Testis Cheat Sheet

Staging:

- Centers around protocol being followed

COG Stage	COG Description	AJCC/NCCN Equivalency
I	Limited to testis/neg margin Excisional biopsy with FS and completion orchiectomy at same setting NED beyond testis LNs <1cm	N0 → I
II	Capsule violation +margin at scrotum or <5cm from cord margin LNs <1cm Failure of STMs to normalize/decrease appropriately	
III	RP LNs ≥ 2cm LNs 1-2cm that fail to resolve in 6 weeks	N_{any} → II
IV	Distant mets	M1 → III

Risk Classification

	Low (stage 1, any age)	**Standard 1 (pre-pubertal)**	**Standard 2 (post-pubertal)**	**Poor (post-pubertal)**
Age (y)	0-50	0-<11	11-<25	11-<25
COG stage	I	II-IV	II-IV	II-IV
IGCCC risk	-	-	Good Seminoma – M1aS_{any} NSGCT – M1aS0/S1	Intermediate/poor Seminoma – M1b, S_{any} NSGCT – MS primary; M1aS2/S3; M1bS_{any}

Other differences:

Scenario	COG	NCCN

RP mass at diagnosis	• Interpretation depends on size
	• >2cm → mets → chemotherapy
	• <1cm → uninvolved → observe
	• 1-2cm → close interval scan in 4-6 weeks
	  • Larger → mets
	  • Same → excision vs mets
	  • Smaller → observe
		• N stage as appropriate
		• Can consider RPLND vs. chemotherapy

PC RP mass	• STMs normal or stable elevated (not rising) → surgery • Surgery is excision of mass only, no RPLND	• STMs normal or decreasing appropriately • Formal RPLND
Chemotherapy	• Must include bleomycin	• insufficient evidence to prefer BEPx3 vs EPx4

Endodermal sinus tumor = YST

BEP carboplatin, etoposide, bleomycin
BEC carboplatin, etoposide bleomycin
B vs b slight difference in dose and freq of bleomycin

AGCT 1531:

- Minimize toxicity while maintaining survival
- Expand AS in low risk (non-testis sites mainly)
- Carbo vs cisplatin in standard risk

AGCT 1532:

- Accelerated vs standard BEP in post-pubertal mets GCT
- COG poor risk/NCCN stage III intermediate/poor risk

MaGIC:

- Collaborative group
- Adult IGCCC risk didn't correlate with pediatric GCTs

- Came up with risk stratification system based on outcomes

Generalizations:

- Peds onc will treat per COG
- Adult onc will teat pr NCCN
- Post-pubertal should be treated per NCCN for improved outcomes per AUA and NCCN guidelines
- Current COG protocols *generally* align, with a few nuances important for study
- How will this influence outcomes?