


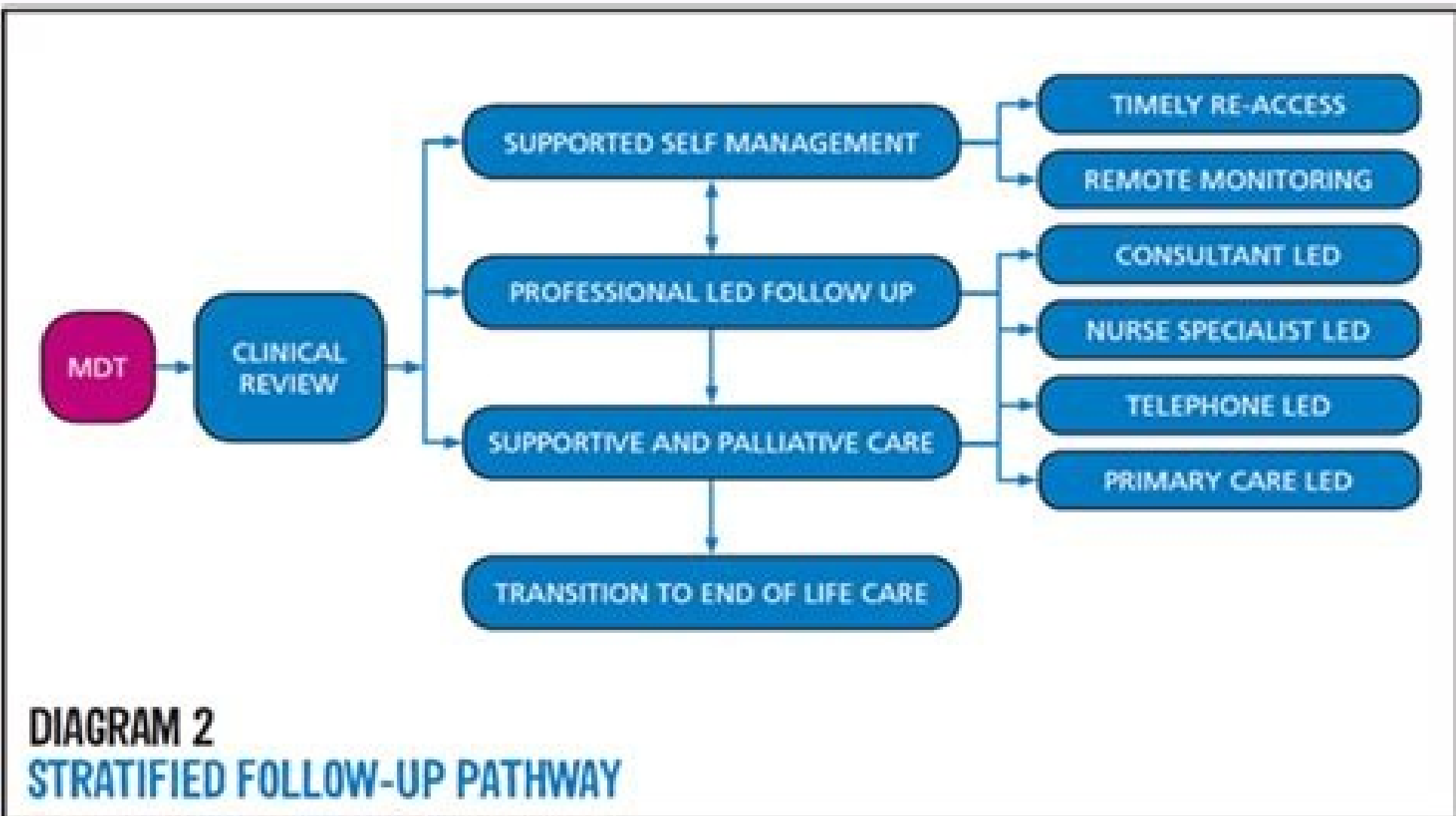
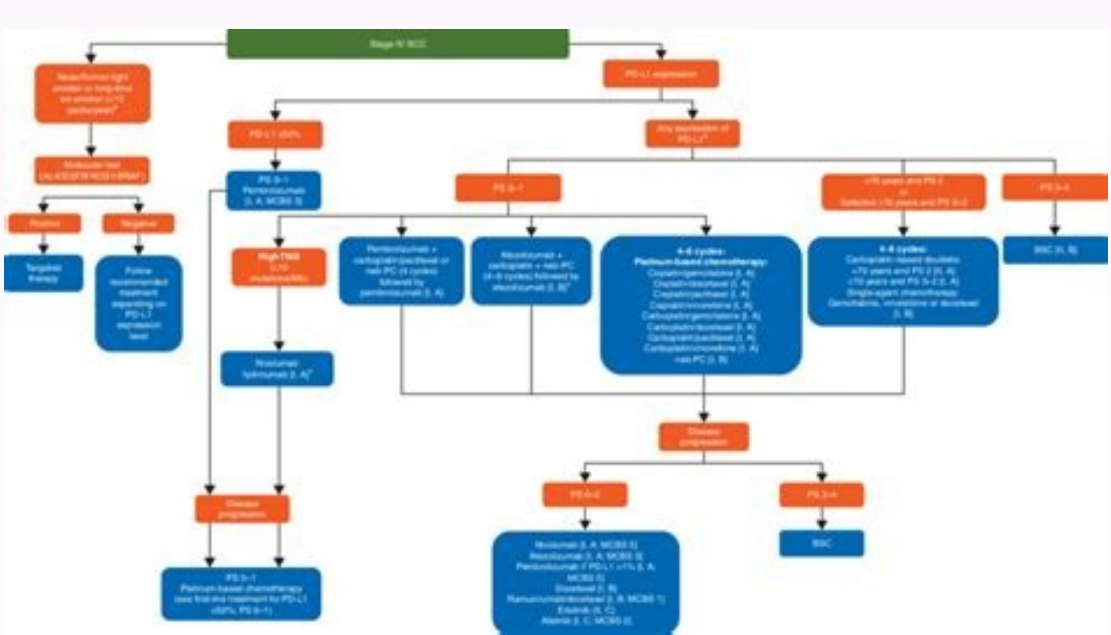
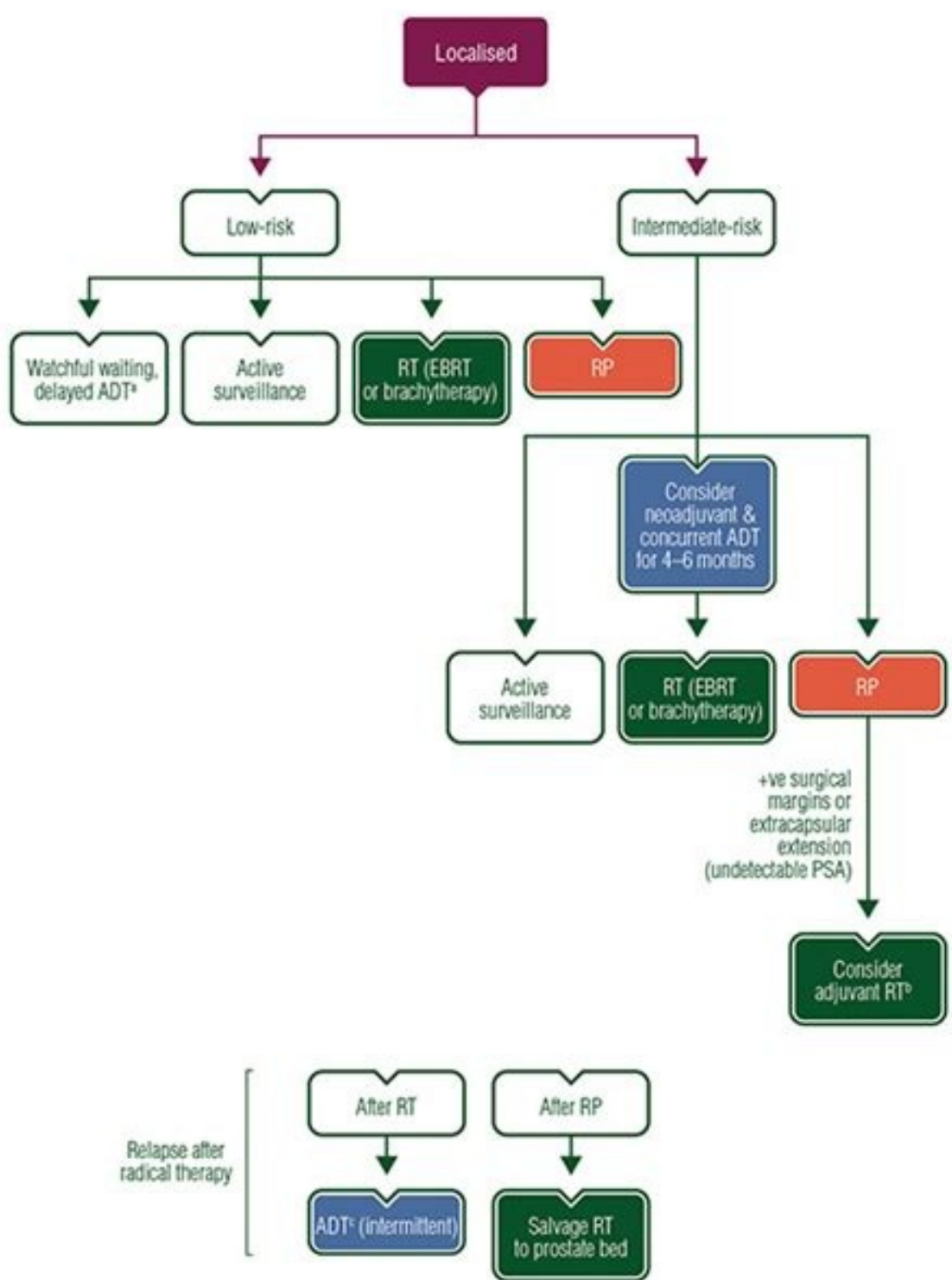
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Table 1. Guideline Recommendations for Surveillance in Colon Cancer

	Stage I			Stage II		
	Colonoscopy	Imaging	Laboratory Tests	Colonoscopy	Imaging	Laboratory Tests
NCCN	At 1 y, repeat in 1 y if advanced adenoma, 3 y if no advanced adenoma, then every 5 y	None	None	At 1 y, repeat in 1 y if advanced adenoma, 3 y if no advanced adenoma, then every 5 y	CT of chest/abdomen/pelvis every 6-12 mo for 5 y	CEA every 3-6 mo for 2 y, then every 6 mo for 5 y
