Cancers of unknown primary site: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up†

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definition, incidence and biology

Cancers of unknown primary site (CUPs) represent a heterogeneous group of metastatic tumours for which a standardised diagnostic work-up fails to identify the site of origin at the time of diagnosis. CUPs account for 3%–5% of all malignancies. The unique biology of these tumours remains almost unknown [1]. Nonetheless, current data suggest that metastatic dissemination can occur in the absence of growth of a primary tumour by virtue of inherent metastatic aggressiveness of cancer cells. Chromosomal instability was recently suggested to account for part of the uncommon clinical presentation, chemoresistance and poor outcome in patients with CUP [2].

diagnosis, pathology and molecular biology

Diagnosis of CUP requires pathology evaluation of a good quality tissue sample. These tumours are categorised by pathology into:

- well- and moderately differentiated adenocarcinomas;
- squamous cell carcinomas;
- carcinomas with neuroendocrine differentiation;
- poorly differentiated carcinomas (including poorly differentiated adenocarcinomas);
- undifferentiated neoplasms.

Immunohistochemistry should be applied meticulously [3, 4] in order to identify the tissue of origin and to exclude hormone-sensitive and potentially curable tumours (i.e. lymphomas and germ-cell tumours) (Table 1) [III, A]. If the diagnosis is carcinoma or adenocarcinoma, immunostaining for prostate-specific antigen (PSA) in male patients and for oestrogen and progesterone receptors in females with axillary node metastases is advisable to rule out hormone-sensitive tumours amenable to specific therapy. Staining for keratins CK7 and CK20 may provide indications of a possible primary site, and staining for chromogranin A and synaptophysin is needed to profile neuroendocrine differentiation (Figure 1). Examples of stainings that are rather specific include CK7+, WT-1+, PAX8+, CK20− (ovarian cancer) and RCC+, PAX8+ (renal cancer).

personalised medicine

Several gene expression profiling assays have become commercially available, claiming to blindly and correctly identify a known primary cancer and a likely tissue of origin in patients with CUP in ~80% [6, 7] [III]. These assays are based on mRNA or miRNA RT-PCR or oligonucleotide microarray technologies [8–10]. No significant differences in the tumour microRNA expression profile were evident when CUP metastases biologically assigned to a primary tissue of origin were compared with metastases from typical solid tumours of known origin [11]. These tests may aid in the diagnosis of the putative primary tumour site in some patients [12]. However, their impact on patient outcome via administration of primary site-specific therapy remains questionable and unproven in randomised trials [13] [IV, C]. A large prospective non-randomised phase II study of 252 patients suggested that survival may be improved by site-specific therapy determined by a gene expression profile assay of the biopsy specimen, particularly for patients with a tissue of origin diagnosis of more responsive tumour types [7]. A prospective randomised phase III trial testing such a precision medicine strategy versus empirical chemotherapy is currently on-going in Europe (NCT01540058).

staging and risk assessment

CUPs are by definition metastatic cancers, and the prognosis for patients with CUP is generally poor. However, an appropriate diagnostic work-up can help to identify a minority of CUP patients who can expect to benefit from directed therapy. The following recommendations epitomise the standard and
optional assessments suggested. Diagnostic and staging guidelines for patients with an anticipatory CUP diagnosis are summarised in Table 2.

Thorough physical examination (including head and neck, rectal, pelvic and breast examination), basic blood and biochemical analyses, and computed tomography (CT) scans of thorax, abdomen and pelvis constitute a minimal basic work-up [IV, B].

Endoscopies should be sign-, symptom- or laboratory abnormality-guided. Serum assessment of α-fetoprotein, human chorionic gonadotropin, plasma chromogranin A and PSA is suggested in male patients to exclude potentially curable extragonadal germ-cell tumours, neuroendocrine tumours and prostate cancers amenable to hormonal treatment.

Whole-body 2-deoxy-2-[18F]fluoro-D-glucose-positron emission tomography (FDG–PET)/CT may contribute to the management of patients with cervical adenopathies from CUP and those with a single CUP metastasis [IV, B]. For other CUPs, the role of FDG–PET is limited [14, 15], making this imaging procedure not mandatory in the systematic work-up [III, C].

