Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
GLIO-4 **External request:** Submission from the American Society for Radiation Oncology (ASTRO) to consider listing hypofractionated RT + concurrent and adjuvant temozolomide on GLIO-4 ahead of standard focal brain RT + concurrent and adjuvant temozolomide for good performance status patients >70 y	Based on the discussion, the panel consensus was to move, "hypofractionated RT + concurrent and adjuvant temozolomide" as the first option listed. • See Submission for references Please note that across the NCCN guidelines the order of therapies listed does not imply preference.	22	0	0	5
GLIO-5 **External request:** Submission from the ASTRO to consider including an additional arrow from resectable that extends directly to the list of non-surgical treatment options listed on the right. An alternative solution for this finding is to revise Unresectable to read, Unresectable or Resection Not Recommended/Elected.	Based on the discussion, the panel consensus was to revise "Unresectable" to read "Unresectable or Resection Not Recommended/Elected." • See Submission for references	22	0	0	5
AMED-2 **External request:** Submission from the ASTRO to revise the algorithm for high-risk disease to recommend craniospinal radiation ***with chemotherapy followed by*** post-radiation chemotherapy.	Based on the discussion, the panel consensus was to revise the algorithm to recommend, "craniospinal radiation ***with chemotherapy followed by*** post-radiation chemotherapy. • See Submission for references	22	0	0	5
PCNS-3 **External request:** Submission from the ASTRO to list re-irradiation as an option for relapsed or refractory CNS lymphoma after prior WBRT in the treatment algorithm.	Based on the discussion, the panel consensus was to include focal irradiation as an option for relapsed or refractory CNS lymphoma after prior WBRT. • See Submission for references	22	0	0	5

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
BRAIN-C (1 of 3) **External request:** Submission from the ASTRO to Acknowledge that a wider variety of approaches with respect to target volume delineation are acceptable by revising to, "The GTV is best defined using pre- and postoperative MRI imaging using enhanced T1 and FLAIR/T2. The GTV is expanded by 2-3 cm (CTV) to account for sub-diagnostic tumor infiltration. ***Strategies for GTV definition vary with respect to the inclusion of edema in an initial target volume. When edema is included in an initial phase of treatment***, fields are usually reduced for the last phase of treatment. ***Both strategies appear to produce similar outcomes***.	Based on the discussion, the panel consensus was to include[new text in bold italics]: " ***When edema is included in an initial phase of treatment,*** fields are usually reduced for the last phase of treatment. ***Both strategies appear to produce similar outcomes***." • See Submission for references	22	0	0	5
BRAIN-C (1 of 3) **External request:** Submission from the ASTRO to include the following under the recommendations for Adult Medulloblastoma and Supratentorial PNET, **"**Consider the use of intensity-modulated radiotherapy or protons if available."	Based on the discussion, the panel consensus was to revise the footnote as follows [new text in bold italics]: "***To reduce toxicity from craniospinal irradiation in adults***, *consider the use of* **intensity-modulated radiotherapy or** *protons if available*". • See Submission for references	22	0	0	5

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
BRAIN-C (2 of 3) Submission from the ASTRO to include the following, "Doses to vertebral body metastases will depend on patient's PS, spine stability, location in relationship to spinal cord, primary histology, ***presence of epidural disease, and overall treatment intent (pain relief, long-term local control, or cure). In patients with uncomplicated spine metastases that are treated primarily for pain relief, 8 Gy in 1 fraction has been shown to provide equivalent pain control to longer fractionation schedules and is more convenient for patients, but may be associated with higher rates of retreatment, which may be a consideration when life expectancy exceeds 6 months.*** ***When lower BED regimens are utilized upfront (i.e. BED ≤ 60 Gy_2, which includes up to 20 Gy in 5 fractions but does not include 30 Gy in 10 fractions), retreatment with similar BED regimens, such 20 Gy in 5 fractions or 8 Gy in 1 fraction, can safely be considered as early as 4 weeks from initial treatment for pain relief. In other cases, doses ranging from 15 Gy in 1 fraction to 40 Gy in 20 fractions have been utilized for tumor control, with careful consideration of tolerance of the spinal cord and/or nerve roots.*** In selected cases, or recurrences after previous radiation, stereotactic radiation (SRS or SBRT) is appropriate. In these instances it is generally recommended that 6 months or more of time between treatments is required."	Based on the discussion, the panel consensus was to include **[changes in bold italics]:** **"**Doses to vertebral body metastases will depend on patient's PS, spine stability, location in relationship to spinal cord, primary histology, ***presence of epidural disease, and overall treatment intent (pain relief, long-term local control, or cure).***" and "***In patients with uncomplicated spine metastases that are treated primarily for pain relief, 8 Gy in 1 fraction has been shown to provide equivalent pain control to longer fractionation schedules and is more convenient for patients, but may be associated with higher rates of retreatment, which may be a consideration when life expectancy exceeds 6 months.When lower BED regimens are utilized upfront (ie, BED ≤60 Gy which includes up to 20 Gy in 5 fractions but does not include 30 Gy in 10 fractions), retreatment with similar BED regimens, such as 20 Gy in 5 fractions or 8 Gy in 1 fraction, can safely be considered as early as 4 weeks from initial treatment for pain relief. In other cases, doses ranging from 15 Gy in 1 fraction to 40 Gy in 20 fractions have been utilized for tumor control, with careful consideration of tolerance of the spinal cord and/or nerve roots***. ***In these cases,*** is generally recommended that 6 months or more of time between treatments is required."	22	0	0	5