



GCUK Standard Prescriptions - Radical doses

Diagnosis	Site	RCR Category	modality	Total Dose (Gy)	Number of fractions	Dose per fraction (Gy)	Schedule	Max Overall Treat Time	Source of prescription	RCR grade A, B is recommended C, D is acceptable
Glioma - High Grade	Brain		x-ray	40	15	2.67	daily	4 weeks	Royal Surrey NHS	
	Brain		x-ray	40-45	20-25	2	daily	4 to 5 weeks	Royal Surrey NHS	
	Brain		x-ray	54-60	30	1.8 to 2	daily		QA Portsmouth NHS	
	Brain		x-ray	59.4	33	1.8	daily		Southampton NHS	
	Brain	NS	x-ray	60	30	2	daily		RCR	A
Glioma - Low Grade	Brain	NS	x-ray	45-50.4	25-28	1.8	daily		RCR	A
	Brain		x-ray	54	30	1.8	daily		RCR	B
Pituitary Tumours	Brain	NS	x-ray	45	25	1.8	daily		RCR	C
Meningioma	Brain		x-ray	50.4	28	1.8	daily		London Neuro-Oncology Protocol	B
	Brain		x-ray	50-60	30	1.67-2	daily		QA Portsmouth NHS (2012)	
Head and Neck cancer	H & N	1	x-ray	66-68	33-34	2	6# per week	5.5 weeks	RCR	A
	H & N		x-ray	72	30	2.4	daily	6 weeks	RCR	A
	H & N		x-ray	66-70	33-35	2	daily	6.5 to 7 weeks	RCR	A
	H & N	1	x-ray	66-70	33-35	2	daily	6 weeks	Nottingham NHS	
	H & N		x-ray	65	30	2.17	daily		Nottingham NHS	
	H & N		x-ray	65/54	30	2.17	daily		Royal Surry NHS	
	H&N		x-ray	60-65/54	30	2-2.17	daily		Royal Surry NHS	
	Nasopharynx	1	x-ray	65/60/54	30	2.17 / 2 / 1.8	daily		QE Birmingham NHS	
	Nasopharynx		x-ray	70/63/56	35	2 / 1.8 / 1.6	daily		Southampton NHS	
	Oropharynx	1	x-ray	55/50/46	20	2.75 / 2.5 / 2.3	daily		QE Birmingham NHS	
Oropharynx		x-ray	65	30	2.17	daily		Royal Surry NHS		

	Tongue		x-ray	50	20	2.5	daily		QE Birmingham NHS	
	Paranasal Sinus		x-ray	60-66/ 54	30-33/30	2 / 1.8	daily		Royal Surry NHS	
	Parotid		x-ray	60/54	30	2 / 1.8	daily		Royal Surry NHS	
	Parotid		x-ray	64	32	2	daily		CRT (PO9-53), <i>Radiotherapy in Practice External Beam Therapy</i>	
	Thyroid		x-ray	66	33	2	daily		Kent Oncology Centre	
	Thyroid		x-ray	60	33	1.82	daily		Kent Oncology Centre	
	Thyroid		x-ray	52	20	2.6	daily		Kent Oncology Centre	
	Thyroid		x-ray	55	20	2.75	daily		Kent Oncology Centre	
	H&N Nodes		x-ray	54Gy	30	1.8	daily		CRT (SO16-2)	
Larynx Cancer - Early-Stage	Larynx	1	x-ray	64-70	32-35	2	daily		RCR	B
	Larynx		x-ray	65/54	30	2.17/1.8	daily		Sussex NHS (CRT)	
	Larynx		x-ray	54-55	20	2.7 to 2.75	daily		RCR	C
	Larynx		x-ray	50-52.5	16	3.13 to 3.28	daily		RCR	C
Larynx - Post operative	Larynx	1	x-ray	60	30	2	daily		Derby East Midlands	
Head and Neck - Post Operative	H & N	1	x-ray	60-64	30-32	2	daily		QA Portsmouth NHS	
	H & N		x-ray	50-55	20	2.5 to 2.75	daily		QA Portsmouth NHS QE Birmingham NHS Royal Surrey County Hospital	
Spinal Ependymoma	Spine		x-ray	54	33	1.64	daily	6.5 weeks	Royal Surrey NHS	
Oesophageal Cancer	Oesophagus	1	x-ray	41.4	23	1.8	daily		Southampton NHS (NEJM); CRT SO16-13	
	Oesophagus		x-ray	45	25	1.8	daily	5weeks	Kent Oncology Centre	
	Oesophagus		x-ray	50	25	2	daily		RCR	B
	Oesophagus		x-ray	50.4	28	1.8	daily		RCR	B
	Oesophagus		x-ray	50	15 or 16	3.34 or 3.13	daily		RCR	C
	Oesophagus		x-ray	50-55	20	2.5 to 2.75	daily		RCR	D

