Survivorship – Benign Salivary Gland Tumor

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ELIGIBILITY

Benign Salivary Tumor treated with surgery only (no radiation), 1 year post-treatment, no recurrent lesions, and NED

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

- Transition[1] to HNSVC within 12 months to include:
  - History and physical exam annually with:
  - MRI neck with and without contrast preferred (CT neck with contrast is appropriate alternative per baseline imaging study)
  - US neck/salivary gland[2] is primarily for lymph node evaluation and as image-guided sampling of suspicious superficial recurrence

MONITORING FOR LATE EFFECTS

Consider:
- Lymphedema assessment
- Xerostomia assessment
- Dental/trismus assessment
- Frey's Syndrome assessment (gustatory sweating)

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling and screening:
- Lifestyle risk assessment[4]
- Cancer screening[5]
- Vaccinations[6] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular risk reduction[7]
- Limit alcohol consumption

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Anxiety/depression
- Body image
- Social support
- Financial stressors

Suspected new primary cancer or recurrent tumor?

DISPOSITION

Yes:
- Return to primary treating physician
  - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[3]

No:
- Continue survivorship monitoring

Refer or consult as indicated

NED = no evidence of disease
HNSVC = Head and Neck Survivorship clinic
US = ultrasound

[1] Patient may prefer local follow-ups with their primary provider or transition to the HNSVC at MD Anderson
[2] Imaging is recommended for 5 years as clinically indicated
[3] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).
[4] See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[5] Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[6] Based on Centers for Disease Control and Prevention (CDC) guidelines
[7] Consider use of Vanderbilt's ABCDE's approach to cardiovascular health

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SUGGESTED READINGS

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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