6 ulusal CERRAHİ ONKOLOJİ KONGRESİ

24 - 27 Şubat 2022 | Gloria Golf Resort – ANTALYA

PROF. DR. AZİZ SÜMER

İSTİNYE ÜNV. TIP FAKÜLTESİ GENEL CERRAHİ ABD

Kanser tedavisinde güncel klavuzlar ve rehberler neler? Ne kadar güvenilir?

KILAVUZ

Kılavuzlar ne kadar güvenilirdir?

Yılda 1000 + kılavuz yayınlanıyor MEDLINE database

Kılavuzlar ne kadar güncel ?

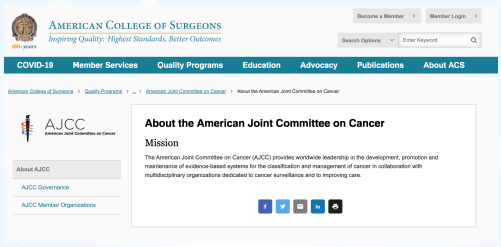
Kesinleşmiş olarak kabul edilen 17 kılavuz
Bunları hazırlayan gruplara gönderilmiş
Değiştirilmesi gereken yönler olup olmadığı

Sonuç;

7 kılavuzda majör, 6 kılavuzda ise minör değişiklikler
Kılavuzların 3 senede bir yeniden gözden geçirilmesi gerektiği
Günümüzde daha kısa süreler…….

Shekelle PG, Ortiz E, Rhodes S et al. Validity of the agency for healthcare research and quality clinical practice guidelines: How quickly do guidelines become outdated? **JAMA** 286:1461, **2001.**

The American Joint Committee on Cancer (AJCC) was established in 1959



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ESMO MISSION

COVID-19 AND CANCER
ABOUT ESMO
MEMBERSHIP
GUIDELINES
MEETINGS
CAREER DEVELOPMENT
RESEARCH
FOR PATIENTS
POLICY

ESMO is committed to offer the best care to people with cancer, through fostering integrated cancer care, supporting oncologists in their professional development, and advocating for sustainable cancer care worldwide.

ESMO is the leading professional organisation for medical oncology. With more than 25,000 members representing oncology professionals from over 160 countries worldwide, ESMO is the society of reference for oncology education and information.

Founded in 1975, ESMO has European roots with a global reach. Home for all oncology stakeholders, ESMO connects professionals with diverse expertise and experience. Its education and information resources support an integrated multi-professional approach to cancer care, from a medical oncology perspective.

ESMO seeks to erase boundaries in cancer care, whether between countries or specialities, and pursue its mission across oncology, worldwide.

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National Comprehensive Cancer Network®

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Guidelines Compendia & Templates Education & Research Patient Resources Business & Policy Global

Home > About > NCCN History

NCCN History

On January 31, 1995, a press conference was held to announce the creation of a national alliance to develop and institute standards of care for the treatment of cancer and perform outcomes research – and so the NCCN was born. With 13 original NCCN Member Institutions, the goal was to ensure delivery of high-quality, cost-effective services to people with cancer across the country. NCCN became a developer and promoter of national programs to facilitate the fulfillment of NCCN Member Institution missions in education, research, and patient care. Now an alliance of 31 of the leading cancer centers, NCCN develops and communicates scientific, evaluative information to better inform the decision-making process between patients and physicians, ultimately improving patient outcomes.

