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# SERVIÇO DE INFORMAÇÃO CIENTÍFICA



A informação ao serviço da saúde

BURNOUT nos Profissionais de  
Saúde

RECOMENDAÇÕES e  
CONSENSOS em Oncologia

Julho 2016

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## Burnout nos Profissionais de Saúde

### Burnout in Portuguese healthcare professionals: An analysis at the National level

Marôco J. Marôco A.L. Leite E. Bastos C. Vazão M.J. Campos J.

Acta Medica Portuguesa (2016) 29:1 (24-30). Date of Publication: 1 Jan 2016

Introduction: Burnout is a psychological syndrome, characterized by a state of high emotional exhaustion, high depersonalization and low personal accomplishment, which leads to erosion of personal, professional and health values. This study reports the incidence of burnout in Portuguese Healthcare professionals. Material and Methods: Burnout in Portugal's health professionals was assessed with the Maslach Burnout Inventory - Human Services Survey, using a zero (never) to six (always) ordinal scale, on a sample of 1 262 nurses and 466 physicians with mean age of 36.8 year (SD = 12.2) and 38.7 (SD = 11.0), respectively. Participants came from all national districts (35% Lisbon, 18% Oporto, 6% Aveiro, 6% Setúbal, 5% Coimbra, 5% Azores and Madeira), working in hospitals (54%), Families' Health Units (30%), Personalized Health Units (8%) and other public or private institutions (8%). Results: Analysis of MBI-HSS scores, stratified by district, revealed that both types of professionals had moderate to high levels of burnout (M = 3.0, SD = 1.7) with no significant differences between the two groups. Vila Real (M = 3.8, SD = 1.7) and Madeira (M = 2.5, SD = 1.5) were the regions where burnout levels were higher and lower, respectively. Burnout levels did not differ significantly between Hospital, Personalized Health Units and Families' Health Centers. Professionals with more years in the function were less affected by Burnout ( $r = -0.15$ ). No significant association was observed with the duration of the working day ( $r = 0.04$ ). The strongest predictor of burnout was the perceived quality of working conditions ( $r = -0.35$ ). Discussion: The occurrence of the burnout syndrome in Portuguese health professionals is frequent, being associated with a poor working conditions perception and reduced professional

experience. The incidence of the burnout syndrome shows regional differences which may be associated with different and suboptimal conditions for health care delivery. Results suggest the need for interventions aimed at improving working conditions and initial job training of health professionals, as requisites for a good professional practice and personal well-being. Conclusions: At the national level, between 2011 and 2013, 21.6% of healthcare professionals showed moderate burnout and 47.8% showed high burnout. The perception of poor working conditions was the main predictor of burnout occurrence among the Portuguese health professionals.

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### **Burnout syndrome in oncology and hematology healthcare professionals**

S. Machavoine J.-L.

Hematologie (2015) 21:5 (280-288). Date of Publication: 1 Sep 2015

Burnout syndrome concern all the categories of healthcare professionals. Burnout etiology is multifactorial, as its prevention and its treatment must be. Prevention has to mobilize in a synergic and concerted way individual, collective and institutional levels altogether. The recognition of burn-out syndrome by the healthcare institution is necessary: prevention must be included in the institutional and social plan. Healthcare professionals training has a major preventive role and must be implemented early in medical and nurse studies (i.e., communication skills training). The support from managers is essential. Supervision meetings between the care team and a trained supervisor allow the participants to analyze their practice and feel supported; psychologists and psychiatrists have a fundamental role in the setting and the supervision of these groups. The prevention of burnout starts by individual positioning (introspection about the work motivation to be caregiver, self-Analysis and involvement in meetings when available). Psychologists and psychiatrists have also an important role in prevention and screening of burnout syndrome during their clinical interventions. Further research is needed for a better evaluation of burnout syndrome prevention and treatment methods.

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**Burnout Syndrome and Demotivation Among Health Care Personnel. Managing Stressful Situations: The Importance of Teamwork**

García-Campayo J. Puebla-Guedea M. Herrera-Mercadal P. Daudén E.

Actas Dermo-Sifiliograficas (2015). Date of Publication: 24 Jul 2015

Almost one-third of our lives is spent in the workplace, where much of our interaction with others takes place and where we are exposed to stressful situations. Work-related stress has consequences for the individual's physical and mental health. Stress and professional burnout syndrome are the main consequences of work situations characterized by a constant state of tension. Stress is the second leading cause of absenteeism in the European Union, and around 12% of European workers are currently affected by burnout syndrome. It is therefore vital to identify demotivated and stressed staff in both large organizations (hospitals and clinics) and smaller centers (private practices) so as to facilitate preventive measures and ensure early intervention in situations of stress, with a view to improving the performance of work teams.

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**Professional exhaustion or “burn out” among doctors in training**

Medhaffar K. Feki I. Feki R. Baati I. Masmoudi J. Jaoua A.

European Psychiatry (2015) 30 SUPPL. 1 (1833). Date of Publication: 31 Mar 2015

Introduction: Burn out is defined as a syndrome of physical and emotional fatigue, which leads to a negative self-perception and negative attitudes at work .It affects particularly caregivers, because they are in tune with the suffering, misery, misfortune, sickness and death. Objective: The objective of our study was to assess the degree of burnout among medical interns. Method: This was a cross-sectional study, which studied a population of 40 interns engaged in Hedi Chaker Hospital in Sfax. To assess burnout, we used a psychometric tool: the Maslach Burn-out Inventory (MBI). With each intern we collected sociodemographic variables (sex, age, marital status, spouse's occupation, number of children), the parameters concerning the occupation (specialty, professional grade, number of hours per week, number of guards per month .), the causes of exhaustion, and if there were consequences. Results: The average age of interns was 28 years 4 months. They were married in 47.5% of cases and 52.5% in single cases. The results of the MBI: - A high level of emotional exhaustion was found in 37.5% of interns, 40%

had moderate levels of emotional exhaustion and 22.5% had a low score of emotional exhaustion. - The “dehumanization of the relationship,” was high in 25%, moderate in 20% of doctors, and 55% spared them. - Personal achievement was high in 25% of doctors, moderate in 35% and poor in 40% of them. Conclusion: Once recognized, the burnout syndrome among medical interns requires concrete actions focusing on their professional lives and their privacy ones.

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**Burnout and work demands predict reduced job satisfaction in health professionals working in a surgery clinic**

Mijakoski D. Karadzinska-Bislimovska J. Basarovska V. Stoleski S. Minov J.

Macedonian Journal of Medical Sciences (2015) 3:1 (166-173). Date of Publication: 15 Mar 2015

**BACKGROUND:** Burnout syndrome develops in health professionals (HPs) as a result of exposure to chronic emotional and interpersonal workplace stressors. Research demonstrates the links between burnout, work demands, and job satisfaction in hospital HPs. **AIMS:** To examine the associations between burnout, work demands and job satisfaction, and to demonstrate the mediation effect of emotional exhaustion on the relationship between work demands and job satisfaction in surgery clinic HPs. **METHODS:** Maslach Burnout Inventory was used for assessment of burnout. Work demands and job satisfaction were measured with Hospital Experience Scale and Job Satisfaction Survey, respectively. In order to examine the role of emotional exhaustion, depersonalization, and work demands, controlling for age, hospital tenure, and unit tenure, a hierarchical multiple regression models were tested for each job satisfaction factor. **RESULTS:** Job satisfaction was negatively predicted by emotional exhaustion. Certain types of work demands negatively predicted different factors of job satisfaction. Emotional exhaustion was a significant partial mediator of the relationship between work demands and job satisfaction. **CONCLUSIONS:** Adequate management of work demands, particularly excessive workload, time pressure, and lack of staff can lead to prevention of burnout and reduced job satisfaction in surgery clinic HPs, and contribute to better quality of patient care.

