Primary brain tumours and cerebral metastases workshop
22.4.16

Summary of workshop group discussions on the content of the scope

Scope section	Notes
Title: Primary brain tumours and cerebral metastases	Currently the proposal is not to include all types of brain cancer – just to focus on meningioma and glioma. The title of the scope should be changed to make this clear.
Who the guideline is for • People using primary brain tumour and cerebral metastases services, families and carers and the public. • Healthcare professionals involved in the multidisciplinary care of people with primary brain tumours and cerebral metastases • Commissioners of brain tumour services (including Clinical Commissioning Groups and NHS England Specialised Commissioning) • Professional delivering shared care, including social services, for people with primary brain tumours and cerebral metastases It may also be relevant for: • Healthcare professionals in primary care	No comments made
1.1 Who is the focus? **Groups that will be covered** • Adults (16 and over) with a radiological diagnosis of glioma, meningioma or 1 or more cerebral metastases	It was noted that the scope only focuses on glioma and meningioma – other types of brain cancer (e.g. pituitary tumours and adult medullablastoma) have not been included. It was explained that it would not be possible to cover all of the different types of brain tumour in a guideline. The proposal was to focus on glioma and meningioma as these are by far the largest patient groups of primary brain tumours. It was suggested that the scope should define what tumours are included under the heading of a glioma as many different sub-types of tumour could potentially fall in this group. It was suggested that the age limit for the guideline should be 18 and over as tumours occurring in people under 18 are different.
1.2 Settings	

Settings that will be covered • All setting in which NHS care is provided • Shared care, including social services	
1.3 Activities, services or aspects of care **Key areas that will be covered** See notes for section 1.5 **Areas that will not be covered** • Identifying people in primary care with suspected primary brain tumours or cerebral metastases and referring them to secondary care.	
1.5 Key issues and questions **1) Investigation of people with radiologically diagnosed glioma**	It was noted that it is not possible to 'diagnose' anything on imaging so this wording should be changed to 'radiologically identified' or similar
1.1) What is the most effective diagnostic imaging to define tumour extent in glioma?	It was noted that there is currently variation in what imaging is done and there is no minimum dataset. It would be important to establish a minimum dataset for diagnosis to form a platform for future clinical trials. It was noted that NICE to do not usually make recommendations on minimum datasets, however the diagnostic accuracy of different imaging modalities could be investigated. It was suggested that it would be useful to look at the diagnostic accuracy of imaging tests for glioma, meningioma and brain metastases.
1.2) Does testing for molecular markers in apparently low grade gliomas improve outcomes?	It was suggested that this question should focus on the use of molecular markers to improve tumour stratification and therefore management. It would also be useful to know what markers were the most effective. It was suggested that this question should cover all gliomas – not just low-grade
2) Management of people with glioma or meningiomas	
2.1) What is the optimal initial treatment (surgery, radiotherapy, observation, surgery + adjuvant radiotherapy) for people with low grade glioma?	This will be a very large question to answer. It was noted that the answer to question 1.2 will significantly influence the answer to question 2.1. The use of molecular markers from stratification is currently being investigated and could prompt a move away

	from the current terminology of low-grade and high-grade glioma. It was suggested that chemotherapy be included as an intervention.
2.2) Is awake craniotomy more effective than standard craniotomy in people with low grade or high grade glioma in an eloquent region of the brain? 2.3) Does 5ALA as an adjunct to craniotomy improve the outcome of patients with high grade glioma, compared to craniotomy alone?	It was noted that one of the main areas of uncertainty is what extent of resection is the most effective. Awake craniotomy, intraoperative MRI, intraoperative ultrasound and 5ALA are different technologies that can be used to achieve a greater extent of resection more safely. It was suggested that questions 2.2. and 2.3 could be combined and look at the optimal extent of resection.
2.4) What is the optimal management (surgery, radiotherapy, chemotherapy, combinations) of people with recurrent glioblastoma after initial standard treatment?	It was suggested that the need to enrol in ongoing clinical trials should be stated in the scope. It was clarified that the guideline can make recommendations for further research in areas where the evidence base if found to be lacking/limited. It was requested that novel therapies also be investigated in this question. There is increasing use, usually in the private sector, of therapies which are off license, expensive and do not have a strong evidence base. It would be important for the guideline to investigate these therapies so patients can be given guidance about them.
2.5) Which people with meningiomas should have adjuvant radiotherapy after surgery?	It was noted that there is a study about to start that will answer this question for a subgroup of people who have middle grade, completely resected meningioma. Unfortunately it will not report until after the guideline has been published. It was suggested that adjuvant be removed from the question so that it focuses on the use of radiotherapy in meningioma. It was also suggested that the question should cover both newly diagnosed and recurrent meningioma.
3) Service configuration for people with glioma or meningioma	It was suggested that the service configuration questions be broadened to cover all brain