November 1993 – NCCN is formally incorporated

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NICE National Institute for Health and Care Excellence

Search NICE... Sign in

Guidance NICE Pathways Standards and indicators Life sciences BNF BNFC CKS About More

Read about our approach to COVID-19

Home > About > Who we are

History of NICE

Creation of NICE

1999

The National Institute for Clinical Excellence became a legal entity in April. Our aim was to create consistent guidelines and end rationing of treatment by postcode across the UK.
Find out more about us

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European Journal of Radiology

A B S T R A C T

Purpose: This study aims to compare three guidelines according to their diagnostic accuracy in the management of thyroid nodules.
Methods: A total of 540 patients with 597 thyroid nodules were enrolled in this study. Sonographic images were classified and scored with the American Thyroid Association (ATA-2015), American College of Radiology (ACR), and European Thyroid Association (EU) Thyroid Imaging, Reporting, and Data Systems (ACR-TIRADS and EU-TIRADS) guidelines. Fine-needle aspiration biopsy (FNAB) was performed, and cytopathological results were reported with the Bethesda system. Outcomes of these three classification systems were then correlated with Bethesda results.
Results: FNAB procedures revealed a total of 447 benign and 45 malignant nodules. With guideline dedicated FNAB criteria; 38 malignant nodules could have been diagnosed with ATA-2015, which is followed by 34 nodules with ACR-TIRADS, and 31 nodules with EU-TIRADS. Nonetheless, 301 benign nodules would have been biopsied with ATA-2015, 143 benign nodules with ACR-TIRADS, 222 benign nodules with EU-TIRADS. The accuracy rate was found to be highest with ACR-TIRADS (59.93 %); while 55.20 % with ATA-2015 and 51.25 % with EU-TIRADS. The sensitivity and specificity ratios of these guidelines were as follows; ATA-2015 (82.22, 53.47), ACR-TIRADS (48.89, 60.63), and EU-TIRADS (86.67, 48.99). A total of 23 nodules (3.8 %) could not be classified with ATA-2015.
Conclusion: Diagnostic strengths, unnecessary recommended FNAB rates, and categorization capabilities differ among various guidelines. Clinicians and interventional radiologists should keep in mind these features in the management of thyroid nodules.

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PERGAMON

European Journal of Cancer

Current Perspective

Decision-making in early breast cancer: guidelines and decision tools

M. Baum[a], P.M. Ravdin[b,*]

Östrojen reseptörü negatif, <5 mm tümörü olan kadınlarda
NCCN (Önermiyor)
NCI (Opsiyon tedavi seçenekleri arasında olmalı)
St. Galen (KT öneriyor)

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Annals of SURGICAL ONCOLOGY

ORIGINAL ARTICLE – BREAST ONCOLOGY

Impact of Consensus Guidelines by the Society of Surgical Oncology and the American Society for Radiation Oncology on Margins for Breast-Conserving Surgery in Stages 1 and 2 Invasive Breast Cancer

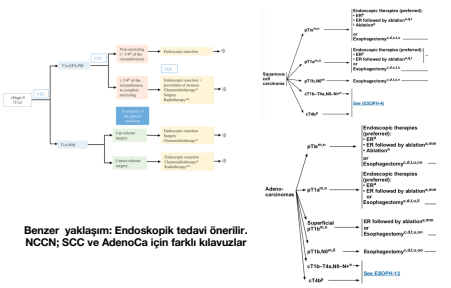
TABLE 1 Re-excision rates and rationale for re-excision

	Group 1	Group 2	*p* value
Re-excision rates	115/597 (19 %)	32/248 (13 %)	**0.03**
Rationale for re-excision			0.28
Negative margins	35/115 (30 %)	7/32 (22 %)	
Positive margins	79/115 (70 %)	25/32 (78 %)	

Bold value indicates statistically significant ($p < 0.05$)

Erken evre - Özofagus Ca

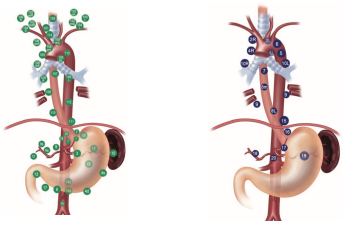
Japon | NCCN



Benzer yaklaşım: Endoskopik tedavi önerilir.
NCCN; SCC ve AdenoCa için farklı kılavuzlar

