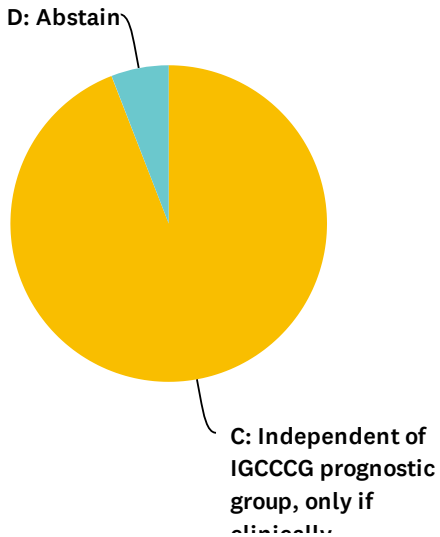
Appendix

Swiss germ-cell cancer consensus recommendations

Swiss Med Wkly. 2021;151:w30023

F1 Orchiectomy should be delayed

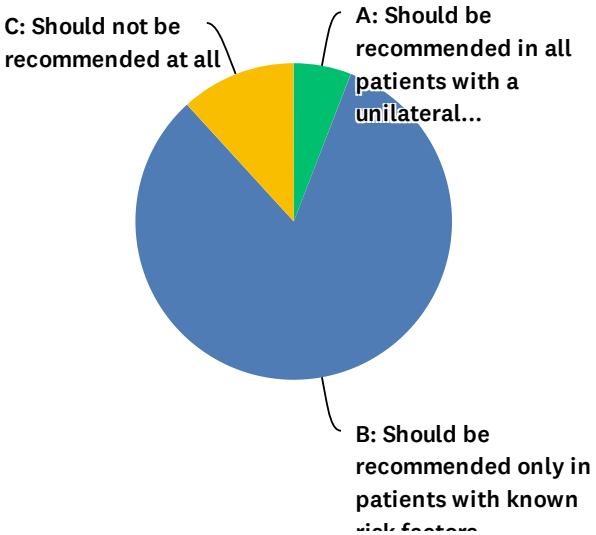
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: In all "intermediate" and "poor" prognosis patients	0.00%	0
B: In all "poor" prognosis patients	0.00%	0
C: Independent of IGCCCG prognostic group, only if clinically indicated, e.g. by symptomatic lung or cns metastases, impeding organ failure or hemorrhage	94.12%	16
D: Abstain	5.88%	1
GESAMT		17

F2 Contralateral testicular biopsy in patients with an unilateral germ-cell tumor

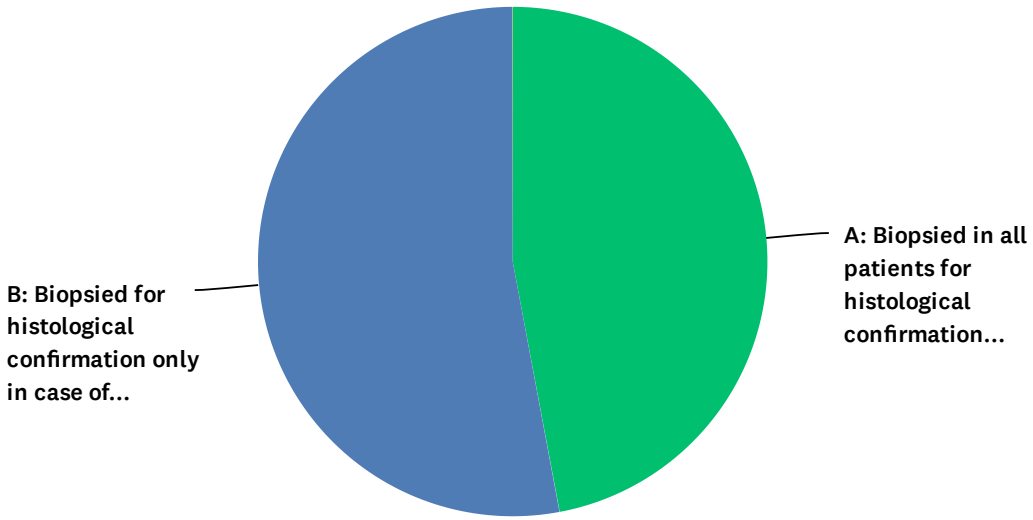
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should be recommended in all patients with a unilateral germ-cell tumor	5.88%	1
B: Should be recommended only in patients with known risk factors (history of maldescensus, low volume or infertility)	82.35%	14
C: Should not be recommended at all	11.76%	2
D: Abstain	0.00%	0
GESAMT		17

F3 Primary extragonadal tumors should have the extragonadal primary

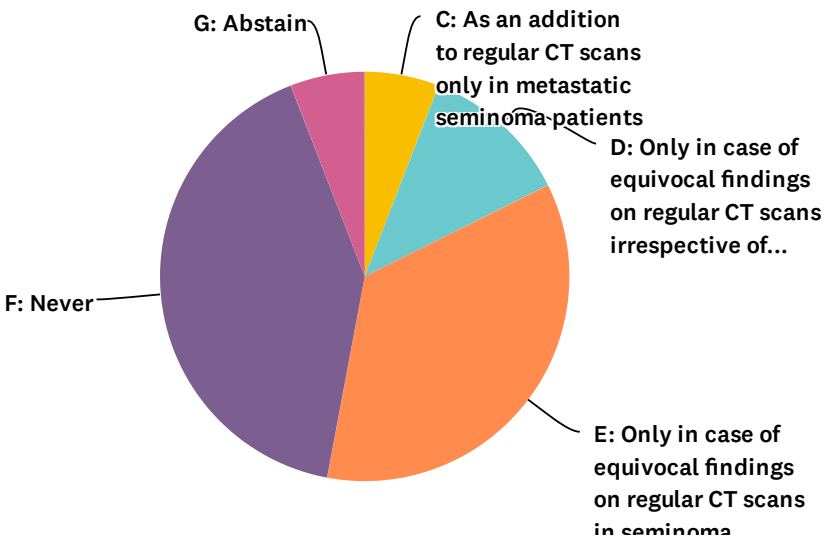
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Biopsied in all patients for histological confirmation irrespective of tumor marker constellation	47.06%	8
B: Biopsied for histological confirmation only in case of equivocal tumor marker constellation	52.94%	9
C: Abstain	0.00%	0
GESAMT		17

F4 PET-CT should be performed as part of initial diagnostic procedures in patients without contraindications to regular CT scans

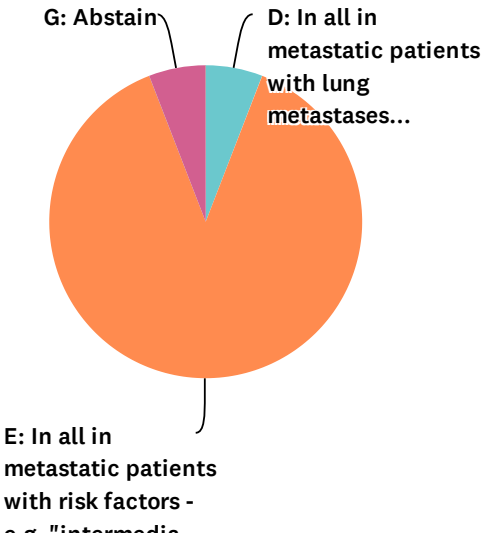
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: As an alternative to regular CT scans in all patients	0.00%	0
B: As an alternative to regular CT scans only seminoma patients	0.00%	0
C: As an addition to regular CT scans only in metastatic seminoma patients	5.88%	1
D: Only in case of equivocal findings on regular CT scans irrespective of histology	11.76%	2
E: Only in case of equivocal findings on regular CT scans in seminoma patients	35.29%	6
F: Never	41.18%	7
G: Abstain	5.88%	1
GESAMT		17

F5 MRI of the brain should be part of the initial diagnostic procedures

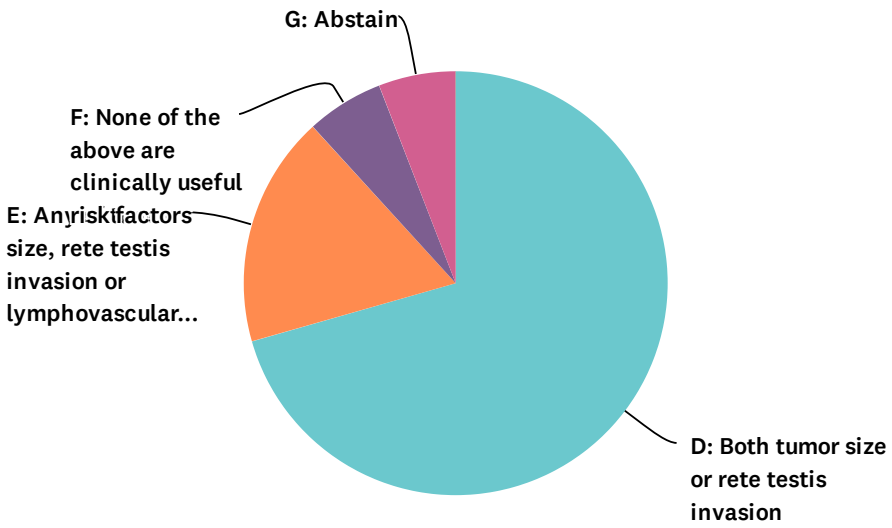
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: In all patients	0.00%	0
B: In all metastatic patients	0.00%	0
C: In all metastatic non-seminoma patients	0.00%	0
D: In all in metastatic patients with lung metastases independent of IGCCCG prognostic group	5.88%	1
E: In all in metastatic patients with risk factors - e.g. "intermediate" prognosis with lung metastases as well as all "poor" prognosis or symptomatic patients	88.24%	15
F: Only in symptomatic patients	0.00%	0
G: Abstain	5.88%	1
GESAMT		17

F6 What do you consider clinically useful risk factors in stage I seminoma

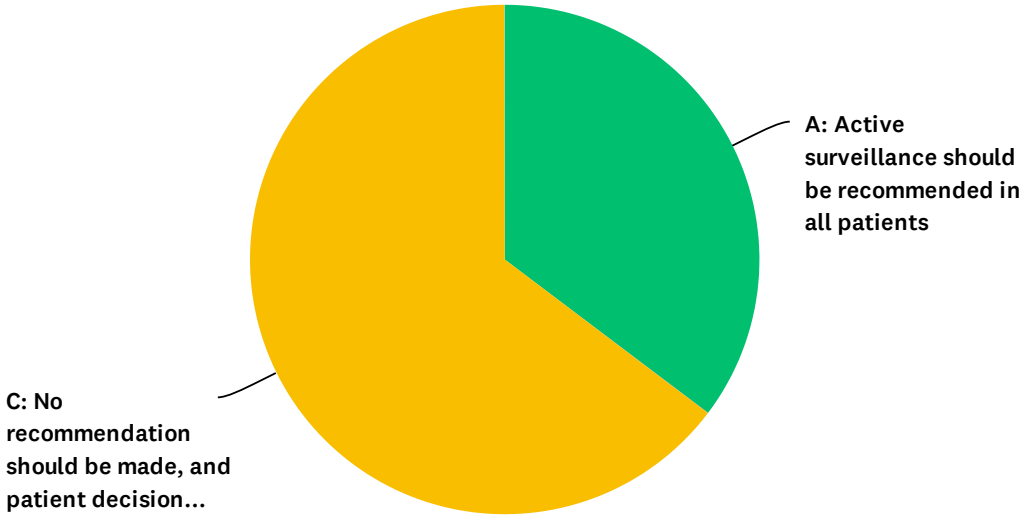
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Only tumor size > 4 cm	0.00%	0
B: Only rete testis invasion	0.00%	0
C: Only lymphovascular invasion	0.00%	0
D: Both tumor size or rete testis invasion	70.59%	12
E: Any of tumor size, rete testis invasion or lymphovascular invasion	17.65%	3
F: None of the above are clinically useful risk factors	5.88%	1
G: Abstain	5.88%	1
GESAMT		17

F7 Active surveillance in patients with seminoma stage I in whom good compliance is expected

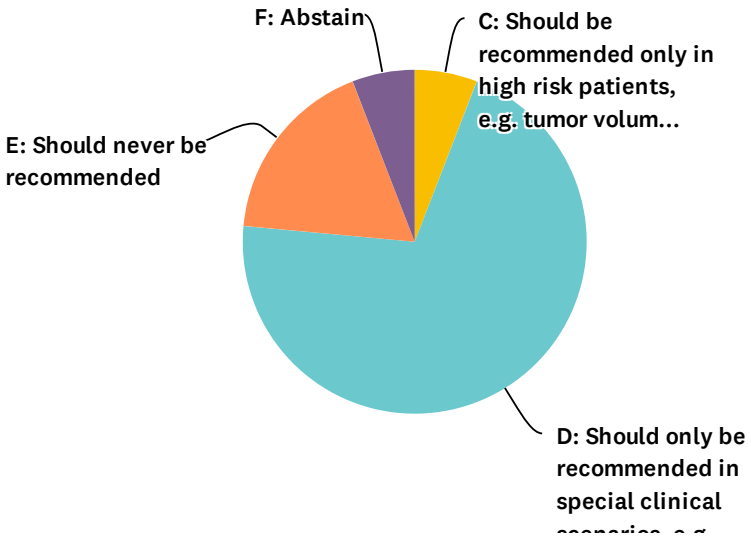
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Active surveillance should be recommended in all patients	35.29%	6
B: Active surveillance should be recommended only in low risk patients, e.g. tumor volume < 4 cm and no infiltration of the rete testis	0.00%	0
C: No recommendation should be made, and patient decision accepted after full information about "pro & cons" of available treatment options	64.71%	11
D: Abstain	0.00%	0
GESAMT		17

