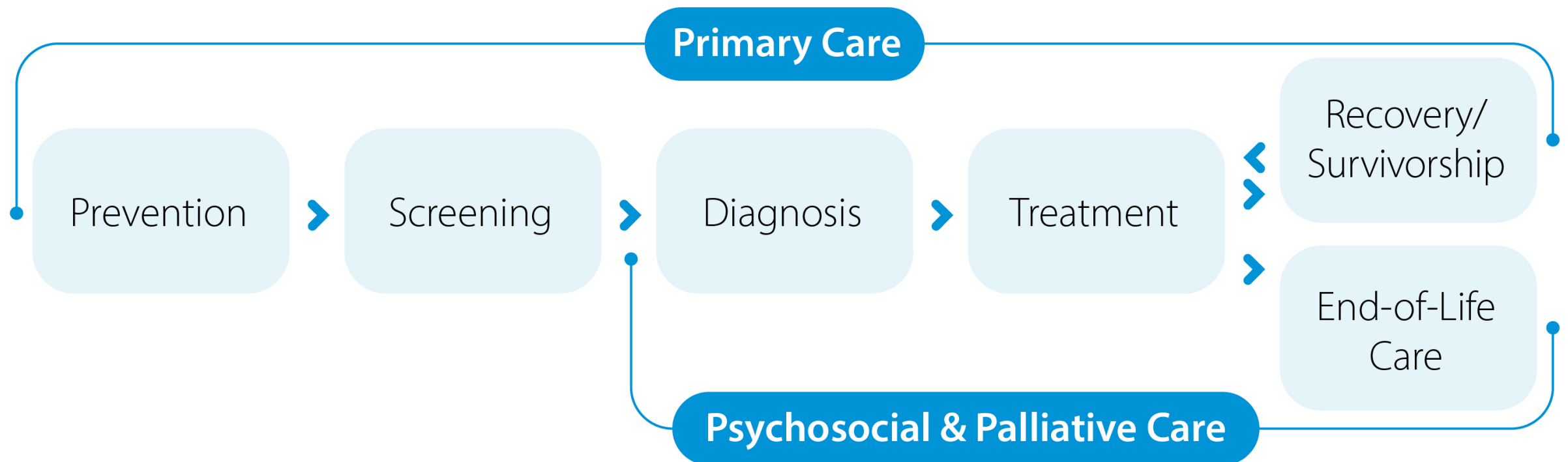


# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

Version 2023.02



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**Ontario Health**  
Cancer Care Ontario

### Target Population





















- Patients with a confirmed HPV-positive oropharyngeal squamous cell carcinoma diagnosis who have undergone the recommended diagnostic and staging procedures outlined in the **Oropharyngeal Squamous Cell Cancer Diagnosis Pathway**.

### Pathway Map Considerations

- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, [Health811](#) is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see [Person-Centered Care Guideline](#) and [EBS #19-2 Provider-Patient Communication](#).\*
- Hyperlinks are used throughout the pathway map to provide information about relevant Ontario Health (Cancer Care Ontario) tools, resources and guidance documents.
- The term ‘health care provider’, used throughout the pathway, includes primary care providers and specialists, nurse practitioners, otolaryngologists, speech language pathologists, registered dietitians, and emergency physicians.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on Multidisciplinary Cancer Conferences, visit [MCC Tools](#).
- For more information on wait time prioritization, visit [Surgery](#).
- Clinical trials should be considered for all phases of the pathway map.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See [Psychosocial Oncology Guidelines Resources](#)
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See [Ontario Fertility Program](#).
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit [EBS #19-3](#).\*
- Counseling and treatment for smoking cessation should be initiated early on in the pathway and continued by care providers throughout the pathway as necessary.
- The following should be considered when weighing the treatment options described in this pathway for patients with potentially life-limiting illness:
  - Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care – including restorative or rehabilitative care - or may become the total focus of care.
  - Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient’s overall approach to care.
- Organizational Guidance for the Care of Patients with Head and Neck Cancer in Ontario recommendations apply across this pathway and establish the minimum requirements to maintain a head and neck disease site program. For more information visit: [GL 5-3ORG](#).

\* **Note. EBS #19-2 and EBS #19-3** are older than 3 years and are currently listed as ‘For Education and Information Purposes’. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

### Pathway Map Legend

Colour Guide	Shape Guide	Line Guide
 Primary Care	 Intervention	 Required
 Palliative Care	 Decision or assessment point	 Possible
 Pathology	 Patient (disease) characteristics	
 Organized Diagnostic Assessment	 Consultation with specialist	
 Surgery	 Exit pathway	
 Radiation Oncology	 Off page reference	
 Medical Oncology	 Referral	
 Radiology		
 Multidisciplinary Cancer Conference (MCC)		
 Genetics		
 Psychosocial Oncology (PSO)		

### Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

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Ontario Health (Cancer Care Ontario) and the pathway map’s content providers (including the physicians who contributed to the information in the pathway map) shall have no liability, whether direct, indirect, consequential, contingent, special, or incidental, related to or arising from the information in the pathway map or its use thereof, whether based on breach of contract or tort (including negligence), and even if advised of the possibility thereof. Anyone using the information in the pathway map does so at his or her own risk, and by using such information, agrees to indemnify Ontario Health (Cancer Care Ontario) and its content providers from any and all liability, loss, damages, costs and expenses (including legal fees and expenses) arising from such person’s use of the information in the pathway map.