Lenfadenektomi - Özofagus Ca

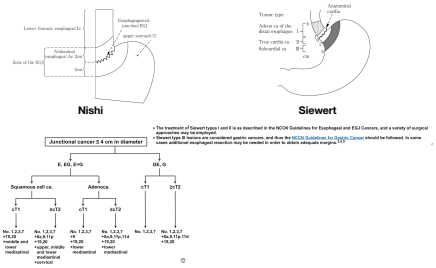
Japon | NCCN



Lenfadenektomi tanımları ve önerilen genişlik farklı

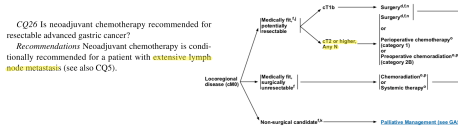
EGJ Ca- Özofagus Ca

Japon | NCCN



Neoadjuvan tedavi - Mide Ca

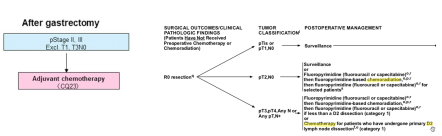
Japon | NCCN



Neoadjuvan tedavi endikasyonları farklı

Adjuvan tedavi - Mide Ca

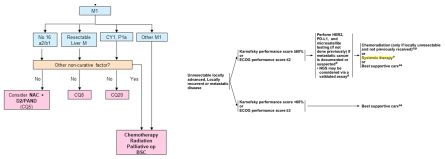
Japon | NCCN



Adjuvan tedavi endikasyonları benzer (T1, T3N0 hariç)
NCCN; RT eklenebilir.

Metastatik hastalık- Mide Ca

Japon | NCCN



Japon kılavuzunda konversiyon cerrahisi opsiyonu mevcut.

Lenf nodu sayısı- Mide Ca

Japon	NCCN
~ >25-30	Number of Lymph Nodes Retrieved • Although it is suggested that at least 15 regional lymph nodes be pathologically assessed, assessment of over 30 lymph nodes is desirable.[2]

Rectal cancer (appropriate for resection)

Both NCCN and ESMO state a formal pretreatment work-up, whereas JSCCR does not. NCCN recommends a complete blood count, chemistry profile, carcinoembryonic antigen (CEA) measurement and colonoscopy, whereas ESMO advises sigmoidoscopy (either rigid or flexible), endoscopic ultrasonography and circumferential resection margin evaluation (*Table 1*). Both NCCN and ESMO advise the use of MRI in patient work-up.

NCCN considers transanal excision only for T1 N0 non-fixed tumours (stage I) that are less than 3 cm in size, occupy less than 30 per cent of the circumference of the bowel and lie within 8 cm of the anal verge; advises transabdominal surgery without neoadjuvant therapy for T1–2 N0 tumours (stage I) that do not meet the previous criteria; and recommends neoadjuvant treatment, followed by surgery after 5–12 weeks, then adjuvant therapy, for all resectable disease from stage II to IV. In contrast, ESMO suggests surgery alone even for cT3a N1 high tumours, leaving postoperative treatment for those with poor prognostic features.

BJS Open

NCCN advises palliative surgery in the setting of symptomatic patients with unresectable metastatic disease, whereas neither ESMO nor JSCCR describes this event.

The same criteria for TME are shared between NCCN and ESMO (mesorectal margin of 5 cm from the tumour distal edge), whereas JSCCR focuses more on the extent of lymph node dissection, which is based on the perceived spread of lymph node metastases and depth of tumour invasion (from D0–1 for pTis to D3 for cT3–4a/b or cN+). JSCCR also recommends lateral lymph node dissection for tumours where the lower border lies distal to the peritoneal reflection or there is invasion beyond the muscularis propria.

Conversely, NCCN does not recommend extended lymph node dissection unless suspicious nodes are present, whereas ESMO highlights the importance of radical resection of mesorectal fat, including all lymph nodes

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Open Access Original research

ESMO Open Cancer Horizons

Differential research impact in cancer practice guidelines' evidence base: lessons from ESMO, NICE and SIGN

Conclusions We showed that ESMO, NICE and SIGN differ in their evidence base of CPGs. Healthcare professionals should be aware of this heterogeneity in effective decision-making of tailored treatments to patients, irrespective of geographic location across Europe.

