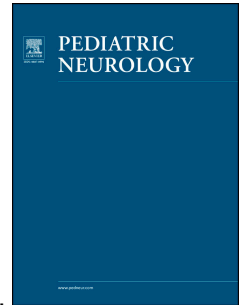


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Updated International Tuberous Sclerosis Complex Diagnostic Criteria and Surveillance and Management Recommendations

Hope Northrup, Mary E. Aronow, E. Martina Bebin, John Bissler, Thomas N. Darling, Petrus J. de Vries, Michael D. Frost, Zoë Fuchs, Elizabeth S. Gosnell, Nishant Gupta, Anna C. Jansen, Sergiusz Józwiak, J. Chris Kingswood, Timothy K. Knilans, Francis X. McCormack, Ashley Pounders, Steven L. Roberds, David F. Rodriguez-Buritica, Jonathan Roth, Julian R. Sampson, Steven Sparagana, Elizabeth Anne Thiele, Howard L. Weiner, James W. Wheless, Alexander J. Towbin, Darcy A. Krueger, on behalf of the International Tuberous Sclerosis Complex Consensus Group

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## Updated International Tuberous Sclerosis Complex Diagnostic Criteria and Surveillance and Management Recommendations

Running Title: Update to TSC Diagnosis and Care

Authors: Hope Northrup<sup>a</sup>, Mary E. Aronow<sup>b</sup>, E. Martina Bebin<sup>c</sup>, John Bissler<sup>d</sup>, Thomas N. Darling<sup>e</sup>, Petrus J. de Vries<sup>f</sup>, Michael D. Frost<sup>g</sup>, Zoë Fuchs<sup>h</sup>, Elizabeth S. Gosnell<sup>i</sup>, Nishant Gupta<sup>j</sup>, Anna C. Jansen<sup>k</sup>, Sergiusz Jóźwiak<sup>l</sup>, J. Chris Kingswood<sup>m</sup>, Timothy K. Knilans<sup>n</sup>, Francis X. McCormack<sup>o</sup>, Ashley Pounders<sup>p</sup>, Steven L. Roberds<sup>q</sup>, David F. Rodriguez-Buritica<sup>r</sup>, Jonathan Roth<sup>s</sup>, Julian R. Sampson<sup>t</sup>, Steven Sparagana<sup>u</sup>, Elizabeth Anne Thiele<sup>v</sup>, Howard L. Weiner<sup>w</sup>, James W. Wheless<sup>x</sup>, Alexander J. Towbin<sup>y</sup>, and Darcy A. Krueger<sup>z</sup> on behalf of the International Tuberous Sclerosis Complex Consensus Group<sup>\*</sup>

Corresponding Author: Darcy A. Krueger, MD, PhD  
 Division of Neurology, Department of Pediatrics  
 Cincinnati Children's Hospital Medical Center  
 University of Cincinnati College of Medicine  
 3333 Burnet Avenue  
 Cincinnati, OH 45229  
 Phone: 513-636-9985  
 Fax: 866-213-7089  
 Email: darcy.krueger@cchmc.org

<sup>a</sup> Department of Pediatrics; McGovern Medical School; University of Texas Health Science Center at Houston, Houston, TX, USA

<sup>b</sup> Retina Service, Massachusetts Eye and Ear, Harvard Medical School, Boston, MA, USA

<sup>c</sup> Department of Neurology, University of Alabama at Birmingham, Birmingham, AL, USA

<sup>d</sup> Department of Pediatrics, University of Tennessee Health Science Center and Le Bonheur Children's Hospital, Memphis, TN, USA

<sup>e</sup> Uniformed Services University of the Health Sciences, Bethesda, MD, USA

<sup>f</sup> Division of Child and Adolescent Psychiatry, University of Cape Town, Cape Town, South Africa

<sup>g</sup> Minnesota Epilepsy Group, St. Paul, MN USA

<sup>h</sup> TSC Alliance, Silver Spring, MD, USA

<sup>i</sup> Department of Pediatrics, University of Cincinnati College of Medicine, and Division of Pediatric Dentistry, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA

<sup>j</sup> Division of Pulmonary, Critical Care and Sleep Medicine; University of Cincinnati, Cincinnati, OH, USA

<sup>k</sup> Pediatric Neurology Unit, Department of Pediatrics, UZ Brussel; Neurogenetics Research Group, Vrije Universiteit Brussel, Brussels, Belgium

<sup>l</sup> Department of Pediatric Neurology, Medical University of Warsaw, Warsaw, Poland

<sup>m</sup> Cardiology Clinical Academic Group, Molecular and Clinical Sciences Research Centre, St Georges University of London, London, England, UK

<sup>n</sup> Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine, Cincinnati, OH, USA

<sup>o</sup> Division of Pulmonary, Critical Care and Sleep Medicine; University of Cincinnati, Cincinnati, OH, USA

<sup>p</sup> TSC Alliance, Silver Spring, MD, USA

<sup>q</sup> TSC Alliance, Silver Spring, MD, USA

<sup>r</sup> Division of Medical Genetics, Department of Pediatrics, McGovern Medical School, University of Texas at Houston Medical Center, Houston, TX, USA

<sup>s</sup> Dana Children's Hospital, Tel Aviv Medical Center, Tel Aviv University, Israel

<sup>t</sup> Institute of Medical Genetics, Division of Cancer and Genetics, Cardiff University Medical School, Cardiff, Wales, UK

<sup>u</sup> Scottish Rite for Children and the University of Texas Southwestern Medical Center, Dallas, TX, USA

<sup>v</sup> Department of Neurology, Massachusetts General Hospital, Boston, MA, USA

<sup>w</sup> Texas Children's Hospital, Baylor College of Medicine, Houston, TX, USA

<sup>x</sup> Professor & Chief of Pediatric Neurology, Le Bonheur Chair in Pediatric Neurology, University of Tennessee Health Science Center; Director, Neuroscience Institute & Le Bonheur Comprehensive Epilepsy Program, Co-Director Le Bonheur Tuberos Sclerosis Center of Excellence, Le Bonheur Children's Hospital, Memphis, TN, USA

<sup>y</sup> Cincinnati Children's Hospital, Department of Radiology; University of Cincinnati College of Medicine, Department of Radiology, Cincinnati, OH, USA

<sup>z</sup> Division of Neurology, Cincinnati Children's Hospital Medical Center; Department of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, OH, USA

\*International Tuberos Sclerosis Complex Consensus Group: Nicholas M. P. Anear, Mary E. Aronow, Ute Bartels, E. Martina Bebin, Moncef Berhouma, John J. Bissler, Klemens Budde, Anna Byars, Harry Chugani, Edward W. Cowen, Peter B. Crino, Paolo Curatolo, Thomas N. Darling, Petrus de Vries, Daniel F. Dilling, David W. Dunn, Rosmary Ekong, Kevin C. Ess, David N. Franz, Michael Frost, Zoë D.B. Fuchs, Elizabeth Gosnell, Lisa Guay-Woodford, Nishant Gupta, Luciana Haddad, Anne Halbert, Adelaide A. Hebert, Elizabeth P. Henske, Gregory L. Holmes, Dena Hook, John Hulbert, Anna Jansen, Simon R. Johnson, Sergiusz Józwiak, Bryan King, J. Christopher Kingswood, Timothy K. Knilans, Mary Kay Koenig, Bruce Korf, Darcy A. Krueger, David J. Kwiatkowski, Francis X. McCormack, Joel Moss, David Mowat, Kate Mowrey, Rima Nabbout, Mark D. Nellist, Hope Northrup, Finbar O'Callaghan, Uday Patel, Ashley Pounders, E. Steve Roach, Steven L. Roberds, David Rodriguez-Buritica, Robb Romp, Jonathan Roth, Micaela Rozenberg, Stephen J. Ruoss, Mustafa Sahin, Julian Sampson, Joshua A. Samuels, Matthias Sauter, Catherine A. Smith, Keyomaurs Soltani, Steven Sparagana, Shoba Srivastava, Clare Stuart, Joyce M. C. Teng, Elizabeth A. Thiele, Alexander J. Towbin, Andrew Trout, Agnies van Eeghen, Stephanie Vanclooster, Henry Z. Wang, Mari Wataya-Kaneda, Howard L. Weiner, James W. Wheless, Patricia Witman, Tim Wright, Joyce Y. Wu, Lisa Young

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**ABSTRACT**

**BACKGROUND:** Tuberous sclerosis complex (TSC) is an autosomal dominant genetic disease affecting multiple body systems with wide variability in presentation. In 2013, *Pediatric Neurology* published articles outlining updated diagnostic criteria and recommendations for surveillance and management of disease manifestations. Advances in knowledge and approvals of new therapies necessitated a revision of those criteria and recommendations. **METHODS:** Chairs and working group co-chairs from the 2012 International TSC Consensus Group were invited to meet face-to-face over two days at the 2018 World TSC Conference July 25-26 in Dallas, TX, USA. Prior to the meeting, working group co-chairs worked with group members via email and telephone to a) review TSC literature since the 2013 publication, b) confirm or amend prior recommendations, and c) provide new recommendations as required. **RESULTS:** Only two changes were made to clinical diagnostic criteria reported in 2013: “multiple cortical tubers and/or radial migration lines” replaced the more general term “cortical dysplasias,” and sclerotic bone lesions were reinstated as a minor criterion. Genetic diagnostic criteria were reaffirmed including highlighting recent findings that some individuals with TSC are genetically mosaic for variants in *TSC1* or *TSC2*. Changes to surveillance and management criteria largely reflected increased emphasis on early screening for EEG abnormalities, enhanced surveillance and management of TSC-associated neuropsychiatric disorders, and new medication approvals. **CONCLUSIONS:** Updated TSC diagnostic criteria and surveillance and management recommendations presented here should provide an improved framework for optimal care of those living with TSC and their families.

