ESMO Standard Operating Procedures (SOPs) for Clinical Practice Guidelines (CPGs) and ESMO Magnitude of Clinical Benefit (ESMO-MCBS) and ESMO Scale for Clinical Actionability of molecular Targets (ESCAT) scores

ESMO Guidelines Committee (GLC)

<table>
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<tr>
<th>Version</th>
<th>ESMO CPG SOP Version 2.0; January 2022</th>
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| Changes in this version | Modified authorship criteria  
Added guidance and requirements for inclusion of specific contributor roles  
Clarified process of selecting and producing joint CPGs with other societies  
Updated ESMO Declaration of Interest (DOI) collection process  
Added guidance on CPG kick-off meetings for author groups  
Modified requirements for quality control and data check  
Clarified requirements for inclusion of ESMO-MCBS scores  
Added guidance and requirements for inclusion of ESCAT scores |
| Approved | Giuseppe Curigliano, GLC Chair |
| Next review planned | After the next GLC meeting (in 2022, date to be confirmed); revisions can be made sooner as required |

Note: this SOP only applies to ESMO CPG publications and full updates. For additional guidance on updates of original CPG publications, please see the separate electronic update (eUpdate) and Clinical Practice Living Guidelines (Living GLs) SOPs. All three SOP documents are available publicly on the ESMO website esmo.org: [http://www.esmo.org/Guidelines/ESMO-Guidelines-Methodology](http://www.esmo.org/Guidelines/ESMO-Guidelines-Methodology).
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1 Introduction

- The target audience for ESMO CPGs is health professionals working in oncology, with an emphasis on medical oncology, across Europe and other parts of the world.
- ESMO CPGs should take into account the content of any published ESMO Consensus Conference Recommendations manuscripts when available. ESMO CPGs and Consensus Conference Recommendations manuscripts are two separate but complementary products.
- CPGs will be submitted to an ESMO journal for evaluation for publication—Annals of Oncology (annalsofoncology.org) or ESMO Open (esmoopen.com). ESMO staff will format all ESMO CPGs to align with ESMO journal style prior to submission.
- ESMO will produce pocket versions of standard CPGs as 'hands-on' booklets with tables, algorithms and ‘bullet point’ recommendations for daily use: Pocket Guidelines. The Subject Editor (SE) of each CPG will be asked to review and comment on the relevant chapter of the Pocket Guidelines. The lead author may also be asked for comment.
- ESMO will produce slide sets containing key recommendations and algorithms. The lead author and SE of the relevant CPG will be asked to review and comment on the slide set.
- ESMO will produce webinars following publication of CPGs, involving case-based discussion around the practical implementation of recommendations.

2 Commissioning of a CPG

CPGs should be proposed for update when there is need for such as judged by the ESMO GLC Chair, a Guidelines Steering Committee (GL-SC) member or the SE. This judgement is based on the availability of new, clinically-significant evidence that necessitates substantial changes or additions to clinical recommendations. New CPGs may also be considered for topics not currently covered by current ESMO CPG titles. In selected circumstances, ESMO may opt to produce joint CPGs with other formally recognised scientific societies, after careful consideration by the GLC of the science, characteristics, scope and strategy. In this case, there is a mutual agreement to follow this SOP and methodology with some adjustments if needed in order to generate consent. ESMO will provide the necessary Memorandum of Understanding (MOU) with the society if applicable as well as a specific Guideline Development Agreement (GDA) for each CPG title (except for CPGs involving EURACAN).

3 Role of ESMO Guidelines staff

Each guideline will have an ESMO Guidelines staff member responsible for communications, planning and oversight throughout the guideline development process. The ESMO Guidelines staff review and edit all guidelines to ensure they adhere to this SOP and ESMO journal requirements but do not serve as authors. Editing support will be provided and medical writing support can also be provided as agreed with the authors. These roles are considered to be ‘non-author contribution’ and do not replace intellectual contribution from the authors. The exact role of each staff member involved in the guideline will be detailed in the Acknowledgements section of the CPG as editing support and/or medical writing support.

4 Authorship

4.1 Author selection process

For each CPG, the SE should propose the lead author to the GLC Chair for approval. Once approved, the SE and lead author should propose the co-authors. The ESMO GL-SC member and the ESMO Faculty coordinator for the subject area should also be involved during co-author proposals to select the best contributors.

The ESMO Guidelines staff will assist the SE and lead author with coordinating the author selection process, obtaining the GLC Chair’s approval of the proposed authors and sending formal invitations (see below). Invitations are sent on behalf of the lead author, SE and the GLC Chair.
4.2 Authorship criteria

The author group should fulfil the below criteria as far as possible while maintaining and prioritising the highest level of expertise:

- The author group should consist of a minimum of 8 authors, including the SE (last author) and, if relevant, any GL-SC member(s).
- Each proposed author should have an internationally recognised profile in the field and good reputation.
- The author group should be diverse, gender-balanced and multidisciplinary, and therefore should include medical oncologists, a surgical oncologist, a radiation oncology specialist and/or other disciplines if appropriate.
- The group should also be multinational with authors representing various countries in Europe and elsewhere to ensure validity as both a European and global guideline.
- The group should be multi-institutional, ideally with authors representing different institutions (i.e. ideally a maximum of one representative from each institution, but exceptions can be granted for rare tumours). This criterion may be easier to achieve for common cancers than for rare cancers.
- At least one early-career, talented expert in the field should be included. There is no specific age requirement; however, these individuals should be relatively junior and their involvement in the ESMO CPG should present a valuable opportunity for their career (members of the ESMO Young Oncologists Committee or the ESMO Leaders Generation Programme may be recommended for consideration pending approval of the SE and the GLC Chair). The ESMO Guidelines staff can provide details of these individuals to SEs and lead authors.
- Inclusion of representative(s) of patient organisations or patient advocacy groups can be considered where appropriate, either as authors if they meet the authorship criteria or as reviewers.

All authors should fulfil all four of the following criteria recommended by the ICMJE:\(^1\):

- Substantial contribution to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or revising it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

For CPGs involving a large multi-author group, all members of the group named as authors should still meet all four of the above ICMJE authorship criteria, including approval of the final manuscript.

