

**I. Study Title:** Does Sex Mediate the Association Between Treatment Exposures and Functional Outcomes?

**II. Working Group and Investigators:**

Primary: Psychology

Secondary: Biostatistics, Chronic Disease

|                      |  |
|----------------------|--|
| Rachel Peterson      | <a href="mailto:Rachel.Peterson@sickkids.ca">Rachel.Peterson@sickkids.ca</a> |
| Kim Edelstein        | <a href="mailto:Kim.Edelstein@uhn.ca">Kim.Edelstein@uhn.ca</a>               |
| Kevin R. Krull       | <a href="mailto:Kevin.Krull@stjude.org">Kevin.Krull@stjude.org</a>           |
| Tyler Alexander      | <a href="mailto:Tyler.Alexander@stjude.org">Tyler.Alexander@stjude.org</a>   |
| Kevin C. Oeffinger   | <a href="mailto:Kevin.Oeffinger@duke.edu">Kevin.Oeffinger@duke.edu</a>       |
| Yutaka Yasui         | <a href="mailto:Yutaka.Yasui@stjude.org">Yutaka.Yasui@stjude.org</a>         |
| Wendy M. Leisenring  | <a href="mailto:WLeisenr@fhcrc.org">WLeisenr@fhcrc.org</a>                   |
| Gregory T. Armstrong | <a href="mailto:Greg.Armstrong@stjude.org">Greg.Armstrong@stjude.org</a>     |
| Leslie L. Robison    | <a href="mailto:Les.Robison@stjude.org">Les.Robison@stjude.org</a>           |
| Rebecca M. Howell    | <a href="mailto:RHowell@mdanderson.org">RHowell@mdanderson.org</a>           |
| Sogol Mostoufi-Moab  | <a href="mailto:Moab@email.chop.edu">Moab@email.chop.edu</a>                 |
| Jordan Marchak       | <a href="mailto:JGillel@emory.edu">JGillel@emory.edu</a>                     |

**III. Background and Rationale:**

An extensive literature on brain and behavior has documented sex differences in cognition, affect, and structural and functional neuroimaging<sup>1</sup>. Sexual dimorphism in humans is thought to be influenced by both genetic and endocrine factors, similar to other mammalian species. Exposure to sex hormones during critical periods in prenatal or pubertal development impacts the development and functions of neural circuitry<sup>2</sup>. These organizational effects of sex hormones include the transient rise in testosterone during prenatal or early postnatal development that masculinizes and defeminizes neural circuits in males, while the absence of testosterone in females results in development of a female neural phenotype<sup>3,4</sup>. Upon gonadal maturation during puberty, testicular and ovarian hormones act on previously sexually differentiated circuits to facilitate expression of sex-typical behaviors<sup>5</sup>.

Sex hormones may also influence changes in brain development. Human neuroimaging studies reveal a linear increase in white matter volume during adolescence, with greater rate of change and larger overall volume of the cerebrum, hippocampus, and amygdala in males compared to females<sup>6-11</sup>. The increase in white matter volume in males has been linked to testosterone and androgen receptor activity<sup>12</sup>. Structural brain MRI studies have also found a negative correlation between estradiol level and age-corrected gray matter volume in adolescent females<sup>13-14</sup>.

Many neurodevelopmental, neuropsychiatric, and psychological disorders also show an uneven sex distribution in regard to their prevalence, age at onset, and treatment response<sup>15</sup>. Within the field of pediatric oncology, researchers have identified sex differences across cancer diagnoses and outcomes<sup>16-17</sup>. With respect to cancer type, males are at greater risk for developing Hodgkin's and Non-Hodgkin's lymphomas, acute lymphoblastic leukemia (ALL),

and ependymomas, whereas females have a higher incidence of thyroid carcinomas and malignant melanomas<sup>18-21</sup>. With respect to outcomes, females are at increased risk for developing chronic health conditions and impaired health status<sup>16; 22-23</sup> as well as neurocognitive deficits and emotional distress<sup>34-35</sup>. Females are thought to be particularly vulnerable to CNS-directed therapy relative to males. Male neurodevelopment may serve as a protective factor, as males shows greater white matter volume increases in childhood secondary to hormone activity relative to females<sup>36</sup>. As such, females may be more sensitive to CNS-directed therapy, which directly impacts their relatively lower white matter volume. Similarly, younger age at diagnosis is associated with poorer outcomes<sup>37</sup>, raising the interesting possibility that cancer and/or cancer treatments during critical developmental periods alter hormone activity and brain development, resulting in neurocognitive and psychological sequelae.

While sex differences in pediatric oncology have been well-documented, our understanding of the association between sex and neurocognitive and psychosocial outcomes in cancer survivors is less known. To our knowledge, no large-scale study has directly examined the role of sex on neurocognitive, psychological, and quality of life outcomes in long-term survivors of childhood cancers.