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### **Communication skills: A preventive factor in burnout syndrome in health professionals**

Leal-Costa C. Díaz-Agea J.L. Tirado-González S. Rodríguez-Marín J. Van-Der Hofstadt C.J.  
Anales del Sistema Sanitario de Navarra (2015) 38:2 (213-223). Date of Publication: 5 Sep  
2015

Background. Health professionals are a group that suffers high levels of job stress and burnout. The aim of this study is to demonstrate empirically that the healthcare count on communication skills helps prevent Burnout Syndrome. Method. An observational, analytical, cross-sectional study was proposed, involving a sample of 927 health professionals (197 doctors, 450 nurses and 280 auxiliary nurses). Participants completed questionnaires measuring communication skills in health care (EHC-PS) and the Maslach Burnout Inventory Human Services Survey (MBI-HSS). Results. A negative and statistically significant correlation between the different dimensions of communication skills and emotional exhaustion and depersonalization dimensions of burnout was obtained. On the other hand, a positive and statistically significant correlation between the dimensions of communication skills and the personal accomplishment dimension of burnout was observed. Conclusions. It was shown that the communication skills of health professionals provide protection from and cushion Burnout Syndrome.

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### **Burnout and self-care considerations for oncology professionals**

Crowe C.  
Journal of Pain Management (2015) 8:3 (191-195). Date of Publication: 1 Jan 2015

The focus of a health care professional's career is to care for other people. Over a lifetime, this often occurs at the expense of his/her own physical and mental health. An increased public awareness about mental health in general leads us to the question, who is taking care of those who take care of us? In the specialty of oncology, physicians and nurses are at increased risk for burnout or burnout syndrome. This review provides a brief look at literature supporting the view that oncology physicians and nurses are at increased risk for burnout, and discusses protective measures.

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## **Burnout, anxiety, depression, and social skills in medical residents**

Pereira-Lima K. Loureiro S.R.

Psychology, health & medicine (2015) 20:3 (353-362). Date of Publication: 2015

The medical residency is recognized as a risk period for the development of burnout and mental health problems, such as anxiety and depression, which have impact on the physician and clientele alike. There is a need for studies that address conditions of risk and protection for the development of such problems. This study aimed to verify the rates of burnout, anxiety, and depression presented by resident physicians, as well as the associations of these problems with social skills, as potential protective factors. The hypothesis was defined that the problems (burnout, anxiety, and depression) would be negatively associated with social skills. A total of 305 medical residents, of both genders, of different specialties, from clinical and surgical areas of a Brazilian university hospital were evaluated using the following standardized self-report instruments: Burnout Syndrome Inventory, Social Skills Inventory, and the Patient Health Questionnaire-4. High rates of burnout and mental health problems were verified and social skills were negatively associated with burnout dimensions such as emotional exhaustion, emotional detachment, and dehumanization, but positively associated with personal accomplishment. Furthermore, residents with indicators of problems presented significantly lower social skills means than those of residents without indicators of burnout, anxiety, or depression. More studies are needed, which include other types of instruments in addition to self-report ones and evaluate not only social skills but also social competence in the professional practice. These should adopt intervention and longitudinal designs that allow the continuity or overcoming of the problems to be verified. Since social skills can be learned, the results of the study highlight the importance of developing the interpersonal skills of the professionals during the training of resident physicians in order to improve their practice.

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## **Burnout levels among Portuguese family doctors: A nationwide survey**

Marcelino G.T. Cerveira J.M. Carvalho I. Costa J.A. Lopes M. Calado N.E. Marques-Vidal P.

BMJ Open (2012) 2:3 Article Number: e001050. Date of Publication: 2012

Aim: To characterise the prevalence of burnout syndrome in a sample of family doctors (FDs) working in the Portuguese National Health System. Design: Cross-sectional survey. Setting: Primary healthcare centres from the 18 continental districts and two archipelagos of Portugal. Method: The Portuguese version of the Maslach Burnout Inventory - Human Services Survey was sent to 40 randomly selected healthcare centres and distributed to the FDs employed. Socio-demographic and work-related data were also collected. Participants were classified as having high, average or low levels of emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA) dimensions of burnout. Results: 371 questionnaires were sent, of which 153 (83 women, age range 29-64 years; response rate 41%) returned. One-quarter (25.3%, 95% CI 18.6% to 33.1%) of FDs scored high for EE, 16.2% (10.7% to 23.2%) for DP and 16.7% (11.1% to 23.6%) for lack of PA. On multivariate analysis, being married, of older age, having many years of practice or working in a personalised healthcare unit tended to be associated with increased burnout components. Men tended to present higher EE and DP but lower lack of PA than women. Finally, the prevalence (95% CI) of burnout ranged between 4.1% (1.5% to 8.6%) and 32.4% (25.0% to 40.6%), depending on the definition used. Conclusions: High burnout is relatively common among Portuguese FDs. Burnout relief measures should be developed in order to prevent a further increase of burnout syndrome among Portuguese FDs.

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## Recomendações e Consensos em Oncologia

Oncology (Williston Park). 2016 Feb;30 (2):187-95, 199.

**The Evolving Biology of Castration-Resistant Prostate Cancer: Review of Recommendations From the Prostate Cancer Clinical Trials Working Group 3.**

Geethakumari PR, Cookson MS, Kelly WK; Prostate Cancer Clinical Trials Working Group 3.

Comment in

Oncology (Williston Park). 2016 Feb;30(2):200, 202.

In 2008, the Prostate Cancer Clinical Trials Working Group 2 (PCWG2) developed consensus guidelines for clinical trial design and conduct that redefined trial endpoints, with a dual-objective paradigm: to (1) controlling, relieving, or eliminating disease manifestations at the start of treatment; and (2) preventing or delaying further disease manifestations. Clinical and translational research in prostate cancer has expanded our current-day understanding of the mechanisms of its pathogenesis, as well as the different clinicopathologic and molecular subtypes of the disease, and has improved the therapeutic armamentarium for the management of metastatic castration-resistant prostate cancer (CRPC). These new advances led to the development of the updated PCWG3 guidelines in 2015. In this review, we analyze our evolving understanding of the biology of CRPC, acquired resistance mechanisms, and emerging therapeutic targets in light of the updated PCWG3 guidelines. We present a joint perspective from the medical oncology and urologic disciplines on the ongoing efforts to advance clinical trial performance in order to discover new therapies for this fatal disease.

PMID: 26888794 [PubMed - indexed for MEDLINE]

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Urology. 2015 Jul;86 (1):35-40.

**Impact of a Genomic Classifier of Metastatic Risk on Postprostatectomy Treatment Recommendations by Radiation Oncologists and Urologists.**

Nguyen PL, Shin H, Yousefi K, Thompson DJ, Hornberger J, Hyatt AS, Badani KK, Morgan TM, Feng FY.

