Occult Primary
(Cancer of Unknown Primary [CUP])
NCCN Guidelines Version 1.2013 Panel Members
Occult Primary

David S. Ettinger, MD/Chair †
The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins

Mark Agulnik, MD †
Robert H. Lurie Comprehensive Cancer Center of Northwestern University

Justin M. Cates, MD, PhD ≠
Vanderbilt-Ingram Cancer Center

Mihaela Cristea, MD †
City of Hope Comprehensive Cancer Center

Efrat Dotan, MD †
Fox Chase Cancer Center

Keith D. Eaton, MD, PhD ‡
Fred Hutchinson Cancer Research Center/Seattle Cancer Center Alliance

Panagiotis M. Fidias, MD ‡
Massachusetts General Hospital Cancer Center

David Gierada, MD φ
Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine

Jon P. Gockerman, MD † ‡
Duke Cancer Institute

Charles R. Handorf, MD, PhD ≠
St. Jude Children’s Research Hospital/University of Tennessee Cancer Institute

Renuka Iyer, MD † ♡
Roswell Park Cancer Institute

Renato Lenzi, MD †
The University of Texas MD Anderson Cancer Center

John Phay, MD ¶
The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute

Leonard Saltz, MD † ‡
Memorial Sloan-Kettering Cancer Center

Lawrence N. Shulman, MD † ‡
Dana-Farber/Brigham and Women’s Cancer Center

Jeffrey B. Smerage, MD, PhD ‡
University of Michigan Comprehensive Cancer Center

Gauri R. Varadhachary, MD †
The University of Texas MD Anderson Cancer Center

Jonathan S. Zager, MD ¶
Moffitt Cancer Center

Weining (Ken) Zhen, MD §
UNMC Eppley Cancer Center at The Nebraska Medical Center

Asif Rashid, MD ≠
The University of Texas MD Anderson Cancer Center

NCCN
Deborah Freedman-Cass, PhD
Mary Anne Bergman

† Medical Oncology
¶ Surgery/Surgical oncology
§ Radiation oncology/Radiotherapy
‡ Hematology/hematology oncology
φ Internal medicine
≠ Pathology
♡ Diagnostic/Interventional Radiology
* Writing Committee Member

NCCN Guidelines Panel Disclosures

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Summary of changes in the 1.2013 version of the Occult Primary Guidelines from the 1.2012 version include:

**OCC-1**
Initial Evaluation
- Deleted “PET/CT scan (category 2B)”
- Placed footnote “b” to “Chest/abdominal/pelvic CT scan.
- Modified footnote “b” to read, “Routine use of PET/CT is not recommended. PET/CT scans may be warranted in some situations.”

**OCC-3**
Additional Workup
- Added “Neck” to “chest/abdominal/pelvic CT scan (if not done).
- Modified 2nd bullet to read, “Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated.” (Also for OCC-4, OCC-5, OCC-6)
- Removed (eg; ER/PR, HER2) after Appropriate immunohistochemistry. (Also for OCC-4, OCC-5, OCC-6)

**OCC-7**
Management Based On Workup Findings
- Last branch 5th bullet, deleted “Mediastinal” Treat per NCCN Testicular Cancer Guidelines in young men.

**OCC-9**
- Second branch: changed ER/PR to “Breast marker”

**OCC-16**
- Two bullets are new to the page:
  - For patients with either active disease, or localized disease in remission, follow-up frequency should be determined by clinical need.
  - For patients with active and incurable disease, psycho-social support, symptom management, end-of-life discussions, palliative care interventions and hospice care should all be considered and utilized as appropriate. See NCCN Palliative Care Guidelines and NCCN Distress Management Guidelines.

**OCC-A (1 of 4)**
- Modified footnote to read, “Other pan-cytokeratin markers are available and may be more appropriate.”

**OCC-A (4 of 4)**
- Under Lung adeno CA
  - Changed CEA+ to “NapsinA”

**OCC-B (2 of 4)**
- The following regimens were added as chemotherapy options for adenocarcinoma:
  - mFOLFOX6
  - CapeOx

**OCC-B (3 of 4)**
- The following regimens were added as chemotherapy options for squamous cell:
  - Paclitaxel/Carboplatin
  - Cisplatin/Gemcitabine
  - mFOLFOX6
  - Paclitaxel/Cisplatin
  - Docetaxel/Carboplatin
  - Docetaxel/Cisplatin
  - Cisplatin/Fluorouracil
  - Paclitaxel/Cisplatin/5-FU was removed as a chemotherapy option for squamous cell carcinoma.

**MS-1**
- The Discussion section has been updated to reflect the changes in the 1.2013 version of the Occult Primary Guidelines.
**INITIAL EVALUATION**

- Complete H&P, including breast, genitourinary, pelvic, and rectal exam, with attention to and review of:
  - Past biopsies or malignancies
  - Removed lesions
  - Spontaneously regressing lesions
  - Existing imaging studies
- CBC
- Electrolytes
- Liver function tests
- Creatinine
- Calcium
- Chest/abdominal/pelvic CT scan
- Hemoccult
- Symptom directed endoscopy

**WORKUP**

- Biopsy:
  - Core needle biopsy (preferred) and/or FNA of most accessible site
  - Consult pathologist for adequacy of specimen and additional studies including immunohistochemical stains.
  - Gene signature profiling for tissue of origin is not recommended for standard management at this time.

**PATHOLOGIC DIAGNOSIS**

- Epithelial; not site specific
- Lymphoma and other hematologic malignancies
- Thyroid carcinoma
- Melanoma
- Sarcoma
- Germ-cell tumor
- Nonmalignant diagnosis

**Suspected metastatic malignancy**

- For many patients the apparent uncertainties surrounding the diagnosis of an unknown primary cancer may result in significant psychosocial distress and increased difficulty in accepting treatment options. Empathetic discussion about the natural history of these types of cancer and their prognosis, and the provision of support and counseling both by the primary oncology team and specialized services may help to alleviate this distress.

- Routine use of PET/CT is not recommended. PET/CT scans may be warranted in some situations.

- Further evaluation and appropriate follow-up

- Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
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CLINICAL PRESENTATION

ADDITIONAL WORKUP<sup>e</sup>

Cervical nodes →

Men and women:
• Neck/chest/abdominal/pelvic CT (if not done)
• Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated
• Appropriate immunohistochemistry<sup>f</sup>

Men:
• > 40 y: PSA

Women:

Axillary nodes →

Supraclavicular nodes →

Men and women:
• Neck/chest/abdominal CT (if not done)
• Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated
• Appropriate immunohistochemistry<sup>f</sup>

Men:
• > 40 y: PSA

Women:

<sup>e</sup>Symptom directed endoscopy can be considered for individual patients based on clinical findings and immunohistochemical markers.

<sup>f</sup>An expanded panel of immunohistochemical markers may be used as appropriate. See Immunohistochemistry Markers for Unknown Primary Cancers (OCC-A).

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**ADDITIONAL WORKUP**

**Men and women:**
- Chest/abdominal/pelvic CT (if not done)
- Beta-hCG, alpha-fetoprotein

**Women:**
- Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated
- Appropriate immunohistochemistry

**Men:**
- > 40 y: PSA
- Testicular ultrasound, if beta-hCG and alpha-fetoprotein markers elevated

**Men and women:**
- Chest/abdominal/pelvic CT (if not done)
- CA-125
- Appropriate immunohistochemistry
- Consider gynecologic oncologist consult if clinically indicated
- Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated
  - Men:
    - > 40 y: PSA

**Men and women:**
- Chest/abdominal/pelvic CT (if not done)
- Urine cytology; cystoscopy if suspicious
- Serum CA19-9 level if pancreatic or biliary tract primary suspected

**Women:**
- CA-125
- Appropriate immunohistochemistry
- Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated
- Gynecologic oncologist consult
  - Men:
    - > 40 y: PSA

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Symptom directed endoscopy can be considered for individual patients based on clinical findings and immunohistochemical markers.

An expanded panel of immunohistochemical markers may be used as appropriate. See Immunohistochemistry Markers for Unknown Primary Cancers (OCC-A).

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**NCCN Guidelines Version 1.2013**

**Occult Primary**

**CLINICAL PRESENTATION**
- Retroperitoneal mass
- Inguinal nodes
- Liver

**ADDITIONAL WORKUP**

**Men and Women:**
- Chest/abdominal/pelvic CT (if not done)
- Urine cytology; consider cystoscopy if suspicious
- Women:
  - CA-125
  - Appropriate immunohistochemistry
  - Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated
  - Gynecologic oncologist consult if clinically indicated
- Men:
  - > 40 y: PSA
  - < 65 y: Beta-hCG, alpha-fetoprotein, testicular ultrasound if markers elevated

**Men and women:**
- Abdominal/pelvic CT (if not done)
- Proctoscopy if clinically indicated
- Women:
  - CA-125
  - Gynecologic oncologist consult
  - Men:
  - > 40 y: PSA

**Men and women:**
- Chest/abdominal/pelvic CT (if not done)
- Endoscopic evaluation
- Serum CA19-9 level if pancreatic or biliary tract primary suspected
- Alpha-fetoprotein
- Women:
  - Appropriate immunohistochemistry
  - Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated

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**See Management Based on Workup Findings (OCC-7)**
**NCCN Guidelines Version 1.2013**

**Occult Primary**

**CLINICAL PRESENTATION**

- **Bone**
  - Adenocarcinoma or Carcinoma not otherwise specified
  - Brain
  - Multiple sites of involvement

**ADDITIONAL WORKUP**

- **Men and women:**
  - Bone scan (if PET/CT scan not previously done)
  - Radiographic studies for painful lesions and/or bone-scan–positive lesions and/or weight-bearing areas
  - Chest/abdominal/pelvic CT (if not done)

- **Women:**
  - Appropriate immunohistochemistry
  - Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated

- **Men:**
  - PSA

- **Men and women:**
  - See [NCCN Central Nervous System Cancers Guidelines](#) for Primary Treatment of CNS Metastatic Lesions
  - Chest/abdominal CT (if not done)

- **Women:**
  - Appropriate immunohistochemistry
  - Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated

- **Men and women**
  - Chest/abdominal/pelvic CT (if not done)

- **Women:**
  - Appropriate immunohistochemistry
  - Mammogram; if non-diagnostic and histopathologic evidence for breast cancer, breast MRI and/or breast ultrasound indicated

- **Men:**
  - PSA

- **Symptom directed endoscopy can be considered for individual patients based on clinical findings and immunohistochemical markers.**

- **An expanded panel of immunohistochemical markers may be used as appropriate.** See [Immunohistochemistry Markers for Unknown Primary Cancers (OCC-A)](#).

