Complete Summary

GUIDELINE TITLE

American Society of Clinical Oncology clinical practice guideline for the use of larynx-preservation strategies in the treatment of laryngeal cancer.

BIBLIOGRAPHIC SOURCE(S)

American Society of Clinical Oncology, Pfister DG, Laurie SA, Weinstein GS, Mendenhall WM, Adelstein DJ, Ang KK, Clayman GL, Fisher SG, Forastiere AA, Harrison LB, Lefebvre JL, Leupold N, List MA, O'Malley BO, Patel S, Posner MR, Schwartz MA, Wolf GT. American Society of Clinical Oncology clinical practice guideline for the use of larynx-preservation strategies in the treatment of laryngeal cancer. J Clin Oncol 2006 Aug 1;24(22):3693-704. [179 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

The American Society of Clinical Oncology (ASCO) Expert Panel will be reconvened every 3 years to discuss potential changes, or more frequently, if new information suggests that more timely modifications may be warranted. When appropriate, the Panel will recommend a revised guideline to the Health Services Research Committee and the ASCO Board for review and approval.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
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SCOPE

DISEASE/CONDITION(S)

Laryngeal cancer

Note: This guideline focuses only on invasive laryngeal cancers with squamous cell carcinoma histology and is most applicable to supraglottic and glottic tumors.

GUIDELINE CATEGORY

Management
Treatment

CLINICAL SPECIALTY

Oncology
Otolaryngology
Radiation Oncology
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To develop a clinical practice guideline for treatment of laryngeal cancer with the intent of preserving the larynx (either the organ itself or its function)

TARGET POPULATION

Patients with laryngeal cancer undergoing larynx-preservation therapies

Note: This guideline is intended for patients outside of clinical trials.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Evaluating patient's suitability for larynx-preservation approach
2. Discussing with the patient the advantages and disadvantages of larynx-preservation therapy compared with total laryngectomy
3. Radiation therapy
4. Concurrent chemoradiation therapy
5. Larynx-preservation surgery (endoscopic resection or open organ-preservation surgery)
6. Surgical treatment of the regional cervical nodes
7. Encouraging the patient to abstain from smoking and alcohol

MAJOR OUTCOMES CONSIDERED

- Overall and disease-free survival rate
- Rate of larynx preservation
- Local-regional control
- Quality of life
- Toxicity
- Cost

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A multidisciplinary Expert Panel determined the clinical management questions to be addressed and reviewed the literature available.

Pertinent information from the published literature through November 2005 was retrieved and reviewed for the creation of the guideline. Articles published from 1990 onward were emphasized. Searches were performed of MEDLINE (National Library of Medicine, Bethesda, MD) and CANCERLIT (National Cancer Institute, National Institutes of Health, Bethesda, MD) for pertinent articles. The search strategy included the following key words: "larynx" plus "chemotherapy," "surgery," "radiation therapy," "organ preservation," "neck management," "diagnosis," "surveillance," "preservation," "head and neck," "staging," or "quality of life"; "organ preservation" plus "head and neck" or "neck management." Directed searches were made of the primary articles. Search results were limited to studies involving humans and English-language articles. The Cochrane Library (http://www.cochrane.org/) was searched using the phrase "larynx cancer." Directed searches based on the bibliographies of primary articles were also performed. Recent data presented at American Society of Clinical Oncology (ASCO) Annual Meetings were added to the evidence for this guideline at the discretion of members of the Expert Panel. The results of randomized controlled trials of site-specific disease were emphasized. Randomized trials that included some patients with laryngeal cancer as well as single-arm, disease site-specific studies were also considered.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

As a service to patients, to its members, and to practicing physicians generally, the American Society of Clinical Oncology (ASCO) convened an Expert Panel under the auspices of the Health Services Committee to develop recommendations regarding the appropriate application of larynx-preservation therapies.

The members of the Expert Panel were selected for their expertise in clinical medicine; medical, radiation, and surgical oncology; diagnostic imaging; clinical research; outcomes/health services research; and related disciplines (biostatistics, quality of life) with a focus on expertise in head and neck and laryngeal cancer.

