

Head and Neck Cancer Guidance

The American Society of Clinical Oncology offers the following clinical guidance on treatment alternatives during shortages of antineoplastic agents. Decisions should be based on specific goals of the therapy where evidence-based medicine has shown survival outcomes and life-extending benefits in both early and advanced stages. For more information on ASCO's general principles during drug shortages, please visit ASCO's [Clinical Guidance page](#). For further consideration of ethical guidance, please visit ASCO's [Ethical Principles and Implementation Strategies page](#).

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General Principles for Head and Neck Cancer

1. Platinum agents (and cisplatin specifically) play a major role for which there is no substitution in the treatment of head and neck cancer patients.
2. This clinical advisory group recommends prioritizing head and neck cancers because there are no curative alternatives or substitutions for this cancer type.
3. Platinum should not be used in combination with radiation for cutaneous squamous cell carcinoma and salivary carcinoma nor in the postoperative radiotherapy setting for anything except positive surgical margins or extranodal extension.

Use of Cisplatin in the Potentially Curative Setting, with and without Concurrent Radiation:

1. For definitive chemotherapy/radiation therapy plans, consider limiting the cumulative concurrent dose at a total dose of 200mg/m.¹⁻³ Weekly dosing at 40 mg/m² to a cumulative dose of 200 mg/m² may be most practical to delay use of drug.
2. In institutions where carboplatin is more readily available than cisplatin, consider use of carboplatin, 5-fluorouracil (5FU) for concurrent chemoradiation.^{4,5} The use of carboplatin and paclitaxel in this setting is another alternative that is less well studied.
3. In situations where neither cisplatin nor carboplatin are available, weekly cetuximab or weekly docetaxel have shown superiority to radiation alone.^{6,7}
4. Cetuximab has been shown to be inferior to cisplatin in the concurrent chemoradiation setting in patients with HPV-associated oropharyngeal carcinoma, therefore should be avoided as a substitution if possible.⁸

5. Immunotherapy concurrent with radiation is not an acceptable substitute for platinum-based chemoradiation. The above alternatives should be considered.
6. Prioritize surgical resection (i.e., TORS) over definitive chemoradiation in patients for whom surgery can deliver comparable functional and oncologic outcomes with a reasonable probability of sparing them platinum-based adjuvant CRT.

Induction Chemotherapy:

1. In mucosal squamous cell carcinomas, there are no known alternatives to carboplatin/cisplatin in any induction regimen including cisplatin, 5-FU (PF), docetaxel, cisplatin, 5-FU (TPF), and docetaxel cisplatin (DP). However, given the lack of clear evidence showing survival improvement with induction therapy in this setting, minimizing use of induction chemotherapy is recommended.
2. For locoregionally advanced nasopharynx cancer, induction chemotherapy typically with TPF or gemcitabine/cisplatin, provides a known survival advantage and should remain prioritized.⁹

Incurable Metastatic or Recurrent Disease:

1. When there is limited availability of platinum, consider initial treatment with pembrolizumab alone for patients with high CPS scores and low-volume disease. Introduce platinum doublets for patients not responding to pembrolizumab alone.
2. In patients for whom combined chemotherapy and immunotherapy are considered optimal and no platinum is available, consider giving a taxane with a checkpoint inhibitor.
3. For patients with recurrent nasopharyngeal carcinoma, consider the use of a gemcitabine plus taxane doublet as a backbone rather than gemcitabine plus platinum doublet.
4. In patients with incurable metastatic or recurrent disease, consider possibly fewer than standard number of cycles of chemotherapy in those who have a substantial early response.
5. In general, after platinum combinations have been used, single-agent therapy is standard and does not usually include cisplatin or carboplatin, therefore standard guidance should apply for patients in this setting.

References:

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