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For many patients the apparent uncertainties surrounding the diagnosis of an unknown primary cancer may result in significant psychosocial distress and increased difficulty in accepting treatment options. Empathetic discussion about the natural history of these types of cancer and their prognosis, and the provision of support and counseling both by the primary oncology team and specialized services may help to alleviate this distress.

See NCCN Distress Management Guidelines.

See Principles of Chemotherapy (OCC-B).

For specialized approaches therapeutic in nature, see discussion (MS-16).

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CLINICAL PRESENTATION

Localized adenocarcinoma or carcinoma not otherwise specified\textsuperscript{a}

- Head and neck
- Supraclavicular (unilateral or bilateral)
- Axillary
- Mediastinum

MANAGEMENT BASED ON WORKUP FINDINGS

- Treat per NCCN Head and Neck Cancer Guidelines
- Treat per NCCN Head and Neck Cancer Guidelines for Occult Primary

Women:
- Treat per NCCN Breast Cancer Guidelines

Men:
- Axillary node dissection, consider RT if clinically indicated ± chemotherapy\textsuperscript{g} (category 2B)

- Treat as poor-risk germ cell tumor per NCCN Testicular Cancer Guidelines or germ cell tumor per NCCN Ovarian Cancer Guidelines

- Treat as poor-risk germ cell tumor per NCCN Testicular Cancer Guidelines or germ cell tumor per NCCN Ovarian Cancer Guidelines or treat per NCCN Non-Small Cell Lung Cancer Guidelines

- Treat per NCCN Non-Small Cell Lung Cancer Guidelines

\textsuperscript{a}For many patients the apparent uncertainties surrounding the diagnosis of an unknown primary cancer may result in significant psychosocial distress and increased difficulty in accepting treatment options. Empathetic discussion about the natural history of these types of cancer and their prognosis, and the provision of support and counseling both by the primary oncology team and specialized services may help to alleviate this distress. See NCCN Distress Management Guidelines.

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See Follow-up (OCC-16)
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See Principles of Chemotherapy (OCC-B).

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Site specific squamous cell carcinoma\(^a\)

- Mediastinum
  - Treat per NCCN Non-Small Cell Lung Cancer Guidelines
  - Clinical trial preferred
  - Chemotherapy\(^g\)
  - Symptom control

- Multiple lung nodules
  - Clinical trial preferred
  - Chemotherapy\(^g\)
  - Symptom control

- Pleural effusion
  - Clinical trial preferred
  - Chemotherapy\(^g\)
  - Symptom control

\(^a\)For many patients the apparent uncertainties surrounding the diagnosis of an unknown primary cancer may result in significant psychosocial distress and increased difficulty in accepting treatment options. Empathetic discussion about the natural history of these types of cancer and their prognosis, and the provision of support and counseling both by the primary oncology team and specialized services may help to alleviate this distress. See NCCN Distress Management Guidelines.

\(^g\)See Principles of Chemotherapy (OCC-B).

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MANAGEMENT BASED ON WORKUP FINDINGS

**Unilateral**
- Lymph node dissection, consider RT if clinically indicated ± chemotherapy

**Bilateral**
- Bilateral lymph node dissection, consider RT if clinically indicated ± chemotherapy (category 2B for RT alone)

**Isolated lesion or painful lesion or bone scan positive lesion with potential for fracture in weight-bearing area**
- Surgery for impending fracture (in patients with good performance status) and/or RT

**Multiple lesions**
- See Disseminated Metastases (OCC-12)

**Site specific squamous cell carcinoma**
- See NCCN Central Nervous System Cancers Guidelines for management of CNS Metastatic Lesions

**Bone**

**Brain**

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See Follow-up (OCC-16)

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g See Principles of Chemotherapy (OCC-B).
FOLLOW-UP FOR ALL OCCULT PRIMARIES  
(NO ACTIVE TREATMENT)

- For patients with either active disease, or localized disease in remission, follow-up frequency should be determined by clinical need
  - H&P
  - Diagnostic tests based on symptomatology

- For patients with active and incurable disease, psychosocial support, symptom management, end-of-life discussions, palliative care interventions and hospice care should all be considered and utilized as appropriate. See NCCN Palliative Care Guidelines and NCCN Distress Management Guidelines
IMMUNOHISTOCHEMISTRY MARKERS FOR UNKNOWN PRIMARY CANCERS:
Immunohistochemistry markers for unknown primary cancers are provided as a resource to assist in localizing a primary but are not uniformly specific or sensitive. Avoid a large series of immunohistochemistry markers. Communication with the pathologist is essential to workup.

KEY SCREENING ANTIBODIES FOR UNDIFFERENTIATED MALIGNANCY

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>CAM5.2</th>
<th>Epithelial Membrane Antigen (EMA)</th>
<th>S-100</th>
<th>Leukocyte Common Antigen (LCA)</th>
<th>Placenta-Like Alkaline Phosphatase (PLAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carcinoma</td>
<td>POS</td>
<td>POS</td>
<td>NEG/POS</td>
<td>NEG</td>
<td>NEG/POS</td>
</tr>
<tr>
<td>Melanoma</td>
<td>NEG</td>
<td>NEG</td>
<td>POS</td>
<td>NEG</td>
<td>NEG</td>
</tr>
<tr>
<td>Lymphoma/Leukemia</td>
<td>NEG</td>
<td>NEG</td>
<td>NEG</td>
<td>POS</td>
<td>NEG</td>
</tr>
<tr>
<td>Nonseminoma Germ Cell Neoplasm</td>
<td>POS</td>
<td>NEG</td>
<td>NEG</td>
<td>NEG</td>
<td>POS</td>
</tr>
<tr>
<td>Germ Cell Seminoma</td>
<td>NEG</td>
<td>NEG</td>
<td>NEG</td>
<td>NEG</td>
<td>POS</td>
</tr>
</tbody>
</table>

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1 Other pan-cytokeratin markers are available and may be more appropriate.
### IMMUNOHISTOCHEMISTRY MARKERS FOR UNKNOWN PRIMARY CANCERS:

Immunohistochemistry markers for unknown primary cancers are provided as a resource to assist in localizing a primary but are not uniformly specific or sensitive. Avoid a large series of immunohistochemistry markers. Communication with the pathologist is essential to workup.

#### TUMOR-SPECIFIC MARKERS AND THEIR STAINING PATTERN*

<table>
<thead>
<tr>
<th>Marker</th>
<th>Tumor</th>
<th>Staining Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTF-1</td>
<td>Lung, thyroid</td>
<td>Nuclear</td>
</tr>
<tr>
<td>Thyroglobulin</td>
<td>Thyroid</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>HepPar-1</td>
<td>Hepatocellular</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>CDX2</td>
<td>Colorectal/douodenal</td>
<td>Nuclear</td>
</tr>
<tr>
<td>Villin</td>
<td>Gastrointestinal (epithelia with brush border)</td>
<td>Apical</td>
</tr>
<tr>
<td>ER/PR</td>
<td>Breast, ovary, endometrium</td>
<td>Nuclear</td>
</tr>
<tr>
<td>GCDFP-15</td>
<td>Breast</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>Mammaglobin</td>
<td>Breast</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>RCC marker</td>
<td>Renal</td>
<td>Membranous</td>
</tr>
<tr>
<td>PSA</td>
<td>Prostate</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>PAP</td>
<td>Prostate</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>Uroplakin III</td>
<td>Urothelial</td>
<td>Membranous</td>
</tr>
<tr>
<td>Inhibin</td>
<td>Sex cord–stromal, adrenocortical</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>Melan-A</td>
<td>Adrenocortical, melanoma</td>
<td>Cytoplasmic</td>
</tr>
<tr>
<td>Calretinin</td>
<td>Mesothelioma, sex cord–stromal, adrenocortical</td>
<td>Nuclear/cytoplasmic</td>
</tr>
<tr>
<td>WT1</td>
<td>Ovarian serous, mesothelioma, Wilms, desmoplasic small round cell</td>
<td>Nuclear</td>
</tr>
<tr>
<td>Mesothelin</td>
<td>Mesothelioma</td>
<td>Cytoplasmic/membranous</td>
</tr>
<tr>
<td>D2-40</td>
<td>Mesothelioma, lymphatic endothelial cell marker</td>
<td>Membranous</td>
</tr>
</tbody>
</table>

* TTF-1, thyroid transcription factor 1; HepPar-1, hepatocyte paraffin 1; ER/PR, estrogen receptor/progesterone receptor; GCDFP-15, gross cystic disease fluid protein 15; RCC, renal cell carcinoma; PSA, prostate-specific antigen; and PAP, prostate acid phosphatase.


