: involved/ compressed/ cannot be commented upon

CCA abutment: Absent / Present

ICA abutment: Absent / Present

ECA abutment: Absent / Present

If present angle of contact for CCA and ICA: <90, 90 – 179, 180 – 269; >270

Strap muscles involvement: Absent / Present

Prevertebral fascia invasion: Absent / Present

Suspicious nodes: above cricoid only / above and below cricoid

Size of the largest node:

Right side: mm and level

Left side: mm and level

Impression:

T stage

N stage

Specific comments, if any:

* Needs additional imaging.

Needs additional imaging/ FNAC correlation.

@ Follow-up/ image guided FNAC correlation.

Neck Imaging Reporting & Data System (NI-RADS)

NIRADS SURVEILLANCE REPORT TEMPLATE

INDICATION: []

Subsite & HPV status: []

Surgery & Chemoradiation: []

TECHNIQUE:

COMPARISON: [<None.>]

FINDINGS:

[<No evidence of recurrent disease is demonstrated at the primary site. >]

[<No pathologically enlarged, necrotic, or otherwise abnormal lymph nodes. >]

Expected post-treatment changes are noted including [<supraglottic mucosal edema and thickening of the skin and subcutaneous soft tissues.>]

There are no findings to suggest a second primary in the imaged aerodigestive tract.

Evaluation of the visualized portions of brain, orbits, spine and lungs show no aggressive lesions suspicious for metastatic involvement.

IMPRESSION:

Primary: [1]. [<Expected post-treatment changes in the neck without evidence of recurrent disease in the primary site >]

Neck: [1], [<No evidence of abnormal lymph nodes.>]

CECT or MRI Surveillance Legend:

Primary

1: No evidence of recurrence: routine surveillance

2: Low suspicion

a) Superficial abnormality (skin, mucosal surface): direct visual inspection

b) Ill-defined deep abnormality: short interval follow-up* or PET

3: High suspicion (new or enlarging discrete nodule/ mass): biopsy

4: Definitive recurrence (path proven, clinical or definitive imaging progression): no biopsy needed

Nodes

1: No evidence of recurrence: routine surveillance

2: Low suspicion: (enlarging lymph node without morphologically abnormal features): short interval follow-up or PET

3: High suspicion (new or enlarging lymph node with morphologically abnormal features): biopsy if clinically needed

4: Definitive recurrence (path proven, clinical or definitive imaging progression): no biopsy needed

*short interval follow- up: 3 months at our institution

CACRNIOMA THYROID CT IMAGING

CT legend:

CT scan of the neck dated:

Primary Thyroid nodule:

Location: Right lobe/Left lobe/Isthmus

Size:

Enhancement: Homogeneous/Heterogeneous

Calcifications: Absent/Present

If present: microcalcification/ macrocalcification/ eggshell

Cystic / Necrotic change: Absent/Present
 Extra-thyroid extension: Absent/Present
 If present CT Grade of ETE*:
 Mediastinal extension: Absent/Present
 Right aberrant subclavian artery: Absent/Present

T STAGE

Strap muscle involvement: yes/No
 T-E groove: Not involved/Involved (Status of vocal cords' indirect sign of RLN involvement)
 Relationship with trachea(SHIN grade #):
 Fat planes with oesophagus: Lost/ maintained. If lost; angle of contact:
 Planes with prevertebral fascia: Lost/ maintained
 Cricopharynx: Not involved/Involved
 Cricoid cartilage: Not involved/Involved
 Angle of contact with CCA (<180 / 180-270/>270):
 Angle of contact with innominate vessels (<180 / 180-270/>270):

N STAGE:

Laterality- Ipsilateral / contralateral / Bilateral
 Compartment: central/ lateral
 Node stations:

Right cervical nodes

LEVELS:	Level I	Level II	Level III	Level IV	Level V	Level VI
Size						
Heterogeneity						
Calcification						
Cystic or necrotic change						
Suspicious/ indeterminate/ benign @						

Left cervical nodes

LEVELS:	Level I	Level II	Level III	Level IV	Level V	Level VI
Size						
Heterogeneity						
Calcification						
Cystic or necrotic change						
Suspicious/ indeterminate/ benign @						

Vascular involvement:

CCA abutment: Absent/Present

ICA abutment: Absent/Present

ECA abutment: Absent/Present

If present angle of contact for CCA and ICA: <90, 90 – 179, 180 – 269; >270

Strap muscles involvement: Absent/Present

Prevertebral fascia invasion: Absent/Present

M Stage

Lung nodules: Absent / Present

If present:

solitary/ multiple

location:

Size:

suspicious/ TSTC@/ Benign

Any other metastatic lesion (hepatic, skeletal): Absent / Present

If yes, specify location and size:

Impression:

T stage

N stage

M stage

Specific comments, if any:

@ Follow-up/ image guided FNAC correlation.

