Supplementary Table 1: Class I recommendations for cardiovascular screening during treatment and the first 12 months after treatment with different cancer therapies

Cancer treatment	**Recommendations during treatment and the first 12 months after treatment**
Anthracycline chemotherapy e.g., doxorubicin, epirubicin, idrarubicin	• Baseline TTE in all patients (IB) • TTE within 12 months after completing treatment (IB) • In high and very high-risk patients, TTE every two cycles and within 3 months of finishing treatment (IC) • Baseline NP and cTn in high and very high-risk patients before chemotherapy (IB) • In high and very high-risk patients, cTn and NP before every cycle and 3 and 12 months after treatment completion (IB)
HER2-targeted therapies e.g., trastuzumab, pertuzumab, neratinib	• Baseline TTE in all patients (IB) • Where HER2-targeted treatment is used in the adjuvant and neo-adjuvant setting, TTE is recommended every 3 months during treatment and once with 12 months of completing treatment (IB) • With metastatic disease, TTE is recommended every 3 months in the first year and if the patient remains without CV toxicity the frequency can reduce to every 6 months (IC) • Pre-treatment baseline NP and cTn measurements are recommended in high and very high-risk patients (IC)
Fluoropyrimidines e.g., 5-Fluorouracil, capecitabine	• A pre-treatment baseline evaluation should be conducted including BP measurement, ECG, lipids, HbA1c and SCORE2 or SCORE2-OP (IC) • Baseline TTE in patients with symptomatic CV disease (IC)

VEGFi's - intravenous MAb's e.g., bevacizumab and oral TKI's e.g., sorafenib	• BP should be measured at every clinical visit for patients given VEGFi, bevacizumab, or ramucirumab (IC) • Daily home monitoring of BP during the first cycle of VEGFi or after any dose increase, and every 2-3 weeks afterwards (IC) • Patients with moderate to high risk of QTc prolongation treated with VEGFi should have monthly QTc monitoring for 3 months then QTc monitoring every 3-6 months (IC) • Baseline TTE in patients treated with VEGFi or bevacizumab at high and very high risk of cardiotoxicity (IC)
Multi-targeted kinase inhibitors targeting BCR-ABL TKI's - recommendations for 2nd generation e.g., nilotinib and 3rd generation e.g., ponatinib TKI's	• Baseline CV risk assessment (IC) • With nilotinib or ponatinib treatment, CV risk assessment every 3 months during first year then every 6-12 months (IC) • Baseline TTE in patients due to receive dasatinib (IC)
Bruton tyrosine kinase inhibitors e.g., ibrutinib	• BP measurement at every clinical visit (IB) • Baseline TTE in high-risk patients before treatment (IC) • TTE in all patients who develop AF on treatment (IC) • Opportunistic AF screening at every clinical visit by pulse-taking or ECG rhythm strip while on treatment (IC)
Multiple myeloma treatment including alkylating agents e.g., cyclophosphamide, immunomodulatory drugs e.g.,	• BP measurement at every clinical visit for patients treated with PI (IC) • NP measurement before treatment with PI in high and very high-risk patients (IC) • NP and cTn measurement at baseline and every 3-6 months in patients with amyloid light chain cardiac amyloidosis (IB)

lenalidomide, PI's e.g., bortezomib and MAb's e.g., daratumumab	• Baseline TTE for multiple myeloma patients prior to PI (IC) • Therapeutic dose LWMH in multiple myeloma patients with prior VTE (IB) • Prophylactic LMWH in multiple myeloma patients with VTE risk factors for at least the first 6 months of therapy (IA)
RAF inhibitors e.g., dabrafenib and MEK inhibitors e.g., binimetinib	• BP monitoring each clinic visit, weekly outpatient monitoring for first 3 months nad monthly thereafter (IC) • For cobimetinib/vemurafenib, ECG monitoring at 2 and 4 weeks after initiation and every 3 months onwards (IC) • Baseline TTE in high and very high-risk patients due to receive combined RAF and MEK inhibitors (IC)
Immune checkpoint inhibitors with MAb's targeting CTLA-4 e.g., ipilimumab, PD-1 e.g., nivolumab, and PD-L1 e.g., atezolizumab	• Baseline ECG, NP and cTn before treatment (IB) • Baseline TTE in high-risk patients before treatment (IB) • CV assessment every 6-12 months in high risk patients needing treatment >12 months (IC)
Androgen deprivation therapies for prostate cancer including GnRH agonists e.g., goserelin, GnRH antagonists e.g., degarelix, 1st generation anti-androgens e.g., bicalutamide, 2nd generation anti-androgens e.g., enzalutamide, androgen metabolism inhibitors e.g., abiraterone	• In patients without pre-existing CV disease, baseline risk assessment with SCORE2 or SCORE2-OP (IB) • Baseline and serial ECGs in those at risk of QTc prolongation during therapy (IB) • Annual CV risk assessment during therapy (IB)

