Long-term follow-up of survivors of childhood cancer (SIGN Clinical Guideline 132)

Hoong-Wei Gan,1,2 Helen A Spoudeas2,3

BACKGROUND

Five-year childhood cancer survival rates have increased to 80–90% for some tumours due to intensified treatments and better supportive care imposed on an incidence stable over four decades.1 2 Between 2005 and 2012, the number of UK survivors has risen from 26 000 to 33 000, or from 1:1000 to 1:715 UK adults.3 4 However, 40% experience chronic severe or life-threatening consequences (‘late effects’) of their tumour and/or its treatment.5 The recent National Cancer Survivorship Initiative (NCSI) has highlighted the unmet need in service provision for adult childhood cancer survivors, with a proposed survivorship framework and stratified care pathways modelled on >20 years’ prior experience.6 7

In March 2013, the Scottish Intercollegiate Guidelines Network (SIGN) published updated guidance on long-term follow-up of childhood cancer survivors to aid the ‘identification, assessment and management of late effects’ aimed at primary, secondary and tertiary healthcare practitioners.8 The Guideline Development Group (GDG) included representatives from paediatric haematology, oncology, endocrinology, reproductive medicine, cardiology, general paediatrics and general practice, as well as a survivor.

PREVIOUS AND OTHER ASSOCIATED GUIDELINES

The previous SIGN 76 guideline was published in 2004. This revision updates information on fertility preservation, cardiac late effects and patient information provision, and provides new sections on subsequent primary cancers (SPCs), bone health and metabolic syndrome. The UK Children’s Cancer Study Group’s (UK CCSG) best practice statement9 is a potentially valuable companion guideline for tertiary care practitioners requiring details of therapeutic regimens and their toxicity profiles to individualise care for those most affected.

KEY ISSUES

Section 11: long-term follow-up provides a useful summary of the recommendations. It recognises the multisystemic and evolving nature of late effects over decades of survival, concluding a need for lifelong multidisciplinary follow-up (table 1). The authors suggest a three-tiered follow-up stratified by disease-related and/or treatment-related morbidity risk (table 2) and list the key multidisciplinary professionals required (box 1).

Subsequent primary cancers (SPCs)—The British Childhood Cancer Survivor Study10 and others have shown an excess SPC risk—>50% due to gastrointestinal, genitourinary, breast and lung cancers—persisting into old age.

