



## Complete Summary

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### GUIDELINE TITLE

Management of stage I seminoma: guideline recommendations.

### BIBLIOGRAPHIC SOURCE(S)

Chung P, Mayhew LA, Warde P, Winqvist E, Lukka H, Genitourinary Cancer Disease Site Group. Management of stage I seminoma: guideline recommendations. Toronto (ON): Cancer Care Ontario (CCO); 2008 Jan 30. 34 p. (Evidence-based series; no. 3-18). [87 references]

### GUIDELINE STATUS

This is the current release of the guideline.

The EVIDENCE-BASED SERIES report, initially the full original Guideline, over time will expand to contain new information emerging from their reviewing and updating activities.

Please visit the [Cancer Care Ontario Web site](#) for details on any new evidence that has emerged and implications to the guidelines.

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## SCOPE

### DISEASE/CONDITION(S)

Stage I testicular seminoma

### GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness  
Management  
Treatment

## **CLINICAL SPECIALTY**

Oncology  
Radiation Oncology

## **INTENDED USERS**

Physicians

## **GUIDELINE OBJECTIVE(S)**

To evaluate the optimal post-orchidectomy management strategy for stage I testicular seminoma

## **TARGET POPULATION**

Adult patients with stage I testicular seminoma

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Post-orchidectomy Management**

1. Surveillance program (physical exam, chest x-ray, computerized tomography of abdomen and pelvis)
2. Dogleg (extended-field) radiation therapy
3. Para-aortic radiation therapy
4. Chemotherapy (carboplatin-based)

## **MAJOR OUTCOMES CONSIDERED**

- Cancer-specific survival
- Long-term toxicity (including second malignancy)
- Quality of life

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

#### **Literature Search Strategy**

The MEDLINE and EMBASE databases were searched for evidence during the month of May 2007, using the following text, MeSH, and EMBASE subject headings: "testicular neoplasms", "testicular cancer", "Neoplasms, germ cell and embryonal", "seminoma", "germinoma", "dysgerminoma", and "germ cell tumor?". These results were combined with the terms "radiotherapy", "surveillance" "watchful waiting", "chemotherapy", and "drug therapy" to provide a base pool of literature on the treatment of testicular cancer, with the total results being limited to human studies published from 1981 through to May 2007. These searches produced a total of 2,913 references. One further reference not published at the time of the literature search but published shortly afterwards was suggested by an author. The American Society of Clinical Oncology (ASCO) abstracts were hand searched for references related to seminoma. Four relevant ASCO abstracts were found, one of which was an update of a previously published paper.

### **Study Selection Criteria**

Studies were selected if they met the following criteria:

#### *Patient Criteria*

- Studies with patients with stage I seminoma diagnosis.
- Studies with multiple stages of seminoma disease where survival and recurrence data were reported separately for stage I patients.
- Studies that included nonseminoma patients, provided that the survival and recurrence data for seminoma patients were reported separately for stage I patients.

#### *Patient Outcomes*

- Studies reporting at least one of survival, recurrence, second malignancy, cardiac toxicity, or quality of life.

#### *Year of Publication*

- Studies published after 1981.

#### *Study Designs/Types*

- Clinical practice guidelines, systematic reviews, randomized controlled trials (RCTs), and non-randomized prospective and retrospective studies.

The following types of articles were excluded:

- Articles published in languages other than English, because of the lack of translation resources.
- Editorials, comments, and case studies.
- Studies conducted in narrow patient groups (e.g., human immunodeficiency virus [HIV]+).
- Non-randomized controlled trial studies with less than 100 patients, or less than 400 patients if examining long-term toxicity or quality of life, as these

were considered underpowered to inform the development of clinical practice guidelines.

- Studies in which staging was performed by lymphangiogram, as the more accurate staging results of computerized tomography (CT) scans may have resulted in a stage migration of patients.

The references were jointly reviewed by two authors (LM and PC).

## **NUMBER OF SOURCE DOCUMENTS**

A total of 50 eligible reports were identified, including seven clinical practice guidelines, one systematic review, three randomized controlled trials (RCTs) focused on treatment options, 24 non-randomized studies of treatment options, and 15 non-randomized long-term toxicity studies.