ESMO Open 2018;3:e000258.

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1442PD Review on adherence to breast cancer guidelines in Europe

L. Neamtiu[1], L. Pylkkanen[1], C. Freeman[2], Z. Saz Parkinson[1], S. Deandrea[1], A. Ulutuk Tekin[1], N. Dimitrova[1], D. Lerda[1]

[1]Health in Society, JRC Joint Research Center - European Commision, Ispra, Italy, [2]Barcelona, Spain

Background: Morbidity and mortality from breast cancer in Europe, as well as costs associated with the disease, remain high. Patients treated according to existing guidelines have better survival. The European Commission Initiative on Breast Cancer (ECIBC) aims to improve quality of care by developing evidence-based breast cancer guidelines and supporting their implementation via a quality assurance scheme for breast cancer services. The goal of this study is to give an overview on compliance with breast cancer guidelines in Europe.

Methods: Studies assessing adherence to guidelines on breast cancer screening, diagnosis, treatment and follow-up were searched via Pubmed. Studies published between 1990 and 2016 were included.

Results: In total, 127 studies (mainly observational, retrospective, prospective, and cross sectional) were analysed. The number of participants varied from 56 to 72 000—with studies based on cancer registry data typically including more than 10 000 patients. Overall, adherence to guidelines was variable. Regarding treatment, (e.g. chemotherapy) adherence ranged from 70% to 96% and was approximately 50% for follow-up. Additional or 'unnecessary' procedures were cited as the main causes of non-compliance to follow-up. On the other hand, adherence with respect to radiotherapy (e.g. compliance with technical guidelines) and some safety-related aspects (e.g. cardiac monitoring during adjuvant trastuzumab therapy and prophylaxis with colony-stimulating factors) was substantially lower. Elderly patients were treated less frequently according to existing guidelines. Professionals with less experience (i.e. <5 years) complied better with guidelines. Use of computerised decision support systems (CDSS) and implementation of a multidisciplinary breast cancer pathway led to better compliance.

Conclusions: In Europe, adherence to guidelines is variable. Implementation of guidelines can help decrease variability in clinical practice, and improve treatment effectiveness and patient safety. Fortunately, adherence can be monitored through the use of quality assurance schemes (e.g., the ECIBC). Incorporating a CDSS within the clinical workflow could reduce the workload of physicians and thus increase their compliance with guidelines.

Melanoma
Breast
GI
Prostate
Lung

Figure 1 Guideline adheren
Recommendation number (s

or 15 recommendations; Legend: #

Annals of Oncology 28 (Supplement 5): v511–v520, 2017 doi:10.1093/annonc/mdx385

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Medicine
Volume 46, Issue 7, July 2018, Pages 393-396

Wording used by NICE guidelines committees

Strength of recommendation	Language used	Strength of evidence
Strong	'Offer', 'Perform', 'Refer', 'Should', 'Advise',	The committee believes the vast majority of
	about', 'Do not routinely'	recommendations are likely to represent effective and cost-effective care, and that the balance between benefits and harms for most people is likely to be positive, but that the evidence is less certain
No recommendation	Nothing stated, research recommendation given	The evidence base was too weak to make a recommendation. Research recommendations are made where additional research is feasible and would be valuable for future decision-making

Importantly, there may be good reasons why clinicians and patients may decide that even a strong recommendation is not the right option. For example, the patient may be quite different from the participants in the research underpinning the recommendation in terms of age, co-morbidities or values and

