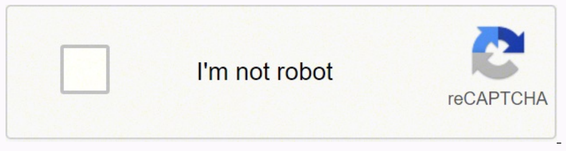


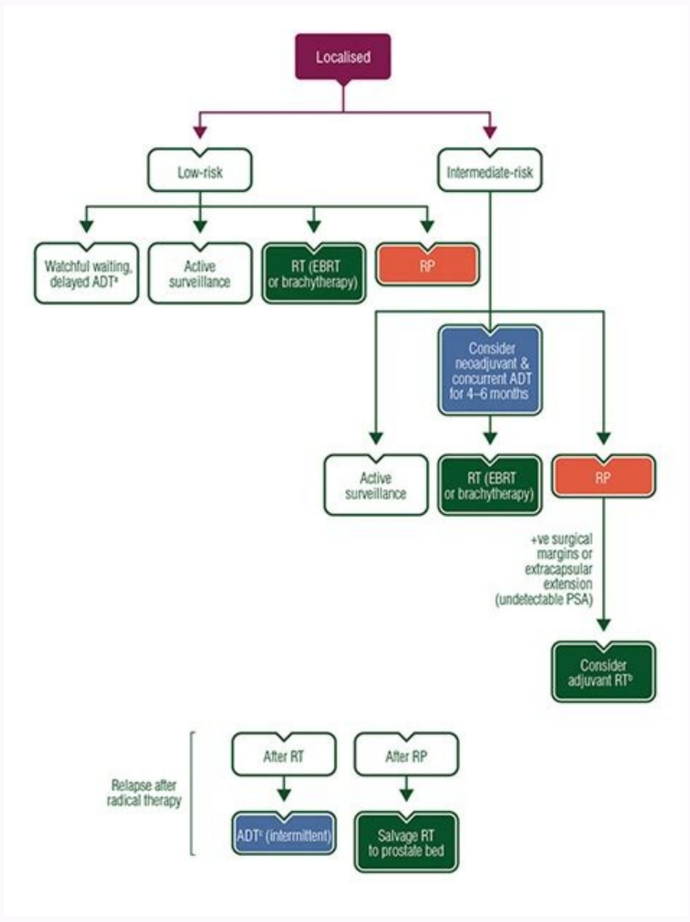
Open

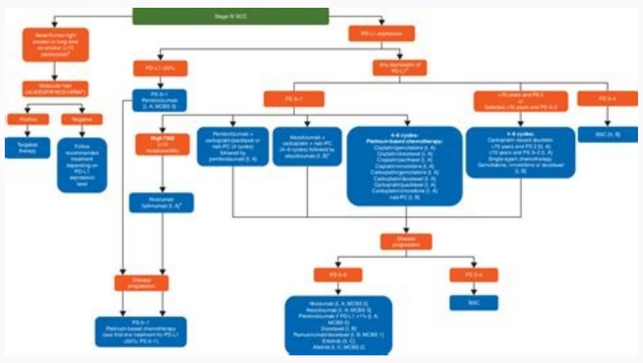
Esmo guidelines prostate cancer 2019

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 5 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 and 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": sampling lymph nodes <12; poorly differentiated tumor; vascular, lymphatic, or perineural invasion; tumor presentation with obstruction or tumor perforation; and pT4 stage.