#### **IV. Specific Aims/Objectives/Hypotheses:**

With better understanding of the sex differences in long-term survivors of pediatric cancer, clinicians can tailor therapies and follow-up interventions to ensure that quality of life is maximized. Therefore, the purpose of this study is three-fold:

**Aim 1a:** To examine sex differences in neurocognitive, emotional, and quality of life outcomes and impairment rates between survivors and same-sex siblings, as measured by the NCQ, BSI-18, and SF-36.

*Hypothesis:* Differences between female survivors and female siblings will be larger than differences between male survivors and male siblings for neurocognitive problems, emotional distress, and quality of life.

**Aim 1b.** To evaluate sex differences in neurocognitive, emotional, and quality of life outcomes and impairment rates among survivors.

*Hypothesis:* Because white and gray matter development vary by sex<sup>38</sup> and female sex is a risk factor for cancer-related cognitive impairment in pediatric cancer survivors<sup>39</sup>, there may be different critical developmental periods during which the male/female brain is more susceptible to injury due to cancer and cancer treatment. It is hypothesized that younger females at time of diagnosis will report worse or greater impairment in neurocognitive function, emotional distress and quality of life compared to same-aged males at time of diagnosis.

**Aim 2:** To identify demographic and treatment factors associated with neurocognitive, emotional and quality of life outcomes and impairment rates in survivors stratified by sex.

*Hypothesis 1:* Younger age at diagnosis, longer time since diagnosis, CNS radiation exposure, chemotherapy exposures, history of transplant or amputation, relapse or second malignancies, and/or greater number of moderate to severe chronic health conditions (CHCs) affecting cardiovascular, pulmonary, or endocrine functions (i.e., grades 2-4 CHCs as defined by the National Cancer Institute's Common Terminology Criteria for

Adverse Events<sup>40-42</sup>) will predict worse neurocognitive, emotional, and quality of life outcomes in females compared to males.

*Hypothesis 2:* History of psychoactive medication usage<sup>43</sup> (i.e., anxiolytics, analgesics, or antidepressants), lower educational attainment, unpartnered relationship status, lack of employment, will be associated with greater neurocognitive and emotional difficulties in females as compared to males.

## V. Analysis Framework:

### Participants:

Survivors and siblings from the original and expansion cohorts who completed the NCQ, SF-36, or BSI-18 will be included in this analysis. Demographic information of survivors and siblings is provided in Table 1. Mean NCQ, BSI-18, and SF-36 scores for male and female survivors and siblings are provided in Table 2.

### Measures:

Dependent variables

- CCSS-NCQ
  - Raw scores (NB for the analyst - not the T-scores in the frozen database, as these were generated for survivors by comparing to the general sibling group and are not sex stratified)
    - Composite task efficiency, emotion regulation, organization, memory
    - FU2 J.1-25 (original cohort); FU5 Q.1-33 (expansion cohort; NB please use the 25 items that are the same as those in the original NCQ and not the additional items in the revised NCQ), survivor and sibling cohorts
  - Impairment (yes/no)
    - Impaired = symptom level reported in top 10% of the sex stratified sibling sample on the following domains: Composite, task efficiency, emotion regulation, organization, and memory.
- SF-36
  - Raw score and T-scores
    - Physical functioning, role limitations due to health, role limitations due to emotional problems, energy/fatigue, emotional well-being, social functioning, pain, general health
    - FU2 (original cohort); FU5 (expansion cohort); survivors and siblings
  - Impairment
    - Impaired = symptom T score  $\leq 40$  compared to normative data on the 8 domains (Physical functioning, role limitations due to health, role limitations due to emotional problems, energy/fatigue, emotional well-being, social functioning, pain, general health)
- BSI-18
  - T-scores using sex-specific norms
    - Composite (GSI), somatization, depression, anxiety
    - FU2 survivors and siblings (original cohort)

- FU5 survivors and siblings (expansion cohort)
- Impairment (yes/no)
  - Impaired = T-scores  $\geq 63$  on the GSI or at least 2 of the 3 subscales (somatization, depression, anxiety)
- Educational attainment:
  - Original cohort FU2 survivors and siblings, item 12
  - Expansion cohort FU5 survivors and siblings, A4
- Marital/Relationship status:
  - Original cohort FU2, survivors and siblings, item 2
  - Expansion cohort, FU5 survivors and siblings M2
- Employment status:
  - Original cohort, survivors and siblings FU2, item 4
  - Expansion cohort, survivors and siblings FU5, A5
- Medications—history of analgesics, antidepressants, or anxiolytic medications:
  - Original cohort Baseline survivors B.9, B.15
  - Original cohort Baseline siblings B.9, B.15
  - Original cohort FU2 survivors Q8, Q9
  - Original cohort FU2 siblings Q8, Q9
  - Expansion cohort baseline B.9-B.10
  - Expansion sibling baseline B.9-B.10
  - Expansion cohort FU5 survivors C2.9, C2.11
  - Expansion cohort FU5 siblings C2.9, C2.11