Fertility—The impact of cancer treatment on the pituitary–gonadal axis, reproductive capacity and options for pretreatment fertility preservation are complex and differ between the sexes (see British Fertility Society review for a fuller discussion11). In boys, post-treatment sub/infertility may exist despite a normal pubertal and potency.12 With intracytoplasmic sperm injection, oligospermia is no barrier to fertility preservation, while long-term spermatogenic recovery is possible.13 By contrast, pubertal delay or secondary amenorrhoea may herald sub/infertility in girls whose options are more limited. Pretreatment gonadotropin-releasing hormone analogues, ovarian transposition and oocyte collection are unproven and/or impracticable. Prepubertal children of either sex have no recommended options outside a clinical trial. Miscarriage rates are increased, but...
<table>
<thead>
<tr>
<th>Late effect</th>
<th>High-risk factors</th>
<th>Specific late effects</th>
<th>Screening methods/ management</th>
<th>Evidence level/grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent primary cancers (SPCs)</td>
<td>Genetic predisposition, eg, NF-1</td>
<td>Delayed presentation &gt;5 years from treatment, at edge of radiation field (eg, mediastinal radiotherapy and breast SPCs)</td>
<td>As per guidance for specific syndromes</td>
<td>3/C</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td></td>
<td></td>
<td>No consensus</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy* (alkylating agents, epipodophyllotoxins)</td>
<td>Increased risk of all SPCs</td>
<td>No consensus</td>
<td>3/C</td>
<td></td>
</tr>
<tr>
<td>Sub-/infertility</td>
<td>Both sexes</td>
<td>Hypogonadotropin hypogonadism (pubertal arrest/ delay)</td>
<td>See individual sections for assessment depending on sex</td>
<td>3</td>
</tr>
<tr>
<td>Cranial radiotherapy</td>
<td>Sexual dysfunction</td>
<td>Consider psychological referral</td>
<td>3–4/D</td>
<td></td>
</tr>
<tr>
<td>Pelvic radiotherapy</td>
<td>Azoospermia</td>
<td>Semen analysis, cryopreservation, FSH, inhibin B</td>
<td>3/D</td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>Azoospermia</td>
<td>Semen analysis, cryopreservation, FSH, inhibin B</td>
<td>2±3/D</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy* (alkylating agents)</td>
<td>Hypergonadotropin hypogonadism (less likely—pubertal arrest/delay, sexual dysfunction)</td>
<td>Regular pubertal assessment, LH, testosterone ± pubertal induction/testosterone supplementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>Hypergonadotropin hypogonadism (pubertal arrest/ delay/ oligoamenorrhoea)</td>
<td>Regular pubertal assessment, FSH, AMH ± oocyte cryopreservation if postpubertal</td>
<td>3/D</td>
<td></td>
</tr>
<tr>
<td>Abdominopelvic radiotherapy</td>
<td>Uterine dysfunction (premature delivery, low birth weight)</td>
<td></td>
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<td></td>
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<tr>
<td>Cardiac effects</td>
<td>Chemotherapy (anthracyclines)</td>
<td>Congestive heart failure</td>
<td>Echocardiography: Fractional shortening (FS) and ejection fraction (EF) measurements</td>
<td>3–4/D</td>
</tr>
<tr>
<td></td>
<td>Cardiac/mediastinal radiotherapy</td>
<td>Cardiovascular (especially coronary artery) disease</td>
<td>2–3 yearly if anthracycline dose &gt;250 mg/m²</td>
<td>3/D</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 yearly if anthracycline dose &lt;250 mg/m²</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Treat as per regular heart failure/cardiovascular disease guidelines</td>
<td></td>
</tr>
<tr>
<td>Bone health</td>
<td>Chemotherapy (glucocorticoids, high dose methotrexate, 6-mercaptopurine)</td>
<td>Osteoporosis (osteonecrosis with glucocorticoids)</td>
<td>Dual energy X-ray absorptiometry (DXA)/ peripheral quantitative CT/ quantitative ultrasound: BMD or bone mineral content (BMC) Z-scores adjusted for age, sex and height 2 years post-end of treatment</td>
<td>3/D</td>
</tr>
<tr>
<td>Cranial radiotherapy</td>
<td>Endocrine dysfunction (GH deficiency, hypogonadism, hypothyroidism)</td>
<td>Serial measurements not required unless abnormal or clinical change</td>
<td></td>
<td></td>
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<tr>
<td>Bone marrow transplantation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Treating the child</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Metabolic syndrome</td>
<td>ALL (especially after bone marrow transplantation)</td>
<td>Obesity</td>
<td>BP and BMI: Annually in all survivors</td>
<td>3–4/D</td>
</tr>
<tr>
<td>Brain tumours (especially after cranial radiotherapy and growth hormone deficiency)</td>
<td>Dyslipidaemia</td>
<td>Fasting glucose, insulin, lipid profile:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac/mediastinal radiotherapy</td>
<td>Insulin resistance</td>
<td>2 yearly if obese/overweight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive outcomes</td>
<td>Cardiovascular disease</td>
<td>5 yearly if normal weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craniotomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive decline</td>
<td>Neuropsychological assessment: Pretreatment and then annually</td>
<td></td>
<td>3/D</td>
<td></td>
</tr>
</tbody>
</table>
there is no excess of congenital or genetic disorders in offspring.

- **Cardiac effects**—Anthracycline-induced heart failure and mediastinal irradiation-induced cardiovascular disease may take years to manifest and may be additive. There is limited evidence for prophylactic ACE inhibitors or β-blockers, hence standard heart failure management is recommended.

- **Bone health**—Bone mineral density (BMD) as measured by DEXA is age-dependent, sex-dependent, puberty-dependent and height-dependent, thus Z-scores rather than T-scores need cautious interpretation. The only evidence-based treatment for osteopenia is sex steroid replacement, although its effect on fracture risk is unknown.

- **Metabolic syndrome**—Studies are limited to acute lymphoblastic leukaemia (ALL) and brain tumour survivors. A normal body mass index (BMI) does not preclude insulin resistance and dyslipidaemia. Annual blood pressure and BMI assessments are recommended.

- **Cognitive/ psychosocial issues**—Cranial irradiation-induced cognitive decline is age-dependent, sex-dependent and dose-dependent and compounded by adjuvant chemotherapy. All survivors are at increased risk of psychosocial maladjustment and warrant consideration for extra educational support.

- **Growth**—All new cancer patients require accurate auxology at diagnosis and regularly thereafter to adult height, although the feasibility of performing this means that low-risk patients will need monitoring in primary or secondary care. Growth velocity requires interpreting in light of puberty and hormone replacement. Growth hormone (GH) replacement is important for bone mineralisation and childhood growth—does not increase cancer recurrence and should be substituted early particularly after spinal irradiation as it cannot fully reverse the detriment on adult height.

- **Thyroid dysfunction**—Low-dose irradiation scatter can cause compensated and frank primary hypothyroidism years after treatment. Secondary hypothyroidism (thyroid-stimulating hormone deficiency) attributed to cranial irradiation is, in our experience, unusual outside the context of suprasellar tumours. Lifelong monitoring is recommended alongside education on self-examination.

- **Information provision**—Information on healthy lifestyle, support networks and the importance of long-term follow-up should be given to all survivors.