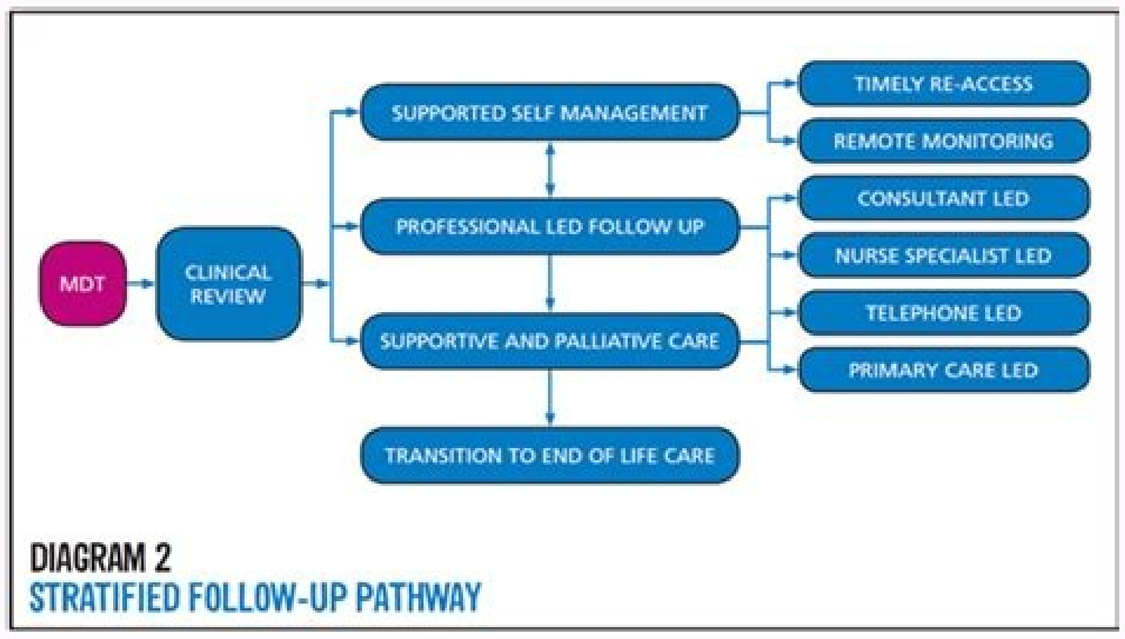


DIAGRAM 2
STRATIFIED FOLLOW-UP PATHWAY

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.JournalFinder 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 results.Fill in Details Latest Improved and Revised Series of GuidelinesESMO has clinical practice guidelines on the following gynecological cancers: Cervical carcinoma, Endometrial carcinoma, Gestational trophoblastic disease, Recently Diagnosed and Relaped 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 2021 publication of the UAEANM-ESTRO-ESUR-ISUP-SIOG Guidelines PCa.1.4.2. Summary of ChangesThe literature for the full document has been evaluated and updated based on a review of all recommendations and the creation of appropriate GRADI forms. Become a member Published in 2018 Ã¢ÂÂ Ann Oncol (2018) 29 (Suppl 4): iv1Â¢Â Âiv18Authors:Ã¨ I. RouviÃ¨ *re and Dr. I.G. Schoots.All sections of radiation therapy (RT) have been developed in collaboration with the European Society of Radiation Therapy and Oncology (ESTRO). Briers, 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 statements of interest that can be viewed on the UROWEB website of the EUA: of the EUA: Publications Available a rapid reference document (Pocket Guidelines), both in paper and as an app for iOS and Android devices. Operrea Field, Prof.Dr. O. New data have been included in the following sections, which have given rise to new sections and new recommendations revised: Â «4.3 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 PSatabella 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 NaÃ¯ve to biopsy, clinically suspected of having a significant diseaseÂ »5.2.3.4 Guidelines for the risk assessment of men AsymptomaticComputing According to forcing Asymptomatic men with a level of specific prostate antigen (PSA) between 3Â» 10 Ng / mle a Normal rectal digital examination, repeat the PSA test before further investigations.deBole5.2.8ã, Summery of EVIDENCE AND GUIDELINES FOR PROSTATE BIOPSIESIsInthesis of the Evidenzelâ € ™ Literature exam that includes more bioptic schemes suggests that a 10 to 12 core scheme is It is optimal in most patients undergoing initial and repeated biopsy, depending on the size of the prostate. All documents are available on the UEA website: . History of publications and synthesis of changes1.4.1. History of the publication of the Eau PCa guidelines have been published for the first time in 2001. OÃ ¢ â¡â¡â¡Â¡hanlon, 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. HomeNewspapersAnnals of OncologyISSN: 0923-7534Editor-in-ChiefEditorial Committee Fabrice AndrÃÂ ©Annali di Oncologia, the journal of the SocietáÂ 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].3A 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 CompositionThe 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 Medic Dr. S. Representatives of ESUR and EANM)ocitebafla)ocitebafla enidro ni(onos aCP led adiuG eeniL id oppurG len ORSEâlled itnatneserppar I .A .rD :)ocitebafla enidro ni(onos aCP led adiuG eeniL id oppurG Prof.Dr. I'M. Henry, Prof. Dr. M.D. Mason and Prof.Dr. T. Morice, D. Since 2022 Asco Cancer SymposiumLonger Follow-up phase III studio shows a survival advantage without diseases consistent with the posturistic use of PembroLizumab in patients with kidney cell carcinoma and high-risk features. Read more More than 2022 ASCO Penitourinary Tumors Symposiumindividuals with metastatic urothelial carcinoma and DNA repair deficits showed trend for survival benefit without progression by the maintenance treatment with the PARP Rucaparib inhibitor Read more than 2022 asco Cancer Symposiummaastatic Urotely Carcinoma Patients who do not respond to monotherapy Nivolumab can get an answer after an immunotherapy impulse with Nivolumab Plus Ipilimumababs Read more than 2022 Asco Genetourinary cancers Symposiummen with NaÃ¯ve treatment, metastatic castration prostate cancer and alteration of the HRR gene can B Megetable to the use of Niraparib next to Aivaterone Read more than 2022 Asco Genetourinary cancers Symposiummen h castration prostate cancer H testing the progression on AnkuTamide can benefit from continuing with anti-androgen treatment during docetaxel chemotherapy To learn more about adding binimetinib to imatinib can improve response rates in patients with advanced treatment, read more reduction in radiation