

## Updated testicular cancer consensus guideline is a concise, balanced, and practical guide for clinicians

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After 30 years of multidisciplinary management of testicular germ cell tumors at Princess Margaret Cancer Centre, I was delighted to help organize a two-day meeting of like-minded clinicians in Toronto in 2007 to develop a consensus for management of an increasing number of men with testicular cancer in Canada. I had participated in a similar exercise in Europe in 2004 and we were seeing an evolving Canadian approach that we believed should be documented to better measure our outcomes, which we felt could be improved upon. Most of us had ridden an exciting and immensely rewarding wave of changing practice that had dramatically improved outcomes.

There were two reasons for the improvement. The first was a tsunami of innovation (unlike few other solid tumors at that time), including better imaging with computed tomography scans, the discovery of cisplatin for systemic therapy, the application of the biomarkers ( $\beta$ -human chorionic gonadotropin and alpha-fetoprotein), improved retroperitoneal surgical techniques, and the understanding of natural history of early-stage disease (active surveillance of stage I disease was safe and reduced morbidity). The second was the recognition that rare diseases are better managed by high-volume, multidisciplinary teams.

This later evolution has occurred in many tumor sites and while we continue to debate the exact definition of *rare*, we understand that with testicular cancer, primary care diagnosis is often delayed and histological and staging accuracy, as well as treatment recommendations, vary between high-volume experts and generalist oncologists. Variation is the enemy of quality outcome.

We published our first Canadian consensus in 2010 due to the persistence of Drs. Lori Wood, Christian Kollmannsberger, Padraig Warde, and other committed clinician luminaries from across Canada. I was privileged to participate in the European Society of Medical Oncology (ESMO) consensus in 2016 and was delighted that Drs. Rob Hamilton, Lori

Wood, and Christina Canil agreed that we should update our Canadian consensus, which appears in this issue of *CUAJ*.<sup>1</sup>

The development process was rigorous. The product is evidence-based, objective, concise, balanced, and above all, a practical guide for clinicians who manage these young men who have so many years of productive life to lose if treatment is unsuccessful.

A group of Canadian expert clinicians have used a Google Groups email list for years to share anonymized problem cases for discussion. The depth of experience and breadth of multidisciplinary knowledge exhibited in the replies has, in many ways, been codified into this consensus guideline, which is a model for not only genitourinary, but all cancers. This is an example of a grass roots professional effort to do the right thing. In 2022, Canadian survival rates are among the best in the world. What we don't report well is that the overall morbidity to achieve these outcomes is among the lowest in the world, if not the lowest. This is a hard measure to validate.

We can use our consensus development experience and successful centralization of testicular cancer care to better deal with the next wave of rare cancers. These will not be defined by rare histologies alone but by subtypes of more common cancers with rare biomarkers and other phenotypes. This is the essence of what we define as personalized cancer care. The use of technology and reorganization of care into networks of care offer unique and exciting opportunities. The value of patient engagement in developing management consensus and guidelines for care are being increasingly recognized as a key to quality as well. I can't wait to see how this will play out.

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### References

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