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus (Committee)

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

## **METHODS USED TO ANALYZE THE EVIDENCE**

Review of Published Meta-Analyses  
Systematic Review with Evidence Tables

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

### **Quality Appraisal**

The Appraisal of Guidelines for Research & Evaluation AGREE tool was used by two independent raters to evaluate the quality of all the identified practice guidelines. While all the domains were considered in evaluation of the guidelines, the rigour of development domain along with the overall rating were considered to be most relevant.

### **Synthesizing the Evidence**

Due to the clinically heterogeneous sources of evidence in this report, no pooling was planned.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

There are no randomized studies of surveillance alone compared to adjuvant therapy. This creates a challenge in articulating the options that optimize cure, expeditiously allow all patients to return to their lives, and avoid patient exposure to interventions that may lead to permanent long-term adverse events. The other challenge to recommending a management option for stage I seminoma is that the available long-term toxicity/survival data are retrospective, with all the inherent problems associated with retrospective data, and yet these data show a clear pattern of treatment-related deaths that cannot be ignored.

The data that exist suggest that virtually all patients with stage I testicular seminoma are cured regardless of the post-orchidectomy management. The five-year survival reported in all the studies identified in this systematic review was over 95%, regardless of management strategy, including surveillance alone with no adjuvant therapy. In non-randomized studies of surveillance alone, the five-year relapse-free rate was consistently reported as over 80%, with no reduction in cause-specific or overall survival. Therefore, it appears that the majority of patients are cured by orchidectomy alone, and those that are not, rarely die from their disease. The available data therefore support the conclusion that surveillance as a management option does not compromise survival. Given this fact, and the acute and long-term toxicity of adjuvant treatment, especially in terms of second malignancies, the use of any form of adjuvant therapy must be given careful consideration. Any adjuvant treatment regime would expose the 80% of patients who would never have a relapse and would be cured by orchidectomy alone to the risk of treatment-related toxicity, a serious consideration given the retrospective data concerning second malignancies and cardiac effects.

The studies that have evaluated radiation therapy (RT) in testicular cancer all report clinically important increases in second malignancy, and treatment is associated with other significant toxicities such as cardiac toxicity. Although changes in the field size and RT dose did occur during the time period examined in these studies, such changes are unlikely to have a large effect on the estimation of risk, as any RT given (regardless of the dose/field delivered) is associated with increase in second malignancy, and it is the absolute size of the risk that may be affected by dose and field size issues. Although the RT treatment given today is not exactly the same as that given to the patients in these long-term toxicity studies, it is sufficiently similar that these issues cannot be ignored or dismissed as being irrelevant to current treatment practices. While further prospective study of these issues would in many ways be ideal, the large numbers of patients needed, and also the long periods of time over which such data needs to be collected, limits the ways in which this information can be obtained. Further clarification of the issue will always be hampered by the inherent difficulties associated with retrospective and non-randomized studies. Further, only a small minority, if any, of patients in the long-term toxicity studies, are likely to have received single-agent carboplatin; thus it is not currently possible to comment definitively on any associated long-term toxicity associated with that treatment.

Surveillance may have an advantage over adjuvant therapy in that both acute and long-term toxicity may potentially be avoided; however, surveillance requires a commitment to more intense and prolonged follow-up from both patients and clinicians. Patient compliance is essential, as the failure to detect relapse at an early stage may compromise survival. In addition, it must be noted that repeated exposure to serial computed tomography (CT) scans poses some potential risk of

second malignancy, albeit less significant than that posed by adjuvant RT. Therefore, the disadvantage of surveillance as a management strategy is that follow-up for surveillance requires more frequent visits and imaging to detect relapse when compared to patients who have received adjuvant therapy. Despite these drawbacks, all the guidelines found and evaluated included surveillance as a treatment option for stage I seminoma, and where the treatments were ranked in order of preference, surveillance was the primary option.

Surveillance has become a well-established management option worldwide. It seems that all men with stage I seminoma should be suitable candidates for surveillance as long as they are able to undergo the follow-up and CT scan procedures. More importantly, these men should have full commitment to be compliant with the designated surveillance schedule. Noncompliance may lead to more advanced disease when relapse is detected clinically, potentially requiring more aggressive treatment for a cure.