ASCO/Cancer Care Ontario	Insufficient data to provide recommendations			At 1 y, then every 3 y or as dictated by previous colonoscopy findings	CT of chest/abdomen/pelvis every 6-12 mo for 3 y	CEA every 3-6 mo for 5 y
ESMO	At 1 y, then every 3-5 y	CT of chest/abdomen/pelvis every 12 mo if high risk, for 3 y	CEA every 3-6 mo for 3 y, then every 6-12 mo for 2 y	At 1 y, then every 3-5 y	CT of chest/abdomen/pelvis every 12 mo if high risk, for 3 y	CEA every 3-6 mo for 3 y, then every 6-12 mo for 2 y
American Cancer Society	At 1 y, repeat in 1 y if advanced adenoma, 3 y if no advanced adenoma, then every 5 y	CT of chest/abdomen/pelvis every 12 mo if high risk, for 5 y	CEA every 3-6 mo for 2 y, then every 6 mo for 2 y	At 1 y, repeat in 1 y if advanced adenoma, 3 y if no advanced adenoma, then every 5 y	CT of chest/abdomen/pelvis every 12 mo if high risk, for 5 y	CEA every 3-6 mo for 2 y, then every 6 mo for 2 y

Abbreviation: CEA, carcinoembryonic antigen.
ESMO definition of "high risk": ≥ 12 poorly differentiated tumor; vascular, lymphatic, or perineural invasion; tumor presentation with obstruction or tumor perforation; and ≥ 4 lymph nodes.