For patients with predominant midline lymph node involvement, the diagnosis of lymphoma or extragonadal germ-cell tumours should be ruled out.

![Table 1. Immunohistochemical work-up in patients with cancers of unknown primary site (CUPs)](image)

The table shows general staining patterns but exceptions exist, especially for S100 and vimentin. Thyroid and neuroendocrine cancers often positive with CK7 and TTF1 but not with NapsinA. PSA, prostate specific antigen; ER, oestrogen receptor; PgR, progesterone receptor; CK, cytokeratin; TTF1, thyroid transcription factor 1; NSE, neuron-specific enolase; AFP, alpha fetoprotein; hCG, human chorionic gonadotropin; PLAP, placental alkaline phosphatase; LCA, leukocyte common antigen.

![Figure 1. Basic immunohistochemical work-up of cancers of unknown primary. Reproduced with permission: [5].](image)

CK 7-/CK 20+  →  Colorectal and Merkel cell carcinoma  →  CEA and CDX-2

CK 7+/CK 20-  →  Lung, breast, thyroid, endometrial, cervical, and pancreatic carcinoma and cholangiocarcinoma  →  TTF-1, ER, PR, GCDFP-15, and CK 19

CK 7+/CK 20+  →  Urothelial, ovarian, and pancreatic cancer and cholangiocarcinoma  →  Urothelin and WT-1

CK 7-/CK 20-  →  Hepatocellular, renal cell, prostate, squamous cell  →  Hep Par-1 and PSA
Distinct subsets of patients with CUP have been defined based on clinical and pathological criteria [2] (Table 3). An additional subset of CUP with a colorectal IHC or molecular profile also seems to have a better prognosis, likely thanks to more active systemic treatments developed over the last two decades for colon cancer [16]. A minority of patients (15%–20%) belong to clinico-pathological subsets with a more favourable prognosis. These favourable-risk CUP patients harbour chemosensitive and potentially curable tumours and may experience long-term disease control with appropriate multidisciplinary management.

The majority of patients (80%–85%) do not belong to specific subsets. Sensitivity to therapy is only modest and median overall survival is generally <1 year (6–10 months). Two prognostic groups can be identified among patients with CUP:

- those with a good performance status (0–1) and a normal lactate dehydrogenase (LDH) value, with a median life expectancy of 1 year, and
- those with either one or both of these prognostic factors (poor performance status and elevated serum LDH), with a median overall survival of only ~4 months [17].

A proposal for the practical management of patients with CUP, including recognition of specific subsets, exclusion of non-CUP neoplasms and the use of prognostic parameters in clinical practice, is summarised in Figure 2.

**treatment**

Therapy should be individually tailored according to the clinico-pathological subset to which the patient belongs [III, B]. Referral to specialised centres is strongly encouraged. The 10%–15% of CUP patients in the

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**Table 2.** Diagnostic and staging guidelines for cancers of unknown primary site (CUPS)

<table>
<thead>
<tr>
<th>Assessment suggested</th>
<th>Target patient population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorough medical history and physical examination</td>
<td>All patients</td>
</tr>
<tr>
<td>Basic blood and biochemistry analyses</td>
<td>All patients</td>
</tr>
<tr>
<td>CT scans of thorax, abdomen and pelvis</td>
<td>All patients</td>
</tr>
<tr>
<td>Mammography</td>
<td>Female patients</td>
</tr>
<tr>
<td>Work-up for CUP subsets</td>
<td>Females with axillary adenocarcinoma</td>
</tr>
<tr>
<td>Serum α-fetoprotein and human chorionic gonadotropin</td>
<td>Patients with midline metastatic disease</td>
</tr>
<tr>
<td>Serum prostate-specific antigen</td>
<td>Males with adenocarcinomatous bone metastases</td>
</tr>
<tr>
<td>Head and neck CT/PET scan (optional)</td>
<td>Cervical squamous cell carcinoma</td>
</tr>
<tr>
<td>Endoscopies</td>
<td>Sign/symptom/laboratory-oriented</td>
</tr>
<tr>
<td>Octreoscan and plasma chromogranin A</td>
<td>Patients with neuroendocrine tumour CUP</td>
</tr>
<tr>
<td>Additional diagnostic pathology</td>
<td>Sign/symptom/laboratory-oriented</td>
</tr>
</tbody>
</table>

CT, computed tomography; MRI, magnetic resonance imaging; PET, positron emission tomography.