There will still be many patients who may choose to receive adjuvant therapy. When adjuvant therapy is chosen, RT remains an option for patients. In the randomized trial reported by Jones et al, 20 Gy (2 Gy/day) was shown to be equivalent to 30 Gy in terms of disease control. One of the rationales for using 20 Gy was to reduce toxicity. While acute toxicity was improved, the follow-up in this trial is insufficient, and it may be underpowered to identify if there is a benefit with respect to long-term toxicity or second malignancy; however, 20 Gy has the advantage of an overall shorter treatment time with good disease control. There is some variation as to what is considered to be the standard radiation dose for stage I seminoma. Consideration should be given not only to the total dose but also to the dose per fraction. In some non-randomized studies, a total dose of 25 Gy given in 1.25 Gy per fraction has provided good in-field local control with low rates of acute toxicity.

In the randomized trial reported by Fossa et al a reduced para-aortic field size was compared to standard extended-field ("dog-leg") RT, with the hypothesis that a reduced field size would lead to reduced toxicity and second malignancy. While the trial demonstrated equivalence between the field sizes in terms of overall prevention of relapse, and also showed reduced acute toxicity, the follow-up is not sufficient to judge any reduction in long-term toxicity or second malignancy. One issue that does arise from this trial and the one reported by Jones et al was that the pattern of relapse was altered. While there was no difference in the overall number of recurrences, in both randomized controlled trials the pelvis was the most common site of relapse in patients treated with para-aortic RT, while pelvic relapse was rare for patients treated with extended-field RT. This is supported by an examination of patterns of relapse in patients in the non-randomized studies. Although only a small proportion of patients ultimately relapse in the pelvis, a pelvic recurrence is a serious event that is not easily detected at an early stage unless a CT scan is used. Therefore, all patients treated with para-aortic RT still require follow-up CT scans of the pelvis, an investigation that is not needed in patients treated with extended-field RT.

Neither of these modified treatments is likely to completely eliminate the risk of second malignancy, and any associated risk reduction remains unknown at this time. Thus, while para-aortic RT to a minimum dose of 20 Gy in 2 Gy fractions is the RT option that may best reduce acute toxicity, owing to concerns about the

additional follow-up needed and pelvic relapses, extended-field RT may still be appropriate.

Data regarding the effects of adjuvant carboplatin therapy are limited, and the duration of follow-up is relatively short; thus, in contrast to RT, more questions remain regarding its use. The conclusion of the randomized trial reported by Oliver et al was that carboplatin was equivalent to RT for prevention of short-term relapse, with improved acute toxicity. However, similar to the reduced-field RT trial discussed above, the pattern of relapse in patients treated with carboplatin was altered such that the majority of the relapses occurred in the retroperitoneal/para-aortic lymph nodes. Given these findings, continued CT monitoring for relapse cannot be eliminated from the follow-up schedule: indeed it should mirror that recommended for surveillance. This trial also has insufficient follow-up to evaluate the durability of disease control and the long-term toxicity of carboplatin in this patient population, as compared to RT. In a meta-analysis of sarcoma patients performed by Tierney et al, adjuvant chemotherapy showed a short-term benefit in the recurrence rate; however, overall survival did not appear to be affected, implying that recurrences may have been delayed as opposed to prevented. Without long-term survival data for chemotherapy in the treatment of seminoma, there is the possibility that recurrences have just been delayed and that late recurrences may still occur. In light of these issues, the use of carboplatin might be best restricted to situations in which there is a contraindication to RT or within a clinical trial.

Given that there are several management options, none of which have proven to have absolute superiority for patients with stage I testicular seminoma, men should be counselled concerning their treatment and the trade-offs associated with the different options after orchidectomy. While physicians may view one management approach as preferable, individual patient preferences must be considered. An individual treatment plan that takes into account the patient's wishes and is developed in consultation with an expert in the treatment of stage I seminoma should be developed for each patient. A summary of the benefits and risks of the different management strategies that physicians may wish to share with their patients appears in Table 5 of the original guideline document.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

## **Development and Internal Review**

This evidence-based series was developed by the Genitourinary Disease Site Group (DSG) of Cancer Care Ontario's Program in Evidence-based Care (CCO's PEBC).