Radiation therapy, surgery, and paediatrics manuscripts may be considered if they show a clear interaction with one of the above fields or are paradigm-shifting. With a broad international editorial board of experts who are leaders in their fields, Annals of Oncology aims to provide the best communication on the fast-moving, and ever-evolving, global oncology landscape. View historical data and other metrics on Journal Insights. Journal Finder uses intelligent search technology and field-specific vocabulary to match your manuscript with Elsevier Journals. Just enter your title and abstract and select the appropriate search field for medical. Fill in Details Latest Improved and Revised Series of Guidelines. ESMO has clinical practice guidelines on the following gynaecological cancers: Cervical carcinoma, Endometrial carcinoma, Gestational trophoblastic disease, Recently Diagnosed and Relapsed Epithelial Ovarian Carcinoma and Non-epithelial Ovarian Carcinoma. This shall include information on incidence, diagnosis, staging and risk assessment, treatment, response assessment and follow-up. This 2022 document presents a limited update of the 2017 publication of the UAEANM-ESTRO-ESUR-ISUP-SIOG Guidelines for Prostate Cancer (PCa). The literature for the full document has been evaluated and updated based on a review of all recommendations and the creation of appropriate GRADE forms. Become a member. Published in 2018. Ann Oncol (2018) 29 (Suppl 4): vi14e4. Authors: A. L. Rouvière * and Dr. J.G. Schoots. All sections of radiation therapy (RT) have been developed in collaboration with the European Society of Radiation Therapy and Oncology (ESTRO). Briens, expert Patient Advocate Hasselt-Belgium representing the patient's voice as delegate from European Prostate Cancer Man. All experts involved in the production of this document presented potential conflict of interest statements of interest that can be viewed on the UROWEB website of the EAU. Publications Available a rapid reference document (Pocket Guidelines), both in paper and as an app for iOS and Android devices. Opereza Field, Prof. Dr. O. New data have been included in the following sections, which have given rise to new sections and new recommendations revised: 4.3.3 Clinically significant prostate carcinoma 4.5.1.2.4. Risk assessment To determine the need for a biopsy 4.5.2.1.2 Repeat the PSA/biopsy 5.5 test: data table on the risk of clinically significant prostate carcinoma (CSPCA), related to the PI-RADS score and the PSA-D categories in men Na'Ve to biopsy, clinically suspected of having a significant disease 5.2.3.4 Guidelines for the risk assessment of men Asymptomatic/Computing According to forcing Asymptomatic men with a level of specific prostate antigen (PSA) between 3 > 10 Ng / mle a Normal rectal digital examination, repeat the PSA test before further investigations. deBole5.2.8a, Summary of EVIDENCE AND GUIDELINES FOR PROSTATE BIOPSIES. In the Evidence 6. Literature exam that includes more biopsic schemes suggests that a 10 to 12 core scheme is optimal in most patients undergoing initial and repeated biopsy, depending on the size of the prostate. All documents are available on the EAU website. History of publications and synthesis of changes 1.4.1. History of the publication of the EAU PCA guidelines have been published for the first time in 2001. OÄ € äjããjãhanlon, a geriatric consultant, representing the international company of Geriatric Oncology (Soig), contributed to the dedicated sections in particular to the Life expectancy, in the state of health and the quality of life. These are abbreviated versions that can request consultation together with integral. Lorusso, J. Pautier & N. HomeNewspapers Annals of Oncology ISSN: 0923-7534 Editor-in-Chief/Editorial Committee Fabrice André Annali di Oncologia, the journal of the SocietÄ European Medical Oncology and Society of Medical Oncology provides fast and efficient peer-reviewed publications on innovative cancer therapies or translation work related to oncology and precision medicine. Key areas of interest include systemic cancer therapy (with a particular focus on targeted molecular agents and new immune therapies), randomized trials (including negative ones), high-level guidelines, and new areas that are emerging as key components of personalized medicine, such as molecular pathology, bioinformatics, modern statistics and biotechnology. Data summaries and recommendations have been modified throughout the current document and several new sections have been added. All chapters of the 2022 PCA guidelines have been updated. Prat, A. These biopsy patterns should be heavily weighted towards the lateral appearance and apex of the prostate gland to maximize sampling of the peripheral area [3]. A systematic review and meta-analysis comparing MRI-targeted transrectal biopsy and transperineal biopsy targeted to MRI-targeted transperineal biopsy M, analyzing 8 studies, showed a greater sensitivity to the detection of csPca when the transperineal approach was used (86% vs. Several scientific publications [1,2] and several translations of all versions of the PCA guidelines are available. The guidelines are not sent and do not purport to be a legal standard of