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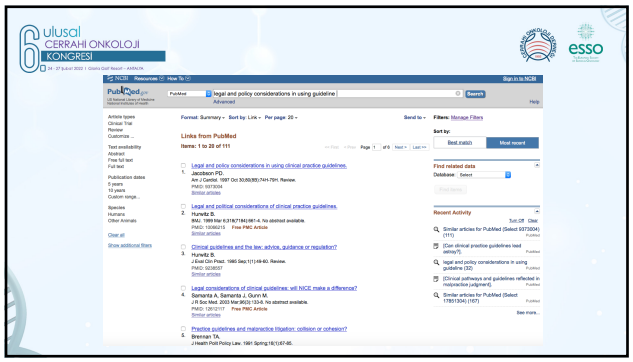
Paediatric Respiratory Reviews

Review

Why Clinical Practice Guidelines Hinder Rather Than Help

Miles Weinberger

We are long overdue to recognize that Guidelines, no matter how detailed and disseminated, cannot substitute for experienced and knowledgeable clinicians, especially if supported by a team of health care professionals committed to patient education and monitoring. The need for specialized programs for adults and children with asthma who require urgent care and hospitalization has recently been recognized in the U.K. [21] The published evidence supports development of specialty care centers if the national asthma statistics are to be improved.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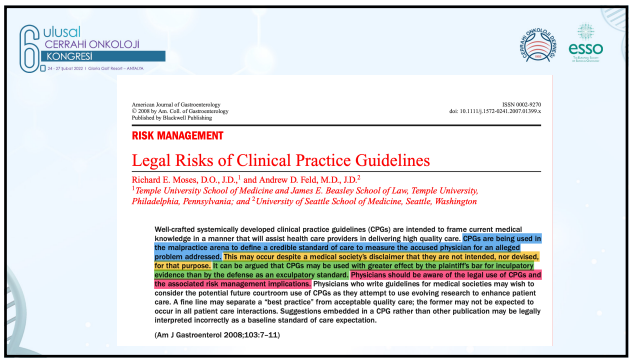
Legal and political considerations of clinical practice guidelines.
Hurwitz B.
Clinical guidelines and the law: advice, guidance or regulation?
Hurwitz B.
Legal considerations of clinical guidelines: will NICE make a difference?
Samanta A, Samanta J, Gunn M.
Practice guidelines and malpractice litigation: collision or cohesion?
Brennan TA.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American Journal of Gastroenterology
RISK MANAGEMENT
Legal Risks of Clinical Practice Guidelines
Richard E. Moses, D.O., J.D.[1] and Andrew D. Feld, M.D., J.D.[2]
[1]Temple University School of Medicine and James E. Beasley School of Law, Temple University, Philadelphia, Pennsylvania; and [2]University of Seattle School of Medicine, Seattle, Washington
Well-crafted systemically developed clinical practice guidelines (CPGs) are intended to frame current medical knowledge in a manner that will assist health care providers in delivering high quality care. CPGs are being used in the malpractice arena to define a credible standard of care to measure the accused physician for an alleged problem addressed. This may occur despite a medical society's disclaimer that they are not intended, nor devised, for that purpose. It can be argued that CPGs may be used with greater effect by the plaintiff's bar for inculpatory evidence than by the defense as an exculpatory standard. Physicians should be aware of the legal use of CPGs and the associated risk management implications. Physicians who write guidelines for medical societies may wish to consider the potential future courtroom use of CPGs as they attempt to use evolving research to enhance patient care. A fine line may separate a "best practice" from acceptable quality care; the former may not be expected to occur in all patient care interactions. Suggestions embedded in a CPG rather than other publication may be legally interpreted incorrectly as a baseline standard of care expectation.
(Am J Gastroenterol 2008;103:7–11)