This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

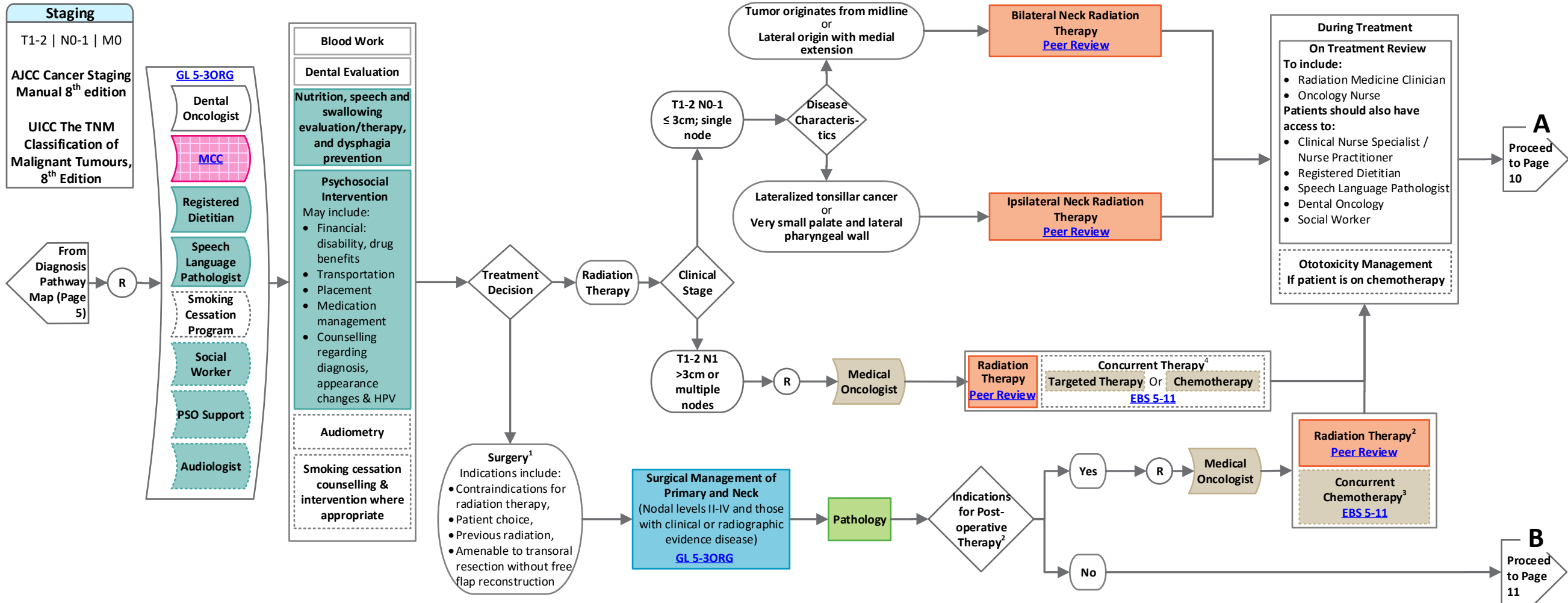
Stage I

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<sup>1</sup> Surgery may be an option for some patients. Patients should be included in trials investigating Transoral Robotic Surgery (TORS) where available.

<sup>2</sup> Indications for post-operative radiotherapy: Close surgical margins OR one or more of the following at the primary site: peri-neural invasion, lymph-vascular invasion OR lymph node involvement (≥ 2 lymph nodes, any lymph node >3 cm (N2+), nodal level IV-V LN positive, extracapsular extension (ECE)).