care. 1.2. Panel Composition The PCA Guidelines Panel is composed of an international multidisciplinary group of urologists, radiologists, medical oncologists, radiologists, a pathologist, a geriatrician and a patient representative. All imaging sections of the text have been developed in collaboration with the European Society of Urogenital Radiology (ESUR) and the European Association of Nuclear Medicine (EANM) Jocitebafala Jocitebafala enidro ni (onos aCP led adiuG eeniL id oppurG len ORSEÄll itatneserppar I .A .rD) Jocitebafala enidro ni onos aCP led adiuG eeniL id oppurG Prof. Dr. P.M. Henry, Prof. Dr. M.D. Mason and Prof. Dr. T. Morice, D. Since 2022 Asco Cancer Symposium Longer Follow-up phase III studio shows a survival advantage without diseases consistent with the posturitic use of Pembrolizumab in patients with kidney cell carcinoma and high-risk features. 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Summary of evidence and guidelines for the treatment of low-risk diseaseSummary of evidenceLESystematic biopsies have been scheduled in AS protocols, the number and frequency of biopsies varied, there is no approved standard.NRRecommendationsStrength ratingActive surveillance (AS)Selection of patientsIf MRI is not available, per-protocol confirmatory prostate biopsies should be performedWeakFollow-up of patientsRepeat biopsies should be performe From as protocols. Ranking patients with low volume group 2 Group 2 group disease included in as protocols, if repeating systematic biopsies based on master resonance performed during monitoring revealing> 3 positive of maximum cities> 50% / IISUP 2 core disease. Materodpraccotherapeuticoffer low-dosing rate brachytherapy at patients with good urinary functionality and favorable intermediate-risk disease.strongoffer low dose rate Boost brachytherapy combined with IMRT / VMAT more igrt at patients with good urinary function and unfavorable intermediate risk disease, in combination with Privation therapy of short-term androgens (ADT) (4 - 6 months). High Dose Boost Boost Brachytherapy combined with Imrt / VMAT Plusgrart at patients with good urinary function and unfavorable disease at intermediate risk, in combination with short term ADT (4 Å å, ~ "6 months). Patients not arranged To undergo ADT, use a total dose of IMRT / VMAT plus igrt (76 Å, ~ "78 GY) or moderate hypofragmentation (60 GY / 20 FX in 4 W EEKS or 70 GY / 28 FX in 6 weeks) or a combination With LDR or BrachyTherapapy Boost.Weak6.2.3.4 Guidelines for radical treatment of high-risk treatment at high risk DistromendationStrengthdradiothapeutic Treatment Treatment with patients with high-risk localized disease and good urinary function, use IMRT / VMAT Plus IGRT with Boost of brachytherapia (High dose rate or low dose rate), in combination with long-term ADT (from 2 to 3 years). WEACARE6.2.4.5 Guidelines for radical treatment of locally advanced monitoring length RataingRadiotherapeutic treater patients with local disease and good urinary function, IMRT / VMAT Plus igrt with brachytherapy boost (high dose rate or dosing rate oihcsir oihcsir otla da irrottaf 2 >o 1NC noc 0M itneizap 1 rep ,enimret ognul a TDA noc enoizanhmoc ni)1NC rep(sulP sulP ivieP la TRGI sulP TAMV / TRMI onorffo odnaug enoretaribã id inna 2 enimret ognul a kaew.Ida noc enoizanhmoc ni)esod atla Gleason > 8 or PSA > 40 ng/mL).Strong6.3.4.4 Summary of evidence and guidelines for imaging in patients with biochemical recurrenceSummary of evidenceLEAfter RP there is no specific PSA threshold defining recurrence.NR6.4.9 Guidelines for the first-line treatment of metastatic diseaseRecommendationsStrength ratingOffer luteinising hormone-releasing hormone (LHRH) antagonists or orchiectomy before starting ADT, especially to patients with impending clinical complications like spinal cord compression or bladder outlet obstruction.StrongOffer early systemic treatment to M1 patients asymptomatic from their tumour.Strong6.5.15 Guidelines for systematic treatments of castrate-resistant diseaseRecommendationStrength ratingNovel agentsOffer 177Lu-PSMA-617 to pre-treated mCRPC patients with one or more metastatic lesions, highly expressing PSMA (exceeding the uptake in the liver) on the diagnostic radiolabelled PSMA PET/CT scan.StrongPowered by Froala EditorPowered by Froala EditorPowered by Froala Editor Colombo, on behalf of the ESMO Guidelines CommitteeThese updated guidelines on non-epithelial ovarian cancer cover prevention, diagnosis, treatment and follow-up for early and advanced stages and recurrences of germ cell tumours, sex cord-stromal tumours and small cell carcinomas of the ovary hypercalcaemic type.Several new treatment algorithms are featured as well as an extensive summary of recommendations. Wiegel.The International Society of Urological Pathology is represented by Prof.Dr. T. The Prostate Cancer (PCa) Guidelines Panel have prepared this guidelines document to assist medical professionals in the evidence-based management of PCa.It must be emphasised that clinical guidelines present the best evidence available to the experts but following guideline recommendations will not necessarily result in the best outcome. Farolfi, Dr. D. D.

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