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### CYTOKERATIN/KERATIN DISTRIBUTION

<table>
<thead>
<tr>
<th>CK 7+ 20+</th>
<th>CK 7- 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ovary mucinous</strong></td>
<td>Colorectal adeno</td>
</tr>
<tr>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Transitional cell</strong></td>
<td>Merkel cell</td>
</tr>
<tr>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Pancreas adeno</strong></td>
<td>Gastric adeno</td>
</tr>
<tr>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Cholangio</strong></td>
<td><strong>Excluded tumors</strong></td>
</tr>
<tr>
<td>65%</td>
<td>≤ 5%</td>
</tr>
<tr>
<td><strong>Gastric adeno</strong></td>
<td>Breast; Carcinoid lung; Cholangio;</td>
</tr>
<tr>
<td>40%</td>
<td>Esoph squam; Germ cell; Lung all</td>
</tr>
<tr>
<td><strong>Excluded tumors</strong></td>
<td>types; Hepatocellular; Ovary;</td>
</tr>
<tr>
<td>≤ 5%</td>
<td>Pancreas adeno; Renal adeno;</td>
</tr>
<tr>
<td>Carcinoid; Germ cell; Esoph squam;</td>
<td>Transitional cell; Uterus</td>
</tr>
<tr>
<td>Head/neck squam; Hepatocellular;</td>
<td>endometrioid</td>
</tr>
<tr>
<td>Lung small cell &amp; squam; Ovary-non</td>
<td></td>
</tr>
<tr>
<td>mucinous; Renal adeno</td>
<td></td>
</tr>
<tr>
<td><strong>CK 7+ 20-</strong></td>
<td><strong>CK 7- 20-</strong></td>
</tr>
<tr>
<td><strong>Ovary non mucinous</strong></td>
<td>Adrenal</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Thyroid (all three types)</strong></td>
<td>Seminoma &amp; YST</td>
</tr>
<tr>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td>Prostate</td>
</tr>
<tr>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Lung adeno</strong></td>
<td>Hepatocellular</td>
</tr>
<tr>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Uterus endometrioid</strong></td>
<td>Renal adeno</td>
</tr>
<tr>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Embryonal</strong></td>
<td>Carcinoid GI &amp; lung</td>
</tr>
<tr>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Mesothelioma</strong></td>
<td>Lung small cell &amp; squam</td>
</tr>
<tr>
<td>65%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Transitional cell</strong></td>
<td>Esoph squam</td>
</tr>
<tr>
<td>35%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Pancreas adeno</strong></td>
<td>Head/neck squam</td>
</tr>
<tr>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Cholangio</strong></td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Excluded tumors</strong></td>
<td><strong>Excluded tumors</strong></td>
</tr>
<tr>
<td>≤ 5%</td>
<td>≤ 5%</td>
</tr>
<tr>
<td><strong>Colorectal adeno; ovary mucinous; seminoma; yolk sac tumor (YST)</strong></td>
<td>Breast; Cholangio; Lung adeno;</td>
</tr>
<tr>
<td></td>
<td>Ovary; Pancreas adeno</td>
</tr>
</tbody>
</table>

adapted from “Applications of immunohistology to non-heme tumor differential diagnosis” by Rouse RV ([http://surgparchecktes.stanford.edu](http://surgparchecktes.stanford.edu)).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
IMMUNOHISTOCHEMISTRY MARKERS FOR UNKNOWN PRIMARY CANCERS:

Immunohistochemistry markers for unknown primary cancers are provided as a resource to assist in localizing a primary but are not uniformly specific or sensitive. Avoid a large series of immunohistochemistry markers. Communication with the pathologist is essential to workup.

Carcinomatous tumors → Broad spectrum CK’s+, S100-, HMB45-, CD45-

<table>
<thead>
<tr>
<th>CK7+/CK20 +</th>
<th>CK7+/CK20 -</th>
<th>CK7-/CK20 +</th>
<th>CK7-/CK20 -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast CA</td>
<td>Cholangio CA</td>
<td>Thyroid CA</td>
<td>Prostate adenoCA</td>
</tr>
<tr>
<td>ER/PR +</td>
<td>CEA+</td>
<td>TTF-1 +Ψ</td>
<td>PSA +</td>
</tr>
<tr>
<td>GCDFP +</td>
<td>CK19 +</td>
<td>thyroglobulin +Ψ</td>
<td>PAP +</td>
</tr>
<tr>
<td>mammoglobin +</td>
<td>MOC31+</td>
<td>CEA - (expect medullary CA)</td>
<td>CEA -</td>
</tr>
<tr>
<td>CEA +</td>
<td>CA19-9 +</td>
<td>SCC of cervix p16 +</td>
<td>uroplakin -</td>
</tr>
<tr>
<td>Endometrioid adeno CA</td>
<td>CDX2 +/-</td>
<td>Lung SmCC (majority)</td>
<td>Lung SmCC</td>
</tr>
<tr>
<td>vimentin +</td>
<td>HepPar1-</td>
<td>TTF-1 +</td>
<td>p63 -</td>
</tr>
<tr>
<td>ER/PR -</td>
<td>Lung SmCC</td>
<td>NE markers* +</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>CEA -</td>
<td>(majority)</td>
<td>p16 -</td>
<td>(~2/3)</td>
</tr>
<tr>
<td>Endocervical adeno CA</td>
<td>DPC4-</td>
<td>Salivary gland tumor</td>
<td>CEA -</td>
</tr>
<tr>
<td>CEA +</td>
<td>p16 +</td>
<td>Urothelial CA (subset)</td>
<td>SCC</td>
</tr>
<tr>
<td>vimentin -</td>
<td>ER/PR -</td>
<td>CDX2 +/-</td>
<td>p63 +</td>
</tr>
<tr>
<td>CEA -</td>
<td>Ovarian serous CA</td>
<td>DPC4-</td>
<td>CD5/6 +</td>
</tr>
<tr>
<td>WT1 +</td>
<td>CDX2 +/-</td>
<td>Gastric adeno CA (subset)</td>
<td>CDX2 +/-</td>
</tr>
<tr>
<td>ER/PR +</td>
<td></td>
<td>CDX2 +/-</td>
<td></td>
</tr>
<tr>
<td>mesothelin +</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEA -</td>
<td>Lung adeno CA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TTF-1 +</td>
<td>NapsinA</td>
<td>CDX2 +/-</td>
<td></td>
</tr>
<tr>
<td>CK5/6 +</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p63 -</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CA, carcinoma; adenoCA, adenocarcinoma; SmCC, small cell carcinoma; SCC, squamous cell carcinoma; RCC, renal cell carcinoma; HCC, hepatocellular carcinoma; †, seminoma is keratin negative, OCT3/4 positive; * NE markers, neuroendocrine markers, including synaptophysin, chromogranin, and CD56; Ψ, undifferentiated anaplastic thyroid carcinoma is often negative for thyroid transcription factor 1 (TTF-1); and Ψ, characteristic canalicular pattern.


Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
PRINCIPLES OF CHEMOTHERAPY

- Consider chemotherapy in symptomatic patients PS 1-2 or asymptomatic patients (PS 0) with an aggressive cancer.
- Base the chemotherapy regimen (listed on the following pages and others) to be used on the histologic type of cancer.

ECOG PERFORMANCE STATUS (PS)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease performance without restriction</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, eg, light house work, office work</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited selfcare, confined to bed or chair more than 50% of waking hrs</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair</td>
</tr>
</tbody>
</table>


Neuroendocrine Tumors

For poorly differentiated (high grade or anaplastic) or small cell subtype other than lung neuroendocrine tumors, see NCCN Small Cell Lung Cancer Guidelines

For well-differentiated neuroendocrine tumors, see NCCN Neuroendocrine Tumors Guidelines—Carcinoid Tumors

Note: All recommendations are category 2A unless otherwise indicated. Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
**SELECTED CHEMOTHERAPY REGIMENS FOR OCCULT PRIMARIES**

**ADENOCARCINOMA**

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Dosage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paclitaxel + Carboplatin</strong></td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td>200 mg/m² 3 h IV</td>
</tr>
<tr>
<td>AUC = 6 Day 1</td>
<td></td>
</tr>
<tr>
<td>Repeat cycle every 3 weeks¹</td>
<td></td>
</tr>
<tr>
<td><strong>Paclitaxel + Carboplatin + Etoposide</strong></td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td>200 mg/m² 1 h IV</td>
</tr>
<tr>
<td>AUC = 6</td>
<td></td>
</tr>
<tr>
<td>Etoposide</td>
<td>50 mg/d PO alternating with 100 mg/d PO Days 1-10</td>
</tr>
<tr>
<td>Repeat cycle every 3 weeks²</td>
<td></td>
</tr>
<tr>
<td><strong>Docetaxel + Carboplatin</strong></td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td>65 mg/m² IV</td>
</tr>
<tr>
<td>AUC = 6 Day 1</td>
<td></td>
</tr>
<tr>
<td>Repeat cycle every 3 weeks³</td>
<td></td>
</tr>
<tr>
<td><strong>Gemcitabine + Cisplatin</strong></td>
<td></td>
</tr>
<tr>
<td>Day 1 and 8</td>
<td>1250 mg/m² IV</td>
</tr>
<tr>
<td>100 mg/m² IV Day 1</td>
<td></td>
</tr>
<tr>
<td>Repeat cycle every 3 weeks⁴</td>
<td></td>
</tr>
<tr>
<td><strong>Gemcitabine + Docetaxel</strong></td>
<td></td>
</tr>
<tr>
<td>Day 1 and 8</td>
<td>1000 mg/m² IV</td>
</tr>
<tr>
<td>75 mg/m² IV Day 8</td>
<td></td>
</tr>
<tr>
<td>Repeat cycle every 3 weeks⁵</td>
<td></td>
</tr>
<tr>
<td><strong>mFOLFOX6</strong></td>
<td></td>
</tr>
<tr>
<td>Oxaliplatin</td>
<td>85 mg/m² IV over 2 hours, Day 1</td>
</tr>
<tr>
<td>Leucovorin</td>
<td>400 mg/m² IV over 2 hours, Day 1</td>
</tr>
<tr>
<td>5-FU 400 mg/m² IV bolus on Day 1, then 1200 mg/m²/d x 2 Days (total 2400 mg/m² over 46-48 hours) IV continuous infusion Repeat cycle every 2 weeks⁶,⁷</td>
<td></td>
</tr>
<tr>
<td><strong>CapeOX</strong></td>
<td></td>
</tr>
<tr>
<td>Oxaliplatin</td>
<td>130 mg/m² IV over 2 hours, Day 1</td>
</tr>
<tr>
<td>Capecitabine</td>
<td>850-1000 mg/m² twice daily PO for 14 Days Repeat cycle every 3 weeks⁶</td>
</tr>
</tbody>
</table>