#### Covariates:

- Health behaviors
  - Tobacco use (yes/no):
    - FU2 survivors
    - FU2 siblings
    - FU5 survivors N9
    - FU5 siblings N9
  - Physical activity: yes/no (i.e., meeting CDC guideline of at least 75 mins of vigorous or >150 mins moderate per week; if <75 vigorous and <150 moderate – count vigorous minutes toward moderate total):
    - FU2 D.2-D.7; FU5 N.16-N.21
- Disease variables
  - Age at diagnosis
  - Time since diagnosis
  - Medical conditions
    - Chronic health conditions (number of moderate to severe CTCAE health conditions)

- Relevant CHCs include cardiovascular, pulmonary, endocrine, neurological exceptive cognitive, hematological, secondary malignancy.
- Treatment variables
  - Radiation (dose) for cranial, chest, abdomen, pelvis
  - Chemotherapy: antimetabolites (dose), anthracyclines (dose), alkylating agents (dose), corticosteroids (yes/no)
  - Bone marrow transplant (yes/no)
  - Amputation (yes/no)
  - Relapse/SMN (yes/no)
- Sociodemographic variables
  - Age:
    - A.1 Date of birth original, expanded, and sibling baseline and date of survey front cover
  - Race:
    - Baseline original A.4
    - Baseline sibling A.4
    - Expanded cohort baseline A.5
    - Expanded sibling baseline A.5

#### **Analyses:**

- Descriptive statistics will be used to characterize the study population for all variables of interest, and comparisons between survivors and siblings will be made using t-tests and chi-square tests as appropriate. Table 1 will show frequencies and percentages for categorical variables and means and SD for continuous variables.
- Table 2 will show mean scores and impairment rates for NCQ, BSI, and SF-36 measures for males and females within each group.

**Aim 1:** To examine differences in neurocognitive, emotional, and quality of life outcomes between survivors and same-sex siblings (Aim 1a) and sex differences among survivors (Aim 1b), separate linear and logistic regressions will be performed for each outcome (Tables 3-4), adjusting for age:

- Predictors: Sex (male, female); Group (survivors, siblings)
- Outcomes:
  - NCQ T-scores and impairment rates at FU2 (original cohort) and FU 5 (expansion cohort) for composite, task efficiency, emotion regulation, organization, memory
  - BSI-18 T-scores and impairment rates at FU 2 (original cohort) and FU 5 (expansion cohort) for Anxiety, Depression, Somatization subscales. Impairment will be defined as GSI or 2+ subscales T-scores  $\geq 63$ .
  - SF-36 T-scores and impairment rates at FU 2 (original cohort) and FU 5 (expansion cohort) for physical functioning, role limitations due to health, role limitations due to emotional problems, energy/fatigue, emotional well-being, social functioning, pain, general health

**Aim 2:** To identify demographic and treatment factors associated with neurocognitive, emotional and quality of life outcomes in survivors by sex, we will perform linear and logistic regressions stratified by sex (Tables 5-8), adjusting for age.

*Of note, age at diagnosis, CNS radiation, disease, chemotherapies, and CHC's are all predictors of neurocognitive outcomes. However, in a developmental model, educational attainment, social relationships, employment and psychoactive medication use is a consequence of neurocognitive and emotional deficits. Also, some of these are pathway processes, so they will need to be examined separately. Therefore, two analyses will be conducted, one with neurocognitive, emotional and quality of life variables as outcomes, and the other with these variables as predictors.*

Model 1: age at diagnosis and cancer diagnosis predicting neurocognitive, emotional and quality of life outcomes, adjusting for age.

Model 2: age at diagnosis and treatment exposures (i.e., radiation, chemotherapy) predicting neurocognitive, emotional and quality of life outcomes, adjusting for age

Model 3: Current age and CHCs predicting neurocognitive, emotional and quality of life outcomes, adjusting for age

Model 4: Neurocognitive and emotional outcomes predicting educational attainment, employment, relationship status outcomes

- Predictors:
  - Younger age at diagnosis (age will be analyzed as a categorical variable (<1 year, 1-4 years, 5-9 years, 10-14 years, 15-20 years) to see if there is a critical developmental period in relation to sex differences)
  - Radiation (cranial, non-cranial, none)
  - Chemotherapy exposures (y/n: anthracyclines; alkylating agents; antimetabolites; corticosteroids)
  - Number of grade 3-4 chronic health conditions
  - Brain tumor diagnosis
  - History of transplant or amputation.

