



# Systematic review of photobiomodulation for the management of oral mucositis in cancer patients and clinical practice guidelines

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## Abstract

**Purpose** To systematically review the literature and update the evidence-based clinical practice guidelines for the use of photobiomodulation (PBM), such as laser and other light therapies, for the prevention and/or treatment of oral mucositis (OM).

**Methods** A systematic review was conducted by the Mucositis Study Group of the Multinational Association of Supportive Care in Cancer/International Society for Oral Oncology (MASCC/ISOO) using PubMed and Web of Science. We followed the MASCC methods for systematic review and guidelines development. The rigorously evaluated evidence for each intervention, in each cancer treatment setting, was assigned a level-of-evidence (LoE). Based on the LoE, one of the following guidelines was determined: Recommendation, Suggestion, or No Guideline Possible.

**Results** Recommendations are made for the prevention of OM and related pain with PBM therapy in cancer patients treated with one of the following modalities: hematopoietic stem cell transplantation, head and neck (H&N) radiotherapy (without chemotherapy), and H&N radiotherapy with chemotherapy. For each of these modalities, we recommend 1–2 clinically effective protocols; the clinician should adhere to all parameters of the protocol selected. Due to inadequate evidence, currently, No Guideline Possible for treatment of established OM or for management of chemotherapy-related OM. The reported clinical settings were extremely variable, limiting data integration.

**Conclusions** The evidence supports the use of specific settings of PBM therapy for the prevention of OM in specific patient populations. Under these circumstances, PBM is recommended for the prevention of OM. The guidelines are subject to continuous update based on new published data.

**Keywords** Cancer · Chemotherapy · Laser therapy · LED · LLLT · Low-level laser therapy · Prevention · Treatment · Oral complications of cancer therapy · Oral mucositis · Pain · Photobiomodulation · Photobiostimulation · Radiotherapy · Stomatitis · Evidence-based · Guidelines

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## Abbreviations

CT	Chemotherapy
GaAlAs	Gallium-aluminum-arsenide
H&N	Head and neck
HeNe	Helium-Neon
HSCT	Hematopoietic stem cell transplantation
InGaAlP	Indium-Gallium-Aluminum-Phosphorus
InGaAs	Indium-Gallium-Arsenide
LED	Light-emitting diode
LLLT	Low-level laser therapy
LoE	Level of evidence

OM	Oral mucositis
MASCC /ISOO	Multinational Association of Supportive Care in Cancer/International Society of Oral Oncology
PBM	Photobiomodulation
PTP	Photobiomodulation therapy parameters
RCT	Randomized controlled trial
RT	Radiotherapy

## Introduction

Oral mucositis (OM) is a debilitating complication of high-dose chemotherapy (CT), radiation therapy (RT) to the head and neck (H&N), and hematopoietic stem cell transplantation (HSCT). OM may be associated with intense pain, increased consumption of opioids (narcotics), increased need for parenteral nutrition, and increased risk of bacteremia [1, 2]. In HSCT patients, OM is associated with a greater risk of 100-day post-HSCT mortality [3].

The term photobiostimulation was coined by Endre Mester following his observation of the effects of low-dose laser treatments on stimulation of wound healing [4]. Later, it was also noted that as well as stimulation, light therapy may also modify certain deleterious processes, such as inflammation or pain, and the term photobiomodulation (PBM) was established [5]. Some studies use the term low-level laser therapy or low-level light therapy (LLLT) to refer to PBM. Currently, PBM includes a broad range of nonionizing light sources such as lasers, light-emitting diodes (LEDs), and broadband visible light in the visible and near-infrared spectrum at very low, non-thermal doses. PBM activates endogenous chromophores eliciting photophysical and photochemical events involving several biological pathways that provide favorable clinical therapeutic results [6]. PBM stimulates and promotes positive tissue processes such as wound healing, regeneration, and immune responses and mediates negative tissue processes such as inflammation, pain, and aberrant immune responses [6, 7]. As such, PBM was suggested for the management of OM [8, 9].