Individuals who do not meet all four criteria should be acknowledged as non-author contributors, either individually or as a group under the Acknowledgements section, with details of the specific contribution, and their written permission obtained in order to include their acknowledgement.

4.3 Contributor roles

Description of individual contributor roles provides transparency over the differing roles of each author and may help to avoid authorship disputes, as well as enable authors to have confidence in the accuracy and integrity of all their co-authors.\(^2,3\)

As well as the authorship criteria outlined above, certain key authors have the specific responsibilities described below. Other responsibilities for the authors below and other co-authors may also be decided upon on a guideline-specific basis, e.g. allocation of specific sections of the manuscript. Contributions will be described in the contributor statement in the Acknowledgements.

4.3.1 Lead author

The lead author acts as the coordinating author and appears as first author, followed by the other co-authors and the SE as last author.

The Lead Author is responsible for:

- Proposing suitable co-authors, in collaboration with the SE.
- Acting as the coordinating author to drive input and contributions from co-authors and to provide progress updates to the ESMO Guidelines Committee and ESMO Guidelines staff.
- Ensuring that the guideline follows the ESMO methodology as closely as possible.
• Certifying that all authors fulfil the ICMJE criteria and describing their contributions using the ESMO Author Responsibility and Acknowledgement Agreement form (see the ESMO website here: https://www.esmo.org/guidelines/esmo-guidelines-methodology).
• Along with the last author (SE), providing review/commentary on related ESMO guideline derivative products, e.g. slide sets and Pocket Guidelines.

4.3.2 Last author and SE
As the Last Author, the SE is responsible for:
• Proposing a suitable first author and co-authors, in collaboration with the GL-SC and relevant ESMO Faculty coordinator.
• Ensuring that the guideline follows the ESMO methodology as closely as possible and providing extensive support to the lead author regarding queries on methodology.
• Providing the cover letter for journal submission, including recommended reviewers (ESMO Faculty where possible).
• Providing commentary on related ESMO guideline derivative products, e.g. slide sets and Pocket Guidelines.

4.3.3 GLC Chair and Deputy Chair
In select cases, the GLC Chair or Deputy Chair will be invited to be a co-author.

4.3.4 GL-SC member
A relevant GL-SC member will be invited to be a co-author on each CPG within his/her tumour area (excluding ex-Officio members, who are members related to their role on another ESMO committee). The GL-SC member can be listed as a joint co-last author (penultimate). Even when the GL-SC member is regarded to be more ‘senior’ than the SE in the field, the current SE will be the last author of the guideline.

4.3.5 ESMO Faculty coordinator
The lead author, the GL-SC member and SE will work with the ESMO Faculty coordinator for the subject area to select the best contributors for the specific guideline.

4.3.6 Representatives of other societies
For joint guidelines with other societies, specific experts will play a central role as a representative of that society, either as co-first author or co-senior author in ‘equal contribution’ mode. These authors will work closely with the ESMO lead author and SE to evaluate the author committee and nominate additional multidisciplinary experts (e.g. non-medical oncologists) if needed. The GLC Chair is responsible for approving the entire author panel including representatives of any other societies. Authorship and publication details will be detailed in a specific GDA for each joint CPG title except for EURACAN (see next paragraph). All authors will be expected to comply with the ESMO methodology detailed in this SOP.

In the field of rare adult solid cancers, ESMO may collaborate with EURACAN, the European Reference Network, on CPGs covering single families of rare adult solid cancer (e.g. sarcomas) or tumours/groups of tumours within such families (e.g. thymomas, within rare thoracic tumours). The decision to proceed with any new ESMO-EURACAN CPGs will be made jointly by the GLC Chair and the respective EURACAN coordinator for that disease area on a case-by-case basis. All authors of ESMO-EURACAN CPGs will be expected to comply with the ESMO methodology detailed in this SOP.

4.4 Order of authorship
Unless otherwise specified and approved by the GLC Chair, the CPG author order is as follows:

First author.
Other co-authors: In alphabetical order of surname.
GLC Chair, Deputy Chair or GL-SC member as co-author: In alphabetical order of surname or as a joint co-last author (penultimate).
Last author: SE.
4.5 **Author invitations**

Once the author group is approved by the GLC Chair, the ESMO Guidelines staff will formally invite all potential authors to participate.

4.6 **ESMO Declaration of Interest**

4.6.1 **Declaration following author invitation**

As part of the author confirmation process, ESMO will verify and/or request that each potential author has an ESMO account and has provided a valid Declaration of Interest (DOI) in the ESMO DOI Platform. The DOI collection process is centrally managed within ESMO, and the financial value of each disclosure will be treated as confidential. For more information, refer to the ESMO DOI policy available here: [https://www.esmo.org/about-esmo/how-we-work/declaration-of-interest](https://www.esmo.org/about-esmo/how-we-work/declaration-of-interest).

Each author must provide DOI information including financial values, even if there is nothing to declare, before the individual's participation in the guideline can begin including kick-off meetings. After all DOIs are received/confirmed, the CPG kick-off meeting (online) can proceed.

Each individual author is responsible for ensuring that their DOI statement in the ESMO DOI Platform is true, up to date and complete.

4.6.2 **Declaration in the final manuscript**

In addition to the DOI provided in the ESMO DOI Platform, each author must provide a written statement to be included in the Disclosures section of the final CPG. Before manuscript submission to an ESMO journal, all authors must review and approve the final manuscript including DOI statements. Disclosures are not included in the manuscript word count.

Example disclosure statement:

"XX has received honoraria from Company-A, has a financially compensated leadership role in Company-B, has stocks or other forms of ownership in Company-C, receives licensing fees or royalties from intellectual property from Company-D, received or currently receives direct research funding as a Project Lead from Company-E, performs work in clinical trials or contracted research for which his/her institution received financial support from Company-F, has performed non-remunerated activities for Company-G, non-remunerated leadership roles for Society-H and has non-remunerated membership or affiliation with Group-I."