**Note:** All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
# SELECTED CHEMOTHERAPY REGIMENS FOR OCCULT PRIMARIES

## SQUAMOUS CELL

<table>
<thead>
<tr>
<th>Paclitaxel</th>
<th>200 mg/m²/3 h IV Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin</td>
<td>AUC = 6 Day 1</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 3 weeks¹</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cisplatin</th>
<th>100 mg/m² IV Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gemcitabine</td>
<td>1250 mg/m² IV Days 1 and 8</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 3 weeks⁴</td>
</tr>
</tbody>
</table>

| mFOLFOX6   | Oxaliplatin 85 mg/m² IV over 2 hours, Day 1 |
|------------| Leucovorin 400 mg/m² IV over 2 hours, Day 1 |
|            | 5-FU 400 mg/m² IV bolus on Day 1, then 1200 mg/m²/d x 2 Days (total 2400 mg/m² over 46-48 hours) IV continuous infusion |
|            | Repeat every 2 weeks⁶,⁷ |

<table>
<thead>
<tr>
<th>Docetaxel</th>
<th>75 mg/m² IV Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisplatin</td>
<td>75 mg/m² IV Day 1</td>
</tr>
<tr>
<td>5-FU</td>
<td>750 mg/m²/d IV continuous infusion Days 1-5</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 3 weeks⁸</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paclitaxel</th>
<th>175 mg/m² IV Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisplatin</td>
<td>60 mg/m² IV Day 1</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 3 weeks⁹</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Docetaxel</th>
<th>75 mg/m² IV Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin</td>
<td>AUC 5 IV Day 1</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 3 weeks¹⁰</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Docetaxel</th>
<th>60 mg/m² IV Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisplatin</td>
<td>80 mg/m² IV Day 1</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 3 weeks¹¹</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cisplatin</th>
<th>20 mg/m² IV Days 1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluorouracil</td>
<td>700 mg/m² IV continuous infusion over 24 hours daily Days 1-5</td>
</tr>
<tr>
<td></td>
<td>Repeat cycle every 4 weeks¹²</td>
</tr>
</tbody>
</table>

---

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REFERENCES FOR SELECTED CHEMOTHERAPY REGIMENS FOR OCCULT PRIMARIES


Discussion

NCCN Categories of Evidence and Consensus

**Category 1:** Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

**Category 2A:** Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

**Category 2B:** Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

**Category 3:** Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise noted.

Overview

Occult primary tumors, or cancers of unknown primary (CUPs), are defined as histologically proven metastatic malignant tumors whose primary site cannot be identified during pretreatment evaluation.\(^1\,^2\) These tumors have a wide variety of clinical presentations and a poor prognosis in most patients. Patients with occult primary tumors often present with general complaints, such as anorexia and weight loss. Early dissemination, aggressiveness, and unpredictability of metastatic pattern are characteristic of these tumors.\(^3\) Life expectancy is very short, with a median survival of 6 to 9 months.\(^4\)

These guidelines provide recommendations for evaluation, workup, management, and follow-up of 3 pathologic diagnoses in patients with epithelial occult primary cancer:

- Adenocarcinoma, or carcinoma not otherwise specified
- Squamous cell carcinoma (SCC)
- Neuroendocrine tumors

The guidelines suggest diagnostic tests based on the location of disease and the patient’s gender. For example, for SCC the guidelines focus on the most common sites of clinical presentation, namely the head and neck nodes, supraclavicular nodes, inguinal nodes, and bone. For adenocarcinoma, 12 different clinical presentations are addressed, with suggested diagnostic tests for each location. For each of the 3 pathologic diagnoses, if a primary tumor is subsequently found, treatment should be based on recommendations in the NCCN Guidelines for the cancer site corresponding to the primary tumor (see list of NCCN Guidelines for Treatment of Cancer by Site, available at [www.NCCN.org](http://www.NCCN.org)).

The management portion of the algorithm focuses on treatment of disseminated or localized disease for adenocarcinoma and site-specific SCC. The panel endorses enrollment of patients in appropriate clinical trials when possible. In most patients, occult primary tumors are refractory to systemic treatments, and chemotherapy is only palliative and does not significantly improve long-term survival. In patients with disseminated disease in particular, the treatment goals are directed toward symptom control and providing the best quality of life possible. However, certain clinical presentations of these tumors are associated with a better prognosis.\(^5\) Special pathologic studies can identify subsets of patients with tumor types that are more responsive to chemotherapy. Treatment options should be individualized for this selected group of patients to achieve optimal response and survival rates.
Epidemiology
Occult primary tumors occur roughly equally in men and women, with an average age at diagnosis of 60 years. An estimated 31,000 cases of cancer of unspecified primary sites will be diagnosed in the United States in 2011, accounting for approximately 2% of all cancers diagnosed in the United States. However, deaths from cancer of unspecified primary site are estimated to be 45,900 in 2012. This discrepancy is believed to be from the lack of specificity in recording the underlying cause of death on death certificates.

A recent analysis of the Swedish Family-Cancer Database revealed that occult primary tumors may have a genetic basis. The analysis showed that 2.8% of occult primary cases were familial (i.e., a parent and offspring were both diagnosed with occult primary cancer). In addition, occult primary tumors were associated with the occurrence of lung, kidney, and colorectal cancers in families, suggesting that these tumor types are often the primary sites of the disease.

A primary tumor site is found in fewer than 30% of patients who present initially with an occult primary tumor. In 20% to 50% of patients, the primary tumor is not identified even after postmortem examination.

Presentation and Prognosis
Multiple sites of involvement are observed in more than 50% of patients with occult primary tumors. Common sites of involvement are the liver, lungs, bones, and lymph nodes. Although certain patterns of metastases suggest possible primaries, occult primaries can metastasize to any site. Therefore, one should not rely on patterns of metastases to determine the primary site.

Patients with occult primary tumors may present with favorable or unfavorable prognostic signs and patterns of presentation. Hemminki et al recently performed a population-based survival analysis of >18,000 patients with occult primary tumors from the Swedish Cancer Registry. The authors list 12-month survival rates and median survival times for each combination of histology and location. Patients with metastases limited to lymph nodes had better prognoses than those with metastases in internal organs.

Most patients have an unfavorable prognosis. Unfavorable features include male gender, pathologic diagnosis of adenocarcinoma with metastases involving multiple organs (liver, lung, or bone), nonpapillary malignant ascites (adenocarcinoma), multiple cerebral metastases (adenocarcinoma or SCC), and adenocarcinoma with multiple lung/pleural or bone lesions. For these patients, an empiric approach to therapy is recommended, although the likelihood of benefit is questionable.

Patients with a favorable prognosis include those with poorly differentiated carcinoma with midline distribution, women with papillary adenocarcinoma of the peritoneal cavity, women with adenocarcinoma involving only axillary lymph nodes, patients with SCC involving cervical lymph nodes (constituting 2% to 5% of all cases of occult primary cancers), patients with isolated inguinal adenopathy (SCC), patients with poorly differentiated neuroendocrine (PDNE) carcinomas, men with blastic bone metastases and elevated prostate-specific antigen (PSA; adenocarcinoma), and patients with a single, small, and potentially resectable tumor. For patients with favorable prognostic features, tailored approaches to treatment, such as locoregional treatments or specific chemotherapy regimens (e.g., 5-FU–based therapy for suspected colon primary or cisplatin-based chemotherapy for possible germ cell tumor), are likely to provide clinical benefit and may prolong survival. However, little data exist to support this idea.
Pathology

Occult primary tumors often have multiple chromosomal abnormalities and overexpression of several genes, including Ras, BCL2, HER2, and p53.\(^{21,22}\) BCL2 and p53 are overexpressed in 40% and 53% of occult primary tumors, respectively.\(^{23}\) The BRD4-NUT oncogene, resulting from the chromosomal translocation t(15;19), has been identified in children and young adults with carcinoma of midline structures and unclear primary sites.\(^{1,24,25}\)

Occult primary cancers can be classified into 5 major subtypes after routine evaluation with light microscopy. The most frequently occurring subtype is well- or moderately differentiated adenocarcinoma (60%), followed by poorly differentiated adenocarcinoma or undifferentiated carcinoma (29%), SCC (5%), and poorly differentiated malignant neoplasm (5%).\(^{1,13}\) Additionally, because of improved histopathologic diagnostic studies, neuroendocrine tumors of unknown primary have been recognized (1%).\(^{26,27}\)

Immunohistochemistry

In patients with occult primary tumors, immunohistochemical studies are useful for the characterization of poorly differentiated or undifferentiated tumors and for cell-type determination and pathologic diagnosis.\(^{28-31}\) However, because immunohistochemistry markers for unknown primary cancers are not uniformly specific or sensitive and because immunohistochemical analysis has not been shown to improve patient outcomes, a large series of marker studies should be avoided. Communication with the pathologist is essential to workup. Immunohistochemical studies should be used in conjunction with imaging studies to select the best possible treatment options for patients with occult primary tumors.