## Introduction

Tuberous sclerosis complex (TSC) is a rare genetic disorder that can affect any organ system [1]. Many manifestations can be associated with severe morbidity and potentially death, so early diagnosis and appropriate life-long surveillance and management are crucial. Given that the clinical manifestations of TSC are varied in age of onset and the extent of systemic involvement and severity, TSC clinical features may present dynamically over the course of an individual's life [2]. The incidence of TSC has been estimated many times and generally falls between 1:6,000 to 1:10,000 live births. A comprehensive study in the UK estimated the incidence at 1:5,800 live births [3], and a more recent study in Germany using the most recent diagnostic criteria [4] estimated the incidence rate from 1:6,760-1:13,520 live births [5].

Major updates to clinical consensus guidelines for the diagnosis, surveillance, and management of TSC were published in 1998 [6], 1999 [7] and 2013 [4, 8]. Recognizing that many new clinical studies and important new drug approvals had occurred or were pending, chairs and co-chairs of working groups involved in the 2012 TSC Clinical Consensus Conference met over two days at the 2018 World TSC Conference organized by the TSC Alliance in collaboration with TSC International (TSCi). Each disease area of TSC was reviewed by its respective working group to identify which recommendations were significantly impacted by advances in understanding TSC pathogenesis and clinical treatment since 2012. Only minor updates were recommended to the diagnostic criteria, but several important changes were recommended to surveillance and management criteria, primarily reflecting increased understanding of TSC-associated neuropsychiatric disorders (TAND) and newly approved medications for epilepsy in TSC with novel mechanisms of action. Over the next two years, the relevant working groups were tasked with drafting new recommendations for each of these areas. In addition, all working groups of the International TSC Consensus Group were asked to review and affirm

recommendations to be continued from 2012, providing additional clarity or emphasis when necessary to address unintended ambiguity or unanticipated obstacles to implementation that had since emerged. Working group deliberations and drafting of updated recommendations continued between 2018-2021, culminating in the current document. The result of these efforts is reported here as current consensus guidelines for diagnosis, surveillance, and management of TSC.

## **Methods**

Updating these guidelines employed the structure and methods as described for the previous update [4, 8] with two exceptions. First, additional experts were consulted either to replace participants in the previous update who were no longer available or to supplement expertise. Second, only 24 individuals, including the chairs and working group co-chairs, met in person during the 2018 World TSC Conference in Dallas, TX, USA, because updates did not need to be as extensive as the changes between 1998 and 2013. Over the next two years, working group co-chairs engaged their working group members to review relevant literature and draft an update to their working group's recommendations.

A comprehensive literature search was performed on May 10, 2018, to prepare for discussions on July 25-26, 2018. This search used the same terms as the previous update [4, 8] from 2012 through 2018. Additional literature searches addressing key questions not included by (or more recent than) the general search were performed as needed by each individual working group.

To assess the strength of evidence and resulting recommendations, the same National Comprehensive Cancer Network (NCCN) Clinical Guidelines framework [9] was used as before [8] (Table 1).

These 2021 International Tuberous Sclerosis Complex Consensus Group surveillance and management recommendations are organized into two sections: (1) recommendations applicable at the time of initial diagnoses and (2) recommendations for ongoing healthcare. There is some



overlap with this approach because certain features discovered upon initial diagnosis may require immediate intervention, additional workup, or specialist referral. By necessity, discussion in this paper is limited to the most relevant and updated points that differ or have evolved since 2013.

### **Diagnostic criteria update**

#### ***Genetic diagnostic criteria***

The International TSC Clinical Consensus Group reaffirms the importance of independent genetic diagnostic criteria and clinical diagnostic criteria [4]. Identification of a pathogenic variant in *TSC1* or *TSC2* is sufficient for the diagnosis or prediction of TSC regardless of clinical findings. This is important because manifestations of TSC are known to arise over time at various ages [10, 11]. Genetic diagnosis of TSC prior to an individual meeting clinical criteria for TSC is beneficial to ensure individuals to undergo necessary surveillance to identify manifestations of TSC as early as possible to enable optimal clinical outcomes.

Determination of pathogenicity of genetic variants of *TSC1* or *TSC2* should follow standards and guidelines of the American College of Medical Genetics (ACMG) for interpretation of sequence variants [12], now widely adopted as the international standard. Broadly, a “pathogenic” variant is one which clearly prevents protein synthesis and/or inactivates the function of the *TSC1* or *TSC2* proteins (e.g., nonsense or frameshift variants, large genomic deletions) or is a missense variant whose effect on protein function has been established by functional assessment [13-16]. *TSC1* and *TSC2* variants whose effect on protein synthesis or function is less certain are not definitely pathogenic and would not be considered diagnostic unless supported by additional ACMG criteria for pathogenicity [12]. Many pathogenic variants identified to date have been carefully curated ([www.lovd.nl/TSC1](http://www.lovd.nl/TSC1), [www.lovd.nl/TSC2](http://www.lovd.nl/TSC2)), but it should be noted that novel pathogenic variants in *TSC1* or *TSC2* continue to be identified as genetic testing is increasingly

accessible and utilized. If the pathogenic variant in an affected relative is known, targeted testing for known familial variants has very high predictive value for family members.

Between 10-15 percent of TSC patients meeting clinical diagnostic criteria have no mutation identified by conventional genetic testing [17]. Therefore, failure to identify a pathogenic variant in *TSC1* or *TSC2* does not exclude a diagnosis of TSC. High read depth approaches in next generation sequencing (NGS) demonstrate low-level mosaic pathogenic variants in some individuals with clinical signs of TSC in whom standard NGS or pre-NGS testing proved normal [17]. Intronic splice site mutations are also important to identify as a potential cause for TSC [17]. Although mosaic individuals may experience fewer findings of TSC, they may develop any manifestation of TSC and are at risk to have offspring who are non-mosaic for TSC [18], so diligent surveillance and genetic counselling are warranted [19].

### ***Clinical diagnostic criteria***

The clinical diagnostic criteria as established at the 2012 Consensus Conference [4] were reviewed by each working group, who then recommended whether to keep, change, add, or delete specific major or minor criteria. The new diagnostic clinical criteria have only two changes from the previous version and now include eleven major features and seven minor features (Table 2). The previous major clinical diagnostic criterion of “cortical dysplasias” was found to be too non-specific in practice and potentially confusing to clinicians, given that TSC is one of several causes of focal cortical dysplasias. The new criterion is “multiple cortical tubers and/or radial migration lines,” which is more specific to TSC.

The Dermatology and Dental working group recommended adding back the minor clinical diagnostic criteria “sclerotic bone lesions.” Sclerotic bone cysts had been eliminated in 2012 as a minor clinical criterion. However, in the intervening years, working group members observed

heightened and unwarranted concern among some medical care providers about the possibility of metastatic cancer. Sclerotic bone lesions are commonly observed in individuals with TSC when high resolution chest CT is performed as surveillance for possible lymphangiomyomatosis (LAM) or abdominal MRI is performed as surveillance for renal angiomyolipoma [20, 21].

These bone lesions are common and relatively specific for TSC [22]. It is important that clinicians understand these lesions are not surprising in TSC and rarely require intervention, and they should not raise undue alarm of possible cancer.

### **Surveillance and management recommendations for individuals with newly suspected or newly diagnosed TSC**

Recommendations are summarized in Table 3. Strength of each following recommendation is Category 3 unless specified otherwise.

#### **Genetics**

All individuals should have a three-generation family history obtained to determine if additional family members are at risk of the condition. Genetic testing is recommended for genetic counseling purposes or when the diagnosis of TSC is suspected or in question but cannot be clinically confirmed (Category 1).

#### **Brain**

All individuals suspected of having TSC, regardless of age, should undergo magnetic resonance imaging (MRI) of the brain to assess for the presence of cortical or subcortical tubers, other types of neuronal migration defects, subependymal nodules (SEN), and subependymal giant cell astrocytomas (SEGA). If MRI is not available or cannot be performed, computed tomography (CT) or head ultrasound (in neonates or infants when fontanelles are open) may be used, although these frequently will not detect all abnormalities revealed by MRI [23, 24]. (Category 1)

Recently, gadolinium deposition in the brain has drawn attention [25], although newer macrocyclic gadolinium agents lower the risk of depositions compared to older linear gadolinium agents [26, 27] and the long-term clinical implications are unknown [25, 28]. While gadolinium can be used to better demonstrate SEGAs, in light of the need for repeated scans during childhood and potential side effects of contrast agents, combined with non-contrast imaging sequences generally sufficient for screening for SEGAs, we recommend avoiding until there is a growing lesion or clinical suspicion of SEGAs. In the latter circumstances, gadolinium can better define the lesion size, characteristics and margins and nearby anatomical structures which may be important for decision making and for planning and monitoring treatment response.