The following questions about squamous cell laryngeal cancer were addressed by the Panel:

1. What are the larynx-preservation treatment options for limited stage (T1, T2) primary site disease that do not compromise survival? What are the considerations in selecting among them?
2. What are the larynx-preservation treatment options for advanced stage (T3, T4) primary site disease that do not compromise survival? What are the considerations in selecting among them?
3. What is the appropriate treatment of the regional cervical nodes for patients with laryngeal cancer who are treated with an organ-preservation approach?
4. Are there methods for prospectively selecting patients with laryngeal cancer to increase the likelihood of success of larynx preservation?

Working groups within the Panel were created on the basis of interests and expertise, to focus on particular management questions and related review of the evidence. Each of these smaller groups developed applicable treatment recommendations and supporting text and identified areas of controversy and conflicting interpretations of the evidence. These subsections were the basis of the final document, which was then synthesized and further critiqued and revised by the Expert Panel.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Comparison of treatment costs for surgical excision and radiation therapy have been reported with varying conclusions that must be interpreted cautiously,

because all have methodologic drawbacks. In general, endoscopic surgical excision is the least expensive modality.

The limited data available regarding the relative costs of surgery compared with radiation-based larynx preservation suggest that direct medical costs are less with primary surgical management. However, potential cost savings related to increased productivity from improved function (i.e., less indirect medical costs) have not been comprehensively assessed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline underwent internal review and approval by the Expert Panel, as well as external review by additional experts, members of the American Society of Clinical Oncology (ASCO) Health Services Committee, and the ASCO Board of Directors.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Summary of Recommended Strategies for Treatment of the Primary Site for Larynx Preservation				
	Organ-Preservation Strategy			
Type of Cancer	**Recommended**	**Other Options**	**Basis for Recommendation**	**Quality of Evidence**
T1 cancer of the glottis: T1—tumor limited to the vocal cord(s) (may involve anterior or posterior commissure) with normal mobility T1a—tumor limited to one vocal cord T1b—tumor involves both vocal cords	Endoscopic resection (selected patients) OR radiation therapy	Open organ-preservation surgery	High local control rates and quality of voice after endoscopic resection compared with radiation therapy; possible cost savings; ability to reserve radiation for possible second primary cancers of the upper aerodigestive tract; however, not suitable for all patients	Comparison of outcomes from case series/ prospective single-arm studies
T2 cancer of the glottis,	Open organ-preservation	Endoscopic resection	Open organ-preservation	Comparison of outcomes from

Summary of Recommended Strategies for Treatment of the Primary Site for Larynx Preservation				
	Organ-Preservation Strategy			
Type of Cancer	**Recommended**	**Other Options**	**Basis for Recommendation**	**Quality of Evidence**
favorable*: T2—tumor extends to supraglottis and/or subglottis, or with impaired vocal cord mobility	surgery OR radiation therapy	(selected patients)	surgery is associated with highest local control rates; however, leads to permanent hoarseness; local control rates after radiation therapy are also high, and functional outcomes may be better	case series/prospective single-arm studies
T2 cancer of the glottis, unfavorable*	Open organ-preservation surgery OR concurrent chemoradiation therapy (selected patients with node-positive disease)	Radiation therapy Endoscopic resection (selected patients)	Higher local control rates after surgery compared with radiation therapy alone; quality of voice after therapy of less concern if vocal cord function is irreversibly compromised by tumor invasion; endoscopic surgery requires careful patient selection For patients with T2 N+ disease, evidence from randomized trials supports concurrent chemoradiation therapy as an organ-preservation option	Comparison of outcomes from case series/ prospective single-arm studies; randomized controlled clinical trials comparing concurrent chemoradiation therapy, and/or induction chemotherapy followed by radiation, and/or radiation therapy alone, and/or surgery followed by radiation
T1-T2 cancer of the supraglottis, favorable*: T1—tumor limited to one subsite of supraglottis with normal vocal cord mobility T2—tumor invades	Open organ-preservation surgery OR radiation therapy	Endoscopic resection (selected patients)	Open organ-preservation surgery associated with highest local control rates; however, requires temporary tracheostomy and may lead to increased risk of aspiration after therapy; local	Comparison of outcomes from case series/ prospective single-arm studies