## **Report Approval Panel Review Prior to External Review**

Prior to the submission of this evidence-based series report for external review, the draft report was reviewed by the PEBC Report Approval Panel, which consists of two members, including an oncologist, with expertise in clinical and methodology issues.

## **External Review**

This guideline was reviewed in draft form at the 1st Canadian Germ Cell Cancer Consensus Conference, October 19-20 2007 in King City, Ontario. Conference attendees consisted of 39 Canadian experts in the field from eight different Canadian provinces (there were no attendees from Prince Edward Island or Newfoundland). Fourteen of the attendees were medical oncologists, thirteen were radiation oncologists, eleven were urologists/urological surgeons, and one was a pathologist. Also present were a nurse practitioner, a radiation therapist, a member of Cancer Care Ontario's PEBC, two invited expert physicians from the United States, two invited expert physicians from Europe, three patients, and the mother of a patient who had passed away from testicular cancer.

Conference attendees were given a presentation on the Ontario guidelines, and then were given presentations on the European and American guidelines. Conference attendees were given the opportunity to discuss the different guidelines and to pose questions to the presenters. They were also given paper copies of the guidelines. The next day, attendees were asked to come to a consensus concerning recommendations for treatment.

With respect to consensus concerning the treatment of stage I seminoma, the attendees all agreed that surveillance was the management option of choice. They also agreed that if adjuvant treatment was chosen, the treatment of choice should be radiation therapy.

As the conference attendees included a majority of those who would be approached for feedback as part of the PEBC's external review process, no additional practitioner feedback was solicited for this document beyond that obtained at the conference.

## **Report Approval Panel Review After External Review**

Once the changes based on the external review process had been incorporated into the document, the draft report was again reviewed by the PEBC Report Approval Panel.

This report reflects the integration of feedback obtained through the external review process with final approval given by the Genitourinary Disease Site Group and the Report Approval Panel of the PEBC.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The Disease Site Group (DSG) recommends surveillance as the preferred option, because adjuvant therapy is associated with important short and long-term toxicities and second malignancy risks with no evidence of improved survival.

- Surveillance or adjuvant therapy (radiation therapy [RT]) ultimately yields equivalent disease control in stage I seminoma.
- Patients should be informed of all treatment options, including the potential benefits and side effects of each treatment. A table of benefits and risks associated with each management option is available in Section 1: Appendix A of the original guideline document.
- A treatment plan should be developed that includes the patient's preferences and clinical judgement of that specific case.

For patients who prefer immediate treatment, or who are unsuitable for primary surveillance, adjuvant RT is the recommended option.

- When adjuvant RT is the preferred option, a radiation dose of at least 20 Gy and no more than 30 Gy is recommended.
- When adjuvant RT is the preferred option, para-aortic and extended-field (i.e., "dogleg") RT are equivalent in prevention of para-aortic recurrence, but are different in terms of short- and long-term toxicity and follow-up requirements.
- In patients treated with adjuvant therapy, post treatment monitoring for disease relapse is still necessary. Except in the specific case of extended-field radiotherapy, the follow-up after adjuvant therapy should be as thorough as the surveillance conducted in the absence of adjuvant therapy.

When neither surveillance nor RT is suitable, adjuvant chemotherapy is the preferred option. Single-agent carboplatin is typically used.

- In patients treated with adjuvant therapy, post-treatment monitoring for disease relapse is still necessary. The follow-up after adjuvant therapy should be as thorough as the surveillance conducted in the absence of adjuvant therapy.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are supported by clinical practice guidelines, one systematic review, randomized controlled trials (RCTs), non-randomized studies of treatment options, and non-randomized long-term toxicity studies.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