*CT ETE grading:

- I, a tumor which was completely enveloped by thyroid parenchyma;
- II, a tumor in which the percentage of the tumor perimeter in contact with the thyroid capsule was 1–25%;
- III, a tumor in which the contact with the capsule was 25–50%;
- IV, a tumor in which the contact with the capsule was >50%

CT Shin grading:

- 0: > 5mm distance between tumor and trachea.
- I: disease abuts external perichondrium.
- II: disease invades into the cartilage +/- destruction.
- III: disease extends into the tracheal mucosa with no elevation/penetration of mucosa.
- IV: disease is full-thickness invasion with expansion of the tracheal mucosa with a bulge

USG THYROID DATED

High frequency USG of the thyroid with Doppler and elastography is performed.

Right thyroid lobe

measures cm.

A well/ill defined solid/cystic/mixed hypoechoic/hyperechoic/isoechoic nodule is seen in the right lobe of thyroid.

It measures 8 x 9 mm in size.

The nodule is wider than taller.

It shows no/complete/irregular halo.

No/microcalcifications/macrocalfications are seen

The lesion shows no/central/peripheral/both central and peripheral vascularity.

It shows no spongiform pattern/ comet tail artifacts.

Extrathyroid extension is not seen.

On elastography it is hard/soft, Asteria ES III.

Left thyroid lobe

measures cm.

A well/ill defined solid/cystic/mixed hypoechoic/hyperechoic/isoechoic nodule is seen in the left lobe of thyroid.

It measures 8 x 9 mm in size.

The nodule is wider than taller.

It shows no/complete/irregular halo.

No/microcalcifications/macrocalfications are seen

The lesion shows no/central/peripheral/both central and peripheral vascularity.

It shows no spongiform pattern/ comet tail artifacts.

Extrathyroid extension is not seen.

On elastography it is hard/soft, Asteria ES III.

Isthmus measures 3 mm.

Few subcm sized reactive appearing nodes are seen in level IB and II region.

There is no suspicious cervical lymphadenopathy.

Bilateral neck vessels are patent.

Impression :-

USG reveals:

Right thyroid nodule appears benign/indeterminate/suspicious on USG with TIRADS score and TMC RSS Score : low/Intermediate/high risk. FNAC correlation is suggested

Left thyroid nodule appears benign/indeterminate/suspicious on USG with TIRADS score and TMC RSS Score : low/Intermediate/high risk. FNAC correlation is suggested.

USG NECK FOR NODAL MAPPING DATED:

High frequency USG of the neck nodes with Doppler is performed.

Neck nodes:

Right cervical nodes

LEVELS:	Level I	Level II	Level III	Level IV	Level V	Level VI
Short-axis diameter						
Long-axis diameter						
Loss of hilum						
Echogenicity						
Microcalcifications						
Vascularity at power Doppler US						
Suspicious/ indeterminate/ benign						

Left cervical nodes

LEVELS:	Level I	Level II	Level III	Level IV	Level V	Level VI
Short-axis diameter						
Long-axis diameter						
Loss of hilum						
Echogenicity						
Microcalcifications						
Vascularity at power Doppler US						
Suspicious/ indeterminate/ benign						

Bilateral neck vessels are patent.

IMPRESSION:

USG reveals:

Reactive/ indeterminate/ suspicious right / left side adenopathy is seen.

Comments: Suggested FNAC correlation.

ANNEXURE -2. PATHOLOGY SYNOPTIC REPORTING FORMATS

(All parameters in regular font are Optimal (b)/core parameters
 Parameters in *Italic red font with ** that are Optional (c)/non-core parameters)

Mucosal Malignancies of Lip and Oral Cavity

Name Age ... Sex Hosp. Case No Pathology No

Date of request Date of reporting Resident Pathologist

Clinical Data:

Operative procedure: Biopsy / Resection / Not specified

*(*Specify the procedure, Document Primary surgery vs. Completion surgery)*

Specimen submitted: (List all the subsites included in the specimen)

Pre-procedural therapy: (Specify - Chemotherapy / Radiotherapy / Targeted therapy)

Gross findings:

Dimensions of Specimen:X.....X.....