Irrelevant parts of the statement, for which the author has no disclosures, should be deleted. Small deviations can be made for grammatical reasons or to avoid repetition. If an author has no disclosures, the statement should read ‘XX has declared no conflicts of interest’.

Each individual author is responsible for ensuring that their DOI statement in the final manuscript is true, up to date and complete (and updated in the ESMO DOI Platform if needed).

5 **CPG kick-off meeting**

After submission of all authors’ DOIs, the ESMO Guidelines staff will organise an online kick-off meeting with all authors to discuss author roles, timelines and manuscript formatting requirements as detailed in this SOP. The ESMO Guidelines staff will provide the lead author with draft presentation slides for the lead author/SE to review and to include author allocations (if possible before the meeting). Proposed timelines can then be discussed in the meeting.

CPG kick-off meetings will cover:

- Author introductions and roles of first author, last author/SE and other co-authors, including GL-SC member (if relevant)
- Key SOP details
  - Overview of thematic structure/sections
  - Use of levels of evidence (LoEs) and grades of recommendation (GoRs)
  - ESMO-standardised treatment/management algorithms
  - ESMO-MCBS
  - ESCAT
  - Supplementary material
• Author allocations, manuscript development and proposed timelines
  o Author agreement form detailing each author’s contribution (to be completed before final manuscript submission)
• ESMO Guidelines staff review and journal submission
  o ESMO provides an author collaboration site for each author group using Microsoft SharePoint Team collaboration software tools. Guidelines staff are not able to support the use of Google docs or other external collaboration sites.
  o If the ESMO Guidelines staff members are to provide medical writing support to the author group, the key roles should be outlined, discussed and agreed upon during the kick-off meeting.
• Overview of the plan/concept for Living GLs and CPG derivative products (e.g. planned ESMO slide sets, pocket guidelines, webinars and Pan-Asian adaptations)
• Any other questions

Following the kick-off meeting, ESMO Guidelines staff will provide a CPG manuscript template (Word document), supplementary material template (Word document) and CPG algorithm template (PowerPoint document). The main manuscript template can only be completed once the author allocations to the writing sections are made.

Similarly, the author agreement form can be drafted for the initial kick-off meeting, but the final version can only be completed by the lead author prior to manuscript submission.

6 Development of the CPG: Main manuscript

Note: a main manuscript template will be provided.

6.1 Extent
ESMO journals follow a strict word count policy. The manuscript should focus on the therapeutic recommendations and should not exceed 10 000 words including tables, figure legends and references (only the manuscript heading, acknowledgements, disclosures and funding are excluded from the word count). Additional information can be included in the supplementary material.

References should not exceed 100 maximum.

Authors will be asked to revise the manuscript and/or remove references if these size limits are not respected.

6.2 Guidance on writing

6.2.1 General guidance
Long discussions about drugs that are controversial or not readily available should be avoided.

When required due to word limit, authors may move some text to the supplementary material. However, clinical recommendations should be kept in the main text.

When relevant, authors are encouraged to consider the relevance of their clinical recommendations to underrepresented demographics/ethnicities and to comment on related gaps in the literature and research when needed.

Drugs that are not yet approved by the European Medicines Agency (EMA) should be identified with the statement ‘at the time of publication, [drug/treatment] is not yet EMA approved [for X indication]’. This phrasing must be used even if a drug is very likely to receive approval soon [i.e. if a Committee for Medicinal Products for Human Use (CHMP) recommendation for approval has been published]. Statements about expected approvals of drugs should be supported with a reference to the Summary of Product Characteristics/Prescribing Information or a pharmaceutical company’s press release if formal EMA approval is not yet publicly available.

6.2.2 Tools available for best practice
The development and writing of ESMO CPGs should follow best practices. To aid this, the following tools may be useful:

The Appraisal of Guidelines, Research and Evaluation (AGREE) Reporting Checklist.6,7
The Template for Intervention Description and Replication (TIDieR) Checklist.


6.2.3 Wording of recommendations

Recommendations should be easy for clinicians to understand and interpret. Therefore, clear details should be provided on the patient population, interventions, comparators and if relevant, the clinical setting. Although passive voice is used in scientific writing to distance researchers from their work, using an active voice rather than passive voice in ESMO CPGs may also enhance clarity, e.g. “Three trials have addressed the question…” as opposed to “The treatment strategies most effective were demonstrated to be…”.

The following phrasing is recommended to aid communication of the strength of recommendation, based on advice from the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) Working Group:

- **Strong positive recommendations (grade A):** ‘the authors recommend…’ or ‘clinicians should’ or ‘Do…’
- **Strong negative recommendations (grade E):** ‘clinicians should not…’; or ‘Do not…’
- **Weak recommendations (grade B and D):** ‘it is suggested…’ or ‘clinicians might…’ or ‘the authors conditionally recommend…’

Recommendations should be accompanied by proper evidence level and grade of recommendation according to the adapted Infectious Diseases Society of America-United States Public Health Service Grading System. Therefore, it is mandatory for all recommendations to be supported with an LoE and GoR, and where relevant ESMO-MCBS scores should also be included.

The LoE describes the quality of existing evidence (trials, cohort studies, case-control studies, expert opinion) that addresses a specific clinical question. The quality of evidence is assessed in terms of number of trials, sample size, methodology, bias and heterogeneity.

The GoR is a composite parameter, as it incorporates both the quality of evidence (as in LoE) as well as the clinical significance/magnitude of benefit or harm given by a novel therapy.

Any therapy can be assigned a GoR, which can be positive (recommended) or negative (not recommended). To avoid confusing negative logic, please construct a logically positive wording for the recommendation, and then assign the appropriate GoR to indicate if the recommendation is positive or negative.

Example:

- **Correct:**
  
  Administration of anti-EGFR antibodies does not result in survival improvement in patients with RAS-mutated advanced colon cancer and is **not recommended** (GoR E).

- To be avoided:
  
  Non-administration of anti-EGFR antibodies is the correct clinical strategy for patients with RAS-mutated advanced colon cancer and is **strongly recommended** (GoR A).