F8 Adjuvant radiotherapy in patients with seminoma stage I

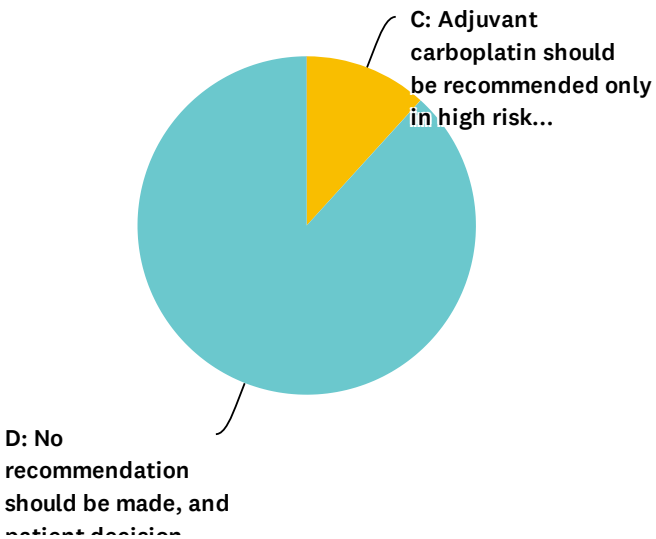
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should be recommended in all patients	0.00%	0
B: Should be recommended only in high risk patients, e.g. tumor volume > 4 cm or infiltration of the rete testis	0.00%	0
C: Should be recommended only in high risk patients, e.g. tumor volume > 4 cm and infiltration of the rete testis	5.88%	1
D: Should only be recommended in special clinical scenarios, e.g. in elderly or frail patients in whom long-term toxicity is of less importance or in patients with contraindications to chemotherapy	70.59%	12
E: Should never be recommended	17.65%	3
F: Abstain	5.88%	1
GESAMT		17

F9 Adjuvant treatment with carboplatin in patients with seminoma stage I in whom good compliance is expected

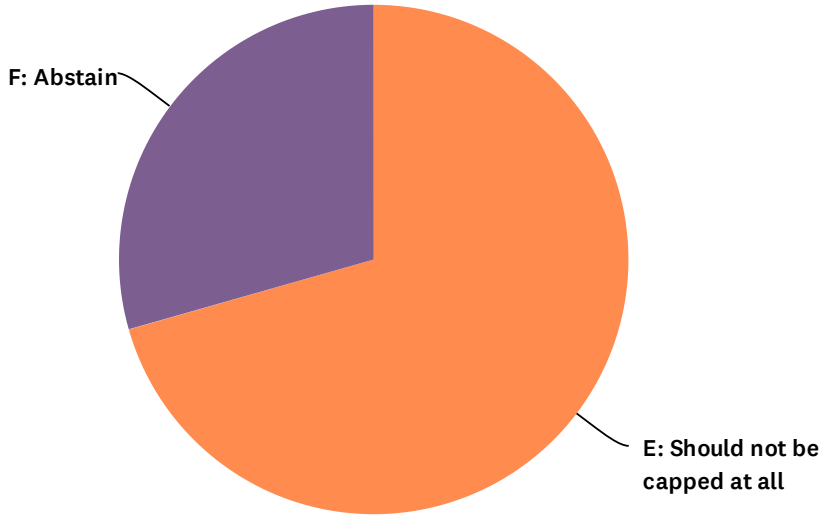
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Adjuvant carboplatin should be recommended in all patients	0.00%	0
B: Adjuvant carboplatin should be recommended only in high risk patients with one risk factor present, e.g. tumor volume > 4 cm or infiltration of the rete testis	0.00%	0
C: Adjuvant carboplatin should be recommended only in high risk patients with two risk factors present, e.g. tumor volume > 4 cm and infiltration of the rete testis	11.76%	2
D: No recommendation should be made, and patient decision accepted after full information about "pro & cons" of available treatment options	88.24%	15
E: Abstain	0.00%	0
GESAMT		17

F10 Adjuvant carboplatin AUC 7 in patients with plausible GFR measurements

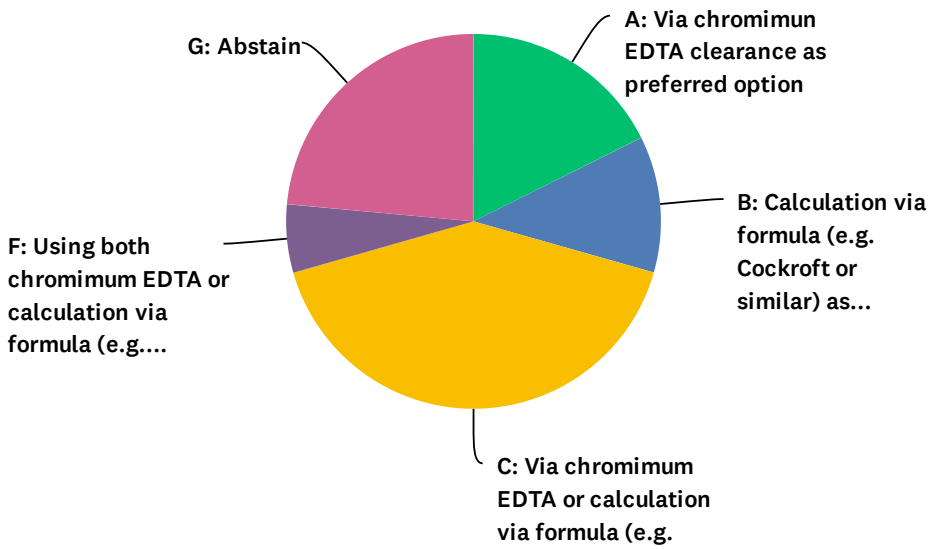
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should be capped in patients with a high renal function at a GFR of 120 ml/min	0.00%	0
B: Should be capped in patients with a high renal function at 1000 mg absolute dose	0.00%	0
C: Should be capped in patients with a high renal function at a GFR of 150 ml/min	0.00%	0
D: Should be capped in patients with a high renal function at 1200 mg absolute dose	0.00%	0
E: Should not be capped at all	70.59%	12
F: Abstain	29.41%	5
GESAMT		17

F11 Glomerular filtration rate (GFR) should be determined

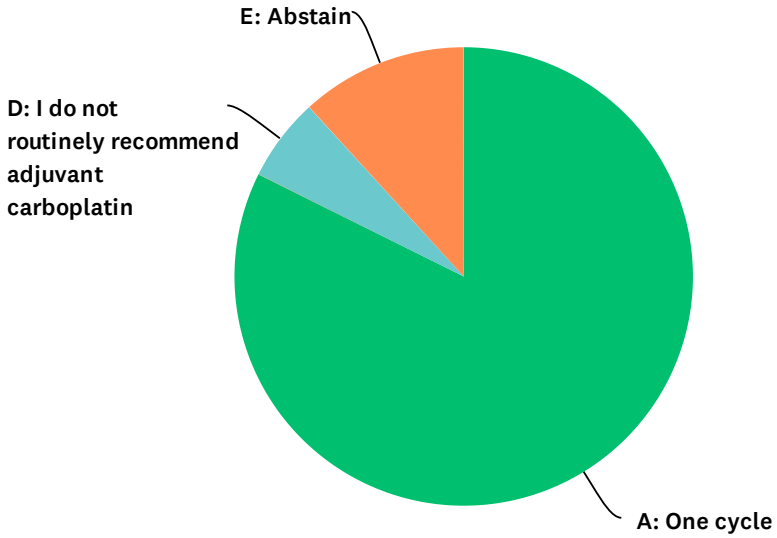
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Via chromimun EDTA clearance as preferred option	17.65%	3
B: Calculation via formula (e.g. Cockroft or similar) as preferred option	11.76%	2
C: Via chromimum EDTA or calculation via formula (e.g. Cockroft or similar) as equal options	41.18%	7
D: Using both chromimum EDTA or calculation via formula (e.g. Cockroft or similar) and take the lower result	0.00%	0
E: Using both chromimum EDTA or calculation via formula (e.g. Cockroft or similar) and take the higher result	0.00%	0
F: Using both chromimum EDTA or calculation via formula (e.g. Cockroft or similar) and take the middle or more plausible value	5.88%	1
G: Abstain	23.53%	4
GESAMT		17

F12 How many cycles of adjuvant carboplatin do you routinely recommend

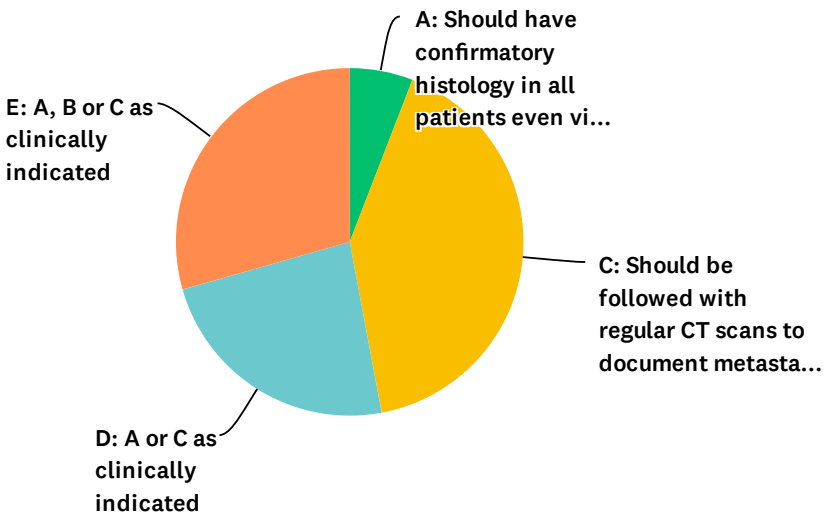
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: One cycle	82.35%	14
B: Two cycles	0.00%	0
C: One or two cycles depending on risk factors	0.00%	0
D: I do not routinely recommend adjuvant carboplatin	5.88%	1
E: Abstain	11.76%	2
GESAMT		17

F13 Outside SAKK 01/18 patients with stage IIA seminoma, but equivocal findings on regular CT scans and no HCG elevation post orchiectomy

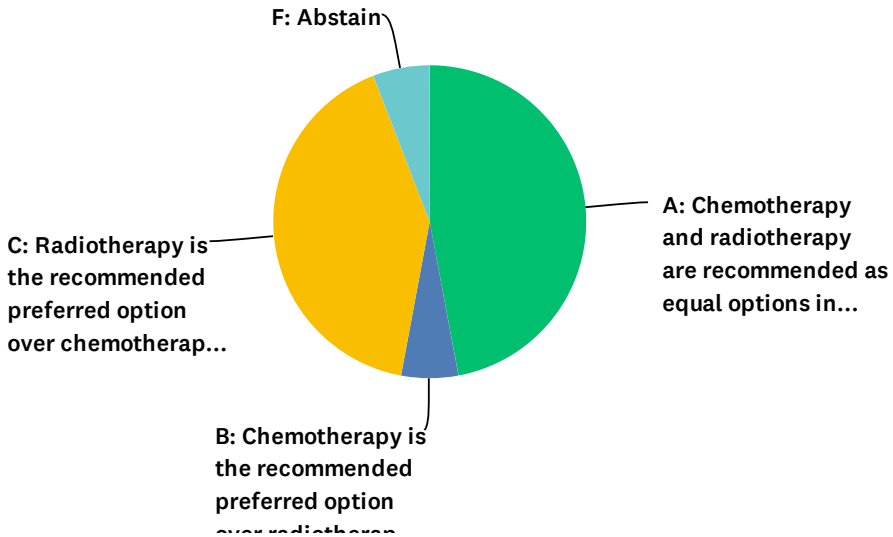
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should have confirmatory histology in all patients even via RPLND if necessary	5.88%	1
B: Should have confirmatory PET-CT scan in all patients	0.00%	0
C: Should be followed with regular CT scans to document metastatic seminoma via radiological progression	41.18%	7
D: A or C as clinically indicated	23.53%	4
E: A, B or C as clinically indicated	29.41%	5
F Abstain	0.00%	0
GESAMT		17

