

**Q&A Session**  
**Radiology and Radiation (R&R)**  
 December 14, 2023

#	Question	Answer
1.	Can you please tell me how to document the summary for this case please? (num of phases of radiation and total dose) 9/12/22 TO 10/14/22 TREATED WITH 6570 CGY/25 F AT 270 CGY/F IMRT TO PROSTATE. TREATED WITH 5000 CGY/25 F AT 200 CGY/F TO SEMINAL VESICLES, IMRT. TREATED WITH 4500 CGY/25 F AT 180 CGY/F TO PELVIC LNS, IMRT.	Based on the information provided here, it appears that this treatment was delivered via SIB (Simultaneous integrated boost). Working on that assumption, this looks to be a 3-phase treatment (a separate phase for each GTV plan). When SIB is used, the total dose is the highest GTV dose administered, 6570 cGy in this case.
2.	How would you code gamma tiles of the brain? What are gamma tiles?	Gamma tiles consist of Cs-131 radioisotopes that are surgically inserted into the post-surgical cavity in the brain. As such, it should be coded to LDH intracavitary brachytherapy (08). Volume is partial brain (1).
3.	What radiation modality is coded for DART followed by seed implant when treating prostate cancer?	Pending response
4.	Just confirming that Rads for Pancreatic cancer has been recently approved for reportability going forward?	That is not correct. Pi-RADS refers to Prostate. Pi-RADS 4 or 5 have been reportable to SEER since 2017.
5.	Text Tip - include the applicable Rads score (if you have it) in your x-ray text, it only take a few seconds to type this	Great tip!
6.	Are you saying that for SEER states we can abstract a case if we only have PI-rads, LI-Rads, etc. We don't need the biopsy?	That is correct
7.	I will often see "lymphadenopathy" mentioned in radiology report with no other specification, but the next physician visit will mention mets to LN. Do we go by that physician statement in staging LN?	If a physician interprets lymphadenopathy has metastatic lymph nodes, then I would consider them malignant.
8.	I have noticed that most lung cancer involves the right lung more so than left, is there a reason?	I found an interesting article on the topic! <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6397910/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6397910/</a>

9.	I missed a few minutes at the beginning, but did you discuss with Dr. Christensen how registrars use ambiguous terminology to identify reportable cases and the pitfalls with that in some cases if that is all that is in the medical record?	We did not discuss the use of ambiguous terminology.
10.	Going back to the PI-rads question for SEER. If we have this on a scan, but there is NO path report done, we can still go ahead and report that in a SEER state?	Yes. It's my understanding it would be picked up as a non-analytic case (assuming you did no further w-up or tx). Report to the central registry, not to CoC.
11.	What class of case should be coded for RADS cases that are reportable only for SEER?	If the patient only had the imaging done, then I would probably assign class of case 30.
12.	Why do some patients with H&N cancers have to have teeth extractions before XRT?	All patients who are about to undergo H&N radiation treatments are referred to a dental consult. If the patient needs dental work, the time is before the start of RT treatments. Patients who have diseased teeth or gum can potentially suffer from serious side effects after being irradiated. The most serious concern for a radiation oncologist is the potential for the patient to develop osteoradionecrosis of the mandible. All H&N patients must be cleared by a dentist prior to the start of treatment.
13.	I have a lung cancer case that received SBRT 6000cGY in 400cGy dose per fraction using photons. The finished letter also stated IMRT was utilized. What would be coded as the planning technique?	Here is the catch; to deliver SBRT treatment, you need an IMRT plan. Code the highest code in the STORE manual, which is 06-SBRT.
14.	How is anxiety/claustrophobia managed? I can't breathe just looking at some of these positioning devices :(	Radiation positioning devices can certainly be problematic for those with anxiety and claustrophobia. I would explain the importance of the immobilization devices and ensure that they were in control. There are cameras and intercoms systems to communicate with the patient the entire time that they are immobilized. If they need a break, I will give it to them. I would also talk to them the entire time to help distract them, let them know how great they were doing and how they were almost done. Some patients need medication to relax. It's rare but they can also be given sedation. When sedation is used it is

		usually a pediatric patient. Patients are typically only in the positioning devices for a few minutes. The key to helping patients get through those few minutes starts with developing a trustworthy relationship prior to using the immobilization devices.
<b>15.</b>	In some cases, I've abstracted, I've noticed over the course of EBRT that some fractions will differ in dose, but when we record/abstract, we are simply dividing total dose by the fractions to get each fraction's dose. Is this averaging of the doses just a way to simplify our reporting of the treatment?	Without additional information, it's a tough question to respond to. A likely scenario is Simultaneous Integrated Boost (SIB). I would refer to you the RT Guide in the STORE manual, which does contain an example of SIB coding.
<b>16.</b>	Is Varian Ethos the only machine that does online adaptive RT? How long has online adaptive RT been around?	All major Linac manufacturers have equipment in the market that can deliver online adaptive RT. Some linacs are CT-based (Ethos), while others are MRI-based (Elekta Unity & Mridian). The recent development spear-headed by Varian with their Ethos Linac is the ability to perform online adaptive RT within the normally allotted treatment time of 15 minutes. Off-line adaptive RT has been around much longer than the online version due to the restrictive lengthy time required for the patient to remain on the treatment couch while a new plan was being generated.
<b>17.</b>	Is there a list with the abbreviations and what they stand for?	The RT Guide does contain an appendix with the most common RT-related abbreviations; unfortunately, the list continues to grow unabated.
<b>18.</b>	What types of issues can you have with your heart from radiation exposure?	Firstly, it's important to note that any side-effect, whether acute or chronic, is dose related. This is why it's critical to minimize dose to organs at risk. Regarding cardiac toxicities, you can potentially have injuries to the coronary arteries, myocardium/pericardium, and heart valves. The severity of the damage to each depends on how much radiation each component of the heart was exposed to.

19.	<ul style="list-style-type: none"> <li>I seem to recall at some point there is planning in place to develop a standardized report for radiation end of treatment summary reporting, is there any update to this?</li> <li>Do any standard setters have a plan or discussion for a universal end of treatment summary similar to the operative standards?</li> </ul>	Progress is being made to standardize the end of treatment summary. It is quite the process to make happen. We are definitely working on it.
20.	I'm sorry for being confused, but I will see one fraction w/ 180cGy and the next fraction 250. When we code it, we can only put the average dose of each fraction. I just wasn't sure if this accuracy mattered in abstracting?	I will need to see the details of the case to interpret it and provide some insight.
21.	Don't we have to have a statement from the MD that chemotherapy is being used as a radiosensitizer in order to be considered a radiosensitizer and not coded as chemotherapy?	Some chemotherapy agents will always act as a radiosensitizer. The question is if the chemotherapy is given at a low enough dose that it should not be coded as chemotherapy. Physician input on that would be helpful.
22.	What role do you think artificial intelligence will play in the future for treatment planning?	If you ask Varian, they will tell you it's already here playing a significant role assisting radiation oncologist and treatment planners/medical physicist with their workload. At this time, AI can contour PTVs and OARs. The role of AI will continue to grow in ways that few of us can anticipate.
23.	I assume the Cerro blocks didn't absorb any of the radiation?	On the contrary, a Cerrobend block has the equivalence of 5 half-value layers, meaning that it attenuates the beam intensity to around 3% of the original intensity (Transmission factor of about 3%). What this means is that any tissue below the Cerrobend block still receives about 3% of the dose. The role of the Cerrobend block is to block the primary beam and focus it on the primary target. The multi-leaf collimators that have replaced Cerrobend blocks in a modern Linac have a transmission factor of about 2%.