<table>
<thead>
<tr>
<th>Guideline Page and Request</th>
<th>Panel Discussion/References</th>
<th>Institution Vote</th>
</tr>
</thead>
</table>
| **GLIO-3/GLIO-4 External Request** | Based on data in the noted reference, the panel consensus was to include the following postoperative adjuvant therapy option for patients with supratentorial glioblastoma, and good performance status:  
- Standard brain RT + concurrent temozolomide and adjuvant temozolomide + alternating electric field therapy  
| **MENI-1 External Request** | To clarify for whom postoperative RT can be considered, the panel consensus supported the following revision to the treatment options for small, symptomatic meningiomas: “Surgery if accessible, followed by RT if WHO Grade III; consider RT for resected WHO Grade II”  
Panel consensus also supported the following revision to the treatment options for small asymptomatic meningiomas: “Surgery if potential neurologic consequences and if accessible, followed by RT if WHO Grade III; consider RT for resected or incompletely resected WHO Grade II and consider RT for incompletely resected WHO Grade I if residual disease is potentially symptomatic.” | YES 16 NO 0 ABSTAIN 0 ABSENT 11 |
| **LEPT-3 External Request** | Panel consensus was to revise the CSI treatment recommendation in the algorithm as follows: "Due to substantial toxicity of craniospinal irradiation (CSI), consider only in highly select patients (eg, leukemia, lymphoma).”  
This revision will be included in the updated discussion section when available. | YES 16 NO 0 ABSTAIN 0 ABSENT 11 |
Panel consensus supported the inclusion of the following expanded description for craniospinal RT for ependymomas: "Whole brain and spine (to bottom of thecal sac) receive 36 Gy in 1.8 Gy fractions, followed by limited field to spine lesions to 45 Gy. (Gross metastatic lesions below the conus could receive higher doses of 54–60 Gy). Primary intracranial site should receive total dose of 54–59.4 Gy in 1.8–2.0 Gy fractions. Consider boosting any gross intracranial metastatic sites to a higher dose while respecting normal tissue tolerances."

This revision will be included in the updated discussion section when available.

Panel consensus was not to include the two proposed additions regarding radiotherapy recommendations for primary spinal tumors based on limited available data.

Panel consensus was not to include additional dosing recommendations for resected or unresectable disease as the current recommended dosing of 45-54 Gy applies to all WHO grade I meningiomas.

Panel consensus supported adding the following RT recommendation for WHO grade I meningiomas: "Stereotactic or image-guided therapy is recommended when using tight margins or when close to critical structures. Conformal radiation therapy (3D-CRT, IMRT, VMAT, etc.) is recommended to spare critical structures and uninvolved tissue."