**Table 3.** Therapy for patients with favourable-risk cancers of unknown primary site (CUPS)

<table>
<thead>
<tr>
<th>CUP subtype</th>
<th>Proposed treatment</th>
<th>Potential equivalent tumour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorly differentiated neuroendocrine carcinomas of an unknown primary</td>
<td>Platinum + etoposide combination chemotherapy</td>
<td>Poorly differentiated neuroendocrine carcinomas with a known primary</td>
</tr>
<tr>
<td>Well-differentiated neuroendocrine tumour of unknown primary</td>
<td>Somatostatin analogues, streptozocin+5-FU, sunitinib, everolimus</td>
<td>Well-differentiated neuroendocrine tumour of a known primary site</td>
</tr>
<tr>
<td>Peritoneal adenocarcinomatosis of a serous papillary histological type in females</td>
<td>Optimal surgical debulking followed by platinum-taxane-based chemotherapy</td>
<td>Ovarian cancer</td>
</tr>
<tr>
<td>Isolated axillary nodal metastases in females</td>
<td>Axillary nodal dissection, mastectomy or breast irradiation and adjuvant chemohormonotherapy</td>
<td>Breast cancer (found in 50%–70% when breast MRI is performed)</td>
</tr>
<tr>
<td>Squamous cell carcinoma involving non-supraclavicular cervical lymph nodes</td>
<td>Neck dissection and/or irradiation of bilateral neck and head–neck axis. For advanced stages induction chemotherapy with platinum-based combination or chemoradiation</td>
<td>Head and neck squamous cell cancer</td>
</tr>
<tr>
<td>CUP with a colorectal IHC (CK20+ CDX2+ CK7–) or molecular profile</td>
<td>Systemic treatment used for colorectal cancer</td>
<td>Metastatic colorectal cancer</td>
</tr>
<tr>
<td>Single metastatic deposit from unknown primary</td>
<td>Resection and/or RT ± systemic therapy</td>
<td>Single metastasis</td>
</tr>
<tr>
<td>Men with blastic bone metastases or IHC/serum PSA expression</td>
<td>Androgen deprivation therapy ± RT</td>
<td>Prostate cancer</td>
</tr>
</tbody>
</table>

5-FU, 5-fluorouracil; MRI, magnetic resonance imaging; IHC, immunohistochemistry; PSA, prostate-specific antigen; RT, radiotherapy; CK, cytokeratin.
favourable-risk subsets should be treated similarly to patients with equivalent known primary tumours with metastatic dissemination [IV, B]. These patients achieve long-term disease control in 30%–60% of cases, and optimal management is pivotal for long-term survival (Table 3). Retrospective analyses confirm that the clinical behaviour, biology, response to treatment and outcome of patients with favourable-risk CUP are not different from similar factors relative to metastatic tumours from a known primary site [18–22].

Patients with poor-risk CUP have a dismal prognosis despite management with a variety of chemotherapeutic combinations in small clinical studies [23]. A review conducted in the 2000s showed no evidence of superior efficacy of any of the administered regimens comprising platinum salts, taxanes or new-generation cytotoxic compounds (gemcitabine, vinca alkaloids or irinotecan) [24]. A randomised prospective phase III study of 198 patients compared gemcitabine/irinotecan with paclitaxel/carboplatin/oral etoposide in fit poor-risk patients and reported significantly less toxicity with the two-drug regimen and equal survival rates [II, A] [25]. On the other hand, the efficacy/toxicity ratio of the cisplatin–gemcitabine combination was found to be better than that of the cisplatin–irinotecan regimen in a randomised phase II trial [I, A] [26]. Finally, better outcome was reported with the two-drug cisplatin–gemcitabine regimen when compared with cisplatin alone, although this was not assessed in a large and adequately powered randomised phase III trial [27] (II). Modest survival prolongation and symptom palliation with preservation of quality of life are currently the only realistic aims of therapy for these patients [II, A], although rare cases of cure have been reported [28]. Consequently, low-toxicity patient-convenient chemotherapy regimens should be administered to reasonably fit poor-risk CUP patients (Table 4). If evaluation of patient demographics, metastatic pattern, results

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**Figure 2.** Clinical management of patients presenting with CUPs. IHC, immunohistochemistry; PS, performance status; LDH, lactate dehydrogenase; OS, overall survival.

