Recommendations for Premature Ovarian Insufficiency Surveillance for Female Survivors of Childhood, Adolescent, and Young Adult Cancer: A Report From the International Late Effects of Childhood Cancer Guideline Harmonization Group in Collaboration With the PanCareSurFup Consortium

Wendy van Dorp, Erasmus University Medical Center
Renée L. Mulder, Emma Children's Hospital
Leontien C.M. Kremer, Emma Children’s Hospital
Melissa M. Hudson, St Jude Children’s Research Hospital
Marry M. van den Heuvel-Eibrink, Princess Maxima Center for Pediatric Oncology
Marleen H. van den Berg, Vrije Universiteit Medical Center
Jennifer M. Levine, Columbia University
Eline van Dulmen-den Broeder, Vrije Universiteit Medical Center
Natascia di Iorgi, University of Genoa
Assunta Albanese, St George's University Hospitals NHS Foundation Trust

Only first 10 authors above; see publication for full author list.

Journal Title: Journal of Clinical Oncology
Volume: Volume 34, Number 28
Publisher: American Society of Clinical Oncology | 2016-10-01, Pages 3440-+
Type of Work: Article | Final Publisher PDF
Publisher DOI: 10.1200/JCO.2015.64.3288
Permanent URL: https://pid.emory.edu/ark:/25593/s4xcc

Final published version: http://dx.doi.org/10.1200/JCO.2015.64.3288

Copyright information:
© 2016 by American Society of Clinical Oncology.

Accessed October 18, 2017 6:23 AM EDT
Recommendations for Premature Ovarian Insufficiency Surveillance for Female Survivors of Childhood, Adolescent, and Young Adult Cancer: A Report From the International Late Effects of Childhood Cancer Guideline Harmonization Group in Collaboration With the PanCareSurFup Consortium


ABSTRACT

Purpose
Female survivors of childhood, adolescent, and young adult (CAYA) cancer who were treated with alkylating agents and/or radiation, with potential exposure of the ovaries, have an increased risk of premature ovarian insufficiency (POI). Clinical practice guidelines can facilitate these survivors’ access to optimal treatment of late effects that may improve health and quality of survival; however, surveillance recommendations vary among the existing long-term follow-up guidelines, which impedes the implementation of screening.

Patients and Methods
The present guideline was developed by using an evidence-based approach and summarizes harmonized POI surveillance recommendations for female survivors of CAYA cancer who were diagnosed at age < 25 years. The recommendations were formulated by an international multidisciplinary panel and graded according to the strength of the evidence and the potential benefit gained from early detection and intervention. The harmonized POI surveillance recommendations were developed by using a transparent process and are intended to facilitate care for survivors of CAYA cancer.

Results and Conclusion
The harmonized set of POI surveillance recommendations is intended to be scientifically rigorous, to positively influence health outcomes, and to facilitate the care for female survivors of CAYA cancer.

J Clin Oncol 34:3440-3450. © 2016 by American Society of Clinical Oncology

INTRODUCTION

The 5-year survival rate for childhood, adolescent, and young adult (CAYA) cancer currently exceeds 80% as a result of the advances that have been achieved in our understanding of cancer biology and cancer therapeutics. 1-7 A prominent concern is the substantially elevated risk of ovarian dysfunction among female survivors who were treated with alkylating agents and/or radiotherapy. 8

The risk of nonsurgical premature ovarian insufficiency (POI)—also referred to as primary ovarian insufficiency, premature ovarian failure or premature menopause—among survivors of CAYA cancer is increased compared with sibling controls, with a cumulative incidence of approximately 8% by age 40 years. 9 POI is associated with infertility but also with other sequelae secondary to estrogen
deficiency, such as osteoporosis, cardiovascular disorders, impaired psycho-social well-being, and compromised sexual health. Survivors who are at risk for ovarian dysfunction related to their cancer treatment, and their health care providers, will benefit from clinical practice guidelines that address long-term surveillance for POI to assure survivors’ timely access to interventions that may preserve health and quality of survival.  

A number of clinical practice guidelines have already been developed by groups in North America and Europe to facilitate the early detection and management of POI. These guidelines differ in the definition of at-risk populations, surveillance modality, and frequency, as well as in their recommendations for interventions. These differences impose barriers to the implementation of screening across a spectrum of clinical settings.

Recognizing the importance of a global consensus in the approach for POI surveillance, an international effort was organized to harmonize the existing screening recommendations for female survivors of CAYA cancer. Herein, we present a summary of the evidence of and recommendations for POI surveillance in survivors of CAYA cancer who were diagnosed at age < 25 years that have been proposed by the International Late Effects of Childhood Cancer Guideline Harmonization Group (IGHG) in collaboration with the European Union–funded PanCareSurFup (PCSF) consortium.  