F14 Outside SAKK 01/18 in patients with stage IIA seminoma

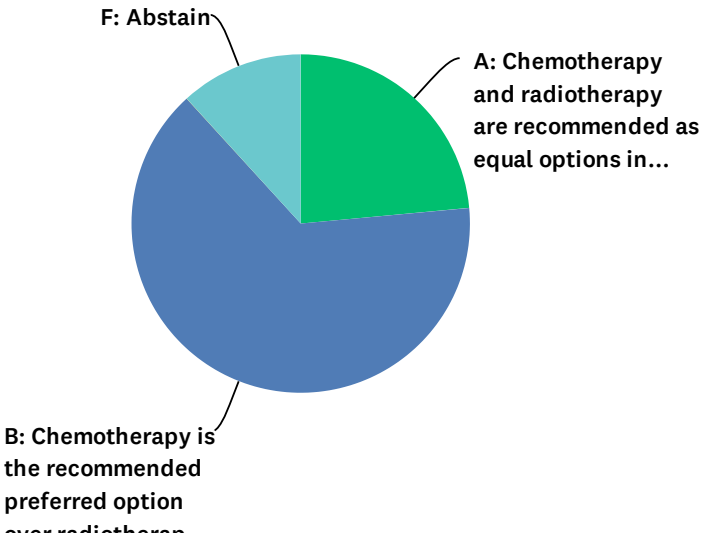
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Chemotherapy and radiotherapy are recommended as equal options in all seminoma stage IIA patients	47.06%	8
B: Chemotherapy is the recommended preferred option over radiotherapy in all stage IIA seminoma patients	5.88%	1
C: Radiotherapy is the recommended preferred option over chemotherapy in stage IIA seminoma patients	41.18%	7
F: Abstain	5.88%	1
GESAMT		17

F15 Outside SAKK 01/18 in patients with stage IIB seminoma

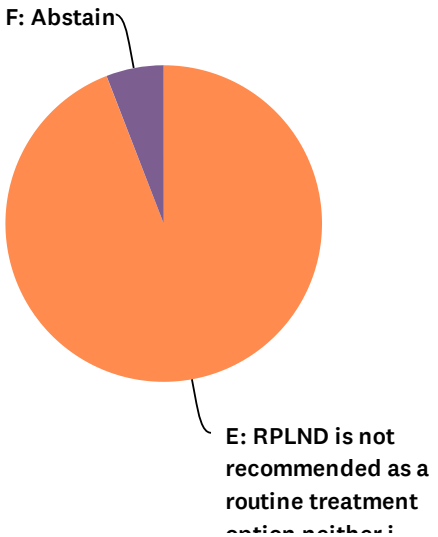
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Chemotherapy and radiotherapy are recommended as equal options in all seminoma stage IIB patients	23.53%	4
B: Chemotherapy is the recommended preferred option over radiotherapy in all stage IIB seminoma patients	64.71%	11
C: Radiotherapy is the recommended preferred option over chemotherapy in stage IIB seminoma patients	0.00%	0
F: Abstain	11.76%	2
GESAMT		17

F16 Outside SAKK 01/18 in patients with stage IIA/B seminoma

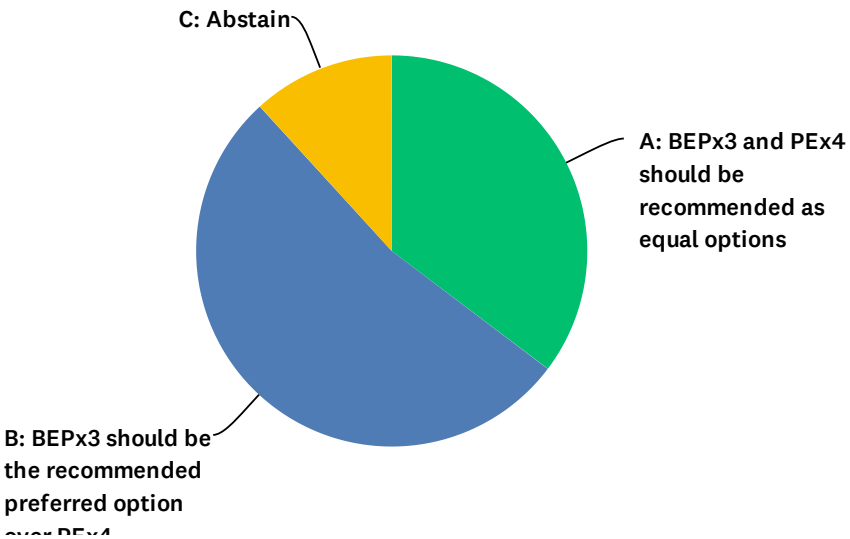
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: RPLND is the recommended preferred option over chemotherapy and radiotherapy in all stage IIA/B seminoma patients	0.00%	0
B: RPLND is the recommended preferred option over chemotherapy and radiotherapy only in stage IIA seminoma patients	0.00%	0
C: RPLND in an equal option to chemotherapy and radiotherapy in all stage IIA/B seminoma patients	0.00%	0
D: RPLND is an equal option to chemotherapy and radiotherapy only in stage IIA seminoma patients	0.00%	0
E: RPLND is not recommended as a routine treatment option neither in stage IIA nor in stage B seminoma patients	94.12%	16
F: Abstain	5.88%	1
GESAMT		17

F17 In patients with "good" prognosis metastatic seminoma who are suitable for bleomycin treatment

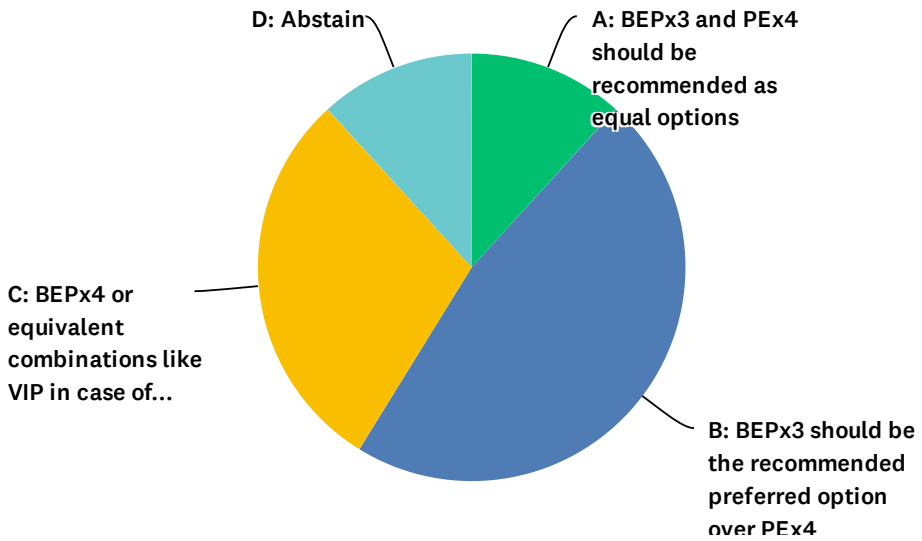
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: BEPx3 and PEx4 should be recommended as equal options	35.29%	6
B: BEPx3 should be the recommended preferred option over PEx4	52.94%	9
C: Abstain	11.76%	2
GESAMT		17

F18 "Good prognosis" seminoma patients, but with a high LDH > 2.5 times the upper limit of normal

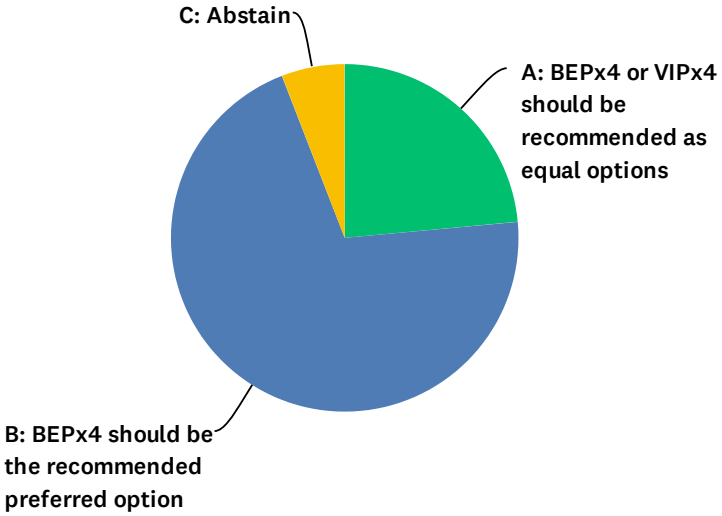
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: BEPx3 and PEx4 should be recommended as equal options	11.76%	2
B: BEPx3 should be the recommended preferred option over PEx4	47.06%	8
C: BEPx4 or equivalent combinations like VIP in case of contraindications to bleomycin should be recommended rather than BEPx3 or PEx4	29.41%	5
D: Abstain	11.76%	2
GESAMT		17

F19 In patients with "intermediate" prognosis metastatic seminoma who are suitable for bleomycin treatment

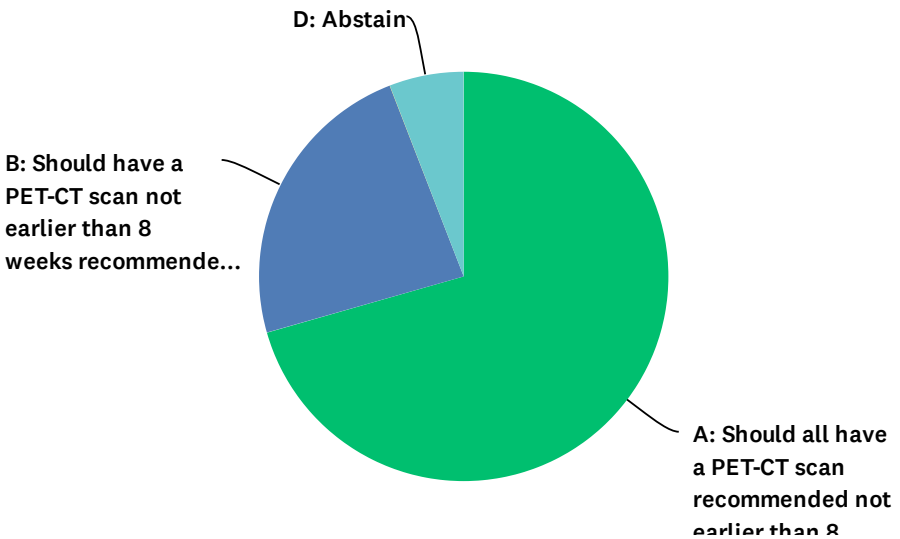
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: BEPx4 or VIPx4 should be recommended as equal options	23.53%	4
B: BEPx4 should be the recommended preferred option	70.59%	12
C: Abstain	5.88%	1
GESAMT		17

F20 Seminoma patients with residual tumors > 3 cm after curative-intent chemotherapy

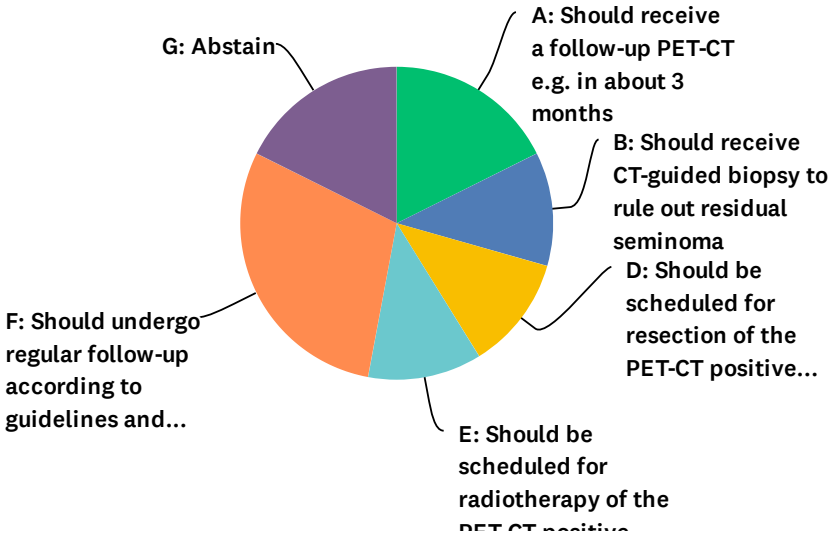
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should all have a PET-CT scan recommended not earlier than 8 weeks after the last chemotherapy dose	70.59%	12
B: Should have a PET-CT scan not earlier than 8 weeks recommended only as an alternative to follow-up with regular CT/MRI scans	23.53%	4
C: Should have no PET-CT scan recommended at all and should be followed with regular CT/MRI scans	0.00%	0
D: Abstain	5.88%	1
GESAMT		17

F21 Seminoma patients with residual tumors > 3 cm after curative-intent chemotherapy and positive residuals in a PET-CT scan not earlier than 8 weeks after chemotherapy