A bullet-point list of all recommendations in each thematic section should be included at the end of the relevant section, including LoEs and GoRs and ESMO-MCBS scores where applicable.

Example:

**Recommendations**

- mpMRI should be carried out before prostate biopsy [I, B].
- A prostate cancer risk calculator and/or mpMRI can be used to confirm the indication for biopsy in men with elevated PSA [III, C].
- Transperineal biopsies are recommended, rather than transrectal ultrasound (TRUS)-guided biopsies [III, B].
- Each biopsy should be reported individually and evaluated using the ISUP Consensus recommendations [II, B].
6.2.4 Precision medicine

Information relating to biomarkers for precision medicine should be included throughout the CPG text in the various sections where relevant and appropriate (e.g. for disease classification, prognosis, prediction and treatment decisions). Information should be given on whether the biomarkers are validated and actionable or targetable (e.g. ESCAT scores).

6.2.5 Quality control

Authors are responsible for performing a data check of any numerical data (i.e. survival rates, p-values, hazard ratios, etc.) reported in the manuscript against the source publications and verifying the accuracy of data and other content included in the guideline.

6.3 Thematic sections

The thematic section structure described below should be used. Some ESMO CPGs (specifically those focused on cancer genetics and palliative/supportive) may not be compatible with these headings and may therefore follow ‘individualised’ structure.

6.3.1 Heading

6.3.1.1 Title

The title should be formatted according to the following example:

Prostate cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up

For the titles that do not include diagnosis, treatment and follow-up, the title should be formatted according to the following example:

Central venous access in oncology: ESMO Clinical Practice Guidelines

6.3.1.2 Authors and affiliations

Provide first initial(s) and last names exactly as they should appear in the final manuscripts. Affiliations must be provided separately for each institution and should include a department where possible.

6.3.1.3 Running header

Please include a short running header, according to the following example, 80 character maximum:

ESMO Clinical Practice Guidelines for prostate cancer

6.3.1.4 Word count

The following details should be included:

Word count: XXX (excluding title page, acknowledgements, funding and disclosure sections); References: X; Tables: X; Figures: X; Supplementary material: 1.

6.3.1.5 Key words

Please include up to five key phrases for ESMO Open and six key phrases for Annals of Oncology can be included. Please review and adapt as needed. Those suggested below are standardised across ESMO CPGs but can be adapted as needed.

X, XX, ESMO Clinical Practice Guideline, diagnosis, treatment, follow-up

6.3.1.6 Highlights (online only)

Highlights are required by ESMO journals for the submission and online promotion of the final manuscript. Please provide three to five bullet points summarising the main points of the article. Each bullet point must not exceed 125 characters per bullet, including spaces.

Those suggested below are standardised across ESMO CPGs but can be adapted if they are not relevant to this title.

- This ESMO Clinical Practice Guideline provides key recommendations for managing [tumour/tissue].
- The guideline covers clinical and pathological diagnosis, staging and risk assessment, treatment and follow-up.
• Treatment and management algorithms for locoregional, advanced/metastatic and recurrent disease are provided.
• ESCAT scores are given to describe the evidence level for genomic alterations as biomarkers for using targeted therapies.
• The author group encompasses a multidisciplinary group of experts from different institutions and countries in Europe and [insert other regions if relevant].
• Recommendations are based on available scientific data and the authors’ collective expert opinion.

Example:
• This ESMO Clinical Practice Guideline provides key recommendations on the management of prostate cancer.
• Authorship includes a multidisciplinary group of experts from different institutions and countries in Europe.
• Key treatment recommendations are provided.
• Recommendations have been updated in the light of new evidence.

6.3.2 Incidence and epidemiology
The ESMO guidelines are Europe-centric but also provide guidance worldwide. Therefore, include details of global incidence and epidemiology when relevant, in addition to European data.

6.3.3 Diagnosis, pathology and molecular biology
A table and/or algorithm detailing diagnostic work up should be included.

6.3.4 Staging and risk assessment
Where possible, refer to the Union for International Cancer Control (UICC) Tumour-Node-Metastasis (TNM) staging system throughout the manuscript. Staging tables should be included in the supplementary material. These tables can be provided by ESMO.

6.3.5 Management of local and locoregional disease
An ESMO-standardised treatment algorithm must be included on therapeutic strategy or management according to stage, risk factors and disease/molecular characteristics.

6.3.6 Management of advanced and metastatic disease
An ESMO-standardised treatment algorithm must be included on therapeutic strategy or management according to stage, risk factors and disease/molecular characteristics.

6.3.7 Follow-up, long-term implications and survivorship
This section will focus on recommendations for patient follow-up and will also include information on long-term toxicities of treatment, second tumours, psychosocial implications, rehabilitation and any other issues related to survivorship. A subsection of supportive and palliative care should be included when appropriate.

6.3.8 Methodology
Methodology is required in the main text of the manuscript.

The following paragraph will be included in all CPGs:

This Clinical Practice Guideline was developed in accordance with the ESMO standard operating procedures for Clinical Practice Guidelines development (https://www.esmo.org/Guidelines/ESMO-Guidelines-Methodology). The relevant literature has been selected by the expert authors. An ESMO-MCBS table with ESMO-MCBS scores is included in Supplementary Table SX. ESMO-MCBS v1.1[ref #] was used to calculate scores for new therapies/indications approved by the EMA or FDA (https://www.esmo.org/Guidelines/ESMO-MCBS). The scores have been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee. The FDA/EMA or other regulatory body approval status of new therapies/indications is reported at the time of writing this CPG. An ESCAT table with ESCAT scores is included in Supplementary Table SXX. ESCAT scores have been defined by the authors and validated by the ESMO Translational Research and Precision Medicine Working Group.[ref ##] Levels of evidence and grades of recommendation have been applied using the system shown in Supplementary Table SXXX.[ref ###] Statements without grading were considered justified standard clinical
practice by the authors. Future updates to this CPG will be published on esmo.org as a Living GL version, to be made available at: [insert original CPG web link on esmo.org].


ref ## = include reference to ESCAT manuscript (framework) in the References section (also include this reference in the supplementary material): Mateo J, Chakravarty D, Dienstmann R, et al. A framework to rank genomic alterations as targets for cancer precision medicine: the ESMO Scale for Clinical Actionability of Molecular Targets (ESCAT). Ann Oncol. 2018;29(9):1895-1902.