The Mucositis Study Group of the Multinational Association of Supportive Care in Cancer/International Society of Oral Oncology (MASCC/ISOO) published comprehensive evidence-based clinical practice guidelines for mucositis, including a section about laser and light therapy [10, 11]. The previous guidelines for laser

and light therapy for the management of OM in cancer patients was based on evidence indexed before 31 December 2010. The MASCC/ISOO recommended the use of LLLT at a wavelength of 650 nm, power of 40 mW, and each square centimeter treated enough to achieve a tissue energy dose of 2 J/cm<sup>2</sup> (2 s/site) for the prevention of OM in adults receiving HSCT conditioned with high-dose CT, with or without total body irradiation. Additionally, MASCC/ISOO suggested the use of LLLT (wavelength 632.8 nm) for the prevention of OM in patients undergoing RT, without concomitant CT, for H&N cancer [11]. No specific details were provided for this later guidelines, and a reservation that it was based on flawed randomized controlled trial (RCT) was published. No guidelines were possible in other patient populations or for other light sources due to insufficient evidence [11]. The authors called for additional well-designed research to evaluate the efficacy of laser and other light therapies in other cancer treatment settings. As part of a comprehensive update of the MASCC/ISOO clinical practice guidelines for the management of mucositis, the aim of this study was to systematically review the peer-reviewed literature since 2011 and update the clinical practice guidelines for the use of PBM (i.e., laser and other light) therapy for OM management. This aim highlights the specific objective of identifying current interventions for mucositis and ranking them based on evidence quality in order to compile guidelines for clinicians to be used in decision-making for the management of OM.

## Methods

The detailed methods are described in Ranna et al. [12]. Briefly, a literature search for relevant papers indexed in the literature from January 1, 2011 to June 30, 2016 was conducted using PubMed and Web of Science, with papers selected for review based on defined inclusion and exclusion criteria [12]. The following keywords were unique for the literature search of this section: CO<sub>2</sub>, Diode, GaAlAs, HeNe, infra-red, InGaAlP, InGaAs, laser, LED, light therapy, light-emitting diode, low-level laser therapy, low-level light therapy, photobiomodulation, phototherapy, and visible light. The keywords that are shared by all sections are listed in the Ranna et al. paper [12]. We also screened the references of the systematic reviews and meta-analyses to identify additional, original studies that were not retrieved in our prior search.

Papers were reviewed by two independent reviewers and data was extracted using standard electronic forms. If there were any doubts within the reviewing team, the corresponding author of the respective study was contacted. Data identified in the current literature search were merged with the papers identified in the 2013 guidelines to cover the entire literature up to June 2016. References identified as related to PBM, laser, and light therapy during the literature triage in other sections were transferred and included in the dataset of this section. Studies reporting overlapping patient populations, or presenting sub-analysis of the same patient population were considered as a single study. Studies were scored for their level of evidence (LoE) based on Somerfield criteria, and flaws were listed according to Hadorn criteria [13, 14]. A well-designed study was defined as a study with no major flaws per the Hadorn criteria. Studies with the most robust study-design (RCTs, controlled clinical trials, and cohort studies) were used for the analysis of the collective LoE for each clinical category. Clinical categories were defined based on (i) the aim of the intervention (prevention or treatment of OM); (ii) the treatment modality [RT, CT, chemoradiotherapy (RT-CT)], or high-dose conditioning therapy for HSCT), and (iii) the route of administration of the intervention (intra-oral, extra-oral, or combined). Guidelines were classified into three types: Recommendation, Suggestion, and No Guideline Possible.

Additionally, all randomized controlled trials (RCTs) were reviewed for reports about topical or systemic adverse effects following PBM therapy. This was considered as complementary data to evaluate the safety of PBM therapy in patients undergoing anti-cancer therapy.

Papers were also reviewed for the PBM therapy parameters, (PTPs) (Box 1) to enable clinical treatment recommendations. A comprehensive assessment of these parameters namely, intensity (or power, mW); power density (or irradiance, mW/cm<sup>2</sup>); energy (J); energy density or fluence, J/cm<sup>2</sup>); site size (treated area, cm<sup>2</sup>); time per site (seconds); number of oral sites treated, treatment probe distance or contact with tissue, mode of operation (continuous versus pulsed); and duration of the treatments relative to the timing of the anti-cancer therapies was performed. We examined these parameters in all manuscripts selected for this review and if they were not reported, we calculated the power density (irradiance, mW/cm<sup>2</sup>). If the PTPs were reported, their validity was confirmed using standard dose equations (irradiance = power/site size; or irradiance = fluence × 1000/time per site). Studies with inconsistent reports of PTPs were excluded from the analysis.