PATIENTS AND METHODS

Detailed information regarding the international guideline harmonization effort and methodology has been previously presented. The current effort evaluates long-term follow-up guidelines for survivors of CAYA cancer that were developed after systematic evaluation of the quality of late effects literature that links cancer treatment with adverse outcomes. The working group consisted of 33 experts from seven countries who represented all relevant disciplines, including pediatric and adolescent oncology and hematology, radiation and medical oncology, gynecology, reproductive endocrinology and infertility, pediatric and adult endocrinology, survivorship care, epidemiology, and guideline methodology, as well as survivors of CAYA cancer. We evaluated concordances and discordances across previously published long-term follow-up guidelines. To achieve consensus, we formulated clinical questions to address areas of discordance for POI surveillance that covered the following key issues: Who needs surveillance? What surveillance modality should be used? At what frequency and for how long should surveillance be performed? When should survivors be referred and what should be done when abnormalities are identified? What should be done when the potential for future fertility is questioned? We performed systematic literature searches in September 2014 to update a previous Cochrane systematic review (1966 to 2010). The clinical questions, inclusion criteria, search strategies, and the selection of studies are provided in the Data Supplement. We generated evidence summaries to answer the relevant clinical questions. When evidence was lacking for survivors of CAYA cancer, we carefully extrapolated evidence from other populations where applicable. In the case of concordance, we extracted and evaluated the evidence cited by the guidelines.

Who Needs POI Surveillance?

There is evidence from cohort studies that the risk of POI is increased in female survivors of CAYA cancer who were treated with alkylating agents. Most studies have focused on alkylating agents as a group, rather than evaluating the risk of a single alkylating agent. Some evidence from one study suggests that cyclophosphamide and procarbazine increase the risk of POI; however, no studies evaluated the individual risk of busulfan, chlorambucil, ifosfamide, mechlorethamine, melphalan, or thiopeta on POI. This is not surprising because most survivors are treated with combination chemotherapy. Of importance, there seems to be no clear threshold for a safe alkylating agent dose. There is a high level of evidence that...
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alkylating agents*</td>
<td>Yes</td>
<td>All survivors</td>
<td>Yes</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>Procarbazine</td>
<td>Yes</td>
<td>Not specified</td>
<td>Yes</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>Temozolomide plus dacarbazine</td>
<td>Yes</td>
<td>Not specified</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Cytarabine</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Carboplatin plus cisplatin</td>
<td>Yes</td>
<td>Not specified</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>RT exposing ovaries†</td>
<td>Yes</td>
<td>Not specified</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Oophorectomy</td>
<td>Yes</td>
<td>Not specified</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Highest risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher doses of alkylating agents</td>
<td>Yes</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Alkylating agent dose</td>
<td></td>
<td>MOPP ≥ 3 cycles; busulfan ≥ 600 mg/m²; cyclophosphamide ≥ 7.5 g/m²; cyclophosphamide for HCT; ifosfamide ≥ 60 g/m²</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Combination alkylating agents</td>
<td>Yes</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Higher doses of RT exposing ovaries</td>
<td>Yes</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>RT dose</td>
<td>One prepubertal: ≥ 10-15 Gy RT ovaries; pubertal: ≥ 5-10 Gy RT ovaries</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Alkylating agents plus RT exposing ovaries</td>
<td>Yes</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Unilateral oophorectomy plus RT exposing ovaries/alkylating agents</td>
<td>Yes</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Bilateral oophorectomy</td>
<td>Yes</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>What surveillance modality should be used?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanner staging</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Concordant</td>
</tr>
<tr>
<td>Height</td>
<td>Yes (testing precocious puberty)</td>
<td>Yes</td>
<td>General recommendation</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>Menstrual/pregnancy history</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>Inspection external genitals</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>FSH</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>LH</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>Estradiol</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not specified</td>
<td>Discordant</td>
</tr>
<tr>
<td>At what frequency should surveillance be performed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanner staging (until sexually mature)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Concordant</td>
</tr>
<tr>
<td>Height</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>Menstrual/pregnancy history</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>Inspection external genitals</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Discordant</td>
</tr>
<tr>
<td>FSH</td>
<td>Baseline at age 13 years and as clinically indicated</td>
<td>Baseline at age 13 years and as clinically indicated</td>
<td>As clinically indicated</td>
<td>N/A</td>
<td>Discordant</td>
</tr>
<tr>
<td>LH</td>
<td>Baseline at age 13 years and as clinically indicated</td>
<td>Baseline at age 13 years and as clinically indicated</td>
<td>As clinically indicated</td>
<td>N/A</td>
<td>Discordant</td>
</tr>
</tbody>
</table>

(continued on following page)
suggests that women who are exposed to higher doses of alkylating agents have an increased risk of POI compared with patients who are treated with a lower dose. The different methods used to score a total alkylating agent dose precludes comparing doses and defining a threshold for ovarian dysfunction. In addition, no studies reported on the risk of POI in female survivors of CAYA cancer who were

<table>
<thead>
<tr>
<th>Table 1. Concordance and Discordance Among Premature Ovarian Insufficiency Surveillance Recommendations (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estradiol</td>
</tr>
<tr>
<td>What should be done when abnormalities are identified?</td>
</tr>
<tr>
<td>Refer to specialist</td>
</tr>
<tr>
<td>Consider hormonal therapy</td>
</tr>
<tr>
<td>Consider assisted reproductive technology</td>
</tr>
</tbody>
</table>

Abbreviations: FSH, follicle-stimulating hormone; HCT, hematopoietic cell transplantation; LH, luteinizing hormone; MOPP, mustargen, oncovin, procarbazine, prednisone; RT, radiotherapy.

