

NCCN Guidelines for Uterine Neoplasms V.1.2020 –Meeting on 06/10/19 and 06/11/19

Guideline Page and Request	Panel Discussion/References	Institution Vote			
		YES	NO	ABSTAIN	ABSENT
<p>Endometrial Carcinoma ENDO-2 External request Submission from the American Society for Radiation Oncology (ASTRO) (04/30/19) to revise how stage II disease is approached in the guideline. For gross cervical involvement, the guideline suggests external beam radiotherapy (EBRT) and brachytherapy to 75-80 Gy to point A/paracervical dose, but using image-guided brachytherapy (IGBT) is more standard now, and request recommending using volume- based target and detailing the high-risk clinical target volume (HR-CTV) for those patients as detailed in the Principles of Radiation Therapy on page UN-A, 2 of 2.</p>	Based upon review of data and discussion, the panel consensus supported the removal of all point A radiation dosing within the guidelines.	22	0	0	7
<p>ENDO-4 External request Submission from ASTRO (04/30/19) requesting that for Stages IA G3 with invasion and IB G1-2 recommend the additional option of “or Consider EBRT if extensive LVSI and no nodal evaluation with other risk factors”</p>	Based upon review of data and discussion, the panel consensus supported not making the requested change.	0	22	0	7
<p>ENDO-4 External request Submission from ASTRO (04/30/19) requesting that external beam radiation (EBRT) ± vaginal brachytherapy should be recommended for stage IB G3 rather than RT (vaginal brachytherapy and/or EBRT).</p>	Based upon review of data and discussion, the panel consensus supported not making the requested change. For Stage IB, G3 the following change was made instead: RT (<i>EBRT and/or vaginal brachytherapy and/or EBRT</i>) ± systemic therapy (<i>category 2B for systemic therapy</i>)	0	22	0	7
<p>ENDO-5 External request Submission from ASTRO (04/30/19) to revise how stage II disease is approached in the guideline. For footnote “s” consider adding “without other high-risk features” for patients for whom adjuvant vaginal brachytherapy (VBT) alone is considered in surgically staged Stage II. Also consider distinguishing these as microscopic Stage II patients, as opposed to macroscopic Stage II, who should not be considered for vaginal brachytherapy alone except after radical hysterectomy.</p>	Based on a review of the data and discussion, the panel did not use the language proposed in the submission. However, the panel supported modifying footnote “s” as follows: Observation or vaginal brachytherapy is also an option for these patients with stage II disease who have had a radical hysterectomy with negative surgical margins and no evidence of extrauterine disease. <i>Vaginal brachytherapy is also an option for low-grade disease with negative surgical staging or minimal invasion. Observation is an option for those patients who have had a radical hysterectomy with negative surgical margins.</i>	22	0	0	7

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<p><u>ENDO-10</u> External request Submission from ASTRO (04/30/19) for locoregional recurrence after EBRT, suggest including salvage interstitial brachytherapy as a treatment option.</p>	<p>Based on a review of the data and discussion, the panel consensus was not to make the recommended change.</p>	0	21	0	8
<p><u>ENDO-11</u> External request Submission from ASTRO (04/30/19) for patients unsuitable for surgery, suggest the guidelines recommend EBRT + Brachytherapy or use “and/or” as is done for endometrioid histology.</p>	<p>Based upon a review of data and discussion, the panel consensus supported not making the recommended change. However, the panel did change the following treatment option for patients not suitable for surgery, from “EBRT ± brachytherapy ± systemic therapy” to EBRT + brachytherapy ± systemic therapy”.</p>	0	21	0	8
<p><u>ENDO-A 1 of 2</u> External request Submission from ASTRO (04/30/19) suggesting that lymphovascular invasion should be classified as none, focal, multifocal/extensive.</p>	<p>Based on a review of the data and discussion, the panel consensus was not to make changes to the current recommendations.</p>	0	21	0	8
<p><u>ENDO-A 2 of 2</u> External request Submission from Promega Corporation to consider emphasizing that MSI testing needs to be given in equal weight and be recommended as a parallel technology with mismatch repair (MMR) protein expression analysis by immunohistochemistry (IHC) for endometrial cancer patients.</p>	<p>Based on a review of the data and discussion, the panel consensus was not to make changes to the current recommendations.</p>	0	21	0	8
<p><u>ENDO-C</u> External request Submission from ASTRO (04/30/19) suggesting to revise how stage II disease is approached in the guideline. Since preoperative RT followed by surgery is a category 2B recommendation in the guidelines, suggest specifying which surgical resection is appropriate for patients with stage II disease on page ENDO-C, 1 of 6.</p>	<p>Based upon review of data and discussion, the panel consensus was to add the following statement to the “Principles of Evaluation and Surgical Staging”: “<i>For stage II patients, extrafascial or radical hysterectomy should be based on preoperative workup with the goal of achieving negative margins.</i>”</p>	22	0	0	7