Focal seizures and epileptic spasms occur in most (63-78%) infants with TSC, and caregivers should be educated to recognize these even if none are reported at time of diagnosis[10]. A helpful resource is the Infantile Spasms Action Network (<https://infantilespasms.org/what-can-it-look-like/>). Also, at time of diagnosis, children with TSC should undergo routine baseline electroencephalogram (EEG), prolonged if necessary to include both awake and sleep stages, even if patient has never reported clinical seizures or epileptic spasms previously. If epileptic spasms or focal seizures are suspected but not able to be confirmed clinically or the baseline EEG reveals abnormalities that are non-specific, the patient should have an 8- to 24-hour video-EEG that includes sleep, which may detect electrographic seizures or interictal epileptiform discharges that have been shown to be strongly predictive of impending epilepsy [29, 30]. Early recognition and control of seizures is highly correlated with improved developmental and neurological outcomes [31-33] and pre-emptive treatment with vigabatrin before the onset of clinical seizures may provide additional benefit of preventing or delaying seizure onset in at-risk infants diagnosed with TSC and epileptiform activity on EEG [34]. However, pre-emptive

treatment with vigabatrin may not be able to improve developmental and neurological outcomes over that achieved by early recognition and control of clinical seizures alone [34, 35]. (Category 2A)

Children with TSC should be referred initially to a pediatric neurologist with expertise in epilepsy associated with TSC. Likewise, adults with TSC should be evaluated by an adult neurologist with expertise in epilepsy associated with TSC. Ongoing management may then be coordinated with a general pediatrician or general neurologist if preferred or necessary (e.g., in regions or countries with limited availability or access to epilepsy or TSC specialists).

#### **TSC-associated neuropsychiatric disorders (TAND)**

The term, “TAND,” and related terminology was introduced in 2013 [8] and readily accepted as an umbrella term encompassing interrelated neuropsychiatric manifestations common in TSC, including behavioral, psychiatric, intellectual, academic, neuropsychological, and psycho-social difficulties and disorders [Figure]. TAND issues are common and are often the most impactful aspect of TSC yet least likely to be addressed and controlled by existing treatments [36]. The TAND Checklist (lifetime version, TAND-L) was developed in 2015 [37, 38] as a screening tool to identify neuropsychiatric concerns in a person of any age by encouraging and guiding conversations between individuals or caregivers and a healthcare provider. The TAND Checklist is freely available and able to be downloaded in 19 languages

(<https://tandconsortium.org/checklists/>).

At diagnosis, all patients should receive comprehensive assessment for TAND manifestations to identify areas needing immediate or early intervention [37] (Category 1). Patients should be referred as appropriate to suitable professionals to initiate evidence-based interventions for any difficulties or disorders identified (Category 1), and parents or caregivers of children and

dependent adults should be educated about TAND to ensure families know what to look for as potential emerging TAND manifestations [37, 39] (Category 2A). Family members may also need psychological and social support while coming to terms with the diagnosis of TSC and TAND, so strategies should be in place to support caregiver wellbeing [40, 41] (Category 2B).

### **Kidney**

At the time of diagnosis, abdominal imaging should be obtained regardless of age. MRI is the preferred modality for evaluation of angiomyolipoma because 25-30% can be fat-poor [42] and may be missed when abdominal US is performed [43]. In the event MRI is not possible an abdominal CT would be the next preferred modality. Intravenous contrast can help with identification of renal cysts and lipid-poor angiomyolipoma on abdominal CT and is likely less harmful than previously feared [44], especially in patients with normal renal function (GFR >60 mL/min/1.73 m<sup>2</sup>) [45, 46].

MRI of the brain and abdomen can be coordinated, thereby limiting the need for multiple sessions of anesthesia if needed for successful MRI. MRI of the abdomen may also reveal aortic aneurysms or extrarenal hamartomas of the liver, neuroendocrine tumors in the pancreas, and other abdominal organs that also can occur in individuals with TSC [47]. In addition to imaging, accurate blood pressure assessment is important because of the increased risk of secondary hypertension [48, 49]. To assess kidney function at time of diagnosis, blood tests should be obtained to determine glomerular filtration rate (GFR) using creatinine or cystatin C equations for adults [50, 51] or children [52, 53]. Patients with reduced muscle mass for any reason, including significant developmental delays, can have artifactually increased estimated GFR if a creatinine equation is used. In such situations, measurement of serum cystatin C concentration can be used to more accurately evaluate GFR [52, 54]. (Category 1)

## Lung

Clinical assessment for LAM and high-resolution CT (HRCT) chest CT should be performed in all females, and symptomatic males, 18 years or older. Ultra-low dose CT acquisition protocols are recommended when possible to limit radiation exposure [55]. High-resolution CT (HRCT) is not needed to diagnose cysts that are characteristic of LAM but can be useful for the differentiation of dependent abnormalities such as pleural/chylous effusions or dependent atelectasis [56]. Minimum intensity projection (MiniIP)-reformatted images [57] also can be used to better identify extremely small cysts.

Key elements of history include information about family history of lung diseases, occupational and environmental exposures, tobacco use, features of connective tissue diseases, dyspnea on exertion, cough, hemoptysis, chest pain and history of pneumothorax. Baseline pulmonary function tests (PFTs) including pre and post bronchodilator spirometry, lung volumes, and diffusion capacity of the lung for carbon monoxide, and six-minute walk test (6MWT) should be performed in individuals with lung cysts consistent with LAM on the screening CT. Although in cross-sectional studies serum vascular endothelial growth factor-D (VEGF-D) has excellent positive and moderate negative predictive value for the presence of LAM in women with TSC [58-60], it has not been tested prospectively as a screening tool to signal the need for a CT and cannot yet be routinely recommended for that purpose. (Category 2A)

Multifocal micronodular pneumocyte hyperplasia (MMPH) refers to benign, nodular proliferation of type II pneumocytes that occurs in both men and women with TSC [61]. Radiologically, MMPH appears as multiple, often diffuse, discrete solid and ground glass nodules, typically ranging between 2-14 mm in diameter, with no consistent central/peripheral or apical/basilar distribution [62]. Given that MMPH has rarely been reported in patients with

sporadic LAM, and that non-MMPH nodules are often radiologically indistinguishable from MMPH, the panel recommends that a radiological diagnosis of MMPH should not be a diagnostic criterion for TSC. A lung biopsy of nodules for the purpose of establishing the diagnosis of TSC is not recommended.

### **Skin**

Comprehensive dermatologic evaluation by an experienced specialist is recommended at the time of diagnosis for all patients. Wood's lamp is helpful in detecting hypomelanotic macules. Anticipatory guidance regarding expectations and potential treatments is advised. Sun protection is recommended, for both adults and children, considering the photosensitivity of hypomelanotic macules and the presence of mutations consistent with those induced by UV radiation in angiofibromas [63]. Intervention with mTOR inhibitors, pulsed-dye or ablative lasers, or surgical excision can be appropriate for large or disfiguring lesions and for lesions prone to bleeding or a source of pain [64].

### **Teeth**

For newly diagnosed infants, baseline oral evaluation and establishment of a primary dental care provider is recommended at the time of the eruption of the first tooth or no later than 12 months of age. If an oral evaluation has not been completed, a baseline evaluation is recommended at time of diagnosis. A simple technique of utilizing dental disclosing solution can assist the practitioner in delineating the enamel pits more effectively [65-67]. Solitary lesions (intraoral fibroma or enamel pit) may occur in the general population. If the practitioner identifies multiple lesions, it would be prudent to screen for other TSC related findings. (Category 2B)



**Heart**

All individuals should have age-appropriate cardiac evaluation at time of diagnosis [68]. In pediatric patients, especially younger than three years of age, an echocardiogram and a 12-15 lead electrocardiogram (ECG) should be obtained to evaluate for rhabdomyomas and arrhythmias, respectively. In those individuals with rhabdomyomas identified via prenatal ultrasound, fetal echocardiogram may be useful to detect those individuals with high risk of heart failure after delivery. (Category 1)

In the absence of cardiac symptoms or concerning medical history, echocardiogram is not necessary in adults, but as conduction defects may still be present and may influence medication choice and dosing [68], a baseline ECG is still recommended. (Category 2A)

**Eye**

A baseline ophthalmologic evaluation, including dilated fundoscopic evaluation, is recommended for all individuals diagnosed with TSC to screen for retinal astrocytic hamartomas and retinal achromic patches. Retinal astrocytic hamartomas are observed in 30-50% of TSC patients, are bilateral in 43% of cases, and multiple in 40%. These lesions are located most frequently in the posterior pole, along the vascular arcades, and adjacent to the optic nerve [69]. (Category 1)

**Other**

Although vascular aneurysms, gastrointestinal polyps, bone cysts, and various endocrinopathies can be associated with TSC [20, 70], there is insufficient evidence to support routine evaluation at the time of diagnosis unless there are clinical symptoms or other concerning history that warrants specific investigation.

## **Ongoing surveillance and management recommendations for individuals previously diagnosed with TSC**

Recommendations are summarized in Table 4. The strength of each following recommendation is Category 3 unless otherwise specified.

### **Genetics**

Genetic testing and counseling should be offered to individuals with TSC and first-degree relatives where this has not been done previously. All affected individuals should be offered clinical assessment and genetic testing in the form of a *TSC1* and *TSC2* panel. When a pathogenic variant has been identified in the index case, genetic testing should be offered to at least the first-degree relatives. (Category 1)

### **Subependymal Giant Cell Astrocytoma (SEGA)**

Individuals with SEGAs presenting with acute deterioration due to obstructive hydrocephalus, or tumoral hemorrhage, should undergo urgent surgical treatment. Minimally invasive surgical techniques are becoming available and may increase surgical safety in selected patients.