*Busulfan, chlorambucil, cyclophosphamide, ifosfamide, mechloretamine (nitrogen mustard), melphalan, thiopeta, carmustine, lomustine.
†Radiotherapy exposing the ovaries: lumbar, sacral, whole spine, flank/hemiabdomen extending below iliac crest, whole abdomen, inverted Y, pelvic, vaginal, bladder, iliac, total lymphoid irradiation, total body irradiation.

<table>
<thead>
<tr>
<th>Table 2. Conclusions of Evidence for POI Surveillance for Female Survivors of CAYA Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>POI risk in survivors of CAYA cancer</td>
</tr>
<tr>
<td>Increased risk after alkylating agents v no alkylating agents</td>
</tr>
<tr>
<td>Increased risk after higher alkylating agent dose v lower dose</td>
</tr>
<tr>
<td>Increased risk after cyclophosphamide v no cyclophosphamide</td>
</tr>
<tr>
<td>Increased risk after higher cyclophosphamide dose v lower dose</td>
</tr>
<tr>
<td>Increased risk after procarbazine v no procarbazine</td>
</tr>
<tr>
<td>Increased risk after higher procarbazine dose v lower dose</td>
</tr>
<tr>
<td>Risk after multiple alkylating agents and other chemotherapeutic agents v single alkylating agents</td>
</tr>
<tr>
<td>Risk after other alkylating agents*</td>
</tr>
<tr>
<td>Risk after platinum agents†</td>
</tr>
<tr>
<td>Increased risk after radiotherapy to which ovaries are potentially exposed v no radiotherapy</td>
</tr>
<tr>
<td>Increased risk after higher dose of radiotherapy to which ovaries are potentially exposed v lower dose</td>
</tr>
<tr>
<td>Increased risk after radiotherapy to which ovaries are potentially exposed and alkylating agents v either treatment in the same dose alone</td>
</tr>
<tr>
<td>Increased risk after treatment at older age v younger age</td>
</tr>
<tr>
<td>Risk after unilateral oophorectomy</td>
</tr>
</tbody>
</table>

What surveillance should be used?

| Diagnostic value of endocrine measurement and ovarian ultrasound to detect POI in survivors of CAYA cancer | No studies |
| Diagnóstico de AMH | No studies |
| Prognostic value of endocrine measurements and ovarian ultrasound to predict POI in survivors of CAYA cancer | No studies |
| Prognóstico de AMH | No studies |
| Prognostic value of estradiol | No studies |
| Prognostic value of AMH | No studies |
| Prognostic value of antral follicle count | No studies |
| Diagnostic value of endocrine measurements to detect POI in the general population | No studies |
| Prognostic value of AMH | No studies |
| Prognostic value of endocrine measurements to predict POI in the general population | No studies |
| AMH predicts time to menopause | Expert opinion36 |
| AMH correlates with ovarian reserve | Expert opinion37-40 |

At what frequency should surveillance be performed?

| POI risk in survivors of CAYA cancer | | |
| Changes in POI risk (deterioration or recovery of gonadal function) during the fertile life span | No studies |

Abbreviations: AMH, anti-Müllerian hormone; CAYA, childhood, adolescent, and young adult; FSH, follicle-stimulating hormone; Level A, high level of evidence; Level B, moderate/low level of evidence; Level C, very low level of evidence; POI, premature ovarian insufficiency.

*Busulfan, chlorambucil, cyclophosphamide, ifosfamide, melphalan, thiopeta, carmustine, lomustine.
†Carboplatin and cisplatin.
General recommendation

Survivors treated with one or more potentially gonadotoxic treatments*, and their providers, should be aware of the risk of premature ovarian insufficiency and its implications for future fertility (level A and level C evidence).

Who needs surveillance?

Counselling regarding the risk of premature ovarian insufficiency and its implications for future fertility is recommended for survivors treated with:

- Alkylating agents in general (level A evidence)
- Cyclophosphamide and procarbazine (level C evidence)
- Radiotherapy potentially exposing the ovaries (level A evidence)

What surveillance modality should be used for pre- and peri-pubertal survivors?

Monitoring of growth (height) and pubertal development and progression (Tanner stage) is recommended for pre-pubertal survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries (expert opinion/no literature search).‡

FSH and oestradiol are recommended for evaluation of premature ovarian insufficiency in pre-pubertal survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries* who fail to initiate or progress through puberty (expert opinion/no literature search).§

What surveillance modality should be used for post-pubertal survivors?