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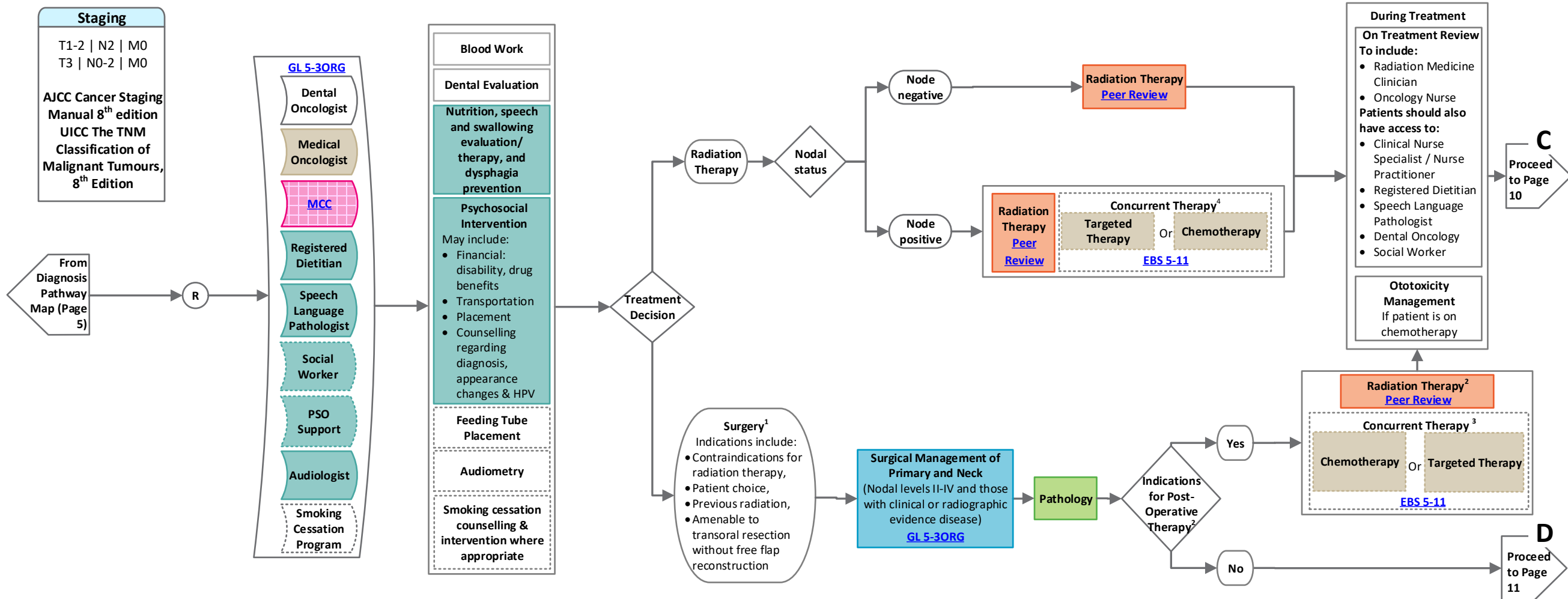
<sup>4</sup> As per EBS 5-11 systemic treatment should not be based on age alone but should be individualized to the patient's situation.

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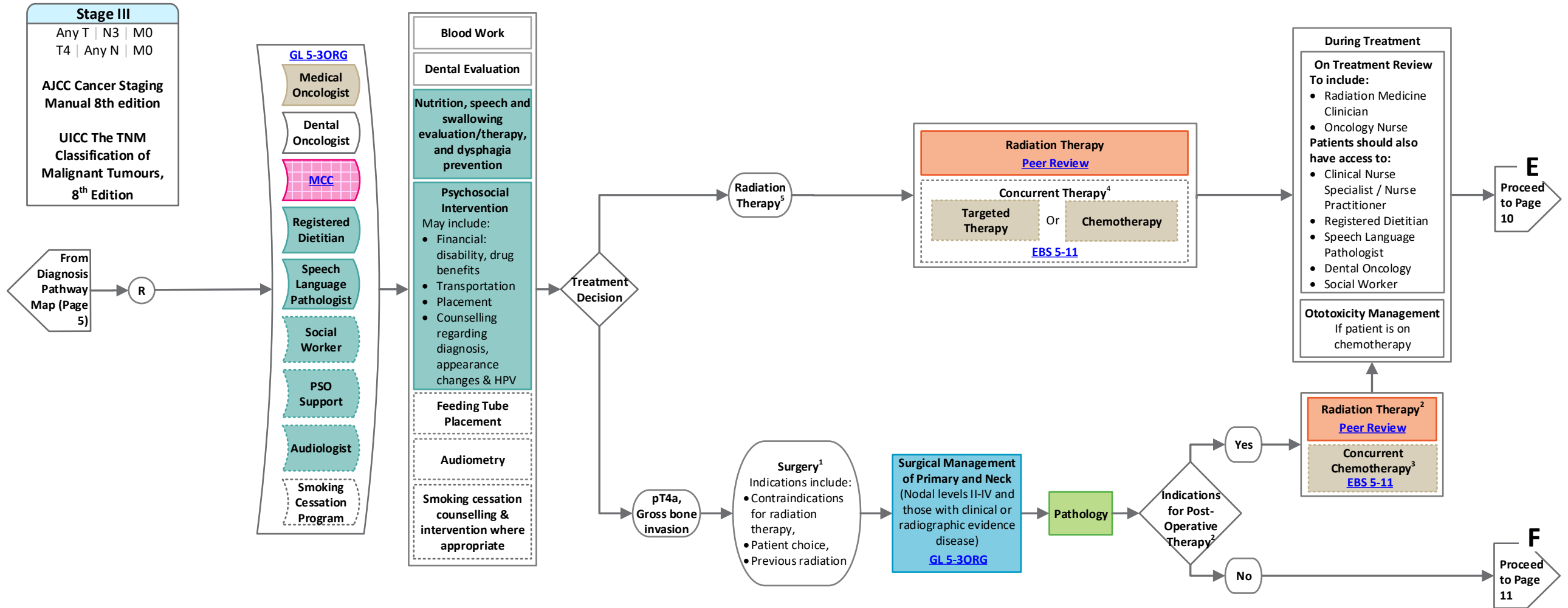
Stage III