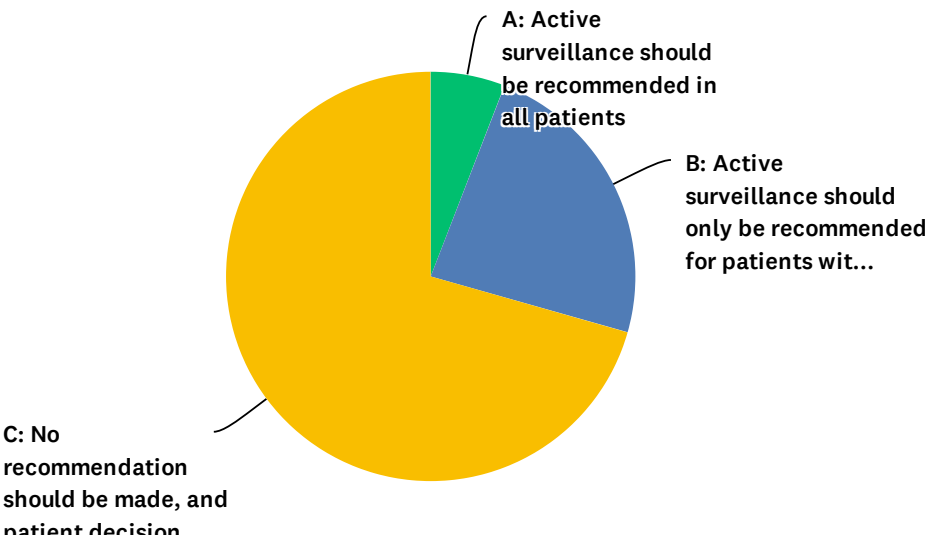
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should receive a follow-up PET-CT e.g. in about 3 months	17.65%	3
B: Should receive CT-guided biopsy to rule out residual seminoma	11.76%	2
D: Should be scheduled for resection of the PET-CT positive residuals, if feasible	11.76%	2
E: Should be scheduled for radiotherapy of the PET-CT positive residuals	11.76%	2
F: Should undergo regular follow-up according to guidelines and receive salvage treatment in case of progression	29.41%	5
G: Abstain	17.65%	3
GESAMT		17

F22 Active surveillance in patients with non-seminoma stage I in whom good compliance is expected

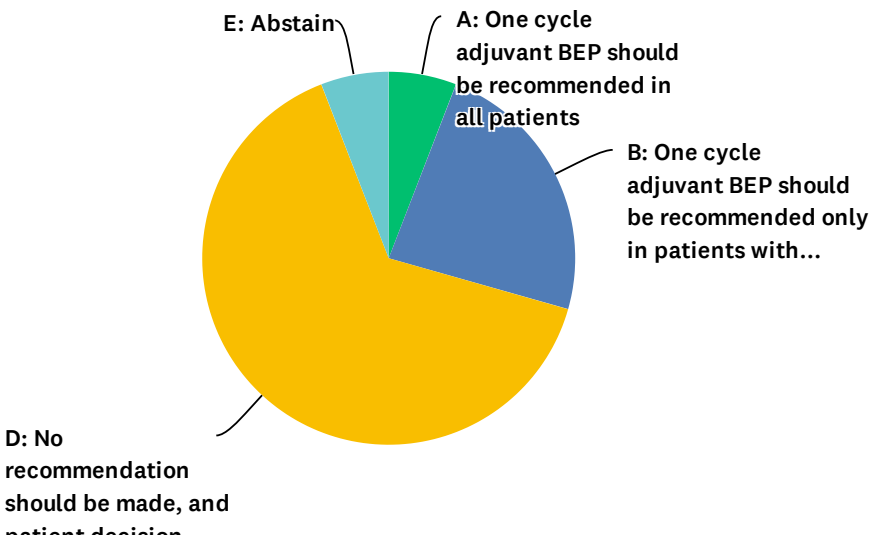
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Active surveillance should be recommended in all patients	5.88%	1
B: Active surveillance should only be recommended for patients with no lympovascular invasion ("low risk" patients)	23.53%	4
C: No recommendation should be made, and patient decision accepted after full information about "pro & cons" of available treatment options	70.59%	12
D: Abstain	0.00%	0
GESAMT		17

F23 Adjuvant treatment with one cycle of BEP in patients with non-seminoma stage I in whom good compliance is expected

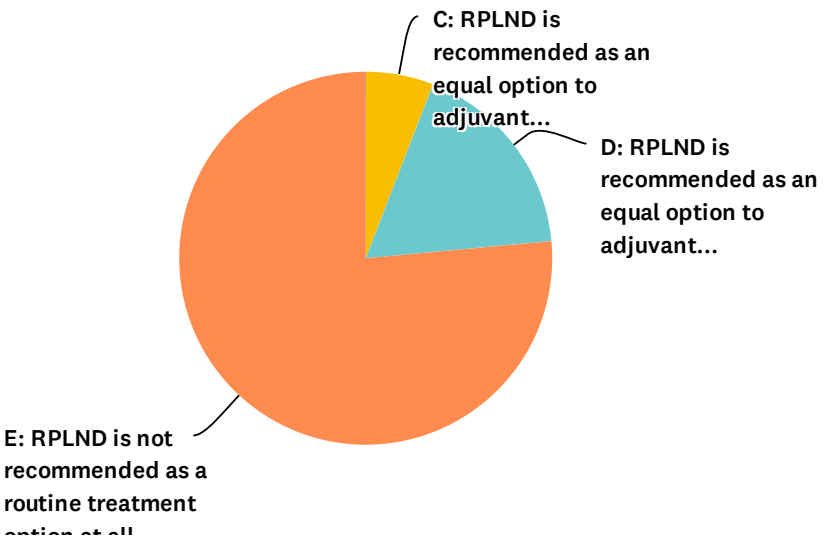
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: One cycle adjuvant BEP should be recommended in all patients	5.88%	1
B: One cycle adjuvant BEP should be recommended only in patients with lymphovascular invasion ("high risk" patients")	23.53%	4
D: No recommendation should be made, and patient decision accepted after full information about "pro & cons" of available treatment options	64.71%	11
E: Abstain	5.88%	1
GESAMT		17

F24 RPLND in patients with non-seminoma stage I in whom good compliance is expected and no teratoma in the primary tumor

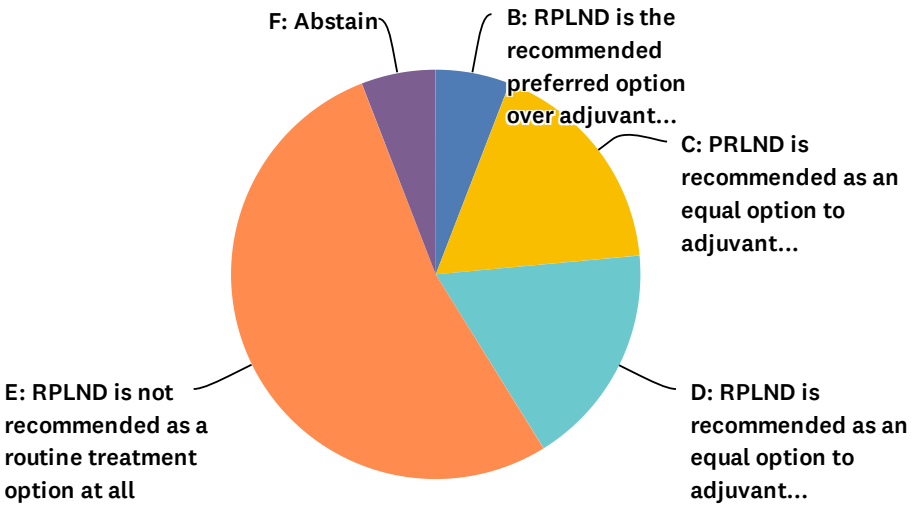
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: RPLND is the recommended preferred option over adjuvant chemotherapy and active surveillance in all patients	0.00%	0
B: RPLND is the recommended preferred option over adjuvant chemotherapy and active surveillance only in "high-risk" patients with evidence of lymphovascular invasion	0.00%	0
C: RPLND is recommended as an equal option to adjuvant chemotherapy and active surveillance in all patients	5.88%	1
D: RPLND is recommended as an equal option to adjuvant chemotherapy and active surveillance only in "high-risk" patients, e.g. with evidence of lymphovascular invasion	17.65%	3
E: RPLND is not recommended as a routine treatment option at all	76.47%	13
F: Abstain	0.00%	0
GESAMT		17

F25 RPLND in patients with non-seminoma stage I in whom good compliance is expected and only some teratoma in the primary tumor (any percentage < 100%)

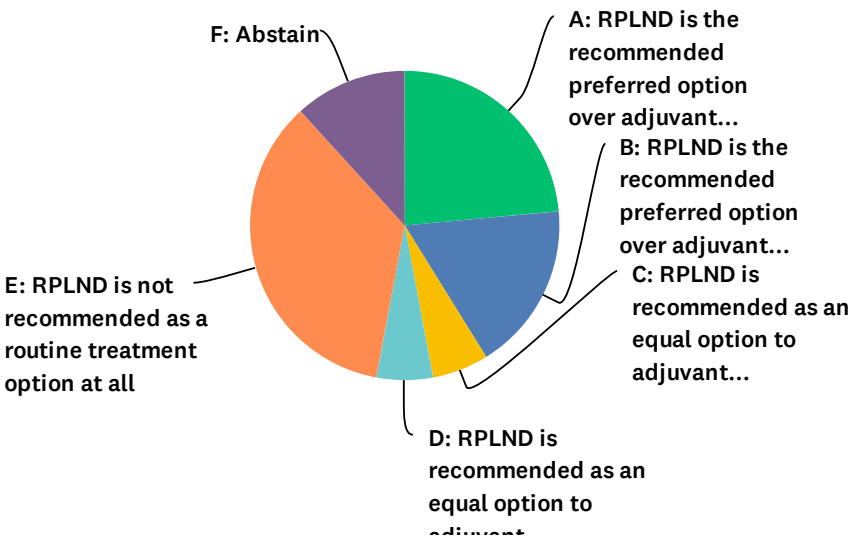
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: RPLND is the recommended preferred option over adjuvant chemotherapy and active surveillance in all patients	0.00%	0
B: RPLND is the recommended preferred option over adjuvant chemotherapy and active surveillance only in "high-risk" patients with evidence of lymphovascular invasion	5.88%	1
C: PRLND is recommended as an equal option to adjuvant chemotherapy and active surveillance in all patients	17.65%	3
D: RPLND is recommended as an equal option to adjuvant chemotherapy and active surveillance only in "high-risk" patients, e.g. with evidence of lymphovascular invasion	17.65%	3
E: RPLND is not recommended as a routine treatment option at all	52.94%	9
F: Abstain	5.88%	1
GESAMT		17

F26 RPLND in patients with non-seminoma stage I with pure teratoma (100%) in the primary tumor in whom good compliance is expected

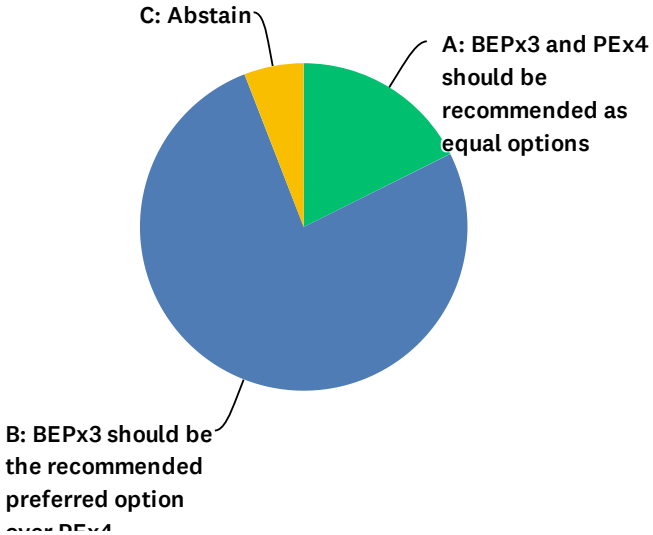
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: RPLND is the recommended preferred option over adjuvant chemotherapy and active surveillance in all patients	23.53%	4
B: RPLND is the recommended preferred option over adjuvant chemotherapy and active surveillance only in "high-risk" patients with evidence of lymphovascular invasion	17.65%	3
C: RPLND is recommended as an equal option to adjuvant chemotherapy and active surveillance in all patients	5.88%	1
D: RPLND is recommended as an equal option to adjuvant chemotherapy and active surveillance only in "high-risk" npatients, e.g. with evidence of lymphovascular invasion	5.88%	1
E: RPLND is not recommended as a routine treatment option at all	35.29%	6
F: Abstain	11.76%	2
GESAMT		17

F27 In patients with "good" prognosis metastatic non-seminoma who are suitable for bleomycin treatment

