UK Consensus on Normal Tissue Dose Constraints for Stereotactic Radiotherapy: Reply to Ghafoor et al.

Madam — We thank Dr Ghafoor and colleagues [1] for their insightful letter and interest in our consensus on stereotactic ablative radiotherapy dose constraints and warmly welcome discussion of the consensus constraints. We also thank Dr Ghafoor et al. for providing valuable data and clinical experience that are not reported in this detail in the available literature to date. However, in the data provided there is no information on the size of the lesions, the fitness of the patients treated, the patient’s lung function or the combined V20.

With reference to the treatment of multiple lung lesions, in our consensus paper we advised that it may be preferable to treat individual lesions on alternate days, which has been the practice of a number of UK centres [2]. The rationale for this was to reduce the dose per fraction to the whole lung and therefore reduce the risk of clinically significant pneumonitis and late fibrosis. We accept that the evidence base for this recommendation regarding treatment on alternate days is lacking and hence we did suggest that more than one lung tumour could be treated on the same day if the combined V20 for all plans was below the tolerance for a single lesion, for small metastases in otherwise fit patients or in the situation of two or more lung lesions in close proximity to each other. In these scenarios it may be preferable to plan and treat these lesions on the same day to avoid any set-up uncertainty.

We agree that it is highly desirable to assess the optimal sequencing of multiple stereotactic ablative radiotherapy treatments to lung lesions through clinical studies. Cognisant of this, we encourage clinicians to recruit the currently open UK studies (e.g. CORE, SARON and HALT), which permit the treatment of multiple lung lesions and which will hopefully provide important information regarding the treatment of multiple lesions in the lung [3–5].

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References


Re-irradiation of the Brain

Madam — Your special issue of Clinical Oncology on re-irradiation was interesting and confirmed what I had practised in selected patients with prostate or bladder cancer, treated to a radical dose some years previously and having symptomatic recurrence needing palliation. However, I must sound a note of caution when considering re-irradiation of the brain [1]. Only once did the authors mention potential cognitive side-effects, dismissed in a single sentence referring to the RTOG 93–05 trial of external beam radiotherapy/carmustine with or without stereotactic radiosurgery, and stating that ‘there was no difference in survival, quality of life or cognitive functioning between the two arms’. This was not referring to conventional re-irradiation of the brain.

The authors seemed to consider only the radionecrosis risk of retreatment. There is, however, a body of literature documenting the cognitive side-effects of cranial irradiation that shows that inclusion of the hippocampus within the