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The Evolving Landscape of Resectable Locally Advanced HNSCC

Announcer:

Welcome to CE on ReachMD. This activity is provided by TotalCME. This episode is part of our MinuteCE curriculum.

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Dr. Uppaluri:

This is CE on ReachMD, and I'm Dr. Ravindra Uppaluri. Today, I'll provide a brief overview of the evolving treatment landscape of resectable locally advanced head and neck squamous cell carcinoma, abbreviated here as LA HNSCC.

For surgically resectable squamous cell carcinoma of the head and neck, management has progressed over the last several decades from a primary surgery-based approach to one integrating surgery with radiation and then with multimodality therapy. In 2004, two phase 3 trials highlighted that addition of cisplatin chemotherapy to adjuvant radiation in patients with high-risk features in the surgically resected specimens improved outcomes.

According to the National Comprehensive Cancer Network Guidelines, surgery is a preferred modality for many patients with locally advanced disease. With an advanced primary tumor, the lymph node basins are also recommended to be addressed surgically. Adjuvant treatment is based on pathology-directed features for the resected primary tumor and lymphadenectomy specimens. Patients with no adverse features are treated with radiation as adjuvant treatment. Those with adverse pathologic features of extranodal extension of tumor in the resected lymph nodes or a positive margin in the primary tumor resection are recommended to undergo adjuvant radiation with addition of cisplatin.

The recommendation for adjuvant treatment was based on studies from European and North American cooperative group studies. These studies provided level 1 evidence for treatment intensification for high-risk pathologic feature patients. These patients who received adjuvant postoperative high-dose cisplatin and radiation had improved outcomes. However, the outcomes remain suboptimal, with these patients still having up to approximately 35% locoregional recurrence plus distant metastatic rate within 1 year of completing treatment.

These 2 studies utilized different criteria for defining high-risk patients from the pathologic specimens. Follow-up analysis of these criteria, as shown in this Venn diagram, identified that positive margins and extracapsular extension—or now called extranodal extension—were the most significant prognostic factors for poor outcomes in these patients.

Here, I discuss the findings from the RTOG cooperative group study. Local or regional recurrence was significantly improved in those patients receiving combined therapy versus radiotherapy alone. Similarly, disease-free survival was significantly longer in the combined therapy group versus the radiation therapy group. However, in this study, overall survival was not significantly different between the 2

groups.

Here are shown data from the European cooperative group study. This study highlighted that the combined therapy group had reduced rates of local or regional relapse compared to the single modality radiotherapy-alone group. Overall survival was also improved in the combined therapy group versus the radiotherapy group alone.

Thus, these 2 studies really have set the standard for the last 2 decades in this field, with patients with high-risk features receiving high-dose cisplatin in addition to adjuvant radiation as a recommended therapy.

However, suboptimal outcomes still are a key concern for patients and providers. These suboptimal outcomes include the toxicities of treatment and the concern for disease recurrence.

Together, despite this standard of care as providing advance for some patients within head and neck cancer, the poor outcomes have engendered further studies, including the KEYNOTE-689 and NIVOPOSTOP study.

Well, my time is up. I hope you found this overview useful. Thank you for listening.

Announcer:

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