West of Scotland Cancer Network

Urological Cancers
Managed Clinical Network

Testis Cancer

Regional Follow-up Guidelines

CMG Prepared by	Drs J White, A Waterston, J Salmond, J Wallace, A Cascaldes, M Qubtia, L Mukhergee, Mr D Hendry
Approved by	Urological Cancers MCN and Prescribing Advisory Subgroup
Issue date	June 2021
Review date	June 2024
Version	5.0 **(Extracted from the Germ Cell CMG V5.0)**

Testis Cancer Regional Follow-up Guidelines

The purpose of the testicular cancer regional follow-up guidelines is to ensure consistency of practice across the West of Scotland and the principles of any revision to the follow-up guideline will continue to ensure that management of patients after initial treatment for testicular cancer are:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guidelines continue to be developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care; and
- Detect and treat recurrent disease.

Follow-up practice has to be patient centred and, ideally, supported by empirical evidence of improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of patients. The construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

It is also recommended that all patients receiving treatment for germ cell cancers should undergo a holistic needs assessment (HNA) by a suitably trained individual at defined time points during follow up care.

The follow up schedules in this guideline are extracted from the Testis Cancer Clinical Management Guideline (CMG) V5.0 which was revised in April 2021. The CMG for stage 1 seminoma was updated following publication of new imaging evidence from the TRISST clinical trial as summarised below:

- *Stage 1 seminoma patients managed with surveillance typically have **6 CT scans** at BWoSCC during their 5 year follow up period. New data has emerged from a large UK-based randomised Phase 3 trial comparing MRI with CT that has shown that **3 MR scans** over the same period is non-inferior to CT.*

These regional guidelines are recommended by the Urological Cancers MCN whose members also recognise that specific needs of individual patients may require to be met by an alternative approach and that this will be provided where necessary and documented in the patient notes.

Stage 1 Seminoma Follow Up Schedule

STRATEGY	Year 1	Year 2	Year 3	Year 4	Year 5
Surveillance	3-4-monthly clinic visit* -No CXR	3-4-monthly clinic visit*-No CXR	6-monthly clinic visit* -No CXR	6-12 -monthly clinic visit*-No CXR	6-12-monthly clinic visit*-No CXR
	6-mont MRI of abdomen§	18 month MRI of abdomen§	36 month MRI of abdomen§	Nil	60 month MRI
Adjuvant para-aortic nodal RT	3-monthly clinic visit*	4-monthly clinic visit*	6-monthly clinic visit*	6-monthly clinic visit*	6-monthly clinic visit*
	annual CT of pelvis	annual CT of pelvis	annual CT of pelvis		
Adjuvant dog-leg RT	3-monthly clinic visit*	4-monthly clinic visit*	6-monthly clinic visit*	6-monthly clinic visit*	6-monthly clinic visit*
Adjuvant carboplatin	4-6-monthly clinic visit*No CXR	4-6-monthly clinic visit*No CXR	6-monthly clinic visit* No CXR	6-12-monthly clinic visit*No CXR	6-12-monthly clinic visit*No CXR
	12 month MRI of abdomen§	Nil	36 month MRI of abdomen§	Nil	60 month MRI of abdomen§

- *each clinic visit involves an assessment of symptoms, clinical examination, (No chest X-ray) & tumour markers (AFP and HCG);
- LDH has not been shown to be helpful in the follow up in patients with germ cell tumours
- § may include MRI of pelvis as well (if prior inguinoscrotal surgery)
- Beyond 5 years discharge with information for GP indicating symptoms for prompt referral
- If clinical of symptoms of androgen deficiency check testosterone SHBG, FSH, LH on early morning sample
- ***BP, fasting lipids and glucose years 1,3 & 5***
  NB PATIENTS ON CLINICAL TRIAL FOLLOW UP SHOULD BE PER THE TRIAL PROTOCOL