Primary Tumor: Cannot be assessed / Not grossly visible / Tumor present

Tumor laterality:

Number of tumor foci:

Tumor location:

Tumor extent: (Extension to other subsites and adjacent organs)

Size of tumor:X.....X.... (Maximum dimension mandatory, specify thickness of tumor)

**Gross appearance of tumor (e.g. Ulcerative/Exophytic/Verrucous)*

**Associated lesions if any*

Underlying Bone (if included in the specimen): Involved / Not involved / Uncertain

Skin (If included in the specimen): Involved / Not involved / Uncertain

Margins: List all the margins and document gross distance of each margin from tumor
 (Specify for all mucosal, bony, soft tissue margins and base separately, as applicable)

Margin	Distance of margin from tumor

Microscopy:

Primary tumor: (Document separately for each tumor focus in case of multifocal tumor)

Histologic type of tumor: (As per WHO 2017 classification)

Grade of tumor:

Microscopic size of tumor: (Specify only if size different from gross tumor size)

Depth of invasion: ≤5 mm / >5 mm and ≤10 mm / >10 mm / Cannot be determined

Pattern of invasion: **PPOI* WPOI (Applicable for squamous cell carcinoma only)

Perineural invasion (PNI): Absent / Present / Cannot be determined

**If PNI present:*

- *Size of the nerve (.... mm)*
- *Location (Intratumoral / Extratumoral)*
- *Extent (Focal / Extensive)*

Lymphovascular emboli: Absent / Present / Cannot be determined

Underlying bone (if included): - Not involved /
- Involved (Cortical erosion vs. Medullary infiltration) /
- Cannot be determined

Skin (If included): Not involved / Involved / Cannot be determined

Margins: Specify for each margin, document distance of closest margin:

- Free /
- Close (specify distance of closest margin) /
- Involved by invasive carcinoma /
- Close to or Involved by severe dysplasia or in situ carcinoma
- Cannot be assessed

**Coexistent pathology:* Including adjacent mucosal pathology (specify)

**Ancillary studies if any:* Specify

***Impression:**

TNM Stage: pT

Lymph Node Dissection

Name Age ... Sex Hosp. Case No Pathology No
Date of request Date of reporting Resident Pathologist

Clinical Data:

***Operative procedure:** *Type of node dissection*

(Specify the procedure, Document Primary surgery vs. Completion surgery)

Specimen submitted: (List all the Lymph node levels and non-lymphoid tissue received)

Pre-procedural therapy: (Specify - Chemotherapy / Radiotherapy/Targeted therapy)

Gross findings:

Lymph nodes:

Laterality Rt. / Lt. / Central / Not known	Level / Site of lymph node	Total No. of nodes dissected	Size of larg- est node

Non-lymphoid tissue: Gross description of: Salivary gland / Skeletal muscle / Nerve / Vein / Other

Microscopy:

***Primary tumor:** *Histologic type of tumor (WHO 2017)*

Lymph nodes: Specify for each level

Laterality: Rt. / Lt. / Central / Not known	Level / Site of lymph node	No. of nodes ex- amined	No. of nodes posi- tive for me- tastases	Extranodal extension (ENE): - Absent - Present (<i>*ENE mi / ≤2 mm</i>) - Present (<i>*ENE ma / >2 mm</i>)

Maximum dimension of largest metastatic focus: mm

Non-lymphoid tissue: Specify

***Impression:**

TNM Stage: pN

Larynx

Name Age ... Sex Hosp. Case No Pathology No
Date of request Date of reporting Resident Pathologist

Clinical Data:

Operative procedure: Biopsy / Resection / Not specified

*(*Specify the procedure, Document Primary surgery vs. Completion surgery)*

Specimen submitted: (List all the subsites included in the specimen)

Pre-procedural therapy: (Specify - Chemotherapy / Radiotherapy / Targeted therapy)

Gross findings:

Dimensions of Specimen:X.....X.....