6.3.9 Acknowledgments

Please include any additional acknowledgements as appropriate, following the format of the example below. Individuals who do not meet all four ICMJE authorship criteria should be acknowledged as non-author contributors, either individually or as a group, and their written permission obtained in order to include their acknowledgement. Editing and writing support will be acknowledged, e.g. from ESMO Guidelines staff or freelancers working on behalf of ESMO.

For manuscripts including ESMO-MCBS scores and/or ESCAT scores, the members of the respective working group as well as the ESMO staff and freelancers working on behalf of ESMO will be acknowledged.

e.g. Manuscript editing support was provided by Louise Green and Richard Lutz (ESMO Guidelines staff) and Angela Corstorphine of Kstorfin Medical Communications Ltd (KMC); this support was funded by ESMO. Nathan Cherny, Chair of the ESMO-MCBS Working Group, Urani Dafni ESMO-MCBS Working Group Member/Frontier Science Foundation Hellas and Giota Zygoura of Frontier Science Foundation Hellas provided review and validation of the ESMO-MCBS scores. Nicola Latino (ESMO Scientific Affairs staff) provided coordination and support of the ESMO-MCBS scores and Angela Corstorphine and Sian-Marie Lucas of KMC provided medical writing and editing support in the preparation of the ESMO-MCBS table; this support was funded by ESMO. Dr Joaquin Mateo (Chair of the ESMO Translational Research and Precision Medicine Working Group) and Dr Svetlana Jezdic (ESMO Medical Affairs Advisor) provided validation support for ESCAT scores.

6.3.10 Funding

A general funding statement is required. The following general statement will be included in all CPGs:

No external funding has been received for the preparation of these guidelines. Production costs have been covered by ESMO from central funds.

6.3.11 Disclosure

See Section 3.6: ESMO Declaration of Interest.

6.3.12 References

Refer to the most recently published randomised controlled trials (RCTs), meta-analyses and/or systematic reviews. Review articles may be used as citations in order to summarise data; however, it is preferable that pivotal RCTs or meta-analyses are cited in order to support a recommendation. Trials used for ESMO-MCBS score calculation(s) should also appear in the reference list. References should not exceed 100 maximum.

Reference managing software should be used with a travelling library available to the ESMO Guidelines office to facilitate formatting for journal submission. Endnote is ESMO’s recommended choice of software and a free version is available online. The Guidelines office will use Endnote 20 for reference formatting and can assist authors as needed with managing the references.

6.3.13 Tables

All tables must be cited within the document and should be included in the manuscript file following the references (separate Word files are not needed but all content should be provided in an editable format).
The references cited in the tables should also be listed after all references that appear in the main manuscript. Suggested tables include:

- Table with diagnostic work-up
- Tables on therapeutic regimens or prognosis

6.3.14 Treatment algorithms (mandatory) and other figures

Note: an algorithm template will be provided. All figures should be provided in an editable format.

Algorithms on therapeutic strategy or management according to stage, risk factors and disease/molecular characteristics are required and must be cited within the document. This is a priority issue for ESMO.

Please include LoEs and GoRs where applicable. Please include all acronyms in alphabetical order by acronym and footnotes in the order shown below.

ESMO-MCBS and/or ESCAT scores will be added in the final version.

ESMO will prepare the final algorithms using standard formatting/colours for publication. The following colour code will be used:

- **Purple** (rgb: 133, 25, 74): general/heading boxes related to stratification, e.g. type of cancer, or patient subgroup
- **Red** (rgb: 224, 81, 54): surgery
- **Dark green** (rgb: 20, 83, 40): radiotherapy
- **Blue** (rgb: 76, 128, 175): systemic anticancer therapy
- **Turquoise** (rgb: 66, 180, 146): combination of treatments (e.g. CRT) or other systemic treatments (allo-SCT, RBC transfusions, antibiotics, steroids, etc.)
- **White** (rgb: 225, 225, 225): other aspects of management not covered by the categories above, e.g. observation and monitoring.

An example of an algorithm for Management/Therapeutic strategy by stage/risk factors is shown below.

---

**Figure 1. HCC treatment options depending on BCLC stage.**

Purple: general categories or stratification; red: surgery; dark green: radiotherapy; blue: systemic anticancer therapy; turquoise: combination of treatments or other systemic treatments; white: other aspects of management.

\* Non-standard, alternative treatment.
ESMO-MCBS v1.1[ref #] was used to calculate scores for new therapies/indications approved by the EMA or FDA. The scores have been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee (https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms).

Noninferiority to sorafenib established; no evaluable benefit.

Regorafenib is not recommended in TKI-naïve patients.

Ramucirumab is only recommended in patients with an AFP level ≥400 ng/ml.

AFP, α-fetoprotein; BCLC, Barcelona Clinic Liver Cancer; BSC, best supportive care; EMA, European Medicines Agency; HCC, hepatocellular carcinoma; LTX, liver transplantation; ESMO-MCBS, European Society for Medical Oncology-Magnitude of Clinical Benefit Scale; SBRT, stereotactic body radiotherapy; SIRT, selective internal radiotherapy; TACE, transarterial chemoembolisation; TKI, tyrosine kinase inhibitor.


For figures including ESCAT scores:

ref ## = include reference to ESCAT manuscript (framework) in the References section (also include this reference in the supplementary material): Mateo J, Chakravarty D, Dienstmann R, et al. A framework to rank genomic alterations as targets for cancer precision medicine: the ESMO Scale for Clinical Actionability of Molecular Targets (ESCAT). Ann Oncol. 2018;29(9):1895-1902.

7 Development of the CPG: Supplementary file

Note: a supplementary file template will be provided.

7.1 Extent

Some required elements will be included as supplementary material, which is excluded from the overall word count limit. The supplementary material should follow the same formatting and style requirements as the main manuscript, including for headings and referencing

The supplementary file does not contribute to the overall word count of the CPG.

