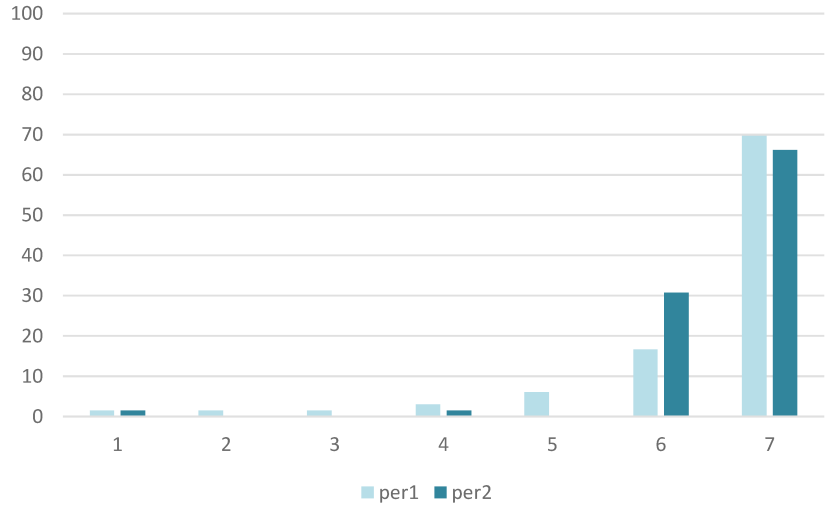
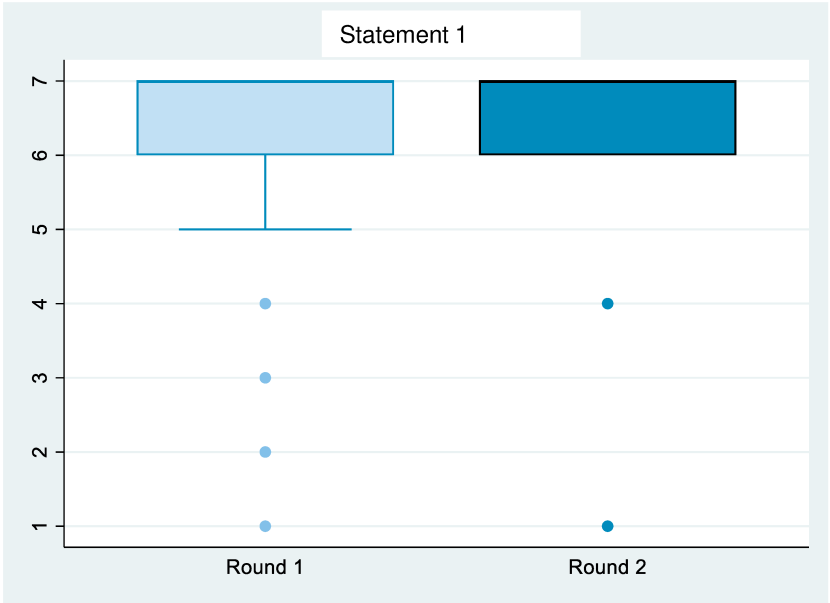
NATIONWIDE MULTIDISCIPLINARY CONSENSUS ON THE CLINICAL MANAGEMENT OF MERKEL CELL CARCINOMA: A DELPHI PANEL

Graphics

Statement 1

At my centre the most appropriate therapeutic diagnostic path is shared and discussed within a multidisciplinary team

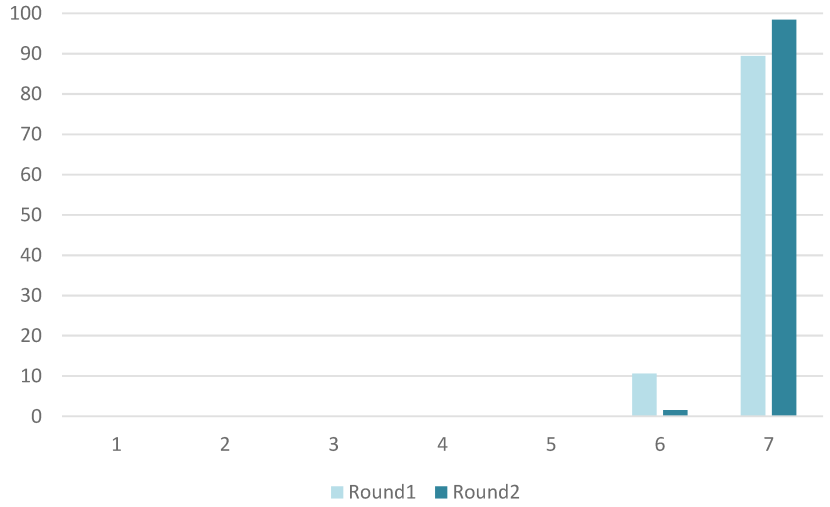


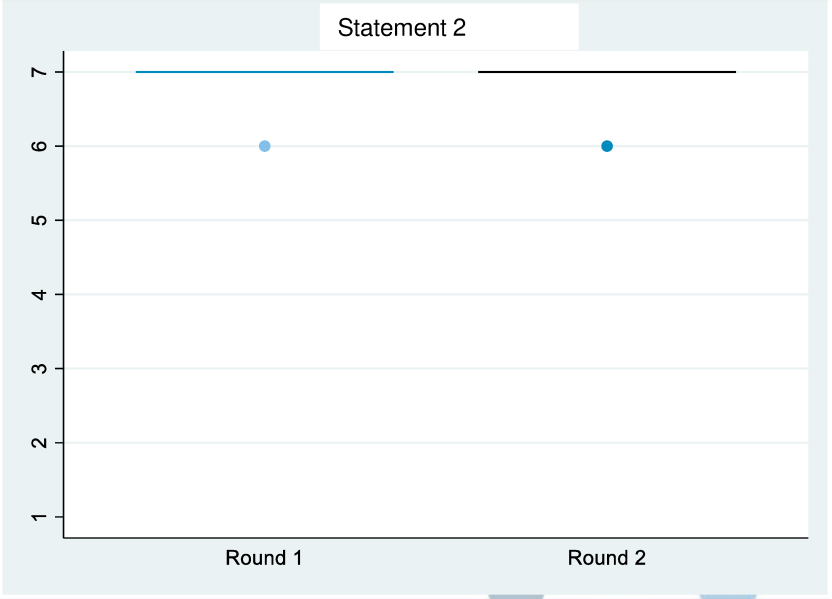


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 2

Faced with new diagnosis of MCC the therapeutic diagnostic path should be shared by a multidisciplinary team

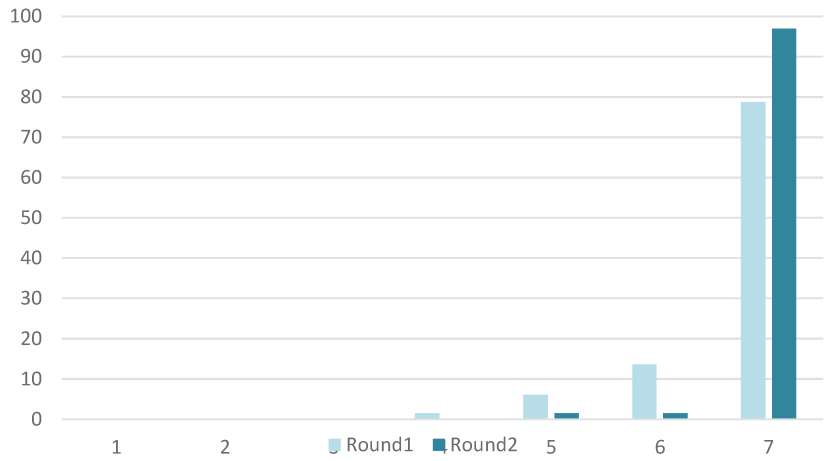


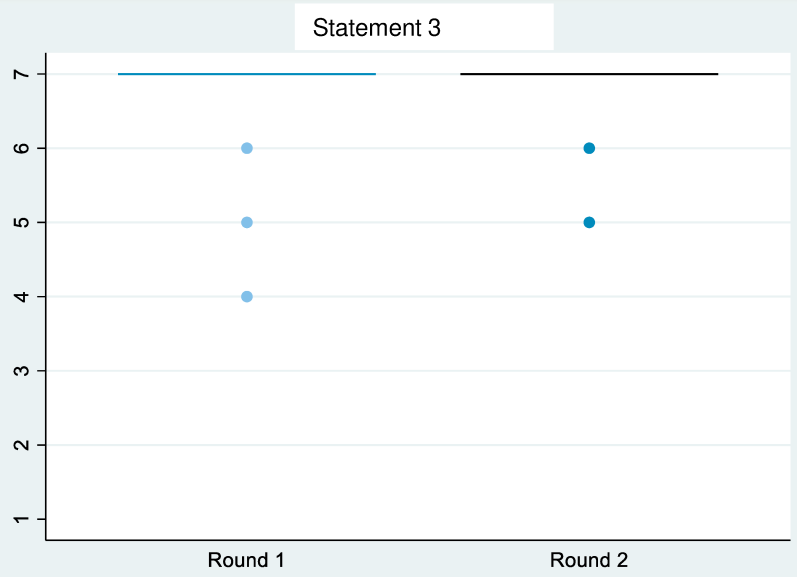


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	7	7	
75° Percentile	7	7	
interquartile range	0	0	

Statement 3

The multidisciplinary team should comprise at least: oncologist, surgeon, dermatologist, pathologist, radiotherapist and radiologist

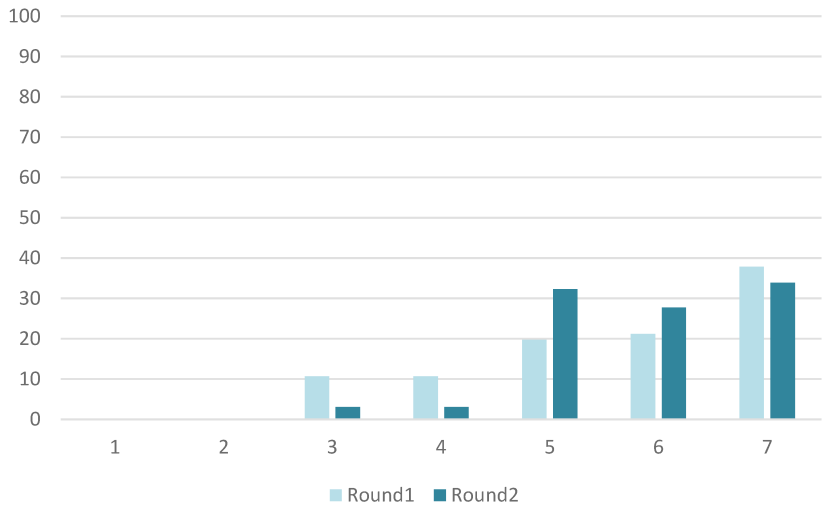


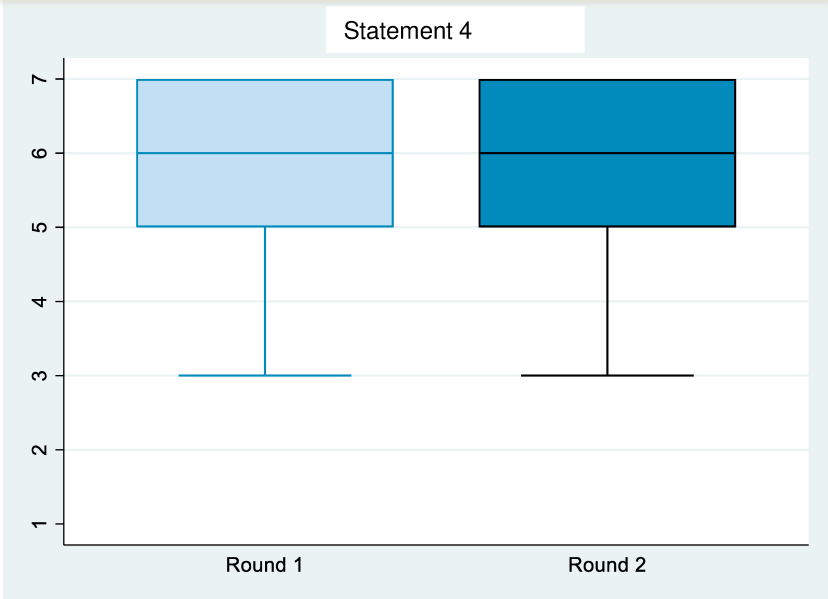


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	7	7	
75° Percentile	7	7	
interquartile range	0	0	