Endoscopic resections are applicable to relatively small lesions, but is not widely used [71-73].

Laser interstitial thermal therapy (LITT) has been described in case reports but long-term results are lacking [74, 75]. Early treatment is recommended and experienced surgical teams are a prerequisite for balanced decision making and reduced patient morbidity and mortality [72, 76, 77]. For large tumors, treatment of hydrocephalus with cerebrospinal fluid (CSF) diversion such as a temporary external ventricular drain (EVD) or ventriculo-peritoneal (VP) shunt may still be required [78] and if the clinical condition allows, neoadjuvant treatment with an mTORi may facilitate surgery by tumor shrinkage, improving tumor-brain interface, and reducing tumor vascularity [79]. Treatment of large, symptomatic SEGA with an mTOR inhibitor (mTORi) in lieu of urgent surgery [80] or to relieve obstructive hydrocephalus due to SEGA [81] has been

reported. However, the mTORi treatment is primarily recommended for individuals with asymptomatic growing or large SEGAs, those with mild to moderate symptoms (including asymptomatic ventriculomegaly), and those who are not surgical candidates or prefer medical treatment over surgery [82]. mTORi may also be favored for potential benefit to treat additional manifestations of TSC that frequently coexist in patients with SEGA, such as medically-refractory epilepsy [83] or renal angiomyolipoma [84]. Well-designed studies demonstrate long-term effects of their use [85, 86]. Shared decision-making with the patients and their parents in selecting the best treatment option should take into consideration the surgical risks (including availability of an experienced surgical team), mTORi availability, cost, expected duration of therapy, and potential side effects, other TSC manifestations (renal angiomyolipoma, refractory seizures, etc.), and SEGA-related factors (location, multiple SEGAs, etc.) [87, 88]. (Category 1)

Treatment with mTORi appears to be dose-responsive [89], and after achieving a primary tumor response it may be possible to reduce dosing to minimize adverse events while maintaining tumor stability [90]. mTORi appear to be safe in young children less than 3 years of age [91-93]. (Category 1)

Optimal outcome is associated with early detection and treatment [94], so surveillance by MRI scanning should be performed every 1-3 years in all individuals with TSC until the age of 25 years when SEGA is most prevalent [95]. It should be noted, however, that recent studies reveal that known SEGAs may enlarge during adulthood [95] and in rare instances newly present in adulthood [96]. Thus, lifelong awareness regarding potentially growing SEGA is warranted. Within the recommended 1-3 year interval, scans should be performed more frequently in those asymptomatic SEGA patients whose SEGAs are larger or growing, or who are developmentally or cognitively disabled and cannot reliably report subtle neurologic symptoms. (Category 2A).

## Epilepsy

The majority of TSC infants will experience their first seizure before 1 year of age [97] and seizure control should be considered a medical emergency in infants with TSC because refractory epilepsy is strongly correlated with poor developmental and cognitive outcomes [31, 32, 97, 98] and earlier recognition and treatment of epilepsy in infancy is associated with better long-term neurological outcomes [31, 33]. Routine EEG in asymptomatic infants with TSC should be obtained every 6 weeks up to age 12 months and every 3 months up to age 24 months, as abnormal EEG very commonly precedes onset of clinical seizures [29, 30], allowing for the earliest possible intervention. (Category 1) It should be noted that the first seizure types to occur in TSC can be infantile spasms, focal seizures, or both, and infantile spasms in TSC is frequently not accompanied by hypsarrhythmia [30].

There is strong evidence for the efficacy of vigabatrin for treatment of infantile spasms associated with TSC [31, 33, 99, 100]; therefore, we recommend vigabatrin as first-line treatment. The prescriber should be aware of possible side effects, particularly potential retinal toxicity associated with peripheral vision loss, and how to monitor for these. While the risk of retinal toxicity or abnormalities on brain MRI may correlate with total cumulative dose [101, 102], improved control of infantile spasms also correlates with dose [103, 104]. Therefore, the relative risks of uncontrolled epilepsy and treatment-related adverse effects should be discussed and weighed by healthcare providers and parents/caregivers together. Vigabatrin should be titrated rapidly up to 100-150 mg/kg/day. If resolution of the hypsarrhythmia pattern on EEG (when present) and abatement of infantile spasms does not occur within two weeks, adrenocorticotrophic hormone (ACTH), synthetic ACTH, or prednisolone can be added as second-line therapy [105]. (Category 1)

The recently completed EPISTOP study found that preventative vigabatrin treatment resulted in reduced risk of seizures, infantile spasms, and drug-resistant epilepsy; however, there was no difference in the prevalence of developmental delay or autism at 2 years of age [34, 35]. These results are promising but the consensus committee determined that additional evidence is needed before preventative treatment with vigabatrin can be recommended for all TSC infants universally. The PREVeNT clinical trial (NCT02849457), with results expected in the next year, should address this need.

Routine EEG is recommended in individuals with known or suspected seizure activity, but frequency should be determined by clinical need rather than a specifically defined interval. Prolonged (24 hours or longer) video EEG is appropriate when seizure occurrence is unclear or when unexplained sleep, behavioral changes, or other alteration in cognitive or neurological function is present. (Category 2A)

Seizures in adults with TSC can begin at any age, can worsen, or can abate over the individual's lifespan. Also, seizure semiology can change in adults with TSC (i.e., focal seizures with impaired awareness may become bilateral, tonic-clonic seizures). Any adult with TSC presenting with new onset seizures or changed seizure semiology should be examined for non-TSC-related events, which can occur with or without TSC (e.g., glioma, subarachnoid hemorrhage, stroke, etc.).

Other than for infantile spasms, antiseizure medication or dietary therapy selection in TSC should generally follow that of other epilepsies. The mTOR inhibitor everolimus [83] and a specific formulation of cannabidiol [106] have been specifically evaluated in randomized controlled clinical trials to treat seizures in TSC and found to be effective and well-tolerated (Category 1).

Both are now approved by many regulatory authorities for adjunctive treatment of seizures associated with TSC. However, no comparative effectiveness data exist to recommend specific anti-seizure medications, everolimus, or cannabidiol over one another in a particular patient. Clinicians should be aware that both everolimus [107] and cannabidiol [108] have important drug interactions with other antiseizure medications, including each other [109, 110]. Dietary interventions including a ketogenic diet [111, 112] or low-glycemic index treatment [113] may be an effective non-pharmacological therapy for patients with TSC with intractable epilepsy, including IS refractory to vigabatrin and hormonal therapies.

Epilepsy surgery should be considered for refractory TSC patients, particularly after failing three medications [114-116]. Special consideration should be given to children at younger ages experiencing neurological regression [117, 118], and evaluation for surgery should be performed at specialized epilepsy centers with experience and expertise in TSC . (Category 2A)

Vagus nerve stimulation (VNS) can be used in TSC for medically refractory epilepsy if surgery is unsuccessful or not an option [119]. There are early data suggesting that responsive neurostimulation may be effective in select adults with TSC and intractable seizures [120].

#### **TSC-Associated Neuropsychiatric Disorder (TAND)**

Annual screening for TAND should be performed throughout the lifespan using validated screening tools such as the TAND Checklist (<https://tandconsortium.org/checklists/>) [37, 38] or more frequently if clinically indicated. If concerns are identified on screening, the individual should be referred for evaluation by appropriate professionals to diagnose and treat the relevant TAND manifestation(s) [39]. (Category 1) In addition to annual screening, formal evaluation of TAND is recommended at key developmental time points (Table 4) [37, 39]. (Category 2A) This may require input from a range of professionals including psychiatrists, psychologists,

neuropsychologists, or other healthcare, educational, and neurodevelopmental experts. Sudden and unexpected change in behavior should prompt physical evaluation to look at potential medical causes (e.g., SEGA, seizures, renal disease, medications) [121]. (Category 1)

Early identification and intervention for TAND manifestations is important for optimal outcomes [121]. No TSC-specific interventions currently exist for any TAND manifestations. However, evidence-based treatment strategies exist for individual disorders under the TAND umbrella, e.g., autism spectrum disorder, attention deficit hyperactivity disorder, and anxiety disorders. Interventions by appropriate specialists should be personalized to the TAND profile of each individual and based on evidence-based practice guidelines or parameters for individual manifestations.

Many people with TSC have academic or scholastic difficulties and may benefit from an individualized educational plan [11, 122, 123]. (Category 2A) Scholastic difficulties may have an impact on occupational functioning into and throughout adult life.