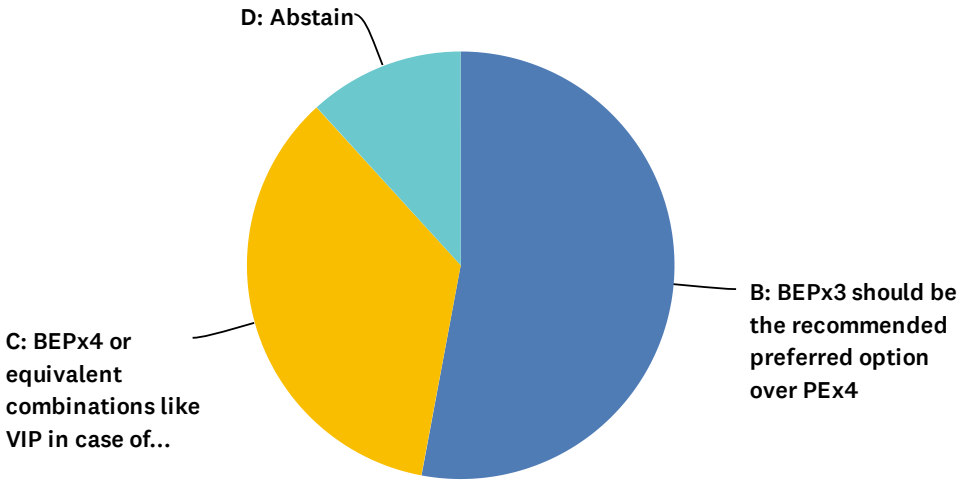
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: BEPx3 and PEx4 should be recommended as equal options	17.65%	3
B: BEPx3 should be the recommended preferred option over PEx4	76.47%	13
C: Abstain	5.88%	1
GESAMT		17

F28 "Good prognosis" non-seminoma patients, but with a high LDH > 2.5 times the upper limit of normal as the only risk factor for classifying as "intermediate" prognosis

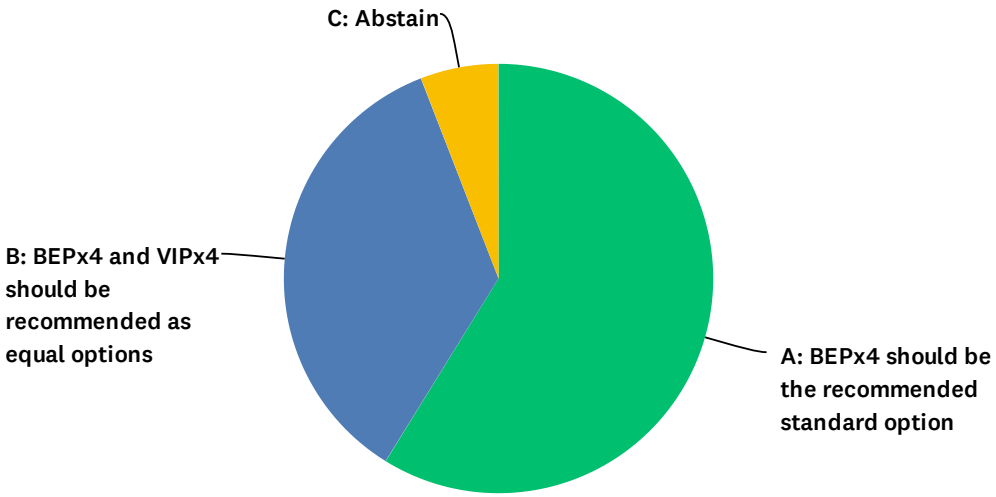
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: BEPx3 and PEx4 should be recommended as equal options	0.00%	0
B: BEPx3 should be the recommended preferred option over PEx4	52.94%	9
C: BEPx4 or equivalent combinations like VIP in case of contraindications to bleomycin should be recommended rather than BEPx3 or PEx4	35.29%	6
D: Abstain	11.76%	2
GESAMT		17

F29 In patients with "intermediate" prognosis metastatic non-seminoma who are suitable for bleomycin treatment

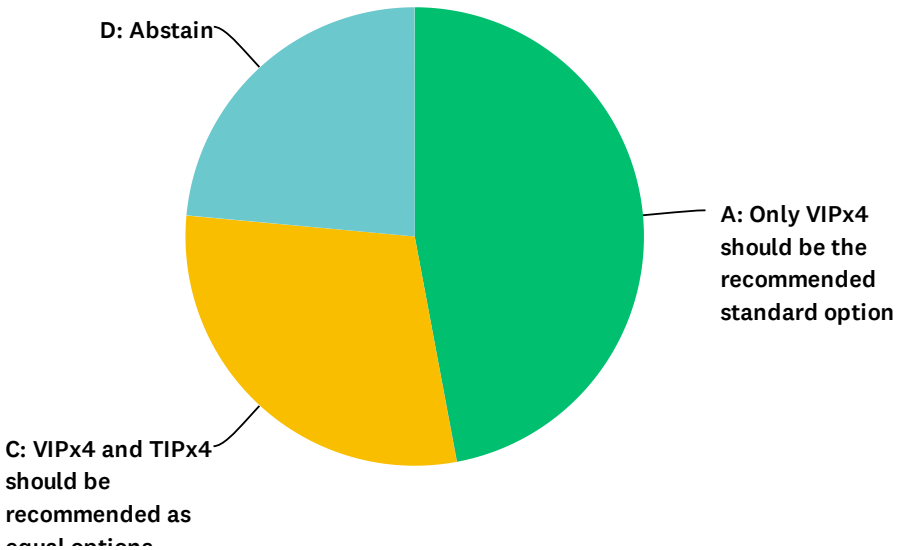
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: BEPx4 should be the recommended standard option	58.82%	10
B: BEPx4 and VIPx4 should be recommended as equal options	35.29%	6
C: Abstain	5.88%	1
GESAMT		17

F30 In patients with "intermediate" prognosis metastatic non-seminoma who are not suitable for bleomycin treatment

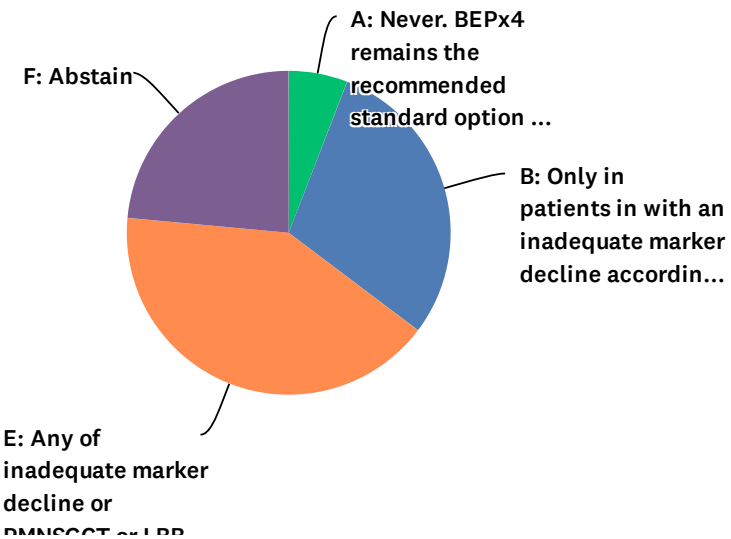
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Only VIPx4 should be the recommended standard option	47.06%	8
B: Only TIPx4 should be the recommended standard option	0.00%	0
C: VIPx4 and TIPx4 should be recommended as equal options	29.41%	5
D: Abstain	23.53%	4
GESAMT		17

F31 In patients with "poor" prognosis metastatic non-seminoma: when would you recommend treatment intensification?

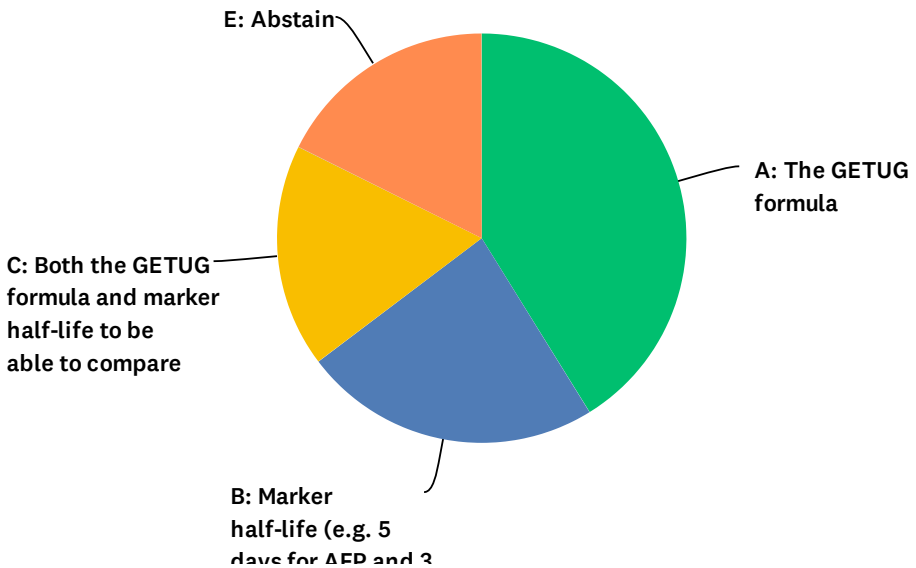
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Never. BEPx4 remains the recommended standard option in all "poor" prognosis metastatic non-seminoma	5.88%	1
B: Only in patients in with an inadequate marker decline according to marker half-life or the GETUG formula	29.41%	5
C: Only in patients with primary mediastinal germ-cell tumors (PMNSGCT)	0.00%	0
D: Only in patients with liver, bone or brain metastases (LBB)	0.00%	0
E: Any of inadequate marker decline or PMNSGCT or LBB	41.18%	7
F: Abstain	23.53%	4
GESAMT		17

F32 Which method do you use to assess marker decline

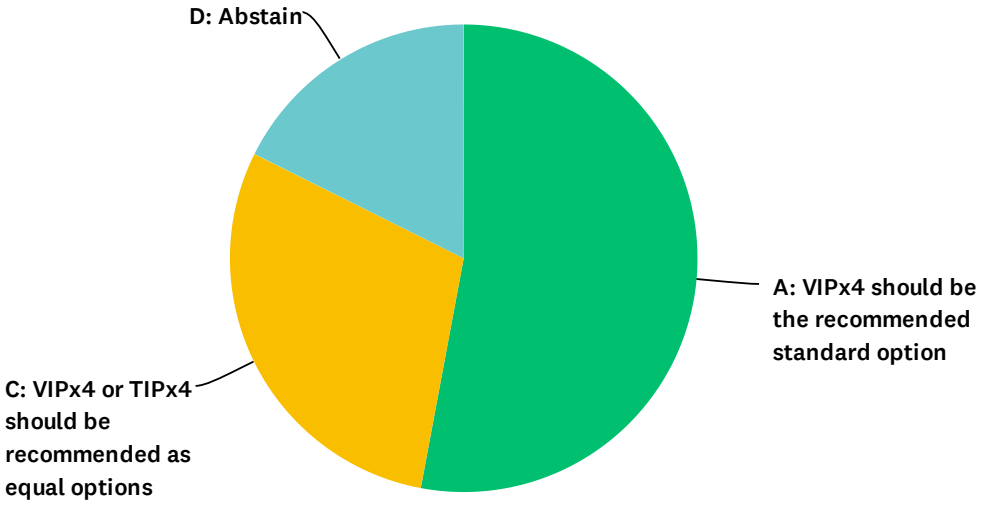
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: The GETUG formula	41.18%	7
B: Marker half-life (e.g. 5 days for AFP and 3 days for hCG)	23.53%	4
C: Both the GETUG formula and marker half-life to be able to compare	17.65%	3
D: I not use marker decline as a risk assessment tool in my clinical practice	0.00%	0
E: Abstain	17.65%	3
GESAMT		17

F33 In patients with "poor" prognosis metastatic non-seminoma who are not suitable for bleomycin treatment and in whom no treatment intensification is indicated

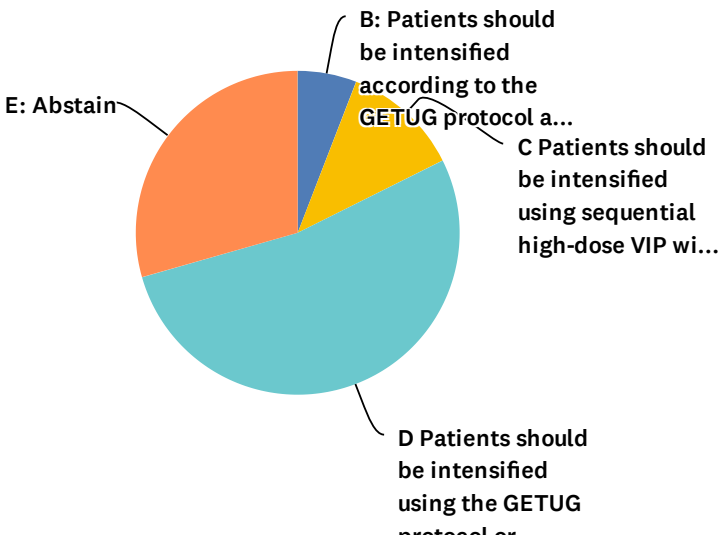
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: VIPx4 should be the recommended standard option	52.94%	9
B: TIPx4 should be the recommended standard option	0.00%	0
C: VIPx4 or TIPx4 should be recommended as equal options	29.41%	5
D: Abstain	17.65%	3
GESAMT		17

F34 In patients with "poor" prognosis metastatic non-seminoma who have an inadequate marker decline either by marker half-life or GETUG fomula