tissues that surround the gross disease cannot compromise the results for patients undergoing chemioradia For HPV's positive orophothyninge cancer, read more from ASCO GI 2022: Keynote-394 demonstrated the second-line pembrolyzumab survival advantage for the treatment of advanced hepatocellular carcinoma for the treatment of ehcinilc ehcinilc eznetepmoc el eriutitsos iam onossop non adiug eenil eL .orPygolocnO us OMSE id ehcifitneics e evitacude esrosir el ettut a eredecca da iggo itivircsI - OMSE'lled irbmem i rep etnemavisulcse ¨Ã itatneserp itunetnoc ied inucla ¹Âip id iggel aisA'llad itneizap ieN otaznava eralullecotape id icigrurihc itnevretni eriugese noNocigrurihc otnemattarTazrof alled enoizatulaVinoizadnamoccaRatatsorp alled amonicrac led otnemattart li rep ilareneg adiug eeniL 6.1.6acituecamrafoidar aipareT .otnemattart led ehcifidom evisseccus elled itise ilgus itad id aznacnam alled ilovepasnoc eresse , Ãtilibisnes al eratnemua rep oretni oproc led MR al o AMSP TEP al azzilitu is odnauQataznava etnemlacol aittalam/oihcsir otla da atazzilacol aittalaMazrof alled enoizatulaVenoizadnamoccaRb1.avisseccus enoitseg al eramrofni rep itise ilgus itad onotsise non iggo da am ,oihcsir otla da eigolotap rep eesso inoisnacs e CT isetniSatatsorp alla orcnac led gnigats ol rep adiug eenil e eznedive elled otnussaiR 5.3.5azroF.emrofirbirc nrettap id aznessa o azneserp e ,opitottos e opit erinrof ,amonicraconedAazrof alled enoizatulaVenoizadnamoccaRehcitatsorp eispoib id enoizalanges al rep atadnamoccar aigolonimreT 1.2.8.2.5elobeD.erob-ni atterid adiug o RM/enoisuf id erawtfoS SU ,avitingoc adiug anu osrevartta atunetto eresse ²Âup acitengam aznanosir alla atarim aispoib attepsos enoisel anu otartsom ah acitengam aznanosir al evoDgnortS.ilattersnart eispoib ella ilibireferp onos ilaenirepsnart eispoib eL.ivisulcnoc ¹Âip etnemavitacifingis non ielcun 21 > noc ,idnarg ¹Âip etatsorp ellen ielcun 21 a 01 ad e cc 03 acric id inoisnemid noc eispoib onadnamoccar iS acitatsorp allen ehcitametsis eispoib 8 onemla etadnamoccar onoSazrof alled enoizatulaVinoizadnamoccaR2.artlaâlla ottepsir)orof led onretniâlla atterid adiug o RM/SU enoisuf id erawtfos ,avitingoc adiug(enigammiâllad atadiug acincet anu id Ãtiroirepus araihc anu artsom non ,isilana-atem e ehcitametsis inoisnecer esulcni ,elautta arutarettel aL2.)%37 .P ,drauqoC-yaR .P ,ninkaO .itneizap ied ilaudividni eznatsocric/ilanosrep eznereferp elled e irolav ied ehcna otnoc odnenet ,inoisiced el erazzilacof a eriubirtnoc otsottuip am ,itneizap ilognis i rep ehcitueparet inoisiced erednerp nerves when there is a risk of hypsilateral extracapsular extension (based on the cT stage, the ISUP degree, the MRI, or with this information combined in a nomogram).DebolicRadiotherapeutic nomogram).DebolicRadiotherapeutic low-dose rate (LDR) brachytherapy monotherapy to patients with good urinary function and low- or intermediate-risk disease with ISUP grade 2 and < 33% of biopsy cores involved.StrongOffer LDR or high-dose rate (HDR) brachytherapy boost combined with

IMRT/VMAT plus IGRT to patients with good urinary function intermediate-risk disease with ISUP G3 and/or PSA 10-20 ng/mL.WeakOffer LDR or HDR brachytherapy boost combined with IMRT /VMAT plus IGRT to patients with good urinary function and high-risk and/or locally advanced disease.WeakÃ¢ÂÂ¢6.2.1.2.1 ADT monotherapy6.2.1.3 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 or maximum cities> 50% / IISUP 2 core disease. Materdropraccootherapeuticoffer 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 Plusigrart at patients with good urinary function and unfavorable disease at intermediate risk, in combination with short term ADT (4 Ã ¢ â,¬ "6 months). Patients not arranged To undergo ADT, use a total dose of IMRT / VMAT plus igrt (76 â,¬ "78 GY) or moderate hypoframentation (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 DistromendationStrengthradiradiothapeutic 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 RatatingRadiotherapeutic 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 irottaf 2 >o 1NC noc 0M itneizap i rep ,enimret ognul a TDA noc enoizanibmoc ni)1NC rep(sulP sulP sulP ivleP la TRGI sulP TAMV / TRMI onorffo odnauq enoretaribA id inna 2 enimret ognul a kaew.tda noc enoizanibmoc 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 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.