Families and caregivers may also need psychological and social support because of the potential impact of TSC on the entire family, so strategies should be in place to provide or refer to appropriate support [40, 41]. (Category 2B). Individuals, families, and caregivers should be educated about TAND so they can identify emerging TAND manifestations across the lifespan [40, 41]. (Category 2B)

### **Kidney**

For asymptomatic, growing angiomyolipoma measuring larger than 3 cm in diameter, treatment with an mTORi is recommended as first-line therapy [84, 124-126]. The EXIST-2 study demonstrated that in 30% of patients on low dose everolimus ( $\leq 5$  mg daily), control of angiomyolipoma was maintained [125] and additional evidence [127] suggests that this benefit generalizes to most TSC patients—not just those who participated in EXIST-2. Protocols for safe

use of everolimus, including pre-immunization, should be followed [128]. The demonstrated continued tolerability is preferable to the renal damage caused by angiomyolipoma progression or by surgical embolization or ablative therapies, as pre-emptive intervention with most recent studies have shown impressively favorable outcomes with preserved GFR and low rates of bleeding, hypertension, or other complications [48]. (Category 1)

At minimum, annual clinical assessment of kidney function, proteinuria, and blood pressure is required in those with normal values; and more frequently in those with findings of renal impairment or hypertension. Transient or variable proteinuria may be a side effect of mTORis but not usually an indication to discontinue treatment [124]. Control of hypertension is also critical, so accurate measurements of blood pressure for patients is crucial, including using age-specific criteria for children [129]. Patients with hypertension should be treated with an inhibitor of the renin-aldosterone-angiotensin system as first line therapy; current experience does not support previous advice that angiotensin-converting enzyme inhibitors should be avoided in those treated with an mTOR inhibitor [130]. (Category 1). Furthermore, angiotensin-converting enzyme inhibitors and angiotensin receptor blockers clearly prolong kidney function in other chronic kidney disease conditions and have been associated with a reduce rate of angiomyolipoma formation when used in the young [131].

The minority of patients who develop advanced renal failure can still benefit from mTORi therapy to prevent bleeding and to possibly slow or stop decline in renal function [124]. For individuals with TSC, all options for renal replacement therapy should be considered, including those with neurological impairment [132]. (Category 2B)

Surveillance imaging for polycystic disease, renal cell carcinoma or other tumors [133, 134], and changes in angiomyolipoma should also be performed. Abdominal MRI, which can be



strategically conducted at the same time as brain surveillance imaging, is the preferred imaging modality. However, if MRI is not available, CT can still provide useful information [135]. The frequency of imaging should be 1-3 years, with yearly scans preferred for tumors that are approaching 3 cm in size and/or appear to be growing. Longer intervals are acceptable in some specific situations in which no tumors are seen or only small tumors (< 1 cm) are seen with minimal growth over time. Selective embolization followed by corticosteroids [136], kidney-sparing resection, or ablative therapy for exophytic lesions are acceptable second-line therapy for asymptomatic angiomyolipoma if medical treatment with an mTORi is contraindicated [126]. For acute hemorrhage, embolization followed by corticosteroids is more appropriate [137]. Nephrectomy is to be avoided because of the high incidence of complications and increased risk of future renal insufficiency, end-stage renal failure, and the poor prognosis that results from chronic kidney disease [41, 126]. (Category 2A)

Fat-poor angiomyolipoma are common in patients with TSC, occurring more commonly in children and those with new angiomyolipoma [48]. Fat-poor angiomyolipoma can be distinguished from carcinoma, as fat-poor angiomyolipoma typically have a slower growth velocity (<5mm/year [in diameter]) than carcinoma. Also, fat-poor angiomyolipoma characteristically grow out of the kidney between other structures rather than compressing surrounding structures, which is more commonly a characteristic of carcinoma [42]. When a lesion cannot be confidently identified as a fat poor angiomyolipoma, a needle biopsy using a sheath technique or an open biopsy may be considered. (Category 2A). Review of biopsy results by a TSC expert pathologist is strongly recommended, with staining using specific antibodies including HMB-45 to distinguish a fat-poor angiomyolipoma from a renal cell carcinoma [138].

**Lung**

Adult women with TSC should be periodically screened for the presence of LAM with a high-resolution computerized tomography (HRCT). Following a negative screening HRCT for LAM, repeat CT imaging should be obtained if pulmonary symptoms develop or approximately every 5-7 years for asymptomatic females through menopause. In patients with evidence of cystic lung disease consistent with LAM on the screening CT, subsequent follow-up CT scan intervals should be determined based on individual circumstances such as the presence or absence of symptoms, the ability to perform reliable PFTs, pre-existing use of mTORis for other TSC indications, treatment response (or the lack thereof), or development of other pulmonary complications. When chest CT is performed, the “as low as reasonably achievable” (ALARA) principle should be employed to minimize the radiation dose to the patient [139]. (Category 2A)

In individuals with evidence of LAM on HRCT, baseline PFTs and 6MWT should be obtained, and full PFTs repeated annually to monitor the rate of disease progression. More frequent spirometry (every 3-6 months) should be considered in: 1) patients with a new LAM diagnosis to establish trajectory of disease progression, 2) patients with progressive symptoms, 3) patients with advanced disease and limited pulmonary reserves, and 4) to monitor treatment response in patients taking mTORis. Post-bronchodilator spirometry is preferred for all patients, to limit variability due to reversible airflow obstruction. In patients who are unable to perform PFTs because of cognitive impairment or other reasons, serial CT imaging may be the best method to assess progression. (Category 2A)

The mTORi sirolimus is recommended as the first line treatment for qualifying LAM patients [140]. (Category 1). In patients unable to perform reliable PFTs, the decision to start sirolimus may be based upon an overall assessment of disease severity and rate of progression as

determined by changes in one or more of the following: extent of cystic lung disease on chest CT, need for supplemental oxygen at rest or with exercise, dyspnea on exertion with minimal activities, recurrent pneumothorax, and elevated serum VEGF-D levels. Consideration may also be given to annual measurement of serum VEGF-D levels as a pharmacodynamic marker of treatment effect, although this use of the test has not been validated. (Category 2B)

A substantial proportion of TSC patients who are discovered to have LAM may already be taking everolimus for other indications [82-84]. In these circumstances, given the extensive molecular similarity and evidence of efficacy in an open-label phase 2 study [141], we recommend continued treatment with everolimus and serial PFT monitoring rather than switching to sirolimus. (Category 2A)

Patients should be counseled that pregnancy in LAM has been associated with accelerated lung function decline and increased risk of pneumothorax [142-145]. Lung transplantation remains a viable management option for TSC patients with end stage LAM [146, 147]. Prior pleurodesis is not a contraindication for lung transplantation [146]. However, the presence of other TSC-related comorbidities, including cognitive impairment, renal dysfunction, or angiomyolipoma burden may influence candidacy as well as outcomes following lung transplantation. (Category 2B)

### **Skin**

Annual skin examinations are recommended for children with TSC. The frequency of dermatologic evaluation in adults depends on the severity of cutaneous manifestations. Close surveillance and intervention are recommended for TSC-related skin lesions that rapidly change in size and/or number, cause functional interference, pain or bleeding, or inhibit social

interactions. Longitudinal follow up with digital photography may be used to monitor skin changes.

Many individuals show improvement in TSC-related skin lesions while taking a systemic mTORi for other manifestations related to TSC [148-150]. (Category 1) In individuals with an inadequate skin response, surgical approaches may be used, taking into consideration the potential for impaired wound healing while on an mTORi. The risk-benefit ratio of a systemic mTORi generally excludes their use for TSC skin lesions alone. Evidence is currently lacking to demonstrate an additive benefit of topical sirolimus (rapamycin) in patients on systemic therapy. Topical sirolimus is safe and effective for treating facial angiofibromas [151, 152] (Category 1), and it may also improve other TSC skin lesions [153-155] (Category 2A). Topical medication is generally applied once or twice daily and compounded by specialty pharmacies at 0.1 to 1% concentration in a variety of vehicles. In Japan, sirolimus gel 0.2% (Rapalimus®, Nobelpharma) was approved by regulatory authorities in 2018. Skin lesions that are smaller and flatter appear to respond better to topical sirolimus than bulky lesions, so early treatment is recommended. Long-term therapy will likely be required to maintain benefit [153, 154]. Adverse effects of topical sirolimus are generally mild, such as application-site skin irritation, dry skin or acne [154]. Systemic absorption of topical sirolimus is typically below the level of detection [151, 152]. Sirolimus has anti-cancer effects, but one study of topical sirolimus reported increased skin tumors in mice treated with a regimen of topical sirolimus and solar simulated light [156]. Pending clinical studies, good sun protection is recommended while using topical sirolimus. Surgical approaches can be effective for treating TSC skin lesions [64, 157, 158]. (Category 2B) Indications for surgical treatment include bleeding, irritation, pain, disfigurement, or impaired function (including vision, breathing, or mobility). Immediate surgical intervention may be

necessary in some patients. For others, the timing of elective surgery should be determined by rate of growth, risk of recurrence, and likelihood of scarring. Younger children with flat angiofibromas may benefit from pulsed-dye laser (PDL) to reduce facial erythema, whereas use of ablative lasers for larger angiofibromas is preferable in later adolescence when the rate of recurrence is lower. PDL has minimal risk of dyspigmentation and scarring, but multiple treatments are usually required, and benefits are usually short-lived when used alone. Ablative approaches flatten the lesions, but general anesthesia is often required, and postoperative recovery can take up to a few weeks [158]. Long-term complications include dyspigmentation, scarring, change of skin texture, and regrowth.

### **Teeth**

A detailed clinical dental inspection or exam should be performed at minimum every 6 months. Patients with special needs and difficulty maintaining oral hygiene may benefit from routine evaluation every 3 months [159]. A panoramic radiograph may be indicated to evaluate dental development or if asymmetry, asymptomatic swelling, or delayed or abnormal tooth eruption occurs. Enamel pits may be managed by preventive measures as first-line treatment (sealants, fluoride). They may be managed by restorations if preventive measures fail, or if symptomatic, carious, or there is an aesthetic concern. Symptomatic or deforming oral fibromas, and bony jaw lesions should be treated with surgical excision or curettage. Referral to a dentist with advanced training should occur for symptomatic or asymptomatic facial swelling to rule out odontogenic origin or intraoral pain associated with teeth or intraoral lesions.