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Legal and Policy Considerations in Using Clinical Practice Guidelines
Peter D. Jacobson, JD, MPH
The increased use of clinical practice guidelines has implications for both public policy and for litigation. Physicians are concerned that the introduction of practice guidelines will reduce their clinical decision-making authority and that the failure to follow clinical practice guidelines will lead to medical liability. Although practice guidelines are an increasing part of medical practice, there has been only limited litigation to determine the extent to which guidelines will be used to set the applicable standard of care. This article discusses the potential legal and public policy issues raised by the introduction and use of clinical practice guidelines. From a legal perspective, the primary issue is whether guidelines will be used to set the "standard of care" or will be one piece of evidence that a jury would use to determine the outcome of medical liability litigation. Based on an assessment of the applicable legal and policy considerations, the article concludes that courts should admit guidelines into evidence, but that they should not be used as the sole determinant of the standard of care. Instead, guidelines should be treated as one piece of evidence to be weighed by the jury. This approach will facilitate physician acceptance of guidelines by not imposing liability for the failure to follow guidelines without additional evidence to determine the standard of care. ©1997 by Excerpta Medica, Inc.
Am J Cardiol 1997;80(8B):74H–79H


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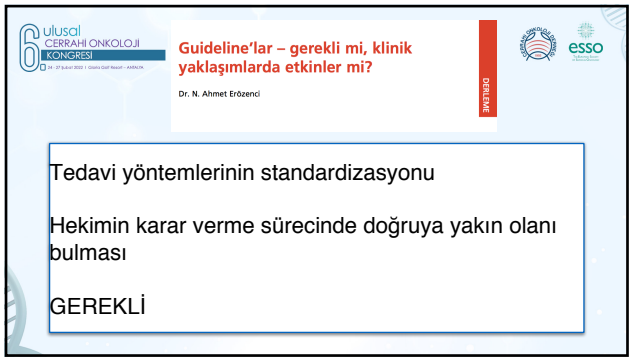
Guidance for Guidelines
Guidelines have been criticized for contradicting dogma or for providing reasons for insurers to deny coverage.
Guidelines have also been questioned when companies with a financial stake in the outcome provide substantial funding for their development.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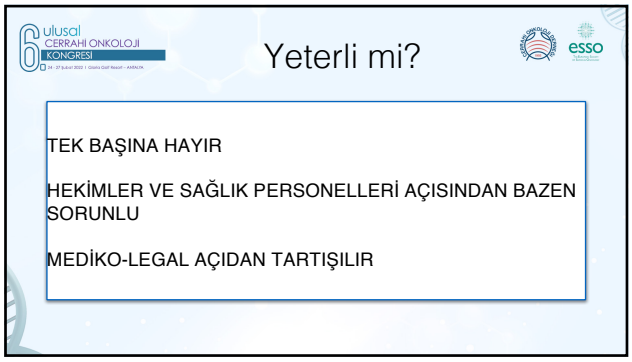
Guideline'lar – gerekli mi, klinik yaklaşımlarda etkinler mi?
DERLEME
Dr. N. Ahmet Erözenci
Tedavi yöntemlerinin standardizasyonu
Hekimin karar verme sürecinde doğruya yakın olanı bulması
GEREKLİ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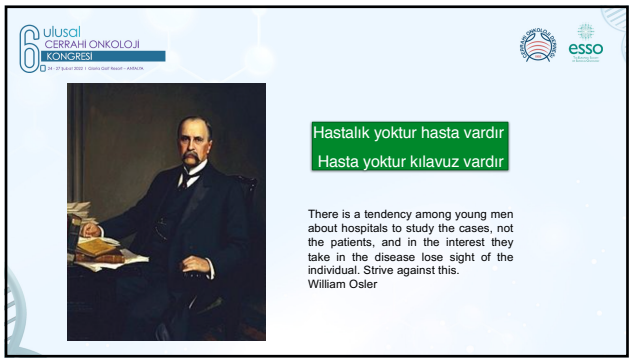
Yeterli mi?
TEK BAŞINA HAYIR
HEKİMLER VE SAĞLIK PERSONELLERİ AÇISINDAN BAZEN SORUNLU
MEDİKO-LEGAL AÇIDAN TARTIŞILIR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Hastalık yoktur hasta vardır
Hasta yoktur kılavuz vardır
There is a tendency among young men about hospitals to study the cases, not the patients, and in the interest they take in the disease lose sight of the individual. Strive against this.
William Osler