A detailed history and physical examination with specific attention for premature ovarian insufficiency symptoms, e.g. amenorrhoea and irregular cycles is recommended for post-pubertal survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries (expert opinion/no literature search).§

FSH and oestradiol are recommended for evaluation of premature ovarian insufficiency in post-pubertal survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries* who present with menstrual cycle dysfunction suggesting premature ovarian insufficiency or who desire assessment about potential for future fertility. Hormone replacement therapy should be discontinued prior to laboratory evaluation when applicable (expert opinion/no studies).‡

AMH is not recommended as the primary surveillance modality for evaluation of premature ovarian insufficiency in survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries* who desire assessment about potential future fertility (expert opinion/no studies).

AMH may be reasonable in conjunction with FSH and oestradiol for identification of premature ovarian insufficiency in survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries* aged ≥26 years who present with menstrual cycle dysfunction suggesting premature ovarian insufficiency or who desire assessment about potential for future fertility (expert opinion/no studies).

When should pre- and peri-pubertal survivors be referred?

Referral to paediatric endocrinology / gynaecology is recommended for any survivor who has

- No signs of puberty by 13 years of age.
- Primary amenorrhoea by 16 years of age.
- Failure of pubertal progression.† (expert opinion/no literature search)

When should post-pubertal survivors be referred?

Referral to gynaecology / reproductive medicine / endocrinology (according to local referral pathways) is recommended for post-pubertal survivors treated with potentially gonadotoxic chemotherapy and/or radiotherapy potentially exposing the ovaries* who present with menstrual cycle dysfunction suggesting premature ovarian insufficiency (expert opinion/no literature search).

What should be done when abnormalities are identified in pre-, peri- and post-pubertal survivors?

Consideration of sex steroid replacement therapy is recommended for pre-, peri- and post-pubertal survivors diagnosed with premature ovarian insufficiency by referral to gynaecology / endocrinology (expert opinion/no literature search).

What should be done when potential for future fertility is questioned?

Referral to gynaecology / reproductive medicine / endocrinology (according to local referral pathways) is recommended for post-pubertal females treated with potentially gonadotoxic chemotherapy and/or ovarian irradiation* without signs and symptoms of premature ovarian insufficiency who desire assessment about potential for future fertility (expert opinion/no literature search).

Fig 1. Harmonized recommendations for POI surveillance in survivors of CAYA cancer. Premature ovarian insufficiency (POI) is defined as a clinical condition developing in any adult female before age 40 years that is characterized by the absence of menses for ≥4 months and two elevated serum follicle-stimulating hormone (FSH) levels in the menopausal range (on the basis of the maximum threshold of the laboratory assay used).* Treatments with evidence of causing POI include alkylating agents in general (level A evidence), cyclophosphamide, procarbazine (level C evidence), and radiotherapy to a field that includes the ovaries (level A evidence). † At least annually, with increasing frequency as clinically indicated based on growth and pubertal progression. ‡ At least for girls of 11 years of age and older, and for girls with primary amenorrhoea (age 16). § If amenorrhoea, measure FSH and oestradiol randomly; if oligomenorrhoea, measure during early follicular phase (day 2-5). ¶ This assessment should be performed after ending oral contraceptive pill/sex steroid replacement therapy use, ideally after two months without oral contraceptive pills. # The absence of initiation of puberty (Tanner stage 2 breast development) in girls 13 years or older or failure to progress in pubertal stage for ≥12 months. AMH, anti-Müllerian hormone; CAYA, childhood, adolescent, and young adult; Level A, high level of evidence; Level B, moderate/low level of evidence; Level C, very low level of evidence.
treated with a combination of alkylating agents and other chemotherapeutic agents compared with single agent chemotherapy. We did not identify studies that assessed the effects of platinum agents on gonadal function in female survivors of CAYA cancer. As a result, no recommendations could be made regarding surveillance after treatment with platinum agents in the absence of other alkylating agents.

Women who were treated with radiotherapy to which the ovaries were potentially exposed are also at an increased risk for developing POI.\textsuperscript{9,29-35} This risk is especially high for women who were treated with higher doses, but a clear threshold for a safe radiotherapy dose could not be defined.\textsuperscript{30,32-34} Mathematic modeling on the basis of data on the rate of oocyte decline suggests that the effective sterilizing dose is 20.3 Gy in infants, 18.4 Gy at age 10 years, and 16.5 Gy at age 20 years (Fig 2).\textsuperscript{41} Moreover, some evidence from one study suggests that treatment with a combination of alkylating agents and radiotherapy to which the ovaries are potentially exposed increases the risk of POI compared with each of these treatments with the same dose alone (Fig 3).\textsuperscript{9} On the basis of the available evidence, female survivors of CAYA cancer who were treated with alkylating agents and/or radiotherapy to which the ovaries were potentially exposed and their health care providers should be aware of the risk of POI and its implications for future fertility (strong recommendation). Consequently, counseling regarding the risk of POI and its implications for future fertility is recommended for these females (strong recommendation).

