NCCN Guidelines® Updates

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Colon Cancer published in this issue (page 1238) include the latest updates. Please note, the complete NCCN Guidelines for Colon Cancer are not published in this issue of *JNCCN*. To view the complete NCCN Guidelines, visit www.NCCN.org. To assist readers interested in noting how the guidelines were updated, highlights of major changes in the most recent versions are printed below.

Colon Cancer

Summary of changes in the 1.2012 version of the NCCN Guidelines for Colon Cancer from the 3.2011 version include:

Clinical Presentation

- Footnote "a" was modified and the following sentence added: "Peritoneal mesothelioma and other extrapleural mesotheliomas may be treated with systemic therapy based on NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Malignant Pleural Mesothelioma, available online at www.NCCN.org (MPM-A)."
- Footnote "b" was modified to add the consideration of risk assessment. (This recommendation also applies to other pages.)
- Footnote "f" was modified, "Observation may be considered, with the understanding that there is significantly greater incidence of adverse outcomes (residual disease, recurrent disease, mortality, and hematogenous metastasis, but not lymph node metastasis) than polypoid malignant polyps. See Principles of Pathologic Review: Endoscopically Removed Malignant Polyps (available online, in these guidelines, at www.NCCN.org [COL-A])."

Findings: locally unresectable or medically inoperable

- Palliative therapy was removed along with previous footnote "i".

Pathologic Stage: T3, N0, M0 at high risk for recurrence or T4, N0, M0

- The combination regimen of capecitabine + oxaliplatin was added as an option in adjuvant therapy with a category 2A designation.
- Footnote "j" was clarified by adding "exclusive of those cancers that are MSI-H" to grade 3–4.

Surveillance

- Chest/abdominal/pelvic CT recommendation changed from 3 y to 3–5 y for patients at high risk for recurrence.

Adjuvant Therapy

- The category designation for CapeOx changed from a category 2A to a category 1.

Treatment for Resectable Synchronous Liver and/or Lung Metastasis Only

- FOLFOX + cetuximab removed as a treatment option.

Adjuvant Therapy for Resectable Synchronous Liver and/or Lung Metastasis Only

- Recommendations following "colectomy, with synchronous or staged liver or lung resection" changed from "active chemotherapy regimen for advanced disease" to "adjuvant therapy for stage III disease."

Treatment for Unresectable Synchronous Liver and/or Lung Metastasis Only

- FOLFOX + cetuximab removed as a treatment option.

Resectable Metachronous Metastases: Primary Treatment

- "Response" was changed to "No progression" and "No response" was changed to "Progression."

The goal of the NCCN Guidelines® Updates is to provide readers with important changes that the NCCN Guidelines Panels have incorporated into an algorithm since it was last published. For a more complete detailing of the updated guideline's modifications, as well as the full algorithm, please access the complete NCCN Guidelines® in this issue or at www.NCCN.org.

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Cont. from page xli.

- For adjuvant therapy recommendations following resection and no previous chemotherapy, "active chemotherapy regimen for advanced disease" changed to "adjuvant therapy for stage III disease."

Principles of Pathologic Review

- BRAF Testing, second bullet: the following sentence was added: "Allele-specific PCR is another acceptable method for detecting BRAF V600E mutation."

Principles of Surgery

- Sub-bullet 2 clarified to read "Clinically positive lymph nodes outside the field of resection considered suspicious should be biopsied or removed, if possible."

Chemotherapy for Advanced or Metastatic Disease

- Patient appropriate for intensive therapy: FOLFOX + cetuximab removed as a treatment option for initial therapy of advanced or metastatic disease.
- Patient not appropriate for intensive therapy: Capecitabine ± bevacizumab added as a treatment option for initial therapy of advanced or metastatic disease.
- Chemotherapy regimen dosing and references expanded and updated.

Principles of Risk Assessment for Stage II Disease

- The following bullet was removed: "Ask the patient how much information they would like to know regarding prognosis"
- Prognosis added to patient/physician discussion in the first bullet.
- Perineural invasion added as a poor prognostic feature (sub-bullet 2) in the second bullet describing considerations for adjuvant therapy.

Principles of Adjuvant Therapy

- Bullet 1: Second sentence removed, "This is an extrapolation from data available."
- Bullet 3: Last sentence removed, "Mature data are not yet available for capecitabine combination regimens" and replaced with "Capecitabine/oxaliplatin is superior to bolus 5-FU/leucovorin" with supporting reference Haller DG, et al. J Clin Oncol 2011;29:1465–1471.

Principles of Radiation Therapy

- Bullet 3 modified: Conformal external beam radiation should be routinely used for T4 non-metastatic disease and intensity modulated radiotherapy (IMRT) reserved only for unique clinical situations including re-irradiation of previously treated patients with recurrent disease.
- Bullet 4 modified: Intraoperative radiotherapy (IORT), if available, should be considered for patients with T4 or recurrent cancers as an additional boost. Preoperative radiation therapy with concurrent 5-fluorouracil based chemotherapy is preferred for these patients to aid resectability. If IORT is not available, additional 10–20 Gy external beam radiation and/or brachytherapy could be considered to a limited volume. The ending of "prior to adjuvant chemotherapy" removed.

Principles of Survivorship

- Cancer Surveillance: The previous bullets were deleted and the following added:
  - ➤ See pages pertaining to pathologic stage in the algorithm.
  - ➤ Long-term surveillance should be carefully managed with routine good medical care and monitoring, including cancer screening, routine health care, and preventive care.
  - ➤ Routine CEA monitoring and routine CT scanning is not recommended beyond 5 years.

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Cont. from page xliii.

- Management of Late Sequelae of Disease or Treatment: The recommendations for Oxaliplatin-induced Neuropathy deleted.
- Cancer Screening Recommendations: The previous bullets were deleted and the following added:
  - These recommendations are for average risk patients. Recommendations for high risk individuals should be made on an individual basis.
  - Breast Cancer: See the NCCN Guidelines for Breast Cancer Screening
  - Cervical Cancer: See the NCCN Guidelines for Cervical Cancer Screening
  - Prostate Cancer: See the NCCN Guidelines for Prostate Cancer Early Detection
- Counseling Regarding Healthy Lifestyle and Wellness: The previous bullets were deleted and the following added:
  - Maintain a healthy body weight throughout life.
  - Adopt a physically active lifestyle (At least 30 minutes of moderate intensity activity on most days of the week). Activity recommendations may require modification based on treatment sequelae (i.e., ostomy, neuropathy).
  - Consume a healthy diet with emphasis on plant sources.
  - Limit alcohol consumption.
  - Smoking cessation counseling as appropriate.
  - Additional health monitoring and immunizations should be performed as indicated under the care of a primary care physician. Survivors are encouraged to maintain a therapeutic relationship with a primary care physician throughout their lifetime.

Erratum

In the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Kidney Cancer that appeared in the September issue of *JNCCN* (*JNCCN* 2011;9:960–977), an error appears in the Targeted Therapy section on page 970. The second sentence of the second paragraph should have read, "The most widely used model for risk stratification is the MSKCC model,[46] which classifies patients according the presence or absence of 5 adverse prognostic factors: Karnofsky performance status of 70 or less, serum LDH level greater than 1.5 times the upper limit of normal (ULN), hemoglobin level below normal, corrected serum calcium level above the ULN, and time from diagnosis and nephrectomy to therapy of ***less than*** 1 year."

These NCCN Guidelines have been corrected online at www.NCCN.org and in the September issue of *JNCCN* available online at www.JNCCN.org.