Survivorship – Meningiomas

ELIGIBILITY

Meningiomas[1] **or** MRI identified presumed meningioma[2]

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Grade 1 Benign[3] after year 2

- Annual MRI[4] for years 3-10 for patients without progressive disease then for years 11 and beyond continue MRI every 2.5-3 years based on recurrence related factors[5]:
  - MRI skull base with and without contrast for skull-base tumors
  - MRI brain with and without contrast for convexity/tentorial tumors
- Assess for recurrence related symptoms at each clinic visit

Grade 2 Atypical[3] after year 3

- Annual MRI[4] for years 4-10 post treatment then for years 11 and beyond continue MRI every 2.5-3 years based on recurrence related factors[5]:
  - MRI skull base with and without contrast for skull-base tumors
  - MRI brain with and without contrast for convexity/tentorial tumors
- Assess for recurrence related symptoms at each clinic visit

MONITORING FOR LATE EFFECTS[7]

Consider:

- Head and neck surgery (for Neuro ENT) for hearing loss and vestibular issues
- Neuro oncology (for neuropsychology) for neurocognitive deficits (*e.g.,* worsening verbal memory, attention) or seizures
- Physical therapy/Occupational therapy for sensory deficits, numbness, weakness in arms or legs, gait disorder, motor deficits, radiation pain, or vestibular rehabilitation for ongoing balance issues
- Audiology for hearing loss
- Ophthalmology/Oculoplastics (ophthalmology plastics) for visual changes
- Speech Pathology for speech problems or swallowing difficulties
- Dermatology for skin exam near site of radiation
- Endocrinology for pituitary hormone function monitoring

→ Refer or consult as indicated

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

→ See Page 2

DISPOSITION

New primary or recurrent disease?

Yes → Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[6]

No → Continue survivorship monitoring

[1] Includes pathology proven meningiomas
[2] Includes brain and skull based tumors
[3] Refer to the World Health Organization (WHO) meningioma classifications
[4] If clinically/radiographically stable after 3-5 years, MRI can be moved to every other year
[5] Recurrence related factors include: Simpson grading, hormone progesterone disorder, high mitotic index, tumor index, necrosis, neurofibromatosis family history, and subtotal resection
[6] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).
[7] Late effects due to tumor and/or treatment

Department of Clinical Effectiveness V2
Approved by The Executive Committee of the Medical Staff on 08/15/2023

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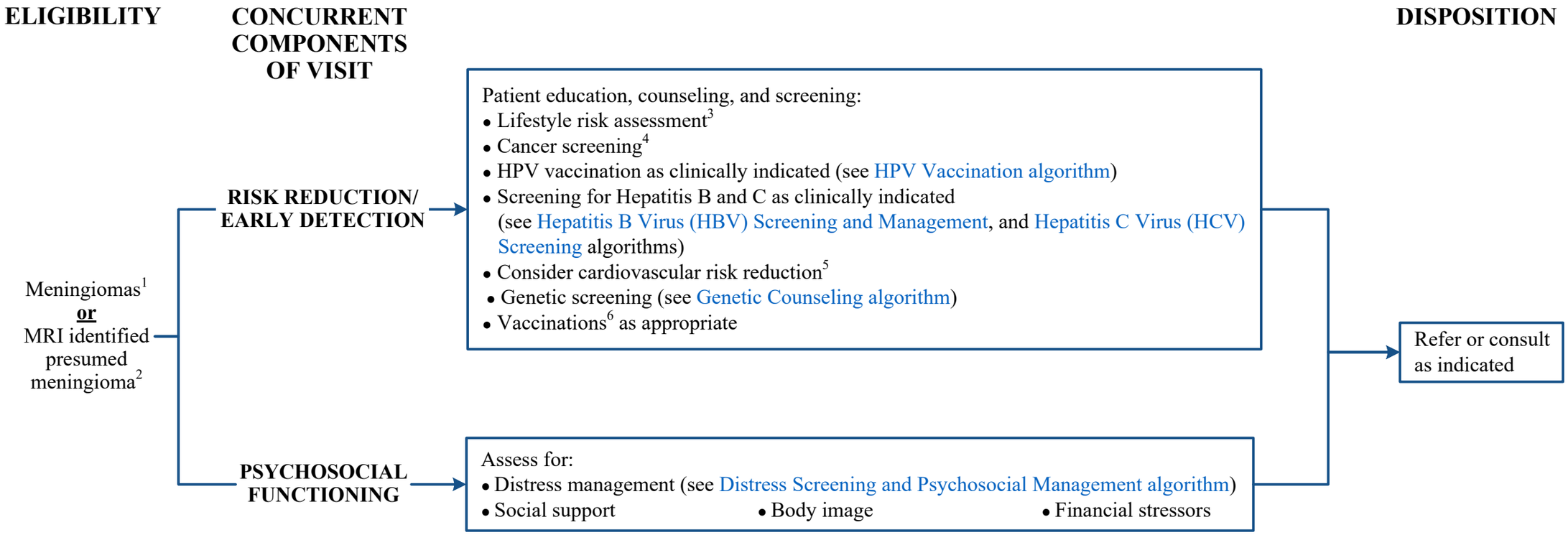

[1] Includes pathology proven meningiomas
[2] Includes brain and skull based tumors
[3] See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[4] Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[5] Consider use of Vanderbilt's ABCDE's approach to cardiovascular health
[6] Based on Centers for Disease Control and Prevention (CDC) guidelines

SUGGESTED READINGS

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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SUGGESTED READINGS -continued

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DEVELOPMENT CREDITS

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