Statement 4

In the minimal criteria for pathological evaluation I believe that the inclusion of the positivity/negativity of Polyomavirus is a useful addition



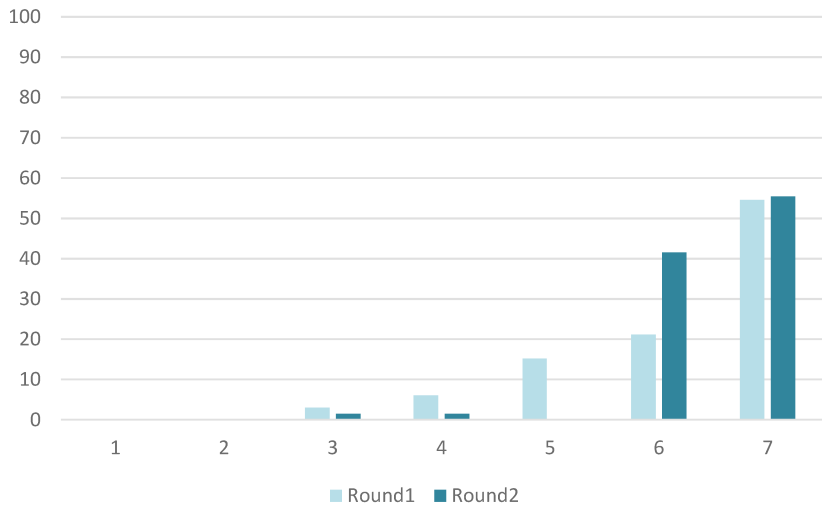


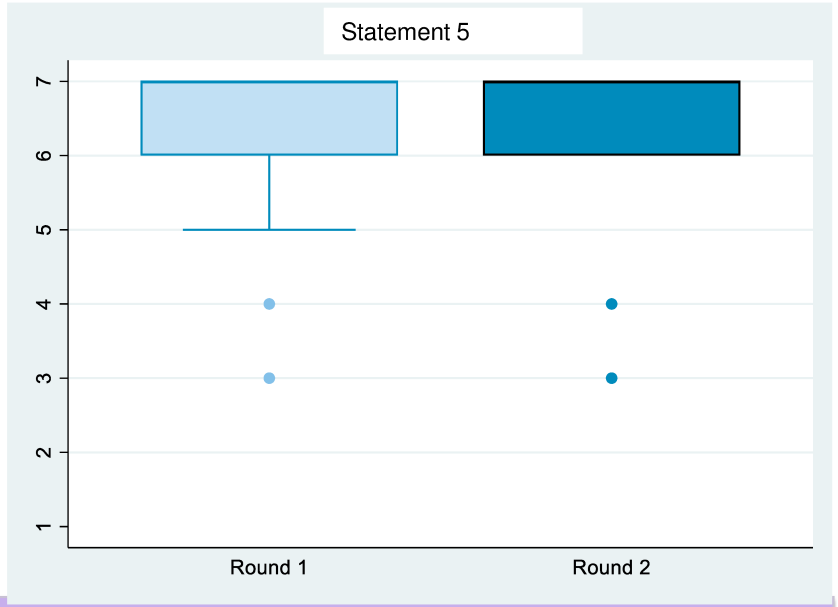
Variazioni tra il primo e il secondo Round = 32%

	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	5	5	
75° Percentile	7	7	
interquartile range	2	2	

Statement 5

In the criteria for pathological evaluation I believe that the inclusion of the expression data of cytokeratin 20 (positive) with paranuclear pattern "dot-like" and TTF-1 (negative) is necessary.

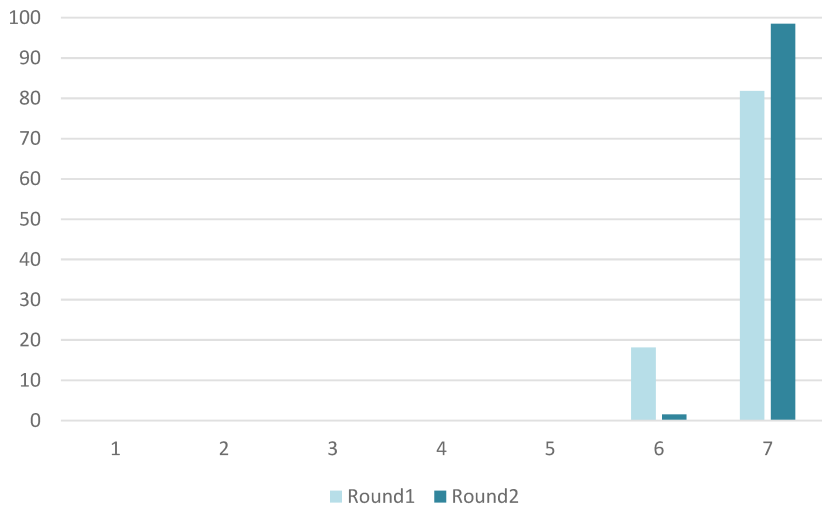


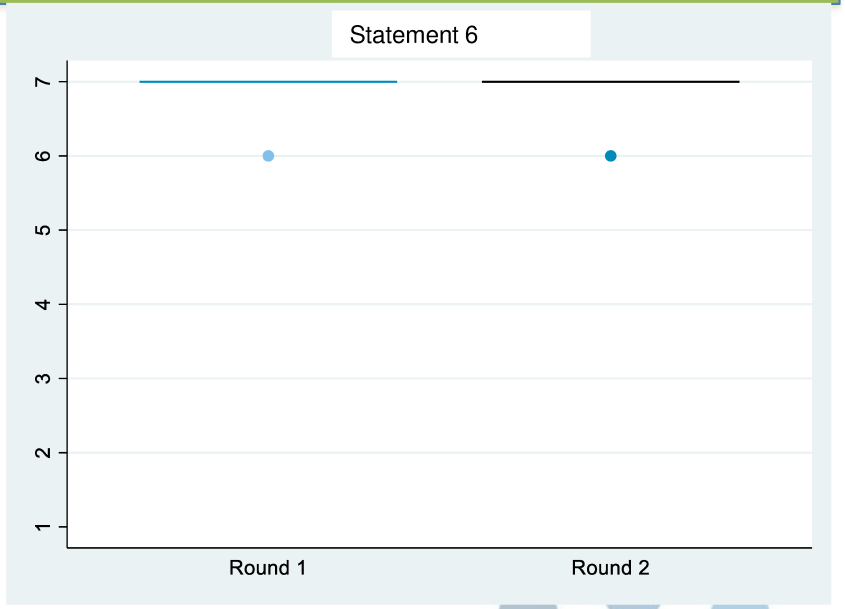


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 6

In the pathological report, the essential information to be reported is: site, maximum size expressed in cm; extra-cutaneous extension (bone, muscle, cartilage belt); lympho-vascular invasion; state of the deep and peripheral margins; pTNM.

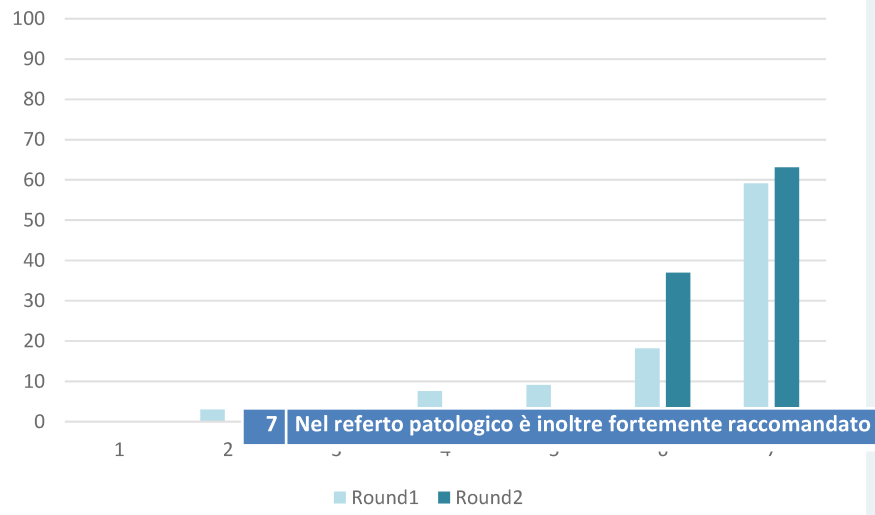


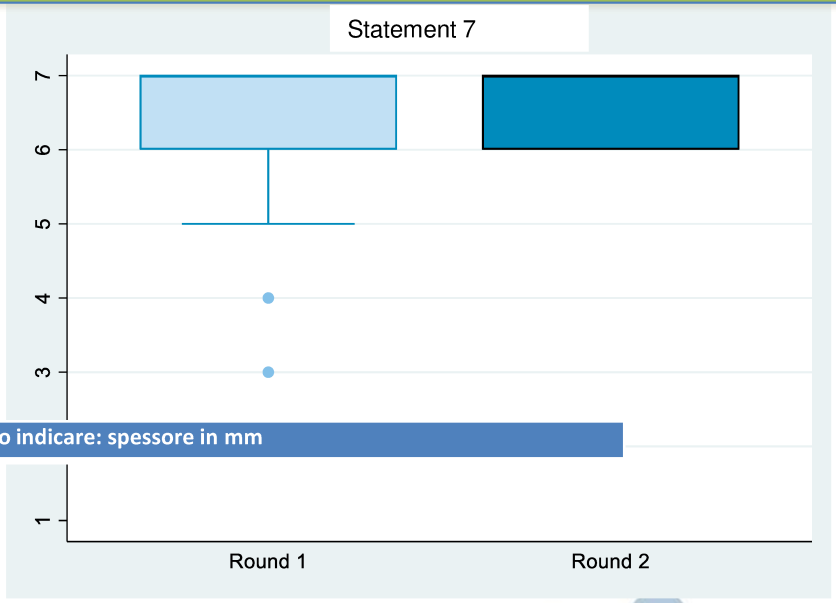


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	7	7	
75° Percentile	7	7	
interquartile range	0	0	

Statement 7

In the pathological report it is also strongly recommended to indicate: thickness in mm; mitotic index (number of mitoses/mm2), infiltrated tumor lymphocyte (absent, brisk, not brisk); growth pattern (nodular vs. infiltrative).

