

NCCN Guidelines for Neuroendocrine Tumors V.1.2017 – Follow-Up on 01/31/17

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
<p><b>NET-5</b> Internal Request: Panel comment to consider the following adjuvant therapy options for locally unresectable and incompletely resected thymus tumors:</p> <ul style="list-style-type: none"> <li>• For low grade (typical): Consider RT +/- cisplatin/etoposide or carboplatin/etoposide</li> <li>• For intermediate grade (atypical): RT +/- cisplatin/etoposide or carboplatin/etoposide</li> </ul>	Based on limited data, panel consensus supported the addition of “consider RT” as a category 3 recommended option for low grade thymus tumors that are unresectable or incompletely resected/have positive margins.	11	3	3	10
	Based on limited data, panel consensus did not support the addition of “consider RT + cisplatin/etoposide or carboplatin/etoposide” for locally unresectable and incompletely resected low grade thymus tumors.	6	8	3	10
	Panel consensus supported the following additions for intermediate grade thymus tumors				
	<ul style="list-style-type: none"> <li>• If incomplete resection or positive margins: <ul style="list-style-type: none"> <li>• RT</li> <li>• RT + cisplatin/etoposide or carboplatin/etoposide</li> </ul> </li> <li>• If locally unresectable: <ul style="list-style-type: none"> <li>• RT</li> <li>• RT + cisplatin/etoposide or carboplatin/etoposide</li> </ul> </li> </ul>	12	2	3	10
		12	2	3	10
		12	2	3	10
		13	1	3	10
<p><b>NET-5</b> Internal Request: Panel comment to consider removing the adjuvant therapy option of chemotherapy alone for unresectable/incompletely resected thymus tumors.</p>	Panel consensus supported the removal of chemotherapy alone from the adjuvant therapy options for unresectable/incompletely resected thymus tumors.	11	3	3	10
<p><b>NET-5</b> Internal Request: Panel comment to consider the removal of 5-FU and capecitabine from the chemotherapy options in footnote “r”: “Consider 5-FU or capecitabine at radiosensitizing doses. Cisplatin or carboplatin with etoposide may be appropriate for patients with atypical or poorly differentiated carcinomas.”</p>	Panel consensus supported the removal of 5-FU and capecitabine, and footnote “r” has been revised as follows: “Cisplatin/etoposide or carboplatin/etoposide may be appropriate for patients with atypical or poorly differentiated carcinomas. Chemoradiation is thought to have most efficacy for tumors with atypical histology or tumors with higher mitotic and proliferative indices (eg, Ki-67).”	10	3	4	10

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<p><b>NET-6</b>                  Internal request:                  Panel comment to consider the addition of the following adjuvant therapy options for low grade (typical) stage IIIA (unresectable or positive margins) and stage IIIB lung neuroendocrine tumors:</p> <ul style="list-style-type: none"> <li>• Consider RT +/- cisplatin/etoposide or carboplatin/etoposide</li> </ul>	<p>Panel consensus supported the inclusion of the following options, as category 3 recommendations, for low grade (typical) stage IIIA (unresectable or positive margins) and stage IIIB lung neuroendocrine tumors:</p> <ol style="list-style-type: none"> <li>1. Consider RT (category 3)</li> <li>2. Consider RT + cisplatin/etoposide or carboplatin/etoposide (category 3)</li> </ol> <p>The following footnote “u” has also been included:                  “Chemoradiation is thought to have most efficacy for tumors with atypical histology or tumors with higher mitotic and proliferative indices (eg, Ki-67). There is limited data on the efficacy of chemoradiation for unresectable IIIA or IIIB, low grade lung neuroendocrine tumors; however some panel members consider chemoradiation in this situation.”</p>	<p>10 8</p>	<p>3 6</p>	<p>4 3</p>	<p>10 10</p>
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