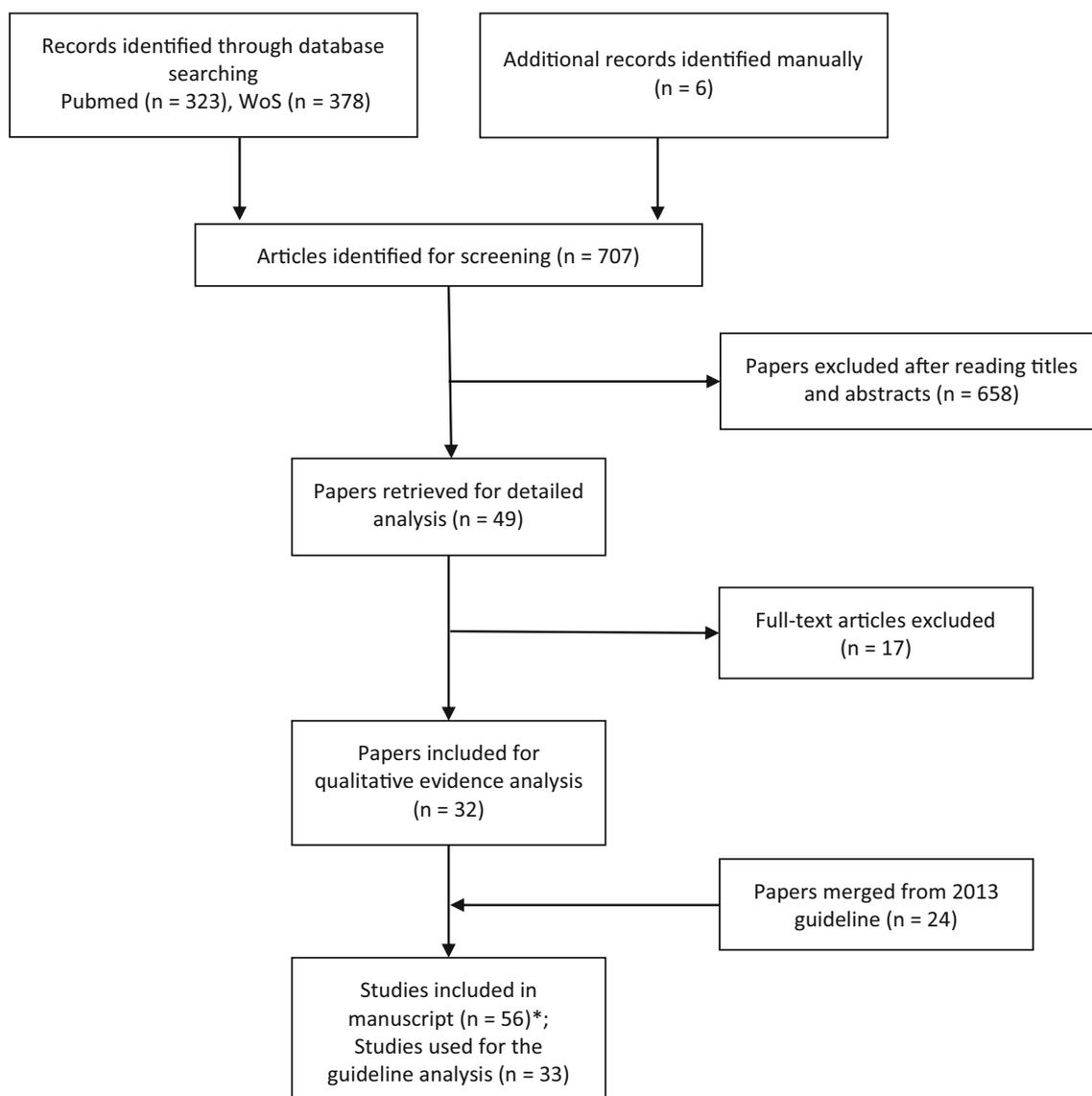
**Box 1** Photobiomodulation therapy parameters (PTPs) required for reproducible reports

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- (1) Device setting–user-determined:
    - i. Critical
      - 1. Irradiance/power density (mW/cm<sup>2</sup>)
      - 2. Fluence/energy density (J/cm<sup>2</sup>)
      - 3. Time per site (sec)
    - ii. Required if the “critical” parameters listed in “(1)i” are not all reported
      - 1. Spot size (cm<sup>2</sup>)
      - 2. Distance from the tissue (cm<sup>2</sup>)
      - 3. Power/intensity (mW)
      - 4. Energy (J)
    - iii. Advised
      - 1. Mode of operation–(continuous/pulsed)
      - 2. Duty cycle (%)
      - 3. Frequency (Hz)
  - (2) Device setting–machine-determined:
    - i. Wavelength (nm)
    - ii. Beam divergence
  - (3) Delivery mode parameters:
    - i. Stationary/motion
    - ii. Distance from the tissue
    - iii. Number of sites
  - (4) Treatment parameters
    - i. Number of sessions
    - ii. Timing compared to the anti-cancer therapy
    - iii. Anatomical location
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## Results

A total of 701 abstracts were retrieved (323 from PubMed and 378 from Web of Science). Six papers were identified on manual literature search. After triage of the abstracts, 49 full text articles were chosen for further review. Following the review of the full papers, an additional 17 papers were excluded as they did not meet the exclusion and inclusion criteria. Following the merging, the data after 2011 with data before 2011, 24 additional papers were added. When overlapping reports were checked and the review PTPs and focus on studies with the most robust study design considered, 23 papers were excluded. Therefore, a total of 33 papers were included in this systematic review (Fig. 1).