Whereas some studies have reported that the age of treatment had no influence on POI,\textsuperscript{9,42,43} other studies have found an increased risk of POI in individuals who were treated at an older age.\textsuperscript{29,35} The inverse relationship of radiation dose to age is likely a consequence of the decline in the primordial follicle pool observed with advancing age.\textsuperscript{32,33} As a result of the inconsistency of the literature, no recommendations could be made regarding surveillance intensity by age at which cancer treatment was started.

Obviously, bilateral oophorectomy results in POI and, therefore, surveillance is unnecessary, but counseling by a health professional is mandatory in view of the POI consequences. We did not identify studies that investigated the association between unilateral oophorectomy and POI. Some evidence in survivors of childhood cancer and women in the general population showed a limited effect of unilateral oophorectomy on anti-Müllerian hormone (AMH) levels and earlier age at menopause.\textsuperscript{44,45} Because of the lack of evidence, no recommendations could be formulated regarding surveillance after treatment with unilateral oophorectomy.

What Surveillance Modality Should Be Used?

The existing guidelines were concordant with the use of a detailed menstrual history and physical examination, with specific attention given to the failure to initiate or progress through puberty and POI symptoms such as hot flashes. Of importance, because POI presents with primary or secondary amenorrhea, standard laboratory evaluation is not recommended as a form of primary surveillance in at-risk female survivors without any symptoms of POI. The monotropic rise in FSH is the hallmark of the menopausal transition\textsuperscript{46}; thus, FSH is important for diagnosing POI.\textsuperscript{24,47} Antral follicle count (AFC) by transvaginal ultrasound is the most established method for assessing ovarian reserve in adult women, but is not part of the current clinical criteria of POI.\textsuperscript{48,49} In survivors of childhood cancer, the additive value of AFC on the current clinical criteria of POI has not been studied.

AMH has been used as a marker of ovarian reserve;\textsuperscript{37,50-52} however, there are no studies that describe the value of AMH in the diagnosis of POI in both survivors of childhood cancer and the general population. In healthy women, AMH represents the best endocrine marker to assess the age-related decline in ovarian reserve,\textsuperscript{53} although a recent validated model of AMH throughout life describes a transition period in early adult life.\textsuperscript{38} Previous studies have found that AMH is correlated with AFC in the general population.\textsuperscript{37-39} Unlike FSH and estradiol, the majority of studies indicate that AMH is relatively stable through the menstrual cycle.\textsuperscript{54-57} A recent analysis by
Overbeek et al\textsuperscript{46} has described possibly significant fluctuations in AMH throughout the menstrual cycle, in particular, in young women. It is clear that in patients age $\geq 25$ years, AMH is inversely correlated with increasing age, which implies that AMH may be a clinically useful marker of ovarian reserve in these women.\textsuperscript{37,58,59} There is a wide range of AMH levels in healthy young adult women, but low AMH levels are indicative of incipient ovarian insufficiency.\textsuperscript{47} In survivors of childhood cancer, AMH has been frequently used as marker of ovarian reserve\textsuperscript{62,49,60,61} and may be useful to distinguish women with POI who have little to no follicles remaining from those who are at risk for POI but still have a reasonably sized follicle pool (AFC $\geq 3$).\textsuperscript{47} AMH may be of additive value for survivors of CAYA cancer who were treated with alkylating agents and/or radiotherapy to which the ovaries were potentially exposed, but if assessed before age 25 years, one should exercise extra caution when interpreting AMH values. On the basis of the evidence and consensus, the working group has agreed that for at-risk pre- and peripubertal survivors, the monitoring of growth and pubertal development and progression is recommended (strong recommendation). Laboratory evaluation of FSH and estradiol is recommended for peripubertal girls who experience a failure to initiate or progress through puberty normally as part of the current clinical criteria of POI (strong recommendation).

For postpubertal females who were treated with alkylating agents and/or radiotherapy to which the ovaries were potentially exposed, we recommend detailed menstrual history and physical examination, with specific attention paid to POI symptoms, for example, amenorrhea, but also irregular cycles as a first sign of the development of POI (strong recommendation). In females who present with menstrual cycle dysfunction that is suggestive of POI or who desire assessment of potential future fertility, laboratory evaluation of FSH and estradiol is recommended (strong recommendation). This assessment should be performed after discontinuing sex steroid hormone replacement or contraceptive hormone therapy when applicable, with careful advice to prevent unwanted pregnancy. The evidence is conflicting on how long a female should discontinue sex steroids before ovarian function is assessed. We have therefore not made a firm recommendation as to how long sex steroids should be omitted before testing, but for practical purposes we would recommend $\geq 2$ months. In the case of amenorrhea, FSH and estradiol can be measured at any time. In the case of oligomenorrhea, FSH and estradiol should be measured, ideally, during early follicular phase (days 2 to 5). In addition, AMH is not recommended as the primary surveillance modality for evaluation of POI in survivors of CAYA cancer; however, on the basis of evidence in the general population, laboratory evaluation of AMH in conjunction with FSH and estradiol may be reasonable for the identification of POI in at-risk survivors age $\geq 25$ years who present with menstrual cycle dysfunction that is suggestive of POI or who desire assessment of potential future fertility (weak recommendation).