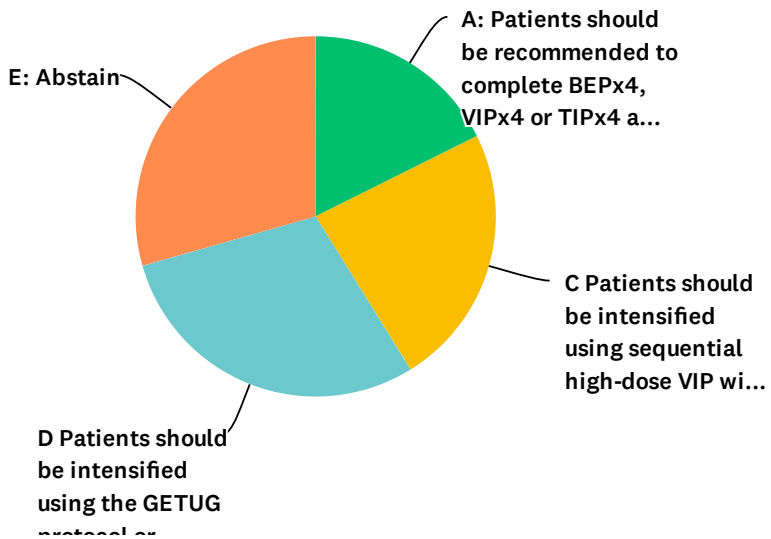
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Patients should be recommended to complete BEPx4, VIPx4 or TIPx4 as the standard option	0.00%	0
B: Patients should be intensified according to the GETUG protocol as the preferred option	5.88%	1
C Patients should be intensified using sequential high-dose VIP with autologous hematopoietic progenitor cells (GTCSG protocol)	11.76%	2
D Patients should be intensified using the GETUG protocol or sequential high-dose VIP with autologous hematopoietic progenitor cells (GTCSG protocol) as equal options	52.94%	9
E: Abstain	29.41%	5
GESAMT		17

F35 In patients with "poor" prognosis metastatic non-seminoma who have an a primary mediastinal non-seminoma

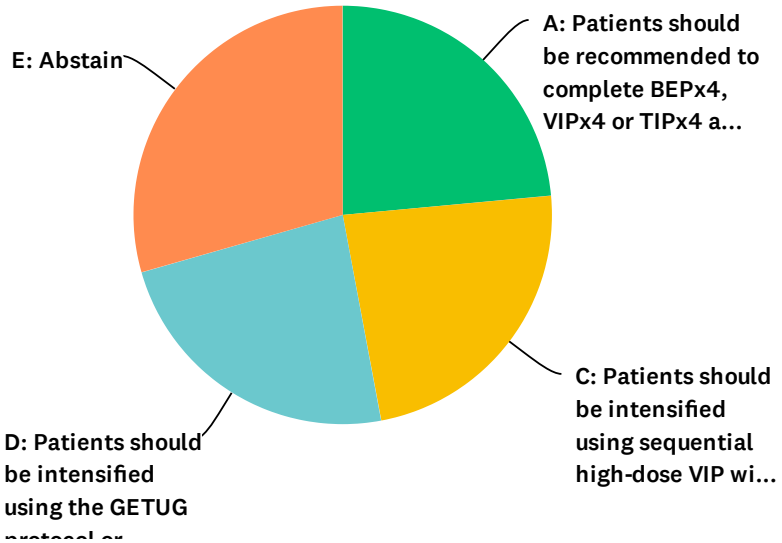
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Patients should be recommended to complete BEPx4, VIPx4 or TIPx4 as the standard option	17.65%	3
B: Patients should be intensified according to the GETUG protocol as the preferred option	0.00%	0
C Patients should be intensified using sequential high-dose VIP with autologous hematopoietic progenitor cells (GTCSG protocol)	23.53%	4
D Patients should be intensified using the GETUG protocol or sequential high-dose VIP with autologous hematopoietic progenitor cells (GTCSG protocol) as equal options	29.41%	5
E: Abstain	29.41%	5
GESAMT		17

F36 In patients with "poor" prognosis metastatic non-seminoma who have liver, bone or brain metastases

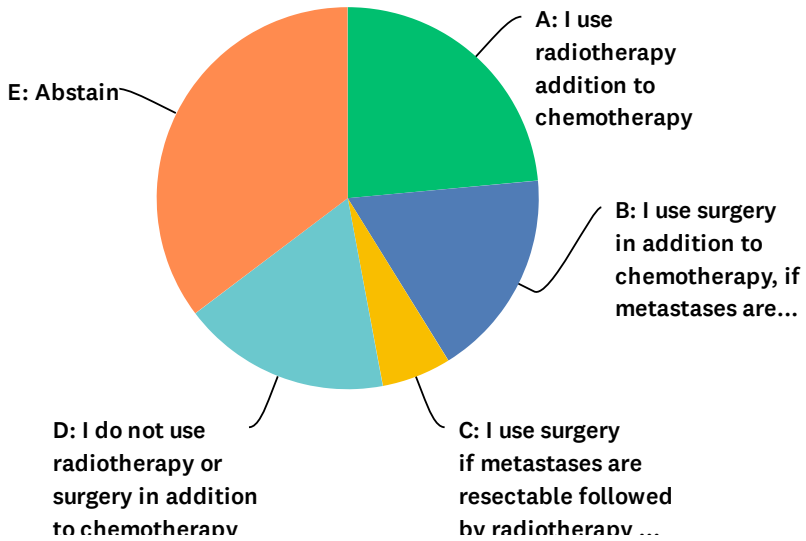
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Patients should be recommended to complete BEPx4, VIPx4 or TIPx4 as the standard option	23.53%	4
B: Patients should be intensified according to the GETUG protocol as the preferred option	0.00%	0
C: Patients should be intensified using sequential high-dose VIP with autologous hematopoietic progenitor cells (GTCSG protocol)	23.53%	4
D: Patients should be intensified using the GETUG protocol or sequential high-dose VIP with autologous hematopoietic progenitor cells (GTCSG protocol) as equal options	23.53%	4
E: Abstain	29.41%	5
GESAMT		17

F37 In patients with brain metastases at initial diagnosis who have no impeding risks such as bleeding, raised intracranial pressure or herniation

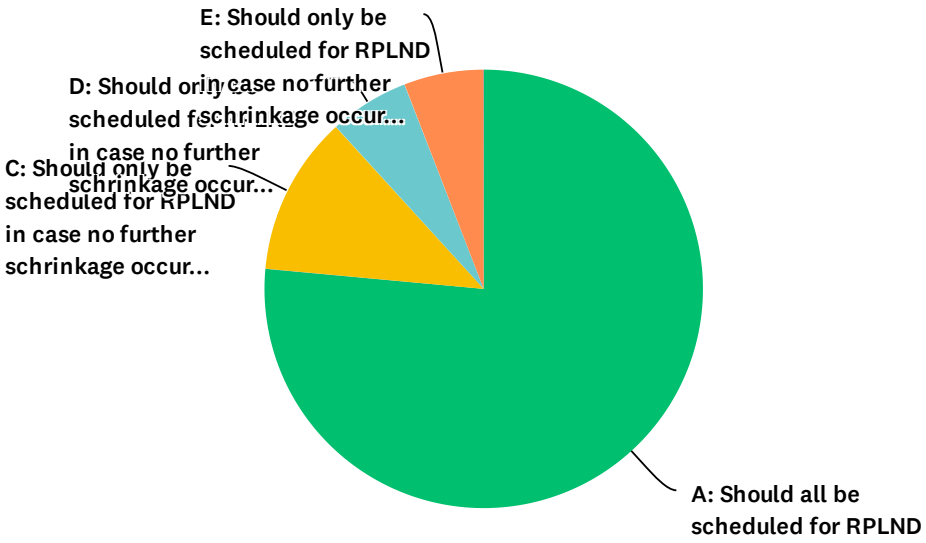
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: I use radiotherapy addition to chemotherapy	23.53%	4
B: I use surgery in addition to chemotherapy, if metastases are resectable	17.65%	3
C: I use surgery if metastases are resectable followed by radiotherapy in addition to chemotherapy	5.88%	1
D: I do not use radiotherapy or surgery in addition to chemotherapy	17.65%	3
E: Abstain	35.29%	6
GESAMT		17

F38 Patients with metastatic non-seminoma with normal tumor markers and residual retroperitoneal tumors > 1 cm after first-line chemotherapy

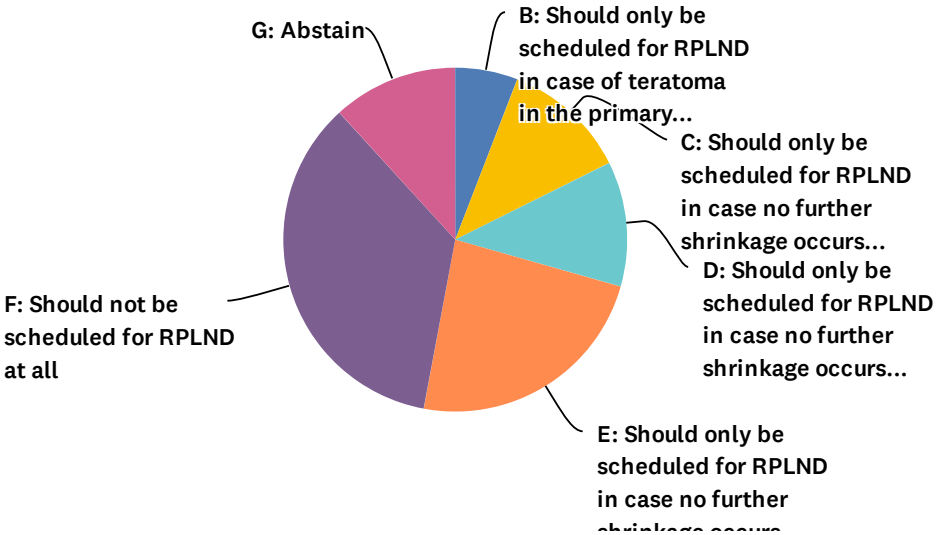
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should all be scheduled for RPLND	76.47%	13
B: Should only be scheduled for RPLND in case of teratoma in the primary tumor	0.00%	0
C: Should only be scheduled for RPLND in case no further schrinkage occurs on a follow-up CT/MRI scan irrespective of the histology of the primary tumor	11.76%	2
D: Should only be scheduled for RPLND in case no further schrinkage occurs on a follow-up CT scan or evidence of teratoma in the primary tumor	5.88%	1
E: Should only be scheduled for RPLND in case no further schrinkage occurs on a follow-up CT scan and evidence of teratoma in the primary tumor	5.88%	1
F: Should not be scheduled for routine RPLND at all	0.00%	0
G: Abstain	0.00%	0
GESAMT		17

F39 Patients with non-seminoma with normal tumor markers and post-chemotherapy residual retroperitoneal tumors < 1 cm after first-line chemotherapy

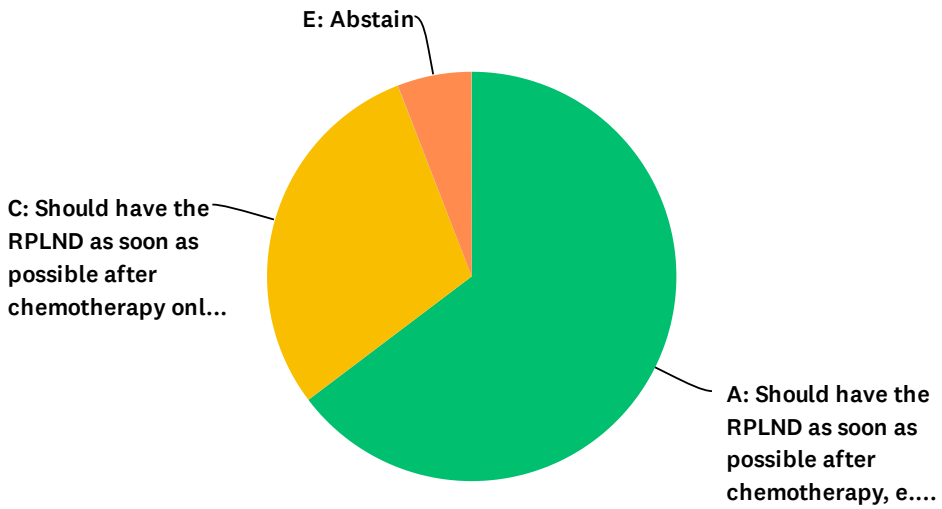
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should all be scheduled for RPLND	0.00%	0
B: Should only be scheduled for RPLND in case of teratoma in the primary tumor	5.88%	1
C: Should only be scheduled for RPLND in case no further shrinkage occurs on a follow-up CT/MRI scan irrespective of the histology of the primary tumor	11.76%	2
D: Should only be scheduled for RPLND in case no further shrinkage occurs on a follow-up CT scan or evidence of teratoma in the primary tumor	11.76%	2
E: Should only be scheduled for RPLND in case no further shrinkage occurs on a follow-up CT scan and evidence of teratoma in the primary tumor	23.53%	4
F: Should not be scheduled for RPLND at all	35.29%	6
G: Abstain	11.76%	2
GESAMT		17

F40 Patients with non-seminoma and residual retroperitoneal tumors > 1 cm and scheduled RPLND