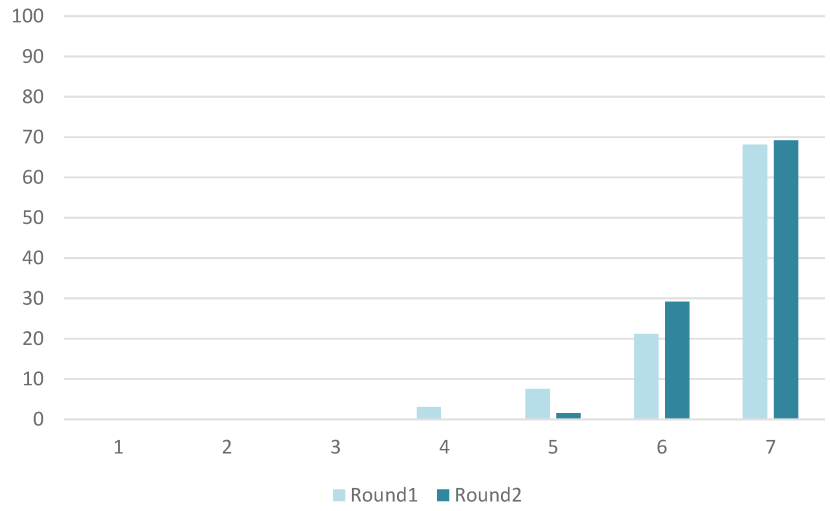


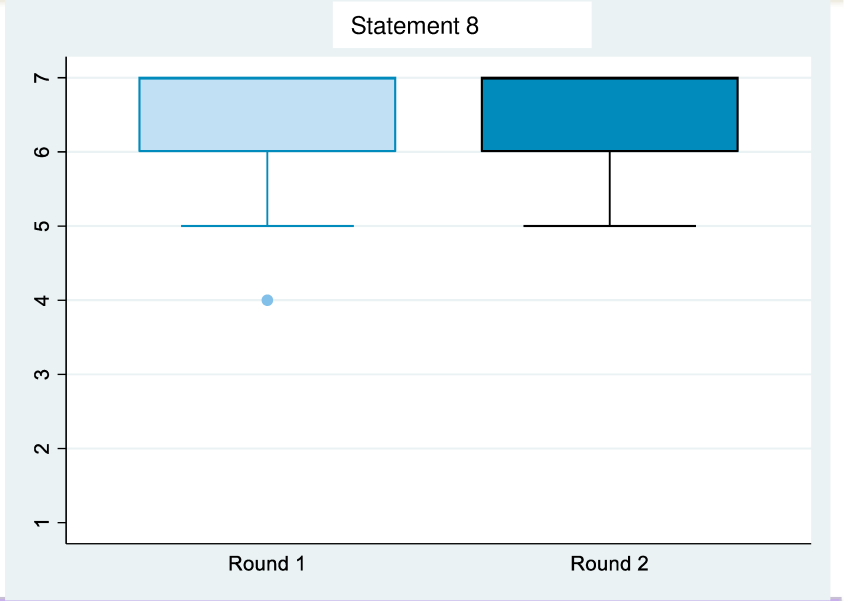


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Affermazione 8

The following are to be considered as elements for diagnostic framing: age, phototype, centre of the lesion, evolution, immuno-compromised (transplanted patient, onco-haematologic, positive HIV, with necessity of immunosuppressive therapy)

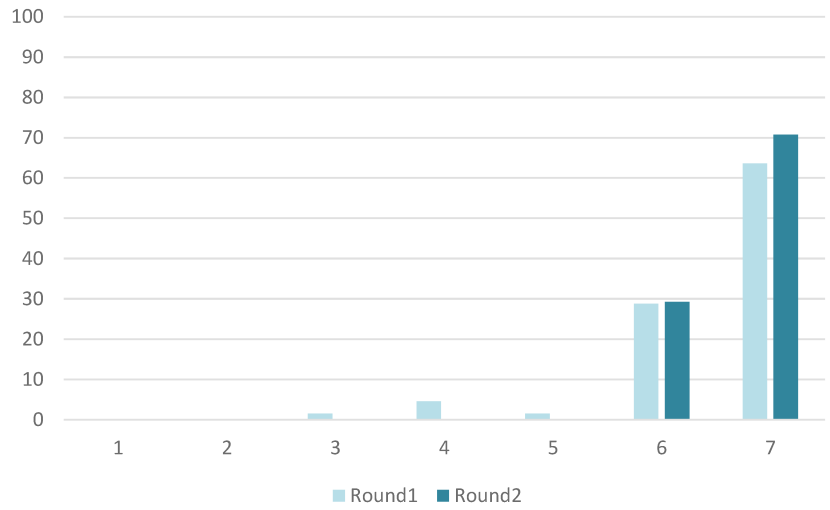


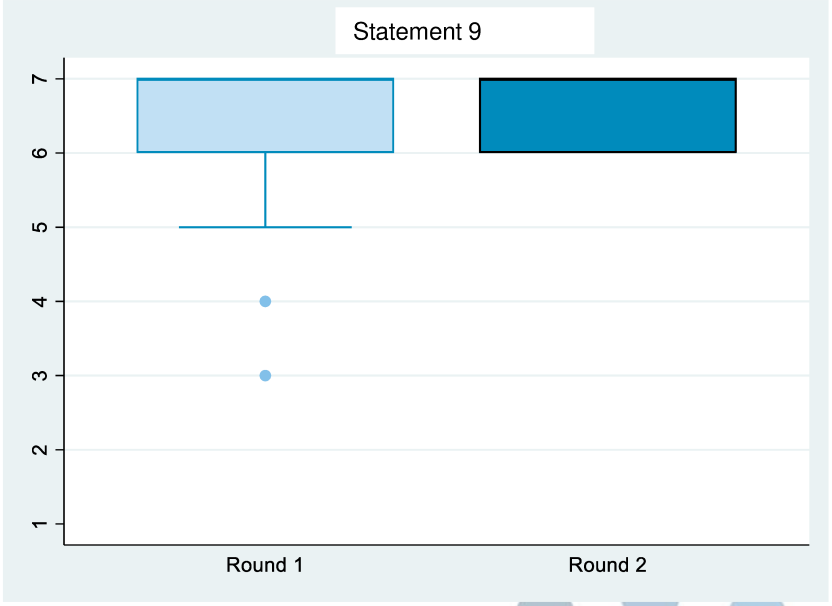


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 9

For proper staging in relation to the site of disease, the imaging tools I consider necessary are CT and/or MRI and/or ultrasound of the lymph node station

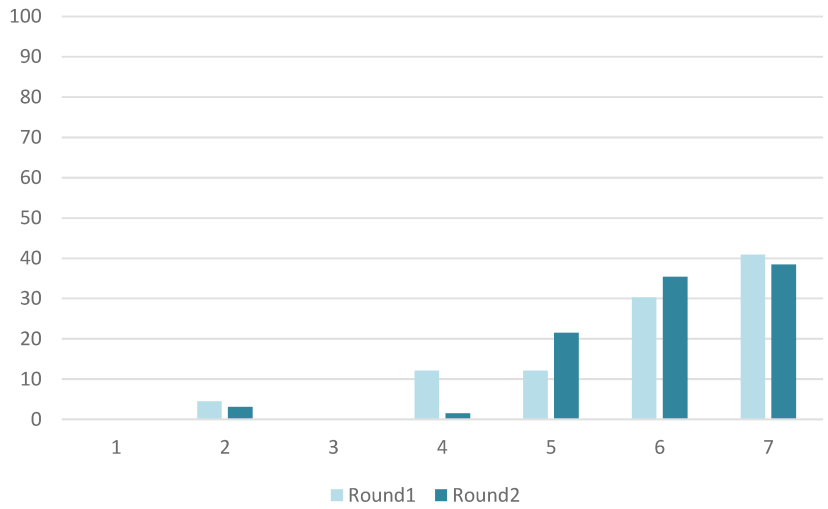


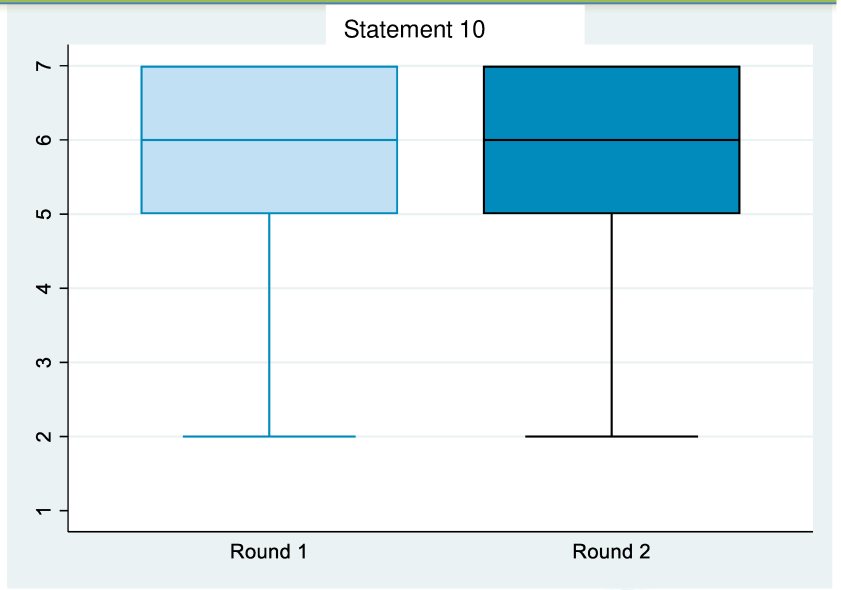


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 10

In the pre-operative staging I consider the PET/CT with 18F-FDG necessary

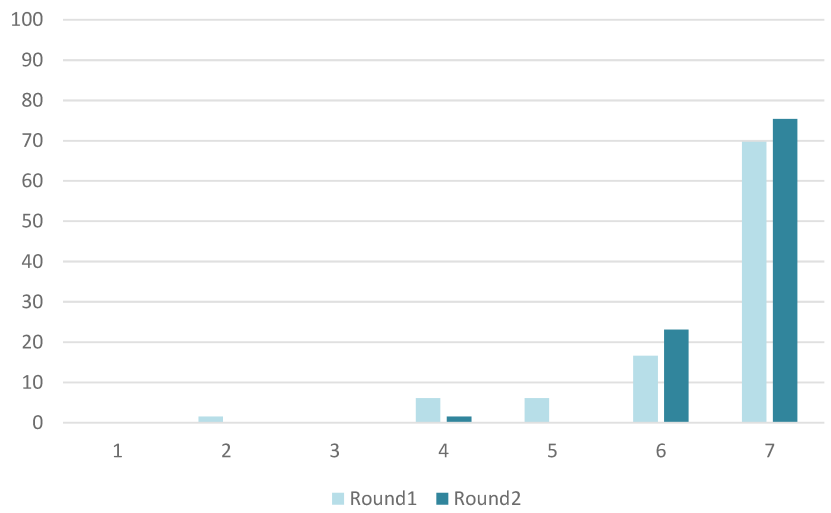


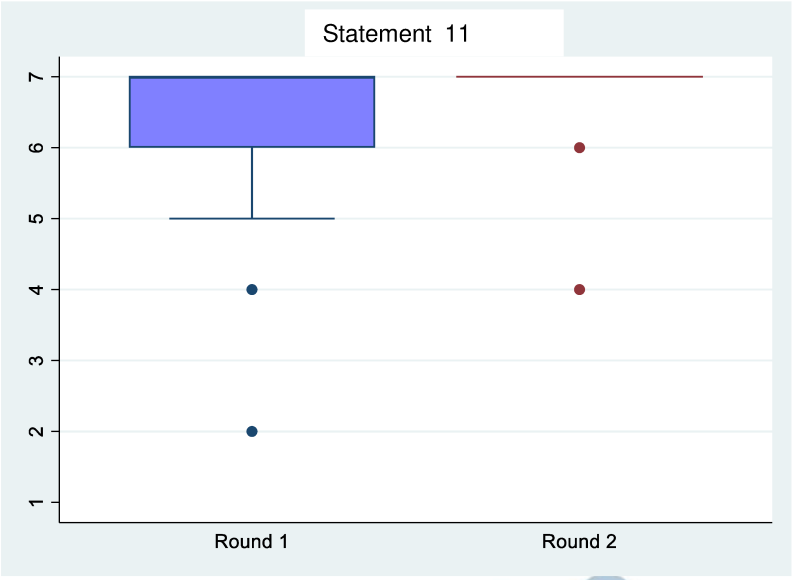


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	5	5	
75° Percentile	7	7	
interquartile range	2	2	