**Table 4.** Commonly used low-toxicity palliative chemotherapy regimens for poor-risk patients with cancers of unknown primary site (CUPs)

<table>
<thead>
<tr>
<th>Chemotherapy (mg/m²)</th>
<th>Time</th>
<th>Interval</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cisplatin 60–75 +  Gemcitabine 1000</td>
<td>Day 1</td>
<td>Q3 weeks</td>
<td>Fit patients, adequate hydration</td>
</tr>
<tr>
<td>Cisplatin 75 +  Etoposide 100</td>
<td>Day 1</td>
<td>Q3 weeks</td>
<td>Fit patients with neuroendocrine-feature CUP, adequate hydration</td>
</tr>
<tr>
<td>Paclitaxel 175 +  Carboplatin AUC 5</td>
<td>Day 1</td>
<td>Q3 weeks</td>
<td>Convenient outpatient regimen, monitor neurotoxicity</td>
</tr>
<tr>
<td>Docetaxel 75 +  Carboplatin AUC 5</td>
<td>Day 1</td>
<td>Q3 weeks</td>
<td>Convenient outpatient regimen, monitor neurotoxicity</td>
</tr>
<tr>
<td>Irinotecan 160 +  Oxaliplatin 80</td>
<td>Day 1</td>
<td>Q3 weeks</td>
<td>Outpatient regimen, monitor for neurotoxicity and diarrhoea</td>
</tr>
<tr>
<td>Oral capcitabine 2000 ±  Oxaliplatin 85–130</td>
<td>Days 1–14</td>
<td>Outpatient regimen, risk for diarrhoea and neurotoxicity</td>
<td></td>
</tr>
<tr>
<td>Gemcitabine 1000/irinotecan 100</td>
<td>Day 1+8</td>
<td>Q3 weeks</td>
<td>Convenient outpatient regimen, monitor diarrhoea</td>
</tr>
</tbody>
</table>

AUC, area under the curve.
of clinical and laboratory tests, imaging data, pathological evaluations and gene expression is relatively unambiguous, a site-specific treatment may be considered, though prospective evidence that this is better than empirical chemotherapy is lacking so far.

Whether targeted agents should be used or not in patients with CUPs is still unknown [29]. Although only a few non-chemotherapy drugs have been tested in patients with CUP, belinostat was randomly assessed and it did not improve the results of the carboplatin-paclitaxel regimen [30]. Preliminary retrospective data suggest that CUP patients with immunohistochemical and/or molecular profile assay diagnoses of ‘colorectal’ carcinomas have response rates and survival after colorectal site-specific therapies (i.e. FOLFOX or FOLFIRI) that are similar to colorectal cancers [16, 31] [IV, B]. These data are from small numbers of patients, and additional prospective validation is necessary to substantiate these preliminary findings.

Participation in clinical trials evaluating combinations of cytotoxic compounds with targeted agents or site-specific therapy in patients with putative primary tumour sites highly suspected from immunohistochemical or microarray studies should be strongly encouraged.

**response evaluation**

Response evaluation is recommended after two or three chemotherapy cycles by individually adequate tests. Quality-of-life issues are particularly relevant for patients with poor-risk CUP for whom excessive treatment-related toxicity is not justified [IV, B].

**follow-up and long-term implications**

There is no evidence that follow-up of asymptomatic patients is needed. Specific examinations as clinically indicated.

**methodology**

These clinical practice guidelines were developed in accordance with the ESMO standard operating procedures for clinical practice guidelines development. The relevant literature has been selected by the expert authors. Levels of evidence and grades of recommendation have been applied using the system shown in Table 5. Statements without grading were considered justified standard clinical practice by the experts and the ESMO faculty. This manuscript has been subjected to an anonymous peer review process.

**acknowledgements**

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**conflict of interest**

The authors have declared no conflicts of interest.

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