**At What Frequency and For How Long Should Surveillance Be Performed?**

Data to support changes in POI risk during the fertile life span is lacking in female survivors of CAYA cancer; therefore, recommendations regarding the initiation and frequency of surveillance are largely based on the consensus of multidisciplinary late effects experts. For postpubertal females, surveillance by laboratory evaluation should only be performed on the basis of clinical indication or when the patient desires assessment of potential future fertility. In the general population, girls initiate puberty, on average, between the age of 8 and 10 years.\textsuperscript{62,63} Of importance, puberty initiation varies by race and ethnicity.\textsuperscript{62} By age 11 years, most girls have Tanner stage 2 breast development. The working group has
agreed that surveillance should be performed at least annually, with increasing frequency as clinically indicated on the basis of growth and pubertal progress as measured by physical examination. Moreover, it is recommended that, for prepubertal females age ≥ 11 years who experience a failure to initiate or progress through puberty, laboratory evaluation should be performed. No recommendations could be made for how long surveillance should be performed.

When Should Survivors Be Referred and What Should Be Done When Abnormalities Are Identified?

The recommendations outlined in this article are for primary surveillance rather than for treatment options; however, because of the health problems induced by estrogen deprivation in patients with POI in the general population, it is important to consider sex hormone replacement therapy for survivors of CAYA cancer with POI because of its benefit to sexual function, bone health, and cardiovascular health. Although POI reduces the risk of radiation-associated breast cancer, the harms of sex steroid replacement therapy on breast cancer risk and the risk of other secondary malignancies in survivors of CAYA cancer is not yet known.

Because the recommendations outlined in this article are for primary surveillance, they do not address all the investigative steps necessary for the diagnosis of POI, such as excluding Turner syndrome or other causes of ovarian insufficiency. As such, endocrinology and gynecology consultation is recommended for prepubertal females who have no signs of puberty by age 13 years and with elevated FSH levels at laboratory screening, primary amenorrhea by age 16 years in the presence of other evidence of puberty, or who experience a failure to initiate or progress through puberty (strong recommendation). For postpubertal females who were treated with alkylating agents and/or radiotherapy to which the ovaries were potentially exposed and who present with menstrual cycle dysfunction that is suggestive of POI, gynecology, endocrinology, and/or reproductive endocrinology consultation is recommended (strong recommendation). In addition, the working group recommends gynecology and endocrinology referral of all survivors who are diagnosed with POI for the consideration of sex steroid replacement therapy and its potential harms and benefits (strong recommendation).

What Should Be Done When Potential For Future Fertility Is Questioned?

Assessment of the ovarian reserve is important in estimating future fertility. Ovarian reserve is a term used to determine the capacity of the ovary to produce mature eggs that are capable of fertilization. The human ovary is believed to contain a finite population of primordial follicles. At 18 to 22 weeks postconception, the female ovary contains its peak number of follicles, approximately 300,000 in the average case, but individual peak populations range from 35,000 to 2.5 million. Direct measurement of the ovarian reserve is not possible, and methods to directly determine the number of primordial follicles have yet to be identified. The size of the primordial follicle pool is reflected by the number of early, growing follicles. AMH is a product of these growing ovarian follicles and can be reliably used as an indirect marker of the ovarian reserve in women age ≥ 25 years. There is evidence for reduced AMH levels in survivors of CAYA cancer who were treated with alkylating agents and/or radiotherapy to which the ovaries were potentially exposed.

Although POI presents with amenorrhea, survivors with regular menstrual cycles who were treated with gonadotoxic therapy are still at risk for a decreased ovarian reserve and may therefore be at risk for reduced fertility. At-risk postpubertal females without signs and symptoms of POI who desire assessment of the potential for future fertility should be referred for gynecology, endocrinology, and/or reproductive endocrinology consultation (strong recommendation).

DISCUSSION

In female survivors of CAYA cancer, gonadal dysfunction is one of the most prevalent long-term adverse effects of treatment that includes alkylating agents and radiotherapy to which the ovaries are potentially exposed. Compelling evidence suggests that female survivors of CAYA cancer who were treated with alkylating agents and/or radiotherapy to which the ovaries are potentially exposed are at an increased risk of POI; however, there is no clear evidence to indicate which type of alkylating agent chemotherapy increases the risk. Although there is evidence that a higher treatment dose is associated with an increased risk of POI, there is virtually no information regarding a safe threshold dose. This, at least in part, might be explained by the complexity of factors that influence the ovarian reserve.

