



Consensus Conference Standard Operating Procedures

ESMO Guidelines Committee, January 2020

CONSENSUS CONFERENCE PROPOSAL:

- Proposal and rationale for Consensus Conference (CC) by Subject Editor (SE).
- Review and approval by the ESMO Guidelines Committee (GLC).
- In case of joint CC with other societies, Memorandum of Understanding (MoU) in place.

CONSENSUS CONFERENCE MEMBERSHIP:

- One CC Chair nominated by SE, the SE being the CC Co-chair. Validation by GLC.
- Up to 40 members providing pan-European and global representation, with priority given to ESMO Faculty members.
- Acknowledged, multidisciplinary experts in the field. Maximum of 4 non-Europeans if they bring scientific expertise.
- Declarations of potential conflicts of interest (Disclosures) are obtained from all invited contributors.
- The CC Chairs break the CC into several topics. Each topic is assigned to a Working Group (WG) with 5-10 members.
- The CC Chairs will appoint a WG Chair to coordinate the activities of each WG.
- Each WG will identify specific questions within each topic to be addressed. The target audience is physicians practicing in the field of oncology.

PREPARATION MEETING:

- A preparation meeting (1 day) must be organised between CC Chairs and the WG Chairs to work on defining the topics and potential questions for each topic. This meeting must take place preferably 6 months prior to and at least 3 months prior to the CC.
- During the preparation meeting, CC Chairs and WG Chairs will select the participants to be invited to the CC.

WG PREPARATION:

- Following the preparation meeting, participants will be invited to join a specific WG and contribute to the preparatory work of the CC.
- WG Chairs will decide how the group will work and will assign specific tasks to each WG member.
- WG members will work on the topics assigned and develop questions via exchange of emails, tele/web conferences, etc. Remote work through a modified Delphi method may also be used (See Appendix, Instruction 1). No funding for formal physical meetings is foreseen.
- WG members are each responsible for conducting a study of relevant evidence for the assigned questions including a narrative review of the evidence and a list of important references.
- In cases where the CC Chairs consider a systematic review of the evidence necessary, this should be done by each WG. No funding is foreseen for systematic review.
- WG Chairs should prepare a summary report for the CC Chairs to review prior to the CC.

CONSENSUS MEETING:

- The CC Chairs are responsible for and have authority over the conference.
- Suggested general outline (3-day conference):

➤ **INTRODUCTION**

Introduction with all participants to discuss the aims, structure and process of the conference.

➤ **WG DISCUSSION PHASE: Parallel break-out sessions, No voting**

A summary report with Questions and Recommendations (including multiple options if needed) is made available to all WG members before the CC. Each WG discusses topics/questions, with a view to finalising specific recommendations with evidence levels. Diverging opinion in Questions and Recommendations should be recorded by each WG if needed for presentation to the Plenary Session.

➤ **JOINT PRESENTATION PHASE: Plenary session(s) with Discussion and Voting**

WG Chairs present the Questions and Recommendations (with all diverging opinions) from their group for discussion. Discussion takes place for each Question and Recommendation. The plenum concludes to a Recommendation statement. Voting for each recommendation takes place and should be stated as percentages of Agree, Disagree, Abstain.

➤ **CONCLUSION PHASE: Final plenary session**

CC Chairs and WG Chairs provide a summary of discussions. This should include the Questions, Recommendations and percentages of agreement for each recommendation. The CC Chairs review with the Member Panel the next steps for manuscript preparation and the timeline for publication.

➤ **SUMMARY MEETING:**

The CC Chairs and WG Chairs may spend some additional time at the end of the conference to discuss decisions and next steps.

POST-CONSENSUS RESOLUTION OF DISAGREEMENTS:

- For each recommendation on a clinical problem, the result of voting with percentage of agreement, disagreement and abstention should be stated during the meeting and reported in the final paper.
- If the results of voting are not stated or <75% agreement on a recommendation or >20% of disagreement is achieved during the meeting, a post-meeting consensus should be achieved by filling a Grading of Recommendations Assessment, Development and Evaluation (GRADE) grid (See Appendix, Instruction 2).
- The statement of recommendation on a specific intervention for a clinical problem is sent to each participant with a GRADE grid to be filled and sent to ESMO staff within 72 hours.
- Results are polled; if <75% consensus is achieved, statements are recirculated by asking for voting again on the same or modified statements.

FINALISATION OF MANUSCRIPT:

- The CC Chairs and WG Chairs finalise the Recommendations with Levels of Evidence (LoEs) and Grades of Recommendation (GoRs) where applicable (See Appendix). For each recommendation, Voting is shown as percentages of Agree, Disagree, Abstain.
- Following the CC, all WGs should send their draft topic manuscripts with Questions, Recommendations and LoEs/GoRs to the CC Chairs within one month.
- CC Chairs incorporate all topic manuscripts in a pre-final manuscript.
- Areas of controversy and dissent are included and acknowledged in the final text.
- LoEs/GoRs and references are provided for every formulated recommendation throughout the document. The grading system must be consistent across guidelines and form the basis for the class of recommendation and LoEs/GoRs documented.