### **Heart**

Until regression of cardiac rhabdomyomas is documented, follow-up echocardiogram should be performed every 1-3 years in asymptomatic patients. In addition, 12-lead ECG is recommended at minimum every 3-5 years to monitor for conduction defects. In patients with clinical

symptoms, additional risk factors, or significant abnormalities on routine echocardiogram or ECG, more frequent interval assessment may be needed and may include ambulatory event monitoring. (Category 1). TSC patients with known history of arrhythmia or ECG abnormalities that indicate an increased risk for arrhythmia should be informed that some prescription and non-prescription medications and natural supplements may further increase the risk of arrhythmia. Such individuals should verify the safety and suitability with their cardiologist or TSC specialist before beginning a new medication or supplement.

### **Eye**

For individuals without ophthalmic manifestations of TSC or for those without visual symptoms at baseline, re-evaluation is recommended annually, or as new clinical concerns arise. The majority of retinal astrocytic hamartomas do not cause vision loss; however, rare cases of aggressive lesions or those causing vision loss due to their location affecting the fovea or optic nerve have been reported [160-163]. In such cases intervention with laser, photodynamic therapy, intravitreal anti-vascular endothelial growth factor, intravitreal steroids, or surgery may be appropriate [162, 163]. More recently mTORis have been used with some success to treat problematic astrocytic hamartomas [160, 161].

For patients receiving vigabatrin, there are specific concerns related to visual field loss which appear to correlate with total cumulative dose [164, 165]. Serial ophthalmologic examination every 3 months is recommended by the United States Food and Drug Administration (FDA). Other modes of surveillance include testing of visual evoked potentials, electroretinography, and optical coherence tomography of the retinal nerve fiber layer. While these tests can be helpful, each has limitations and are somewhat impractical as they can require sedation. The American

Association for Pediatric Ophthalmology and Strabismus supports serial dilated fundus examination for children using vigabatrin [166]. (Category 2B)

### **Other**

Due to surveillance protocols, there is a growing number of reports of functional and nonfunctional pancreatic neuroendocrine tumors (PNETs) in association with TSC. Functional PNETs are often identified early based on presence of symptoms. Preliminary reports note instances where nonfunctional PNETs were missed during early surveillance [167]. To address the potential gap in care, the endocrine group recommends special attention to pancreatic lesions on abdominal imaging studies performed for the surveillance of renal lesions and consideration of abdominal MRI with fine pancreatic cuts [168]. Compared to other tumor susceptibility syndromes, the risk for endocrine tumors in TSC remains low [169, 170]. Biopsy of non-functional suspicious lesions is recommended only when lesions are unusually large, growing, symptomatic, multiple, or exhibit other suspicious characteristics. Functional PNETs require standard of care evaluation and management as in patients without TSC.

In the event unexpected thyroid nodules appear on chest CT scans of TSC patients, those nodules should be evaluated as per standard-of-care [171]. There is no evidence of increased risk of thyroid nodules or thyroid cancer in patients with TSC [172].

### **Other clinical considerations in patients with TSC**

The previously published recommendations for surveillance and management of TSC highlighted several key areas regarding care coordination for individuals with TSC. Those guidelines have been translated into seventeen languages and primarily focused on the role of specialized TSC clinics and advocacy groups in educating patients, families, and healthcare professionals on the manifestations, natural history, and care for people with TSC. An important

addition to this section concerns the use of mTORis in TSC care, which are approved by many regulatory authorities worldwide and commonly used for certain manifestations of TSC.

### ***Practical Guidance for the use of mTOR Inhibitors in TSC Patients***

The use of mTORis, sirolimus and everolimus, has become the cornerstone in management of tumors associated with TSC. The first TSC-specific regulatory approval occurred in 2010, when everolimus was approved by the FDA for the treatment of SEGA. Today, everolimus is now approved in many countries around the world for the treatment of renal angiomyolipoma and/or and partial onset epilepsy associated with TSC in addition to SEGA. Sirolimus was first approved for treatment of LAM associated with TSC in Japan in 2014, followed by approval in the United States a year later.

When initiating therapy with an mTORi, baseline laboratory studies should include a fasting lipid panel, comprehensive metabolic panel, cystatin C quantification, urine analysis, and complete blood count with differential. These panels should be repeated shortly after treatment is started in addition to measurements of mTORi trough level and levels of concomitant medications, particularly if they are strong enzyme inhibitors or inducers (e.g., some antiseizure medications such as carbamazepine and oxcarbazepine are known to reduce mTORi trough levels, whereas some antimicrobials such as clarithromycin and ketoconazole) [173].

Cannabidiol is reported to increase mTORi trough levels [109, 110]. Laboratory studies including mTORi trough levels should be rechecked periodically during treatment, particularly when a strong enzyme inhibitor or inducer is introduced to a patient's treatment regimen. In general, adverse events of systemic therapy with mTORis are mild-to-moderate [87], including patients treated at young ages [91, 93]. However, when such therapies are prescribed, it is not uncommon for adverse events, such as oral ulceration, hyperlipidemia, and hyperglycemia, to



necessitate dose-reduction or temporary suspension of treatment [174, 175]. Individuals undergoing major surgical procedures while on mTORi therapy should be informed about potential impairment of wound healing and potential immunosuppressive properties that can exacerbate infections in rare instances or impact the safety of immunization with live vaccines (which commonly include vaccines used against measles, mumps, rubella, varicella, and Yellow fever) [174, 175]. mTORi therapy also has been associated with menstrual cycle disturbances [176] and ovarian cysts [177]. Standard practice is to temporarily halt mTORi therapy 1-2 weeks before planned surgeries or immunizations or during any prolonged or new-onset significant infections or other adverse effects and then resume treatment after recovery (typically 1-2 weeks after vaccination and 2-4 weeks after surgery). Recurrent or severe adverse events may also require lower dosing of the mTORi when treatment is resumed. Note that benefit has been demonstrated even if resultant blood trough levels of mTORi at the lower end or even below the recommended reference range (5-15 ng/ml) [107, 178].

### ***Quality of Life & Burden of Care***

TSC may present a severe physical, mental, and financial burden to both the individual with TSC and their caregivers. As described previously [41], many individuals with TSC experience TAND. Management of stress associated with TSC and its complexities is crucial to the mental wellbeing of the individual with TSC and caregivers. Healthcare providers should help families and caregivers make connections with secondary care teams, including therapists, social workers, and other counselors to learn about their region's resources such as respite care and other mental health support programs. Caregivers' and siblings' physical and mental health should not be overlooked.

### ***Access to Care***

The International Tuberous Sclerosis Complex Consensus Group is comprised of more than 80 TSC specialists from 14 countries (6 continents) with a broad range of medical expertise and specialization. These updated consensus recommendations are based on extensive practical experience and best available scientific evidence and as such represent the most up-to-date standard of care for individuals with TSC throughout their lifespan, regardless of where they live. Effort should be made to implement and adhere to these standards fully whenever possible. However, we recognize significant barriers at the individual, regional, or country level frequently exist that can hinder availability or access to specific technologies, treatments, or medical specialists on which some consensus recommendations depend. The previous guidelines [8] have been translated into seventeen languages and in Portugal these were accepted as care standards for TSC and formally adopted by the National Ministry of Health. Several additional international groups have published their approach to implementing the previous guidelines from 2012 [179-181]; these articles may serve as manuals for regions of similar size, economies, and/or health systems. Local medical providers and specialists may also need to adapt specific recommendations in such circumstances best they are able while continuing efforts to remedy and overcome these barriers for the optimal treatment of their patients.

Local and international advocacy groups are essential partners in helping individuals and families navigate the TSC care landscape in their region, providing psychosocial support, and educating healthcare providers and individuals and families affected by TSC. In the US, the TSC Alliance serves this role ([www.tscalliance.org](http://www.tscalliance.org)), as do the 38 TSC advocacy groups from different countries of Tuberous Sclerosis Complex International (TSCi, [www.tscinternational.org](http://www.tscinternational.org)). TSCi has written a companion piece whitepaper published contemporaneously, *Beyond the Guidelines: How we can improve health care for people with*

*tuberous sclerosis complex (TSC) around the world*, which focuses the issues of care coordination and access to care through a global lens.

### ***Care Coordination and Transition of Care***

Healthcare transition from pediatric to adult care is challenging in the chronic disease setting, even more so in TSC due to its involvement of many major organ systems requiring focused attention from specialists. Ideally, a multi-disciplinary team would manage clinical transition [41, 182, 183]. Two recent papers discuss the transition from pediatric to adult care in greater detail, specifically in the care of individuals with TSC [184, 185]. The Child Neurology Foundation recently convened a multi-disciplinary team which produced a consensus statement outlining eight common principles that define the child neurologist's role in this important transition [186].

Given the complexities and variety of manifestations across the lifespan, it is essential to have support from a local healthcare professional available (e.g., primary care physician), in addition to coordinated support from TSC specialists and other care providers that often are located at regional or national referral centers [187]. In countries where government policies to assist patients with rare diseases have not yet been implemented, advocacy group-supported research initiatives centered at teaching hospitals have been instrumental in establishing multispecialty medical teams for the care of individuals with TSC. Secure software for telecommunications may provide additional opportunities for coordinated care among patients, local medical providers, and TSC specialists when medically appropriate and permitted by government regulators.