Important limitations of previous studies on the impact of alkylating agents and radiotherapy doses include the use of different scoring models, which preclude the comparison of study results. To effectively estimate POI risk as it relates to radiotherapy, the exact dose received by the ovaries should be on the basis of accurate dosimetry derived from information of the total dose and the specific radiotherapy technology. So far, most literature, and, therefore, our conclusions, are based on studies that include survivors who were treated in eras during which dosimetry was not easily achievable. Therefore, we recommend that future studies use consistent methods to comprehensively calculate treatment doses, including modern radiotherapy dose-volume histograms.

Elaborating on the latter, some survivors develop POI at relatively low gonadotoxic treatment doses and others do not seem to be affected, which suggests that other factors, such as the age of a patient at treatment, cumulative chemotherapy and radiotherapy dose, combinations of these modalities, and genetic variation may play a role in the pretreatment primordial follicle pool. In both the general population and in survivors of childhood cancer, polymorphisms have been associated with post-treatment ovarian reserve, even independently from the administered gonadotoxic cancer treatment. Genetic variation, when further elucidated, could advance our understanding of the pathogenesis of treatment-related POI and may improve patient-tailored counseling and surveillance throughout life.

There is agreement across previously published long-term follow-up guidelines that POI surveillance should include Tanner stage and menstrual history. In the case of clinical symptoms of POI, such as irregular menstrual cycles, we recommend laboratory evaluation with FSH and estradiol. Because these markers vary throughout the menstrual cycle and are affected by hormonal contraceptive therapy and sex steroid replacement therapy, testing should be performed during the early follicular phase in survivors.
Effect of different types of alkylating agent chemotherapy on the risk of POI in female survivors of CAYA cancer
Safe alkylating agents dose with regard to the risk of POI in female survivors of CAYA cancer
Safe radiotherapy dose to which the ovaries are potentially exposed with regard to the risk of POI in female survivors of CAYA cancer
Diagnostic value of AMH to detect POI in female survivors of CAYA cancer
Prognostic value of AMH to predict POI in female survivors of CAYA cancer
Diagnostic value of AFC to detect POI in female survivors of CAYA cancer
Prognostic value of AFC to predict POI in female survivors of CAYA cancer
Prognostic value of FSH and estradiol to predict POI in female survivors of CAYA cancer
Lifetime risk of POI in survivors of CAYA cancer treated with alkylating agents and/or radiotherapy to which the ovaries are potentially exposed
Potential recovery of ovarian dysfunction in female survivors of CAYA cancer treated with alkylating agents and/or radiotherapy to which the ovaries are potentially exposed
Use of FSH, estradiol, AFC, and AMH in the prediction of fertility in female survivors of CAYA cancer
Efficacy of oral vs transdermal estrogen replacement for puberty induction on final height and sexual development in female survivors of CAYA cancer with gonadal failure
Efficacy of oral vs transdermal hormone replacement therapy on bone health, cardiovascular health, and mental health in female survivors of CAYA cancer with POI
Risk of secondary malignancies in female survivors of CAYA cancer treated with HRT
Risk of secondary malignancies in female survivors of CAYA cancer using HRT and treated with radiotherapy to which the breasts are potentially exposed
Examination of the role of genetic susceptibility on subsequent POI risk in survivors of CAYA cancer treated with alkylating agents and/or radiotherapy to which the ovaries are potentially exposed

Abbreviations: AFC, antral follicle count; AMH, anti-Müllerian hormone; CAYA, childhood, adolescent, and young adult; FSH, follicle-stimulating hormone; HRT, hormone replacement therapy; POI, premature ovarian insufficiency.
Conception and design: Wendy van Dorp, Renée L. Mulder, Leontien C.M. Kremer, Melissa M. Hudson, Marry M. van den Heuvel-Eibrink, Marleen H. van den Berg, Jennifer M. Levine, Eline van Dunlumen-Broeder, Natascia di Iorgi, Assunta Albanese, William H. Wallace, Riccardo Haupt

Financial support: Wendy van Dorp, Renée L. Mulder, Leontien C.M. Kremer, Melissa M. Hudson, Riccardo Haupt

Administrative support: Leontien C.M. Kremer, Renée L. Mulder, Melissa M. Hudson

Collection and assembly of data: Wendy van Dorp, Renée L. Mulder, Leontien C.M. Kremer, Melissa M. Hudson, Marry M. van den Heuvel-Eibrink, Marleen H. van den Berg, Jennifer M. Levine, Eline van Dunlumen-Broeder, Natascia di Iorgi, Assunta Albanese, William H. Wallace, Riccardo Haupt

Data analysis and interpretation: All authors

Manuscript writing: All authors

Final approval of manuscript: All authors

REFERENCES


www.jco.org

© 2016 by American Society of Clinical Oncology
3449
80. International Society of Paediatric Oncology: No child should die of cancer. http://www.isop-online.org/