To evaluate whether sex moderates the relationship between significant variables identified from Aim 2 and NCQ, BSI, and SF-36 responses. A moderation analysis will be performed similar to those conducted previously in CCSS (e.g., Armstrong NEJM paper, Turcotte JAMA paper) (Table 9).

- Predictors: The significant variables from Aim 2
- Moderator: Sex
- Outcomes: NCQ, BSI, SF-36

**Figures/Tables:**

Table 1. Demographic and clinical characteristics of survivors of childhood cancer and sibling groups.

| Characteristics   | Survivors      |                  |   | Siblings         |                  |   |
|---|----------------|------------------|---|------------------|------------------|---|
|   | Males<br>N (%) | Females<br>N (%) | p | Males n<br>N (%) | Females<br>N (%) | p |
| <b>Race</b>   |                |                  |   |                  |                  |   |
| White   |                |                  |   |                  |                  |   |
| Black   |                |                  |   |                  |                  |   |
| Other   |                |                  |   |                  |                  |   |
| <b>Ethnicity</b>  |                |                  |   |                  |                  |   |
| Hispanic  |                |                  |   |                  |                  |   |
| Non-Hispanic  |                |                  |   |                  |                  |   |
| <b>Age at baseline survey</b>                           |                |                  |   |                  |                  |   |
| 18-29 yrs   |                |                  |   |                  |                  |   |
| 30-39 yrs   |                |                  |   |                  |                  |   |
| 40-54 yrs   |                |                  |   |                  |                  |   |
| <b>Education</b>  |                |                  |   |                  |                  |   |
| 1-8 years   |                |                  |   |                  |                  |   |
| 9-12 years  |                |                  |   |                  |                  |   |
| Completed high school/GED                               |                |                  |   |                  |                  |   |
| Training after HS other than college                    |                |                  |   |                  |                  |   |
| Some college  |                |                  |   |                  |                  |   |
| College graduate  |                |                  |   |                  |                  |   |
| Post-graduate level                                     |                |                  |   |                  |                  |   |
| <b>Current tobacco use</b>                              |                |                  |   |                  |                  |   |
| Yes   |                |                  |   |                  |                  |   |
| <b>Current physical activity meeting CDC guidelines</b> |                |                  |   |                  |                  |   |
| Yes   |                |                  |   |                  |                  |   |
| <b>Physically Active (% meeting CDC guidelines)</b>     |                |                  |   |                  |                  |   |
| Yes   |                |                  |   |                  |                  |   |
| <b>Employment status</b>                                |                |                  |   |                  |                  |   |
| Working full-time                                       |                |                  |   |                  |                  |   |
| Working part-time                                       |                |                  |   |                  |                  |   |
| Not seeking paid work                                   |                |                  |   |                  |                  |   |
| Unemployed  |                |                  |   |                  |                  |   |
| Retired   |                |                  |   |                  |                  |   |
| Student   |                |                  |   |                  |                  |   |
| <b>Relationship status</b>                              |                |                  |   |                  |                  |   |
| Single  |                |                  |   |                  |                  |   |
| Married/living as married                               |                |                  |   |                  |                  |   |

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| Widowed  |  |  |  |  |  |  |
| Divorced   |  |  |  |  |  |  |
| Separated  |  |  |  |  |  |  |
| <b>Age at diagnosis</b>  |  |  |  |  |  |  |
| < 1 yr   |  |  |  |  |  |  |
| 1-4 yrs  |  |  |  |  |  |  |
| 5-9 yrs  |  |  |  |  |  |  |
| 10-14 yrs  |  |  |  |  |  |  |
| 15-20 yrs  |  |  |  |  |  |  |
| <b>Cancer diagnosis</b>  |  |  |  |  |  |  |
| Leukemia   |  |  |  |  |  |  |
| CNS malignancy   |  |  |  |  |  |  |
| Hodgkin lymphoma   |  |  |  |  |  |  |
| Non-Hodgkin lymphoma   |  |  |  |  |  |  |
| Kidney tumors  |  |  |  |  |  |  |
| Neuroblastomas   |  |  |  |  |  |  |
| Soft tissue sarcoma  |  |  |  |  |  |  |
| Bone tumors  |  |  |  |  |  |  |
| <b>Chemotherapy</b>  |  |  |  |  |  |  |
| Antimetabolites  |  |  |  |  |  |  |
| Anthracyclines   |  |  |  |  |  |  |
| Alkylating agents  |  |  |  |  |  |  |
| Corticosteroids  |  |  |  |  |  |  |
| <b>Radiation treatment</b>   |  |  |  |  |  |  |
| Cranial  |  |  |  |  |  |  |
| Non-cranial  |  |  |  |  |  |  |
| None   |  |  |  |  |  |  |
| <b>Chronic health conditions</b>                                     |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| <b>Psychoactive medication use</b>                                   |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| <b>Clinically significant psychiatric symptomatology<sup>1</sup></b> |  |  |  |  |  |  |
| Yes  |  |  |  |  |  |  |

