

NCCN Guidelines for Central Nervous System Cancer V.1.2016 –Teleconference on 02/05/2016

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
<p>GLIO-3/GLIO-4 External Request External submission from Novocure Inc. to consider the inclusion of tumor treating fields (TTFields) as a treatment for adult patients with histologically-confirmed newly diagnosed glioblastoma in combination with temozolomide following maximal debulking surgery and completion of radiation therapy together with concomitant standard of care chemotherapy.</p>	<p>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:</p> <ul style="list-style-type: none"> Standard brain RT + concurrent temozolomide and adjuvant temozolomide + alternating electric field therapy <p>Reference: Stupp R, Taillibert S, Kanner AA, et al. Maintenance therapy with tumor-treating fields plus temozolomide vs temozolomide alone for glioblastoma: a randomized clinical trial. JAMA 2015;314:2535-2543.</p>	16	0	0	11
<p>MENI-1 External Request External submission from The American Society for Radiation Oncology (ASTRO) to consider revising the postoperative RT recommendations for small symptomatic meningiomas, to include those with resected or incompletely resected WHO grade II or incompletely resected WHO Grade I disease.</p>	<p>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; <i>consider RT for resected WHO Grade II</i>”</p> <p>Panel consensus also supported the following revision to the treatment options for small <i>asymptomatic</i> meningiomas: “Surgery if potential neurologic consequences and if accessible, followed by RT if WHO Grade III; consider RT for resected <i>or incompletely resected</i> WHO Grade II <i>and consider RT for incompletely resected WHO Grade I if residual disease is potentially symptomatic.</i>”</p>	16	0	0	11
<p>LEPT-3 External Request External submission from ASTRO to consider adding the following footnote regarding treatment with craniospinal irradiation (CSI), and also apply the revision to the discussion text: “CSI is associated with substantial toxicity and should only be considered for highly select patients.”</p>	<p>Panel consensus was to revise the CSI treatment recommendation in the algorithm as follows: “<i>Due to substantial toxicity of craniospinal irradiation (CSI), consider only in highly select patients (eg, leukemia, lymphoma).</i>”</p> <p>This revision will be included in the updated discussion section when available.</p>	16	0	0	11

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<p>BRAIN-C (1 of 3) External Request External submission from ASTRO to consider expanding the description of craniospinal RT for ependymomas, in the algorithm and discussion text, including the option of boosting for gross metastatic disease.</p>	<p>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. (<i>Gross metastatic lesions below the conus could receive higher doses of 54–60 Gy</i>). Primary <i>intracranial</i> site should receive total dose of 54–59.4 Gy in 1.8–2.0 Gy fractions. <i>Consider boosting any gross intracranial metastatic sites to a higher dose while respecting normal tissue tolerances.</i>”</p> <p>This revision will be included in the updated discussion section when available.</p>	16	0	0	11
<p>BRAIN-C (2 of 3) External Request External submission from ASTRO to consider adding the following bullets regarding radiation therapy for primary spinal cord tumors:</p> <ul style="list-style-type: none"> • In select patients, or recurrences after prior radiation, stereotactic radiation techniques (SRS, SBRT) are appropriate. • It is critical to consider tolerance of the spinal cord and/or spinal nerve roots, and conformal radiation therapy (3D-CRT, IMRT, VMAT, etc.) is recommended to spare critical structures. 	<p>Panel consensus was not to include the two proposed additions regarding radiotherapy recommendations for primary spinal tumors based on limited available data.</p>	0	16	0	
<p>BRAIN-C (2 of 3) External Request External submission from ASTRO to consider adding the following to the RT recommendations for meningiomas:</p> <ul style="list-style-type: none"> • [WHO grade I meningiomas]: “A dose of greater than 50 Gy is recommended for incompletely resected or unresectable disease.” • “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.” 	<ul style="list-style-type: none"> • 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.” 	0	16	0	11
		16	0	0	11