Key Screening Markers for Undifferentiated Malignancy

Carcinomas are usually positive for wide-spectrum cytokeratins and epithelial membrane antigen. S-100 is usually expressed in melanoma, clear cell sarcoma, glioma, and malignant peripheral nerve sheath tumors. HMB45 is also highly specific for melanoma.\(^{32}\) Leukocyte common antigen (LCA or CD45) is expressed in virtually all hematolymphoid malignancies and is highly specific for non-Hodgkin lymphoma. Placental alkaline phosphatase is mainly found in seminomas but is also expressed in some nonseminoma germ cell tumors, and genitourinary, gastrointestinal, and pulmonary carcinomas.

Cytokeratins 7 and 20

Cytokeratins are useful for cell-type determination in primary and metastatic carcinomas. Low-molecular-weight cytokeratins (CK7 and CK20) are the 2 most common immunostains used in occult primary tumors to define subsets of carcinomas.\(^{33-35}\) CK7 is mainly found in tumors of the lung, ovary, endometrium, thyroid, and breast. CK20 is usually expressed in gastrointestinal, urothelial, and Merkel cell carcinomas. CK7-positive/CK20-negative staining narrows the diagnosis to lung, breast, thyroid, pancreatic, ovarian, endometrioid, gastric, urothelial, or endocervical carcinomas. CK7-negative/CK20-positive cells are indicative of colorectal, gastric, and Merkel cell carcinomas. The CK7/CK20 phenotype is also useful for differentiating between prostate (CK7-negative/CK20-negative) and urothelial (CK7-positive/CK20-positive or -negative) carcinomas.

Additional Markers for Carcinomatous Tumors

For carcinomatous tumors that stain positively for broad spectrum cytokeratins, but negatively for S100, HMB45, and CD45, additional markers can be assessed to help identify the tissue of origin.\(^{32}\) Markers can be chosen based on CK7 and CK20 staining results (see Immunohistochemistry Markers for Unknown Primary Cancers [OCC-A...
page 4 of 4] in these guidelines. However, a large series of immunohistochemistry markers should be avoided.

The use of TTF-1 staining distinguishes lung and thyroid primary tumors from other CK7-positive tumors, because most lung and thyroid carcinomas are positive for TTF-1. Thyroglobulin is a very specific marker for thyroid carcinoma (papillary and follicular). GCDFP-15 and uroplakin III are highly specific markers for breast and urothelial cancer, respectively; however, neither is very sensitive for the deduction of breast and urothelial carcinomas. Uroplakin III is expressed in approximately 60% and 50% of primary and metastatic urothelial carcinomas, respectively. In a study involving 690 neoplasms, GCDFP-15 was able to identify breast carcinomas with a sensitivity of 74% and a specificity of 95%.36

WT1 is a sensitive marker for epithelioid mesothelioma and is also positive in almost all cases of ovarian serous carcinoma, including high-grade forms.32 The p53 homologue nuclear transcription factor, p63, can also be useful for identifying carcinomas with squamous cell, urothelial, and myoepithelial differentiation. Most poorly differentiated SCCs (86%) show immunoreactivity for p63, whereas only 14% of non-SCCs are positive for p63.37 Malignant mesotheliomas are consistently negative for p63, whereas p63 is expressed in 70% to 95% of urothelial carcinomas.32,37

CK5 and CK6 can be useful for the differential diagnosis of poorly differentiated metastatic SCC.37 Most poorly differentiated SCCs (84%) show CK5/6 positivity, whereas only 21% of non-SCCs are positive for CK5/6.37 In addition to poorly differentiated SCCs, urothelial carcinomas (35%) and all mesotheliomas express CK5 and CK6.37 Carcinoembryonic antigen (CEA) can be useful for the differential diagnosis of gastrointestinal adenocarcinomas and endocervical cancer from cancers from other sites of origin.32

Molecular Profiling

Recently, several gene expression profiling (GEP) assays have been developed to attempt to identify the tissue of origin in patients with occult primary cancers.38,39 It is noteworthy that thus far the literature on this approach, as with the literature on immunohistochemistry application in the workup of CUP, has focused far more on establishing a tissue of origin than on establishing whether such an identification leads to a better outcome in patients. Consequently, the panel currently feels that data are insufficient to confirm that molecular profiling should be used routinely in the diagnostic workup of patients with CUP. Neither immunohistochemistry, a diagnostic tool in widespread use, nor GEP should be used indiscriminately.

Talantov et al40 developed a molecular assay that is designed to detect tumors originating from the lung, breast, colon, ovary, pancreas, and prostate by evaluating the expression of 10 specific genes using real-time quantitative reverse transcription-polymerase chain reaction (qRT-PCR). In a blinded study, this assay identified the tissue of origin of metastatic carcinomas for which the primary was known in 204 of 260 tested samples, with an overall accuracy of 78%. Varadhachary et al41 assessed the feasibility of this assay retrospectively in 104 patients with CUP. A presumed tissue of origin was identified in 61% of patients, and the results were believed to be compatible with clinicopathological features and response to therapy in most cases. Similarly, Ma et al42 developed a 92-gene-based qRT-PCR assay to identify the site of origin of metastatic tumors, especially in patients with CUP. In a retrospective multicenter study, this assay identified primary sites in 75% of patients after the initial diagnosis of CUP.43
GEP tests are now commercially available and are being evaluated in prospective clinical studies in an attempt to determine if the information they provide translates into clinically meaningful benefit for patients. Preliminary data from a prospective study in which treatments were based on the identification of primary sites by the 92-gene assay showed that clinical features and response to treatment were generally consistent with assay results. Similarly, 32 patients whose tumors were classified as being of colorectal origin by both of these GEP assays (the 10-gene assay of Talantov et al and the 92-gene assay of Ma et al) showed a response to colorectal chemotherapy regimens as expected for patients with stage IV colorectal cancer. However, similar response rates might be expected from empiric use of these regimens in a good performance status (PS) group of patients with unknown primary cancer predominantly below the diaphragm. Thus, the clinical benefit, if any, that might be derived from the use of these molecular assays remains to be determined.

Using a microarray approach, Monzon et al developed a 1550-gene test, which had an 88% sensitivity and a 99% specificity in diagnosing uncertain primary tumors in a blinded multicenter validation study. This test is also commercially available. Another microarray GEP assay has been developed that assesses the expression of 495 genes to identify tissue of origin of occult primary tumors. This assay has also been validated, but is not currently commercially available.

Another form of molecular profiling has recently generated some interest for its potential to identify the tissue of origin of CUPs. This assay is based on the presence of microRNAs (miRNAs), which are noncoding RNAs that regulate gene expression and show high tissue specificity. Using a panel of 48 miRNAs, blinded sets of samples were identified with an accuracy of 85% to 89%. When this assay was prospectively studied in patients with occult primary tumors, the tissue of origin diagnosed was consistent with clinical and/or pathologic features of the disease in 62 of 74 patients (84%). This assay is also commercially available. This research group recently developed a second-generation microarray assessing the levels of 64 miRNAs to identify 42 tumor types. The assay was validated on a set of 509 blinded samples and showed a sensitivity of 85%.

A recent review compares the 3 commercially available tests. As noted, outcomes data are not currently available to recommend routine use of molecular profiling in the workup of occult primary tumors; likewise, no such data exist to endorse the automatic or indiscriminate use of immunohistochemistry. Until more robust outcomes and comparative effectiveness data are available, pathologists and oncologists must collaborate on the judicious use of these modalities on a case by case basis, with the best possible individualized patient outcome in mind.

**Initial Evaluation**

These guidelines recommend that patients undergo an initial evaluation, including a detailed review of biopsy findings. At this point, a specific pathologic diagnosis may be made (ie, epithelial occult primary [not site specific]; thyroid, lymphoma, or other hematologic malignancy; melanoma, sarcoma, or germ cell tumor).

Initial evaluation of a patient with a suspected metastatic malignancy should include a complete history and physical examination, including breast, genitourinary, pelvic, and rectal examinations, with attention to and review of past biopsies or malignancies, removed lesions, spontaneously regressing lesions, and existing imaging studies; routine laboratory studies (ie, CBC, electrolytes, liver function tests, creatinine, calcium); occult blood stool testing; and symptom-directed endoscopy. Other diagnostic studies should be based on the clinical presentation...
and subsequent histopathologic findings. CT scans of the chest, abdomen, and pelvis are also recommended. It is important to determine if the initially identified malignancy is localized or disseminated, because the treatment for localized and disseminated disease may be different.

**PET and PET/CT Scans**

In the past several years, PET scans and combination PET/CT scans have become 2 of the most frequently used imaging modalities in the management of patients with occult primary cancers. PET scans have been shown to be a useful method for the diagnosis, staging, and restaging of many malignancies, and might be warranted in some situations. PET scans have shown intermediate specificity and high sensitivity in a few small studies, but larger studies are warranted to determine the clinical utility and role of PET scans in patients with occult primary tumors. In a comprehensive review of 10 published studies, Seve et al concluded that PET is a valuable imaging modality for patients with occult primary tumors with a single site of metastasis if therapy with a curative intent is planned.

One of the limitations of PET scans has been the limited accuracy of anatomic localization of functional abnormalities because of very little accumulation of 18F-fluorodeoxyglucose tracer in some neoplastic tissues. In these cases, the combination of a PET scan with either a CT scan or MRI can be more useful. Studies on the use of PET/CT scans for detecting occult primary tumors have reported that the combination of PET/CT identified the primary site in 25% to 57% of patients. A recent meta-analysis and systemic review on the use of PET/CT in patients with occult primaries found that primary tumors were detected in 37% of 433 patients from 11 studies, with pooled sensitivity and specificity both at 84%. These results indicate that combined modality scanning could play an important role in the diagnosis of occult primary tumors. However, these results must be confirmed in larger clinical studies with long-term follow-up.