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<sup>5</sup> Platinum-containing agents (single or multi-agent) alone or in combination with other agents; other systemic therapy options may also exist including targeted therapies such as Nivolumab or Pembrolizumab as indicated. Consider referral to Head & Neck centre.

# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

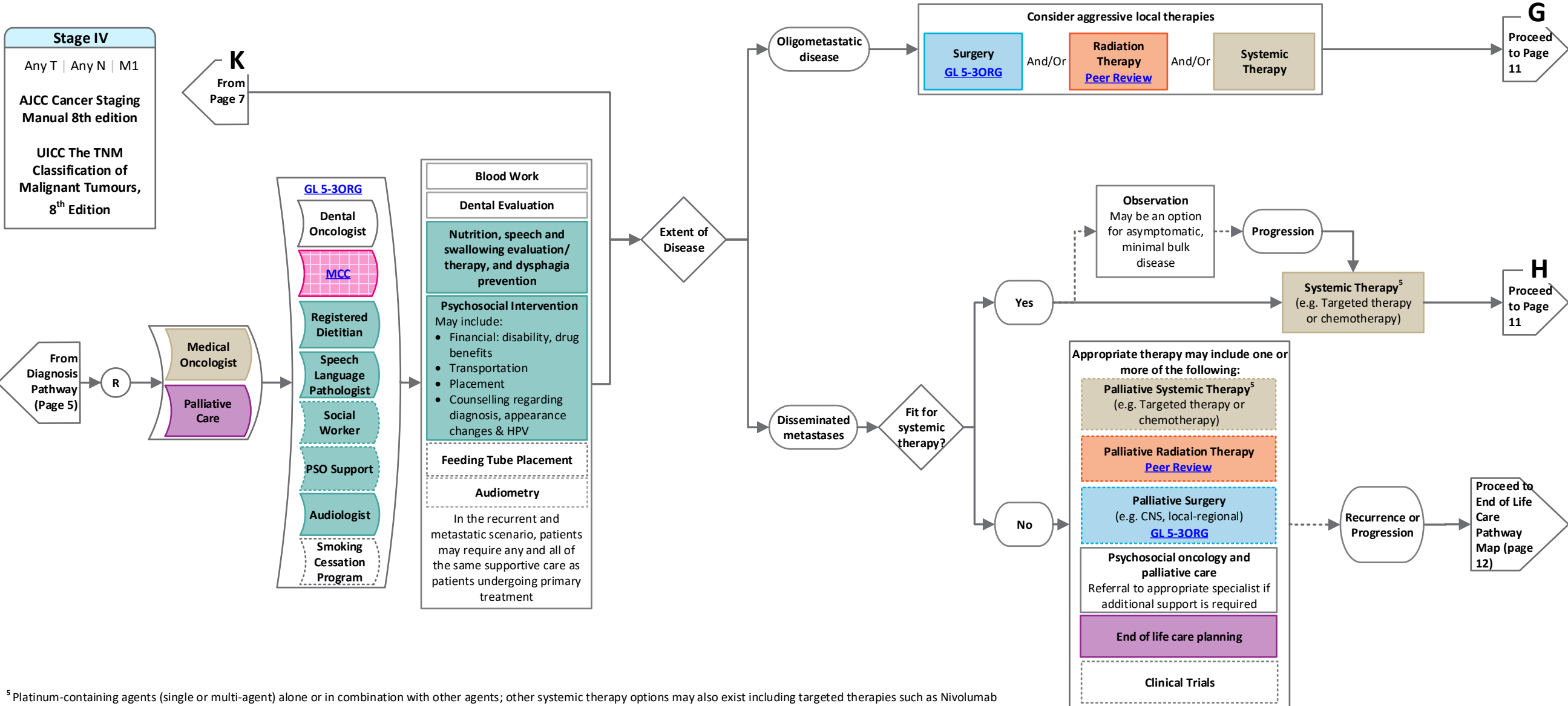
## Stage IV Metastatic Disease

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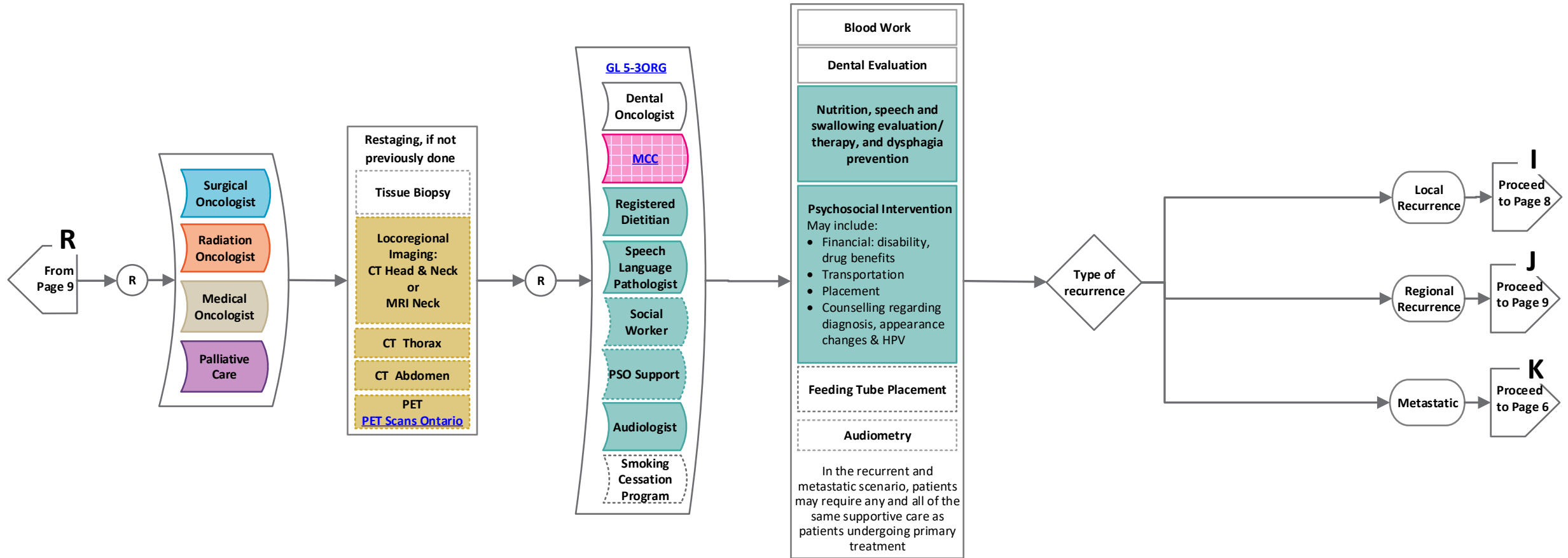
# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

## Recurrence

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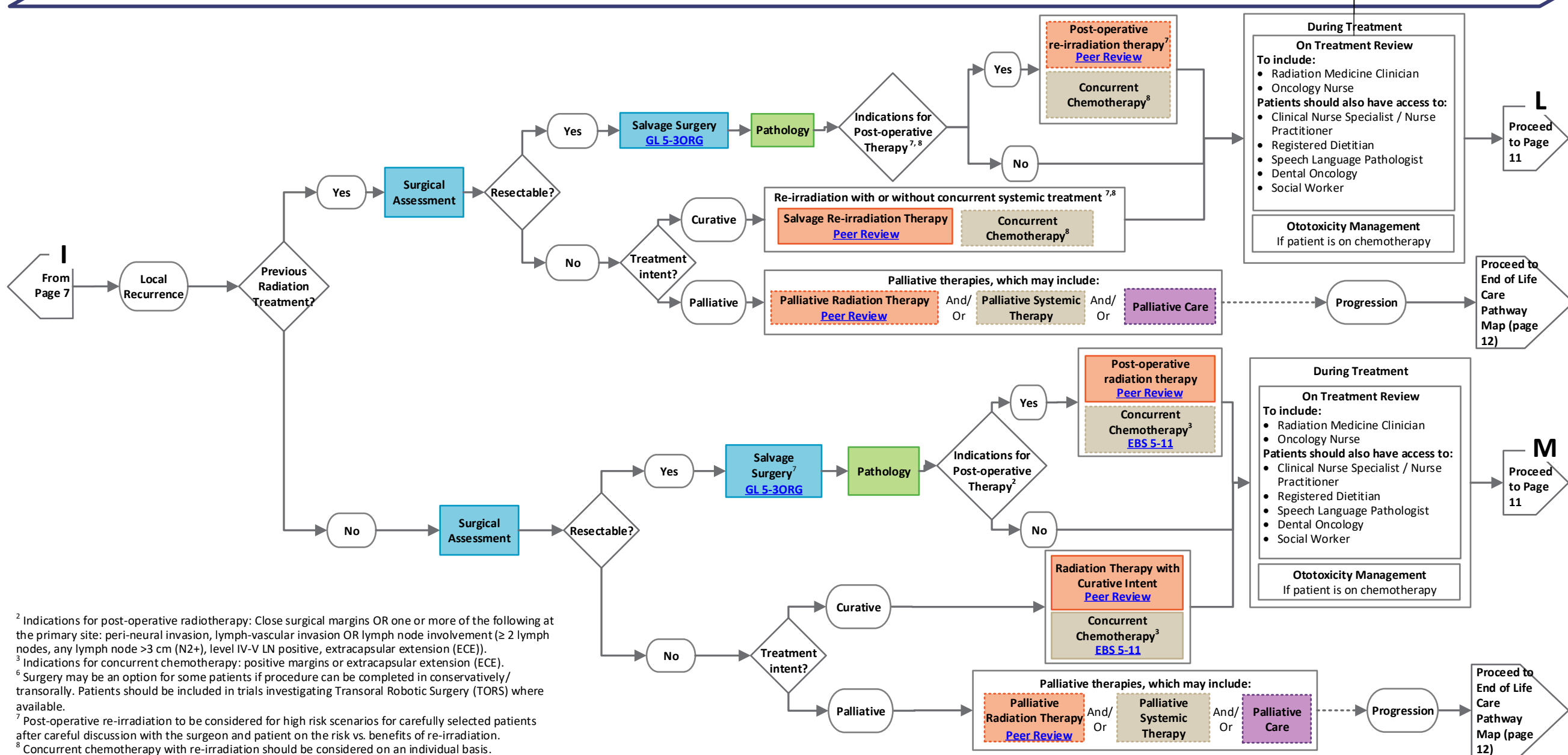
# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