	Oesophagus		x-ray	60	30	2	daily		RCR	D
Lung Cancer - Non Small Cell (NSCLC) Sub groups: SCC, Adenocarcinoma, Large Cell Carcinoma	Lung (NSCLC)	1	x-ray	52.5-55	20	2.63 to 2.75	daily	4 weeks	RCR	C
	Lung (NSCLC)		x-ray	60-66	30-33	2	daily	6.5 weeks	RCR	B
	Lung (NSCLC)	1	x-ray	54	36	1.5	3# per day	12 days	RCR	A
Lung Cancer - Small Cell (SCLC)	Lung (SCLC)		x-ray	50	25	2	daily		RCR	C
	Lung (SCLC)	1	x-ray	45	30	1.5	2# per day	3 weeks	RCR	C
	Lung (SCLC)		x-ray	40	15	2.67	daily	3 weeks	QA Portsmouth NHS, Royal Surrey NHS	
	Cranium (SCLC) prophylactic	1	x-ray	24-30	8-10	3	daily		RCR	A
	Cranium (SCLC) prophylactic		x-ray	25	10	2.5	daily		Royal Surry NHS	
Breast Cancer	Breast		x-ray	50	25	2	daily	5 weeks	RCR	B
	Breast		x-ray	40	15	2.67	daily	3 weeks	RCR	B
	Breast		x-ray	50.4	28	1.80	daily		Royal Surrey NHS	
	Breast	2	x-ray	50	30	1.67	daily		Royal Surrey NHS	
	Breast		x-ray	28.5-6	5-6	5.70	1 per week		Addenbrookes NHS	
	Breast		x-ray	26	5	5.20	daily		FAST FORWARD	RCR
	Breast		x-ray	36	6	6.00	1 per week	6 weeks	Southampton NHS	
	Supraclavicular Fossa		x-ray	40	15	2.67	daily	3 weeks	Mount Vernon NHS (MVCN)	
	Supraclavicular Fossa		x-ray	50	25	2.00	daily	5 weeks	QA Portsmouth NHS	
	Axilla +/- Supraclavicular Fossa		x-ray	40	15	2.67	daily	3 weeks	Sussex NHS	
	Axilla +/- Supraclavicular Fossa		x-ray	50	25	2.00	daily	5 weeks	Mount Vernon NHS (MVCN)	
	Breast boost		x-ray	9	3	3.00	daily		Royal Berkshire NHS	
	Breast boost		electron	9	3	3.00	daily		Royal Berkshire NHS	
	Breast boost		x-ray	10	5	2	daily		Sussex NHS	
Breast boost		electron	10	5	2	daily		QE Birmingham NHS, Northampton NHS		
Breast boost		x-ray	10.5	3	3.5	daily		CRT (Gen-2), to match existing electron prescription		
Breast boost		electron	10.5	3	3.5	daily		Mount Vernon NHS (MVCN)		
Breast boost		x-ray	12.8	4	3.2	daily		CRT (Gen-2), to match existing electron prescription		

	Breast boost		electron	12.8	4	3.2	daily		QA Portsmouth NHS	
	Breast boost	2	x-ray	12	4	3	daily		CRT (Gen-2), to match existing electron prescription	
	Breast boost		electron	12	4	3	daily		Sussex NHS	
	Breast boost		electron/ Xray	5	2	2.5	daily		QE Birmingham NHS	
	Breast boost		x-ray	12-12.5	5	2.5	daily		CRT (Gen-2), to match existing electron prescription	
	Breast boost		electron	12-12.5	5	2.5	daily		QE Birmingham NHS	
	Breast boost		electron/x ray	13.35	5	2.67	daily		Royal Surrey NHS	
	Breast boost		x-ray	16	8	2	daily		CRT (Gen-2), to match existing electron prescription	
	Breast boost		x-ray	12	4	3	daily		QE Birmingham NHS	
	Breast boost		electron	16	8	2	daily		RCR	
	Breast IMC		x-ray	40	15	2.67	daily		RCR consensus guidelines November 2016	
	Breast Simultaneous integrated boost		x-ray	48	15	2.67/3.2	daily		Breast Care 2015;10:44-49	
	Uterus		Xray	40	20	2	daily		Derby East Midlands	
Uterine Corpus Carcinoma	Uterus	NS	x-ray	45	25	1.8	daily		RCR	C, D
	Uterus	NS	x-ray	45	25	1.8	daily		RCR	
	Endometrium		x-ray	50.4	28	1.8	daily		QA Portsmouth NHS	
	Endometrium		x-ray	45-50.4	25-28	1.8	daily		Royal Surry NHS	
	Endometrium		x-ray	45	25	1.8	daily		Royal Surry NHS	
	Endometrium		x-ray	50.4	28	1.8	5.5weeks		Royal Surry NHS	
	Uterine Sarcoma		x-ray	45	25	1.8	daily		Royal Surry NHS	
Cervical Carcinoma - Early-Stage	Cervix	1	x-ray	50.4	28	1.8	daily		RCR	B
	Cervix		x-ray	40-45	20	2 to 2.25	daily	4 weeks	RCR	C
	Cervix		x-ray	45	25	1.8	daily	5 weeks	Royal Surry NHS	