- Data from large prospective randomized controlled trials (RCTs) and large prospective cohorts of stage I seminoma patients identified in a systematic review of the evidence indicate that overall survival at five years is greater than 95%, regardless of the initial treatment strategy adopted. The challenge remains to define the optimal management approach to minimize toxicity while maintaining excellent results.
- Data from large prospective cohorts of primary surveillance identified in a systematic review of the evidence indicate that surveillance is safe and that 80-85% of patients do not require any post-orchidectomy treatment. In addition, when a policy of routine radiation therapy (RT) for relapse is utilised, there is no increase in the proportion of patients requiring systemic chemotherapy compared to those treated with adjuvant RT.
- An RCT compared 20 Gy to 30 Gy in a non-inferiority design and found no difference in relapse-free survival between the methods (hazard ratio [HR] for relapse, 1.11; 90% confidence interval [CI], 0.54 to 2.28; log rank  $p=0.81$ ).
- An RCT compared para-aortic to "dogleg" radiotherapy in a non-inferiority design, and found no difference in three-year relapse-free survival.
- An RCT compared RT at 20 Gy or 30 Gy with a single cycle of carboplatin (area under curve [AUC]=7) in a non-inferiority design, and found no difference in three-year relapse-free survival (HR, 1.28; 90% CI, 0.85-1.93;  $p=0.32$ ).

### **POTENTIAL HARMS**

- Evidence from RCTs supports the conclusion that para-aortic RT leads to a greater risk of pelvic recurrence but also less short-term toxicity than does extended-field RT. This has also been confirmed in non-randomized trials.
- Twelve population-based studies demonstrated a consistent increase in the risk of second malignancy associated with RT compared to population expected rates. The largest of these combined fourteen population-based registries including 10,534 patients with seminoma (all stages) treated with RT and no chemotherapy who had at least 10 years follow-up. Compared with matched cohorts from corresponding registries, the overall relative risk for a second non-testicular malignancy was 2.0 (95% CI, 1.8-2.2). For a 35-year-old patient with seminoma (most treated with RT), the cumulative 40-year risk of a second malignancy was 36%, compared with 23% in the normal population. Another study compared 5,265 stage I seminoma patients treated with adjuvant RT against 1,499 patients managed with surveillance and found a second malignancy observed-to-expected ratio of 1.93 ( $p<0.05$ ).
- Two studies addressed the cardiac toxicity associated with radiation therapy (RT). In the MD Anderson series, 453 patients treated between 1951 and 1999 had a standardized cardiac mortality ratio of 1.80 (95% confidence interval [CI], 1.01-2.98) after 15 years if only infradiaphragmatic and no mediastinal radiation therapy was used. A similar increase in cardiac events

(risk ratio, 2.4 [95% CI, 1.04-5.45]) was reported in a cohort of 992 patients treated at the Royal Marsden Hospital. The etiology of this effect is currently unclear.

## **Summary of Risks of Different Management Strategies of Stage I Seminoma**

### *Surveillance*

- Requires frequent follow-up computerized tomography (CT) scans, with associated long-term risks
- Some patients may experience anxiety related to risk of recurrence

### *Dogleg Radiation Therapy*

- Long-term second cancer risk
- Long-term cardiac risk
- A large majority of patients are overtreated

### *Para-Aortic Radiation Therapy*

- Requires frequent follow-up CT scans, with associated long-term risks
- Long-term second cancer risk
- Long-term cardiac risk
- A large majority of patients are overtreated

### *Chemotherapy*

- Long-term survival unknown
- Long-term toxicity unknown
- Requires frequent follow-up CT scans, with associated long-term risks
- A large majority of patients are overtreated

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

- The minimum surveillance program should be a physical examination every three to four months, chest X-ray every six to twelve months, and computerised tomography (CT) of the abdomen and pelvis every three to four months in the first three years and then less often thereafter.
- In addition, follow-up should include appropriate investigations of sites at risk of relapse. This approach can be based on the risk of relapse.
- When a primary surveillance approach is adopted, patients should be informed of their estimated risk of recurrence and the need for frequent surveillance as described above.
- Prognostic factors for relapse on surveillance have been identified (tumour size, rete testis invasion) and low, intermediate, and high-risk groups for disease progression defined. This has led to the introduction of a risk-adapted approach by some groups. However, the prognostic model underlying this risk-adapted strategy has not been prospectively validated. In addition, the