Affiliations
Wendy van Dorp and Sebastian J. Neggers, Erasmus University Medical Centre; Wendy van Dorp, Sophia Children’s Hospital, Rotterdam; Renée L. Mulder and Leontien C.M. Kremer, Emma Children’s Hospital and Academic Medical Centre; Marleen H. van den Berg, Eline van Dulmen-den Broeder, and Cornelis B. Lambalk, Vrije Universiteit Medical Center, Amsterdam; Marry M. van den Heuvel-Eibrink, Princess Maxima Center for Pediatric Oncology; Hanneke M. van Santen, Wilhelmina Children’s Hospital, University Medical Center, Utrecht, the Netherlands; Melissa M. Hudson, St Jude Children’s Research Hospital, Memphis, TN; Jennifer M. Levine, Columbia University Medical Center; Kevin C. Oeffinger, Memorial Sloan Kettering Cancer Center, New York; Louis S. Constine, University of Rochester Medical Center, Rochester, NY; Natascia di Iorgi, University of Genoa; Riccardo Haupt, Istituto Giannina Gaslini, Genoa; Andreas Corrias and Alessandro Mussa, University of Turin, Turin; Alberto Revelli, S. Anna Hospital and University of Torino, Torino, Italy; Assunta Albanese, St George’s University Hospitals NHS Foundation Trust; Gill Levitt and Alison Leiper, Great Ormond St Hospital for Children NHS Foundation Trust, London; Roderick Skinner, Great North Children’s Hospital and Newcastle University, Newcastle upon Tyne; Andrew Tooogood, Queen Elizabeth Hospital Birmingham, University Hospitals Birmingham NHS Foundation Trust, Birmingham; William H. Wallace, Royal Hospital for Sick Children, Edinburgh, United Kingdom; Saro H. Armenian, City of Hope, Duarte, CA; Smita Bhatia and Wendy Landier, University of Alabama at Birmingham, Birmingham, AL; Rebecca Deans, University of New South Wales, Sydney, New South Wales, Australia; Uta Dirksen, Westfalian Wilhelms University Muenster, University Hospital Muenster, Germany; Clarisa R. Gracia, University of Pennsylvania, Philadelphia, PA; Lars Hjorth, Skåne University Hospital and Lund University, Lund, Sweden; Leah Kroon, Seattle Children’s Hospital, Seattle, WA; and Lillian Meacham, Emory University and Aflac Cancer Center Children’s Healthcare of Atlanta, Atlanta, GA.
AUTHORS’ DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Recommendations for Premature Ovarian Insufficiency Surveillance for Female Survivors of Childhood, Adolescent, and Young Adult Cancer: A Report from the International Late Effects of Childhood Cancer Guideline Harmonization Group in Collaboration with the PanCareSurFup Consortium

The following represents disclosure information provided by authors of this manuscript. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to www.asco.org/rwc or jco.ascopubs.org/site/ifc.

Wendy van Dorp
No relationship to disclose

Renée L. Mulder
No relationship to disclose

Leontien C.N. Kremer
No relationship to disclose

Melissa M. Hudson
No relationship to disclose

Marry M. van den Heuvel-Eibrink
No relationship to disclose

Marleen H. van den Berg
No relationship to disclose

Jennifer M. Levine
No relationship to disclose

Eline van Dulmen-den Broeder
No relationship to disclose

Natacia di Iorgi
No relationship to disclose

Assunta Albanese
No relationship to disclose

Saro H. Armenian
No relationship to disclose

Smita Bhatia
No relationship to disclose

Louis S. Constine
Honouraria: UpToDate, Springer, Lippincott
Travel, Accommodations, Expenses: IBA

Andreas Corrias
No relationship to disclose

Rebecca Deans
No relationship to disclose

Uta Dirksen
No relationship to disclose

Clarisa R. Gracia
No relationship to disclose

Lars Hjorth
Stock or Other Ownership: Bioinvent
Consulting or Advisory Role: Takeda Pharmaceuticals

Leah Kroon
No relationship to disclose

Cornelis B. Lambalk
Consulting or Advisory Role: Ferring
Research Funding: Ferring (Inst), Merck (Inst)

Wendy Landier
Research Funding: Merck Sharp & Dohme (Inst)

Gill Levitt
No relationship to disclose

Alison Leiper
No relationship to disclose

Lillian Meacham
No relationship to disclose

Alessandro Mussa
No relationship to disclose

Sebastian J. Neggers
No relationship to disclose

Kevin C. Oeffinger
No relationship to disclose

Alberto Revelli
Honouraria: Merck Serono, MSD
Consulting or Advisory Role: Merck Serono, MSD
Speakers’ Bureau: Merck Serono, MSD
Research Funding: Merck Serono (Inst), MSD (Inst)

Hanneke M. van Santen
Research Funding: Pfizer
Travel, Accommodations, Expenses: Ferring

Roderick Skinner
Consulting or Advisory Role: Pfizer

Andrew Toogood
Honouraria: Novo Nordisk

William H. Wallace
No relationship to disclose

Riccardo Haupt
No relationship to disclose

www.jco.org © 2016 by American Society of Clinical Oncology
We thank J.S.E. Laven, R. Anderson, and C. Sklar for critically appraising the recommendations and manuscript as external reviewers, and T.W. Kelsey and R. Rechis as patient representatives.