**OBJECTIVE:** To evaluate how a genomic classifier (GC) that predicts the risk of metastasis after prostatectomy would impact adjuvant treatment recommendations made by radiation oncologists and urologists. The 2 specialties often disagree about postprostatectomy adjuvant treatment recommendations. **MATERIALS AND METHODS:** Twenty-six radiation oncologists and 20 urologists with genitourinary oncology expertise reviewed de-identified clinical results from 11 patients after radical prostatectomy and made adjuvant treatment recommendations. The same cases were later randomized and reassigned, and treatment recommendations were made using the clinical information and GC test results together. **RESULTS:** Using clinical information alone, observation was recommended in 42% of decisions made by urologists vs 23% by radiation oncologists ( $P < .0001$ ). The GC test results altered 35% and 45% of treatment recommendations made by radiation oncologists and urologists, respectively. Multivariate analysis showed GC risk was the strongest factor influencing treatment recommendations by both specialties, with an adjusted odds ratio of 4.17 (95% confidence interval [CI], 2.26-7.70) and 6.51 (95% CI, 4.29-9.88) for radiation oncologists and urologists, respectively. GC results indicating high metastatic risk resulted in intensification of treatment, whereas low metastatic risk resulted in less aggressive recommendations. The GC results increased interdisciplinary agreement in treatment recommendations, as the odds of a recommendation for adjuvant treatment by urologists vs radiation oncologists increased from 0.27 (95% CI, 0.17-0.44) to 0.46 (95% CI, 0.29-0.75) after results of the GC test were available. **CONCLUSION:** The GC test significantly influenced adjuvant postprostatectomy treatment recommendations, reduced disagreement between radiation oncologists and urologists, and has the potential to enhance personalization of postprostatectomy care.

PMID: 26142578 [PubMed - indexed for MEDLINE]

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Ann Oncol. 2015 Aug;26(8):1589-604.

**Management of patients with advanced prostate cancer: recommendations of the St Gallen Advanced Prostate Cancer Consensus Conference (APCCC) 2015.**

Gillessen S, Omlin A, Attard G, de Bono JS, Efstathiou E, Fizazi

K, Halabi S, Nelson PS, Sartor O, Smith MR, Soule HR, Akaza H, Beer TM, Beltran H, Chinnaiyan AM, Daugaard G, Davis ID, De Santis M, Drake CG, Eeles RA, Fanti S, Gleave ME, Heidenreich A, Hussain M, James ND, Lecouvet FE, Logothetis CJ, Mastris K, Nilsson S, Oh WK, Olmos D, Padhani AR, Parker C, Rubin MA, Schalken JA, Scher HI, Sella A, Shore ND, Small EJ, Sternberg CN, Suzuki H, Sweeney CJ, Tannock IF, Tombal B.

Comment in

Ann Oncol. 2015 Nov;26(11):2354.

Ann Oncol. 2015 Nov;26(11):2354-5.

The first St Gallen Advanced Prostate Cancer Consensus Conference (APCCC) Expert Panel identified and reviewed the available evidence for the ten most important areas of controversy in advanced prostate cancer (APC) management. The successful registration of several drugs for castration-resistant prostate cancer and the recent studies of chemo-hormonal therapy in men with castration-naïve prostate cancer have led to considerable uncertainty as to the best treatment choices, sequence of treatment options and appropriate patient selection. Management recommendations based on expert opinion, and not based on a critical review of the available evidence, are presented. The various recommendations carried differing degrees of support, as reflected in the wording of the article text and in the detailed voting results recorded in supplementary Material, available at Annals of Oncology online. Detailed decisions on treatment as always will involve consideration of disease extent and location, prior treatments, host factors, patient preferences as well as logistical and economic constraints. Inclusion of men with APC in clinical trials should be encouraged.

PMCID: PMC4511225

PMID: 26041764 [PubMed - indexed for MEDLINE]

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J Oncol Pract. 2015 May;11(3):e445-9.

**Prostate cancer survivorship care guidelines: American Society of Clinical Oncology practice guideline endorsement.**

Resnick MJ, Lacchetti C, Penson DF; American Society of Clinical Oncology.

PMID: 25829527 [PubMed - indexed for MEDLINE]

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Chest. 2015 Dec;148(6):1365-7.

**Development of Guidelines for the Management of Pulmonary Nodules: Toward Better Implementation.**

Baldwin DR.

PMCID: PMC4665732 [Available on 2016-12-01]

PMID: 26621288 [PubMed - indexed for MEDLINE]

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Clin Radiol. 2016 Jan;71(1):18-22.

**Pulmonary nodules again? The 2015 British Thoracic Society guidelines on the investigation and management of pulmonary nodules.**

Baldwin DR, Callister ME, Graham R, Gleeson F; members of the Guideline Development Group.

PMID: 26607915 [PubMed - indexed for MEDLINE]

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Semin Oncol. 2015 Oct;42 Suppl 2:S19-28.

**Incorporating Immunotherapy Into the Treatment of Non-Small Cell Lung Cancer: Practical Guidance for the Clinic.**

Socinski MA.

Immunotherapy provides unique challenges in the clinic, as nivolumab is a first-in-class agent for non-small cell lung cancer (NSCLC). Unlike other NSCLC therapies, immunotherapy cannot currently be selected based on a patient's clinical characteristics or a tumor's molecular characteristics, although some evidence suggests that programmed death ligand 1 (PD-L1) may be useful as a molecular biomarker in the future. Histology is currently important to the use of nivolumab because it is only approved in squamous cell NSCLC. However, recent evidence shows a similar survival benefit of nivolumab in nonsquamous disease, so histology will likely not be a distinguishing factor in the future. It has been discovered that immunotherapy often has delayed response kinetics, leading to the development of immune-related response criteria

(irRC) in 2009. The irRC have distinguishing characteristics from traditional Response Evaluation Criteria in Solid Tumors (RECIST) criteria that prevent physicians from prematurely discontinuing immunotherapy. In addition to these differences in response criteria, the safety profiles of immunotherapeutic agents are distinct from other NSCLC therapies. The toxicities frequently associated with immunotherapies are unlike common chemotherapy toxicities because they are autoimmune in nature. Thus, physicians are presented with the challenge of appropriately identifying and managing these unfamiliar immune-related adverse events.

PMID: 26477471 [PubMed - indexed for MEDLINE]

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J Thorac Oncol. 2015 Jun;10(6):872-82.

<p><b>Stereotactic Ablative Radiation Therapy for the Treatment of Early-stage Non-Small-Cell Lung Cancer: CEPO Review and Recommendations.</b></p>
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Boily G, Filion É, Rakovich G, Kopek N, Tremblay L, Samson B, Goulet S, Roy I; Comité de l'évolution des pratiques en oncologie.

**BACKGROUND:** Lung cancer is the second most diagnosed cancer and the leading cause of cancer-related mortality in Canada. Surgical resection is the treatment of choice for patients with stage I non-small-cell lung cancer (NSCLC). However, 20% to 30% of them are deemed medically inoperable and may be offered radiation therapy. Standard external-beam radiation therapy (EBRT) is associated with high rates of local recurrence and poor long-term survival. Stereotactic ablative radiation therapy (SABR) is increasingly being proposed for inoperable patients, and the use of this treatment modality for operable patients is also being contemplated. The objective of this guideline is to review the efficacy and safety of SABR in these two clinical situations and to develop evidence-based recommendations. **METHOD:** A review of the scientific literature published up to December 2013 was performed. A total of 44 publications were included. **RECOMMENDATIONS:** Considering the evidence available to date, the Comité de l'évolution des pratiques en oncologie recommends the following: (1) for medically operable patients with stage T1-2N0M0 NSCLC, surgery remains the standard treatment because comparative data regarding the efficacy of SABR and surgery are currently insufficient for SABR to be considered an equivalent alternative to surgery for these patients; (2) for medically inoperable patients with stage T1-2N0M0 NSCLC or medically operable patients who refuse surgery, SABR should be preferred to standard EBRT (grade B recommendation); (3) the biological equivalent dose (BED(10)) used for SABR treatment should be at least 100 Gy (grade B recommendation); (4) for patients with a central tumor, a large-volume tumor (large planning target volume) or severe pulmonary comorbidity, a risk-adaptive schedule should be

used (dose reduction or increase in the number of fractions; grade B recommendation); (5) the choice of using SABR to treat NSCLC should be discussed within tumor boards; treatment with SABR (or with standard EBRT) should not be considered for patients whose life expectancy is very limited because of comorbidities (grade D recommendation).

