Guidelines for Nutrition in Adults with Head and Neck Cancer: The American Society for Parenteral and Enteral Nutrition

PRACTICE TOOL

Head and neck cancer is the seventh most common cancer worldwide. Maintaining adequate nutrition is important because malnutrition and muscle loss contribute to worse outcomes, yet many patients cannot maintain sufficient oral intake during treatment. This guideline provides ASPEN's recommendations for nutrition care in these patients. Kiss N, Findlay M, Frowen J, et al. Guidelines for nutrition in adults with head and neck cancer: The American Society for Parenteral and Enteral Nutrition. *JPEN J Parenter Enteral Nutr.* 2026 Mar 3. doi: 10.1002/jpen.70067.

Questions	Guideline Recommendations
1a. In adult patients with head and neck cancer receiving chemoradiation or radiation, does earlier enteral nutrition (EN) versus later EN change progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicities, unplanned hospital admission?	**1a.** In adults with head and neck cancer planned for or receiving radiotherapy with or without chemotherapy or other systemic therapy, we suggest initiation of enteral feeding where there is clinical evidence that nutritional intake or status is compromised, despite other strategies (oral nutrition supplements, food fortification) having been attempted. This should be individualized to oral nutrition intake, symptom burden, and nutrition status while considering individual treatment plans and clinical, psychosocial, and socioeconomic status.
1b. In adult patients with head and neck cancer, does longer post-operative nutrition (EN or oral nutrition supplements) versus shorter duration of nutrition support change progression-free survival, overall survival, nutrition intake, time to transition to full oral diet, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, length of stay, surgical complications, hospital readmissions?	**1b.** In adults with head and neck cancer, we suggest early commencement (within 24 hours) of post-operative nutrition intake (EN, oral, or otherwise) to meet estimated nutrition requirements. Early initiation of oral intake should occur in consultation with the surgical team, dietitian, and speech pathologist. To meet nutrition requirements, oral intake should be increased gradually, and supplementary enteral feeding should be maintained until sufficient oral intake is established. Early initiation of oral intake may be inappropriate in certain situations, making consultation with surgical, speech, and nutrition teams critical.
1c. In adult patients with head and neck cancer, does increasing the frequency of dietetic intervention versus standard care during chemoradiation or radiation and up to 3 months post-treatment change progression-free survival, overall survival, nutrition intake, time to transition to full oral diet, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicities, unplanned hospital admissions?	**1c.** In adults with head and neck cancer receiving radiotherapy with or without chemotherapy or other systemic therapy, we recommend weekly consultation with a dietitian during treatment and every two weeks for up to 6 weeks after treatment to maintain nutrition status and quality of life while preventing unplanned hospital admissions and early cessation of treatment.
1d. In adult patients with head and neck cancer, does longer pre- and postoperative intervention by a dietitian compared to shorter intervention duration change progression-free survival, overall survival, nutrition intake, time to transition to full oral diet nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, length of stay, surgical complications, hospital readmissions?	**1d.** In adults with head and neck cancer, we recommend that the duration of dietitian intervention pre- and postoperatively should be individualized according to the patient's nutrition status, swallowing function, symptom burden, and clinical, psychosocial, and socioeconomic status. Intervention should continue while there remains a risk to nutrition status from nutrition-impact symptoms, reduced dietary intake, continued indication for nutrition support, and/or other factors relating to nutritional risk. Patients undergoing certain surgical procedures, such as those with extensive surgical resections (e.g., free flap reconstructions) or with dysphagia, may require dietetic support for a longer duration.