### UNDERLYING EVIDENCE BASE

These SIGN guidelines represent a synthesis of systematic reviews summarising the best available evidence in accordance with standardised methodology. Unlike the National Institute for Health and Care Excellence (NICE), SIGN does not require a mandatory cost-effectiveness analysis. Recommendations graded A–D are based on a
Table 2  Suggested risk stratification of levels of follow-up for 5-year childhood cancer survivors after completion of treatment (reproduced from SIGN 132: Long term follow up of survivors of childhood cancer by kind permission)8

<table>
<thead>
<tr>
<th>Level</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery alone Low-risk chemotherapy</td>
<td>Postal/ telephone</td>
<td>1–2 yearly</td>
<td>Survivors of Wilms’ tumour stage II/III Langerhans cell histiocytosis (single system disease) Germ cell tumours (surgery only)</td>
</tr>
<tr>
<td>2</td>
<td>Chemotherapy Cranial radiotherapy ≤24 Gy</td>
<td>Nurse/ primary care-led</td>
<td>1–2 yearly</td>
<td>Majority of survivors</td>
</tr>
<tr>
<td>3</td>
<td>Any other radiotherapy (cranial radiotherapy &gt;24 Gy)</td>
<td>Medically supervised dedicated long-term follow-up clinic</td>
<td>Annually</td>
<td>Survivors of Bone marrow transplantation Stage 4 patients of any tumour type</td>
</tr>
</tbody>
</table>

Box 1  Suggested members of the multidisciplinary follow-up team (with one member nominated as the key worker) (reproduced by kind permission from Scottish Intercollegiate Guidelines Network (SIGN) 132: Long term follow up of survivors of childhood cancer)8

- Adult oncologist
- Paediatric oncologist
- Radiation oncologist
- Paediatric neurosurgery
- Paediatric endocrinologist
- Paediatric neurologist
- Specialist nurse/nurse practitioner
- Clinical psychologist
- General practitioner
- Dentist
- Optician
- Social worker

Clinical bottom line

- Childhood cancer survivors require lifelong monitoring to limit late consequences of their tumour and/or treatment, but the optimum service delivery model remains incompletely defined.
- While risk factors associated with certain late effects are known, many evolve over decades, with data interpretation confounded by retrospective and cross-sectional study designs.
- Tertiary centres are developing one-stop age-appropriate multidisciplinary services for those at highest risk, but the majority will remain in primary and secondary care.
- All practitioners must thus be aware of consequences of cancer care and thresholds for referral. In this respect, the SIGN guidance provides a helpful way forward for much needed service development and summarises the current evidence base.
- More prospective long-term morbidity outcome studies are required from current interventional trials to define the balance between improving survival with increasing treatment intensity and the quality of survivorship.

HOW DO I IMPLEMENT THESE GUIDELINES IN MY PRACTICE?

- Primary care practitioners need to be alert to the many late organ toxicities incurred by increasing treatment intensity that may manifest decades after treatment. Lifelong surveillance for endocrinopathies, subfertility, SPCs, cardiovascular disease, obesity and metabolic syndrome particularly in low-risk patients can only realistically occur in primary care, alongside supporting healthy lifestyle behaviours (including monitoring vitamin D status) and participation in secondary/tertiary follow-up. Young adult survivors may seek support for psychological illness or subfertility.
- Secondary care practitioners will monitor growth, puberty, thyroid function and neurocognitive development until adulthood, with appropriate specialist referral. Letters of support may be required for missed school attendances, statementing and disability living allowance applications. Adult physicians will be responsible for lifelong monitoring of cardiovascular disease, obesity, thyroid function, bone and sexual health, fertility and SPCs.
- Tertiary care practitioners should see all those at highest risk (brain, pelvic, bone tumour and transplant survivors) for hypothalamopituitary hormone dysfunction, fertility counselling, cardiac and cognitive assessments and psychological support. Clear end-of-treatment summaries with information regarding long-term surveillance needs and likely consequences are required. Implicit in the latter are the increased resources needed for such age-appropriate tertiary assessment and rehabilitation services.

CONTROVERSIES AND UNADDRESSED ISSUES

The level of care provided to childhood cancer survivors remains highly variable across the UK,19 and controlled trials on the optimum frequency, duration and...
quality of follow-up are still needed to determine the effectiveness of secondary prevention of, for example, congestive cardiac failure or hypocortisolaemic (Addisonian) crises. A pan-European prospective cohort study of ~80 000 childhood cancer survivors (PanCareSurFup) is currently examining risk factors for cardiac disease, SPCs and late mortality. Several issues not discussed in the guideline are summarised in box 2.

**FURTHER RESOURCES**

- National Cancer Survivorship Initiative (NCSI) website http://www.ncsi.org.uk/
- Pan-European Network for Care of Survivors after Childhood and Adolescent Cancer (PanCare) http://www.pancare.eu/en/

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