All supplementary tables must be cited within the document and should be included in the supplementary file following the references (separate word files are not needed but all content should be provided in an editable format).

Required supplementary tables include:

- Supplementary biomarkers and molecular targets for precision medicines and corresponding ESCAT scores (ESCAT table; if applicable)
- Supplementary table(s) with staging system [preferably tumour–node–metastasis (TNM)]^4 and stage groups
- Supplementary ESMO-MCBS table with ESMO-MCBS scores for new therapies/indications approved by the EMA or FDA (if applicable)
- Supplementary LoE/GoR table (required for all ESMO guidelines)

7.2 Precision medicine and ESMO Scale for Clinical Actionability of molecular Targets (ESCAT) scores

Information relating to actionability, clinical utility and clinical validity of biomarkers and molecular targets for precision medicine should be included throughout the CPG text in the various sections where relevant and appropriate, e.g. regarding diagnosis, staging and classification, prognosis, use in medical treatment decisions and follow-up and monitoring.

Where relevant, the guideline authors should calculate and include ESCAT scores for any genomic alteration–drug matches included in the guideline, evaluating previously published ESCAT scores if available or interacting with the ESMO Translational Research and Precision Medicine Working Group (TRPM WG) if no ESCAT scores are available. The TRPM WG will review and validate ESCAT scores proposed by the authors. The ESMO Guidelines office can assist with this process.
ESCAT scores should be included in the main manuscript with the recommendations and in algorithms, alongside the LoE/GoR and ESMO-MCBS scores, along with a reference in the main manuscript to the supplementary file, e.g. ‘For personalised therapy approaches, ESCAT classifications [ref #] need to be considered (Supplementary Table S1).’

An ESCAT table ‘Biomarkers and molecular targets for precision medicines and corresponding ESCAT scores is recommended in the supplementary file. A template table is given below.

### 7.2.1 ESCAT criteria

The ESCAT score defines clinical evidence-based criteria for prioritising genomic alterations for use as markers to select patients for targeted therapies. The scale is comprised of six tiers based on implications for patient management (Tier I-X; see Table below). These tiers are sub-divided by level of clinical evidence. For pragmatic clinical guidance, the most relevant ESCAT tiers for guidelines may be Tier I and II (targets ready for implementation in routine clinical decisions; and investigational targets that likely define a patient population that benefits from a targeted drug but additional data are needed, respectively).

#### Criteria for defining the ESCAT score for genomic alternation–drug matches

<table>
<thead>
<tr>
<th>ESCAT Tier</th>
<th>Clinical value class</th>
<th>Clinical implication</th>
<th>Level of evidence</th>
<th>Overall ESCAT score (include the in guideline)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ready for routine use</td>
<td>I: Alteration–drug match is associated with improved outcome in clinical trials.</td>
<td>Drug administered to patients with the specific molecular alteration has led to improved clinical outcome in prospective clinical trial(s).</td>
<td>A: prospective, randomised clinical trials show the alteration–drug match in a specific tumour type results in a clinically meaningful improvement of a survival endpoint.</td>
<td>I-A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to the treatment should be considered standard of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>B: prospective, non-randomised clinical trials show that the alteration–drug match in a specific tumour type, results in clinically meaningful benefit as defined by ESMO-MCBS v1.1.</td>
<td>I-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C: clinical trials across tumour types or basket clinical trials show clinical benefit associated with the alteration–drug match, with similar benefit observed across tumour types.</td>
<td>I-C</td>
</tr>
<tr>
<td>Investigational</td>
<td>II: alteration–drug match is associated with antitumour activity, but Drug administered to a molecularly defined patient population is likely to result in clinical benefit in a given tumour</td>
<td>Treatment to be considered ‘preferable’. in the context of evidence collection either as a</td>
<td>A: retrospective studies show patients with the specific alteration in a specific tumour type experience clinically meaningful benefit with matched drug</td>
<td>II-A</td>
</tr>
<tr>
<td>Hypothetical target</td>
<td>III: alteration–drug match suspected to improve outcome based on clinical trial data in other tumour type(s) or with similar molecular alteration.</td>
<td>Drug previously shown to benefit the molecularly defined subset in another tumour type (or with a different mutation in the same gene), efficacy therefore is anticipated for but not proved.</td>
<td>Clinical trials to be discussed with patients.</td>
<td>A: clinical benefit demonstrated in patients with the specific alteration (as tiers I and II above) but in a different tumour type. Limited/absence of clinical evidence available for the patient-specific cancer type or broadly across cancer types.</td>
</tr>
<tr>
<td>Combination development</td>
<td>V: alteration–drug match is associated with objective response,</td>
<td>Drug is active but does not prolong PFS or OS, probably in part due to mechanisms of adaptation.</td>
<td>Clinical trials assessing drug combination strategies could be considered.</td>
<td>Prospective studies show that targeted therapy is associated with objective responses, but this does not lead to improved outcome.</td>
</tr>
</tbody>
</table>
but without clinically meaningful benefit.

**X:** lack of evidence for actionability.

There is no evidence, clinical or preclinical, that a genomic alteration is a potential therapeutic target.

The finding should not be taken into account for clinical decision.

No evidence that the genomic alteration is therapeutically actionable.

---


### 7.2.2 ESCAT template

**Supplementary Table SX.** Biomarkers and molecular targets for precision medicines and corresponding ESCAT scores

<table>
<thead>
<tr>
<th>Biomarker or genomic alteration</th>
<th>Method of detection</th>
<th>Drug match</th>
<th>ESCAT score&lt;sup&gt;a,b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>List the biomarker or genomic alteration.</td>
<td>Describe the methodology or assay used to measure the biomarker/genomic alteration.</td>
<td>List the actionable treatment regimen related to the biomarker or genomic alteration.</td>
<td>Scores should be calculated by CPG authors and validated by the ESMO Translational Research and Precision Medicine Working Group. References should be included.[1] State ‘N/A’ if an ESCAT score is not relevant for the biomarker (e.g. the biomarker is not a genomic alteration).</td>
</tr>
</tbody>
</table>

**EXAMPLE:**

*NTRK* mutations[ref #]

Sanger sequencing or NGS

*NTRK* inhibitors (e.g. larotrectinib, entrectinib)

I-C

---

The following acronyms and footnotes should be added:

ESCAT, ESMO Scale for Clinical Actionability of molecular Targets.