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## Figures and Tables

Figure: Spectrum of TAND levels and features in TSC. Courtesy of Petrus de Vries, Anna

Jansen, and Stephanie Vanclooster on behalf of the International TAND Consortium

(<https://tandconsortium.org/about/>)

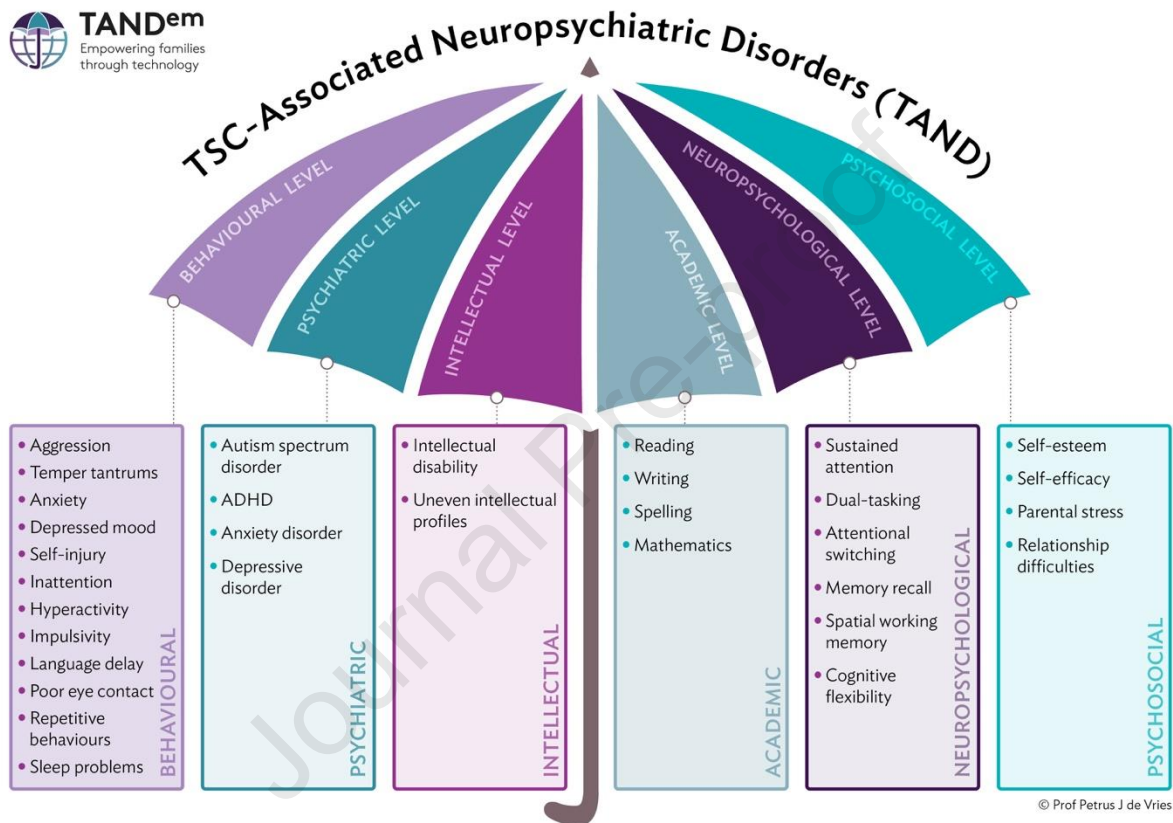


Table 1: Recommendation categories and descriptions

Category	Description	Supporting Evidence
1	Based upon high-level evidence, there is uniform consensus that the intervention is appropriate	At least one convincing class I study OR at least two convincing and consistent class II studies OR at least three convincing and consistent class III studies
2A	Based upon lower-level evidence, there is uniform consensus that the intervention is appropriate	At least one convincing class II study OR at least two convincing and consistent class III studies
2B	Based upon lower-level evidence, there is consensus that the intervention is appropriate	At least one convincing class III study OR at least two convincing and consistent class IV studies
3	Based upon any level of evidence, a consensus on appropriate intervention cannot be reached	Class I-IV studies that are conflicting or inadequate to form a consensus

#### Class Definitions for Supporting Evidence

Class I: evidence provided by a prospective, randomized, controlled clinical trial with masked outcome assessment, in a representative population.

Class II: evidence provided by a prospective matched group cohort study in a representative population with masked outcome assessment.

Class III: evidence provided by all other controlled trials (including well-defined natural history controls or patients serving as own controls) in a representative population, where outcome assessment is independent of patient treatment.

Class IV: evidence provided by uncontrolled studies, case series, case reports, or expert opinion.

Table 2: Diagnostic Criteria

Major Criteria	Minor Criteria
Hypomelanotic macules ( $\geq 3$ ; at least 5mm diameter)	“Confetti” skin lesions
Angiofibroma ( $\geq 3$ ) or fibrous cephalic plaque	Dental enamel pits ( $\geq 3$ )
Ungual fibromas ( $\geq 2$ )	Intraoral fibromas ( $\geq 2$ )
Shagreen patch	Retinal achromic patch
Multiple retinal hamartomas	Multiple renal cysts
Multiple cortical tubers and/or radial migration lines	Nonrenal hamartomas
Subependymal nodule ( $\geq 2$ )	Sclerotic bone lesions
Subependymal giant cell astrocytoma	
Cardiac rhabdomyoma	
Lymphangiomyomatosis (LAM)**	
Angiomyolipomas ( $\geq 2$ )**	

**Definite TSC:** 2 major features or 1 major feature with 2 minor features

**Possible TSC:** either 1 major feature or  $\geq 2$  minor features

\* includes tubers and cerebral white matter radial migration lines

\*\* a combination of the 2 Major clinical features LAM and angiomyolipomas without other features does not meet criteria for a Definite Diagnosis

**Genetic diagnosis:** A pathogenic variant\* in *TSC1* or *TSC2* is diagnostic for TSC

\*Most TSC-causing variants are sequence variants that clearly prevent TSC1 or TSC2 protein production. Some variants compatible with protein production (e.g., some missense changes) are well established as disease-causing. Other variant types should be considered with caution.

TABLE 3: Surveillance and management recommendations for newly diagnosed or suspected tuberous sclerosis complex (TSC)

<b>Organ System or Specialty Area</b>	<b>Recommendations</b>
<b><u>Genetics</u></b>	Obtain three generation family history to assess for additional family members at risk of TSC
	Offer genetic testing for family counseling or when TSC diagnosis is in question but cannot be clinically confirmed
<b><u>Brain</u></b>	Obtain magnetic resonance imaging (MRI) of the brain to assess for the presence of tubers, subependymal nodules (SEN), migrational defects, and subependymal giant cell astrocytoma (SEGA)
	During infancy, educate parents to recognize infantile spasms and focal seizures, even if none have occurred at the time of first diagnosis
	Obtain baseline routine electroencephalogram (EEG) while awake and asleep. If abnormal, especially if features of TAND are also present, follow-up with 8 - 24hr video EEG to assess for seizure activity.
<b><u>TAND</u></b>	Perform comprehensive assessment for TSC-associated neuropsychiatric disorders (TAND) across all levels of potential TAND manifestations (see figure of TAND umbrella for details of levels)
	Refer as appropriate to suitable professionals to initiate evidence-based interventions based on the TAND profile of needs identified above
	Provide parent/caregiver education and training about TAND to ensure families know what to look out for in emerging TAND manifestations (e.g. autism spectrum disorder, language disorders, attention deficit hyperactivity disorder, anxiety disorders)
	Provide psychological and social support to families around diagnosis, coming to terms with the diagnosis of TSC and TAND, and ensure strategies are in place to support caregiver wellbeing
<b><u>Kidney</u></b>	Obtain MRI of the abdomen to assess for the presence of angiomyolipomas and renal cysts
	Screen for hypertension by obtaining an accurate blood pressure
	Evaluate renal function by determination of glomerular filtration rate (GFR)
<b><u>Lung</u></b>	Inquire about tobacco exposure, connective tissue disease manifestations, signs of chyle leak, and pulmonary manifestations of dyspnea, cough, and spontaneous pneumothorax in all adult patients with TSC.
	Perform baseline chest CT in all females, and symptomatic males, starting at the age of 18 years or older.
	Perform baseline PFTs and 6MWT in patients with evidence of cystic lung disease consistent with LAM on the screening chest CT.
<b><u>Skin</u></b>	Perform a detailed clinical dermatologic inspection/exam.