Statement 11

Sentinel lymph node assessment is necessary for reliable diagnosis/staging in the absence of clinical and/or radiological evidence of lymph node involvement

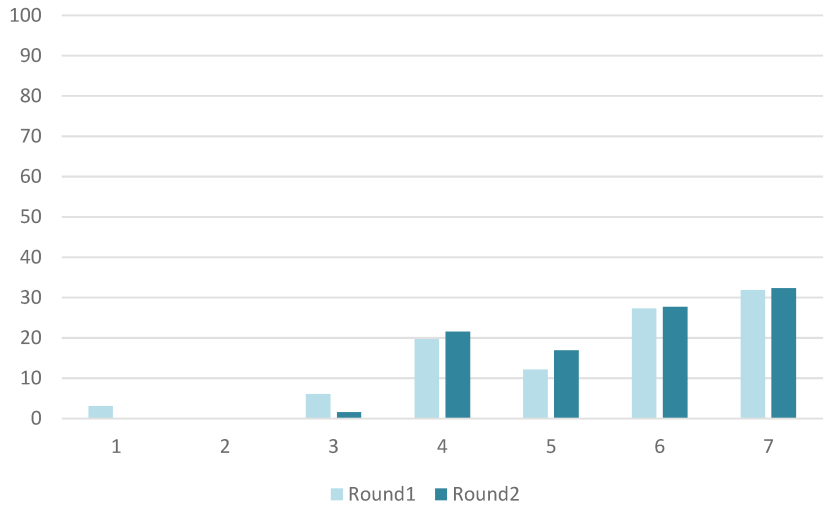


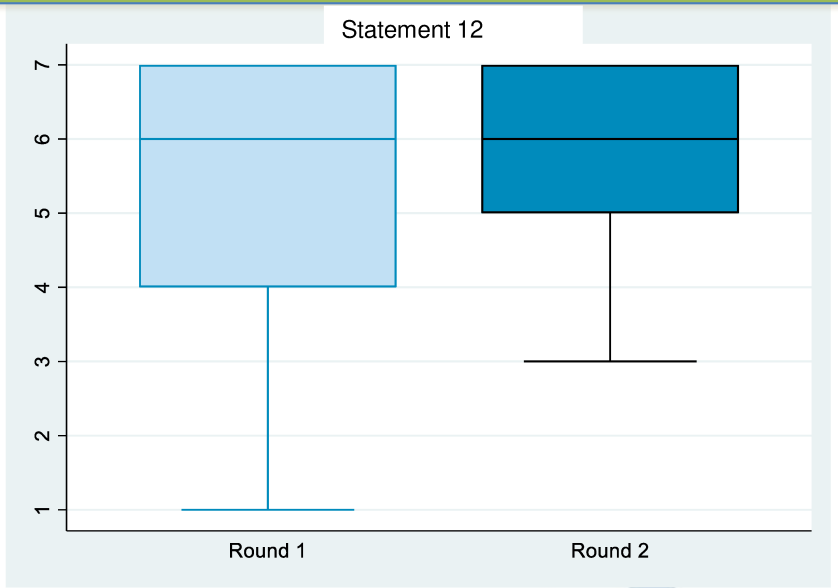


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	7	
75° Percentile	7	7	
interquartile range	1	0	

Statement 12

I always consider the possibility of an adjuvant radiotherapy on the previous site of the primary lesion

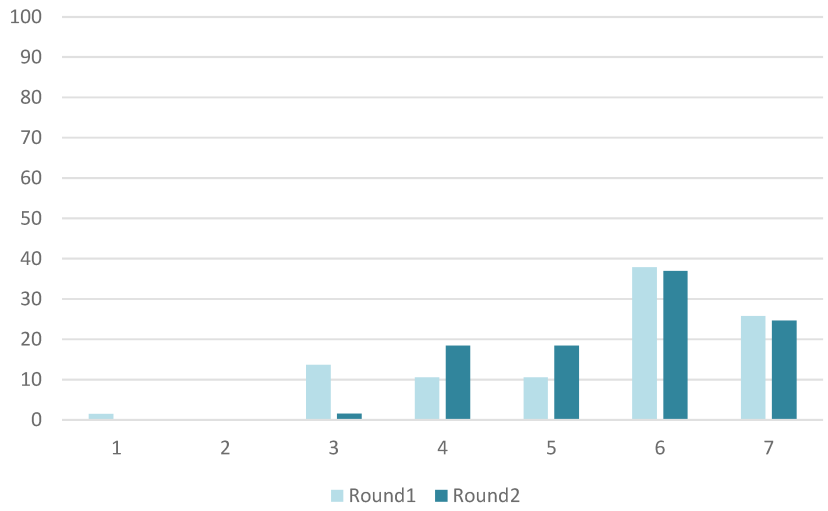


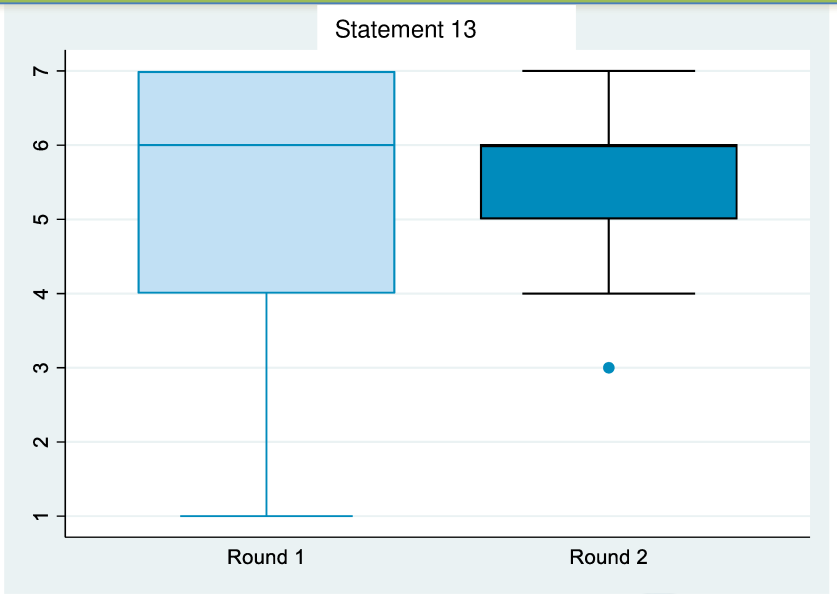


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	4	5	
75° Percentile	7	7	
interquartile range	3	2	

Statement 13

I always consider the possibility of an adjuvant lymph node radiation therapy

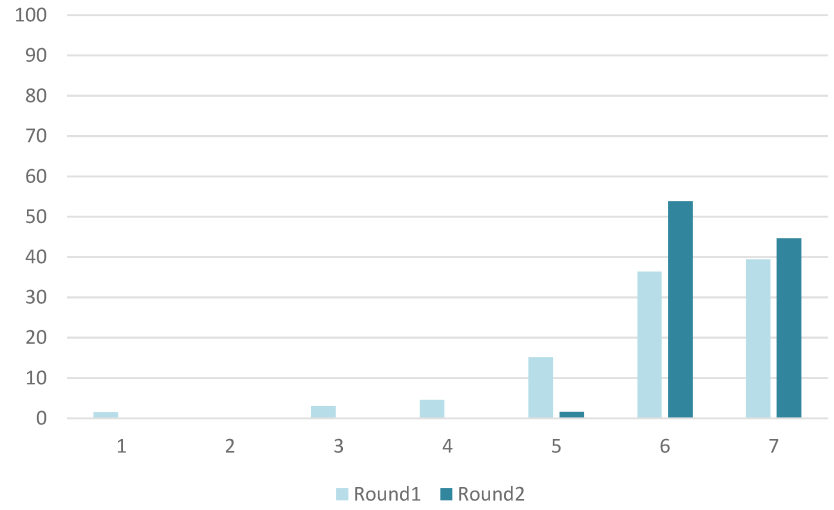


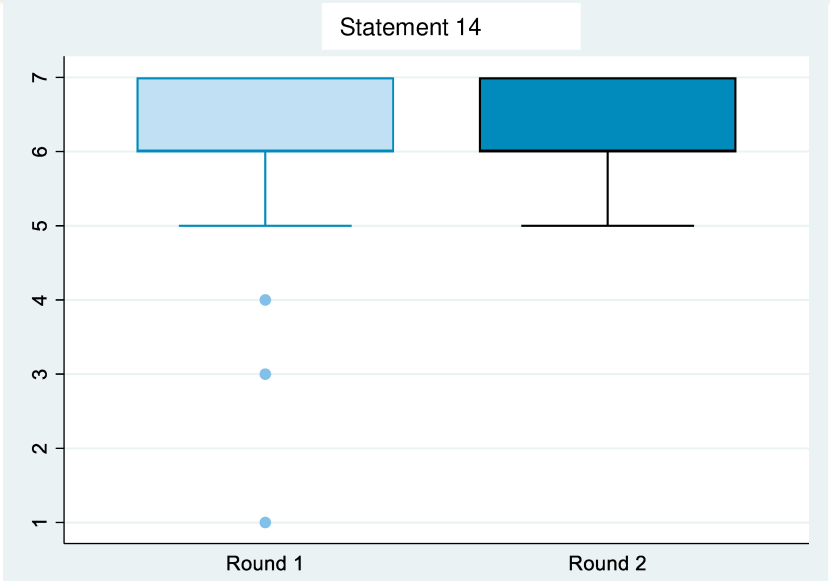


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	4	5	
75° Percentile	7	6	
interquartile range	3	1	

Statement 14

In case of only lymph node disease, with no evidence of primary cutaneous location and distant metastasis, I would adopt the same therapeutic strategy as the locally advanced MCC with known primary site

