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Myeloid Growth Factors NCCN Panel
submissions@nccn.org

Dear Panel Members,

I am having trouble arriving at consensus among members of my team regarding interpretation of the NCCN Guidelines for Myeloid Growth Factors in patients on palliative chemotherapy.

Request: Clarify the use of MGFs in the palliative setting

Changes Recommended: Provide further direction on when to use MGFs in the palliative setting within the guidelines rather than just the discussion portion, see "consider G-CSF" on pages MGF-1, -2 and -3.

FDA Approval: N/A

Rationale: The current MGF Guidelines are open to multiple interpretations and clarification is needed.

Citation: N/A

Briefly, in thoughtful presentations on G-CSF in the palliative setting, I have seen recommendations for MGFs is indicated in some but not all patients who otherwise meet criteria per guidelines. A recommendation for an initial dose decrease may be more appropriate if there are concerns about admission for febrile neutropenia and toxicity. The meta-analysis by Lyman, et al.[1] indicates that the overall improvement in survival with the use of MGFs is 3.4%, higher in dose dense regimens and lower in standard dose regimens. Since we are not talking about cure in the palliative setting, we are generally talking about very short improvements in median survival (1-2 weeks?). My experience is that most

[1] Lyman GH, Dale DC, Wolff DA, et al. JCO 2010;282914-2924.

patients do not choose MGFs based on financial toxicity. I do believe there are many patients in whom proceeding at full dose with G-CSF is appropriate to prevent neutropenic fever after a documented discussion on the relative advantages and risks, including financial toxicity, bone pain and ~0.5% risk of AML/MDS.

I would like to see an item added to the Guidelines such that "Consider G-CSF" (ex. in 10-20% risk patients with risk factors) points to curative or palliative options, and if it is palliative that there is direction to discuss dose reduction vs. G-CSF plus full dose if risk justifies the toxicities. I would include high financial toxicity, bone pain, risk of AML/MDS, and others in the footnotes.

I would be interested in discussing this with your team from our perspective of a community oncology practice where we enroll significant numbers of patients on clinical trials.

Sincerely,

W.T. Stephenson, MD