Continued on next page

Questions	Guideline Recommendations
2a. In adult patients with head and neck cancer receiving any treatment modality, does nutrition screening versus not screening impact progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicities, surgical complications, length of stay, unplanned hospital admission or readmission?	**2a.** In adults with head and neck cancer, we recommend that all patients be screened for malnutrition using a validated tool at their first presentation to the healthcare facility and regularly throughout treatment and recovery to facilitate timely referral for nutrition intervention. In certain patient subgroups who are at higher risk of malnutrition, screening may be bypassed if processes are established for automatic referral to a dietitian.
2b. In adult patients with head and neck cancer receiving any treatment modality, does nutrition assessment versus no nutrition assessment change progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicities, surgical complications, length of stay, unplanned hospital admission or readmission?	**2b.** In adults with head and neck cancer, we recommend that patients undergo a comprehensive nutrition assessment if they have been screened and found to be at risk of malnutrition, if they are automatically referred through established protocols due to high malnutrition risk, or if they present with an enteral access device, either planned or already in situ. We further recommend this assessment be performed by a dietitian or other qualified nutrition professional using a tool that has been validated in the oncology population (e.g., patient-generated subjective global assessment (PG-SGA) or subjective global assessment (SGA).
3a. In adult patients with head and neck cancer receiving any treatment modality, does intensive nutrition therapy designed to meet current recommendations for protein intake versus standard care change progression-free survival, overall survival, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admission or readmission?	**3a.** In adults with head and neck cancer receiving any modality of treatment, we recommend a protein intake of 1.2-1.5 g/kg/day, which would meet the needs of most patients with head and neck cancer. This may be met and maintained through one or a combination of oral intake, oral nutrition supplements, or EN to meet protein requirements and should be tailored to symptom burden and nutrition status while considering individual treatment plans, clinical, psychosocial, and socioeconomic status.
3b. In adult patients with head and neck cancer receiving any treatment modality, does intensive nutrition therapy designed to meet current recommendations for energy intake versus standard care change progression-free survival, overall survival, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admission or readmission?	**3b.** In adults with head and neck cancer receiving any modality of treatment, we recommend an energy intake of at least 30 kcal/kg/day. This may be met and maintained through one or a combination of oral intake, oral nutrition supplements, or EN to meet energy requirements and should be tailored to symptom burden and nutrition status while considering individual treatment plans, clinical, psychosocial, and socioeconomic status. Nutrition status should be monitored regularly to determine if energy intake is sufficient, noting that sufficient energy intake is also important to ensure protein intake is utilized for the preservation of muscle mass.
4a. In adult patients with head and neck cancer receiving any treatment modality, does estimating protein requirements based on an alternate body weight or composition versus standard care (actual weight) change progression-free survival, overall survival, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admissions or readmission?	**4a.** In adults with head and neck cancer receiving any treatment modality, due to insufficient evidence at present to demonstrate a benefit from individualizing protein requirements based on body composition, we suggest estimating protein requirements based on actual body weight. However, the risk of overestimating protein requirements in patients with obesity is higher. An acceptable solution to this may be to use the higher end of ideal body weight or to use actual body weight, while using clinical judgment to determine if the resulting target protein amount is achievable. We recommend ongoing monitoring of nutrition intake alongside nutrition status, muscle mass, muscle strength, and physical performance as an indication of adequacy of protein intake.

Continued on next page

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4b. In adult patients with head and neck cancer receiving any treatment modality, does estimating energy requirements based on an alternate body weight or composition versus standard care (actual weight) change progression-free survival, overall survival, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admission or readmission?	**4b.** In adults with head and neck cancer receiving any treatment modality, we suggest estimating energy requirements based on actual body weight due to insufficient evidence at present to demonstrate a benefit from individualizing energy requirements based on body composition. However, the risk of overestimating energy requirements in patients with obesity is higher. In this situation, either ideal body weight or actual body weight may be used with clinical judgment to determine if the resulting target energy requirement is achievable. We recommend ongoing monitoring of nutrition intake alongside weight, nutrition status, muscle mass, muscle strength, and physical performance as an indication of adequacy of energy intake.
5. In adult patients with head and neck cancer receiving any treatment modality, does gastrostomy feeding (via PEG or radiologically inserted gastrostomy (RIG)) versus nasogastric tube (NGT) feeding change progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, dysphagia, incidence of stricture, fistula development, global quality of life, fatigue, return to work, performance status, treatment completion, feeding tube dependence, time of transition to full oral diet, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admission or readmission?	**5.** In adults with head and neck cancer receiving any treatment modality, we suggest that the decision to place a PEG or RIG tube versus an NGT is made through discussion amongst interdisciplinary team members that includes a dietitian or other member with nutrition training. The decision regarding the type of enteral access device should be based on the clinical situation (including tumor location and stage), symptom burden (especially preexisting dysphagia), treatment plan, psychosocial situation, and the anticipated duration of enteral feeding. If EN is indicated, feeding via PEG/RIG may be more appropriate when anticipated for longer durations (commonly greater than 4-6 weeks); otherwise, an NGT should be considered.
6. In adult patients with head and neck cancer receiving any treatment modality, does more frequent speech pathology intervention compared to standard of care change time to transition to full oral diet, progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, dysphagia, global quality of life, fatigue, return to work, performance status, treatment completion feeding tube dependence, incidence of stricture, fistula development, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admission or readmission?	**6.** In adults with head and neck cancer receiving any treatment modality, we recommend consultation by a speech pathologist before treatment (surgery or radiotherapy with or without chemotherapy) for baseline assessment and education if the treatment is likely to affect swallowing function, or in the case of pre-existing dysphagia. We recommend that the frequency of consultation by a speech pathologist during and after radiotherapy (with or without chemotherapy) and after surgery be guided by the treatment plan, as well as the severity of dysphagia and other treatment toxicities. Additional considerations include clinical, psychosocial, and socioeconomic status. Interventions should be tailored to reduce dysphagia risk, minimize malnutrition, and improve quality of life. These interventions may include the maintenance of oral intake throughout radiotherapy (if safe to do so), prophylactic or therapeutic swallowing exercises, texture modification, swallowing maneuvers, compensatory strategies, and education.
7. In adult patients with head and neck cancer undergoing any treatment modality, does an interdisciplinary approach to nutrition management versus standard care change progression-free survival, overall survival, nutrition intake, time to transition to full oral diet, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion feeding tube dependence, treatment interruptions, treatment toxicity, surgical complications, length of stay, unplanned hospital admission or readmission?	**7.** In adults with head and neck cancer, we recommend an interdisciplinary approach to nutrition management. An interdisciplinary approach should involve collaboration between health professionals with the expertise to manage any symptom or issue that is affecting or anticipated to affect the patient's nutrition intake or nutrition status. We recommend that the core team for nutrition management include dietitians, nurses, pharmacists, physicians, and speech pathologists. Additional members may include dental professionals, physical therapists, psychologists, and social workers.