<sup>1</sup>(GSI or at least two BSI subscales > 63)

Table 2. Reported neurocognitive problems, emotional distress, and quality of life and impairment rates in survivor and sibling groups, by sex.

|                    | Mean T-Score <sup>1</sup> (SD) |           |          |           | Impairment rate (%) |           |           |
|--------------------|--------------------------------|-----------|----------|-----------|---------------------|-----------|-----------|
|                    | Males                          |           | Females  |           | Males               |           | Fem       |
|                    | Siblings                       | Survivors | Siblings | Survivors | Siblings            | Survivors | Survivors |
| <b>NCQ</b>         |                                |           |          |           |                     |           |           |
| Composite          |                                |           |          |           |                     |           |           |
| Task Efficiency    |                                |           |          |           |                     |           |           |
| Emotion Regulation |                                |           |          |           |                     |           |           |





|                      |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|
| limitations          |  |  |  |  |  |  |  |  |  |  |  |  |
| Energy/Fatigue       |  |  |  |  |  |  |  |  |  |  |  |  |
| Emotional well-being |  |  |  |  |  |  |  |  |  |  |  |  |
| Social functioning   |  |  |  |  |  |  |  |  |  |  |  |  |
| Pain                 |  |  |  |  |  |  |  |  |  |  |  |  |
| General Health       |  |  |  |  |  |  |  |  |  |  |  |  |

<sup>a</sup> These are p values from comparing survivors with same-sex siblings.

<sup>b</sup> These are p values from comparing the survivor-sibling differences between the sexes.

Table 4. Logistic regressions exploring associations between sex and impairment rates in self-reported neurocognitive, emotional, and QOL functioning in survivors, relative to siblings, adjusted for age.

|                            | <b>Males</b>       |          | <b>Females</b>     |          |                     |
|----------------------------|--------------------|----------|--------------------|----------|---------------------|
|                            | <i>OR (95% CI)</i> | <i>p</i> | <i>OR (95% CI)</i> | <i>p</i> | <i>Difference M</i> |
| <b>NCQ</b>                 |                    |          |                    |          |                     |
| Task Efficiency            |                    |          |                    |          |                     |
| Emotional Regulation       |                    |          |                    |          |                     |
| Organization               |                    |          |                    |          |                     |
| Memory                     |                    |          |                    |          |                     |
| <b>BSI-18</b>              |                    |          |                    |          |                     |
| GSI                        |                    |          |                    |          |                     |
| Depression                 |                    |          |                    |          |                     |
| Anxiety                    |                    |          |                    |          |                     |
| Somatization               |                    |          |                    |          |                     |
| <b>SF-36</b>               |                    |          |                    |          |                     |
| Physical functioning       |                    |          |                    |          |                     |
| Health role limitations    |                    |          |                    |          |                     |
| Emotional role limitations |                    |          |                    |          |                     |
| Energy/Fatigue             |                    |          |                    |          |                     |
| Emotional well-being       |                    |          |                    |          |                     |
| Social functioning         |                    |          |                    |          |                     |
| Pain                       |                    |          |                    |          |                     |
| General Health             |                    |          |                    |          |                     |

<sup>a</sup> These are p values from comparing the differences between survivors by sex.























Table 8c. Logistic regression exploring the relationship between education, marital status, and employment status and neurocognitive impairment in survivors relative to siblings stratified by sex.

|                      | Males              |          |                           |          |                    |          | Females            |          |                           |          |                    |          |
|----------------------|--------------------|----------|---------------------------|----------|--------------------|----------|--------------------|----------|---------------------------|----------|--------------------|----------|
|                      | College graduate   |          | Married/living as married |          | Employed full-time |          | College graduate   |          | Married/living as married |          | Employed full-time |          |
|                      | <i>OR (95% CI)</i> | <i>p</i> | <i>OR (95% CI)</i>        | <i>p</i> | <i>OR (95% CI)</i> | <i>p</i> | <i>OR (95% CI)</i> | <i>p</i> | <i>OR (95% CI)</i>        | <i>p</i> | <i>OR (95% CI)</i> | <i>p</i> |
| <b>NCQ</b>           |                    |          |                           |          |                    |          |                    |          |                           |          |                    |          |
| Composite            |                    |          |                           |          |                    |          |                    |          |                           |          |                    |          |
| Task efficiency      |                    |          |                           |          |                    |          |                    |          |                           |          |                    |          |
| Emotional Regulation |                    |          |                           |          |                    |          |                    |          |                           |          |                    |          |
| Organization         |                    |          |                           |          |                    |          |                    |          |                           |          |                    |          |

