UniversitätsSpital Zürich

ESMO Consensus Empfehlungen 2017

What‘s old, **what‘s new**, what‘s missing ?

Jörg Beyer, Klinik für Onkologie

Offenlegung Interessenskonflikte

JAHRESTAGUNG 2017 STUTTGART 29.9.–3.10.

1. Anstellungsverhältnis oder Führungsposition **Keine**
2. Beratungs- bzw. Gutachtertätigkeit **Keine**
3. Besitz von Geschäftsanteilen, Aktien oder Fonds **Keine**
4. Patent, Urheberrecht, Verkaufslizenz **Keine**
5. Honorare **Bayer, Astellas, Janssen, Roche**
6. Finanzierung wissenschaftlicher Untersuchungen **Keine**
7. Andere finanzielle Beziehungen **Keine**
8. Immaterielle Interessenkonflikte **Keine**

Background

- European Consensus Conference in November 2011 in Berlin
- European Consensus Conference Guidelines published in 2013
- ESMO Guidelines published in 2013
- Update Consensus Conference held in November 2016 in Paris

Background

- Diagnostic work-up & patient assessment
- Stage I disease
- Metastatic disease
- Salvage treatment, specialized surgery and rare clinical problems
- Survivorship & follow-up schedules

Diagnostic work-up

- No specific **risk factors** mentioned
- No **screening** for „high risk“ patients

- **Risk factors**

  > Cryptorchidism
  > Hypospadia
  > Inguinal hernia
  > Family history (brother >> father)

- **Trageted Screening recommended despite lack of evidence ?**

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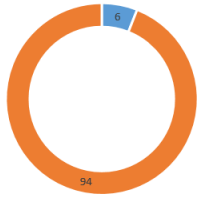

No

Pathology

- **T**esticular **I**ntraepithelial **N**eoplasia or short „**TIN**“ as precursor lesion

- New name for TIN: **G**erm **C**ell **N**eoplasia **I**n **S**itu or short „**GCNIS**“
- Minimum dataset guidelines for pathology reports
- **Review by experienced pathologist (> 30 cases per year)?**

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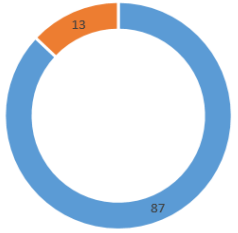

Yes

Imaging

- Computed tomography (CT) scan of the abdomen and pelvis is mandatory
- Positron emission tomography (**PET**) scanning does not contribute to initial staging

- Computed tomography (CT) of the thorax, abdomen and pelvis is the imaging modality of choice.
- **PET-CT is recommended for staging**

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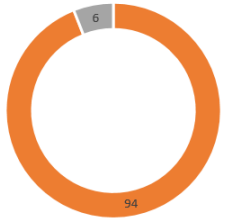

No

- An **MRI** can be recommended for follow-up of the retroperitoneum, if standard protocols are used and the results are reported by an experienced radiologist

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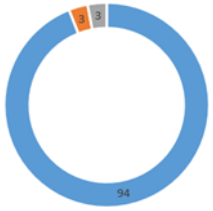

Yes

Stage I Seminoma

- The predictive value of **‘risk factors’**, such as rete testis infiltration and tumour size ≥4 cm, is controversial

- **Both rete testis stromal invasion and primary tumor size should be considered as risk factors for relapse in stage I**

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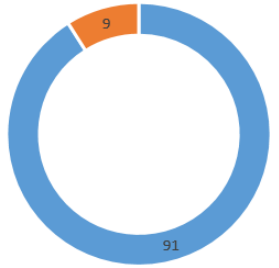

Yes

- **Larger tumors confer higher risk of recurrence as a continuous variable. There is no definitive cut-off value.**

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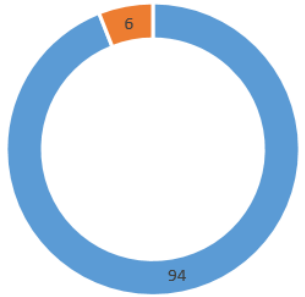


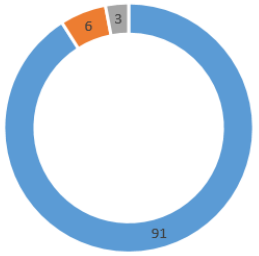
Yes

Stage I Seminoma

- Surveillance is the preferred strategy.