The complete list of reviewed papers is presented in the online materials. While numerous studies were



**Fig. 1** Flow diagram of the information flow through the different phases of the systematic review. \*The complete list of these 56 papers is presented in the online materials [65–85]. WoS, Web of Science

reviewed, guidelines were reserved for the most reproducible studies with robust design and positive results; protocols are listed in Table 1. The remaining studies included in this analysis are in Table 2 (intra-oral applications), Table 3 (extra-oral applications), and Table 4 (combined intra- and extra-oral applications).

The following sections present the data for specific clinical conditions where PBM therapy has been used, i.e., aim of intervention, anti-cancer therapy, and patient population. Details of device type and PTPs are presented in the respective tables. Adherence to the treatment parameters is essential to achieve the reported benefits; interchanging parameters and extrapolations among protocols are not recommended.

### Prevention of oral mucositis in hematopoietic stem cell transplantation

**Guideline** The panel recommends the use of intra-oral PBM therapy using low-level laser therapy for the prevention of OM in adult patients receiving HSCT conditioned with high-dose CT, with or without total body irradiation using one of the selected protocols in Table 1 (LoE I); following the specific PTPs of the selected protocol is recommended for optimal therapy.

Intra-oral PBM was reported to be beneficial for the prevention of OM and related pain in HSCT patients in numerous RCTs (Table 2) [8, 15, 22–27, 44]. The overall trend noted

**Table 1** Recommended intra-oral photobiomodulation therapy protocols for the prevention of oral mucositis

Cancer treatment modality	Protocol	Wavelength (nm)	Power density (irradiance; mW/cm <sup>2</sup> )	Time per spot (sec)	Energy density (fluence; J/cm <sup>2</sup> )	Spot size (cm <sup>2</sup> )	Number of sites	Distance from the tissue	Frequency	Duration	Based on reference
HSCT	#1	632.8	31.25	40	1.0	0.8	18	<1 cm	Daily	From day after cessation of conditioning for 5 days	Barasch et al., 1995 [8]
	#2	650	1000*	2	2.0	0.04	54–70	In contact	Daily	From 1st day of conditioning till day +2 post-HSCT (for 7–13 days)	Schubert et al., 2007 [15]
RT	#1	632.8	24	125	3.0	1	12	<1 cm	5 days/wk.	Entire RT course	Gautam et al., 2015 [16]
RT-CT	#1	660	417*	10	4.2	0.24	72	In contact	5 days/wk.	Entire RT course	Antunes et al., 2013 [17]
	#2	660	625*	10	6.2	0.04	69	In contact	3 days/wk. (alternate days)	Entire RT course	Oton-Leite et al., 2015 [18]

\*Potential thermal effect. The clinician is advised to pay attention to the combination of specific parameters

CT, chemotherapy; HSCT, hematopoietic stem cell transplantation; IO, intra-oral; NR, not reported; PBM, photobiomodulation; RT, radiotherapy; wk., week

from the available evidence is that intra-oral PBM therapy at wavelengths of 630 to 660 nm (red) is beneficial for preventing OM and related pain in HSCT patients. Significant variations were noted in PTPs (Table 2). An RCT using visible light supports this guideline as the peak of the emission spectrum used in this study was in the range of 625–660 nm (Table 2: entire spectrum used—top row; peak of the emission spectrum—bottom row) [27].

Extra-oral PBM for the management of OM was reported to have a beneficial effect in the prevention of OM in HSCT patients (Table 3). While there was evidence of clinical efficacy in two studies, one RCT and a cohort study, the LoE does not enable a guideline for extra-oral PBM [42, 43].

### Prevention of oral mucositis in cancer patients treated with chemotherapy

**Guideline** No guideline possible.

Based on the current literature, no guideline is possible for intra-oral PBM for the prevention of OM in cancer patients treated with CT due to the absence of RCTs and significant variability of the PTPs in the studies with low LoE (Table 2) [28–31].

### Prevention of oral mucositis in head and neck cancer patients treated with radiotherapy

**Guideline** The panel recommends the use of intra-oral PBM therapy using low-level laser therapy for prevention of OM in adult patients receiving RT to the H&N (without CT) (LoE II) (Table 1); the specific PTPs of the selected protocol should be followed for optimal therapy. Safety considerations unique to patients with oral cancer should be considered.

The efficacy of intra-oral PBM at wavelength of 632.8 nm for prevention of OM and related pain in cancer patients treated with RT to the H&N (without CT) was reported in several studies (Table 2) [16, 34, 35].

A single study combined both extra- and intra-oral laser application for the prevention of OM in patients treated with RT to the H&N and reported positive clinical results (Table 4). [35] Due to limited evidence and low LoE, no guideline is possible for this protocol.

### Prevention of oral mucositis in head and neck cancer patients treated with radiotherapy and chemotherapy

**Guideline** The panel recommends the use of intra-oral PBM therapy using low-level laser therapy for the prevention of OM in adult patients receiving RT and CT for H&N cancer (LoE I) (Table 1); the specific PTPs of

**Table 2** Studies addressing intra-oral photobiomodulation for the management of oral mucositis

Cancer treatment modality	Aim	RCTs										Non-RCTs-study design (effectiveness)	Overall level of evidence	Guideline category
		Author, Year	Cancer type	PBM source	Wave-length (nm)	Power (mW)	Energy density (Fluence; J/cm <sup>2</sup> )	Time (sec)	Power density (irradiance; mW/cm <sup>2</sup> )	Sites	Effectiveness			
HSCT	P	<b>Barasch et al. 1995 [8] *</b>	<b>Hematol</b>	<b>He-Ne laser</b>	<b>632.8</b>	<b>25</b>	<b>1</b>	<b>40</b>	<b>31.25</b>	<b>18</b>	Y (1,3)	Jaguar et al. 2007 [19] - 4 (Y)	I	R
		Cowen et al. 1997 [22]	Hematol	He-Ne laser	632.8	60	1.5	10	150	75	Y (1,2)	Bezinelli et al. 2014 [20] - 3 (Y)		
		Antunes et al. 2007 [14] *	Hematol	Diode laser	660	46.7	4	16.7	238	165	Y (1,2)	De Paula Eduardo et al. 2015 [21] - 3 (Y)		
		<b>Schubert et al. 2007 [15] *</b>	<b>Hematol</b>	<b>Diode laser</b>	<b>650</b>	<b>40</b>	<b>2</b>	<b>2</b>	<b>1000</b>	<b>54-70</b>	Y (1,3)	Bezinelli et al. - 4 (Y)		
		Khouri et al. 2009 [23]	Hematol	Diode laser	660/780	25	6.3	10	630	5	Y (1)			
		Silva et al. 2011 [24]	Hematol	Diode laser	660	40	4	4	1000	80	Y (1)			
		Silva et al. 2015 [25]	Hematol	Diode laser	660	40	4	4	1000	80	Y (1,2)			
		Ferreira et al. 2016 [26]	Hematol	Diode laser	650	100	70	20	3571	27	Y (1,3)			
		Elad et al., 2011 [27] *	Hematol	Visible light	400-900	125	1.4-1.8	90	160-200	3	Y (1,3)			
	CT	T P	None None	-									Freitas et al. 2014 [28] - 4 (Y)	III
CT/HSCT	T P	None None	-									Ottaviani et al. 2013 [29] - 4 (Y)	IV	NGP
	T	Amadori et al. 2016 [33]	Hematol & solid ca. ^	Diode laser	830	150	4.5	30	150	7	Y (2,3)	Cunha et al. 2012 [30] - 3 (Y)	III	NGP
RT	P	Bensadoun et al. 1999 [34]	H&N	He-Ne laser	632.8	60	2	33	60	9	Y (1,2,3)	Gobbo et al. 2016 [31] - 4 (Y)	II	R
		<b>Gautam et al. 2015 [16] *</b>	<b>H&amp;N</b>	<b>He-Ne laser</b>	<b>632.8</b>	<b>24</b>	<b>3</b>	<b>125</b>	<b>24</b>	<b>12</b>	Y (1,2,3,4)	Chermetz et al. 2014 [32] - 4 (Y) ^	III	NGP
RT-CT	T P	None None	H&N		660	10	2.5	10	250	9	N	None	I	R