	tumours and brain metastases as these issues are relevant the whole population
3.1) What is the most effective provision of support services after treatment for people with gliomas and meningiomas? 3.2) What is the most effective provision of rehabilitation services after treatment for people with gliomas and meningiomas?	It was noted that rehabilitation is a big challenge for people with brain tumours and evaluation of the evidence in this area would be useful. It was suggested that 'after treatment' be removed from these questions as support and rehabilitation may be needed before, during and after treatment. It was noted that there have been issues with people who have brain tumours not being given rehabilitation because they are not going to live long.
4) Follow-up of people with glioma or meningioma 4.1) What is the most effective follow-up protocol to detect recurrence (duration, frequency, tests) for people treated for meningioma? 4.2) What is the most effective surveillance protocol (including no surveillance) for late effects of treatment for low grade glioma?	It was suggested that there should be a question looking at the most effective follow up protocol for glioma, meningioma and brain metastases. These questions should also investigate the most effective surveillance protocol for identifying late effects. There was debate over whether 'no surveillance' should be included in the question.
5) Management of people with cerebral metastases	
5.1) What is the most effective local treatment (surgery, stereotactic radiotherapy, whole brain radiotherapy, combinations) for people with a single cerebral metastasis? 5.2) What is the most effective local treatment (surgery, stereotactic radiotherapy, whole brain radiotherapy, combinations, no treatment) for people with multiple cerebral metastases?	It was noted that there is significant variation in survival depending on the site of the primary tumour. The evidence will need to be examined according to primary site. It was noted that 'local treatment' could be misinterpreted as meaning geographically local. Stakeholders were happy with the distinction between a single cerebral metastasis and multiple cerebral metastases.
6) Follow-up of people with cerebral metastases	
6.1) What is the most effective follow-up protocol to detect brain recurrence (duration, frequency, tests) for people with treated cerebral metastases?	It was noted that this is an area of wide variation so it would be good to have guidance on what to do.

	The term ‘brain recurrence’ could be confusing. Suggest changing to ‘intracranial recurrence’

Additional questions to include

The management of adult medulloblastoma

These people cannot be managed in the same way as children with medulloblastoma and so guidance is needed. The majority of stakeholders considered that there was very little evidence in this area to get a meaningful answer to the question. Also this is a rare tumour and only affects small numbers of people so it may not be a worthwhile use of a question to investigate it.

The management of schwannomas

There are questions around when to do treatment and what treatment to give (radiotherapy versus surgery). It was noted by stakeholders that these are a skull base tumour and therefore managed by a different team

The role of radiotherapy in pituitary tumours

The majority of stakeholders considered that the management of pituitary tumours would be a guideline in itself as they are managed very differently to other brain tumours.

Suggested membership of the guideline committee

The following amendments were suggested to the guideline committee list:

- Include a medical oncologist (possibly as an expert advisor) – for novel therapies that will be developed in future
- Increase the number of clinical oncologists to 3 as most of the questions will require input from this specialty
- Increase the number of AHPs to 2
- Queried whether or not there needs to be 2 neuro-radiologists. Stakeholders felt this wasn’t necessary
- Suggested that palliative care doctor could be an expert advisor rather than a core committee member.