	Cervix		x-ray	50.4	28	1.8	daily	5.5 weeks	Royal Surry NHS	
Cervical Carcinoma - Locally Advanced	Cervix	1	x-ray	50.4	28	1.8	daily	56 days	RCR	B
Cervical Carcinoma - Locally Advanced / Advanced	Cervix		x-ray	50.4	28	1.8	daily	5.5 weeks	Royal Surry NHS	
	Cervix		x-ray	50.4	28	1.8	daily	5.5 weeks	Royal Surry NHS	
	Para-aortic Nodes		x-ray	45	25	1.8	daily	5 weeks	Royal Surry NHS	
Vaginal Cancer	Vagina		x-ray	50.4Gy	28	1.8	daily		QA Portsmouth NHS	
	Vagina		x-ray	45	25	1.8	daily	5 weeks	Royal Surry NHS	
	Vagina		x-ray	45-50.4 (Ph1) 15-20 (Ph2)	25-28 (Ph1) 7-10 (Ph2)	1.8	daily	5 weeks 2 weeks	Royal Surry NHS	
Vulval Cancer - Operable	Vulva	1	x-ray	45	25	1.8	daily		RCR	B
	Vulva		x-ray	60	32-33	1.8	daily		Royal Surry NHS	
Vulval Cancer - Inoperable	Vulva	1	x-ray	45	25	1.8	daily		RCR	B
Rectal Cancer	Rectum		x-ray	25	5	5	daily	1 week	RCR	A
	Rectum	NS	x-ray	45	25	1.8	daily		RCR	A
	Rectum		x-ray							B
	Rectum		x-ray	45 + boost 5.4 to 9	25 + boost 3 to 5	1.8	daily		RCR	A
	Rectum		x-ray						RCR	B
	unresectable disease			52	25	2.08				
			x-ray				daily			
	Rectum + Nodes			45	25	1.8				
Rectum			50.4	28	1.8	daily		NUH Trust (2014)		
Rectum		x-ray	50	25		daily				
Nodes		x-ray	59.36	28	2.12	daily		NUH Trust (2014)		

Anal Cancer	Anal	2	x-ray	45	20	2.25	daily		RCR	
	Anal		x-ray	45	25	1.8	daily		RCR	
	Anal		x-ray	50	25	2	daily		RCR	D
	Anal		x-ray	50.4	28	1.8	daily		RCR	D
	Anal		x-ray	50.4	28	1.8	daily		CRT WD6-??, National Guidance for IMRT in Anal Cancer (2014)	
	Anal		x-ray	53.2	28	1.9	daily		National Guidance for IMRT in Anal Cancer (April 2016)	
	Anal		x-ray	59.4	33	1.8	daily		Nottingham University Hospital (NUH)	
	Nodes	x-ray	40	28	1.43	daily		CRT WD6-??, National Guidance for IMRT in Anal Cancer (2014)		
	Nodes	x-ray	43	33	1.3	daily		Nottingham University Hospital (NUH)		
	Nodes	x-ray	50.4	28	1.8	daily		CRT WD6-??, National Guidance for IMRT in Anal Cancer (2014)		
Nodes	x-ray	55	33	1.66	daily		Nottingham University Hospital (NUH)			
Bladder Cancer	Bladder	2	x-ray	60-64	30-32	2	daily	6 to 6.5 weeks	RCR	B
	Bladder		x-ray	50-52.5	20	2.5 to 2.63	daily		RCR	B
	Bladder		x-ray	55	20	2.75	daily		QE Birmingham NHS	
	Bladder		x-ray	60-66	33	1.81 to 2	daily		Mount Vernon NHS (MVCN)	
Prostate	Prostate	2	x-ray	74-78	37-39	2	daily	7.5 to 8 weeks	RCR	A
	Prostate		x-ray	78	37	2.1	daily	7.5 weeks	Koyal Surrey Protocol	
	Prostate		x-ray	50	16	3.13	daily		Approved by CRT 27/11/14 - see	
	Prostate		x-ray	45	25	1.8	daily		RCR	C
	Prostate		x-ray	45	25	1.8	daily		Sussex NHS	
	Prostate		x-ray	72	32	2.25	daily	6.5 weeks	Clatterbridge	
	Prostate		x-ray	60	20	3	daily		Mount Vernon NHS (MVCN)	
	Prostate		x-ray	55	20	2.75	daily	4 weeks		
	Prostate	x-ray	62	20	3.1	daily	4 weeks	PACE Trial		
	Prostate (EBRT+HDR)	x-ray	44	22	2	daily	5 weeks	Royal Surrey NHS (2014)		
Prostate (EBRT+HDR)	x-ray	46	23	2	daily		Mount Vernon NHS (MVCN)			