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<p>ENDO-D External request Submission from EMD Serono (06/04/19) to review clinical study data and under “Useful in Certain Circumstances” consider adding “Avelumab for dMMR tumors” for the treatment of recurrent or dMMR endometrial cancer.</p>	<p>Based on a review of the data and discussion, the panel consensus did not support the inclusion of avelumab as a treatment option for dMMR endometrial tumors.</p> <ul style="list-style-type: none"> • Konstantinopoulos PA, et al. Phase 2, two-group, two-stage study of avelumab in patients with microsatellite stable (MSS), microsatellite instable (MSI), and polymerase epsilon (POLE) mutated recurrent/persistent endometrial cancer. Presented at: 2019 ASCO Annual Meeting; May 31-June 4, 2019; Chicago, IL. Abstract 5502. 	0	21	0	8
<p>ENDO-D External request Submission from Oncology Analytics, Inc. (12/27/19) to revise the corresponding footnote for lenvatinib/pembrolizumab as follows: Used in combination (lenvatinib/pembrolizumab) for patients with advanced or recurrent disease only <i>that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) in patients who are not candidates for curative surgery or radiation, with disease progression following prior systemic therapy</i></p>	<p>The panel addressed this request prior to receiving the submission by adding the following corresponding footnote to lenvatinib/pembrolizumab: <i>For advanced or recurrent disease that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) in patients who are not candidates for curative surgery or radiation and have progressed on prior systemic therapy.</i></p>	N/A	N/A	N/A	N/A
<p>ENDO-D Internal request Comment to reassess the data for the inclusion of ifosfamide/paclitaxel for carcinosarcoma as a category 1 recommendation.</p>	<p>Based on review of the data, the panel consensus was to change ifosfamide/paclitaxel regimen for the treatment of carcinosarcoma from a category 1 to a category 2A recommendation</p>	21	0	0	8
<p>ENDO-D Internal request Comment to reassess the data for the inclusion of carboplatin/paclitaxel and specify its use as a treatment option for carcinosarcoma.</p>	<p>Based on review of the data and discussion, the panel consensus was that carboplatin/paclitaxel for the treatment of carcinosarcoma is supported by high-level evidence. Under preferred chemotherapy regimens, the recommendation changed to carboplatin/paclitaxel (<i>category 1 for carcinosarcoma</i>).</p>	21	0	0	8
<p>Uterine Sarcoma UTSARC-3 Internal request Reassess the data for the consideration of systemic therapy as an additional therapy option for patients with high-grade endometrial stromal sarcoma (ESS), undifferentiated uterine sarcoma (UUS), uterine leiomyosarcoma (uLMS).</p>	<p>The panel consensus supported the removal of the recommendation “consider systemic therapy (category 2B)” as an additional therapy option for patients with high-grade ESS, UUS, uLMS.</p>	0	22	0	8