Primary Tumor: Cannot be assessed / Not grossly visible / Tumor present

Tumor laterality:

Number of tumor foci:

Tumor location:

Tumor extent: (Extension to other subsites and adjacent organs)

Size of tumor:X.....X..... (Maximum dimension mandatory)

**Gross appearance of tumor (e.g. Ulcerative/Exophytic/Verrucous)*

**Associated lesions if any*

Margins: List all the margins and document gross distance of each margin from tumor
(Specify for all mucosal and soft tissue margins separately, as applicable)

Margin	Distance of margin from tumor

***Adjacent tissue:** *Thyroid gland, Tracheostomy stoma (Specify)*

Microscopy:

Primary tumor: (Document separately for each tumor focus in case of multifocal tumor)

Histologic type of tumor: (As per WHO 2017 classification)

Grade of tumor:

Microscopic size of tumor: (Specify only if size different from gross tumor size)

Extent of tumor invasion: Specify involvement of other/adjacent structures/spaces:
Pre-epiglottic space,

**Paraglottic space* involvement

Thyroid and/or Cricoid cartilage involvement (**Partial / Complete*)

**Pattern of invasion:* (*Applicable for squamous cell carcinoma only*)

Perineural invasion (PNI): Absent / Present / Cannot be determined

**If PNI present:*

- *Size of the nerve (... mm)*
- *Location (Intratymoral / Extratymoral)*
- *Extent (Focal / Extensive)*

Lymphovascular emboli: Absent / Present / Cannot be determined

Margins: Specify for each margin, document distance of closest margin:

- Free /
- Close (specify distance of closest margin) /
- Involved by invasive carcinoma /
- Close to or Involved by severe dysplasia or in situ carcinoma
- Cannot be assessed

**Coexistent pathology:* *Including adjacent mucosal pathology (Dysplasia, hyperplasia - specify)*

**Ancillary studies if any:* *Specify*

***Impression:**

TNM Stage: pT

Nose and Paranasal Sinuses

Name Age ... Sex Hosp. Case No Pathology No
 Date of request Date of reporting Resident Pathologist

Clinical Data:

Operative procedure: Biopsy / Resection / Not specified

*(*Specify the procedure, Document Primary surgery vs. Completion surgery)*

Specimen submitted: (List all the subsites included in the specimen)

Pre-procedural therapy: (Specify - Chemotherapy / Radiotherapy / Targeted therapy)

Gross findings:

Dimensions of Specimen:X.....X.....

Primary Tumor: Cannot be assessed / Not grossly visible / Tumor present

Tumor laterality:

Number of tumor foci:

Tumor location:

Tumor extent:(Extension to other subsites and adjacent organs)

Size of tumor:X.....X.... (Maximum dimension mandatory)

**Associated lesions if any*

Bone/Cartilage (if included in the specimen): Involved / Not involved / Uncertain

Skin (If included in the specimen): Involved / Not involved / Uncertain

Margins: List all the margins and document gross distance of each margin from tumor
 (Specify for all mucosal, bony, soft tissue margins and base separately, as applicable)

Margin	Distance of margin from tumor

**Adjacent tissue:* Specify if applicable

Microscopy:

Primary tumor: (Document separately for each tumor focus in case of multifocal tumor)

Histologic type of tumor: (As per WHO 2017 classification)

Grade of tumor:

Microscopic size of tumor: (Specify only if size different from gross tumor size)

Extent of tumor invasion: Specify involvement of other/adjacent structures/spaces

Perineural invasion (PNI): Absent / Present / Cannot be determined

**If PNI present:*

- *Size of the nerve (... mm)*
- *Location (Intratumoral / Extratumoral)*
- *Extent (Focal / Extensive)*

Lymphovascular emboli: Absent / Present / Cannot be determined

Bone/Cartilage (if included): - Not involved /
- Involved (Cortical erosion vs. Medullary infiltration for bone) /
- Cannot be determined

Skin (If included): Not involved / Involved / Cannot be determined

Margins: Specify for each margin, document distance of

closest margin:

- Free /
- Close (specify distance of closest margin) /
- Involved by invasive carcinoma /
- Close to or Involved by severe dysplasia or in situ carcinoma
- Cannot be assessed

**Adjacent tissue: Specify if applicable*

**Coexistent pathology: Including adjacent mucosal pathology (specify)*

**Ancillary studies if any: Specify*

***Impression:**

TNM Stage: pT

Salivary Glands

Name Age ... Sex Hosp. Case No Pathology No
 Date of request Date of reporting Resident Pathologist

Clinical Data:

Operative procedure: Biopsy / Resection / Not specified
*(*Specify the procedure, Document Primary surgery vs. Completion surgery)*

Specimen submitted: (List all the subsites included in the specimen)

Pre-procedural therapy: (Specify - Chemotherapy / Radiotherapy / Targeted therapy)

Gross findings:

Dimensions of Specimen:X.....X.....