PMID: 26001140 [PubMed - indexed for MEDLINE]

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Lancet Oncol. 2015 Jun;16 (6):e268.

**ASTRO issues new guidance for radiotherapy in NSCLC.**

Yaqub F.

PMID: 25975634 [PubMed - indexed for MEDLINE]

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Nat Med. 2015 Nov;21(11):1350-6.

**The consensus molecular subtypes of colorectal cancer.**

Guinney J, Dienstmann R, Wang X, de Reyniès A(5), Schlicker A, Soneson C, Marisa L, Roepman P, Nyamundanda G, Angelino P, Bot BM, Morris JS, Simon IM, Gerster S, Fessler E, De Sousa E Melo F, Missiaglia E, Ramay H, Barras D, Homicsko K, Maru D, Manyam GC, Broom B, Boige V, Perez-Villamil B, Laderas T, Salazar R, Gray JW, Hanahan D, Tabernero J, Bernards R, Friend SH, Laurent-Puig P, Medema JP, Sadanandam A, Wessels L, Delorenzi M, Kopetz S, Vermeulen L, Tejpar S.

Comment in

BMJ. 2015;351:h5433.

Colorectal cancer (CRC) is a frequently lethal disease with heterogeneous outcomes and drug responses. To resolve inconsistencies among the reported gene expression-based CRC classifications and facilitate clinical translation, we formed an international consortium dedicated to large-scale data sharing and analytics across expert groups. We show marked interconnectivity between six independent classification systems coalescing into four consensus molecular subtypes (CMSs) with distinguishing features: CMS1 (microsatellite instability immune, 14%), hypermutated, microsatellite unstable and strong immune activation; CMS2 (canonical, 37%), epithelial, marked WNT and MYC signaling activation; CMS3 (metabolic,

13%), epithelial and evident metabolic dysregulation; and CMS4 (mesenchymal, 23%), prominent transforming growth factor- $\beta$  activation, stromal invasion and angiogenesis. Samples with mixed features (13%) possibly represent a transition phenotype or intratumoral heterogeneity. We consider the CMS groups the most robust classification system currently available for CRC-with clear biological interpretability-and the basis for future clinical stratification and subtype-based targeted interventions.

PMCID: PMC4636487

PMID: 26457759 [PubMed - indexed for MEDLINE]

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Cancer Treat Rev. 2015 Nov;41 (9):729-41

**Managing synchronous liver metastases from colorectal cancer: a multidisciplinary international consensus.**

Adam R, de Gramont A, Figueras J, Kokudo N, Kunstlinger F, Loyer E, Poston G, Rougier P, Rubbia-Brandt L, Sobrero A, Teh C, Tejpar S, Van Cutsem E, Vauthey JN, Pålman L; of the EGOSLIM (Expert Group on OncoSurgery management of Liver Metastases) group.

An international panel of multidisciplinary experts convened to develop recommendations for managing patients with colorectal cancer (CRC) and synchronous liver metastases (CRCLM). A modified Delphi method was used. CRCLM is defined as liver metastases detected at or before diagnosis of the primary CRC. Early and late metachronous metastases are defined as those detected  $\leq 12$  months and  $> 12$  months after surgery, respectively. To provide information on potential curability, use of high-quality contrast-enhanced computed tomography (CT) before chemotherapy is recommended. Magnetic resonance imaging is increasingly being used preoperatively to aid detection of subcentimetric metastases, and alongside CT in difficult situations. To evaluate operability, radiology should provide information on: nodule size and number, segmental localization and relationship with major vessels, response after neoadjuvant chemotherapy, non-tumoral liver condition and anticipated remnant liver volume. Pathological evaluation should assess response to preoperative chemotherapy for both the primary tumour and metastases, and provide information on the tumour, margin size and micrometastases. Although the treatment strategy depends on the clinical scenario, the consensus was for chemotherapy before surgery in most cases. When the primary CRC is asymptomatic, liver surgery may be performed first (reverse approach). When CRCLM are unresectable, the goal of preoperative chemotherapy is to downsize tumours to allow resection. Hepatic resection should not be denied to patients with stable disease after optimal chemotherapy, provided an adequate

liver remnant with inflow and outflow preservation remains. All patients with synchronous CRCLM should be evaluated by a hepatobiliary multidisciplinary team.

PMID: 26417845 [PubMed - indexed for MEDLINE]

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J Oncol Pract. 2015 May;11(3):e437-41.

**Hereditary colorectal cancer syndromes: American Society of Clinical Oncology clinical practice guideline endorsement of the familial risk-colorectal cancer: European Society for Medical Oncology clinical practice guidelines.**

Stoffel EM, Mangu PB, Limburg PJ; American Society of Clinical Oncology; European Society for Medical Oncology.

PMID: 25829526 [PubMed - indexed for MEDLINE]

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Obstet Gynecol. 2015 Jul;126(1):171-4.

**Staging Classification for Cancer of the Ovary, Fallopian Tube, and Peritoneum: Abridged Republication of Guidelines From the International Federation of Gynecology and Obstetrics (FIGO).**

Prat J; FIGO Committee on Gynecologic Oncology.

PMID: 26241270 [PubMed - indexed for MEDLINE]

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Gynecol Oncol. 2015 Sep;138(3):712-6.

**Consensus in controversy: The modified Delphi method applied to Gynecologic Oncology practice.**

Cohn DE, Havrilesky LJ, Osann K, Lipscomb J, Hsieh S, Walker JL, Wright AA, Alvarez RD, Karlan BY, Bristow RE, DiSilvestro PA, Wakabayashi MT, Morgan R, Mukamel DB, Wenzel L.

**OBJECTIVES:** To determine the degree of consensus regarding the probabilities of outcomes associated with IP/IV and IV chemotherapy. **METHODS:** A survey was administered to an expert panel using the Delphi method. Ten ovarian cancer experts were asked to estimate outcomes for patients receiving IP/IV or IV chemotherapy. The clinical estimates were: 1) probability of completing six cycles of chemotherapy, 2) probability of surviving five years, 3) median survival, and 4) probability of ER/hospital visits during treatment. Estimates for two patients, one with a low comorbidity index (patient 1) and the other with a moderate index (patient 2), were included. The survey was administered in three rounds, and panelists could revise their subsequent responses based on review of the anonymous opinions of their peers. **RESULTS:** The ranges were smaller for IV compared with IP/IV therapy. Ranges decreased with each round. Consensus converged around outcomes related to IP/IV chemotherapy for: 1) completion of 6 cycles of therapy (type 1 patient, 62%, type 2 patient, 43%); 2) percentage of patients surviving 5 years (type 1 patient, 66%, type 2 patient, 47%); and 3) median survival (type 1 patient, 83 months, type 2 patient, 58 months). The group required three rounds to achieve consensus on the probabilities of ER/hospital visits (type 1 patient, 24%, type 2 patient, 35%). **CONCLUSIONS:** Initial estimates of survival and adverse events associated with IP/IV chemotherapy differ among experts. The Delphi process works to build consensus and may be a pragmatic tool to inform patients of their expected outcomes.

PMID: 26177553 [PubMed - indexed for MEDLINE]

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World J Surg Oncol. 2015 Aug 7;13:237.