Summary of Recommended Strategies for Treatment of the Primary Site for Larynx Preservation				
	Organ-Preservation Strategy			
Type of Cancer	**Recommended**	**Other Options**	**Basis for Recommendation**	**Quality of Evidence**
mucosa of more than one adjacent subsite of supraglottis or glottis or region outside the supraglottis (e.g., mucosa of base of tongue, vallecula, medial wall of pyriform sinus) without fixation of the larynx			control rates after radiation therapy are also high, and functional outcomes may be better	
T2 cancer of the supraglottis, unfavorable*	Open organ-preservation surgery OR concurrent chemoradiation therapy (selected patients with node-positive disease)	Radiation therapy Endoscopic resection (selected patients)	Open organ-preservation surgery is more likely to yield higher local control rates than radiation therapy; for patients with T2 N+ disease, evidence from randomized trials supports concurrent chemoradiation therapy as an organ-preservation option	Comparison of outcomes from case series/ prospective single-arm studies; randomized controlled clinical trials comparing concurrent chemoradiation therapy, and/or induction chemotherapy followed by radiation, and/or radiation therapy alone, and/or surgery followed by radiation
T3-T4 cancers of the glottis or supraglottis: T3 glottis—tumor limited to the larynx with vocal cord fixation,	Concurrent chemoradiation therapy OR open organ-preservation surgery (in highly selected patients)	Radiation therapy	Highest rate of larynx preservation is associated with concurrent chemoradiation therapy compared with other radiation-based approaches, at the cost of higher	Randomized controlled clinical trials comparing concurrent chemoradiation therapy, and/or induction chemotherapy followed by

Summary of Recommended Strategies for Treatment of the Primary Site for Larynx Preservation				
	Organ-Preservation Strategy			
Type of Cancer	**Recommended**	**Other Options**	**Basis for Recommendation**	**Quality of Evidence**
and/or invades paraglottic space, and/or minor thyroid cartilage erosion (e.g., inner cortex) T3 supraglottis—tumor limited to larynx with vocal cord fixation and/or invades any of the following: postcricoid area, pre-epiglottic tissues, paraglottic space, and/or minor thyroid cartilage erosion (e.g., inner cortex) T4a glottis or supraglottis—tumor invades through the thyroid cartilage and/or invades tissues beyond the larynx (e.g., trachea, soft tissues of neck including deep extrinsic muscle of the tongue, strap muscles, thyroid, or esophagus) T4b glottis or supraglottis—tumor invades			acute toxicities but without more long-term difficulties in speech and swallowing; when salvage total laryngectomy incorporated, no difference in overall survival; organ preservation surgery is an option in highly selected patients (e.g., there are patients with T3 supraglottic cancers that have minimal or moderate pre-epiglottic invasion and are candidates for organ preserving surgery)	radiation, and/or radiation therapy alone; and/or surgery followed by radiation; comparison of outcomes from case series/prospective single-arm studies

Summary of Recommended Strategies for Treatment of the Primary Site for Larynx Preservation				
	Organ-Preservation Strategy			
Type of Cancer	**Recommended**	**Other Options**	**Basis for Recommendation**	**Quality of Evidence**
prevertebral space, encases carotid artery, or invades mediastinal structures				

*A favorable T2 glottic lesion is defined as a superficial tumor, on radiographic imaging, with normal cord mobility. An unfavorable T2 glottic lesion is defined as a deeply invasive tumor on radiographic imaging, with or without subglottic extension, with impaired cord mobility (indicating deeper invasion). A favorable supraglottic lesion is defined as a T1 or T2 tumor with superficial invasion on radiographic imaging and preserved cord mobility, and/or tumor of the aryepiglottic fold with minimal involvement of the medial wall of the pyriform sinus. More locally advanced and invasive T2 supraglottic lesions are considered unfavorable.

What are the larynx-preservation treatment options for limited stage (T1, T2) primary site disease that do not compromise survival? What are the considerations in selecting treatment options in this setting?