<sup>a</sup> ESCAT scores apply to genomic alterations only. These scores have been defined by the guideline authors and validated by the ESMO Translational Research and Precision Medicine Working Group.

<sup>b</sup> I-A, alteration–drug match is associated with improved outcome with evidence from randomised clinical trials showing the alteration–drug match in a specific tumour type results in a clinically meaningful improvement of a survival endpoint;
I-B, alteration–drug match is associated with improved outcome with evidence from prospective, nonrandomised clinical trials showing that the alteration–drug match in a specific tumour type results in clinically meaningful benefit as defined by ESMO-MCBS v1.1; I-C, alteration–drug match is associated with improved outcome with evidence from clinical trials across tumour types or basket clinical trials showing clinical benefit associated with the alteration–drug match, with similar benefit observed across tumour types; III-A, alteration–drug match is suspected to improve outcome based on patients with the specific alteration but in a different tumour type, with limited/absence of clinical evidence available for the patient-specific cancer type or broadly across cancer types.[ref #]

ref # = include pivotal trial reference(s).


### 7.3 Supplementary Table(s) with staging system (preferably TNM) and stage groups

Please include any appropriate staging tables as supplementary files. Where possible, refer to the Union for International Cancer Control (UICC) staging system. These tables can be provided by ESMO.

### 7.4 Supplementary ESMO-MCBS table

Where applicable, ESMO-MCBS calculations will be performed by the ESMO-MCBS Working Group and validated by the GLC.

Relevant ESMO-MCBS scores will be summarised in the CPG in a separate ESMO-MCBS table provided by ESMO-MCBS staff. The table will be included as a supplementary file: ‘Supplementary Table SX. ESMO-MCBS table for new therapies/indications in [tumour type].’ This table is to be used as a tool to provide basic information on the new therapy rather than the formal tool producing the ESMO-MCBS score. Scores and table will be calculated by the ESMO-MCBS Working Group after the first draft of the CPG is received by the Guidelines staff. Authors of the CPG should evaluate the scores and any queries should be addressed to the Guidelines staff for consideration and response from the ESMO-MCBS WG. In case of disagreement, arbitration is performed by the ESMO-MCBS WG Chair and, when necessary, by the ESMO Board.

When an ESMO-MCBS score has been produced for a new therapy or a new indication of existing therapy by the EMA or the FDA, it should appear next to the LoE/GoR in the text and in the algorithms whenever a recommendation on the therapy is formulated (e.g. [I, A; ESMO-MCBS v1.1 score: 4]).

The ESMO-MCBS score must be included for any drug that is included in the manuscript where relevant. However, if scores are available for drugs not mentioned in the guidelines (e.g. outdated treatments), the authors are not obliged to include this information. Authors may choose to add specific commentary to scores if they feel additional explanation will be needed by the readership.

Scientific progress can be captured in the CPG text. CPGs can include scores for drugs that are not yet EMA or FDA approved, providing the lack of approval is clearly stated and there is support for the score from a peer-reviewed publication. Only include non-approved therapies that fulfil four criteria:

1. Recommendations and algorithms – scientific breakthrough noted in recommendations and algorithms if substantial, clinical benefit and imminent regulatory approval;
2. LoE and GoR must be included;
3. Studies/drug efficacy should be evaluated and published in a peer-reviewed medical journal (Note: ESMO does not apply ESMO-MCBS scores based on findings reported in abstracts); and
4. The text must clearly highlight that the recommendation is not approved by a regulatory authority (e.g. ‘not EMA approved’ or similar text is included after the ESMO-MCBS score).

This footnote should be added:

ESMO-MCBS v1.1[ref #] was used to calculate scores for new therapies/indications approved by the EMA or FDA. The scores have been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee (https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms).

ref # = include reference to ESMO-MCBS manuscript (v1.1 in the References section (also include this reference in the supplementary material); Cherny NI, Dafni U, Bogaerts J, et al. ESMO-Magnitude of Clinical Benefit Scale version 1.1. Ann Oncol. 2017;28(10):2340-2366.
### Supplementary Table SX. ESMO-MCBS table for new therapies/indications in XXX

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Disease setting</th>
<th>Trial</th>
<th>Control</th>
<th>Absolute survival gain</th>
<th>HR (95% CI)</th>
<th>QoL/Toxicity</th>
<th>ESMO-MCBS Score&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the new therapy</td>
<td>Describe the disease setting. Specify (Neo)adjuvant or advanced</td>
<td>Trial acronym (trial name if acronym is not available)&lt;sup&gt;1&lt;/sup&gt; phase of trial, NCT number</td>
<td>Describe the control arm</td>
<td>Median, in months (state OS, PFS or both)</td>
<td>Median and 95% CI</td>
<td>Improved or Deteriorated or Similar or Not Available</td>
<td>Score X (Form X)</td>
</tr>
</tbody>
</table>

CI, confidence interval; EMA, European Medicines Agency; ESMO-MCBS, ESMO-Magnitude of Clinical Benefit Scale; HR, hazard ratio; OS, overall survival; PFS, progression-free survival; QoL, quality of life.

<sup>a</sup>ESMO-MCBS v1.1.<sup>2</sup> was used to calculate scores for new therapies/indications approved by the EMA or the FDA. The scores have been calculated by the ESMO-MCBS Working Group and validated by the ESMO Guidelines Committee ([https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms](https://www.esmo.org/guidelines/esmo-mcbs/esmo-mcbs-evaluation-forms)).

Include in References:
1. Pivotal trial reference(s).

#### 7.5 Supplementary LoE/GoR table

The following table will be included as a supplementary file to explain the methodology regarding the LoEs and GoRs.