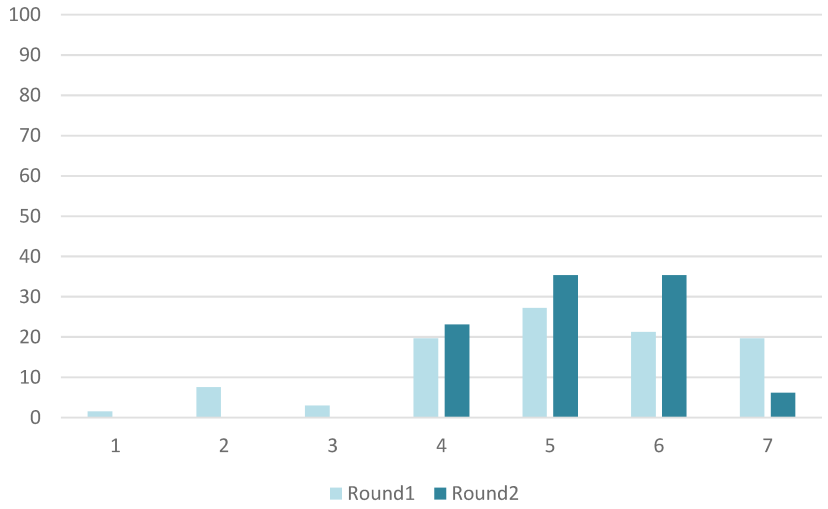


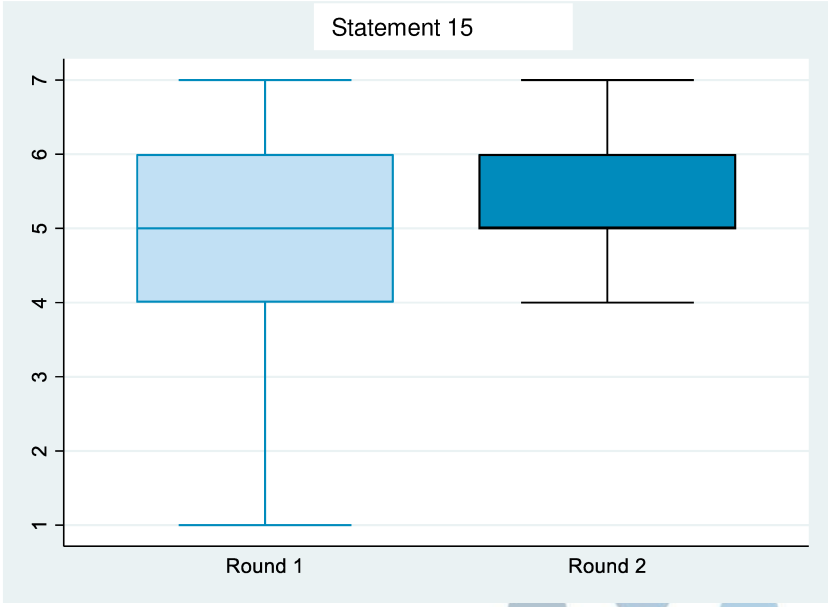


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 15

In the presence of disease without diagnosis of cutaneous primitivity, the prognosis is better overall, at equal stages N and M

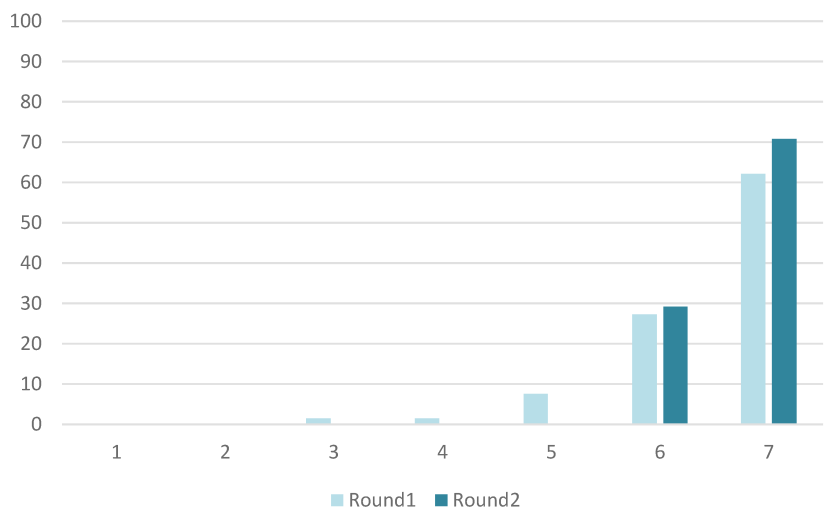


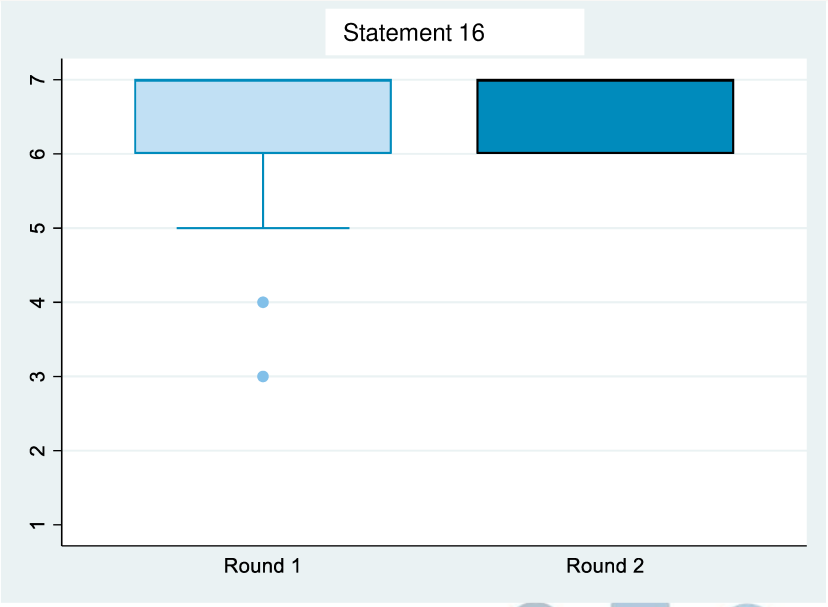


	Round 1	Round 2	
Median	5	5	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	4	5	
75° Percentile	6	6	
interquartile range	2	1	

Statement 16

The involvement of several lymph node stations belonging to different districts and not radically resectable is considered as a metastatic disease

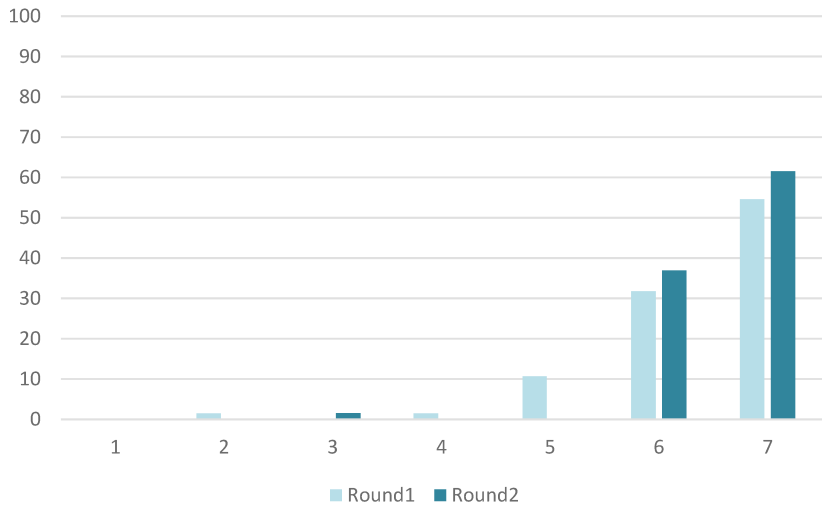


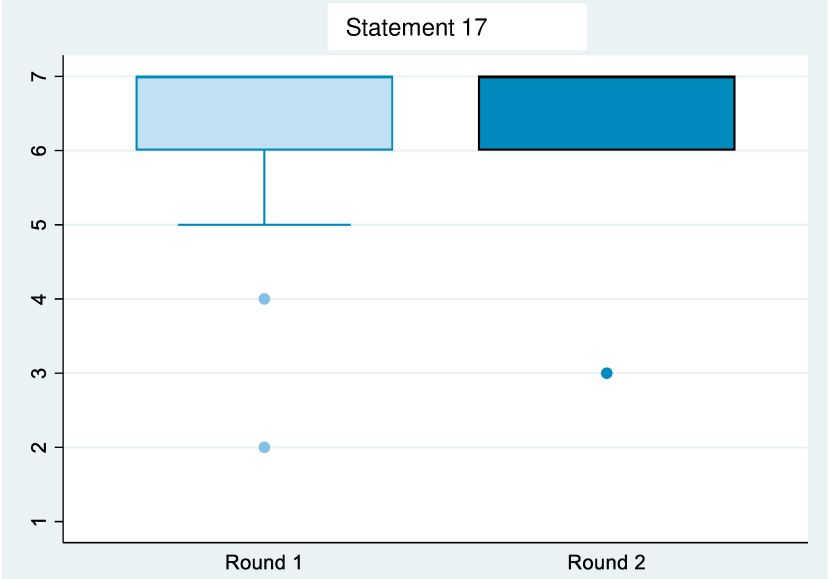


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 17

An immunocompromised patient with advanced MCC can be treated with immunotherapy after multidisciplinary risk/benefit assessment in collaboration with the specialists treating him (haematologist, infectiologist, rheumatologist, etc.)

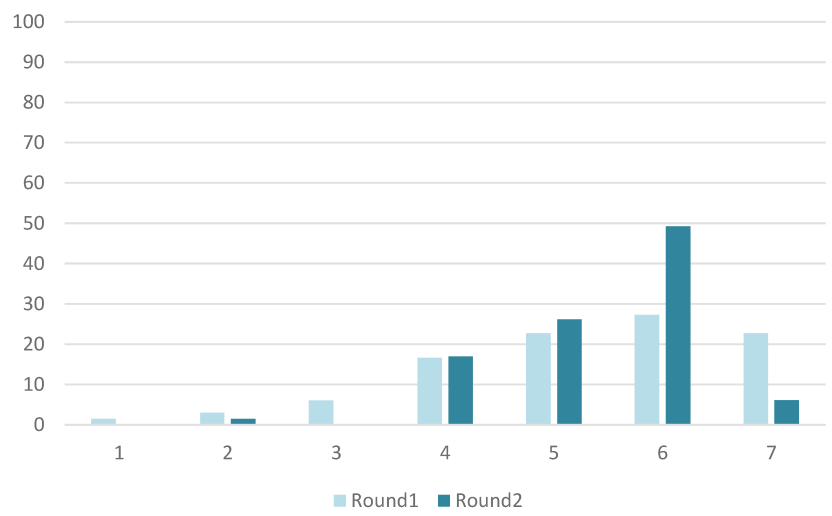


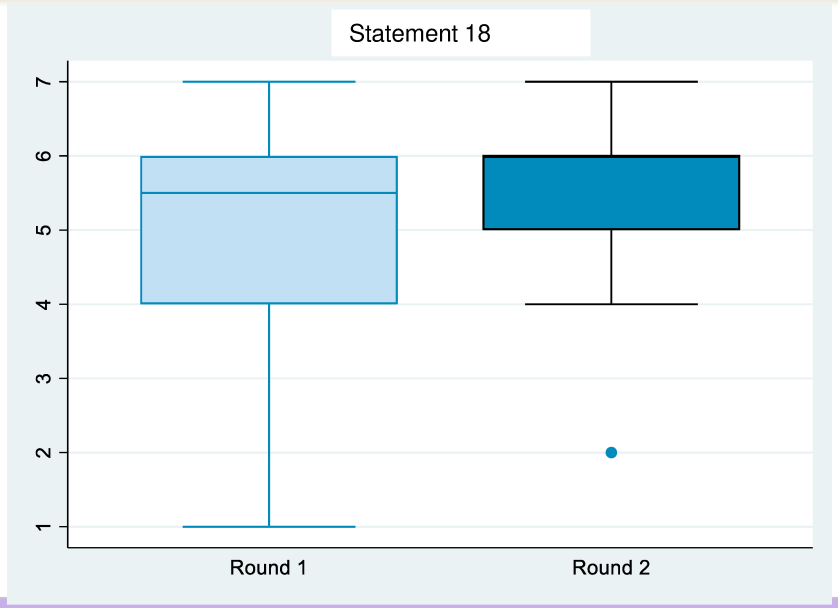


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 18

In a patient with complete clinical-instrumental response I would consider suspending treatment based on the clinical characteristics, response duration and after discussion with the patient