Endocrine therapies for breast cancer including SERM's e.g., tamoxifen and aromatase inhibitors e.g., letrozole	• In patients without pre-existing CV disease, baseline risk assessment and estimation of 10-year risk of fatal and non-fatal events with SCORE2 or SCORE2-OP (IC) • Annual CV risk assessment during therapy for those with a high 10-year risk of fatal and non-fatal events (according to SCORE2 or SCORE2-OP score; IC)
CDK 4/6 inhibitors e.g., palbociclib, ribociclib, abemaciclib	• For patients on ribociclib, QTc monitoring at baseline, and day 14 and 28 of treatment (IA) • For patients on ribociclib, QTc monitoring with any dose increase (IB)
ALK inhibitors e.g., crizotinib and epidermal growth factor receptor inhibitors e.g., osimertinib	• Baseline CV risk assessment in all patients (IC) • Baseline TTE prior to treatment with osimertinib (IB)
CAR-T and TIL therapies	• Baseline ECG, NP, and cTn in all patients prior to treatment (IC) • Baseline TTE in patients with pre-existing CV disease prior to treatment (IC) • NP and cTn measurement alongside TTE in patients with CRS of American Society for Transplantation and Cellular Therapy grade ≥ 2 (IC)
Radiotherapy to a volume including the heart	• Baseline CV assessment and estimation of 10-year risk of fatal and non-fatal events with SCORE2 or SCORE2-OP (IB)
HSCT (this incorporates a multi-factorial treatment with conditioning, which can include radiation, chemotherapy and immunosuppression in the case of allogeneic transplants)	• Baseline and serial CV risk assessment (3 and 12 months, then every 12 months) with BP measurement, ECG, lipids and HbA1c (IC) • Echocardiography prior to HSCT in all patients (IC)

The level of evidence varies: level A, data from randomised controlled trials (RCTs) or meta-analysis; level B, data from a single RCT or large non-randomised studies; level C, expert consensus, small studies, retrospective studies or registry data. Abbreviations: TTE, trans-thoracic echocardiography; NP, natriuretic peptide; cTn, cardiac troponin; HER2, human epidermal receptor 2; CV, cardiovascular; BP, blood pressure; ECG, electro-cardiogram; HbA1c, glycated haemoglobin; SCORE2, Systematic Coronary Risk Estimation 2; SCORE2-OP, Systematic Coronary Risk Estimation 2-Older Persons; VEGFi, vascular endothelial growth factor inhibitor; MAb, monoclonal antibody; TKI, tyrosine kinase inhibitor; QTc, corrected QT interval; BCR-ABL, breakpoint cluster region-Abelson oncogene locus; AF, atrial fibrillation ; PI, proteosome inhibitor; LMWH, low molecular weight heparin; VTE, venous thromboembolism; RAF, rapidly accelerated fibrosarcoma; MEK, mitogen-activated extracellular signal-regulated kinase; CTLA-4, cytotoxic T-lymphocyte associated protein 4; PD-1, programmed cell death protein-1; PD-L1, programmed cell death ligand-1; GnRH, gonadotropin-releasing hormone; SERM, selective oestrogen receptor modulator; CDK 4/6, cyclin dependent kinase 4/6; ALK, anaplastic lymphoma kinase; CAR-T, chimeric antigen receptor T-cell; TIL, tumour-infiltrating lymphocyte; CRS, cytokine release syndrome; HSCT, haematopoietic stem cell transplantation. This table was adapted from recommendation tables 7 to 22 from [21] with permission from Oxford University Press.