Prostate Cancer	Prostate (EBRT+HDR or LDR)		x-ray	36	12	3	daily		Royal Surrey NHS (2019)
	Prostate (EBRT+HDR)		x-ray	45	25	1.8	daily	5 weeks	Royal Surrey NHS (2014)
	Prostate (EBRT+HDR)	2	x-ray	37.5	15	2.5	daily		HDR Prostate Boost Protocol (PROT22) / CRT (Gen4)
	Prostate (EBRT+HDR)		x-ray	50	25	2	daily		Southampton NHS (2014)
	Prostate (EBRT+HDR)		x-ray	50	28	1.79	daily		Royal Surrey NHS (2014)
	Prostate nodes (EBRT+HDR)		x-ray	46	23	2	daily		Mount Vernon NHS (MVCN)
	seminal vesicles		x-ray	59.2	37	1.6	daily	7.5 weeks	Royal Surrey NHS
	seminal vesicles		x-ray	60	37	1.62	daily		Royal Surry Protocol Approved by CRT 27/11/14 - see
	seminal vesicles	2	x-ray	64	37	1.73	daily		Sussex NHS
	seminal vesicles		x-ray	66.6	37	1.8	daily		Oxford NHS
	base of seminal vesicles		x-ray	64	37	1.73	daily		Sussex NHS
	Prostate nodes	2	x-ray	62	39	1.59	daily		Mount Vernon NHS (MVCN)
			x-ray	60	37	1.62			Mount Vernon NHS (MVCN)
			x-ray	50	32/33	1.56/1.52			Charringcross/ Hammersmith
			x-ray	55	37	1.49			Sussex NHS
Involved Nodes		x-ray	65-74	37-39	1.75-2	daily		Genesiscare Prostate Protocol	
Salvage Prostate (post-prostatectomy)	Prostate bed	2	x-ray	52.5	20	2.63	daily		Mount Vernon NHS (MVCN)
			x-ray	64	32	2			QA Portsmouth NHS
			x-ray	66	33	2			Royal Surry NHS
	Prostate bed boost	2	x-ray	71.6	33	2.17	daily		Royal Surrey NHS
			x-ray	70-74	35-37	2			Oxford NHS
	Pelvic nodes	2	x-ray	53.4	33	1.62	daily		Royal Surry NHS
Xray			54	33	1.64			Oxford NHS	
x-ray			60	33	1.82			Sussex NHS	

			x-ray	55	33	1.67			Sussex NHS	
Penile Cancer	Penis		x-ray	45	25	1.80	daily	5 weeks	Nottingham & Northampton NHS	
Seminoma	Seminoma	NS	x-ray	20	10	2	daily		RCR	B
			x-ray	20	8	2.5	daily	10 days	RCR	B
			x-ray	20-30	10-15	2	daily		Oxford NHS	
			Xray	30	15	2	daily		Oxford NHS	
Pancreas	Pancreas	2	x-ray	45	25	1.8	daily		QA Portsmouth NHS	
	Pancreas		x-ray	50.4	28	1.8	daily		Northampton NHS	
Lymphoma - early-stage Hodgkin's	Lymphoma		x-ray	20	10	2	daily		Royal Surrey NHS; CRT OX4-7	
Lymphoma - early-stage Hodgkin's	Lymphoma	NS	x-ray	30	15	2	daily		RCR	B
Lymphoma - advanced Hodgkin's	Lymphoma		x-ray	30-34	15-20	1.8 to 2	daily	3 to 4 weeks	RCR	C
Lymphoma - intermediate/high-grade non-Hodgkin's	Lymphoma	NS	x-ray	30-45		2	daily	3 to 4.5 weeks	RCR	B
Lymphoma - stage 1 low-grade non-Hodgkin's	Lymphoma		x-ray	24-40	12-20	2	daily	2.5 to 4 weeks	RCR	C
Lymphoma - intermediate/high-grade non-Hodgkin's	Lymphoma		x-ray	30	15	2	daily	3 weeks	Royal Surrey NHS	
Desmoid Tumours	Desmoid	NS	x-ray	50-56	25-28	2	daily	5 to 5.5 weeks	RCR	C
Resectable Sarcoma	Sarcoma	NS	x-ray	50	25	2	daily		RCR	C
	Sarcoma		x-ray	50 + boost 10 or 16	25 + boost 5 or 8	2	daily		RCR	C
Un-Resectable Sarcoma	Sarcoma	NS	x-ray	50-55	20	2.5-2.75	daily		Northampton General Hospital NHS	
	Sarcoma	NS	x-ray	66	33	2	daily	6.5 weeks	RCR	C
Ewings-type tumours and PNET	Sarcoma	1	x-ray	45	25	1.8	daily		RCR	D
	Sarcoma		x-ray	55 to 60	28 to 30	~2	daily	5 to 5.6 weeks	RCR	D
Plasmacytoma	Bone		x-ray	45	25	1.8	daily	5 weeks	CRT (B74-1), <i>Practical Radiotherapy Planning 3rd edition</i>	
	Skin		electron	18	1	18	single		QA Portsmouth NHS	
	Skin		electron	35	5	7	daily		QE Birmingham NHS	
	Skin		electron	37.5	5	7.5	daily	5-7 days	QA Portsmouth NHS	

Skin - SCC	Skin	1	electron	40	10	4	daily		CRT (SO16-18), <i>Radiotherapy in Practice External Beam Therapy</i>
	Skin		electron	45	9	5	daily		QE Birmingham NHS
	Skin		electron	45	10	4.5	3 per week		North London Cancer Network (NMH, UCLH RFH)
	Skin		electron	50	20	2.5	daily	4 weeks	EMCN Treatment Protocols
	Skin		electron	55	20	2.75	daily		QE Birmingham NHS
Skin - BCC	Skin	2	electron	37.5	5	7.5	daily	5-7 days	QA Portsmouth NHS
	Skin		photons	40	10	4	daily	2 weeks	Southampton NHS
	Skin		electron	45	10	4.5	daily	12 days	QE Birmingham NHS
	Skin		electron	45	9	5	3 per week	15 days	QE Birmingham NHS
	Skin		electron/ Xrays	50	15	3.33	daily	3 weeks	RCR Guidelines
	Skin		electron	35	5	7	daily	5 days	QE Birmingham NHS
Melanoma	Skin		electron	50	20	2.5	daily	4 weeks	CRT (PO9-30), <i>Practical Radiotherapy Planning 2nd edition</i> CAI (NG5-10) East Midlands Cancer Network (EMCN) policy for Skin-Melanoma CRT (SO16-17), <i>Practical Radiotherapy Planning 4th edition</i>
	Skin		photons	50	20	2.5	daily	4 weeks	
	H & N		x-ray	60	30	2	daily	6 weeks	
Merkel Cell	Skin		electron	35	5	7	daily	1 week	Royal Surrey Skin Protocols version 3 15/5/2012 (AJP 25/2/2017)
	Skin		electron	45	9	5	3#per week	2 weeks	
	Skin		electron	50	25	2	daily	5 weeks	
	skin		electron	55	20	2.75	daily	4 weeks	
	Skin		electron	60	30	2	daily	6 weeks	

Comment	Standard Fields (see CORP RT36 - discuss with Regional Physicist if not using 'standard fields')
WHO Grade III,IV; Dose regime listed as for older patients	VMAT or conformal - discuss with ClinOnc
WHO Grade III,IV; Phase 2: ~15Gy, 2Gy/# over 2 weeks	VMAT or conformal - discuss with ClinOnc
CNS Tumours protocol issued 15th Aug 2012	VMAT or conformal - discuss with ClinOnc
Southampton General Protocol - anaplastic gliomas (astrocytoma or oligodendroglioma)	VMAT or conformal - discuss with ClinOnc VMAT or conformal - discuss with ClinOnc
	VMAT or conformal - discuss with ClinOnc VMAT or conformal - discuss with ClinOnc
	VMAT or conformal - discuss with ClinOnc
	VMAT or conformal - discuss with ClinOnc
RCR: "DAHANCA" regimen	VMAT
RCR: Concomitant Boost	VMAT
RCR: Synchronous Chemotherapy	VMAT
oral cavity, floor of mouth, tongue, oropharynx, nasopharynx boost dependant on nodal involvement	VMAT
IMRT to nasopharynx, oropharynx, hypopharynx, oral cavity	VMAT
SIB- IMRT. Primary RT. Includes Oropharynx (including tonsil, tongue, soft palate), Hypopharynx, Larynx, Nasopharynx, Oral cavity (including oral tongue, floor of mouth, buccal mucosa, retromolar trigone, mucosa of upper and lower alveolus, hard palate) PTV1: High dose PTV, PTV2: Elective PTV. Consider 66-70Gy at 2Gy/# if large PTV1	VMAT
SIB-IMRT. Post-operative RT. Includes Oropharynx (including tonsil, tongue, soft palate), Hypopharynx, Larynx, Nasopharynx, Oral cavity (including oral tongue, floor of mouth, buccal mucosa, retromolar trigone, mucosa of upper and lower alveolus, hard palate) PTV1: High dose PTV, PTV2: Elective PTV. Consider 66-70Gy at 2Gy/# if large PTV1	VMAT
IMRT 65Gy to primary tumour/involved nodes, 60Gy intermediate dose, 54Gy prophylactic dose (e.g. uninvolved nodes)	VMAT
SCC; IMRT	VMAT
IMRT 55Gy to primary tumour/involved nodes, 50Gy intermediate dose (e.g. post-neck dissection/high risk microscopic disease), 46Gy prophylactic dose (e.g. uninvolved nodes)	VMAT
SIB-IMRT. High dose PTV - Primary RT & Post-operative RT. 66Gy/33# (positive margins/ECS). 66-70Gy in daily 2Gy fractions should be considered where large volumes (> 8cm length or more than 1 anatomical subsite are included in the high dose PTV) are to be irradiated due to potential increased toxicity.	VMAT

Surgery & post-operative radiotherapy: T3/T4 Tumours	VMAT
65Gy/30# if significant residual disease. Prophylactic treatment of nodal levels is rarely used	VMAT
Postoperative dose: 60Gy/30# (unless positive margins and / or extracapsular spread, 66Gy in 33# or 65Gy in 30# if significant residual disease)	VMAT
Post op; recommended for adenoid cystic carcinomas	VMAT
Primary treatment or post-operative; Elective nodal irradiation 52Gy/33-30# or 44Gy/20#	VMAT
Post operative; 60Gy/30# accepted for single volume; Elective nodal irradiation 52Gy/33-30# or 44Gy/20#	VMAT
Post Operative; Elective nodal irradiation 52Gy/33-30# or 44Gy/20#	VMAT
Primary treatment; Elective nodal irradiation 52Gy/33-30# or 44Gy/20#	VMAT
Prophylactic dose (e.g. uninvolved nodes). Simultaneous with SCC H&N primary irradiation (excluding Larynx)	VMAT
SIB-IMRT. Oropharynx/Hypopharynx/Larynx: Early disease, medically inoperable, locally advanced, Post-op: Oropharynx T4, hypopharynx / larynx pT3-4 disease, pN2/ N3, extracapsular spread (ECS), positive margins, nodal disease in levels IV or V, perineural / vascular invasion.	VMAT or conformal - discuss with ClinOnc VMAT VMAT or conformal - discuss with ClinOnc
RCR: Small Volume Only	VMAT or conformal - discuss with ClinOnc
	VMAT or conformal - discuss with ClinOnc
QA P'mth specifies 'small volumes'	VMAT or conformal - discuss with ClinOnc
QE specifies 55/20 for primary tumour/involved nodes, 50/20 for intermediate dose (e.g. post-neck dissection/high risk microscopic disease)	VMAT or conformal - discuss with ClinOnc
Royal Surrey- 50Gy/20#	
Dose dependent on length of cord irradiated. 45Gy/25# over 5 weeks is alternative option. 6MV Photons. Prescribed to the ICRU reference Point. Can present in rare instances within pelvic region (as per CRT GU1-38). In this instance case should be referred to CRT as non-standard.	Single PA field
Pre-op, Chemo-Rad	Discuss with Reg Phys (VMAT or conformal)
Adjuvant Radiotherapy. R1 Resection (circumferential margin positive)	Discuss with Reg Phys (VMAT or conformal)
Chemo-Rad	Discuss with Reg Phys (VMAT or conformal)
Chemo-Rad	Discuss with Reg Phys (VMAT or conformal)
Definitive Radiotherapy (RT only) tumours 5cm or less in length	Discuss with Reg Phys (VMAT or conformal)
Definitive Radiotherapy (RT only) tumours 5cm or less in length	Discuss with Reg Phys (VMAT or conformal)

Definitive Radiotherapy (RT only) tumours 5cm or less in length	Discuss with Reg Phys (VMAT or conformal)
Accelerated hypo-fractionated (NCRN SOCCAR)	Discuss with Reg Phys (VMAT or conformal)
concurrent or adjuvant chemo	Discuss with Reg Phys (VMAT or conformal)
continuous hyperfractionated RT (CHART)	Discuss with Reg Phys (VMAT or conformal)
hyperfractionated	Discuss with Reg Phys (VMAT or conformal) Discuss with Reg Phys (VMAT or conformal) Discuss with Reg Phys (VMAT or conformal)
RCR: for selected patients with SCLC prophylactic cranial RT is recommended for achieving good, partial or complete response after chemotherapy	Discuss with Reg Phys (VMAT or conformal)
SCLC Protocol	Discuss with Reg Phys (VMAT or conformal)
after Becker, Latissimus Dorsi or TRAM flap reconstruction	Tangential fields
after Becker, Latissimus Dorsi or TRAM flap reconstruction	Tangential fields
Special situation for locally advanced tumours that are inoperable. the nodal fields do not normally receive more than 24-28.5Gy	Tangential fields
Introduced due to Covid-19 outbreak to fast track patients treatments. 3 year data to be released at ESTRO in August 2020	Tangential fields
Unfit patients with advanced disease to the partial or whole breast only	Tangential fields
Supraclavicular fossa only	Single field
Supraclavicular fossa only	Single field
If the mid-axilla dose is less than 85%, consider daily Post Axilla field in addition to Ant S'Clav field	Single AP field, add PA field if needed
If the mid-axilla dose falls below 80%-85%, consider daily Post Axilla field in addition to Ant S'Clav field	Single AP field, add PA field if needed
mini-tangents	mini-tangents
QE: 5-15Gy delivered in 2-8 fractions Northampton: No modality specified	electron field
	mini-tangents
	electron field
	mini-tangents
	electron field
	mini-tangents

	electron field
	mini-tangents
	electron field
	electron field
	mini-tangents
	electron field
dose used for both electrons & photons	electron field/photons
	mini-tangents
	mini-tangents
	electron field
IMC irradiation can be considered for patients at high risk of LC (T4 and N2-2). It can also be considered for patients with 1-3 axillary macrometastases and central or medial disease. Any referrals outside of these indications must still be referred to CAT.	wide tangentials or VMAT with DIBH where possible. Dose constraints heart V17Gy <10%, ipsilateral lung V17Gy < 35%, Mean contralateral breast <3.5Gy, mean heart dose <6Gy
Post Operative	Tangents with integrated VMAT arc to boost, treated in DIBH
	VMAT or conventional - discuss with ClinOnc
RCR: grade C: 45-46 in 1.8-2Gy daily fractions, over 4.5 to 5 weeks grade D: 40-46Gy in 20-25 fractions	VMAT or conventional - discuss with ClinOnc
60Gy/25# concomitant boost with whole pelvis 45Gy/25#	VMAT or conventional - discuss with ClinOnc
EBRT plus brachytherapy to vaginal vault (8-10Gy/2#/1 week or 10-15Gy/2-3#/1-2 week) Node negative use 45Gy to true pelvis; if External, Internal or Common Iliac nodes +ve use 50.4Gy, 2fields +unilateral or bilateral pelvic side wall boosts, 5Gy/3#/3days; If Para-Aortic nodes +ve use 45Gy/25#/5 weeks to cover extended pelvis + para-aortics +5.4Gy/3# to extended pelvis Medically inoperable Stage I and II, Intrauterine brachytherapy boost 14Gy/2# or 12Gy/3# HDR to serosa	VMAT or conventional - discuss with ClinOnc
Inoperable Stage III, Intrauterine brachytherapy boost 14Gy/2#/8 days to Point A + Unilateral or Bilateral Pelvic Side Wall boost, 5.4Gy/3#/3days	VMAT or conventional - discuss with ClinOnc
Stage I, II and III with no residual disease + HDR cylinder to vaginal vault 8Gy/2#/1 week Stage III with residual disease + CT planned small volume RT to residual tumour, 14.4-19.8Gy/8-11#/ 2 weeks	VMAT or conventional - discuss with ClinOnc
RCR: 40-50.4 in 1.8-2Gy daily fractions over, over 4.5 to 5 weeks with Chemotherapy	VMAT or conventional - discuss with ClinOnc
RCR: with Brachytherapy	VMAT or conventional - discuss with ClinOnc
Stage1B1 and IIA1; HDR tube and ovoids, 14Gy/2#/1 week to pt A	VMAT or conventional - discuss with ClinOnc

Stage IB2 and IIA2; HDR tube and ovoids, 14Gy/2#/1 week to pt A	VMAT or conventional - discuss with ClinOnc
RCC: 40-50.4 in 1.8-2Gy daily fractions over, over 4.5 to 5 weeks <i>with Brachytherapy where possible (possibly chemo for stage 2)</i>	VMAT or conventional - discuss with ClinOnc
Stage IIB and IIIB; Stage IVA; HDR tube and ovoids, 14Gy/2#/1 week + unilateral or bilateral PSW boost 5Gy/3#/3 days	VMAT or conventional - discuss with ClinOnc
Stage IIIA; HDR tube and cylinder, 8-12Gy/2#/1 week	VMAT or conventional - discuss with ClinOnc
Stage IVB; parallel-opposed, or P/A field matched to pelvic field	VMAT or parallel-opposed, or P/A field matched to pelvic field
4 fields (Dose reduced to 45Gy/25# in the elderly or unfit); Brachytherapy post EBRT	VMAT or conventional - discuss with ClinOnc
Stage II, node negative; Ph1 EBRT, Ph2 Brachytherapy 10-15Gy/2-3#/3-8days	VMAT or conventional - discuss with ClinOnc
Stage III-IVB or stage II node positive; Phase 2 alternative, HDR 10-15Gy/2-3#/3-8days	VMAT or conventional - discuss with ClinOnc
post-operative RT to inguinal & pelvic nodes	VMAT or conventional - discuss with ClinOnc
Phase I (45Gy/25#/5weeks) conformal plan, anterior or posterior parallel opposed fields or direct electron field. Consider Bolus. Phase II (15Gy/7-8#/2weeks +/- additional 5Gy if macroscopic disease) individualised according to disease (3 field, parallel opposed or direct electron)	VMAT or conventional - discuss with ClinOnc
RCC: chemoRT <i>possible surgery or second phase brachytherapy total dose 60-65Gy</i>	VMAT or conventional - discuss with ClinOnc
pre-op, followed by surgery within one week	VMAT or conventional - discuss with ClinOnc
pre-op, followed by surgery 6-10 weeks later	VMAT or conventional - discuss with ClinOnc
post-op	VMAT or conventional - discuss with ClinOnc
pre-op, followed by surgery 6-10 weeks later, RCC describe 2 phases, CPUK may deliver this in one IMRT phase including simultaneous <i>integrated boost</i> post-op, RCC describe 2 phases, CPUK may deliver this in one IMRT phase including simultaneous <i>integrated boost</i>	VMAT or conventional - discuss with ClinOnc
Oxford Rectum Protocol - SIB dose 52Gy to treat areas of unresectable disease e.g. pelvic side wall.	VMAT
Primary tumour +/- any involved extra-mesorectal LNs	VMAT
	VMAT
SIB; Involved nodes (~9Gy boost)	VMAT

ChemoRad	VMAT or conventional - discuss with ClinOnc
ChemoRad	VMAT or conventional - discuss with ClinOnc
ChemoRad shrinking field technique, CPUK may deliver as IMRT single phase	VMAT or conventional - discuss with ClinOnc
ChemoRad, 2 phase RT technique, CPUK may deliver as IMRT single phase	VMAT or conventional - discuss with ClinOnc
IMRT; Gross anal disease; T1N0 or T2 N0 (and T3N0 at clinicians discretion)	VMAT
IMRT;Gross anal disease; T4N0 or Tany N+ (and T3N0 at clinicians discretion), up 56Gy/28# at clinicians discretion supported by the PLATO trial.(AJP/CM 24/2/17)	VMAT
High Risk (T3+, N1+), IMRT SIB	VMAT
IMRT; Elective nodes; T1N0 or T2 N0 (and T3N0 at clinicians discretion) or T4N0 or Tany N+ (and T3N0 at clinicians discretion)	VMAT
High Risk, No HDR/ N>3cm,elective nodes, IMRT SIB	VMAT
IMRT; Gross nodal disease; T4N0 or Tany N+ (and T3N0 at clinicians discretion)	VMAT
High Risk, No HDR/ N>3cm, involved nodes, IMRT SIB	VMAT
Urology Protocols	VMAT or conventional - discuss with ClinOnc
with subsequent boost	VMAT or conventional - discuss with ClinOnc
CKI including K.Sikora, K.Alonzi, S.Hynd, J.Pettinger approved to add this dose on 2/11/14, accepting the rationale that OAR doses are delivered in the standard 37#, and that 78Gy to prostate is very acceptable. P. Shaffer has written to confirm he is using this as a standard dose at	VMAT
Prostate only + Brachytherapy boost	VMAT
High Risk- Clinical T3a, MRIT3b; PSA >20; Gleason 8-10 (any one)	VMAT
Accepted in the new Genescare Protocol	VMAT
Non SABR arm of PACE Trial been adopted for Clinical use at Leicester Royal	VMAT
Radical EBRT to the prostate only followed by i-125 seed implant. If nodes and seminal vesicles are to be treated with IMRT/RA then 50Gy/28# daily is used	VMAT
patients also having HDR boost	VMAT