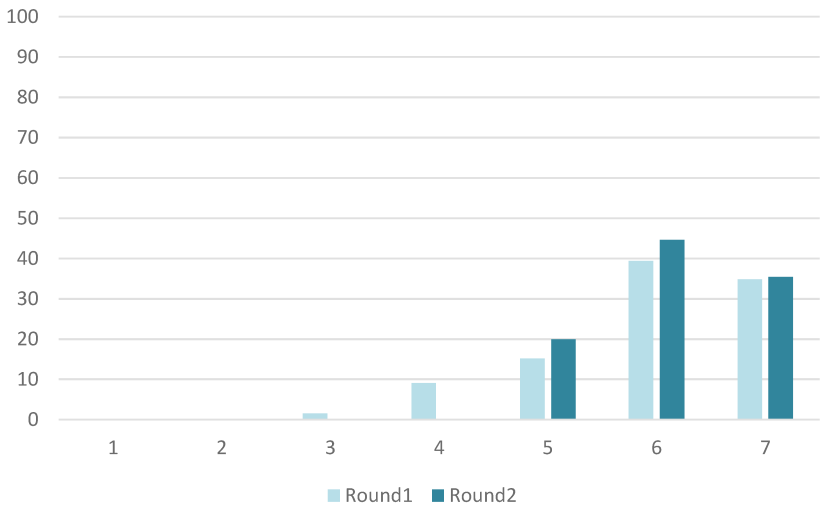


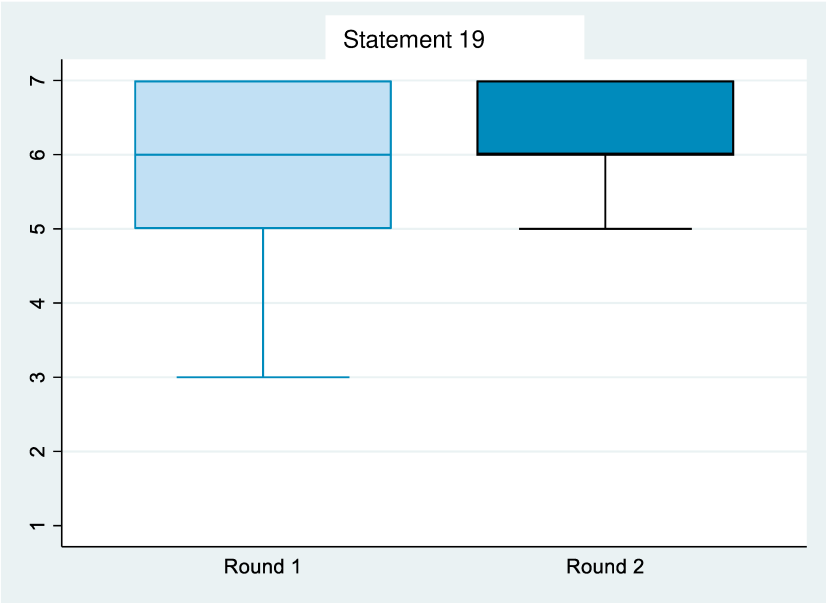


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	4	5	
75° Percentile	6	6	
interquartile range	2	1	

Statement 19

In a patient on immunotherapy I would continue the treatment even beyond progression, in the presence of clinical benefit

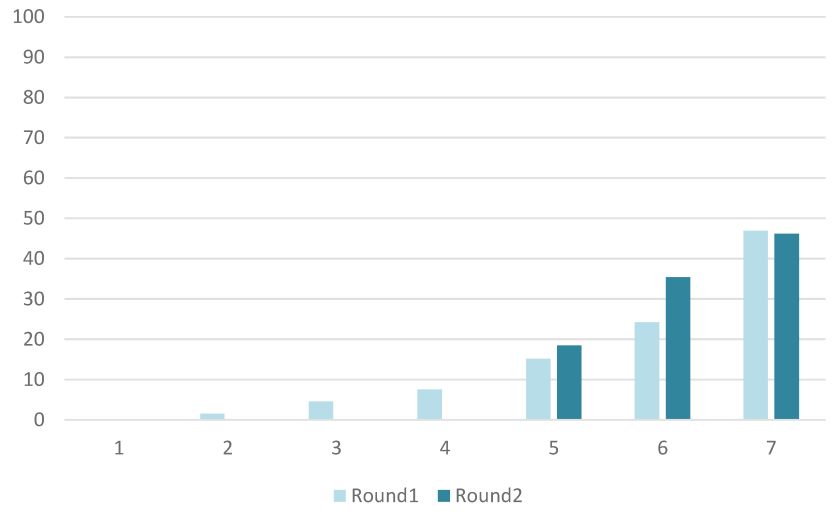


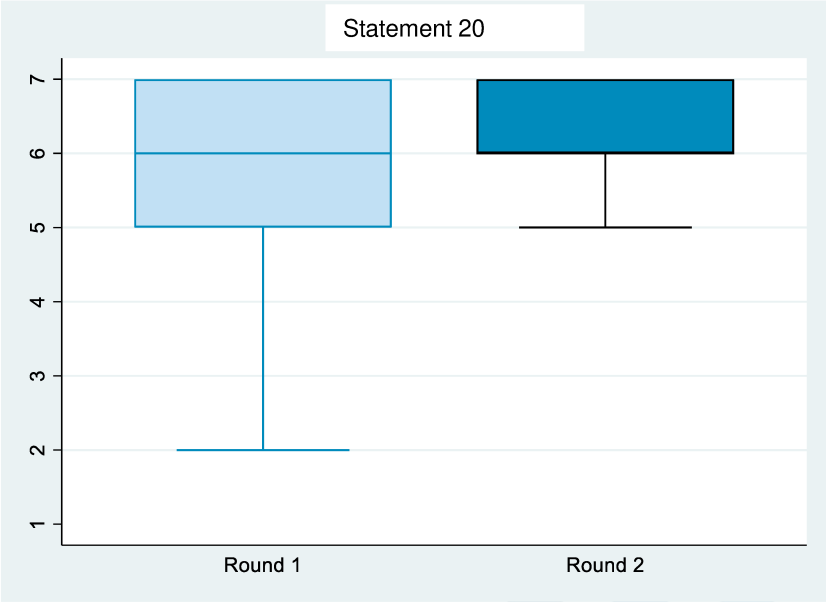


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	5	6	
75° Percentile	7	7	
interquartile range	2	1	

Statement 20

In clinical practice I would apply the immune RECIST criteria for the management of patients over time and evaluation under immunotherapy

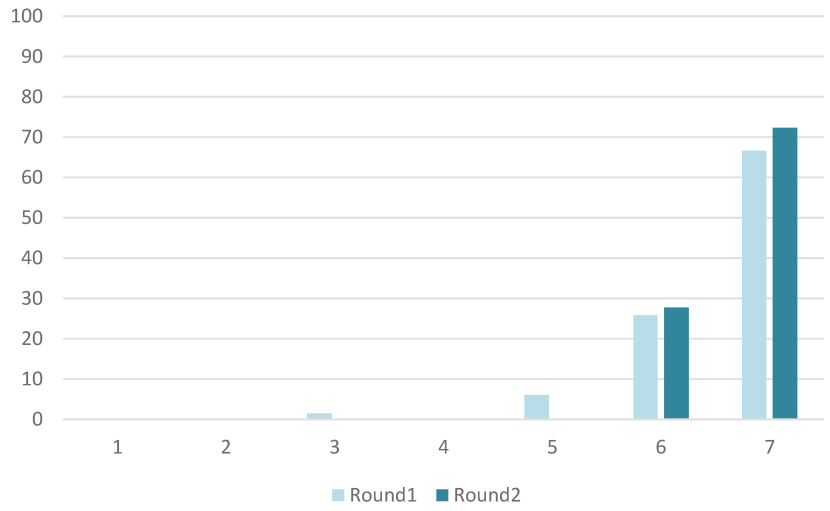


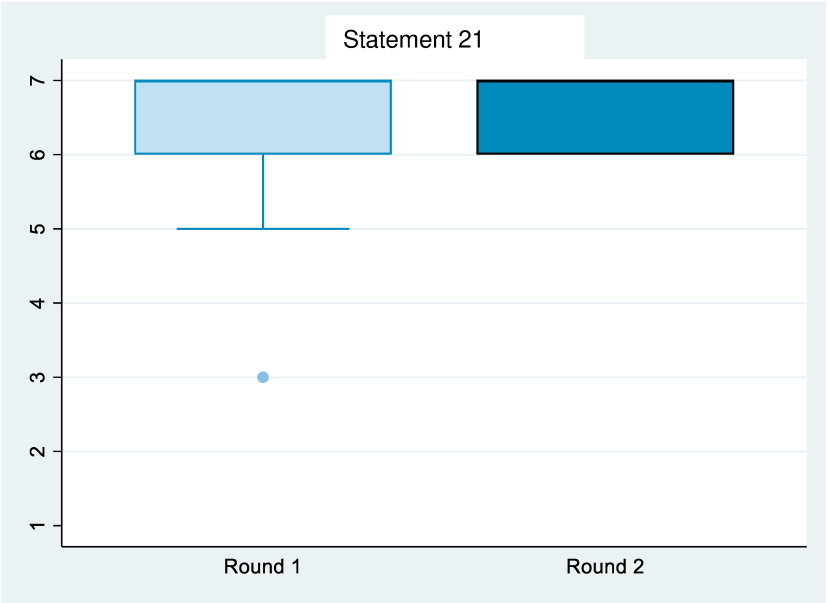


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	5	6	
75° Percentile	7	7	
interquartile range	2	1	

Statement 21

In the case of curative surgery with demolitive impact, I would discuss with the patient alternative therapeutical medical and/or radiotherapeutic options