Although PET or PET/CT scans detect more primary sites (24% to 40%) than conventional imaging techniques (20% to 27%), their exact role remains undefined because of the lack of prospective clinical trials comparing PET/CT scans with conventional imaging modalities. Therefore, the panel does not recommend using PET/CT scans for routine screening. However, PET/CT scans may be warranted in some situations, especially when considering local or regional therapy.

**Workup**

Patients with a suspected occult primary tumor will typically present to the oncologist after undergoing an initial core needle biopsy (preferred) and/or fine needle aspiration. Accurate pathologic assessment of the biopsied material is most important. Therefore, the pathologist must be consulted to determine whether additional biopsy material is necessary (eg, core needle, incisional, or excisional biopsy). Light microscopic examination of the biopsy material is usually performed first. Other techniques include electron microscopy and flow cytometry. Although immunohistochemical stains can be informative (see *Immunohistochemistry*, above), large panels of immunohistochemical markers should be avoided. If CT scans of the neck, chest, abdomen, and pelvis were not performed previously, they are varyingly indicated depending on the clinical presentation.

This initial evaluation will identify a primary site in approximately 30% of patients presenting with occult metastases. These patients should be treated according to the appropriate NCCN Guidelines for Treatment of Cancer by Site (see list of NCCN Guidelines for Treatment of Cancer by Site, available at www.NCCN.org).
For the remaining patients, a great deal of controversy remains regarding whether an exhaustive, time-consuming, costly evaluation should be conducted to search for the primary tumor beyond these initial tests, as opposed to a more directed evaluation based on the complete history and physical examination, clinical presentation, histopathologic diagnosis, and metastatic sites of involvement. Suggested diagnostic tests for each pathologic subtype, location, and gender (where appropriate) are indicated in the guidelines and are discussed later. Additional studies can be important in determining whether the occult primary cancer is potentially curable, or in diagnosing a possible treatable disease associated with long-term survival. Effective therapies are available for lymphoma, breast, ovarian, thyroid, prostate, and germ cell tumors.

**Workup for Possible Breast Primary**
Adenocarcinoma with positive axillary nodes and mediastinal nodes in a woman is highly suggestive of a breast primary. Adenocarcinoma in the supraclavicular nodes, chest, peritoneum, retroperitoneum, liver, bone, or brain could also indicate primary breast cancer in women. These guidelines suggest the use of a mammogram for these patients. Appropriate testing for immunohistochemical markers is also recommended. MRI and/or ultrasound of the breast should be considered for a patient with a non-diagnostic mammogram and histopathologic evidence of breast cancer. MRI should also be considered when mammography is not adequate to assess the extent of the disease, especially in women with dense breast tissue, positive axillary nodes, and suspected occult primary breast tumor, or to evaluate the chest wall.\(^69\) Breast MRI has been shown to be useful in identifying the primary site in patients with occult primary breast cancer and may also facilitate breast conservation in selected women by allowing for lumpectomy instead of mastectomy.\(^70\) In one report, the primary site was identified using MRI in approximately half of the women presenting with axillary metastases, irrespective of breast density.\(^71\)

For a woman with involvement of the mediastinum whose workup does not indicate primary breast cancer, additional consultation with a pathologist to determine whether further analysis would help differentiate between breast and non-small cell lung cancer should be considered.

**Workup for Possible Germ Cell Primary**
Involvement of mediastinal nodes in patients with adenocarcinoma suggests a possible germ cell tumor, as does a retroperitoneal mass in men younger than 65 years. Thus, these guidelines suggest β-human chorionic gonadotropin (β-hCG) and α-fetoprotein (AFP) measurements. Testicular ultrasound should also be considered if β-hCG and AFP levels are elevated in a man with a mediastinal or retroperitoneal mass.

For patients with involvement of the mediastinum whose workup does not indicate a primary germ cell tumor, additional consultation with a pathologist to determine whether further analysis would help differentiate between testicular or ovarian germ cell cancer and non-small cell lung cancer should be considered.

**Workup for Possible Ovarian Primary**
An occult non-germ cell ovarian primary tumor is suspected for mediastinal, inguinal, chest, peritoneal, or retroperitoneal malignancies. Testing for the ovarian cancer marker CA-125 is recommended in these cases, as is a gynecologic oncologic consultation, if clinically indicated.
Workup for Possible Prostate Primary
All men older than 40 years with an adenocarcinoma or carcinoma not otherwise specified, except those with metastases limited to the liver or brain, should undergo a PSA test. In addition, men presenting with bone metastases or multiple sites of involvement should have PSA levels assessed regardless of age.

Additional Workup for Adenocarcinoma or Carcinoma Not Otherwise Specified
In patients with peritoneal disease or liver involvement, serum CA 19-9 level can be considered if pancreatic or biliary tract primary is suspected. A bone scan (if a PET/CT scan was not previously performed) and radiographic studies are recommended for adenocarcinoma involving painful or bone scan-positive bone lesions. Urine cytology is recommended for patients presenting with a retroperitoneal mass, followed by cystoscopy for suspicious findings. In patients with inguinal lymph node involvement, the guidelines include proctoscopy for men and women, if clinically indicated, to assess for rectal or anal cancer. Endoscopic evaluation is recommended for patients presenting with malignancy in the liver, but is not routinely recommended in patients presenting with malignant ascites (ie, peritoneal presentation). In the absence of a positive fecal occult blood test or other clinical factors suggesting a tumor in the colon, the diagnostic yield of colonoscopy is less than 5%. The use of AFP as a marker for hepatocellular carcinoma as part of the additional workup in adenocarcinoma or carcinoma not otherwise specified in the liver is also recommended.

Workup for SCC
SCC can be present in the nodes of the head and neck region, and in the supraclavicular, axillary, and inguinal nodes. CT scans of the abdomen and pelvis; perineal and lower extremity examination; gynecologic oncology consult; and anal endoscopy are recommended for patients with SCC with inguinal node involvement. A bone scan (if a PET/CT scan was not previously performed) and radiographic studies are recommended for SCC involving painful or bone scan-positive bone lesions.

The workup recommendations for Occult Primary in the NCCN Guidelines for Head and Neck Cancers should be followed for unknown primary lesions in the head and neck and supraclavicular nodes (to view the most recent version of these guidelines, visit the NCCN Web site at www.NCCN.org [OCC-1]).

Workup for Neuroendocrine Tumors
Neuroendocrine tumors can metastasize to several sites, including the head and neck, supraclavicular lymph nodes, lung, inguinal nodes, liver, bone, brain, and skin. The workup recommendations for Neuroendocrine Unknown Primary in the NCCN Guidelines for Neuroendocrine Tumors should be followed (available at www.NCCN.org [NUP-1]).

Management
Psychosocial Distress
For many patients, the apparent uncertainties surrounding the diagnosis of CUP may result in significant psychosocial distress and increased difficulty in accepting treatment options. Empathetic discussion about the natural history of these types of cancer and their prognoses, and the provision of support and counseling by the primary oncology team and specialized services, may help alleviate this distress. Please see the NCCN Guidelines for Distress Management (to
view the most recent version of these guidelines, visit the NCCN Web site at www.NCCN.org).

Supportive Care

In addition to psychosocial support, patients with active and incurable CUP often require symptom management and palliative care interventions. Given the natural history of this disease, end-of-life discussion should be initiated early in the clinical course. Hospice care should also be considered and utilized as appropriate. Please see the NCCN Guidelines for Palliative Care (to view the most recent version of these guidelines, visit the NCCN Web site at www.NCCN.org).

Treatment Based on Workup Findings

Localized adenocarcinoma or carcinoma not otherwise specified is treated according to the most likely primary site.

Adenocarcinoma

Patients with localized adenocarcinoma involving supraclavicular nodes (unilateral or bilateral) or in the head and neck should be treated according to the Occult Primary pathway described in the NCCN Guidelines for Head and Neck Cancers (available at www.NCCN.org [OCC-1]). Those presenting with localized adenocarcinoma with a peritoneal mass or ascites consistent with ovarian histology should be treated according to the NCCN Guidelines for Ovarian Cancer.\(^{74,75}\) Localized adenocarcinoma with a retroperitoneal mass consistent with germ cell histology should be treated according to the NCCN Guidelines for Testicular Cancer or NCCN Guidelines for Ovarian Cancer (Malignant Germ Cell Tumors pathway). For women with localized adenocarcinoma involving axillary nodes and those who are breast-marker positive and have pleural effusion, these guidelines recommend treatment according to the NCCN Guidelines for Breast Cancer. To view the most recent versions of these guidelines, visit the NCCN Web site at www.NCCN.org.

Localized adenocarcinoma occurring in the mediastinum most likely derives from either a germ cell tumor or a non-small cell lung tumor. Additional consultation with a pathologist should be considered to determine if further analysis would help determine the origin of the primary tumor. In the absence of additional diagnostic information, the recommended treatment depends on the age of the patient at diagnosis. Patients younger than 40 years and those between 40 and 50 years of age should be treated for poor-risk germ cell tumors according to the NCCN Guidelines for Testicular Cancer or the NCCN Guidelines for Ovarian Cancer. Alternatively, patients aged 40 to 50 years could be treated according to the NCCN Guidelines for Non-Small Cell Lung Cancer. Patients aged 50 years or older should be treated according to the NCCN Guidelines for Non-Small Cell Lung Cancer. To view the most recent versions of these guidelines, visit the NCCN Web site at www.NCCN.org.