**Table 3** Studies addressing extra-oral photobiomodulation for the management of oral mucositis

Cancer treatment modality	Aim	Author, year	Cancer type	PBM source	Wave-length (nm)	Power (mW)	Fluence (J/cm <sup>2</sup> )	Time (sec)	Irradiance (mW/cm <sup>2</sup> )	Sites	Effectiveness	Non-RCTs	Overall level of evidence	Guideline category
HSCT	P	Hodgson et al. 2012 [42]	Hematol <sup>^</sup>	LED	670	-	4	80	50	3	Y (3)	Whelan et al., 2002 [43]-4 (Y)	II	NGP

Flawless studies, based on Hadorn Criteria [12], are in Bold

<sup>^</sup>pediatric

Cancer treatment modality key: *HSCT*; hematopoietic stem cell transplantation

Aim key: *P*, prevention

Effectiveness key: 3, Pain severity;

Guideline category key: *NGP*, no guideline possible;

*Hematol*, hematologic malignancies; *LED*, light-emitting diode; *PBM*, photobiomodulation; *RCT*, randomized controlled study; *Y*, yes

the selected protocol should be followed for optimal therapy. Safety considerations unique to patients with oral cancer should be considered.

The efficacy of intra-oral PBM at wavelengths of 632.8 nm and 660 nm for the prevention of OM and related pain in H&N cancer patients treated by RT with CT were reported in several RCTs (Table 2) [17, 18, 36, 37]. One study reported clinical ineffectiveness at 660-nm wavelength despite the PTPs falling within the range of other positive studies [36]. The exact reason for this discrepancy remains unclear even after detailed analyses of the dose and delivery parameters.

### Mixed cancer patient populations

Several studies examined the efficacy of PBM therapy for management of OM in a non-uniform group of cancer patients or mixed anti-cancer treatment modalities (Table 2) [32, 33, 39–41]. However, no guidelines are currently possible due to the significant heterogeneity in treatment parameters and patient populations.

### Safety analysis

In all analyzed RCTs, no short- or long-term adverse events with PBM treatments were reported, despite significant variations in the PTPs. However, in one cohort study, 15% of patients experienced an immediate (non-painful) burning sensation after intra-oral 635-nm diode laser treatment [29].

### Discussion

This paper aimed at systematically reviewing the evidence about PBM, previously termed low-level light or laser therapy, for OM, and accordingly update the MASCC/ISOO clinical practice guidelines for the management of OM [11]. Each guideline is outlined according to the cancer patient population, anti-cancer therapy, and parameters for PBM therapy. The panel identified evidence to support clinical practice guidelines for three specific clinical indications as follows:

- (i) Recommendation for the prevention of OM with intra-oral PBM therapy, with specific PTPs, in HSCT patients. The current systematic review reiterates the 2013 guidelines [11] in this patient population and further extends the PTPs that may be utilized;
- (ii) Recommendation for the prevention of OM with intra-oral PBM therapy, with specific PTPs, in cancer patients treated with H&N RT (without CT). This is an upgrade

**Table 4** Studies addressing combined extra-oral and intra-oral photobiomodulation for the management of oral mucositis

Cancer treatment modality	Aim	RCTs	Non-RCTs – study design (effective)	Overall level of evidence	Guideline category
RT	P	None	Arora et al. 2008 [35] – 3 (Y)	IV	NGP

NGP, no guideline possible; P, prevention; RCT, randomized controlled trial; RT, radiotherapy; Y, yes; Study design key: 3, non-randomized controlled trial

of the 2013 guideline level [11] from Suggestion to Recommendation;

- (iii) Recommendation for the prevention of OM with intra-oral PBM therapy, with specific PTPs, in cancer patients treated with H&N RT with CT. This is a new guideline based on recent evidence.

It should be noted that, currently, there is no evidence-based guideline for the treatment of established OM with PBM therapy and its associated pain; the guidelines are for the prevention of OM with PBM therapy. The guideline determination was influenced mostly by RCTs that met strict clinical and scientific criteria; however, clinical studies with lower LoE were assessed and contributed to the conclusions. Studies in which the PTPs were not reproducible were omitted from guideline determination.