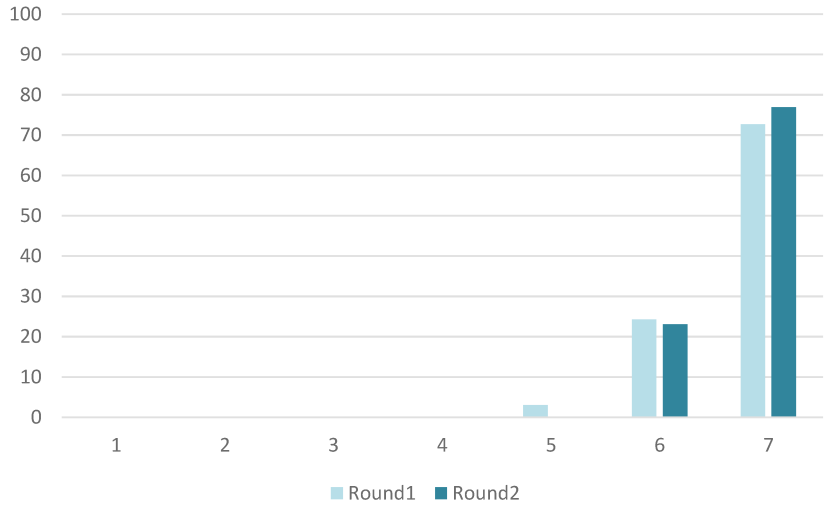


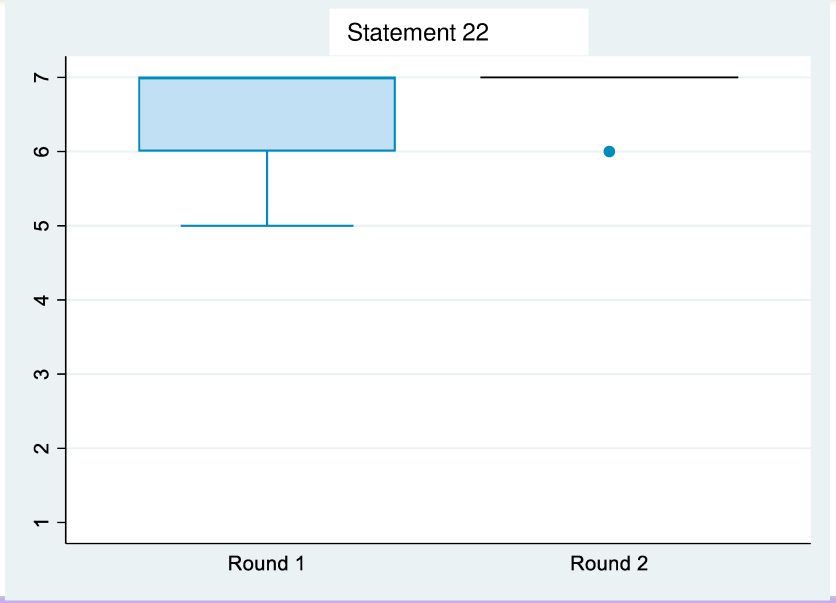


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 22

The patient with regional recurrence no longer susceptible to radical surgery should be managed with radiotherapy and/or medical therapy (immunotherapy in the first instance or if contraindications alternatively chemotherapy)

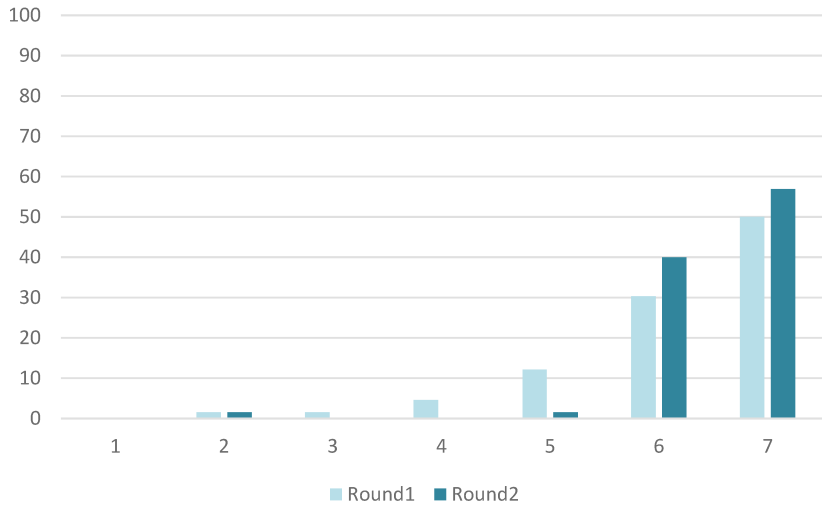


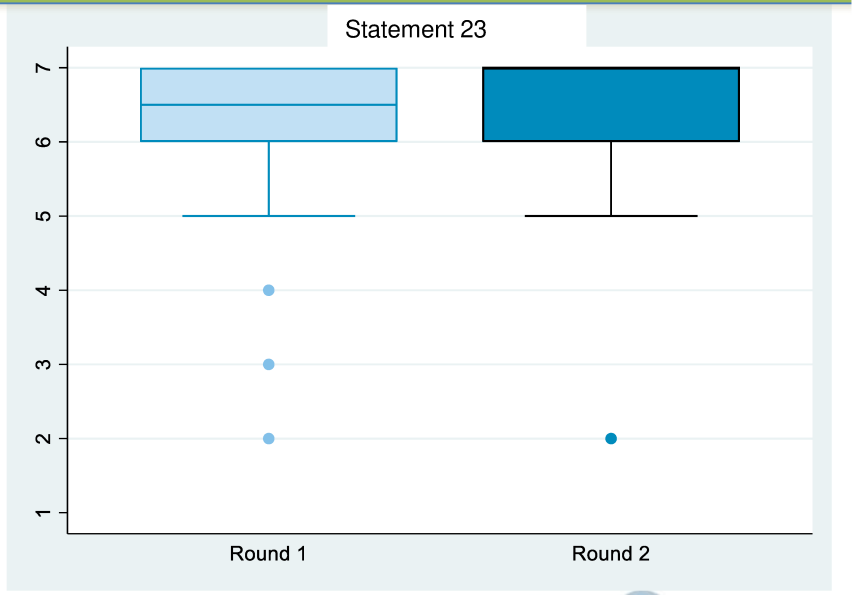


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	7	
75° Percentile	7	7	
interquartile range	1	0	

Statement 23

During immunotherapy I would treat the focal progression with the addition of radiotherapy.

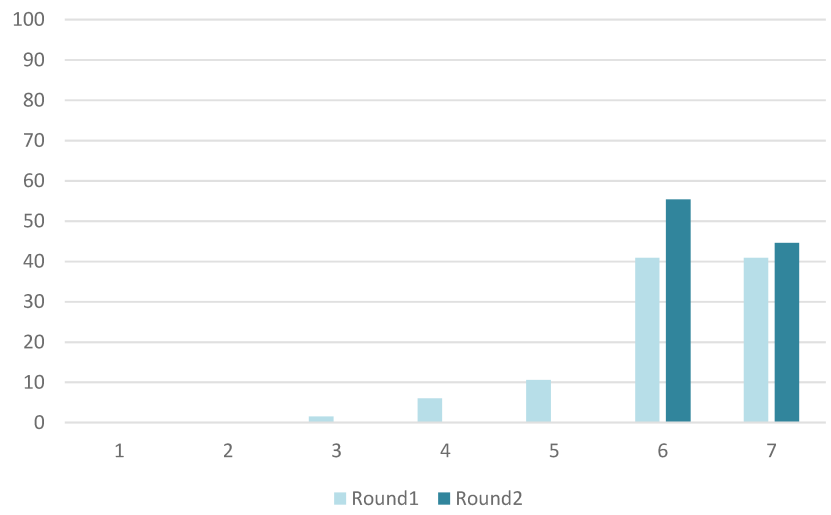


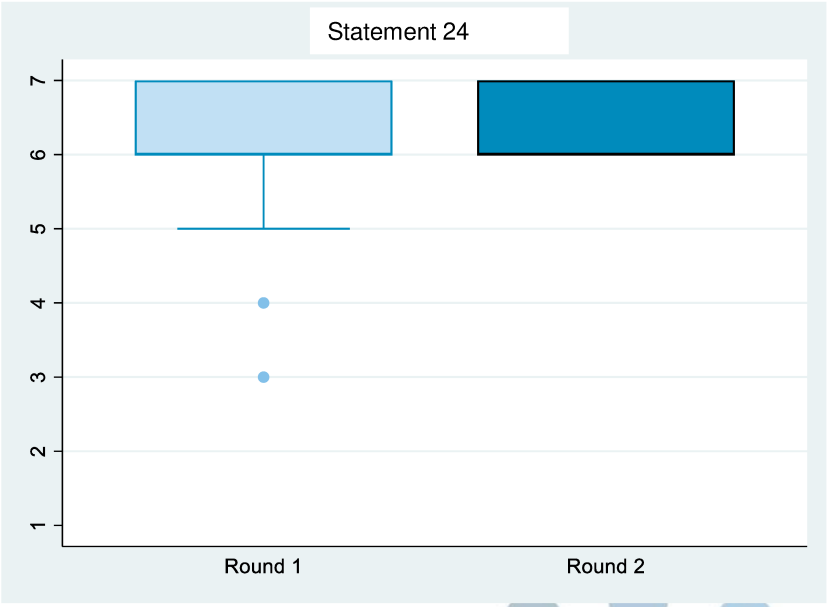


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 24

. I consider the design and conduct of the JAVELIN Merkel 200 registration study (part A and part B) with Avelumab, entirely adequate to obtain reliable results

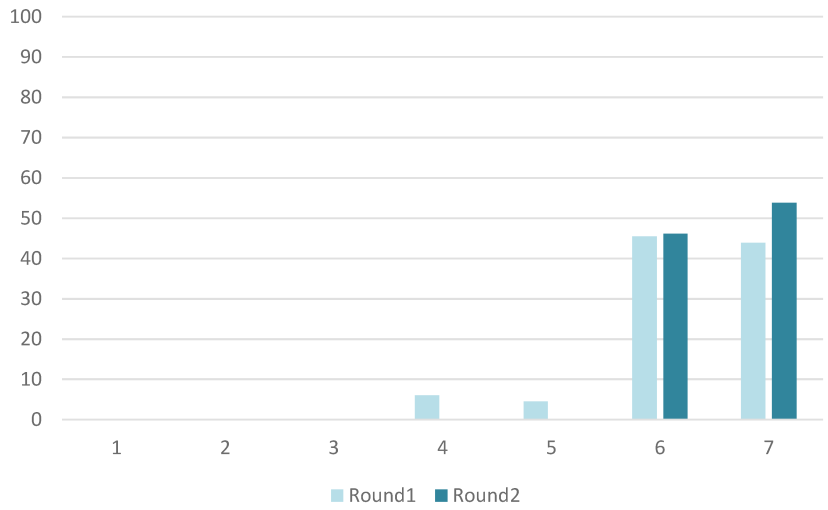


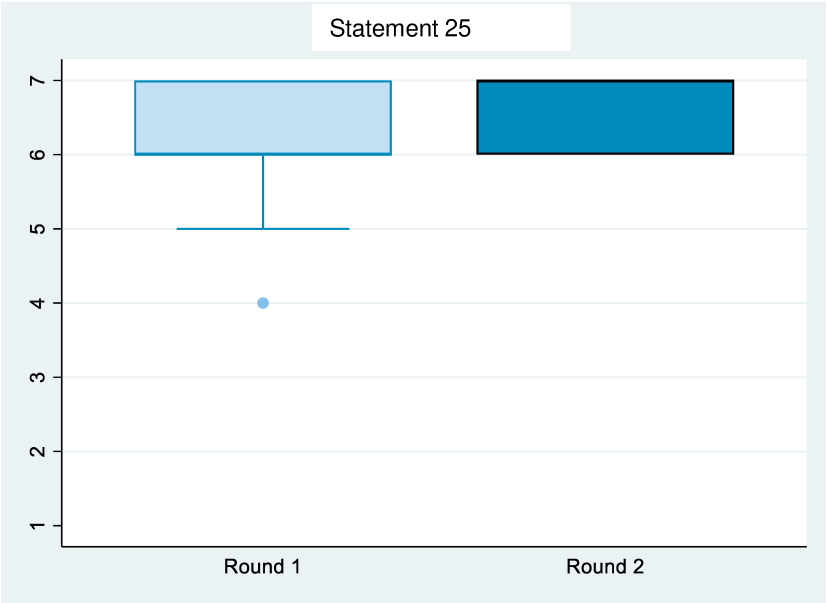


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 25

I believe that the expanded access program (EAP) data for Avelumab have concrete clinical implications for patient management with metastatic MCC