Table 9. Analysis of sex as a moderator between significant demographic, disease, and treatment effects and self-reported neurocognitive, emotional, and quality of life functioning.

|                    | Path a<br>sig. variables →<br>functioning<br>without sex effect |          | Path b:<br>Sex → neurocognitive,<br>emotional, and QOL<br>functioning |          | Mediation path a*b |               |          |
|--------------------|---|----------|---|----------|--------------------|---------------|----------|
|                    | $\beta$   | <i>p</i> | $\beta$   | <i>p</i> | <i>value</i>       | <i>95% CI</i> | <i>p</i> |
| <b>NCQ</b>         |   |          |   |          |                    |               |          |
| Composite          |   |          |   |          |                    |               |          |
| Task Efficiency    |   |          |   |          |                    |               |          |
| Emotion Regulation |   |          |   |          |                    |               |          |
| Organization       |   |          |   |          |                    |               |          |
| Memory             |   |          |   |          |                    |               |          |
| <b>BSI-18</b>      |   |          |   |          |                    |               |          |
| GSI                |   |          |   |          |                    |               |          |
| Depression         |   |          |   |          |                    |               |          |

|                            |  |  |  |  |  |  |  |
|----------------------------|--|--|--|--|--|--|--|
| Anxiety                    |  |  |  |  |  |  |  |
| Somatization               |  |  |  |  |  |  |  |
| <b>SF-36</b>               |  |  |  |  |  |  |  |
| Physical functioning       |  |  |  |  |  |  |  |
| Health role limitations    |  |  |  |  |  |  |  |
| Emotional role limitations |  |  |  |  |  |  |  |
| Energy/Fatigue             |  |  |  |  |  |  |  |
| Emotional well-being       |  |  |  |  |  |  |  |
| Social functioning         |  |  |  |  |  |  |  |
| Pain                       |  |  |  |  |  |  |  |
| General Health             |  |  |  |  |  |  |  |

### References

1. McCarthy, M. M., Nugent, B. M., & Lenz, K. M. (2017). Neuroimmunology and neuroepigenetics in the establishment of sex differences in the brain. *Nature Reviews Neuroscience*, 18(8), 471.
2. Berenbaum, S. A., & Beltz, A. M. (2011). Sexual differentiation of human behavior: effects of prenatal and pubertal organizational hormones. *Frontiers in neuroendocrinology*, 32(2), 183-200.
3. Phoenix, C. H., Goy, R. W., Gerall, A. A., & Young, W. C. (1959). Organizing action of prenatally administered testosterone propionate on the tissues mediating mating behavior in the female guinea pig. *Endocrinology*, 65(3), 369-382.
4. Schulz, K. M., Molenda-Figueira, H. A., & Sisk, C. L. (2009). Back to the future: the organizational–activational hypothesis adapted to puberty and adolescence. *Hormones and behavior*, 55(5), 597-604.
5. Sisk, C. L., & Zehr, J. L. (2005). Pubertal hormones organize the adolescent brain and behavior. *Frontiers in neuroendocrinology*, 26(3-4), 163-174.
6. De Bellis, M. D., Keshavan, M. S., Beers, S. R., Hall, J., Frustaci, K., Masalehdan, A., ... & Boring, A. M. (2001). Sex differences in brain maturation during childhood and adolescence. *Cerebral cortex*, 11(6), 552-557.