Other locations of unknown primary adenocarcinomas are not associated with a common primary site. Treatment recommendations in these cases are thus general and involve local and systemic therapies. For example, axillary node dissection and radiation therapy to axilla for gross extracapsular extension with or without chemotherapy is recommended for men with localized adenocarcinoma or carcinoma not otherwise specified with involvement of axillary nodes (category 2B). Surgery can be considered for resectable lung nodules, and chemotherapy can be considered with or without resection. Lymph node dissection is recommended for inguinal nodal involvement; radiation therapy with or without chemotherapy can also be considered if clinically indicated (category 2B recommendation for the use of
radiation therapy alone in the case of bilateral inguinal node involvement).  

Surgical resection with or without chemotherapy is recommended for patients with localized adenocarcinoma in the liver. If surgery is medically contraindicated or if the tumor is unresectable, these guidelines recommend chemotherapy and/or locoregional treatment options as described in the NCCN Guidelines for Hepatobiliary Cancers (available at www.NCCN.org).

For patients with good PS and bone lesions with potential for fracture in a weight-bearing area, surgery and/or radiation therapy are options. In the case of patients with poor PS or those with isolated or painful bone lesions, radiation therapy is recommended. Patients with brain metastases should be managed according to the recommendations for treating metastatic lesions in the NCCN Guidelines for Central Nervous System Cancers (available at www.NCCN.org). Chemotherapy can be considered for patients presenting with hormone-negative pleural effusion or ascites/peritoneal mass of non-ovarian origin. In the case of a retroperitoneal mass of non-germ cell histology, surgery and/or radiation therapy is recommended, with chemotherapy considered in select patients (category 2B).

For patients with disseminated carcinoma of unknown primary, a clinical trial is preferred with the additional recommendations of symptom control, consideration of chemotherapy on an individual basis, and specialized approaches (see Specialized Approaches, below).

**SCC**

Patients with site-specific SCC with localized axillary or inguinal involvement of lymph nodes may benefit from lymph node dissection with or without subsequent chemotherapy. Radiation therapy can be considered if clinically indicated (category 2B recommendation in the case of bilateral inguinal node involvement for the use of RT alone). Chemotherapy is not recommended if the tumor has a high likelihood of cutaneous origin.

Patients with unilateral and bilateral involvement of the supraclavicular lymph nodes or with SCC involvement in the head and neck should be treated according to the recommendations for treatment of Occult Primary tumors described in the NCCN Guidelines for Head and Neck Cancers (available at www.NCCN.org [OCC-1]). Patients with site-specific SCC in the mediastinum should be treated according to the NCCN Guidelines for Non-Small Cell Lung Cancer. Participation in a clinical trial is the preferred treatment option for patients with multiple lung nodules or pleural effusion. Alternatively, chemotherapy can also be considered for this group of patients.

Surgery and/or radiation therapy for impending fracture are options for patients with an isolated bone lesion and good PS. Patients with brain metastases should be managed according to the recommendations for metastatic lesions in the NCCN Guidelines for Central Nervous System Cancers (available at www.NCCN.org).

For patients with disseminated SCC of unknown primary, a clinical trial is preferred with the additional recommendations of symptom control and the consideration of chemotherapy on an individual basis.

**Neuroendocrine Tumors**

Management of neuroendocrine tumors should follow the Neuroendocrine Unknown Primary pathway of the NCCN Guidelines for Neuroendocrine Tumors (available at www.NCCN.org [NUP-1]).
Chemotherapy

Many chemotherapeutic regimens have been evaluated in patients with occult primary tumors in an attempt to prolong survival and provide relief of symptoms when present. Studies conducted in the 1980s used 5-FU–based or cisplatin-based chemotherapeutic regimens. Most of the patients in these studies had adenocarcinoma, with only 5% to 10% having poorly differentiated carcinoma. Overall response rates to these regimens were 20% to 35%, with median survival times of 5 to 10 months. However, some of the studies reported longer median survival duration. These older regimens are not used as standard treatment for adenocarcinoma, because complete response is rarely observed.

In more recent years, various regimens have shown efficacy in the treatment of patients with occult primary tumors in phase II studies. However, a recent systematic review of chemotherapy trials in patients with occult primary tumors of unfavorable presentations concluded that no specific regimen can be recommended as standard of care. In general, chemotherapy shows limited efficacy and considerable toxicity in patients with occult primary tumors. Therefore, these guidelines recommend that chemotherapy for patients with disseminated disease be limited to symptomatic patients with a PS of 1 to 2 or to asymptomatic patients with a PS of 0 and aggressive cancer. The choice of the regimen should be based on the histologic type of cancer. Regimens in addition to those listed in the guidelines can be considered.

Adenocarcinoma

Poorly differentiated carcinomas and adenocarcinomas or undifferentiated CUPs respond differently from well- to moderately differentiated CUPs. Tumors in the former group seem to be highly responsive to cisplatin-based combination chemotherapy. Objective response rates reported in 2 studies from the early 1990s were 53% (van der Gaast et al) and 63% (Hainsworth et al) with complete response rates of 12% and 26%, respectively. In one study, patients who had tumors with extragonadal germ cell features showed a high response rate. In the other, patients with undifferentiated carcinomas had a better response rate than those with poorly differentiated adenocarcinomas (79% vs. 35%; \( P = .02 \)).

In more recent years, newer regimens containing taxanes and/or gemcitabine have shown efficacy in phase II studies in the treatment of patients with occult primary tumors. Schneider et al reported that the combination of carboplatin, gemcitabine, and capecitabine was active in occult primary tumors in patients with good PS. Median progression-free survival (PFS) was 6.2 months, and 1- and 2-year survival rates were 35.6% and 14.2%, respectively. In another phase II study conducted by the Minnie Pearl Cancer Research Network, the combination of carboplatin, gemcitabine, and paclitaxel followed by weekly paclitaxel was active and tolerable for patients with occult primary tumors and poor prognostic features. Similarly, gemcitabine plus oxaliplatin was assessed in patients with occult primary tumors in a phase II study. This well-tolerated combination gave a median overall survival (OS) of 12.8 months (95% CI, 8.5–18.5 months) and PFS of 3.1 months (95% CI, 1.7–6 months).

Recently, molecularly targeted agents have been tested for efficacy in treating patients with CUP. Hainsworth et al reported that the combination of bevacizumab and erlotinib (alone or combined with paclitaxel and carboplatin) had substantial activity as first- or second-line therapy in patients with occult primary tumors. In a phase II trial, the combination of bevacizumab and erlotinib induced partial responses in 10% of patients and stable disease in 61% of patients. Median survival was 7.4 months (1-year survival, 33%), which, in retrospective comparison, was superior to that observed by the same group with
gemcitabine alone and gemcitabine and irinotecan (3 and 4.5 months, respectively). In a recent multicenter phase II study, the combination of paclitaxel and carboplatin with bevacizumab and erlotinib was active and well-tolerated as first-line therapy in patients with CUP. After a median follow-up of 19 months, the median PFS time and 2-year OS rates were 8 months (38% PFS at 1 year) and 27%, respectively.

The following regimens are included in the guidelines for treating adenocarcinoma of unknown primary, based on the results of phase II and/or III studies, as described. Regimens other than those listed below can also be considered.

**Paclitaxel and Carboplatin with or without Etoposide**

In phase II studies, the combination of paclitaxel and carboplatin with or without etoposide was found to be effective for the treatment of adenocarcinoma of occult primary tumors. In the Hellenic Cooperative Oncology Group study, the combination of paclitaxel and carboplatin produced an overall response rate of 38.7% according to intention-to-treat (ITT) analysis; no difference was seen in the response rates for adenocarcinomas and undifferentiated carcinomas. In another phase II trial, long-term follow-up of patients treated with the triple drug combination of paclitaxel, carboplatin, and oral etoposide showed 1-, 2-, and 3-year survival rates of 48%, 20%, and 14%, respectively.

In one study, taxane-based chemotherapy (paclitaxel/carboplatin/etoposide; docetaxel/cisplatin; or docetaxel/carboplatin) was associated with long-term survival in some patients with CUP, with 1-, 2-, 3-, and 4-year survival rates of 42%, 22%, 17%, and 17%, respectively. The median survival was 10 months.

In a recent phase III randomized study, the triple drug regimen had comparable efficacy to gemcitabine and irinotecan in the first-line treatment of patients with CUP. In a randomized prospective phase II study conducted by the German CUP Study Group, the paclitaxel and carboplatin combination showed better clinical activity than the gemcitabine and vinorelbine combination. The median OS, 1-year survival rate, and response rate were 11.0 months, 38%, and 23.8%, respectively, for patients treated with paclitaxel and carboplatin, compared with 7.0 months, 29%, and 20%, respectively, for those treated with gemcitabine and vinorelbine. Sequential treatment with paclitaxel/carboplatin/etoposide and gemcitabine/irinotecan was also found to be active in patients with occult primary tumors. Although survival was similar to that observed in previous phase II trials, the overall toxicity of sequential treatment was found to be greater than that observed with other regimens.

**Carboplatin with Docetaxel**

Greco et al reported that docetaxel in combination with either cisplatin or carboplatin was active in patients with adenocarcinoma and poorly differentiated adenocarcinoma. Major response to therapy was observed in 26% of patients receiving docetaxel and cisplatin, with a median survival of 8 months and 1-year survival of 42%. In patients receiving docetaxel and carboplatin, the corresponding response rate was 22%, with a median survival of 8 months and 1-year survival of 29%. Docetaxel in combination with carboplatin was better tolerated than docetaxel with cisplatin in this study.

In a report of the Hellenic Cooperative Oncology Group phase II study, a 1-hour treatment with docetaxel and carboplatin every 3 weeks was found to be safe and effective as a palliative treatment for patients with adenocarcinoma or poorly differentiated carcinoma with a PS of 0 to 2. Median time to progression was 5.5 months, whereas OS was
16.2 months. Survival was better in favorable-risk patients (23 months vs. 5 months for those with visceral metastases). Predictors of superior outcome included good PS and low volume disease.