For two cancer patient populations, HSCT and RT-CT, there were several protocols based on flawless RCTs, and each is a viable option for clinical application. The guideline states that once a certain protocol is selected, the entire PTPs of that protocol should be followed and parameters should not be interchanged or extrapolated. For example, for the prevention of OM in HSCT patients, two protocols are recommended (Table 1). If the first option is selected, the clinician may choose a specific protocol with a 632.8 nm (Helium-Neon) laser with an irradiance (power density) of 31.25 mW/cm<sup>2</sup>, spot size of 0.8 cm<sup>2</sup>, application for 40 s on each site, fluence (energy density) of 1 J/cm<sup>2</sup>, on 18 sites in the oral mucosa, for five daily sessions from day after cessation of HSCT conditioning (Table 1). Given the complexity of the light-tissue interactions and incomplete understanding of the precise roles and contributions of each of these PTPs, interchanging these parameters may not result in the demonstrated clinical efficacy and can potentially impact clinical safety. With a better understanding of these variables and additional clinical trials, specific range of PTPs will likely be better defined. Accordingly, we anticipate that the guidelines will be changed in the future. Nonetheless, it is prudent to emphasize these recommended protocols represent the current literature, and do not exclude other PTPs that have not been studied systematically to date. Moreover, future studies may prove efficacy in settings that were previously thought to be inefficient.

The current standard PBM dose reporting models are based on irradiance per site (mW/cm<sup>2</sup>), time of treatment (sec) and fluence (J/cm<sup>2</sup>), and possibly the cumulative energy per

session (total energy delivered per session) [6]. Irradiance per site likely reflects the threshold dose needed to biologically activate relevant therapeutic responses while the total energy possibly reflects the overall tissue dose needed to generate a sufficient clinical outcome. Theoretically, the cumulative energy is derived from the number of sites treated in each session, and/or the number of sessions conducted. Our attempts to correlate these PTPs with the clinical outcome did not identify a trend. Therefore, we encourage investigators to report well-designed studies about OM with negative results too.

Conducting a RCT is a complex and major undertaking. To examine the effect of low-dose biophotonics adds significant additional complexity due to the scale and kinetics of light-biological tissue interactions. Over the years, as revealed in this systematic review, clinical study design in laser and light therapy and the level of reporting of PTPs have improved dramatically. In this guideline update, numerous RCTs were assessed and more details were provided on the physical parameters. A list of PTPs that should be included when reporting PBM therapy is presented in Box 1. The importance of the detailed reporting of PTPs was discussed in the literature extensively [45–49].

The precise PBM dose delivered to the tissue is critical due to the biphasic dose response, termed the Arndt Scultz curve, where PBM therapy can activate or inhibit biological responses. [46] There are a few nuances that may influence the actual PBM dose delivered and should be considered when operating a PBM device or conducting a clinical trial: (1) the fiber optic is not necessarily identical to the probe tip, affecting reported probe surface and spot size; (2) the tip output may decrease with time, therefore routine calibration is recommended; (3) the precise distance of the probe from the tissue (estimated or calibrated) has a significant impact on the energy distribution; and (4) the specific time spent on each site (steady probe position or in-motion application) needs to be accurately reported, as approximation may hinder comparison between study outcomes. Generally, it is advisable to confer with a physicist specializing in optics or a radiation biologist to ensure the PBM settings are appropriate. We believe these recommendations will not only enable standardization of protocol parameters and improve quality of reporting, they will also improve consistency and reproducibility of clinical therapeutic outcomes.

Another major variable noted in the analysis of these studies was the number of treatment sites during each session. While it is relatively easy to locate and treat apparent clinical lesions, for preventive therapy for large mucosal areas, the number and location of the sites of the PBM therapy required to generate a clinical outcome are ambiguous. A point source would treat a limited tissue volume, and therefore large beam-spot, multi-probe clusters, novel delivery devices, or extra-oral approaches may be advantageous.

Extra-oral application of PBM has some clinical advantages regarding convenience of use because of the intra-oral discomfort and restricted mouth opening associated with OM. Moreover, these extra-oral devices offer operator convenience, enabling the treatment of large areas in a reasonable time [50]. It is important to emphasize that dose delivery for extra-oral approaches as well as the treatment dosimetry to the oral tissues remain challenging and require further investigation.

This systematic review shows that the settings used in RCTs for PBM therapy for OM did not result in immediate adverse events. However, one cohort study reported immediate burning sensation in 15% of patients, but no persistent symptoms were noted [29]. These observations demonstrate that PBM therapy is well-tolerated in cancer patients.

There is a discussion in the literature about the potential long-term risk of PBM therapy for malignant transformation, progression, or recurrence [51]. Whether PBM administered in regions anatomically associated with a tumor negatively impacts tumor treatment response or behavior is currently unknown. The suggested biological pathways induced by PBM, the conflicting in-vitro data

of PBM-influenced tumor cell behaviors, and the limited clinical data about long-term safety demand caution when considering PBM for the management of OM. In the current literature, follow-up data has been presented in two studies [52, 53]. The authors claimed that PBM increased the progression free survival of H&N cancer patients treated with RT-CT [52]. However, until substantial long-term safety data is available, the use of PBM in areas with known or possible tumors should be considered cautiously. The patient should be informed about the possible benefits and risks before treatment.

