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 puberty 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>Dependent on syndrome&lt;br&gt;Delayed presentation &gt;5 years from treatment, at edge of radiation field (eg, mediastinal radiotherapy and breast SPCs)&lt;br&gt;Chemotherapy* (alkylating agents, epipodophyllotoxins)</td>
<td>As per guidance for specific syndromes&lt;br&gt;No consensus&lt;br&gt;Promote healthy lifestyle behaviours</td>
<td>3/C</td>
</tr>
<tr>
<td>Sub-/infertility</td>
<td>Both sexes&lt;br&gt;Cranial radiotherapy</td>
<td>Hypogonadotropic hypogonadism (pubertal arrest/delay)&lt;br&gt;Sexual dysfunction&lt;br&gt;Chemotherapy* (alkylating agents)&lt;br&gt;Gonadal radiotherapy/total body irradiation (TBI)&lt;br&gt;Girls&lt;br&gt;Chemotherapy* (alkylating agents)&lt;br&gt;Abdominopelvic radiotherapy</td>
<td>See individual sections for assessment depending on sex&lt;br&gt;Consider psychological referral&lt;br&gt;Semen analysis+cryopreservation, FSH, inhibin B&lt;br&gt;Regular pubertal assessment, LH, testosterone ±pubertal induction/ testosterone supplementation&lt;br&gt;Regular pubertal assessment, FSH, AMH&lt;br&gt;±oocyte cryopreservation if postpubertal</td>
<td>3–4/D</td>
</tr>
<tr>
<td>Cardiac effects</td>
<td>Chemotherapy (anthracyclines)</td>
<td>Congestive heart failure</td>
<td>Echocardiography: Fractional shortening (FS) and ejection fraction (EF) measurements&lt;br&gt;2–3 yearly if anthracycline dose &gt;250 mg/m²&lt;br&gt;5 yearly if anthracycline dose &lt;250 mg/m²&lt;br&gt;Treat as per regular heart failure/cardiovascular disease guidelines&lt;br&gt;Promote healthy lifestyle behaviours</td>
<td>3–4/D</td>
</tr>
<tr>
<td>Bone health</td>
<td>Chemotherapy (glucocorticoids, high dose methotrexate, 6-mercaptopurine)&lt;br&gt;Cranial radiotherapy&lt;br&gt;Bone marrow transplantation&lt;br&gt;Endocrine dysfunction (GH deficiency, hypogonadism, hypothyroidism)</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&lt;br&gt;Serial measurements not required unless abnormal or clinical change&lt;br&gt;Promote healthy lifestyle behaviours</td>
<td>3/D</td>
</tr>
<tr>
<td>Metabolic syndrome</td>
<td>ALL (especially after bone marrow transplantation)&lt;br&gt;Brain tumours (especially after cranial radiotherapy and growth hormone deficiency)</td>
<td>Obesity&lt;br&gt;Dyslipidaemia&lt;br&gt;Insulin resistance&lt;br&gt;Cardiovascular disease</td>
<td>BP and BMI: Annually in all survivors&lt;br&gt;Fasting glucose, insulin, lipid profile: 2 yearly if obese/ overweight&lt;br&gt;5-yearly if normal weight&lt;br&gt;Treat as per regular obesity guidelines</td>
<td>3–4/D</td>
</tr>
<tr>
<td>Cognitive outcomes</td>
<td>Cranial radiotherapy</td>
<td>Cognitive decline&lt;br&gt;Psychosocial dysfunction</td>
<td>Neuropsychological assessment: Pretreatment and then annually</td>
<td>3/D</td>
</tr>
</tbody>
</table>

Continued
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—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 I/II 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) Megatherapy (i.e., high-dose chemotherapy)</td>
<td>Medically supervised long-term follow-up clinic</td>
<td>Annually</td>
<td>Survivors of any brain tumour Bone marrow transplantation Stage 4 patients of any tumour type</td>
</tr>
</tbody>
</table>

SIGN, Scottish Intercollegiate Guidelines Network.

hierarchy of evidence from level 1 (meta-analyses, systematic reviews or randomised controlled trials) to level 4 (expert opinion).

**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 hypothalamic-pituitary 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

- Scottish Intercollegiate Guidelines Network (SIGN) 132: Long-term follow-up of survivors of childhood cancer
  http://www.sign.ac.uk/pdf/sign132.pdf
- 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/

Acknowledgements We would like to thank SIGN for their kind permission in the use of table 2 and box 1 for this review.

Contributors H-WG wrote the initial manuscript draft, and HAS provided significant editions and useful expert opinion.

Competing interests None.

Provenance and peer review Commissioned; externally peer reviewed.

Open Access This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 3.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/3.0/

REFERENCES


20 Hjorth L, Kvarnstrom E. Pancare Childhood and Adolescent Cancer Survivor Care and Follow-up Studies. 2013. [cited 2013 2 December 2013]; http://www.pancaresurfup.eu