## Local Recurrence

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<sup>6</sup> Surgery may be an option for some patients if procedure can be completed in conservatively/transorally. Patients should be included in trials investigating Transoral Robotic Surgery (TORS) where available.

<sup>7</sup> Post-operative re-irradiation to be considered for high risk scenarios for carefully selected patients after careful discussion with the surgeon and patient on the risk vs. benefits of re-irradiation.

<sup>8</sup> Concurrent chemotherapy with re-irradiation should be considered on an individual basis.



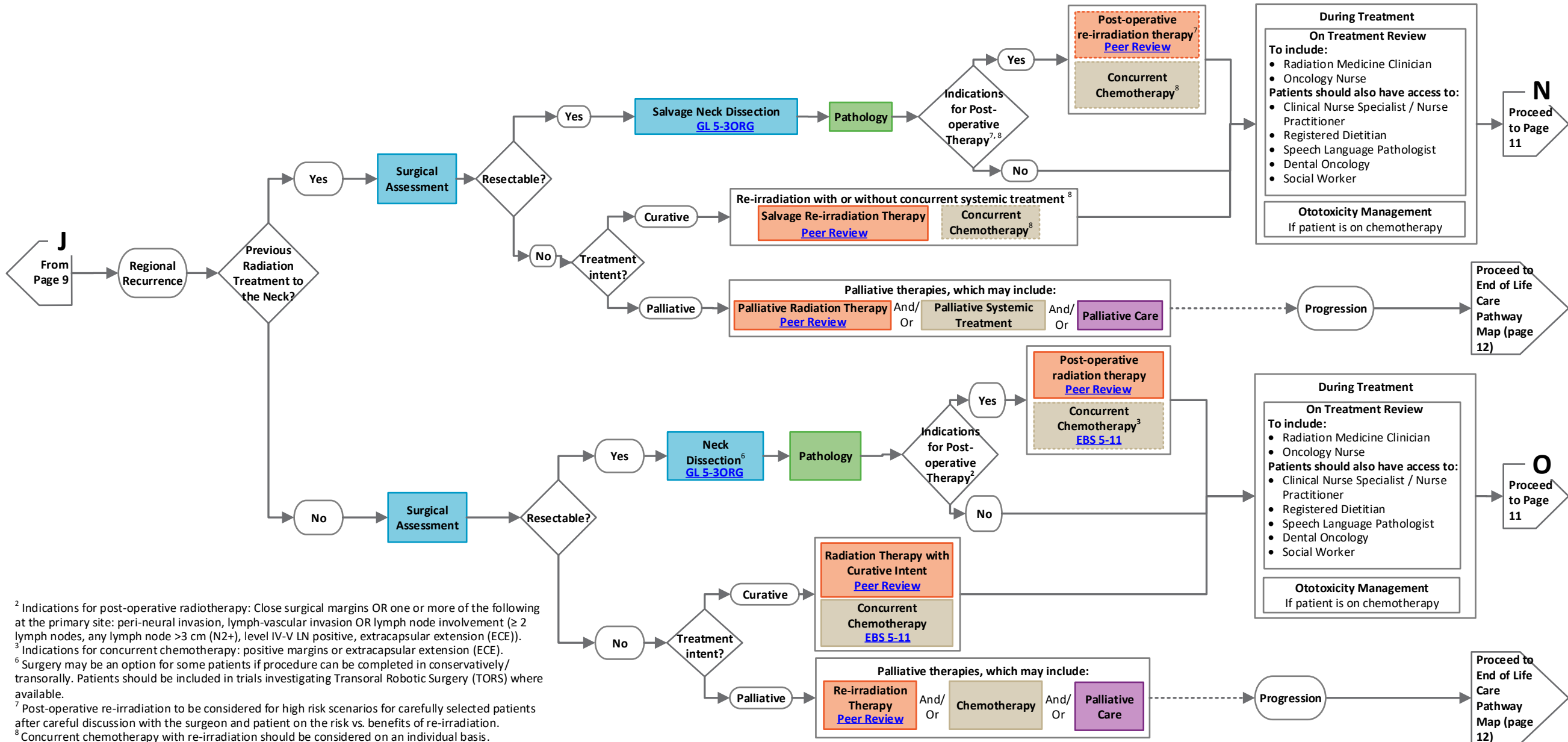
# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