<b>The Manchester guidelines for contralateral risk-reducing mastectomy.</b>
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Basu NN , Ross GL, Evans DG, Barr L.

**BACKGROUND:** Rates of contralateral risk-reducing mastectomy (CRRM) are rising, despite a decreasing global incidence of contralateral breast cancer. Reasons for requesting this procedure are complex, and we have previously shown a variable practice amongst breast and plastic surgeons in England. We propose a protocol, based on a published systematic review, a national UK survey and the Manchester experience of CRRM. **METHODS:** We reviewed the literature for risk factors for contralateral breast cancer and have devised a 5-step process that includes history taking, calculating contralateral breast cancer risk, cooling off period/counselling, multi-disciplinary assessment and consent. Members of the multi-disciplinary team included the breast surgeon, plastic surgeon and geneticist, who formulated guidelines.

**RESULTS:** A simple formula to calculate the life-time risk of contralateral breast cancer has been devised. This allows stratification of breast cancer patients into different risk-groups: low,

above average, moderate and high risk. Recommendations vary according to different risk groups. CONCLUSION: These guidelines are a useful tool for clinicians counselling women requesting CRRM. Risk assessment is mandatory in this group of patients, and our formula allows evidence-based recommendations to be made.

PMCID: PMC4527227

PMID: 26245209 [PubMed - indexed for MEDLINE]

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Radiother Oncol. 2015 Jun;115(3):342-8.

**Recommendations from GEC ESTRO Breast Cancer Working Group (I): Target definition and target delineation for accelerated or boost Partial Breast Irradiation using multicatheter interstitial brachytherapy after breast conserving closed cavity surgery.**

Strnad V, Hannoun-Levi JM, Guinot JL, Lössl K, Kauer-Dorner D, Resch A, Kovács G, Major T, Van Limbergen E; Working Group Breast Cancer of GEC-ESTRO.

OBJECTIVE: The aim was to develop a delineation guideline for target definition for APBI or boost by consensus of the Breast Working Group of GEC-ESTRO. PROPOSED RECOMMENDATIONS: Appropriate delineation of CTV (PTV) with low inter- and intra-observer variability in clinical practice is complex and needs various steps as: (1) Detailed knowledge of primary surgical procedure, of all details of pathology, as well as of preoperative imaging. (2) Definition of tumour localization before breast conserving surgery inside the breast and translation of this information in the postoperative CT imaging data set. (3) Calculation of the size of total safety margins. The size should be at least 2 cm. (4) Definition of the target. (5) Delineation of the target according to defined rules. CONCLUSION: Providing guidelines based on the consensus of a group of experts should make it possible to achieve a reproducible and consistent definition of CTV (PTV) for Accelerated Partial Breast Irradiation (APBI) or boost irradiation after breast conserving closed cavity surgery, and helps to define it after selected cases of oncoplastic surgery.

PMID: 26104975 [PubMed - indexed for MEDLINE]

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Ann Oncol. 2015 Aug;26(8):1519-20.

**St Gallen International Expert Consensus on the primary therapy of early breast cancer: an invaluable tool for physicians and scientists.**

Ignatiadis M, Buyse M, Sotiriou C.

Comment on

Ann Oncol. 2015 Aug;26(8):1533-46.

PMID: 26063634 [PubMed - indexed for MEDLINE]

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Ann Oncol. 2015 Aug;26(8):1533-46.

**Tailoring therapies—improving the management of early breast cancer: St Gallen International Expert Consensus on the Primary Therapy of Early Breast Cancer 2015.**

Coates AS, Winer EP, Goldhirsch A, Gelber RD, Gnant M, Piccart-Gebhart M, Thürlimann B, Senn HJ; Panel Members.

Comment in

Ann Oncol. 2015 Aug;26(8):1519-20.

The 14th St Gallen International Breast Cancer Conference (2015) reviewed substantial new evidence on locoregional and systemic therapies for early breast cancer. Further experience has supported the adequacy of tumor margins defined as 'no ink on invasive tumor or DCIS' and the safety of omitting axillary dissection in specific cohorts. Radiotherapy trials support irradiation of regional nodes in node-positive disease. Considering subdivisions within luminal disease, the Panel was more concerned with indications for the use of specific therapies, rather than surrogate identification of intrinsic subtypes as measured by multiparameter molecular tests. For the treatment of HER2-positive disease in patients with node-negative cancers up to 1 cm, the Panel endorsed a simplified regimen comprising paclitaxel and trastuzumab without anthracycline as adjuvant therapy. For premenopausal patients with endocrine responsive disease, the Panel endorsed the role of ovarian function suppression with either tamoxifen or exemestane for patients at higher risk. The Panel noted the value of an LHRH agonist given during chemotherapy for premenopausal women with ER-negative disease in protecting against premature ovarian failure and preserving fertility. The Panel noted increasing evidence for the prognostic value of commonly used multiparameter molecular markers, some of which also carried prognostic information for late relapse. The Panel noted that the results of such tests, where available, were frequently used to assist decisions about the inclusion of cytotoxic

chemotherapy in the treatment of patients with luminal disease, but noted that threshold values had not been established for this purpose for any of these tests. Multiparameter molecular assays are expensive and therefore unavailable in much of the world. The majority of new breast cancer cases and breast cancer deaths now occur in less developed regions of the world. In these areas, less expensive pathology tests may provide valuable information. The Panel recommendations on treatment are not intended to apply to all patients, but rather to establish norms appropriate for the majority. Again, economic considerations may require that less expensive and only marginally less effective therapies may be necessary in less resourced areas. Panel recommendations do not imply unanimous agreement among Panel members. Indeed, very few of the 200 questions received 100% agreement from the Panel. In the text below, wording is intended to convey the strength of Panel support for each recommendation, while details of Panel voting on each question are available in supplementary Appendix S2, available at Annals of Oncology online.

PMCID: PMC4511219

PMID: 25939896 [PubMed - indexed for MEDLINE]

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Lancet Oncol. 2015 Sep;16(9):e435-46.

<b>Consensus on biomarkers for neuroendocrine tumour disease.</b>
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Oberg K, Modlin IM, De Herder W, Pavel M, Klimstra D, Frilling A, Metz DC, Heaney A, Kwekkeboom D, Strosberg J, Meyer T, Moss SF, Washington K, Wolin E, Liu E, Goldenring J.

Management of neuroendocrine neoplasia represents a clinical challenge because of its late presentation, lack of treatment options, and limitations in present imaging modalities and biomarkers to guide management. Monoanalyte biomarkers have poor sensitivity, specificity, and predictive ability. A National Cancer Institute summit, held in 2007, on neuroendocrine tumours noted biomarker limitations to be a crucial unmet need in the management of neuroendocrine tumours. A multinational consensus meeting of multidisciplinary experts in neuroendocrine tumours assessed the use of current biomarkers and defined the prerequisites for novel biomarkers via the Delphi method. Consensus (at >75%) was achieved for 88 (82%) of 107 assessment questions. The panel concluded that circulating multianalyte biomarkers provide the highest sensitivity and specificity necessary for minimum disease detection and that this type of biomarker had sufficient information to predict treatment effectiveness and prognosis. The panel also concluded that no monoanalyte biomarker of neuroendocrine tumours has yet fulfilled these criteria and there is insufficient information to support the clinical use of miRNA or circulating tumour cells as useful prognostic markers for this disease. The

panel considered that trials measuring multianalytes (eg, neuroendocrine gene transcripts) should also identify how such information can optimise the management of patients with neuroendocrine tumours.

PMID: 26370353 [PubMed - indexed for MEDLINE]

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HPB (Oxford). 2015 Aug;17(8):681-90.