Evidence base. There are no randomized studies in which radiation therapy was compared with conservation surgery with respect to local control or survival for patients with limited-stage laryngeal cancer. Similarly, there are no randomized controlled data on comparison of functional outcomes, specifically the quality of voice and swallowing ability, after surgery or radiation therapy for patients with this stage of disease.

The recommendations to address these questions are based on evidence from prospective and retrospective cohort studies. The recommendations for T2 N+ disease are based on data from randomized controlled trials of chemoradiotherapy therapy (with either induction or concurrent chemotherapy compared with radiation therapy alone or surgery followed by adjuvant radiation therapy). The outcomes assessed included overall survival, disease-free survival, rates of laryngeal preservation, local-regional control, toxicity of therapy, and cost.

Limited-stage disease represents a spectrum. Treatment selection can be challenging, as the evidence base for most decisions is derived from nonrandomized studies and various factors need to be considered when choosing therapy. Selected examples for glottic cancer are illustrative. If voice outcome is predicted to be good after endoscopic laser resection for a T1 glottic cancer (e.g., a superficial tumor located in the middle third of the cord, especially on its free edge), then use of this modality is more efficient and thus preferred. However, lesions that are indistinct, especially those arising in the context of widespread, abnormal-appearing mucosa, are more suitable for radiation therapy than for surgery. Radiation therapy is preferred by many clinicians for treatment of T2 glottic carcinoma characterized as superficial on radiographic imaging, with preserved cord mobility, as local control rates are high and anticipated functional

outcomes are good. But some investigators have noted compromised survival after the failure of radiation therapy inT2glottic carcinoma indicating the importance of obtaining initial local control. As such, supracricoid partial laryngectomy with cricohyoidoepliglottopexy remains a reasonable alternative for patients with a T2 glottic carcinoma who after pretreatment counseling would be willing to sacrifice voice quality in an effort to improve local control. Induction chemotherapy has been investigated as treatment for patients with limited-stage laryngeal cancer. However, insufficient data are currently available to recommend such an approach outside the context of a clinical trial.

Recommendations

- All patients with T1-T2 laryngeal cancer should be treated, at least initially, with intent to preserve the larynx.
- T1-T2 laryngeal cancer can be treated with radiation or larynx-preservation surgery with similar survival outcomes. Selection of treatment depends on patient factors, local expertise, and the availability of appropriate support and rehabilitative services. Every effort should be made to avoid combining surgery with radiation therapy because functional outcomes may be compromised by combined-modality therapy; single-modality treatment is effective for limited-stage, invasive cancer of the larynx.
- Surgical excision of the primary tumor with intent to preserve the larynx should be undertaken with the aim of achieving tumor-free margins; so-called narrow-margin excision followed by postoperative radiation therapy is not an acceptable treatment approach.
- Local tumor recurrence after radiation therapy may be amenable to salvage by organ-preservation surgery, but total laryngectomy will be necessary for a substantial proportion of patients, especially those with index T2 tumors.
- Concurrent chemoradiotherapy therapy may be used for larynx preservation for selected patients with stage III, T2 N+ cancers when total laryngectomy is the only surgical option, when the functional outcome after larynx-preservation surgery is expected to be unsatisfactory, or when surgical expertise in such procedures is not available.
- Limited-stage laryngeal cancer constitutes a wide spectrum of disease. The clinician must exercise judgment when recommending treatment in this category. For a given patient, factors that may influence the selection of treatment modality include extent and volume of tumor; involvement of the anterior commissure; lymph node metastasis; the patient's age, occupation, preference, and compliance; availability of expertise in radiation therapy or surgery; and history of a malignant lesion in the head and neck.

What are the larynx-preservation treatment options for advanced stage (T3, T4) primary site disease that do not compromise survival? What are the considerations in selecting among them?

Evidence base. The recommendations to address these questions are based on evidence from randomized controlled trials of different radiation fractionation schedules, chemoradiotherapy therapy (either induction or concurrent) compared with radiation therapy alone or surgery followed by adjuvant radiation therapy, on meta-analysis or other secondary analysis of data from randomized clinical trials, and on prospective and retrospective cohort studies. The outcomes evaluated

included overall survival, disease-free survival, rates of laryngeal preservation, local-regional control, toxicity of therapy, and cost.