Additionally, laser safety standards must be used while delivering PBM as per the American National Standard Institute (ANSI Z136.1, 2014). Furthermore, standard precautions to prevent the spread of infectious disease should be followed.

The data reported in the literature present benefits for the prevention of OM and its associated pain in certain cancer populations. The pain relief correlated with reduced OM severity over time. We did not observe consistent RCT-derived data on response time in terms of the interval between PBM application and reported pain relief. However, in a cohort study, Sandoval et al. described immediate pain relief after application of 660-nm laser therapy in two-thirds of their cohort of mixed cancer patients with symptomatic OM [41]. Such data may be of great relevance for treating OM-associated pain.

Several studies were published after the cutoff date (i.e., June 2016) and are considered late-breaking reports. These studies refer to intra-oral PBM application using a variety of

**Table 5** Studies addressing intra-oral photobiomodulation for the management of oral mucositis in pediatric patients

Cancer treatment modality	Aim	RCTs					Non-RCTs–study design	Comment
		Author, year	Cancer type	PBM source	Wavelength (nm)	Effectiveness		
RT/RT-CT	T	Medeiros-Filho 2017 [58]	H&N ^	Diode laser	808 808 + 660	Y (1)	None	Photodynamic therapy (methylene blue)
HSCT/CT	T	Vitale 2017 [59] Gobbo 2018 [60]	Hematol ^ Hematol & solid ca. ^	Diode laser	970 660 + 970	Y (1,2,3,4) Y (1,3)	None	
CT	T	Ribeiro da Silva 2018 [61]	Hematol & solid ca. ^	Laser	660	N	Leite Cavalcanti 2018 [62] - 3	Photodynamic therapy (methylene blue)

^pediatric

Cancer treatment modality key: *RT*, radiotherapy; *CT*, chemotherapy; *HSCT*, hematopoietic stem cell transplantation

Aim key: *T*, treatment

Effectiveness key: 1, Mucositis severity; 2, Mucositis duration; 3, Pain severity; 4, Pain duration

Study design key: 3, non-randomized controlled trial

ca, cancer; *H&N*, head and neck malignancies; *Hematol*, hematologic malignancies; *N*, no; *RCT*, randomized controlled trial; *Y*, yes

PTPs. This new evidence does not change the collective LoE and the guidelines set above [54–57].

PBM therapy may be considered a patient-friendly treatment modality, especially in pediatric patients that may not be able to comply with other modalities, such as mouthwash. A few recent studies on pediatric patient populations demonstrated the efficacy of intra-oral PBM (Table 5). [58–61] This adds to the previous studies in pediatric patients (Tables 2 and 3); however, the stratification of current evidence according to the type of OM and objective of study, as well as the LoE and power of the studies, do not allow setting a guideline for pediatric patients. Interestingly, these studies included, for the first time, evidence about the effectiveness of the application of PBM for the treatment of established OM, including using a photosensitizer (methylene blue) [58, 61].

Implementing the updated guidelines may be challenged by practical and economic considerations, e.g., cost, facility requirements, trained personnel, and local regulatory requirements. Additionally, the application of the guidelines may be challenged by device availability and if the available device is able to deliver the recommended PTPs. Studies have demonstrated the applicability of delivering a course of PBM therapy to cancer patients for the prevention of OM [50, 63]. Considering these challenges, PBM therapy should be considered by the clinician, among other methods recommended by the MASCC/ISOO Mucositis Study Group, where facility allows PBM therapy and when health economic justifies its use.

In summary, we conducted a systematic review and developed evidence-based clinical guidelines for PBM therapy for specific cancer patient populations. We noted the variation in the parameters presented by the various RCTs. More well-designed RCTs, including pediatric patient populations and patients treated with chemotherapy, are needed to clarify the promising potential of PBM in the management of OM in cancer patients.

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### Compliance with ethical standards

**Conflict of interest** Per the MASCC Guidelines policy, employees of commercial entities were not eligible to serve on this MASCC Guidelines Panel. The following authors disclose no conflict of interest: YZ, ERF, HSA, RJB, LAG, AM, RGN, VR, WJET, AV, RL, CAM, KKFC and SE. The following authors disclose a potential conflict of interest as detailed

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Immediate Past-President of North American Association for Photobiomodulation Therapy, Chair of Society for Photonics and Engineers, Mechanisms for Photobiomodulation Therapy, Technical Group member of Photobiomodulation therapy, Optical Society of America, Program Chair of Society for Advanced Wound Care, Wound Healing Society.

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