<b>Gallbladder cancer: expert consensus statement.</b>
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Aloia TA, Járufe N, Javle M, Maithel SK, Roa JC, Adsay V, Coimbra FJ, Jarnagin WR.

Comment in

HPB (Oxford). 2015 Aug;17(8):664-5.

An American Hepato-Pancreato-Biliary Association (AHPBA)-sponsored consensus meeting of expert panellists was convened on 15 January 2014 to review current evidence on the management of gallbladder carcinoma in order to establish practice guidelines. In summary, within high incidence areas, the assessment of routine gallbladder specimens should include the microscopic evaluation of a minimum of three sections and the cystic duct margin; specimens with dysplasia or proven cancer should be extensively sampled. Provided the patient is medically fit for surgery, data support the resection of all gallbladder polyps of >1.0 cm in diameter and those with imaging evidence of vascular stalks. The minimum staging evaluation of patients with suspected or proven gallbladder cancer includes contrasted cross-sectional imaging and diagnostic laparoscopy. Adequate lymphadenectomy includes assessment of any suspicious regional nodes, evaluation of the aortocaval nodal basin, and a goal recovery of at least six nodes. Patients with confirmed metastases to N2 nodal stations do not benefit from radical resection and should receive systemic and/or palliative treatments. Primary resection of patients with early T-stage (T1b-2) disease should include en bloc resection of adjacent liver parenchyma. Patients with T1b, T2 or T3 disease that is incidentally identified in a cholecystectomy specimen should undergo re-resection unless this is contraindicated by advanced disease or poor performance status. Re-resection should include complete portal lymphadenectomy and bile duct resection only when needed to achieve a negative margin (R0) resection. Patients with preoperatively staged T3 or T4 N1 disease should be considered for clinical trials of neoadjuvant chemotherapy. Following R0 resection of T2-4 disease in N1 gallbladder cancer, patients should be considered for adjuvant systemic chemotherapy and/or chemoradiotherapy.

PMCID: PMC4527853 [Available on 2016-08-01]

PMID: 26172135 [PubMed - indexed for MEDLINE]

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Crit Rev Oncol Hematol. 2015 Jan;93(1):36-49.

**Current clinical practice guidelines on chemotherapy and radiotherapy for the treatment of non-metastatic muscle-invasive urothelial cancer: a systematic review and critical evaluation by the Hellenic Genito-Urinary Cancer Group (HGUCG).**

Zagouri F, Peroukidis S, Tzannis K, Kouloulias V, Bamias A; Hellenic Genito-Urinary Cancer Group (HGUCG).

Radical cystectomy is the treatment of choice in localized muscle-invasive urothelial cancer. Nevertheless, relapses are frequent and systemic chemotherapy has been employed in order to reduce this risk. In addition, bladder preservation strategies are appealing. During the last decade, there has been a difficulty in conducting and completing large-scale trials in urothelial cancer. This has resulted in relatively few changes in the existing guidelines. Recent studies have created renewed interest in certain fields, such as the role of chemo-radiotherapy and management of unfit patients. In addition, application of certain guidelines has been limited in everyday practice. We conducted a systematic review of the existing guidelines and recent randomized trials not included in these guidelines, and developed a treatment algorithm, regarding non-surgical therapies for non-metastatic, muscle-invasive urothelial cancer based predominantly on patients' fitness for the available therapeutic modalities.

PMID: 25205597 [PubMed - indexed for MEDLINE]

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Am J Surg Pathol. 2015 Dec;39(12):1730-41.

**A Revised Classification System and Recommendations From the Baltimore Consensus Meeting for Neoplastic Precursor Lesions in the Pancreas.**

Basturk O, Hong SM, Wood LD, Adsay NV, Albores-Saavedra J, Biankin AV, Brosens LA, Fukushima N, Goggins M, Hruban RH, Kato Y, Klimstra DS, Klöppel G, Krasinskas A, Longnecker DS, Matthaei H, Offerhaus GJ, Shimizu M, Takaori K, Terris B, Yachida S, Esposito I, Furukawa T; Baltimore Consensus Meeting.

International experts met to discuss recent advances and to revise the 2004 recommendations for assessing and reporting precursor lesions to invasive carcinomas of the pancreas, including pancreatic intraepithelial neoplasia (PanIN), intraductal papillary mucinous neoplasm (IPMN), mucinous cystic neoplasm, and other lesions. Consensus recommendations include the following: (1) To improve concordance and to align with practical consequences, a 2-tiered system (low vs. high grade) is proposed for all precursor lesions, with the provision that the current PanIN-2 and neoplasms with intermediate-grade dysplasia now be categorized as low grade. Thus, "high-grade dysplasia" is to be reserved for only the uppermost end of the spectrum ("carcinoma in situ"-type lesions). (2) Current data indicate that PanIN of any grade at a margin of a resected pancreas with invasive carcinoma does not have prognostic implications; the clinical significance of dysplasia at a margin in a resected pancreas with IPMN lacking invasive carcinoma remains to be determined. (3) Intraductal lesions 0.5 to 1 cm can be either large PanINs or small IPMNs. The term "incipient IPMN" should be reserved for lesions in this size with intestinal or oncocytic papillae or GNAS mutations. (4) Measurement of the distance between an IPMN and invasive carcinoma and sampling of intervening tissue are recommended to assess concomitant versus associated status. Conceptually, concomitant invasive carcinoma (in contrast with the "associated" group) ought to be genetically distinct from an IPMN elsewhere in the gland. (5) "Intraductal spread of invasive carcinoma" (aka, "colonization") is recommended to describe lesions of invasive carcinoma invading back into and extending along the ductal system, which may morphologically mimic high-grade PanIN or even IPMN. (6) "Simple mucinous cyst" is recommended to describe cysts >1 cm having gastric-type flat mucinous lining at most minimal atypia without ovarian-type stroma to distinguish them from IPMN. (7) Human lesions resembling the acinar to ductal metaplasia and atypical flat lesions of genetically engineered mouse models exist and may reflect an alternate pathway of carcinogenesis; however, their biological significance requires further study. These revised recommendations are expected to improve our management and understanding of precursor lesions in the pancreas.

PMCID: PMC4646710 [Available on 2016-12-01]

PMID: 26559377 [PubMed - indexed for MEDLINE]

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Haematologica. 2015 Oct;100(10):1254-66.

**European Myeloma Network guidelines for the management of multiple myeloma-related complications.**

Terpos E, Kleber M, Engelhardt M, Zweegman S, Gay F, Kastritis E, van de Donk NW, Bruno B, Sezer O, Broijl A, Bringhen S, Beksac M, Larocca A, Hajek R, Musto P, Johnsen HE, Morabito

F, Ludwig H, Cavo M, Einsele H, Sonneveld P, Dimopoulos MA, Palumbo A; European Myeloma Network.

The European Myeloma Network provides recommendations for the management of the most common complications of multiple myeloma. Whole body low-dose computed tomography is more sensitive than conventional radiography in depicting osteolytic disease and thus we recommend it as the novel standard for the detection of lytic lesions in myeloma (grade 1A). Myeloma patients with adequate renal function and bone disease at diagnosis should be treated with zoledronic acid or pamidronate (grade 1A). Symptomatic patients without lytic lesions on conventional radiography can be treated with zoledronic acid (grade 1B), but its advantage is not clear for patients with no bone involvement on computed tomography or magnetic resonance imaging. In asymptomatic myeloma, bisphosphonates are not recommended (grade 1A). Zoledronic acid should be given continuously, but it is not clear if patients who achieve at least a very good partial response benefit from its continuous use (grade 1B). Treatment with erythropoietic-stimulating agents may be initiated in patients with persistent symptomatic anemia (hemoglobin <10g/dL) in whom other causes of anemia have been excluded (grade 1B). Erythropoietic agents should be stopped after 6-8 weeks if no adequate hemoglobin response is achieved. For renal impairment, bortezomib-based regimens are the current standard of care (grade 1A). For the management of treatment-induced peripheral neuropathy, drug modification is needed (grade 1C). Vaccination against influenza is recommended; vaccination against streptococcus pneumonia and hemophilus influenza is appropriate, but efficacy is not guaranteed due to suboptimal immune response (grade 1C). Prophylactic aciclovir (or valacyclovir) is recommended for patients receiving proteasome inhibitors, autologous or allogeneic transplantation (grade 1A).