Recommendations

- Organ-preservation surgery, concurrent chemoradiotherapy therapy, and radiation therapy alone, all with further surgery reserved for salvage, offer potential for larynx preservation without compromising survival. Anticipated success rates for larynx preservation, associated toxicities, and suitability for a given patient will vary among these approaches. Selection of a treatment option will depend on patient factors, local expertise, and the availability of appropriate support and rehabilitation services.
- All patients should be evaluated regarding their suitability for a larynx-preservation approach, and they should be apprised of these treatment options. No larynx-preservation approach offers a survival advantage compared with total laryngectomy and appropriate adjuvant treatment.
- A minority of patients with T3-T4 primary site disease will be suitable for specialized organ-preservation procedures, such as a supracricoid partial laryngectomy. The addition of postoperative radiation therapy will compromise anticipated functional outcomes. Induction chemotherapy before organ-preservation surgery is not recommended outside of a clinical trial.
- Concurrent chemoradiotherapy therapy offers a significantly higher chance of larynx preservation than does radiation therapy alone or induction chemotherapy followed by radiation, albeit at the cost of higher acute in-field toxicities.
- The best available evidence supports the use of cisplatin as the drug of choice in this setting.
- There is insufficient evidence to indicate that survival or larynx-preservation outcomes are improved by the addition of induction chemotherapy before concurrent treatment or the use of concurrent chemotherapy with altered fractionated radiation therapy in this setting.
- For patients who desire larynx-preservation therapy but are not candidates for organ-preservation surgery or chemoradiotherapy therapy, radiation therapy alone is an appropriate treatment. With this last approach, survival is similar to that associated with chemoradiotherapy therapy when salvage surgery is incorporated, but the likelihood of larynx preservation is lower.

What is the appropriate treatment of the regional cervical nodes in patients with laryngeal cancer who are treated with an organ-preservation approach?

Evidence base. There are no randomized studies that address treatment of the neck for limited-stage disease in the primary site. The randomized studies of more advanced primary disease do not focus on treatment of the neck as a primary end point.

The recommendations to address this question are based on evidence from derivative analyses of randomized controlled trials of chemoradiotherapy (either induction or concurrent) compared with radiation therapy alone or surgery followed by adjuvant radiation therapy, a randomized trial comparing the different types of neck dissection, and on prospective and retrospective cohort studies. With respect to adjuvant therapy, evidence was drawn from randomized

controlled trials of radiation therapy compared with concurrent chemoradiotherapy. The outcomes assessed included overall survival, disease-free survival, local-regional control, and toxicity of therapy.

Recommendations

- Most patients with T1-T2 lesions of the glottis and clinically negative cervical nodes (N0) do not require routine elective treatment of the neck.
- Patients with advanced lesions of the glottis and all patients with supraglottic lesions should have elective treatment of the neck, even if clinically N0.
- Patients with clinically involved regional cervical nodes (N1) who are treated with definitive radiation therapy or chemoradiotherapy therapy and who have a complete clinical response do not require elective neck dissection. Neck dissection should be performed for patients who do not have a complete clinical response to radiation therapy.
- Surgical treatment of the neck is recommended for patients with N2 or N3 disease who are treated with definitive radiation therapy or chemoradiotherapy therapy, regardless of response. Some surgeons and patients are reluctant to risk the morbidity of neck dissection, given the prospect of a negative pathologic diagnosis in most cases, but there is no standard imaging approach in this setting that has been validated to significantly improve on this decision-making process. Salvage surgery for recurrent disease in the neck is rarely successful if subsequently required in this setting. These two points should be discussed with all patients who have an apparent complete clinical response to radiation therapy or chemoradiotherapy therapy and choose to be followed up with expectant observation.
- Patients with clinically involved cervical nodes who are treated with surgery for the primary lesion should have neck dissection. If there are poor-risk features, adjuvant concurrent chemoradiotherapy therapy is indicated.

Are there methods for prospectively selecting patients with laryngeal cancer to increase the likelihood of successful larynx preservation?

