Supplementary Table I: Strong recommendations in MEN 1 and MEN2

Strong recommendations in MEN1 clinical practice guidelines: high quality of evidence according to the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system.
Strength of recommendation and the quality of evidence: we recommend-high quality.
1. Genetic testing: All individuals offered MEN1 mutation testing should be provided with genetic counseling before testing.
2. Genetic testing: MEN1 germline mutation testing should be undertaken, by a clinical genetics laboratory accredited in mutation analysis of the MEN1 gene.
3. Parathyroid tumors: Screening for primary hyperparathyroidism should include annual assessment of plasma calcium and PTH concentrations.
4. Pancreatic Neuroendocrine tumors (NET): The main aim for pancreatic (NET) is to maintain patients disease- and symptom-free for as long as possible and to maintain a good quality of life.
5. Pancreatic NET: The aim of treatment for individuals with symptomatic functioning pancreatic NET including insulinoma is to achieve cure, if possible, by surgery.
6. Pancreatic NET: Medical therapies for gastrinoma include proton-pump inhibitors and somatostatin analogs to suppress hyperacidity.
7. Pancreatic NET: A histopathologist with expertise in NET should review all tumor tissues. Tumors should be classified according to the World Health Organization 2010 classification, Union for International Cancer Control TNM (7th edition), and the European Neuroendocrine Tumor Society site-specific T-staging system.
8. Pituitary tumors: Treatment of MEN1-associated pituitary tumors is similar to that for non-MEN1 pituitary tumors and consists of appropriate medical therapy (e.g. dopamine agonists for prolactinoma; octreotide or lanreotide for somatotrophinomas) or selective transsphenoidal surgical hypophysectomy, with radiotherapy reserved for residual unresectable tumor tissue.
9. Thymic, bronchopulmonary and gastric NET: Biochemical evaluation with urinary 5-hydroxyindoleacetic acid and chromogranin A is not helpful.
10. Thymic, bronchopulmonary and gastric NET: Endoscopic ultrasound and somatostatin receptor scintigraphy may aid the diagnosis of gastric NET (gastric carcinoid type 2).

11. Thymic, bronchopulmonary and gastric NET: Curative surgery, where possible, is the treatment of choice for thymic and bronchial carcinoid tumors.
Grade A recommendations in Revised American Thyroid Association Guidelines for the Management of Medullary Thyroid Carcinoma: strongly recommends.
1. RECOMMENDATION 10 Regarding hereditary (MTC), the duty to warn a competent and capacitated patient or surrogate decision maker of the risk that an inherited RET mutation may pose to family members is a standard of care. This warning is ideally fulfilled in the setting of genetic counseling and should include a request for the patient to participate in identifying at-risk relatives. The "duty to warn" discussion should be a part of the informed consent process, in which there is full disclosure of the seriousness of the disease and available forms of prevention and treatment. When a patient refuses to notify relatives or legal dependents of their risks, the physician should consider whether he has an ethical duty or obligation to warn family members at risk. He should consult a trained clinical ethicist either at his medical center or another medical facility or contact the American Thyroid Association Ethics Committee for guidance (in USA).
2. RECOMMENDATION 11 With pediatric patients who have not reached the age of consent, it may be necessary for physicians to seek state intervention to prevent harm when there is parental refusal to inform their children of the risk of developing a malignant tumor. Practitioners with pediatric populations should consult published documents for guidance.
3. RECOMMENDATION 12 The duty to warn of genetic risk extends to both preconception and prenatal contexts. Genetic counseling about the options of pre-implantation or prenatal diagnostic testing should be considered for all RET mutation carriers of childbearing age, particularly those with MEN2B. Parents who do not wish to have prenatal RET mutation testing should be offered genetic counseling and informed of the availability of genetic testing of their child to detect a mutated RET allele. This is particularly important for mutations associated with the onset of MTC before 5 years of age.
4. RECOMMENDATION 65 In patients with significant tumor burden and symptomatic or progressive metastatic disease according to response evaluation criteria in solid tumors (RECIST) treatment with Tyrosine kinase inhibitors (TKIs) targeting both RET and vascular endothelial growth factor (VEGFR) tyrosine kinases should be considered as systemic therapy. The TKIs vandetanib or cabozantinib can be used as single-agent first-line systemic therapy in patients with advanced progressive MTC.