### Supplementary Table SX. Levels of evidence and grades of recommendation (adapted from the Infectious Diseases Society of America-United States Public Health Service Grading System<sup>a</sup>)

#### Levels of evidence

| I | Evidence from at least one large randomised, controlled trial of good methodological quality (low potential for bias) or meta-analyses of well-conducted randomised trials without heterogeneity |
| II | Small randomised trials or large randomised trials with a suspicion of bias (lower methodological quality) or meta-analyses of such trials or of trials with demonstrated heterogeneity |
| III | Prospective cohort studies |
| IV | Retrospective cohort studies or case–control studies |
| V | Studies without control group, case reports, expert opinions |

#### Grades of recommendation
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Strong evidence for efficacy with a substantial clinical benefit, strongly recommended</td>
</tr>
<tr>
<td>B</td>
<td>Strong or moderate evidence for efficacy but with a limited clinical benefit, generally recommended</td>
</tr>
<tr>
<td>C</td>
<td>Insufficient evidence for efficacy or benefit does not outweigh the risk or the disadvantages (adverse events, costs, etc.), optional</td>
</tr>
<tr>
<td>D</td>
<td>Moderate evidence against efficacy or for adverse outcome, generally not recommended</td>
</tr>
<tr>
<td>E</td>
<td>Strong evidence against efficacy or for adverse outcome, never recommended</td>
</tr>
</tbody>
</table>

*Reprinted by permission of Oxford University Press on behalf of the Infectious Diseases Society of America [Ref#].

Include in References:


8 Final review and submission

ESMO Guidelines staff carry out the final review and submission and ensure that the final version adheres to the SOP and journal requirements prior to submission.

8.1 Author Responsibility and Acknowledgement Agreement form

Authors should be able to take public responsibility for the CPG and have confidence in the accuracy and integrity of all their co-authors. To aid this, before manuscript submission, the lead author is responsible for confirming that all co-authors fulfil these criteria using the ESMO Author Responsibility and Acknowledgement Agreement form provided on the ESMO website here: https://www.esmo.org/guidelines/esmo-guidelines-methodology. The lead author should provide specific details of each author’s role in developing the CPG. The completed form must be returned to the ESMO Guidelines office for manuscript submission to proceed.

8.2 ESMO Journal requirements

The SE will provide a cover letter for the manuscript submission summarising important details of the CPG, a list of proposed reviewers and professional social media profiles of authors; authors can recommend 3-5 reviewers to propose to the journal, and where possible these should be ESMO Faculty: https://www.esmo.org/about-esmo/organisational-structure/educational-committee/esmo-faculty

Three individuals who are not recommended as reviewers can also be proposed.

ESMO Journals request the social media profiles of authors that will be tagged by ESMO/Annals of Oncology or ESMO Open when the publication is made available online, e.g. https://twitter.com/yourname. Providing this information is voluntary.

In addition, @myESMO is included as standard, as well as other organisational accounts for joint guidelines and @rarecancer where relevant.

8.3 Final review and DOIs

ESMO Guidelines staff will circulate the finalised manuscript to all co-authors and gather approvals:

- All authors must approve the manuscript before submission
- Each author will review/update their final disclosure statement for the manuscript, which should reflect the DOI that is available from the ESMO DOI platform

ESMO Guidelines staff will submit the manuscript and keep authors informed of progress.
9 CPG eUpdates and Living GLs

In the case of a significant breakthrough that necessitates rapid communication as updated CPG content or in the case of a new EMA or FDA indication bearing an ESMO-MCBS score, the GL-SC member or the SE will coordinate with the guideline authors to produce an update to the ESMO CPG, preferably a Living GL update (only for selected titles during 2022) or as an eUpdate. This update will be published on the ESMO website linked to the corresponding original CPG. eUpdates are also submitted to an ESMO journal for simultaneous publication.

Please see the eUpdate and Living GL SOPs for additional guidance about these publications, available here: http://www.esmo.org/Guidelines/ESMO-Guidelines-Methodology.

10 References used in this SOP


## Appendix

### 11.1 Definitions and function of the different types of ESMO Guidelines

A brief overview of the definitions and suitability of the different types of ESMO guidelines is given in the table below.

<table>
<thead>
<tr>
<th>Type of ESMO Guideline</th>
<th>Definition</th>
<th>Suitability</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPG</td>
<td>A full set of recommendations for the diagnosis, management, treatment and follow-up of a specific cancer type, patient group, or clinical setting, supported by peer-reviewed data and clinical rationale.</td>
<td>New titles can be proposed for topics not covered by existing ESMO CPGs. A full update to a CPG for an existing title may be appropriate when many clinical recommendations throughout the CPG have become outdated. If updates are minor and limited to a specific section, an eUpdate may be more appropriate than full CPG update.</td>
</tr>
<tr>
<td>eUpdate</td>
<td>Online update of a specific section of an existing CPG. Published simultaneously on esmo.org as well as in an ESMO journal as Letters to the Editor or Special Articles to allow for greater awareness.</td>
<td>Intended to be quick and flexible. Suitable when a more time-consuming update of the full CPG is not necessary, and when a clinically important breakthrough from a peer-reviewed publication needs to be rapidly communicated, or a new MCBS score is issued. To reduce the chance that readers miss important updates, it is preferable to issue fewer eUpdates covering multiple recommendations rather than many individual eUpdates.</td>
</tr>
<tr>
<td>Living GL (expected from July 2022; to replace the use of eUpdates over time)</td>
<td>Online update of new CPGs or CPG updates. Simultaneous version published on esmo.org when the CPG is published online that includes key recommendations, treatment algorithms and other details. Updated on a regular basis (every 3-12 months), with updates integrated into the online version. The Living GL updates are available on esmo.org and are linked to the original CPG on which the updates are based is published in an ESMO journal.</td>
<td>Intended for all future CPG titles from July 2022 to address clinically important breakthroughs and updates to recommendations. To reduce the chance that readers miss important updates, and due to the intensity of work needed for each Living G, updates to existing Living GLs should currently be combined when possible, for a maximum or four updates per year. This process will be reviewed and improved as the operation of Living GLs develops further.</td>
</tr>
</tbody>
</table>