- The pre-final manuscript is circulated to all members of the CC expert panel for a final check and comments/suggestions. The Chairs finalise the document and forward it to the GLC for approval.
- Authorship includes all members of the CC expert panel. Only those participating at the CC can be included as authors, although the CC Chairs have the final decision.
- All members of the CC expert panel will be listed as authors on the manuscript, either as named authors following the manuscript title or in the Member Panel included as an Appendix. Lead authors are normally listed in this order: CC Chair, WG Chairs (alphabetical) and SE (Co-chair, last). In the event of multiple manuscripts per WG, the WG members are listed by name for their respective WG manuscripts.
- 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 and funding are excluded from the word count). A shorter manuscript is preferred to allow for modifications following peer review. Additional information can be included in supplementary files. 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. The final manuscript will be submitted to ESMO journals for consideration for publication.

ORGANISATION/FUNDING/UPDATE OF CC:

- No funding should originate from the industry in order to safeguard the integrity of the guidelines (only ESMO or professional networks).
- No involvement of industry representatives in CC. Participation of patient representatives/advocacy groups is optional.
- eUpdates may be performed by CC Chairs, GLC on a case by case basis; these will be included in the ESMO Guidelines section of the ESMO website.

APPENDIX

Instruction 1: Modified Delphi method for Remote Work of WGs before the CC [1]

It is a method used to gather opinion from large numbers of participants working independently who answer questionnaires in two or more rounds. After each round a facilitator provides in a short period of time, an anonymous summary of the contributions and ask the participants to revise their answer(s) in light of the summary results within 48 hours. The process terminates after a predefined stop criteria (number of rounds, achievements of consensus, stability of results).

Delphi Questionnaires in each WG:

- After the questions are finalised, the WG Chairs produce a Delphi Questionnaire comprising the questions, each with Alternative Options/Answers or “Do You Agree” sections.
- The Delphi Questionnaire is circulated to all WG members.
- The answers are anonymised and collated in a summary report prepared by ESMO staff and forwarded to all WG members.
- The Delphi Questionnaire is sent to all WG members for a second round.
- The final round questions and answers are collated to a Summary with Questions and Recommendation options.

Include in References:

1. Jones Y and Hunter D. Qualitative research: consensus methods for medical and health services research. BMJ 1995; 311: 376–388.

Instruction 2: Use of GRADE grid for post-CC dissents [2]

For each recommendation, the participant fills a GRADE grid Module 1 by defining his opinion on quality of evidence (based on available data) [3] and the balance between desirable (beneficial health outcomes, cost savings, less burden for patients and staff) and undesirable effects. Quality of evidence and balance between desirable/undesirable effects influences the strength of recommendations (the higher the quality of evidence or the larger the difference between the desirable and the undesirable effects, the more likely a strong recommendation is warranted). The questionnaire is sent to ESMO staff within 72 hours, who then circulate a polling summary which reflects the collective judgement on strong

recommendation in favour of an intervention (desirable outweigh undesirable effects), weak or no recommendation at all.

The GRADE grid:

- Participants are provided with guidance on factors to be taken into account in formulating the recommendation.

	Grade score				
	1	2	0	-2	-1
Superiority of intervention Balance between desirable and undesirable consequences of intervention	Definitely superior AND desirable clearly outweigh undesirable	Probably superior AND desirable probably outweigh undesirable	Equal to other option OR trade-offs equally balanced or uncertain	Probably inferior OR undesirable probably outweigh desirable	Definitely inferior OR undesirable clearly outweigh desirable
Recommendation	Strong: definitely do it	Weak: probably do it	No specific recommendation	Weak: probably don't do it	Strong: definitely don't do it
For each proposition below, please mark with a "X" the cell which best corresponds to your assessment					
Example: Chemotherapy + Drug A should be the preferable option over Chemotherapy + Drug B for X-type Y cancer patients with Z as the aim		X			

Include in References:

2. Jaeschke R, Guyatt GH, Dellinger P et al. Use of GRADE grid to reach decision on clinical practice guidelines when consensus is elusive. *BMJ* 2008; 337: a744.
3. Guyatt GH, Oxman AD, Kunz R et al. What is quality of evidence and why is it important to clinicians? *BMJ* 2008; 336: 995–998.

LoEs and GoRs

Evidence levels are mandatory. Recommendations should be accompanied by an evidence level and grade of recommendation according to the adapted Infectious Diseases Society of America-United States Public Health Service Grading System.

The LoE describes the quality of existing evidence (trials, cohort studies, case-control studies, expert opinion) that address 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 varies from positive (recommended) to negative (not recommended). To avoid confusion, please refer to the Therapy being evaluated as a logically positive definition and then assign the appropriate GoR (which can be positive or negative).

Accordingly, always use the GoR in the following template manner:

Administration of Therapy A (logically positive definition) > GoR assigned (positive: Recommended or negative: Not Recommended). Please avoid doing the opposite.

EXAMPLES:

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).

Supplementary Levels of Evidence and Grades of Recommendation Table

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

Supplementary Table X. Levels of evidence and grades of recommendation (adapted from the Infectious Diseases Society of America-United States Public Health Service Grading System^a)

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, experts opinions

Grades of recommendation

A	Strong evidence for efficacy with a substantial clinical benefit, strongly recommended
B	Strong or moderate evidence for efficacy but with a limited clinical benefit, generally recommended
C	Insufficient evidence for efficacy or benefit does not outweigh the risk or the disadvantages (adverse events, costs, etc.), optional
D	Moderate evidence against efficacy or for adverse outcome, generally not recommended
E	Strong evidence against efficacy or for adverse outcome, never recommended

^aBy permission of the Infectious Diseases Society of America [X].

Include in References:

X. Dykewicz CA. Summary of the guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients. Clin Infect Dis 2001; 33: 139–144.