- risk stratification provided is limited, as even in the highest risk group over 65% of patients do not require additional therapy after orchidectomy. Thus, a risk-adapted approach cannot be recommended at this time.
- Due to the low incidence of testicular cancers, management is best performed in a multidisciplinary environment within centres familiar with the management of the disease.
  - If adjuvant therapy is planned, sperm banking (and scrotal shielding with RT) should be offered if future fertility is of concern to the patient.
  - With extended-field radiation therapy (RT), there is evidence from randomized controlled trials (RCTs) and non-randomized trials that the risk of pelvic recurrence is greatly reduced, and therefore regular abdominal/pelvic computerised tomography is not necessary as part of the ongoing surveillance/follow-up program.
  - With para-aortic RT, the continuation of pelvic CT scanning on a routine basis is necessary. However, there is also evidence that short-term toxicity is reduced with para-aortic RT compared to extended-field RT. This trade-off should be discussed with the patient as part of the decision-making process.
  - The main concern with adjuvant RT is the potential for the induction of second non-testicular malignancies. In addition, long-term survivors of testicular seminoma treated with adjuvant RT are at an excess risk of death as a result of cardiac disease. These toxicities should be discussed fully with the patient.
  - The follow-up of patients treated with carboplatin in a randomized trial is still relatively short, and the long-term toxic effects of carboplatin are not yet fully known. Additionally, evidence from the randomized trial suggests that the risk of para-aortic recurrence is sufficiently high to warrant abdominal/pelvic CT on a regular basis.
  - The use of carboplatin may be restricted to specific situations outside a clinical trial, for instance where adjuvant therapy is preferred and there is a contraindication to RT. Patients should be informed of these possible risks in order to fully consider their options, particularly in comparison to surveillance.
  - The authors suggest that the optimal dose is not yet known and may be higher than that used in the trial.
  - Care has been taken in the preparation of the information contained in this report. Nonetheless, any person seeking to apply or consult the report is expected to use independent medical judgment in the context of individual clinical circumstances or seek out the supervision of a qualified clinician. Cancer Care Ontario makes no representation or guarantees of any kind whatsoever regarding the report content or use or application and disclaims any responsibility for its application or use in any way.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

**IOM DOMAIN**

Effectiveness  
Patient-centeredness

**IDENTIFYING INFORMATION AND AVAILABILITY**

**BIBLIOGRAPHIC SOURCE(S)**

Chung P, Mayhew LA, Warde P, Winqvist E, Lukka H, Genitourinary Cancer Disease Site Group. Management of stage I seminoma: guideline recommendations. Toronto (ON): Cancer Care Ontario (CCO); 2008 Jan 30. 34 p. (Evidence-based series; no. 3-18). [87 references]

**ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

2008 Jan 30

**GUIDELINE DEVELOPER(S)**

Program in Evidence-based Care - State/Local Government Agency [Non-U.S.]

**GUIDELINE DEVELOPER COMMENT**

The Program in Evidence-based Care (PEBC) is a Province of Ontario initiative sponsored by Cancer Care Ontario and the Ontario Ministry of Health and Long-Term Care.

**SOURCE(S) OF FUNDING**

Cancer Care Ontario  
Ontario Ministry of Health and Long-Term Care

**GUIDELINE COMMITTEE**

Provincial Genitourinary Cancer Disease Site Group

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

For a current list of past and present members, please see the [Cancer Care Ontario Web site](#).

**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

The authors of this guideline were asked to disclose potential conflicts of interest relating to this systematic review, and none were declared.

## **GUIDELINE STATUS**

This is the current release of the guideline.

The EVIDENCE-BASED SERIES report, initially the full original Guideline, over time will expand to contain new information emerging from their reviewing and updating activities.

Please visit the [Cancer Care Ontario Web site](#) for details on any new evidence that has emerged and implications to the guidelines.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [Cancer Care Ontario Web site](#).

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- Management of stage I seminoma: guideline recommendations. Summary. Toronto (ON): Cancer Care Ontario (CCO), 2008 Jan. 7 p. (Practice guideline; no. 3-18). Electronic copies: Available in Portable Document Format (PDF) from the [Cancer Care Ontario Web site](#).
- Browman GP, Levine MN, Mohide EA, Hayward RSA, Pritchard KI, Gafni A, et al. The practice guidelines development cycle: a conceptual tool for practice guidelines development and implementation. *J Clin Oncol* 1995;13(2):502-12.

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This summary was completed by ECRI Institute on July 17, 2008. The information was verified by the guideline developer on August 20, 2008.

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