## Regional Recurrence

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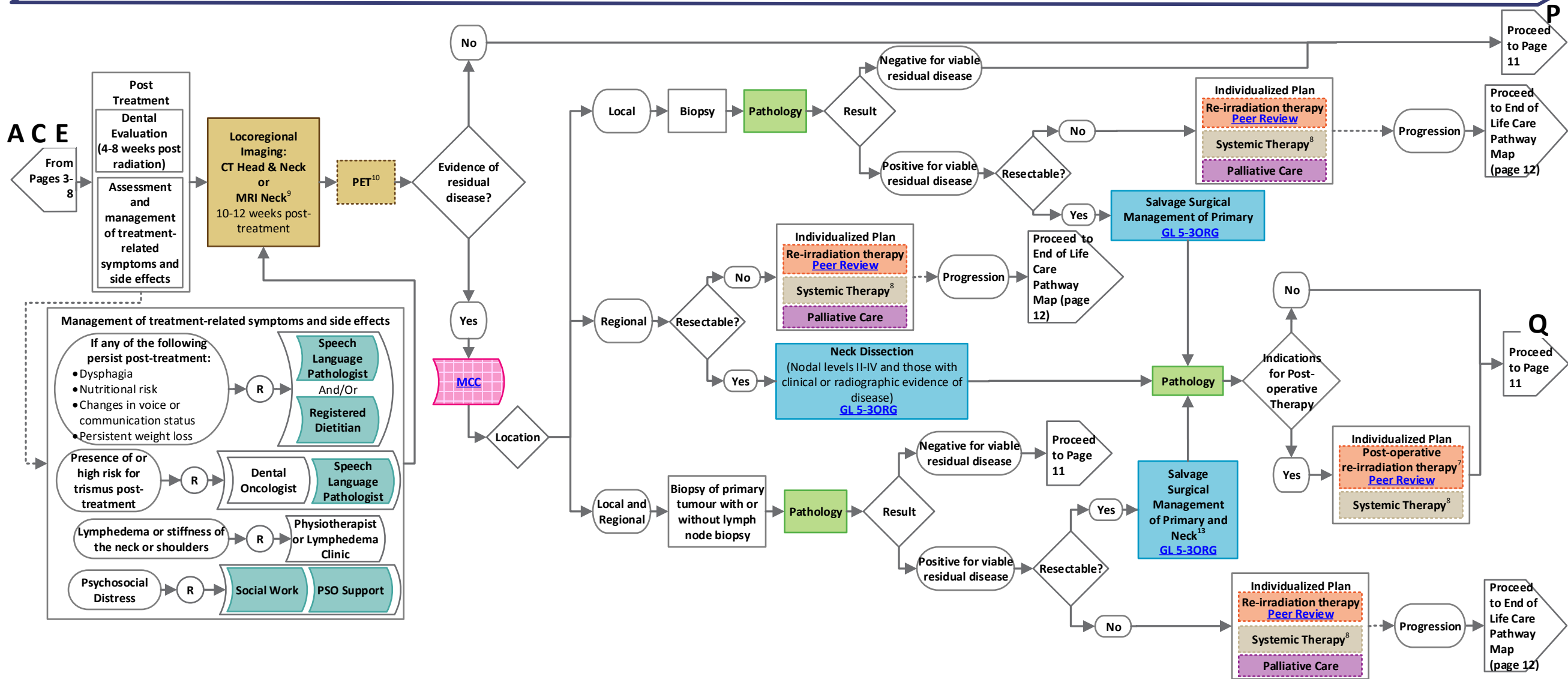
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<sup>8</sup> Concurrent chemotherapy with re-irradiation should be considered on an individual basis.