**Cisplatin with Gemcitabine**

The efficacy and toxicity of cisplatin with either gemcitabine or irinotecan were evaluated in a randomized phase II study conducted by the French Study Group on Carcinomas of Unknown Primary (GEFCAPI 01). Well-differentiated adenocarcinoma was the most common histology, with one-fourth of patients having a single metastatic site. Objective response rates were 55% for the gemcitabine and cisplatin arm and 38% for the irinotecan and cisplatin arm. Median survival rates were 8 and 6 months, respectively, for these 2 combination regimens, which were both associated with significant toxicities. The GEFCAPI 02 trial randomly assigned 52 patients to cisplatin with or without gemcitabine. Outcomes were similar between the arms, but trended better for the combination (1-year survival for the combination and cisplatin alone were 46% and 35%, respectively; $P = .73$). Toxicity was significantly greater with the addition of gemcitabine.

**Gemcitabine with Docetaxel**

A non-cisplatin–based regimen containing gemcitabine and docetaxel was found to be well-tolerated and active as first-line therapy in patients with occult primary tumors. The overall response rate was 40%, with a median survival of 10 months.

**Capecitabine with Oxaliplatin and 5-FU/Leucovorin with Oxaliplatin**

The combination of capecitabine and oxaliplatin (CapeOx) has been tested in phase II studies for first-line and second-line treatment of patients with carcinoma of unknown primary. This regimen gave response rates ranging from 12% to 19%, with disease-free survival of 2.3 to 3.7 months and OS of 3.9 to 9.7 months. This regimen appears to be active and well-tolerated and is an acceptable option for this patient population.

Although 5-FU/leucovorin/oxaliplatin (FOLFOX) has not been tested in patients with unknown primary tumors, FOLFOX has been shown to be equivalent to CapeOx in colorectal cancer. The panel therefore supports FOLFOX (mFOLFOX6) as an acceptable treatment option for these patients.

**SCC**

Platinum-based regimens have been used to treat disseminated SCC. Historically, the combination of cisplatin and 5-FU was the most frequently used regimen for patients with SCC of unknown primary.

Overall, only a few small studies have assessed chemotherapy regimens in patients with SCC occult primaries, and the panel lists possible regimens based on evidence from studies of patients with SCC of known primary and small studies of patients with occult primary tumors. Regimens other than those listed can also be considered.

**Carboplatin with Paclitaxel**

The combination of carboplatin and paclitaxel is used in non-small cell lung, gastric, and esophageal cancers.

In the Hellenic Cooperative Oncology Group phase II study of patients with CUP (discussed above for adenocarcinoma), 3 patients had tumors of squamous cell histology. One of these patients had an objective response of 3 months duration after carboplatin/paclitaxel.

**Carboplatin with Docetaxel**

The combination of carboplatin and docetaxel is used in head and neck and non-small cell lung cancers.
The combination of carboplatin and docetaxel was assessed in a phase II trial of 47 patients with occult primary adenocarcinomas or poorly differentiated carcinomas, with a response rate of 32% and median OS of 16.2 months.  

**Cisplatin with Paclitaxel**  
The combination of cisplatin and paclitaxel is used in head and neck cancer, non-small cell lung cancer, and esophageal cancer.  

In a randomized phase III trial of patients with advanced head and neck cancer, no significant differences were seen in patients treated with cisplatin/paclitaxel compared with patients treated with cisplatin/5-FU.  

This regimen has also been assessed in a phase II study of patients with unfavorable presentations of occult primary tumors. Three of the 31 patients had SCC. The regimen gave an overall response rate of 42%, and the median OS was 11 months (95% CI, 8.3–13.5).  

**Cisplatin with Docetaxel**  
The combination of cisplatin and docetaxel is used in non-small cell lung, esophageal, and gastric cancers.  

In a multi-center phase II trial of 34 evaluable patients with metastatic squamous cell esophageal cancer, cisplatin/docetaxel gave an objective tumor response rate of 33% in the ITT population. The median PFS and OS times were 5.0 months and 8.3 months, respectively.  

The safety and efficacy of this regimen has also been assessed in 45 patients with occult primary tumors. The reported overall response rate was 65.1%, and the median OS was 11.8 months. Two patients had tumors of SCC histology, and both had a partial response to the cisplatin/docetaxel regimen.  

**Cisplatin with 5-FU**  
This historic regimen has been tested in patients with SCC of unknown primary. It is also used in the treatment of metastatic anal, head and neck, esophageal, and gastric cancers.  

More recently, Kusaba et al reviewed their experiences of treating patients with occult primary tumors with this regimen. They reported a response rate of 54.5% and a median OS of 10 months.  

**Cisplatin with Docetaxel and 5-FU**  
The combination of cisplatin, docetaxel, and 5-FU is used in head and neck cancer, gastrointestinal cancer, and esophageal cancer.  

In a randomized phase III trial of 501 patients with advanced SCC of the head and neck, patients received cisplatin and 5-FU with or without docetaxel followed by chemoradiation. The overall response rates after induction chemotherapy were 72% and 64% in the 3-drug and 2-drug arms, respectively.  

**Cisplatin with Gemcitabine**  
The combination of cisplatin and gemcitabine is used in non-small cell lung cancer.  

The GEFCAPI 02 trial compared cisplatin to cisplatin plus gemcitabine in 52 patients with occult primary tumors. Although the trial was terminated early due to poor accrual, there was a trend towards better OS with the addition of gemcitabine (11 months vs. 8 months, with overlapping CIs).  

mFOLFOX6  
The panel lists mFOLFOX6 as a possible regimen for occult primary SCC, based on the evidence discussed above for...
adenocarcinoma.\textsuperscript{111,112} FOLFOX is used in SCC of the esophagus and stomach.\textsuperscript{145,146}

**Neuroendocrine Tumors**

Neuroendocrine carcinomas of unknown primary site are uncommon, and their clinical behavior is dependent on the tumor grade and differentiation.\textsuperscript{147} Neuroendocrine tumors, regardless of grade, represent a favorable prognostic subset of occult primary tumors that are responsive to combination chemotherapy, and long-term survival is possible in a minority of patients.\textsuperscript{26}

Hainsworth et al\textsuperscript{148} evaluated the efficacy of a combination regimen containing paclitaxel, carboplatin, and etoposide in metastatic PDNE carcinomas in patients who had received no prior treatment. Of these patients, 62\% had PDNE carcinoma of unknown primary site; patients with known primary sites were also eligible for the study. Major responses were observed in 53\% of the patients, and the median survival was 14.5 months; 2- and 3-year survival rates were 33\% and 24\%, respectively. The results of this trial showed that PDNE carcinomas are chemosensitive, with a high overall response rate to combination chemotherapy and a minority of complete responses.

PDNE tumors can also be treated following small cell lung cancer regimens. In a randomized phase III trial (JCOG 9702), the combination of carboplatin plus etoposide was equally as efficient as cisplatin plus etoposide in elderly or poor-risk patients with extensive small cell lung cancer who were not previously treated.\textsuperscript{149} No significant differences were seen in response rate (73\% for both regimens) and median OS (10.6 months for carboplatin and etoposide vs. 9.9 months for cisplatin and etoposide).

In one study, the combination of cisplatin and etoposide produced significant responses in patients with poorly differentiated, rapidly progressing neuroendocrine tumors (carcinoids and pancreatic neuroendocrine tumors of known primaries) when used as a second- or third-line treatment.\textsuperscript{150} In 2 small series of patients, temozolomide, as a single agent or in combination with thalidomide, was found to be effective in the treatment of advanced or metastatic neuroendocrine tumors.\textsuperscript{151,152}

The panel recommends that poorly differentiated (high-grade or anaplastic) or small cell subtypes other than lung neuroendocrine tumors be treated following the NCCN Guidelines for Small Cell Lung Cancer. Well-differentiated neuroendocrine tumors should be treated as carcinoid tumors in the NCCN Guidelines for Neuroendocrine Tumors.

**Radiation Therapy**

Radiation therapy is a treatment option for a variety of localized tumors, particularly as follow-up treatment after lymph node dissection for the involvement of axillary or inguinal nodes if more than 2 nodes are involved or extracapsular extension is present. Radiation therapy alone may also be considered for bone lesions, a retroperitoneal mass with a non-germ cell histology, or supraclavicular nodal involvement in site-specific SCC.

**Locoregional Therapeutic Options**

In patients with unresectable localized liver lesions (either adenocarcinoma or neuroendocrine), locoregional therapeutic options may be considered. Locoregional therapeutic options include hepatic artery infusion, chemoembolization, hepatic cryosurgery, radiofrequency ablation of hepatic lesions, or percutaneous ethanol injections.
Specialized Approaches

Specialized approaches are suggested as a treatment option in all patients with disseminated metastases. The term emphasizes the importance of an individual approach. Specialized approaches may include palliative treatment options, such as thoracentesis and paracentesis; novel forms of drug delivery; targeted therapies, such as radioimmunotherapy; and novel forms of radiation therapy, such as intraoperative radiation therapy, intensity-modulated radiation therapy, image-guided radiation therapy, or proton therapy.¹⁵³

Follow-up

For patients with either active disease or localized disease in remission, follow-up frequency should be determined by clinical need. Follow-up consists of a history and physical, with diagnostic tests for symptomatic patients.

For patients with active and incurable disease, psychosocial support, symptom management, end-of-life discussions, palliative care interventions, and hospice care should all be considered and used as appropriate (see *Psychosocial Distress and Supportive Care*, above). Please see the NCCN Guidelines for Distress Management and the NCCN Guidelines for Palliative Care (to view the most recent versions of these guidelines, visit the NCCN Web site at [www.NCCN.org](http://www.NCCN.org)).
References


17. Hemminki K, Bevier M, Hemminki A, Sundquist J. Survival in cancer of unknown primary site: population-based analysis by site and