Primary Tumor: Cannot be assessed / Not grossly visible / Tumor present

Tumor laterality:

Number of tumor foci:

Tumor location:

Tumor extent: (Extr glandular extension to adjacent structures – specify)

Size of tumor:X.....X.... (Largest dimension mandatory)

**Gross appearance of tumor*

**Associated lesions if any*

Margins: Document gross distance of all margin from tumor

Microscopy:

Primary tumor: (Document separately for each tumor focus in case of multifocal tumor)

Histologic type of tumor: (As per WHO 2017 classification)

Grade of tumor:

Microscopic size of tumor: (Specify only if size different from gross tumor size)

Extent of tumor invasion: Specify involvement of other/adjacent structures/spaces

Perineural invasion (PNI): Absent / Present / Cannot be determined

**If PNI present:*

- *Size of the nerve (... mm)*
- *Location (Intratumoral / Extratumoral)*
- *Extent (Focal / Extensive)*

Lymphovascular emboli: Absent / Present / Cannot be determined

Margins: Specify for each margin, document distance of closest margin:

- Free /
- Close (specify distance of closest margin) /
- Involved by invasive carcinoma /
- Close to or Involved by severe dysplasia or in situ carcinoma
- Cannot be assessed

**Coexistent pathology:* Including adjacent mucosal pathology (specify)

**Ancillary studies if any:* Specify

***Impression:**

TNM Stage: pT

Ear

Name Age ... Sex Hosp. Case No Pathology No

Date of request Date of reporting Resident Pathologist

Clinical Data:

Operative procedure: Biopsy / Resection / Not specified

*(*Specify the procedure, Document Primary surgery vs. Completion surgery)*

National Cancer Grid Head & Neck Cancer Management Guidelines 2019

Specimen submitted: (List all the subsites included in the specimen)
Pre-procedural therapy: (Specify - Chemotherapy / Radiotherapy / Targeted therapy)

Gross findings:

Dimensions of Specimen:X.....X.....
Primary Tumor: Cannot be assessed / Not grossly visible / Tumor present
 Tumor laterality:
 Number of tumor foci:
 Tumor location:
 Tumor extent:(Extension to other subsites and adjacent organs)
 Size of tumor:X.....X.... (Maximum dimension mandatory)
**Associated lesions if any*

Bone/Cartilage (if included in the specimen): Involved / Not involved / Uncertain
Skin (If included in the specimen): Involved / Not involved / Uncertain
Margins: List all the margins and document gross distance of each margin from tumor

Margin	Distance of margin from tumor

Microscopy:

Primary tumor: (Document separately for each tumor focus in case of multifocal tumor)
 Histologic type of tumor: (As per WHO 2017 classification)
 Grade of tumor:
 Microscopic size of tumor: (Specify only if size different from gross tumor size)
 Extent of tumor invasion: Specify involvement of other/adjacent structures/spaces
Perineural invasion (PNI): Absent / Present / Cannot be determined

**If PNI present:*

- *Size of the nerve (... mm)*
- *Location (Intratymoral / Extratumoral)*
- *Extent (Focal / Extensive)*

Lymphovascular emboli: Absent / Present / Cannot be determined

Bone/Cartilage (if included): - Not involved /
- Involved (Cortical erosion vs. Medullary infiltration for bone) /
- Cannot be determined

Skin (If included): Not involved / Involved / Cannot be determined

Margins: Specify for each margin, document distance of
closest margin:

- Free /
- Close (specify distance of closest margin) /
- Involved by invasive carcinoma /
- Close to or Involved by severe dysplasia or in situ carcinoma
- Cannot be assessed

***Coexistent pathology:** *Including adjacent mucosal pathology (specify)*

***Ancillary studies if any:** *Specify*

***Impression:**

TNM Stage: pT