7. Giedd, J. N., Blumenthal, J., Jeffries, N. O., Castellanos, F. X., Liu, H., Zijdenbos, A., ... & Rapoport, J. L. (1999). Brain development during childhood and adolescence: a longitudinal MRI study. *Nature neuroscience*, 2(10), 861.
8. Gur, R. C., Turetsky, B. I., Matsui, M., Yan, M., Bilker, W., Hughett, P., & Gur, R. E. (1999). Sex differences in brain gray and white matter in healthy young adults: correlations with cognitive performance. *Journal of Neuroscience*, 19(10), 4065-4072.
9. Lenroot, R. K., & Giedd, J. N. (2006). Brain development in children and adolescents: insights from anatomical magnetic resonance imaging. *Neuroscience & biobehavioral reviews*, 30(6), 718-729.
10. Paus, T. (2010). Sex differences in the human brain: a developmental perspective. *Progress in brain research*, 186, 13-28.
11. Perrin, J. S., Leonard, G., Perron, M., Pike, G. B., Pitiot, A., Richer, L., ... & Paus, T. (2009). Sex differences in the growth of white matter during adolescence. *Neuroimage*, 45(4), 1055-1066.
12. Perrin, J. S., Hervé, P. Y., Leonard, G., Perron, M., Pike, G. B., Pitiot, A., ... & Paus, T. (2008). Growth of white matter in the adolescent brain: role of testosterone and androgen receptor. *Journal of Neuroscience*, 28(38), 9519-9524.
13. Goldstein, J. M., Seidman, L. J., Horton, N. J., Makris, N., Kennedy, D. N., Caviness Jr, V. S., ... & Tsuang, M. T. (2001). Normal sexual dimorphism of the adult human brain assessed by in vivo magnetic resonance imaging. *Cerebral cortex*, 11(6), 490-497.
14. Peper, J. S., Brouwer, R. M., Schnack, H. G., van Baal, G. C., van Leeuwen, M., van den Berg, S. M., ... & Pol, H. E. H. (2009). Sex steroids and brain structure in pubertal boys and girls. *Psychoneuroendocrinology*, 34(3), 332-342.
15. Bao, A. M., & Swaab, D. F. (2010). Sex differences in the brain, behavior, and neuropsychiatric disorders. *The Neuroscientist*, 16(5), 550-565.
16. Armstrong, G. T., Sklar, C. A., Hudson, M. M., & Robison, L. L. (2007). Long-term health status among survivors of childhood cancer: does sex matter? *Journal of clinical oncology*, 25(28), 4477-4489.
17. Dixon, S. B., Bjornard, K. L., Alberts, N. M., Armstrong, G. T., Brinkman, T. M., Chemaitilly, W., ... & Green, D. M. (2018). Factors influencing risk-based care of the childhood cancer survivor in the 21st century. *CA: a cancer journal for clinicians*, 68(2), 133-152.

18. Holmes, L., Hossain, J., Desvignes-Kendrick, M., & Opara, F. (2012). Sex variability in pediatric leukemia survival: Large cohort evidence. *ISRN oncology*, 2012.
19. Siegel, R. L., Miller, K. D., & Jemal, A. (2017). Cancer statistics, 2017. *CA: a cancer journal for clinicians*, 67(1), 7-30.
20. Linet, M. S., Wacholder, S., & Zahm, S. H. (2003). Interpreting epidemiologic research: lessons from studies of childhood cancer. *Pediatrics*, 112(Supplement 1), 218-232.
21. Ries, L. A. G., Smith, M. A., Gurney, J. G., Linet, M., Tamra, T., Young, J. L., & Bunin, G. (1999). Cancer incidence and survival among children and adolescents: United States SEER Program 1975-1995. *Cancer incidence and survival among children and adolescents: United States SEER Program 1975-1995*.
22. Lipshultz, S. E., Lipsitz, S. R., Mone, S. M., Goorin, A. M., Sallan, S. E., Sanders, S. P., ... & Colan, S. D. (1995). Female sex and higher drug dose as risk factors for late cardiotoxic effects of doxorubicin therapy for childhood cancer. *New England Journal of Medicine*, 332(26), 1738-1744.
23. Chemaitilly, W., Mertens, A. C., Mitby, P., Whitton, J., Stovall, M., Yasui, Y., ... & Sklar, C. A. (2006). Acute ovarian failure in the childhood cancer survivor study. *The Journal of Clinical Endocrinology & Metabolism*, 91(5), 1723-1728.
24. Green, D. M., Grigoriev, Y. A., Nan, B., Takashima, J. R., Norkool, P. A., D'angelo, G. J., & Breslow, N. E. (2001). Congestive heart failure after treatment for Wilms' tumor: a report from the National Wilms' Tumor Study group. *Journal of Clinical Oncology*, 19(7), 1926-1934.
25. Green, D. M., Kawashima, T., Stovall, M., Leisenring, W., Sklar, C. A., Mertens, A. C., ... & Robison, L. L. (2009). Fertility of female survivors of childhood cancer: a report from the childhood cancer survivor study. *Journal of Clinical Oncology*, 27(16), 2677.
26. Greenen, M. M., Cardous-Ubbink, M. C., Kremer, L. C., van den Bos, C., van der Pal, H. J., Heinen, R. C., ... & Hart, A. A. (2007). Medical assessment of adverse health outcomes in long-term survivors of childhood cancer. *JAMA*, 297(24), 2705-2715.
27. Hudson, M. M., Mertens, A. C., Yasui, Y., Hobbie, W., Chen, H., Gurney, J. G., ... & Oeffinger, K. C. (2003). Health status of adult long-term survivors of childhood cancer: a report from the Childhood Cancer Survivor Study. *JAMA*, 290(12), 1583-1592.