- **Patients with seminoma and a low risk of relapse should not be offered adjuvant chemotherapy**

Vote:



Yes

- **In patients with seminoma and a higher risk of relapse, surveillance or adjuvant carboplatin are options**

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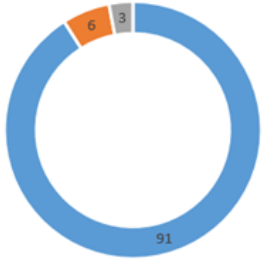

Yes

Stage I Non-Seminoma

- Stage I disease implies excellent survival rates and is categorized by absence or presence of **vascular invasion** into ‘low risk’ or ‘high risk’ for relapse, respectively
- **Surveillance** is the standard for low-risk disease
- For **high risk** there are two standard treatment options: surveillance or adjuvant chemo-therapy. Survival is the same whichever option is used.
- Nerve-sparing **RPLND** may be carried out in case of contra-indications against the two previous strategies

- **LVI** is the major validated risk factor. The risk of relapse without adjuvant therapy is 50%
- **In patients with low-risk non-seminoma surveillance is recommended**

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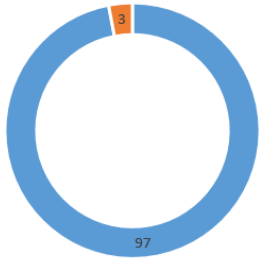

Yes

- **In patients with high-risk non-seminoma, adjuvant chemotherapy is recommended**

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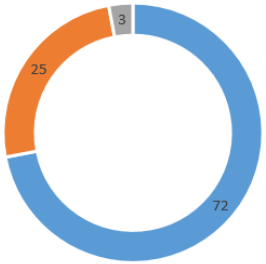


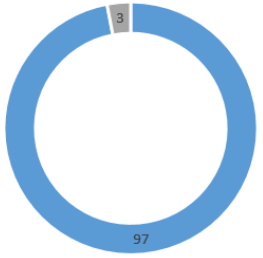
No consensus

Adjuvant chemo & Relapse

- Compared with radiotherapy, in **seminoma** one course of carboplatin results in similar relapse rates, but less treatment-related toxicities
- In **non-seminoma** adjuvant chemotherapy with one or two cycles of BEP

- **One course is the standard adjuvant chemotherapy**

Vote:



Yes

- **Treatment of relapse after adjuvant chemotherapy according to the prognostic classification for metastatic disease**

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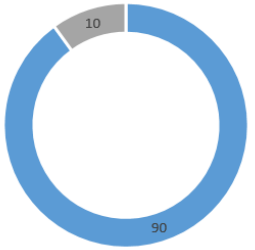

Yes

Role of RPLND

- In patients not suitable for surveillance or adjuvant chemotherapy, open nervesparing **RPLND** in highly experienced centres is an option.
- Some experts consider nerve-sparing **RPLND** the preferred treatment of patients with teratoma and somatic transformation in the primary tumor

- **RPLND is the standard treatment in patients with clinical stage I teratoma with malignant somatic transformation**

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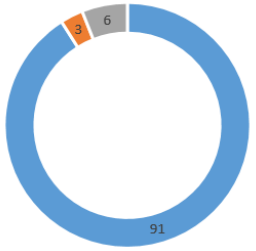
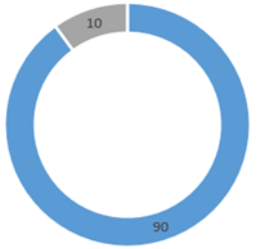


Yes

- **In Non-seminoma with localized abdominal marker-negative relapse, RPLND is the preferred option**
- **Vote:**



Yes

Stage IIA/B Seminoma

- In stage II A seminoma, treatment options consist of either cisplatin-based chemotherapy or radiotherapy with 30 Gy
- In stage IIB seminoma, three cycles of BEP represent the standard therapy

- **Patients with clinical stage IIA seminoma can be treated with chemotherapy or radiotherapy (30 Gy)**

Vote:

- **Patients with clinical stage IIB seminoma should be treated with 3xBEP or 4xEP. Radiotherapy (36 Gy) should only be given in selected cases**

Vote:

Stage IIA/B Seminoma

- In stage II A seminoma, treatment options consist of either cisplatin-based chemotherapy or radiotherapy with 30 Gy
- In stage IIB seminoma, three cycles of BEP represent the standard therapy

Studie

- **Patients with clinical stage IIA seminoma can be treated with chemotherapy or radiotherapy (30 Gy)**

Vote:

- **Patients with clinical stage IIB seminoma should be treated with 3xBEP or 4xEP. Radiotherapy (36 Gy) should only be given in selected cases**

Vote:

Stage IIA/B Non-Seminoma

- Metastatic Stage IIA/B **non-seminoma** not purely consisting of teratoma should be treated according to the IGCCCG recommendations
- **Small lymph nodes might not represent metastases** implying the risk of over-treatment. This may be avoided by

  > Close follow-up with abdominal imaging every 6 weeks until regression or progression

  > Primary nerve-sparing RPLND

- **Treatment for stage IIA non-seminoma and normal STM is either BEP/EP ± RPLND, or primary RPLND ± adjuvant chemotherapy.**

Vote:

- **Treatment for stage IIB non-seminoma and normal STM is either BEP/EP ± RPLND, or primary RPLND ± adjuvant chemotherapy.**

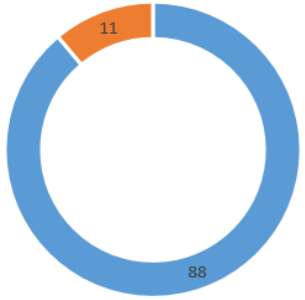
Vote:

Treatment „intermediate“

- Four cycles of BEP still represent standard treatment of patients with **intermediate** or poor prognosis

- **The recommended treatment for intermediate risk patients are BEPx4 or VIPx4 followed by resection of residual masses when present.**

Vote:



Yes

Brain metastases

- No statements

- Chemotherapy according to IGCCCG poor risk is recommended as standard of care
- There are no high-quality data for the routine use of post-chemotherapy local treatments (surgery or radiation)
- **Patients with residual oligo brain mets after chemotherapy, and normal STM should be considered for additional surgery or stereotactic radiation**

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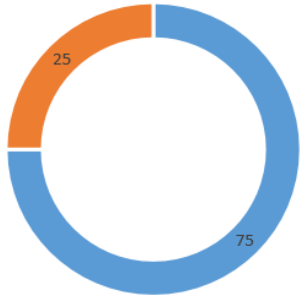

Yes

Advanced & Patients at risk

- No statements

- **In advanced metastatic GCT and/or organ failure, orchiectomy can be postponed until the completion of chemotherapy.**

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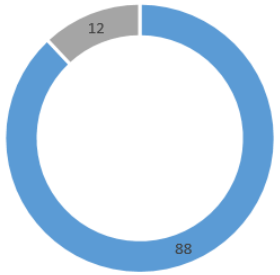


Yes

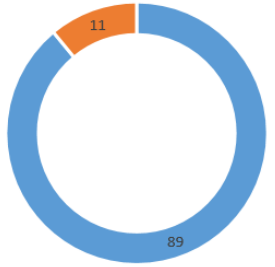
- In patients with very advanced disease 2-3 days of full dose cisplatin and etoposide are suggested, with continuation of chemo when the patient has recovered
- Patients with poor renal function should not routinely be treated with carboplatin but should be referred to high-volume centres

Post-Chemotherapy

- In case of complete response, no further treatment is necessary. **Residual lymphnodes** exceeding 10 mm in diameter, should be removed by open nerve-sparing **RPLND**
- Patients with **elevated tumor markers** should receive treatment based on individualized recommendations by experts.
- **Rising tumor markers** indicate progressive GCT, usually requiring highly specialised multi-disciplinary therapy

- **PC-RPLND is indicated in non-seminoma and residual lesions ≥1 cm in size**

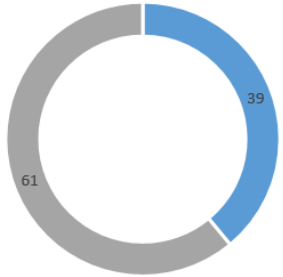
Vote:



Yes

- **Patients with declining/low-level plateau of STM should proceed to surgery. Those with increasing STM should undergo full salvage chemo before residual tumor resection**

Vote:



???

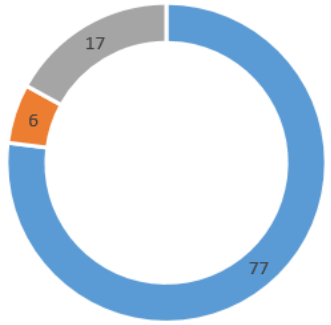
Salvage surgery

- No statements

- **Immediate salvage surgery *(instead of chemotherapy)* should be considered**
- > In non-seminoma relapsing with localized resectable lesions and negative STM as lesions may be due to enlarging teratoma without malignant components

  > In late relapses in both seminoma and non-seminoma due to the high incidence of chemotherapy-refractory disease

Vote:



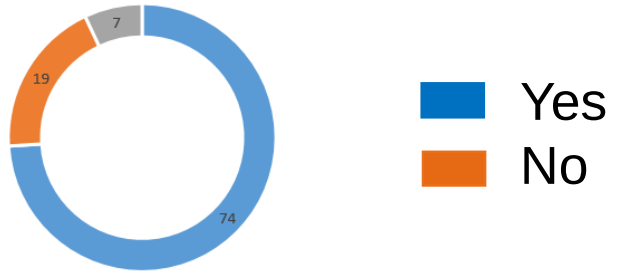
Yes

Follow-up

- Besides **early detection of relapse**, follow-up should be directed towards **prevention, detection and treatment of late toxicity** for the increasing number of GCC survivors
- Determination of testosterone levels is recommended during follow-up, although it is not always clear when and at what level **testosterone replacement** should be offered

- Patients should be informed of the potential **long-term toxicities**, i.e. ototoxicity, neuro-toxicity, 2nd cancers, CVD as well as sexual difficulties, fatigue and cognitive dysfunction.
- Patients should be reassured that long-term **HRQoL** is very similar to that in men without treatment for testicular cancer.
- **Physical activity** and a **healthy lifestyle** should be recommended to all patients
- **Patients with low testosterone levels should not routinely be offered replacement therapy**

Vote:



Centralization of care

- Referral to **high volume centers** only for specialized surgery, i.e. RPLND

- **Besides orchiectomy, treatment of all patients with GCT should be conducted in high-volume centres**

Vote: