

APPLIED

MEDIA PLANNER 2015

RADIATION ONCOLOGY™

MEDIA PLANNER 2015

Applied Radiation Oncology is a quarterly physician-authored journal published in print and online, featuring educational, practical, and actionable information for radiation oncology professionals striving to enhance the efficacy, value, and quality of radiotherapy.

Circulation to radiation oncologists and medical physicists includes: Print edition 5000+ and digital edition 5400+.

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Reach 3,800+ radiation oncology professionals in print and 5400+ with our digital edition

Applied Radiation Oncology is published 4 times a year: March, June, September, and December

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2015 Editorial Calendar

Month (space reservation & material deadlines)	Topics	Events
March reserve by 02-11; materials by 02-13	Focus: Liver cancer Liver resection for hepatocellular carcinoma Turf wars in liver cancer treatment Economics of proton therapy Technology Trends: Radiation oncology quality vs safety	ESTRO, April 24-28 National Proton Conference, March 30-April 2 ACRO 2015 Annual Meeting, May 14-16
June reserve by 05-20; materials by 05-22	Focus: Brain tumors in pediatrics Proton beam therapy for pediatric brain tumors SBRT and SRS for pediatric CNS/spine/brain cancer Technology Trends: IMRT	AAPM 2015, July 12-16
September reserve by 08-26; materials by 08-28	Focus: Head and neck cancer IGRT and ART for head and neck Head and neck treatment planning Technology Trends: Advances in treatment planning	ASTRO 2015, October 18-21
December reserve by 11-18; materials by 11-25	Focus: Gynecological cancer Uterine cancer treatment Image-guided brachytherapy for gynecologic malignancies Technology Trends: Proton therapy	

APPLIED RADIATION ONCOLOGY

Stereotactic body radiation therapy (SBRT) for lung cancer

Kevin L. Stephans, MD

Stereotactic body radiation therapy (SBRT) has evolved over the past 15 years and revolutionized the management of early stage non-small cell lung cancer (NSCLC). Compared to conventional radiation therapy, SBRT offers superior outcomes, with and greater patient convenience. SBRT likewise offers local control and cancer outcomes approaching surgical resection* with lower risk of treatment-related morbidity, making SBRT the treatment of choice for medically inoperable and many high-risk surgical candidates. Encouraging results in the population have led to the investigation of SBRT's role in operable stage I NSCLC. Long oligometastatic, stage I non-small cell lung cancer, and potentially therapy for locally advanced NSCLC. The lessons learned in the lung SBRT experience also serve as a model for developing SBRT in other solid-site sites, including the liver, pancreas, adrenal gland and prostate.

Technique
SBRT treatment planning begins with careful identification of the target with motion limited to <5-10 mm. This may be accomplished by abdominal compression (Figure 1), respiratory gating using either cone-beam CT or external respiratory surrogates, or frame tracking/respiratory modeling. Immobilization should be assessed by either fluoroscopy or 4DCT imaging at simulation, and verified by cone-beam CT (CBCT) or other imaging during treatment. Historically, the planning target volume (PTV) was created from a clinical expansion (1 cm superior, 3 mm

anterior-posterior therapy.*** The use of IMRT in treating small lung tumors is controversial due to concerns of potential underdosing, although IMRT is allowed in recent protocols such as RTOG 0815** and reported outcomes with IMRT have been on par with other techniques.*** Planning should utilize orthogonal cone-beam CT (CBCT) acquisition, as there is a suggestion that proton beam algorithms may compute more weight than more variable radiotherapy.*** The institution uses the 4D-derived average CT as the planning target for the best estimate of density and tumor center-of-mass. Planning should focus on minimizing contamination and sparing on the fall-off. Heterogeneity is acceptable and may be desirable for proton therapy, but fall-off should be critical. Initial structures are not overrepresented in Figure 2 and 3). Comments should be based on appropriate protocols for the target being treated, such as RTOG 0815, 0915, or large institutional experience.

Image guidance during treatment initially consisted of lung registration followed by post-fire, although multiple approaches have been used. The use of respiratory motion, and a partial can be created by tracking the breathing cycle to a CBCT image at the time of treatment, generally introducing a systematic error that occasionally exceeds the PTV expansion.*** One should not use the average CT as the reference for matching, or otherwise handle only to lung anatomy if using a free-breathing image while verifying that the CBCT tumor falls within the PTV.

Patients should be continually re-scanned with CT after treatment for respiratory movement resulting in significant fibrotic reactions may occur (Figure 3).*** Concerning limitations on CT include an enlarging mass-like density,




FIGURE 1. Axial cone-beam CT (CBCT) image showing abdominal compression used for SBRT treatment.

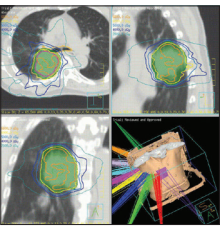


FIGURE 2. Representative three-dimensional distribution for a central lesion. Proton isochore map overlaid with isochore for 50 Gy in fractions, and the patient used that treated in 5 Gy in 5 fractions based on a risk adapted approach.

* Stephans KL, Anderson KE, et al. J Clin Oncol. 2014;32(15):1553-1560. ** RTOG 0815. *** Stephans KL, Anderson KE, et al. J Clin Oncol. 2014;32(15):1553-1560.

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