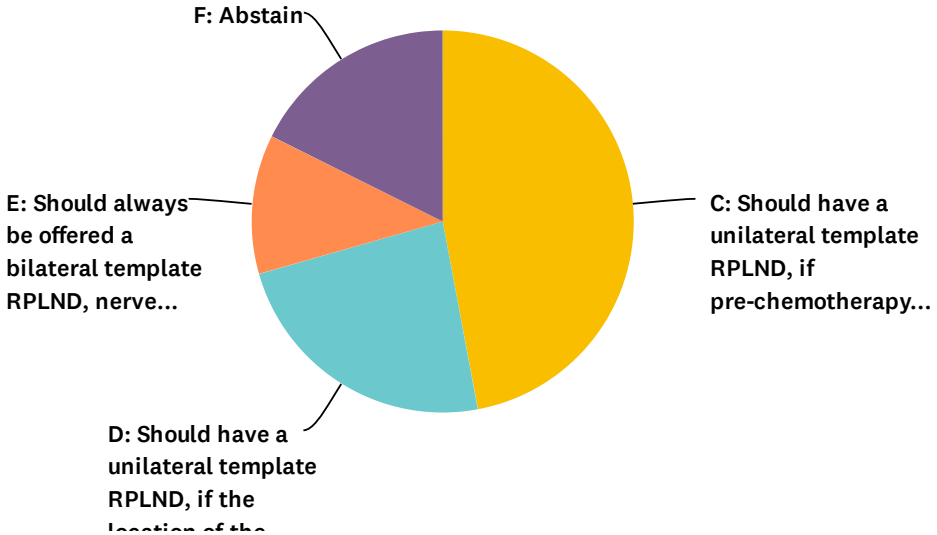
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should have the RPLND as soon as possible after chemotherapy, e.g. not later than 12 weeks after chemotherapy	64.71%	11
B: Should have the RPLND when no more shrinkage occurs on follow-up CT/MRI scans	0.00%	0
C: Should have the RPLND as soon as possible after chemotherapy only in "high risk" patients - e.g. "poor" prognosis initial presentation or a marker plateau after chemo as well as all patients after salvage chemotherapy. All other patients should have the RPLND when no more shrinkage occurs on follow-up CT/MRI scans	29.41%	5
D: Should not be scheduled for routine RPLND at all	0.00%	0
E: Abstain	5.88%	1
GESAMT		17

F41 Patients with non-seminoma and residual retroperitoneal tumors > 1 cm and scheduled RPLND

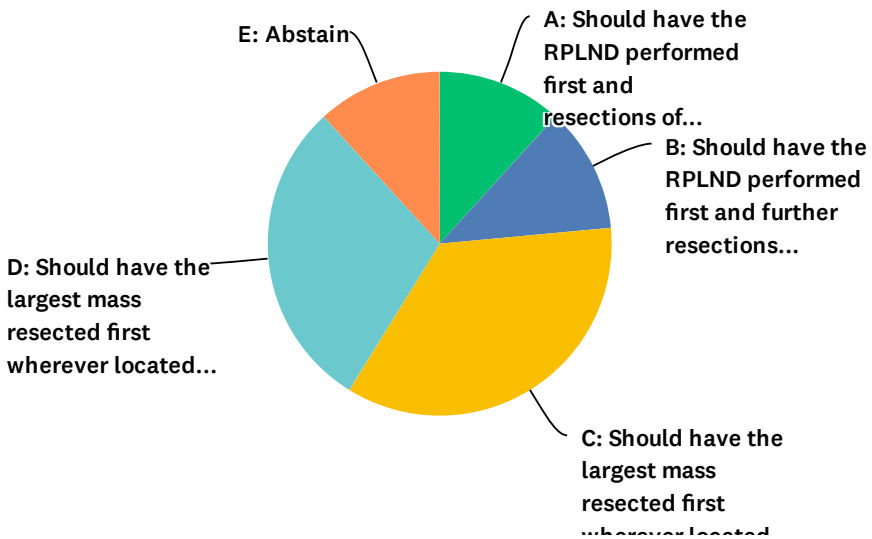
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should have the RPLND performed as resection only of visible residuals ("pick-up" lymphadenectomy)	0.00%	0
B: Should always be offered a unilateral template RPLND	0.00%	0
C: Should have a unilateral template RPLND, if pre-chemotherapy and post-chemotherapy scans showed unilateral retroperitoneal disease only (SWENOTECA rule)	47.06%	8
D: Should have a unilateral template RPLND, if the location of the residual mass <5 cm and corresponds to the primary landing zone of testis cancer (Heidenreich rule)	23.53%	4
E: Should always be offered a bilateral template RPLND, nerve sparing should be attempted if possible	11.76%	2
F: Abstain	17.65%	3
GESAMT		17

F42 Patients with gonadal or primary retroperitoneal non-seminoma and extra-retroperitoneal residuals after first-line chemotherapy

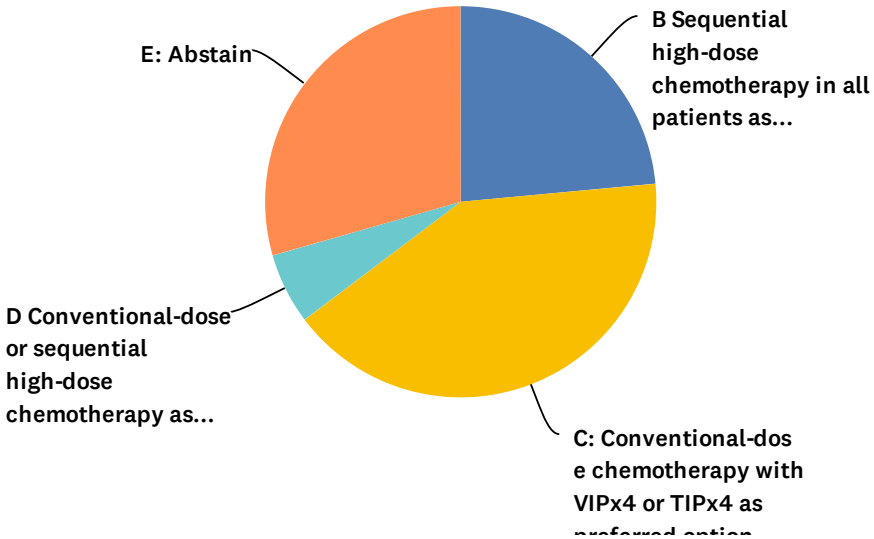
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should have the RPLND performed first and resections of further resectable residual lesions irrespective of the histology at RPLND	11.76%	2
B: Should have the RPLND performed first and further resections depending on the histology only in case of vital tumor and/or teratoma	11.76%	2
C: Should have the largest mass resected first wherever located followed by resection of other residual lesions irrespective of the histology	35.29%	6
D: Should have the largest mass resected first wherever located followed by resection of other residual lesions only in case of vital tumor and/or teratoma	29.41%	5
E: Abstain	11.76%	2
GESAMT		17

F43 Outside the prospective "TIGER" trial, patients with first relapse from a CR, NED, or PRm- after 3-4 cycles first-line chemotherapy should be offered

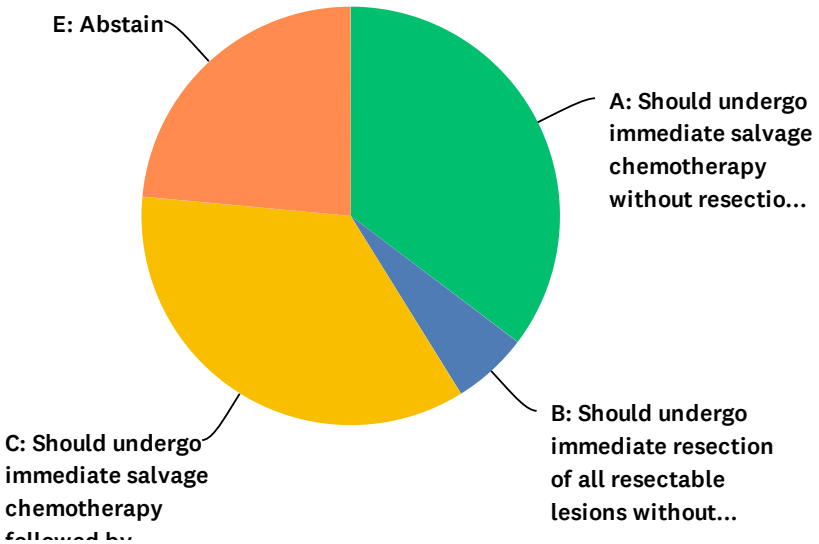
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Conventional-dose chemotherapy with VIPx4 or TIPx4 as preferred option in all patients irrespective of risk factors	0.00%	0
B Sequential high-dose chemotherapy in all patients as preferred option irrespective of risk factors	23.53%	4
C: Conventional-dose chemotherapy with VIPx4 or TIPx4 as preferred option in very low and low-risk patients and sequential high-dose chemotherapy as preferred option in all other patients	41.18%	7
D Conventional-dose or sequential high-dose chemotherapy as equal options irrespective of risk factors	5.88%	1
E: Abstain	29.41%	5
GESAMT		17

F44 Patients with histologically proven late relapse seminoma > 2 years after cisplatin-based curative intent first-line chemotherapy and resectable disease

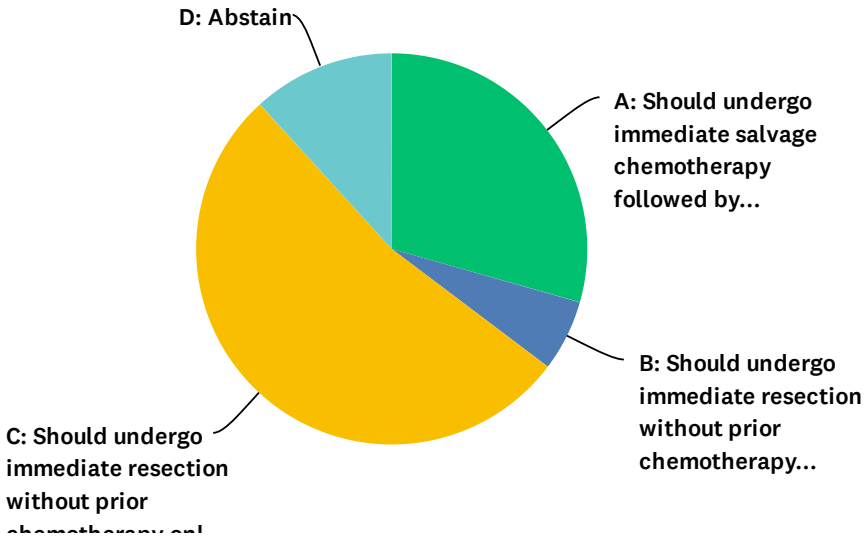
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should undergo immediate salvage chemotherapy without resection even if resectable lesions are present	35.29%	6
B: Should undergo immediate resection of all resectable lesions without prior salvage chemotherapy	5.88%	1
C: Should undergo immediate salvage chemotherapy followed by resection of all resectable lesions	35.29%	6
D: Should undergo radiotherapy	0.00%	0
E: Abstain	23.53%	4
GESAMT		17

F45 Patients with histologically proven late relapse non-seminoma > 2 years after cisplatin-based curative intent first-line chemotherapy and resectable disease

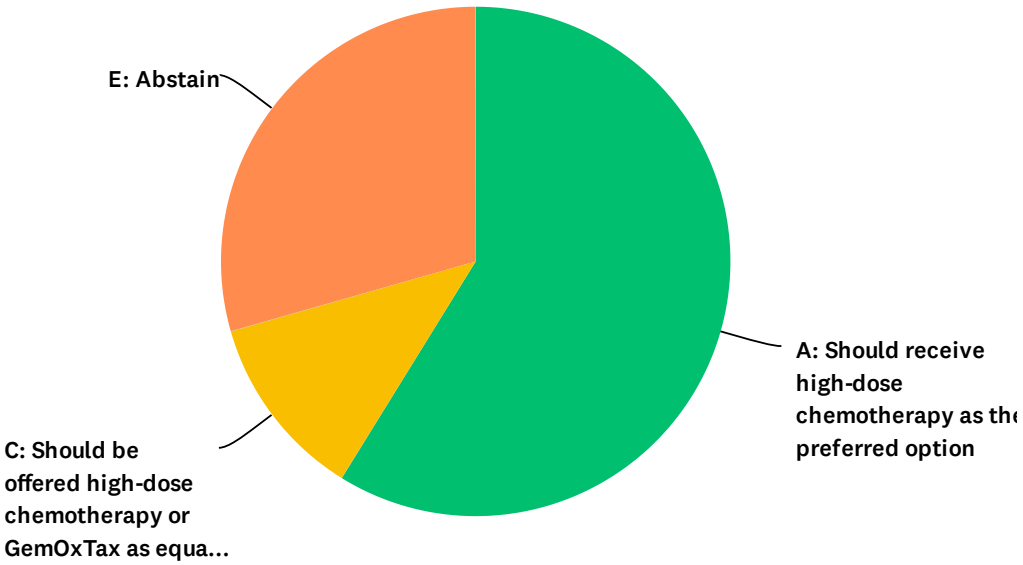
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should undergo immediate salvage chemotherapy followed by resection of all resectable lesions are present	29.41%	5
B: Should undergo immediate resection without prior chemotherapy irrespective of marker levels and marker dynamics	5.88%	1
C: Should undergo immediate resection without prior chemotherapy only with low marker levels and/or slowly rising markers	52.94%	9
D: Abstain	11.76%	2
GESAMT		17