Evidence base. The recommendations addressing this question are based on evidence from prospective and retrospective cohort studies of clinical, radiographic, and/or pathologic parameters associated with clinical outcomes and on derivative analyses of a randomized controlled trial. The outcomes assessed included overall survival, disease-free survival, local-regional control, and rates of laryngeal preservation.

Recommendations

- There are no validated markers that consistently predict outcomes of larynx-preservation therapy. However, patients with tumor penetration through cartilage into soft tissues are considered poor candidates for a larynx-preservation approach. Primary surgery, usually total laryngectomy, is commonly recommended in this setting.
- Selection of therapy for an individual patient requires assessment by a multidisciplinary team, as well as consideration of patient comorbidity, psychosocial situation and preferences, and local therapeutic expertise.

- Continued cigarette smoking appears to be associated with a worse outcome after radiation therapy. Patients should be encouraged to abstain from smoking after diagnosis and throughout treatment.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations for limited stage (T1, T2) primary site disease are based on evidence from prospective and retrospective cohort studies. The recommendations for T2 N+ disease are based on data from randomized controlled trials of chemoradiotherapy therapy (with either induction or concurrent chemotherapy compared with radiation therapy alone or surgery followed by adjuvant radiation therapy).

The recommendations for advanced stage (T3, T4) primary site disease are based on evidence from randomized controlled trials of different radiation fractionation schedules, chemoradiotherapy therapy (either induction or concurrent) compared with radiation therapy alone or surgery followed by adjuvant radiation therapy, on meta-analysis or other secondary analysis of data from randomized clinical trials, and on prospective and retrospective cohort studies.

The recommendations for the appropriate treatment of the regional cervical nodes in patients with laryngeal cancer are based on evidence from derivative analyses of randomized controlled trials of chemoradiotherapy (either induction or concurrent) compared with radiation therapy alone or surgery followed by adjuvant radiation therapy, a randomized trial comparing the different types of neck dissection, and on prospective and retrospective cohort studies. With respect to adjuvant therapy, evidence was drawn from randomized controlled trials of radiation therapy compared with concurrent chemoradiotherapy.

The recommendations for methods for prospectively selecting patients with laryngeal cancer to increase the likelihood of successful larynx preservation are based on evidence from prospective and retrospective cohort studies of clinical, radiographic, and/or pathologic parameters associated with clinical outcomes and on derivative analyses of a randomized controlled trial.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Larynx-preservation therapy is intended to offer improved function and quality of life for patients with laryngeal cancer without compromising survival. Optimal patient selection increases the likelihood of a successful outcome.

POTENTIAL HARMS

Adverse effects of treatment include weight loss, feeding tube required, febrile neutropenia, swallowing difficulties, persistent dysphagia, aspiration, chronic tracheostomy, toxic death, and radiation toxicity.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

It is important to realize that many management questions have not been comprehensively addressed in randomized trials and guidelines cannot always account for individual variation among patients. A guideline is not intended to supplant physician judgment with respect to particular patients or special clinical situations and cannot be considered inclusive of all proper methods of care or exclusive of other treatments reasonably directed at obtaining the same results. Accordingly, the American Society of Clinical Oncology (ASCO) considers adherence to this guideline to be voluntary, with the ultimate determination regarding its application to be made by the physician in light of each patient's individual circumstances. In addition, the guideline describes administration of therapies in clinical practice; it cannot be assumed to apply to interventions performed in the context of clinical trials, given that clinical studies are designed to test innovative and novel therapies in a disease and setting for which better therapy is needed.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources
Personal Digital Assistant (PDA) Downloads
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Society of Clinical Oncology, Pfister DG, Laurie SA, Weinstein GS, Mendenhall WM, Adelstein DJ, Ang KK, Clayman GL, Fisher SG, Forastiere AA, Harrison LB, Lefebvre JL, Leupold N, List MA, O'Malley BO, Patel S, Posner MR, Schwartz MA, Wolf GT. American Society of Clinical Oncology clinical practice guideline for the use of larynx-preservation strategies in the treatment of laryngeal cancer. J Clin Oncol 2006 Aug 1;24(22):3693-704. [179 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Aug 1