28. Kelly, K. M. (2015). Hodgkin lymphoma in children and adolescents: improving the therapeutic index. *Blood*, *126*(22), 2452-2458.
29. Mulrooney, D. A., Yeazel, M. W., Kawashima, T., Mertens, A. C., Mitby, P., Stovall, M., ... & Leisenring, W. M. (2009). Cardiac outcomes in a cohort of adult survivors of childhood and adolescent cancer: retrospective analysis of the Childhood Cancer Survivor Study cohort. *BMJ*, *339*, b4606.
30. Oeffinger, K. C., Mertens, A. C., Sklar, C. A., Kawashima, T., Hudson, M. M., Meadows, A. T., ... & Schwartz, C. L. (2006). Chronic health conditions in adult survivors of childhood cancer. *New England Journal of Medicine*, *355*(15), 1572-1582.
31. Reulen, R. C., Winter, D. L., Lancashire, E. R., Zeegers, M. P., Jenney, M. E., Walters, S. J., ... & Hawkins, M. M. (2007). Health-status of adult survivors of childhood cancer: A large-scale population-based study from the British childhood cancer survivor study. *International journal of cancer*, *121*(3), 633-640.
32. Sklar, C. (1999). Reproductive physiology and treatment-related loss of sex hormone production. *Medical and Pediatric Oncology: The Official Journal of SIOP—International Society of Pediatric Oncology (Société Internationale d'Oncologie Pédiatrique)*, *33*(1), 2-8.
33. Wallace, W. H. B., Thomson, A. B., Saran, F., & Kelsey, T. W. (2005). Predicting age of ovarian failure after radiation to a field that includes the ovaries. *International Journal of Radiation Oncology\* Biology\* Physics*, *62*(3), 738-744.
34. Von der Weid, N., Mosimann, I., Hirt, A., Wacker, P., Beck, M. N., Imbach, P., ... & Wagner, H. P. (2003). Intellectual outcome in children and adolescents with acute lymphoblastic leukaemia treated with chemotherapy alone: age-and sex-related differences. *European Journal of Cancer*, *39*(3), 359-365.
35. De Frias, C. M., Nilsson, L. G., & Herlitz, A. (2006). Sex differences in cognition are stable over a 10-year period in adulthood and old age. *Aging, Neuropsychology, and Cognition*, *13*(3-4), 574-587.
36. Rajamani, R., Muthuvel, A., Senthilvelan, M., & Sheeladevi, R. (2006). Oxidative stress induced by methotrexate alone and in the presence of methanol in discrete regions of the rodent brain, retina and optic nerve. *Toxicology letters*, *165*(3), 265-273.
37. Butler, R. W., & Haser, J. K. (2006). Neurocognitive effects of treatment for childhood cancer. *Mental retardation and developmental disabilities research reviews*, *12*(3), 184-191.

38. Ruigrok, A. N., Salimi-Khorshidi, G., Lai, M. C., Baron-Cohen, S., Lombardo, M. V., Tait, R. J., & Suckling, J. (2014). A meta-analysis of sex differences in human brain structure. *Neuroscience & Biobehavioral Reviews*, 39, 34-50.
39. Hardy, S. J., Krull, K. R., Wefel, J. S., & Janelins, M. (2018). Cognitive changes in cancer survivors. *American Society of Clinical Oncology Educational Book*, 38, 795-806.
40. Oeffinger, K. C., Mertens, A. C., Sklar, C. A., Kawashima, T., Hudson, M. M., Meadows, A. T., ... & Schwartz, C. L. (2006). Childhood Cancer Survivor Study. *Chronic health conditions in adult survivors of childhood cancer. N Engl J Med*, 355(15), 1572-1582.
41. National Cancer Institute. Cancer Therapy Evaluation Program (CTEP). Common Terminology Criteria for Adverse Events (CTCAE). Published May 28, 2009. (updated June 14, 2010).  
<http://ctep.cancer.gov/protocolDevelopment/electronicapplications/ctc.htm>.
42. Cheung, Y. T., Brinkman, T. M., Li, C., Mzayek, Y., Srivastava, D., Ness, K. K., ... & Armstrong, G. T. (2018). Chronic health conditions and neurocognitive function in aging survivors of childhood cancer: A report from the Childhood Cancer Survivor Study. *JNCI: Journal of the National Cancer Institute*, 110(4), 411-419.
43. Brinkman, T. M., Ullrich, N. J., Zhang, N., Green, D. M., Zeltzer, L. K., Lommel, K. M., ... & Krull, K. R. (2013). Prevalence and predictors of prescription psychoactive medication use in adult survivors of childhood cancer: a report from the Childhood Cancer Survivor Study. *Journal of Cancer Survivorship*, 7(1), 104-114.