<b><u>Teeth</u></b>	Perform a detailed clinical dental inspection/exam
<b><u>Heart</u></b>	Consider fetal echocardiography to detect individuals with high risk of heart failure after delivery when rhabdomyomas are identified via prenatal ultrasound
	Obtain an echocardiogram in pediatric patients, especially if younger than three years of age
	Obtain an electrocardiogram an all ages to assess for underlying conduction defects
<b><u>Eye</u></b>	Perform a complete ophthalmologic evaluation, including dilated fundoscopy, to assess for retinal findings (astrocytic hamartoma and achromic patch) and visual field deficits

TABLE 4: Surveillance and management recommendations for patients already diagnosed with definite or possible TSC

<b>Organ System or Specialty Area</b>	<b>Recommendations</b>
<b><u>Genetics</u></b>	Offer genetic testing and family counseling if not done previously.
<b><u>Brain</u></b>	Obtain magnetic resonance imaging (MRI) of the brain every 1-3 yr in asymptomatic TSC patients younger than age 25 yr to monitor for new occurrence of subependymal giant cell astrocytoma (SEGA). Patients with large or growing SEGA, or with SEGA causing ventricular enlargement who are asymptomatic, should undergo MRI scans more frequently and the patients and their families should be educated regarding the potential of new symptoms. Patients with asymptomatic SEGA in childhood should continue to be imaged periodically as adults to ensure there is no growth.
	Surgical resection should be performed for acutely symptomatic SEGA. Cerebral spinal fluid diversion (shunt) may also be necessary. Either surgical resection or medical treatment with mechanistic target of rapamycin complex (mTOR) inhibitors may be used for growing but otherwise asymptomatic SEGA. For large tumors, if clinical condition enables, neoadjuvant treatment with mTORi may facilitate surgery. Minimally invasive surgical techniques may increase surgical safety in selected patients. In determining the best treatment option, discussion of the complication risks, adverse effects, cost, length of treatment, and potential impact on TSC-associated comorbidities should be included in the decision-making process.
	Obtain routine EEG in asymptomatic infants with TSC every 6 weeks up to age 12 months and every 3 months up to age 24 months, as abnormal EEG frequently precedes onset of clinical seizures.
	Obtain routine electroencephalograph (EEG) in individuals with known or suspected seizure activity. The frequency of routine EEG should be determined by clinical need rather than a specific defined interval. Prolonged video EEG, 24 hr or longer, is appropriate when seizure occurrence is unclear or when unexplained sleep, behavioral changes, or other alteration in cognitive or neurological function is present
	Vigabatrin is the recommended first-line therapy for infantile spasms. Adrenocorticotrophic hormone (ACTH), synthetic ACTH or prednisolone can be used if treatment with full-dose vigabatrin for 2 weeks has not correlated with clinical and EEG improvement.
	Other than infantile spasms, antiseizure medications for other seizure types in TSC should generally follow that of other epilepsies. Everolimus and a specific cannabidiol formulation are approved by regulatory authorities for treatment of seizures associated with TSC. No comparative effectiveness data exist to recommend antiseizure medications, everolimus, cannabidiol, or dietary therapies over one another in specific subsets of patients.

	Epilepsy surgery should be considered for refractory TSC patients, particularly after failing three medications. Special consideration should be given to children at younger ages experiencing neurological regression, and evaluation for surgery should be performed at centers with experience and expertise in TSC.
<b><u>TAND</u></b>	Perform annual screening for TAND, using validated screening tools such as the TAND Checklist ( <a href="https://tandconsortium.org/checklists/">https://tandconsortium.org/checklists/</a> ). Screening may be done more frequently depending on clinical needs. When any concerns are identified on screening, proceed to further evaluations by appropriate professionals to diagnose and treat the relevant TAND manifestation(s).
	Perform comprehensive formal evaluation for TAND across all levels of TAND (see figure of TAND umbrella) at key developmental time points: infancy (0-3 yr), preschool (3-6 yr), pre-middle school (6-9 yr), adolescence (12-16 yr), early adulthood (18-25 yr), and as needed thereafter.
	Refer to appropriate professionals for the management/intervention of relevant TAND manifestations. Interventions should be personalized to the TAND profile of each individual and be based on evidence-based practice guidelines/practice parameters for individual manifestations (e.g. autism spectrum disorder, attention deficit hyperactivity disorder, anxiety disorder)
	Aim for early identification of TAND manifestations and early intervention
	Many people with TSC have academic/scholastic difficulties. Therefore, always consider the need for an individual educational program (IEP/IEDP)
	Sudden and unexpected change in behavior should prompt physical evaluation to look at potential medical causes (e.g., SEGA, seizures, renal disease, medications).
	Provide psychological and social support to families and caregivers and ensure strategies are in place to support caregiver wellbeing. Continue to provide parent/caregiver education and training about TAND to ensure families know what to look out for in emerging TAND manifestations across the lifespan.
<b><u>Kidney</u></b>	Obtain MRI of the abdomen to assess for the progression of angiomyolipoma and renal cystic disease every 1 - 3 years throughout the lifetime of the patient
	Assess renal function including determination of glomerular filtration rate, proteinuria, and blood pressure at least annually
	Embolization followed by corticosteroids is first-line therapy for angiomyolipoma presenting with acute hemorrhage. Nephrectomy is to be avoided. For asymptomatic, growing angiomyolipoma measuring larger than 3 cm in diameter, treatment with an mTOR inhibitor is the recommended first line therapy. Selective embolization or kidney-sparing resection are acceptable second-line therapy for asymptomatic angiomyolipoma.

<b><u>Lung</u></b>	Inquire about smoking, occupational exposures, connective tissue disease symptoms, chyle leak, and pulmonary manifestations such as dyspnea, cough, and spontaneous pneumothorax in all adult patients at each clinic visit.
	For adult females with a negative screening chest CT who remain asymptomatic, repeat to screen for the presence of LAM every 5-7 years through menopause.
	For patients with evidence of cystic lung disease consistent with LAM on screening chest CT, follow-up scan intervals should be determined on a case-by-case basis depending upon the individual circumstances such as the presence or absence of symptoms, the ability to perform reliable PFTs, pre-existing use of mTORis for other TSC indications, treatment response (or the lack thereof), or development of other pulmonary complications.
	Perform routine serial pulmonary function test monitoring at least annually in patients with evidence of LAM on chest CT, and more frequently in patients who are progressing rapidly or who are being monitored for response to therapy.
	Use mTOR inhibitors for treatment of LAM in patients with abnormal lung function (forced expiratory volume in one-second (FEV1) < 70% predicted), physiological evidence of substantial disease burden (abnormal diffusing capacity of the lungs for carbon monoxide [DLCO] (<80% or less than lower limit of normal [when available]), air trapping (residual volume (RV) > 120%), resting or exercise-induced oxygen desaturation), rapid decline (rate of decline in FEV1 > 90ml/year), and problematic chylous effusions.
	Counsel patients regarding the risk of pregnancy and exogenous estrogen use. Avoid routine use of hormonal therapy or doxycycline for the treatment of LAM. Advise patients against tobacco smoke exposure including the use of electronic cigarettes and vaping.
	Trial inhaled bronchodilators in patients with symptoms of wheezing, dyspnea, chest tightness, or obstructive defect on spirometry, with continued use in patients who derive symptomatic benefit.
	Consider measurement of annual vascular endothelial growth factor-D (VEGF-D) levels in patients who are unable to perform reliable pulmonary function tests to monitor adequacy of pharmacodynamic suppression of the mTOR pathway.
	Encourage age-appropriate vaccinations, such as annual influenza vaccination, inactivated recombinant shingles vaccination, and both 13-valent and 23-valent pneumococcal vaccinations. Patients on mTOR inhibitors should receive the recombinant varicella vaccine regardless of age and avoid all live vaccines
	Educate patients and families about the signs and symptoms of a pneumothorax and advise them to seek medical attention if they experience any of these symptoms. Offer pleurodesis following the first episode of

	pneumothorax rather than waiting for a recurrent event. Counsel patients that pleurodesis does not preclude future lung transplantation.
<b><u>Skin</u></b>	Perform annual skin examinations for children with TSC. Adult dermatologic evaluation frequency depends on the cutaneous manifestation. Close surveillance and intervention are generally recommended for TSC-related skin lesions that rapidly change in size and/or number, cause functional interference, pain, or bleeding, or inhibit social interactions.
	Provide ongoing education on sun protection.
	For flat or minimally elevated lesions, topical mTOR inhibitor treatment is recommended. Watch for improvement in skin lesions over several months; if lesions do not improve, or if earlier intervention is indicated, then consider use of surgical approaches. For protuberant lesions, consider surgical approaches (e.g. excision, lasers).
<b><u>Teeth</u></b>	Perform a detailed clinical dental inspection/exam at minimum every 6 months. Take a panoramic radiograph to evaluate dental development or if asymmetry, asymptomatic swelling, or delayed/ abnormal tooth eruption occurs. Enamel pits may be managed by preventive measures as first-line treatment (sealants, fluoride). They may be managed by restorations if preventive measures fail, or if symptomatic, carious, or there is an aesthetic concern. Symptomatic or deforming oral fibromas and bony jaw lesions should be treated with surgical excision or curettage when present.
<b><u>Heart</u></b>	Obtain an echocardiogram every 1 - 3 years in asymptomatic pediatric patients until regression of cardiac rhabdomyomas is documented. More frequent or advanced diagnostic assessment may be required for symptomatic patients
	Obtain electrocardiogram every 3 – 5 years in asymptomatic patients of all ages to monitor for conduction defects. More frequent or advanced diagnostic assessment such as ambulatory and event monitoring may be required for symptomatic patients.
<b><u>Eye</u></b>	Perform annual ophthalmic evaluation for those with or without visual symptoms at baseline. Rare cases of aggressive lesions or those causing vision loss due to their location affecting the fovea or optic nerve may require intervention. mTOR inhibitors have been used with some success to treat problematic retinal astrocytic hamartomas.
	For patients receiving vigabatrin, there are specific concerns related to visual field loss which appears to correlate with total cumulative dose. Physicians responsible for monitoring children on vigabatrin can offer serial fundoscopic examinations to detect retinal changes.
<b><u>Other</u></b>	Identification of unexpected functional and nonfunctional pancreatic neuroendocrine tumors (PNETS) have been found during abdominal MRI surveillance in individuals with TSC. Further monitoring and evaluation should be referred to endocrinology.

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