<sup>9</sup> Same modality should be used as baseline imaging

<sup>10</sup> Restaging after chemoradiotherapy treatment to assess patients with N1-N3 squamous-cell carcinoma of the H&N, if patients have residual neck nodes ≥ 1.5cm on re-staging CT performed 10-12 weeks post therapy for HPV positive disease.

# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

## Follow-Up

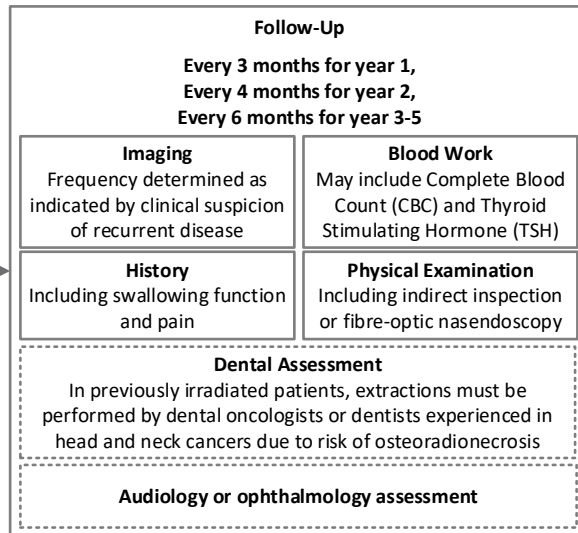
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B D F  
G H L  
M N O  
P Q

From  
Pages 3-8



Result

No Recurrence or Progression

Return to primary care provider for follow-up

Recurrence or Progression

R  
Proceed to Page 7

### Management of treatment-related symptoms and side effects

If any of the following persist post-treatment:

- Dysphagia
- Nutritional risk
- Changes in voice or communication status
- Persistent weight loss

Speech Language Pathologist  
And/Or  
Registered Dietitian

Trismus is noted or persists post treatment

Dental Oncologist  
Speech Language Pathologist

Lymphedema or stiffness of the neck or shoulders

Physiotherapist or Lymphedema Clinic

Psychosocial Distress

Social Work  
PSO Support

# HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

## End of Life Care

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### Pathway Map

**Target Population:**  
Individuals with cancer approaching the last 3 months of life and their families.

While this section of the pathway is focused on the care delivered at the **end of life**, palliative care should be initiated much earlier in the illness trajectory. In particular, providers can introduce a palliative approach to care as early as the time of diagnosis.

**Triggers that suggest patients are nearing the last few months and weeks of life**

- ECOG/Patient-ECOG/PRFS = 4  
OR
- PPS ≤ 50
- Declining performance status/functional ability

Screen, Assess, Plan, Manage and Follow Up



**End of Life Care planning and implementation**  
Collaboration and consultation between specialist-level care teams and primary care teams



Conversations to determine where care should be provided and who will be responsible for providing the care

### End of Life Care

#### □ Key conversations to revisit Goals of Care and to discuss and document key treatment decisions

- Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
- Explore the patient's views on medications, tests, resuscitation, intensive care and preferred location of death
- If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment
- Review Goals of Care and patient preferences regularly, particularly when there is a change in clinical status

#### □ Screen for specific end of life psychosocial issues

- Assess and address patient and families' loss, grief and bereavement needs including anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Provide appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and make referrals to available resources and/or specialized services to address identified needs as required
- Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

#### □ Identify patients who could benefit from specialized palliative care services (consultation or transfer)

- As patient and family/caregiver needs increase and/or change over time consult with palliative care specialists and/or other providers with additional expertise, as required. Transfer care only if/when needs become more extensive or complex than the current team can handle
- Discuss referral with the patient and their family/caregiver

#### □ Proactively develop and implement a plan for expected death

- Explore place-of-death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic
- Prepare and support the family to understand what to expect, and plan for when a loved one is actively dying, including understanding probable symptoms, as well as the processes with death certification and how to engage funeral services
- Discuss emergency plans with patient and family (including who to contact, and when to use or avoid Emergency Medical Services)

#### □ Home care planning (if this is where care will be delivered)

- Contact the patient's primary care and home and community care providers and relevant specialist physicians to ensure an effective transfer of information related to their care. If the patient is transitioning from the hospital, this should include collaborating to develop a transition plan
- Introduce patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.)
- Connect with home and community care services early (not just in the last 2-4 weeks)
- Ensure resources and services are in place to support the patient and their family/caregiver, and address identified needs
- Anticipate/plan for pain and symptom management, including consideration for a Symptom Response Kit to facilitate access to pain, dyspnea, and delirium medication for emergency purposes
- If the patient consents to withholding cardiopulmonary resuscitation, a 'Do Not Resuscitate' order must be documented in their medical record, and a Do Not Resuscitate Confirmation (DNR-C) Form should be completed. This form should be readily accessible in the home, to ensure that the patient's wishes for a natural death are respected by Emergency Medical Services

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