PMCID: PMC4591757

PMID: 26432383 [PubMed - indexed for MEDLINE]

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Lancet Oncol. 2015 Sep;16(9):e470-7.

<b>Consensus on the management of intracranial germ-cell tumours.</b>
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Murray MJ, Bartels U, Nishikawa R, Fangusaro J, Matsutani M, Nicholson JC.

The management of intracranial germ-cell tumours is complex because of varied clinical presentations, tumour sites, treatments and outcomes, and the need for multidisciplinary input. Participants of the 2013 Third International CNS Germ Cell Tumour Symposium (Cambridge, UK) agreed to undertake a multidisciplinary Delphi process to identify consensus in the clinical

management of intracranial germ-cell tumours. 77 delegates from the symposium were selected as suitable experts in the field and were invited to participate in the Delphi survey, of which 64 (83%) responded to the invitation. Invited participants represented multiple disciplines from Asia, Australasia, Europe, and the Americas. 38 consensus statements encompassing aspects of intracranial germ-cell tumour work-up, staging, treatment, and follow-up were prepared. To achieve consensus, statements required at least 70% agreement from at least 60% of respondents. Overall, 34 (89%) of 38 statements met consensus criteria. This international Delphi approach has defined key areas of consensus that will help guide and streamline clinical management of patients with intracranial germ-cell tumours. Additionally, the Delphi approach identified areas of different understanding and clinical practice internationally in the management of these tumours, areas which should be the focus of future collaborative studies. Such efforts should translate into improved patient outcomes.

PMID: 26370356 [PubMed - indexed for MEDLINE]

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Curr Opin Oncol. 2015 Jul;27(4):332-7.

<b>Surveillance recommendations for patients with germline TP53 mutations.</b>
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Ballinger ML, Mitchell G, Thomas DM.

**PURPOSE OF REVIEW:** Li-Fraumeni syndrome is associated with germline TP53 mutations and carriers have a high lifetime risk of cancer, the most common being sarcoma, breast cancer, brain tumors, adrenocortical carcinoma and leukemia. Germline TP53 mutation carriers are increasingly being identified as more genomic sequencing is performed in both clinical and research settings. There is a pressing clinical need for effective cancer risk management approaches in this group. **RECENT FINDINGS:** Current clinical surveillance guidelines mainly focus on breast and bowel cancer risk with little consideration for the other cancers common to the syndrome. Imaging technologies are such that the utilization of whole-body MRI imaging for surveillance is viable. Globally, several research groups have included whole-body MRI along with other diagnostic measures in formulating surveillance protocols for TP53 mutation carriers. Early reports suggest a survival benefit. **SUMMARY:** Surveillance protocols for TP53 mutation carriers have the potential to improve outcomes in individuals and families. Further research is needed to guide the development of an effective and comprehensive surveillance schedule.

PMID: 26049273 [PubMed - indexed for MEDLINE]

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BMJ. 2015 Jul 29; 351:h3708.

**Melanoma: summary of NICE guidance.**

Macbeth F, Newton-Bishop J, O'Connell S, Hawkins JE; Guideline Development Group.

PMID: 26223435 [PubMed - indexed for MEDLINE]

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HPB (Oxford). 2015 Aug;17(8):669-80.

**Intrahepatic cholangiocarcinoma: expert consensus statement.**

Weber SM, Ribero D, O'Reilly EM, Kokudo N, Miyazaki M, Pawlik TM.

Comment in

HPB (Oxford). 2015 Aug;17(8):661-3.

An American Hepato-Pancreato-Biliary Association (AHPBA)-sponsored consensus meeting of expert panellists met on 15 January 2014 to review current evidence on the management of intrahepatic cholangiocarcinoma (ICC) in order to establish practice guidelines and to agree on consensus statements. The treatment of ICC requires a coordinated, multidisciplinary approach to optimize survival. Biopsy is not necessary if the surgeon suspects ICC and is planning curative resection, although biopsy should be obtained before systemic or locoregional therapies are initiated. Assessment of resectability is best accomplished using cross-sectional imaging [computed tomography (CT) or magnetic resonance imaging (MRI)], but the role of positron emission tomography (PET) is unclear. Resectability in ICC is defined by the ability to completely remove the disease while leaving an adequate liver remnant. Extrahepatic disease, multiple bilobar or multicentric tumours, and lymph node metastases beyond the primary echelon are contraindications to resection. Regional lymphadenectomy should be considered a standard part of surgical therapy. In patients with high-risk features, the routine use of diagnostic laparoscopy is recommended. The preoperative diagnosis of combined hepatocellular carcinoma and cholangiocarcinoma (cHCC-CC) by imaging studies is extremely difficult. Surgical resection remains the mainstay of treatment, but survival is worse than in HCC alone. There are no adequately powered, randomized Phase III trials that can provide definitive recommendations for adjuvant therapy for ICC. Patients with high-risk features (lymphovascular invasion, multicentricity or satellitosis, large tumours) should be encouraged to enrol in clinical trials and to consider adjuvant therapy. Cisplatin plus gemcitabine represents the standard-of-

care, front-line systemic therapy for metastatic ICC. Genomic analyses of biliary cancers support the development of targeted therapeutic interventions.

PMCID: PMC4527852 [Available on 2016-08-01]

PMID: 26172134 [PubMed - indexed for MEDLINE]

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J Am Coll Radiol. 2015 Jul;12(7):655-6.

**Guidelines for Management of Thyroid Nodules.**

Hall FM.

Comment on

J Am Coll Radiol. 2015 Feb;12(2):143-50.

PMID: 26143563 [PubMed - indexed for MEDLINE]

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Thyroid. 2015 Jun;25(6):567-610.

**Revised American Thyroid Association guidelines for the management of medullary thyroid carcinoma.**

Wells SA Jr, Asa SL, Dralle H, Elisei R, Evans DB, Gagel RF, Lee N, Machens A, Moley JF, Pacini F, Raue F, Frank-Raue K, Robinson B, Rosenthal MS, Santoro M, Schlumberger M, Shah M, Waguespack SG; American Thyroid Association Guidelines Task Force on Medullary Thyroid Carcinoma.

Comment in

Thyroid. 2015 Aug;25(8):973-4.

**INTRODUCTION:** The American Thyroid Association appointed a Task Force of experts to revise the original Medullary Thyroid Carcinoma: Management Guidelines of the American Thyroid Association. **METHODS:** The Task Force identified relevant articles using a systematic PubMed search, supplemented with additional published materials, and then created evidence-based recommendations, which were set in categories using criteria adapted from the United States Preventive Services Task Force Agency for Healthcare Research and Quality. The original guidelines provided abundant source material and an excellent organizational structure that served as the basis for the current revised document. **RESULTS:** The revised guidelines

are focused primarily on the diagnosis and treatment of patients with sporadic medullary thyroid carcinoma (MTC) and hereditary MTC. CONCLUSIONS: The Task Force developed 67 evidence-based recommendations to assist clinicians in the care of patients with MTC. The Task Force considers the recommendations to represent current, rational, and optimal medical practice.