(ASCENDE-RT trial ,Journal of Clinical Oncology 2015 33:7_suppl, 3-3)	VMAT
Radical EBRT to the prostate only followed by i-125 seed implant. If nodes and seminal vesicles are to be treated with IMRT/RA then 50Gy/28# daily is used	VMAT
EBRT - 37.5Gy/15# + HDR - 15Gy/1# (EBRT or HDR delivered first) Lymph node dose described (refer to protocol).	VMAT
HDR 15Gy/1# + EBRT 50Gy/25# to prostate / seminal vesicles and pelvic lymph nodes	VMAT
If nodes and seminal vesicles are to be treated with IMRT then dose/# should be used	VMAT
patients also having HDR boost	VMAT
IMRT, Simultaneous with PTVprostate receiving 74Gy/37#	VMAT
CRT including K.Sikora, R.Alonzi, S.Hynd, J.Pettingell approved to add this dose on 27/11/14 as this is so similar to 59.2Gy in 37#. Will continue to try to obtain written protocols from Trusts. See CRT GU1-47. 28/11/14 - Protocol received	VMAT
simultaneous with Prostate + base of seminal vesicles receiving 74Gy (Intermediate Risk)	VMAT
IMRT, Simultaneous with PTVprostate receiving 74Gy/37#	VMAT
simultaneous with Prostate only receiving 74Gy (Low risk)	VMAT
Simultaneous with prostate to 78Gy/39# and 70Gy/39# to enlarged lymph nodes boost	VMAT
simultaneous with prostate to 74Gy	VMAT
simultaneous with prostate to 72Gy and 64Gy to SVs	VMAT
Pelvic nodes	VMAT
Genesiscare Prostate Protocol	VMAT
	VMAT
	VMAT
	VMAT
Boost to visible gross disease	VMAT
Boost to visible gross disease	VMAT
simultaneous with 66/33 to prostate bed	VMAT
Elective nodal irradiation; simultaneous with 66Gy/33# to prostate bed	VMAT
Involved Pelvic nodes, Post Operative, simultaneous with 66Gy to Prostate Bed	VMAT

Pelvic nodes, Post Operative, simultaneous with 66Gy to Prostate bed	VMAT
	VMAT or conventional - discuss with ClinOnc
may be to PA region only	single PA field or parallel opposed fields - discuss with ClinOnc single PA field or parallel opposed fields - discuss with ClinOnc
+5-10Gy in 2-5 x 2-2.5 Gy fractions boost to visible disease x5/week; MPD; Stage 2	parallel opposed fields
+ 5-10Gy in 2-5 x2-2.5Gy# x5/wk boost to residual/recurrent mass; MPD; Residual Disease / Relapse	parallel opposed fields
concurrent chemotherapy	VMAT VMAT
Undetectable disease after short course chemotherapy	VMAT or conventional - discuss with ClinOnc
also chemo (RCR also mentions 20/10 depending on chemo)	VMAT or conventional - discuss with ClinOnc
residual disease after partial response to Chemotherapy	VMAT or conventional - discuss with ClinOnc
combined modality therapy	VMAT or conventional - discuss with ClinOnc
	VMAT or conventional - discuss with ClinOnc
Non cutaneous NHLs only	VMAT or conventional - discuss with ClinOnc
definitive or post-op	VMAT or conventional - discuss with ClinOnc
pre-op,	VMAT or conventional - discuss with ClinOnc
post-op, RCR describe 2 phases, 50/25 followed by boost of 10Gy for patients with low risk of recurrence or 16Gy for higher risk.	VMAT or conventional - discuss with ClinOnc
High dose palliation	VMAT or conventional - discuss with ClinOnc
RT only (no evidence of metastatic disease)	VMAT or conventional - discuss with ClinOnc
Microscopic Disease	VMAT or conventional - discuss with ClinOnc
Gross Disease	VMAT or conventional - discuss with ClinOnc
Solitary bone plasmacytoma	VMAT or conventional - discuss with ClinOnc
also found in QEH protocols	electron field
	electron field
Field size ≤ 3cm; Field size >3cm and ≤ 5cm (elderly patients)	electron field

	electron field
	electron field
Skin dose to 95% or more, encompass the target depth with the 90% isodose	electron field
	electron field
	electron field
Field size \leq 3cm; Field size $>$ 3cm and \leq 5cm (elderly patients)	electron field
electron doses require a 10% increase of dose per fraction compared with photons, to allow for the corresponding reduction in RBE	conventional multi-field plan - discuss with ClinOnc
	electron field
	electron field
	Plan or direct electron
	electron field
Post Op-Melanoma	electron field
no stipulation on photons or electrons	discuss with clin onc
Post Op-Melanoma; *treated concurrently with nodal dose 54Gy/30#. Nodal dose added to RT37	VMAT

choice of modality is a the clinicians discretion depending upon tumour site, size and depth