GUIDELINE DEVELOPER(S)

American Society of Clinical Oncology - Medical Specialty Society

SOURCE(S) OF FUNDING

American Society of Clinical Oncology

GUIDELINE COMMITTEE

American Society of Clinical Oncology (ASCO) Expert Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Panel Members: David G. Pfister, MD (*Co-Chair*) Memorial Sloan-Kettering Cancer Center; Gregory T. Wolf, MD (*Co-Chair*) University of Michigan Hospital; David J. Adelstein, MD, Cleveland Clinic Foundation; Kie-Kian Ang, MD, PhD, University of Texas M.D. Anderson Cancer Center; Gary L. Clayman, MD, University of Texas M.D. Anderson Cancer Center; Susan G. Fisher, PhD, University of Rochester; Arlene A. Forastiere, MD, Johns Hopkins University, The Sidney Kimmel Cancer Center; Louis B. Harrison, MD, Beth Israel Health Care System; Scott A. Laurie, MD, The Ottawa Hospital Regional Cancer Centre; Jean-Louis Lefebvre, MD, Centre Oscar-Lambret; Nancy Leupold, MS, Support for People with Oral and Head and Neck Cancer (SPONHC); Marcy A. List, PhD, University of Chicago; William M. Mendenhall, MD, University of Florida; Bernard O'Malley, MD, Princeton Radiology Association; Marshall R. Posner, MD, Dana-Farber Cancer Institute; Michael A. Schwartz, MD, Oncology Hematology Associates; Snehal Patel, MD, Memorial Sloan-Kettering Cancer Center; Gregory S. Weinstein, MD, University of Pennsylvania School of Medicine

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Although all authors completed the disclosure declaration, the following authors or their immediate family members indicated a financial interest. No conflict exists for drugs or devices used in a study if they are not being evaluated as part of the investigation. For a detailed description of the disclosure categories, or for more information about American Society of Clinical Oncology's (ASCO's) conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

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Authors	Employment	Leadership	Consultant	Stock	Honoraria	Research Funds	Testimony	Other
			Amgen (A); Sanofi-Aventis (A); Caltech (A); Med Immune (A)		Sanofi-Aventis (A); Bristol-Myers Squibb (A);Med Immune (A)			
Michael A. Schwartz*								
Gregory T. Wolf*								

Dollar Amount Codes: (A) <$10,000; (B) $10,000-99,999; (C) ≥$100,000; (N/R) Not Required

*No significant financial relationships to disclose.

GUIDELINE STATUS

This is the current release of the guideline.

The American Society of Clinical Oncology (ASCO) Expert Panel will be reconvened every 3 years to discuss potential changes, or more frequently, if new information suggests that more timely modifications may be warranted. When appropriate, the Panel will recommend a revised guideline to the Health Services Research Committee and the ASCO Board for review and approval.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Society of Clinical Oncology (ASCO) Web site.

Print copies: Available from American Society of Clinical Oncology, Cancer Policy and Clinical Affairs, 1900 Duke Street, Suite 200, Alexandria, VA 22314; E-mail: guidelines@asco.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- American Society of Clinical Oncology clinical practice guideline for the use of larynx-preservation strategies in the treatment of laryngeal cancer. Unabridged version. 2006 Feb. 69 p. Electronic copies: Available in Portable Document Format (PDF) from the American Society of Clinical Oncology (ASCO) Web site.
- ASCO clinical practice guideline for the use of larynx-preservation strategies in the treatment of laryngeal cancer: guideline summary. J Oncol Prac 2006

Sep; 2(5):258-61. Electronic copies: Available in Portable Document Format (PDF) from the *Journal of Oncology Practice* Web site.
- Use of larynx-preservation strategies in the treatment of laryngeal cancer. Slide set. 2006. 30 p. Electronic copies: Available in Portable Document Format (PDF) from the American Society of Clinical Oncology (ASCO) Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Guidelines are available for Personal Digital Assistant (PDA) download from the ASCO Web site.

PATIENT RESOURCES

The following is available:

- ASCO patient guide: preserving the larynx during cancer treatment. 2006 Jul. 3 p.

Available from the Cancer.Net Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site

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