F46 Patients with late relapse germ-cell tumors > 2 years after cisplatin-based curative intent first-line chemotherapy and non-resectable disease who are "fit" for any further treatment

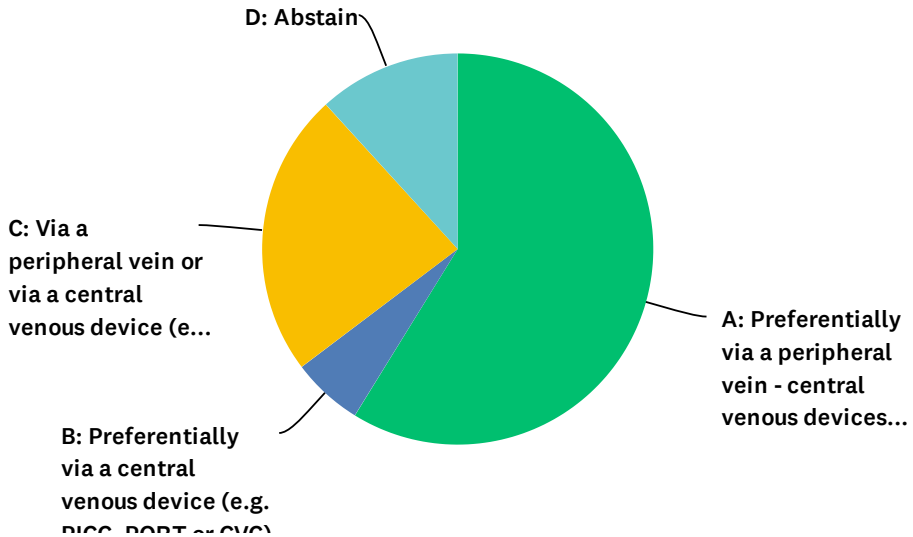
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should receive high-dose chemotherapy as the preferred option	58.82%	10
B: Should receive alternative treatments such as GemOxTax as the preferred option	0.00%	0
C: Should be offered high-dose chemotherapy or GemOxTax as equal options	11.76%	2
D: Should not receive any combination chemotherapy, but palliative e.g. single agent treatments with low toxicity or best supportive care	0.00%	0
E: Abstain	29.41%	5
GESAMT		17

F47 Application of chemotherapy should be applied

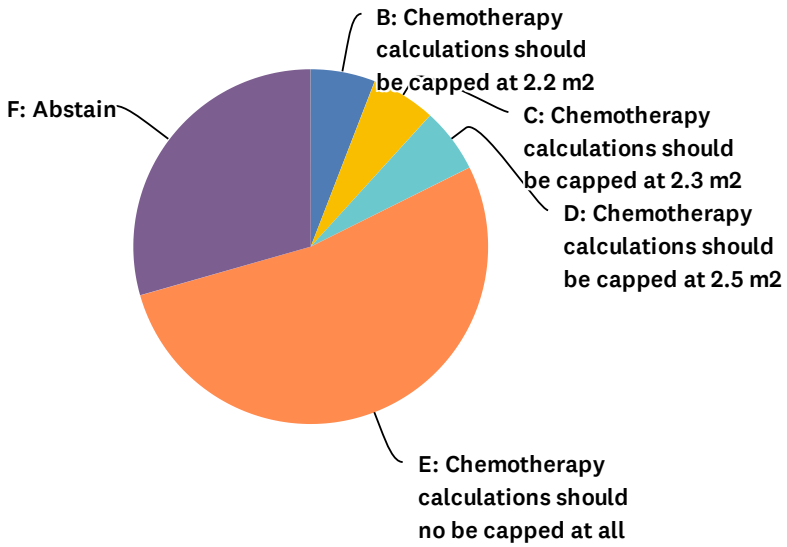
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Preferentially via a peripheral vein - central venous devices should be avoided	58.82%	10
B: Preferentially via a central venous device (e.g. PICC, PORT or CVC)	5.88%	1
C: Via a peripheral vein or via a central venous device (e.g. PICC, PORT or CVC) as equal options based on convenience and/or patient preferences	23.53%	4
D: Abstain	11.76%	2
GESAMT		17

F48 In patients with a high body surface

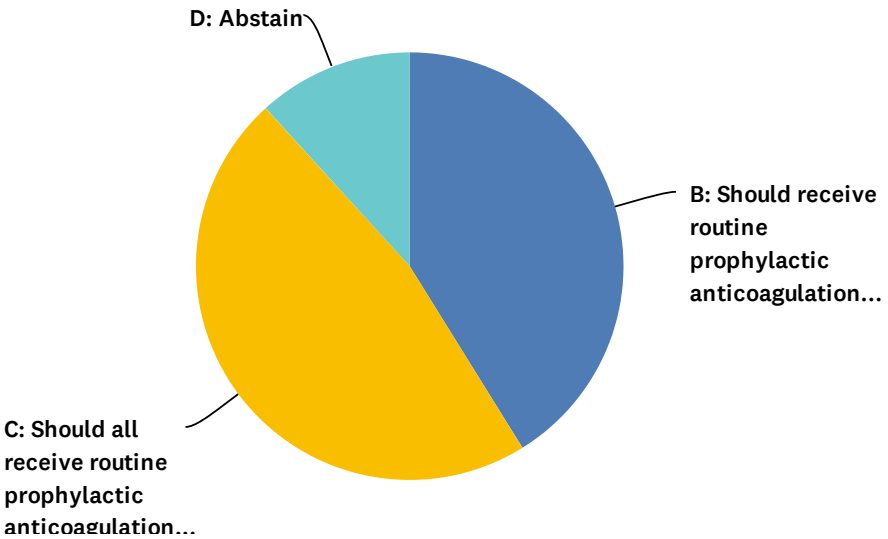
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Chemotherapy calculations should be capped at 2.0 m2	0.00%	0
B: Chemotherapy calculations should be capped at 2.2 m2	5.88%	1
C: Chemotherapy calculations should be capped at 2.3 m2	5.88%	1
D: Chemotherapy calculations should be capped at 2.5 m2	5.88%	1
E: Chemotherapy calculations should no be capped at all	52.94%	9
F: Abstain	29.41%	5
GESAMT		17

F49 Patients with metastatic seminoma or non-seminoma scheduled for curative-intent cisplatin-based chemotherapy without a history of previous venous thromboembolism and provided that there are no relevant risk factors for bleeding (e.g. large brain metastases, hemoptosis, or extensive chorio-carcinoma)

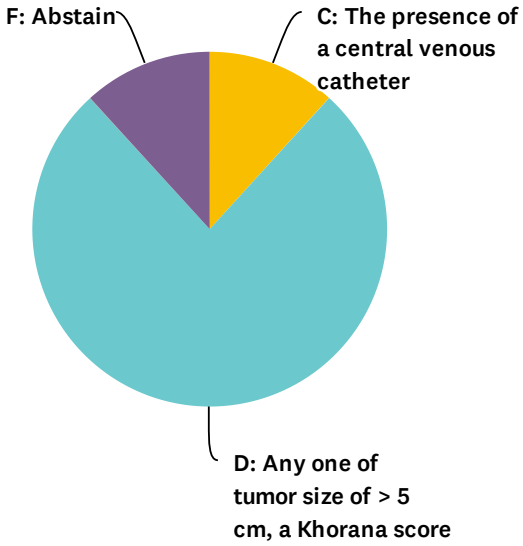
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should not receive routine prophylactic anticoagulation	0.00%	0
B: Should receive routine prophylactic anticoagulation only in the presence of risk factors for venous thrombembolism	41.18%	7
C: Should all receive routine prophylactic anticoagulation irrespective of risk factors for venous thrombembolism	47.06%	8
D: Abstain	11.76%	2
GESAMT		17

F50 Risk factors for venous thromboembolism in patients without a history of previous venous thromboembolism and metastatic seminoma or non-seminoma scheduled for curative intent cisplatin-based chemotherapy

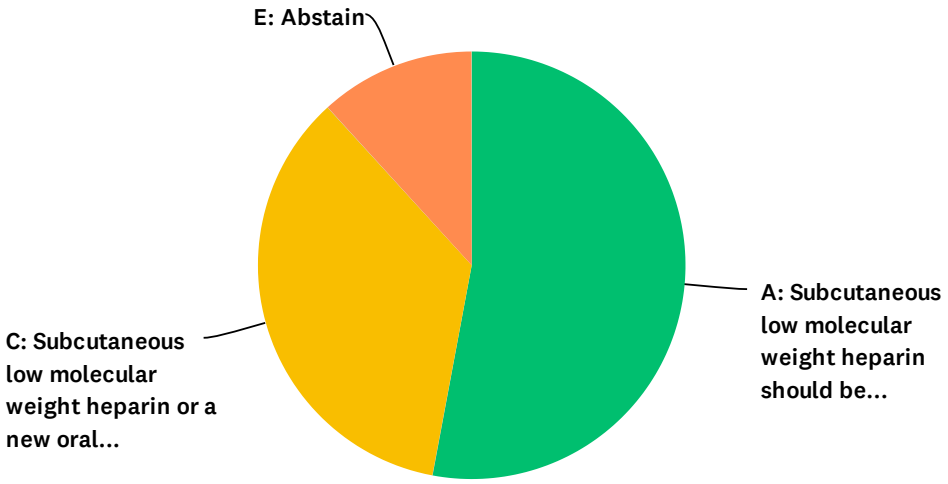
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: An abdominal tumor size of > 5 cm	0.00%	0
B A Khorana score > 2	0.00%	0
C: The presence of a central venous catheter	11.76%	2
D: Any one of tumor size of > 5 cm, a Khorana score > 2 or the presence of central venous catheter	76.47%	13
E None of the above	0.00%	0
F: Abstain	11.76%	2
GESAMT		17

F51 If prophylactic anticoagulation is used in metastatic seminoma or non-seminoma without a history of previous venous thromboembolism who are scheduled for curative-intent cisplatin-based chemotherapy

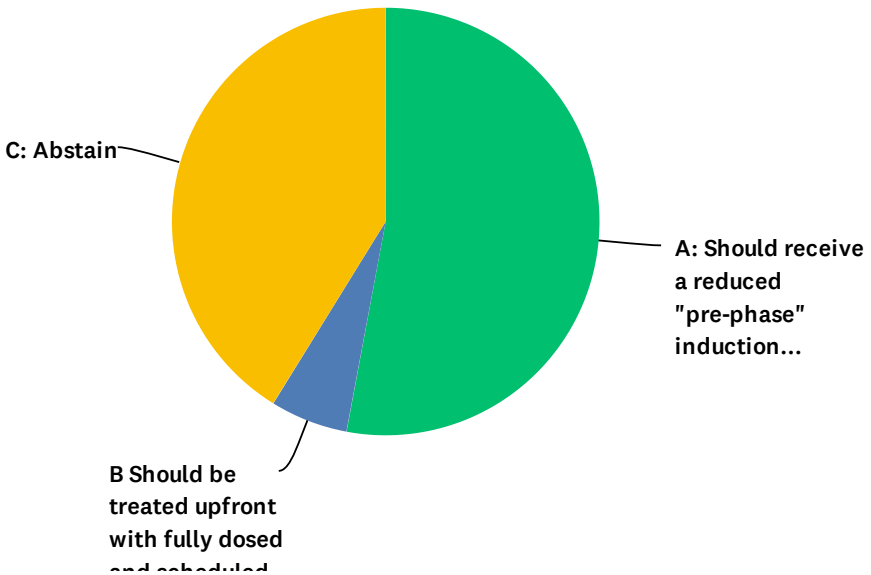
Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Subcutaneous low molecular weight heparin should be recommended as the preferred option, e.g. enoxaparin or dalteparin	52.94%	9
B A new oral anticoagulant should be recommended as the preferred option, e.g. rivaroxaban, edoxaban, apixaban	0.00%	0
C: Subcutaneous low molecular weight heparin or a new oral anticoagulant should be recommended as equal options	35.29%	6
D: Prophylactic anticoagulation should not be recommended	0.00%	0
E: Abstain	11.76%	2
GESAMT		17

F52 Patients with a very high tumor burden at initial presentation

Beantwortet: 17 Übersprungen: 0



ANTWORTOPTIONEN	BEANTWORTUNGEN	
A: Should receive a reduced "pre-phase" induction chemotherapy based on organ function to avoid tumor lysis or severe organ dysfunction followed by fully dosed and scheduled first-line treatment as per guideline	52.94%	9
B Should be treated upfront with fully dosed and scheduled first-line treatment as per guideline	5.88%	1
C: Abstain	41.18%	7
GESAMT		17