

GenesisCare Radiotherapy Protocols during Pandemic

At GenesisCare, we are committed to providing the best possible treatments for cancer patients when they need it. We are following current evidence, leveraging our advanced technologies and following robust infection control procedures to ensure our patients continue to receive excellent care during the COVID-19 pandemic.

We appreciate that during this pandemic, clinical protocols need to be adapted and technique capabilities maximised to ensure all cancer patients are treated without delays and their long-term outcomes are not compromised.

The following protocols and techniques are delivered at all our centres and are aligned with the Royal College of Radiologists guidelines.

1.0 Gynaecological Malignancies

1.1 Cervical Cancer and Vaginal cancers

- Consider pelvic radiotherapy to replace limiting surgical options. Preferred regimes include 45Gy/25# or 50.4Gy/28# for bulky or node positive cancers.
- Concurrent weekly Cisplatin rather than carboplatin should be considered if patients <70y old and fit but consider omitting chemotherapy for the >70y old or unfit patients.
- An SIB technique to boost positive nodes should be considered and a pelvic boost can be delivered if there are limited brachytherapy options (16-20Gy in 8-11 fractions).
- All treatments delivered using IGRT and IMRT techniques.

1.2 Endometrial cancer

- Radical pelvic radiotherapy is offered to replace limiting surgical options, using 40Gy/20# with IMRT and IGRT.
- Adjuvant pelvic radiotherapy should be considered for high risk patients.
- Vault brachytherapy alone should be considered for intermediate risk patients or unfit/older high risk patients.

1.3 Vulva cancer

- Radical chemoradiotherapy (45-50.4Gy/25-28#) with concurrent weekly cisplatin should be considered as alternative to surgery. Consider omitting chemotherapy in >70y olds and unfit patients.
- Adjuvant pelvic radiotherapy should be considered to patients with positive nodes, positive margins or residual disease.

2. Breast cancers

2.1 Whole Breast Irradiation and Partial Breast irradiation

- Adjuvant WBI using 40Gy/15# or 26Gy/5# using the Fast Forward trial criteria (node- patients post lumpectomy or mastectomy).
- Clinicians should discuss risk/benefits of hypofractionated protocol with patients, in all cases and including complex mammoplastic techniques or high risk disease patients.
- PBI should be considered for patients who meet the ESTRO criteria (ER+/Her2-, ≤ 3 cm, N0, IDC, not multifocal or lobular disease, >50 y of age), using IMPORT LOW 40Gy/15# or Fast Forward 26Gy/5# daily or Florence Trial 30Gy/5# non-consecutive days.
- Patient considered for Boost, should be offered SIB 48Gy/15# as per IMPORT High (preferred technique) or sequential boost (If SIB not indicated).

2.2 Advanced and Metastatic Breast Cancer

- Patients considered for regional nodal irradiation, should be offered 40Gy/15# and planned using VMAT and DIBH regardless of laterality.
- In case of Oligometastatic disease, SABR should be considered which can delay the need for palliative chemotherapy.

3. Head and Neck cancers

- Consider radical radiotherapy with or without concomitant chemotherapy depending on fitness and age and choose hypofractionated regimes.
- Vulnerable patients are all >60 y of age, with respiratory or cardiovascular disease.
- Follow NICE guidance when SACT is considered.

4. Lower GI patients

4.1 Rectal cancers

- Consider short course radiotherapy with 25Gy/5# to replace long course 45Gy-50.4Gy/25#-28# if >70 y or unfit patients or to delay surgery. For young and fit patients, we should continue to offer long course radiotherapy.
- Consider omitting adjuvant chemotherapy in >60 y and use fewer cycles as per NICE SACT guidance.

4.2 Anal cancers

- We should continue to offer radical chemoradiotherapy to all patients unless >70 y of age and very unfit, where palliative 30Gy/10# is appropriate.

5. Urological malignancies

5.1 Prostate cancer

- We continue to offer radical prostate radiotherapy with 20-37# as per GenesisCare protocol when clinicians decide this is safe to do so.
- Patient should be considered for 5# prostate radiotherapy on the MR-Linac
- High risk patients after radical prostatectomy and/or with rapidly raising PSA should be considered for adjuvant prostate bed radiotherapy.
- Fit and well patients should be considered for Space OAR insertion under local anaesthetic at GenesisCare.
- Palliative patients with PSMA positive PET, should be considered for Lutetium PSMA in preference to palliative chemotherapy due to lower overall toxicity.
- Consider SABR for oligometastatic disease to delay hormonal or chemotherapy treatments.

5.2 Bladder cancer

- Consider radical chemoradiotherapy with 55Gy/20# in case of limiting surgical options and consider omitting chemotherapy in >70y old or unfit patients.
- All delivered with IMRT and IGRT.

6. Sarcomas

- Postoperative radiotherapy with 60-66Gy/30-33# or consider hypofractionated Regimes such as 40-45Gy/15-20# or 30Gy/6 weekly #.

7. Upper GI malignancies

7.1 Oesophagogastric cancer

- Neoadjuvant chemoradiotherapy with hypofractionated regimes should be considered such as 40Gy/15# (with registry to collect data), using weekly carbo/taxol chemotherapy.
- If neoadjuvant chemotherapy is considered for 1-3 cycles, ensure patients are covered with GCSF to reduce immunosuppression.
- For radical chemoradiotherapy, consider 50Gy/16# or 45Gy/15# for tumours up to 5cm and 50-55Gy/20# for tumour 5-10cm. Consider weekly carbo/taxol if patient fit.

7.2 Pancreatic and Liver cancers

- Consider radical/palliative radiotherapy on the MR-Linac using fully adaptive protocols to delay need for chemotherapy or surgery.

8. Lung cancers

- Consider SABR treatment on the MR Linac for Primary Lung cancer with curative or palliative intent, to avoid need for chemotherapy or surgery.

9. Neurological malignancies

- Consider standard (60Gy/30#) or hypofractionation regimes (40GY/15#) with or without concurrent temozolamide for high grade gliomas
- Consider SRS/SRT for low grade glioma with limited surgical facilities.
- Consider single fraction SRS for single or oligometastases in the brain.