Continued on next page

Questions	Guideline Recommendations
8. In adult patients with head and neck cancer receiving any treatment modality, does a pharmaceutical appetite stimulant compared to no pharmaceutical appetite stimulant change progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicities, surgical complications, length of stay, unplanned hospital admission or readmission?	**8.** In adults with head and neck cancer who are experiencing anorexia and receiving any treatment modality, we suggest dietary counseling (including oral nutrition supplements or enteral feeding) and management of other symptoms that are affecting oral intake as first-line strategies to address anorexia and improve nutrition intake. Otherwise, a pharmaceutical appetite stimulant may be considered for short-term use where clinically appropriate. In conjunction with the medical team and dietitian, this decision should ideally include discussion with a pharmacist specializing in oncology.
9. In adult patients with head and neck cancer receiving chemoradiation or radiation, does continuing oral intake (if tolerated) after the initiation of EN compared to not continuing oral intake change progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia (skeletal muscle mass + strength), myeosteatosis, dysphagia, incidence of stricture, global quality of life, fatigue, return to work, performance status, treatment completion, feeding tube dependence, time of transition to a full oral diet, surgical complications, length of stay or hospital readmission?	**9.** In adults with head and neck cancer who have commenced EN and who can safely continue oral intake per consult with a speech pathologist, we suggest that continuing any degree of oral intake may be beneficial for maintaining swallow function. The amount, type, and texture of the oral intake will be dependent upon swallow safety and treatment toxicities. The volume and timing of enteral feeding should be adjusted according to what is consumed orally to optimize the opportunity for the patient to continue oral intake while also ensuring that nutrition requirements are met.
10. In adult patients with head and neck cancer receiving any treatment modality, does use of special purpose nutrients (e.g., arginine, glutamine) compared to not using special purpose nutrients change progression-free survival, overall survival, nutrition intake, nutrition status, weight, muscle mass, sarcopenia, myeosteatosis, global quality of life, fatigue, return to work, performance status, treatment completion, treatment interruptions, treatment toxicities, surgical complications, length of stay, unplanned hospital admission or readmission?	**10. Arginine:** Given the limited evidence on progression-free and overall survival and some evidence of benefit for decreased fistula development and length of stay in adults with head and neck cancer, we suggest that using arginine-supplemented nutrition may be acceptable at the discretion of the interdisciplinary team. **Glutamine:** Oral/enteral glutamine has been shown to reduce the severity of oral mucositis, with the potential to reduce other treatment toxicities and hospitalization, and improve treatment completion. We therefore suggest that the use of oral/enteral glutamine in patients with head and neck cancer may be acceptable at the discretion of the interdisciplinary team. Intravenous glutamine is more controversial due to one small study that reported increased mortality in the patients receiving intravenous glutamine and recent preclinical trials suggesting mechanisms through which glutamine may contribute to tumor growth and treatment resistance. For this reason, we suggest not adding parenteral glutamine to standard nutrition therapy in patients with head and neck cancer until further research becomes available to confirm its safety. **Omega-3 fatty acids:** Given the inconsistent evidence for benefit but no evidence of significant harms in patients with head and neck cancer, we suggest that omega-3-supplemented nutrition is unlikely to be harmful and may be used or not at the discretion of the interdisciplinary team. **Combined special purpose nutrient formulas:** In patients with head and neck cancer, given the inconsistent evidence for benefit but no evidence of significant harms, we suggest that the use of combined special-purpose nutrient or immunonutrition-supplemented formulas is unlikely to be harmful and may be used or not at the discretion of the interdisciplinary team.