Testicular Cancer (Germ Cell)

Cancer Centre of Southeastern Ontario
Standard Management Guidelines

Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with Testicular Cancer (Germ Cell)

Section	Activity	Activity Description	Details	Reference(s)
AA	Cancer Centre Referrals		• All patients post-orchiectomy warrant Cancer Center referral • Multidisciplinary case conference discussion may be considered for all patients, and is important for all patients with high-risk features or nodal/visceral metastatic disease	
A	Diagnosis		• Pathology and local staging via inguinal orchiectomy • Patients presenting with non-testis primary or widely metastatic disease with strongly elevated markers may be diagnosed in the absence of histopathology	
B	Pathology	Synoptic Report	• Synoptic reporting as per accepted standard • Information germane to risk-stratification is included (e.g. size, invasion, stage, etc.)	College of American Pathologists (CAP) Guideline Synoptic Template
C	History and Physical exam		• Must include scrotal, abdominal examination, lymph node palpation • Respiratory examination in all patients who are considered for chemotherapy • Other evaluations as clinically indicated	
D	Investigations		• CT abdomen/pelvis and CXR • CT chest only if indicated (e.g. markers elevated post-	

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			orchiectomy) • CT head as indicated; consider if extremely elevated markers or suggestive symptoms or findings • Tumour markers (αFP, βHCG, LDH) at diagnosis, post-orchiectomy (and at all surveillance or post-treatment visits) • Pulmonary function tests if considered for chemotherapy	

E	Primary management	Clinical Stage I	• Non-risk-adapted surveillance is appropriate if indicated (patient acceptance, expectation of high compliance)
			• Seminoma:
			  ○ Discussion of the role of adjuvant single-agent carboplatin and abdominal radiation is appropriate for all patients, and these modalities are indicated in selected patients
			• Non-Seminoma Germ Cell Tumour (NSGCT):
			  ○ Discussion of adjuvant Bleomycin-Etoposide-Cisplatin (BEP) chemotherapy (2 cycles) or Primary Retroperitoneal Lymph Node Dissection (RPLND) is appropriate for all patients, and these modalities are indicated in selected patients
				Canadian Consensus Statement (1)

F	Primary management	Clinical Stage II	• Seminoma: ○ BEP chemotherapy (3 cycles) or radiation therapy are indicated. Medical oncology and	Cancer Care Ontario Adjuvant/

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			radiation oncology referral are indicated • NSGCT o BEP chemotherapy (3 cycles) or primary RPLND are indicated. o If BEP contraindicated (e.g. due to lung function), EP (i.e. without Bleomycin) (4 cycles)	Curative/ Neo-Adjuvant Systemic Therapy
G	Primary management	Clinical Stage III-IV	Risk stratification by International Germ Cell Cancer (IGCC) classification • Good risk – BEP (3 cycles) • Intermediate risk – BEP (3-4 cycles) • Poor risk – BEP (4 cycles) Clinical scenario may alter tolerability of some agents (especially Bleomycin)	Canadian Consensus Statement (1)
H	End of Treatment Management	Seminoma and NSGCT	• Follow as per National Comprehensive Cancer Network (NCCN) Guideline	NCCN Guideline Link
		Residual mass – seminoma	• PET scan indicated in select cases • Post-Chemo RPLND in cases of PET+, discrete mass, markers normal	
		Residual mass - NSGCT	• Consideration of Post-Chemo RPLND for any visible mass >1cm in site of prior disease; selected cases if <1cm • Markers must be normal for Post-Chemo RPLND	
I	Recurrent Disease		• Management is dependent on clinical scenario (timing of recurrence, markers, prior treatment) • All cases should be brought to Multidisciplinary Case	

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			Conference (MCC)	
J	Controversies		• EPx4 chemotherapy instead of BEPx3 for some intermediate and good risk patients • VIP/TIP instead of EPx4 in patients with poor risk disease and pulmonary indications to avoid bleomycin may be considered • Non-risk-adapted surveillance is not universally accepted in the management of clinical stage I disease	
K	Clinical Trials		• Patients should be considered for clinical trials if available	

References

1. Wood et al Can Urol Assoc J 2012;4(2):e19-e38

Back to Top

Revisions

- 2014/02/13: Draft created
- 2014/04/02: Revisions to text, addition of links and references
- 2014/04/09: Revisions to text
- 2014/06/09: Revisions to text, addition of links and references
- 2014/06/25: Discussed at CCSEO Disease Site Group Chairs Council and conditionally approved pending minor revisions
- 2014/06/26: Revisions to text following discussion at CCSEO Disease Site Group Chairs Council (2014/06/25)

Back to Top