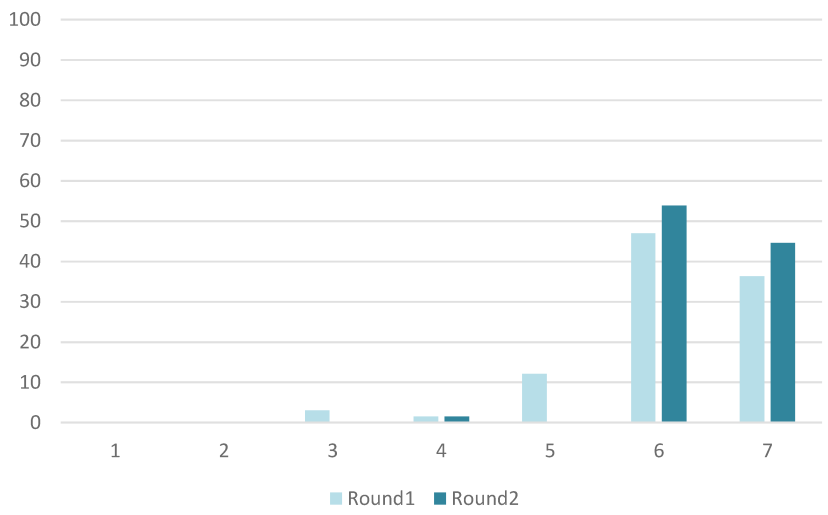


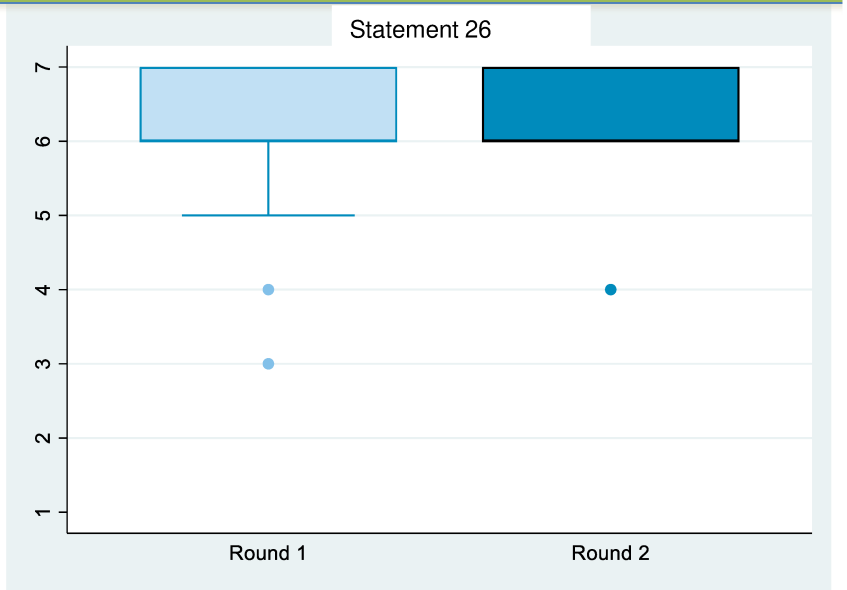


	Round 1	Round 2	
Median	6	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 26

. I believe the indications in the national guidelines that refer to the Italian Association of Medical Oncology (AIOM) and international guidelines such as those of the National Comprehensive Cancer Network (NCCN), are clear and usable

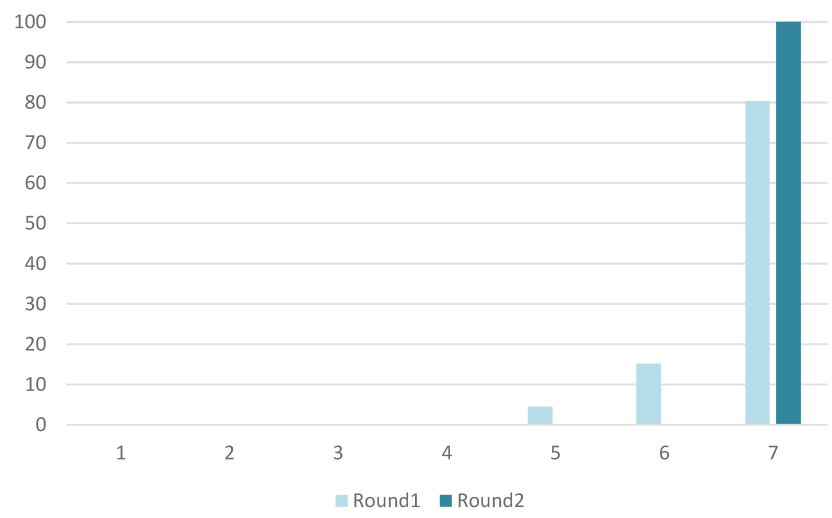


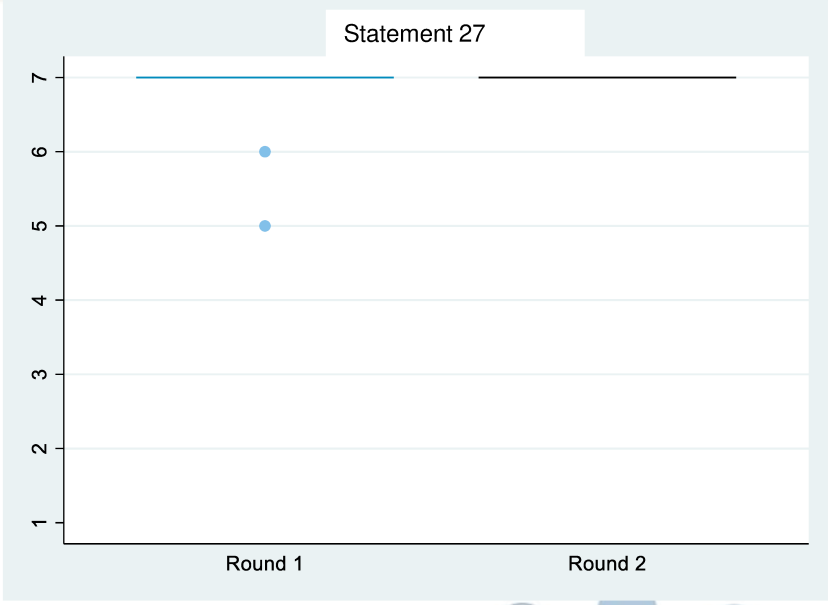


	Round 1	Round 2	
Median	6	6	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	6	6	
75° Percentile	7	7	
interquartile range	1	1	

Statement 27

The patient with MCC should be managed within a dedicated network with HUB and SPOKE centres, with reference centres that have a multidisciplinary team

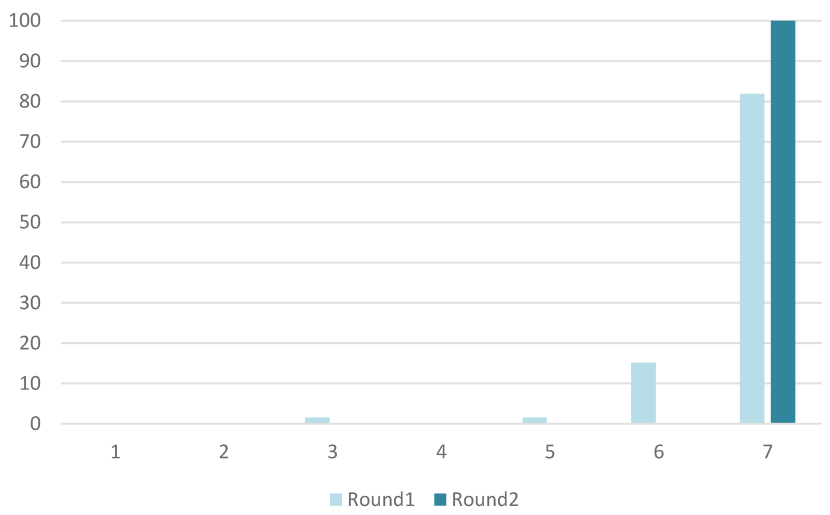


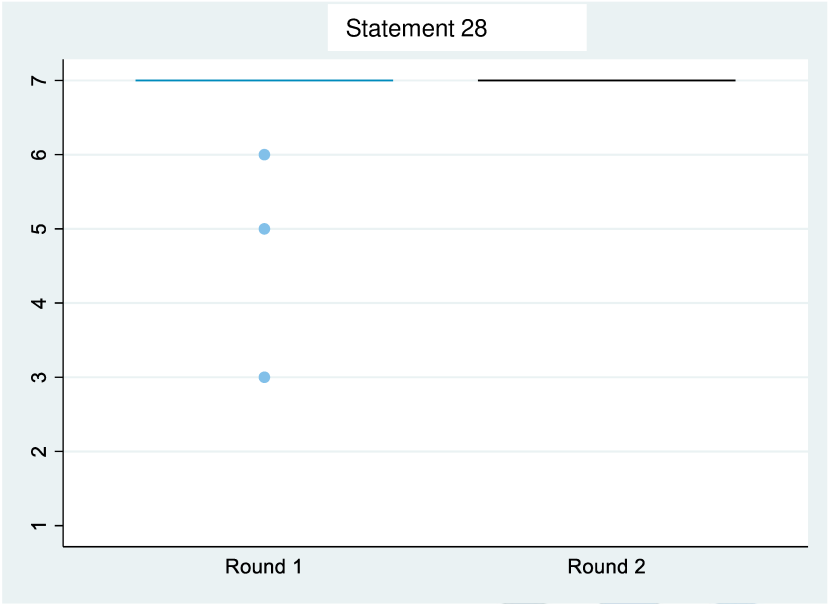


	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	7	7	
75° Percentile	7	7	
interquartile range	0	0	

Statement 28

I believe clinical radiological follow-up is always needed in patients with Merkel cell carcinoma





	Round 1	Round 2	
Median	7	7	AGREEMENT AND CONSENSUS WITH THE STATEMENT
25° Percentile	7	7	
75° Percentile	7	7	
Range Interquartilico	0	0	