PMCID: PMC4490627 [Available on 2016-06-01]

PMID: 25810047 [PubMed - indexed for MEDLINE]

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Int J Radiat Oncol Biol Phys. 2015 Jul 15;92(4):911-20.

<b>Expert Consensus Contouring Guidelines for Intensity Modulated Radiation Therapy in Esophageal and Gastroesophageal Junction Cancer.</b>
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Wu AJ, Bosch WR, Chang DT, Hong TS, Jabbour SK, Kleinberg LR, Mamon HJ, Thomas CR Jr, Goodman KA.

**PURPOSE/OBJECTIVE(S):** Current guidelines for esophageal cancer contouring are derived from traditional 2-dimensional fields based on bony landmarks, and they do not provide sufficient anatomic detail to ensure consistent contouring for more conformal radiation therapy techniques such as intensity modulated radiation therapy (IMRT). Therefore, we convened an expert panel with the specific aim to derive contouring guidelines and generate an atlas for the clinical target volume (CTV) in esophageal or gastroesophageal junction (GEJ) cancer. **METHODS AND MATERIALS:** Eight expert academically based gastrointestinal radiation oncologists participated. Three sample cases were chosen: a GEJ cancer, a distal esophageal cancer, and a mid-upper esophageal cancer. Uniform computed tomographic (CT) simulation datasets and accompanying diagnostic positron emission tomographic/CT images were distributed to each expert, and the expert was instructed to generate gross tumor volume (GTV) and CTV contours for each case. All contours were aggregated and subjected to quantitative analysis to assess the degree of concordance between experts and to generate draft consensus contours. The panel then refined these contours to generate the contouring atlas. **RESULTS:** The  $\kappa$  statistics indicated substantial agreement between panelists for each of the 3 test cases. A consensus CTV atlas was generated for the 3 test cases, each representing common anatomic presentations of esophageal cancer. The panel agreed on guidelines and principles to facilitate the generalizability of the atlas to individual cases. **CONCLUSIONS:** This expert panel successfully reached agreement on contouring guidelines for esophageal and GEJ IMRT and generated a reference CTV atlas. This atlas will serve as a reference for IMRT

contours for clinical practice and prospective trial design. Subsequent patterns of failure analyses of clinical datasets using these guidelines may require modification in the future.

PMCID: PMC4481325 [Available on 2016-07-15]

PMID: 26104943 [PubMed - indexed for MEDLINE]

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Int J Radiat Oncol Biol Phys. 2015 Jul 1;92(3):602-12.

<b>Treatment Guidelines for Preoperative Radiation Therapy for Retroperitoneal Sarcoma: Preliminary Consensus of an International Expert Panel.</b>
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Baldini EH, Wang D, Haas RL, Catton CN, Indelicato DJ, Kirsch DG, Roberge D, Salerno K, Deville C, Guadagnolo BA, O'Sullivan B, Petersen IA, Le Pechoux C, Abrams RA, DeLaney TF.

**PURPOSE:** Evidence for external beam radiation therapy (RT) as part of treatment for retroperitoneal sarcoma (RPS) is limited. Preoperative RT is the subject of a current randomized trial, but the results will not be available for many years. In the meantime, many practitioners use preoperative RT for RPS, and although this approach is used in practice, there are no radiation treatment guidelines. An international expert panel was convened to develop consensus treatment guidelines for preoperative RT for RPS. **METHODS AND MATERIALS:** An expert panel of 15 academic radiation oncologists who specialize in the treatment of sarcoma was assembled. A systematic review of reports related to RT for RPS, RT for extremity sarcoma, and RT-related toxicities for organs at risk was performed. Due to the paucity of high-quality published data on the subject of RT for RPS, consensus recommendations were based largely on expert opinion derived from clinical experience and extrapolation of relevant published reports. It is intended that these clinical practice guidelines be updated as pertinent data become available. **RESULTS:** Treatment guidelines for preoperative RT for RPS are presented. **CONCLUSIONS:** An international panel of radiation oncologists who specialize in sarcoma reached consensus guidelines for preoperative RT for RPS. Many of the recommendations are based on expert opinion because of the absence of higher level evidence and, thus, are best regarded as preliminary. We emphasize that the role of preoperative RT for RPS has not been proven, and we await data from the European Organization for Research and Treatment of Cancer (EORTC) study of preoperative radiotherapy plus surgery versus surgery alone for patients with RPS. Further data are also anticipated pertaining to normal tissue dose constraints, particularly for bowel tolerance. Nonetheless, as we await these data, the guidelines herein can be used to establish treatment uniformity to aid future assessments of efficacy and toxicity.

PMID: 26068493 [PubMed - indexed for MEDLINE]

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J Hepatobiliary Pancreat Sci. 2015 Apr;22(4):249-73.

**Clinical practice guidelines for the management of biliary tract cancers 2015: the 2nd English edition.**

Miyazaki M, Yoshitomi H, Miyakawa S, Uesaka K, Unno M, Endo I, Ota T, Ohtsuka M, Kinoshita H, Shimada K, Shimizu H, Tabata M, Chijiwa K, Nagino M, Hirano S, Wakai T, Wada K, Isayama H, Okusaka T, Tsuyuguchi T, Fujita N, Furuse J, Yamao K, Murakami K, Yamazaki H, Kijima H, Nakanuma Y, Yoshida M, Takayashiki T, Takada T.

Erratum in

J Hepatobiliary Pancreat Sci. 2015 Jun;22(6):510. Isayama, Hiroyuki [corrected to Isayama, Hiroyuki].

**BACKGROUND:** The Japanese Society of Hepato-Biliary-Pancreatic Surgery launched the clinical practice guidelines for the management of biliary tract and ampullary carcinomas in 2008. Novel treatment modalities and handling of clinical issues have been proposed after the publication. New approaches for editing clinical guidelines, such as the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system, also have been introduced for better and clearer grading of recommendations. **METHODS:** Clinical questions (CQs) were proposed in seven topics. Recommendation, grade of recommendation and statement for each CQ were discussed and finalized by evidence-based approach. Recommendation was graded to grade 1 (strong) and 2 (weak) according to the concept of GRADE system. **RESULTS:** The 29 CQs covered seven topics: (1) prophylactic treatment, (2) diagnosis, (3) biliary drainage, (4) surgical treatment, (5) chemotherapy, (6) radiation therapy, and (7) pathology. In 27 CQs, 19 recommendations were rated strong and 11 recommendations weak. Each CQ included the statement of how the recommendation was graded. **CONCLUSIONS:** This guideline provides recommendation for important clinical aspects based on evidence. Future collaboration with cancer registry will be a key for assessment of the guidelines and establishment of new evidence. Free full-text articles and a mobile application of this guideline are available via <http://www.jshbps.jp/en/guideline/biliary-tract2.html>.

PMID: 25787274 [PubMed - indexed for MEDLINE]

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Bull Am Coll Surg. 2016 Feb;101(2):33-4.

**Dissemination and implementation: Translating cancer guidelines and clinical trial outcomes into everyday practice.**

Wilke LG, Dickson-Witmer D, Boughey JC.

PMID: 26995861 [PubMed - indexed for MEDLINE]

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Future Oncol. 2015;11(14):2021-5.

**Should the 'echo guidelines' be followed in cancer patients?**

Herrmann J(1), Yang EH(2).

PMID: 26198830 [PubMed - indexed for MEDLINE]

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