Stage 1 NSGCT/Mixed Germ Cell Cancer Follow Up Schedule

<table>
<tr><th>STRATEGY</th><th colspan="2">Year 1</th><th>Year 2</th><th>Year 3</th><th>Year 4</th><th>Year 5‼</th></tr>
<tr><td rowspan="3">T1 Low Risk Surveillance</td><td>0-3 months</td><td>4 weekly clinic visit*</td><td rowspan="2">™8-12-weekly clinic visit*
6 monthly CXR</td><td rowspan="2">™12-16- weekly clinic visit*
No CXR</td><td rowspan="2">6-12-monthly clinic visit*
No CXR</td><td rowspan="2">6-12-monthly clinic visit*
No CXR</td></tr>
<tr><td>3-12 months</td><td>™4-8 weekly clinic visit*</td></tr>
<tr><td colspan="2">CT scan of abdomen at 3 and 12 months §</td><td>Nil</td><td>Nil</td><td>Nil</td><td>CT CAP
@ 60 months if TD\YST</td></tr>
<tr><td rowspan="2">T2≥ High Risk Surveillance</td><td colspan="2">monthly clinic visit*(No CXR)</td><td>2-monthly clinic visit*</td><td>3-monthly clinic visit*</td><td>4-monthly clinic visit*</td><td>6-monthly clinic visit*</td></tr>
<tr><td colspan="2">CT CAP at 3, 6 and 12 months</td><td>CT CAP at 18 & 24 months</td><td>Nil</td><td>Nil</td><td>CT CAP
@ 60 months if TD\YST</td></tr>
<tr><td rowspan="2">T2≥ High Risk Post 2 cycles of Adjuvant $BE_{360}P$&</td><td colspan="2">2-monthly clinic visit* for 6 months, then 2-3-monthly for 6 months</td><td>3-monthly clinic visit*</td><td>6-monthly clinic visit*</td><td>6-monthly clinic visit*</td><td>6-monthly clinic visit*</td></tr>
<tr><td colspan="6">CT of chest, abdomen§ after adjuvant treatment & if CT normal, no further routine CT scans</td></tr>
<tr><td rowspan="3">T2≥ High Risk <u>Post 1 cycle</u> of Adjuvant $BE_{500}P$</td><td>0-6 months</td><td>8 weekly visit*</td><td>3-monthly clinic visit*</td><td rowspan="3">4-monthly clinic visit*</td><td rowspan="3">6-monthly clinic visit*</td><td>6-monthly clinic visit*</td></tr>
<tr><td>7-12 months</td><td>12 weekly visit*</td><td rowspan="2">CT CAP
24 months</td><td>CT CAP
60 months</td></tr>
<tr><td>CT CAP</td><td>6 &12 months</td></tr>
</table>

- *each clinic visit involves an assessment of symptoms, clinical examination, chest x-ray (**alternate visits T1 low risk, only year 1**) & tumour markers (AFP and HCG);
- LDH has not been shown to be helpful in the follow up in patients with germ cell tumours.
- ™ those with raised pre-operative markers should be considered for the follow up with the minimum of interval between visits
- § may include CT of pelvis as well (if prior inguinoscrotal surgery)
- ‼ No discharge for those with teratoma in initial orchidectomy specimen
- Beyond 5 years discharge with information for GP indicating symptoms for prompt referral
- If clinical of symptoms of androgen deficiency check testosterone SHBG, FSH, LH on early morning sample
- ***BP, fasting lipids and glucose years 1,3 & 5***
- & Historic follow up only, not offered for new patients.

<u>NB PATIENTS ON CLINICAL TRIALS FOLLOW UP SHOULD BE PER THE TRIAL PROTOCOL</u>

Metastatic Seminoma Follow Up Schedule
(Post Radiotherapy for Stage IIA/B, Post-Chemotherapy for Stage II-IV)

STRATEGY	Year 1	Year 2	Year 3	Year 4	Year 5
After radical radiotherapy or chemotherapy	3-monthly clinic visit* 6 monthly CXR	4-monthly clinic visit* Annual CXR	6-monthly clinic visit* Annual CXR	6-monthly clinic visit* Annual CXR	6-monthly clinic visit* Annual CXR
	If post treatment CT abdomen and pelvis scan is normal, no further routine CT scans. If post treatment CT scan abnormal, repeat the CT scan every six months for 18 months but stop as soon as CT scan is normal or appearance is stable				

*each clinic visit involves an assessment of symptoms, clinical examination, chest X-ray & tumour markers (AFP and HCG);
LDH has not been shown to be helpful in the follow up in patients with germ cell tumours
Beyond 5 years discharge with information for GP indicating symptoms for prompt referral
If clinical of symptoms of androgen deficiency check testosterone SHBG, FSH, LH on early morning sample
BP, fasting lipids and glucose years 1,3 & 5

NB PATIENTS ON CLINICAL TRIALS FOLLOW UP SHOULD BE PER THE TRIAL PROTOCOL

NSGCT/Mixed Germ Cell Cancer (Stage IM-IV) Follow Up Schedule

STRATEGY	Year 1	Year 2	Year 3	Year 4	Year 5‼
After chemotherapy (+/- resection of residual masses)	1-3 monthly clinic visit* for 6 months, then 2-3monthly for 6 months. 6 monthly CXR	3-monthly clinic visit* Annual CXR	6-monthly clinic visit* Annual CXR	6-monthly clinic visit* Annual CXR	6-monthly clinic visit* Annual CXR
	CT of chest, abdomen after treatment and if CT normal, no further routine CT scans. If post-treatment CT is abnormal, then on-going imaging of the area of abnormality is required. (MRI can replace CT to reduce radiation exposure) CT/MRI at 60 months if TD/YST				

*each clinic visit involves an assessment of symptoms, clinical examination & tumour markers (AFP and HCG);
LDH has not been shown to be helpful in the follow up in patients with germ cell tumours
‼ No discharge for those with teratoma in initial orchidectomy or subsequent resection specimens or for poor prognosis patients
Beyond 5 years discharge with information for GP indicating symptoms for prompt referral
If clinical of symptoms of androgen deficiency check testosterone SHBG, FSH, LH on early morning sample
BP, fasting lipids and glucose years 1,3 & 5

NB PATIENTS WHO RELAPSE AFTER FIRST LINE TREAMENT AND RECEIVED SUBSEQUENT TREAMENT WILL HAVE BESPOKE FOLLOW UP AS DIRECTED BY BWOSCC GERM CELL TEAM

NB PATIENTS ON CLINICAL TRIALS FOLLOW UP SHOULD BE PER THE TRIAL PROTOCOL