Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 1. Please select your centre ID number (provided by the RCR):

* 2. Please select your centre name:

* 3. Please enter your email address:

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

GTV to CTV margins

Primary site

* 4. Use the ‘5+5’ technique to generate CTVs for well-defined head and neck cancer in oropharynx: a volumetric expansion of 5 mm from GTVp to define the high-dose CTV and a 10 mm margin from GTVp for a lower-dose CTV.

- ◯ Complete adoption > Q6
- ◯ Non or partial adoption > Q5

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 5. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 6. Use of 5+5 technique to generate CTVs for well defined head and neck cancer in sites other than oropharynx:

- ◯ Complete adoption > Q8
- ◯ Non or partial adoption > Q7

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 7. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 8. Consider using larger margins from GTV (eg 10–15 mm) if there are concerns regarding the certainty of GTVp determination based on the quality of imaging or clinical information.

- ◯ Complete adoption > Q10
- ◯ Non or partial adoption > Q9

Consensus statement implementation v5

* 9. Reasons of non or partial adoption

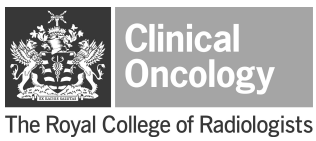
Consensus statement implementation v5

* 10. Edit the CTVs to:
– Exclude air cavities
– Exclude structures limited by anatomical barriers that prevent microscopic disease extension boundaries (eg bone and fascia)
– Include any other region at high risk of containing microscopic tumour.

- ◯ Complete adoption > Q12
- ◯ Non or partial adoption > Q11

Consensus statement implementation v5

* 11. Reasons of non or partial adoption



Consensus statement implementation v5

* 12. Consider using a larger craniocaudal margin (eg 15 mm) from GTV for the lower-dose CTV in the case of hypopharyngeal posterior pharyngeal wall tumours, due to the risk of submucosal extension.

- ◯ Complete adoption > Q14
- ◯ Non or partial adoption > Q13

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 13. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Lymph nodes

* 14. Delineate involved nodes with no obvious extra nodal extension as GTVn. Expand GTVn by 5 mm to form the high-dose CTVn, editing from bone and air as for CTVp.

- ◯ Complete adoption > Q16
- ◯ Non or partial adoption > Q15

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 15. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 16. Use a 10 mm margin around nodes with obvious extranodal extension (eg into the sternocleidomastoid muscle) to form the high-dose CTV.

- ◯ Complete adoption > Q18
- ◯ Non or partial adoption > Q17

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 17. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

* 18. Consider a larger margin (up to 20 mm) to include more of an involved muscle above and below the site of infiltration within a lower-dose CTV.

- ◯ Complete adoption > Q20
- ◯ Non or partial adoption > Q19

Consensus statement implementation v5

* 19. Reasons of non or partial adoption

Consensus statement implementation v5

* 20. Delineate the rest of an involved nodal level to form part of a lower-dose CTV, extending at least 10 mm craniocaudally from GTVn.

- ◯ Complete adoption > Q22
- ◯ Non or partial adoption > Q21

Consensus statement implementation v5

* 21. Reasons of non or partial adoption

Consensus statement implementation v5

Unilateral radiotherapy for cancer of the oropharynx

22. Offer unilateral curative radiotherapy for lateralised T1-2 squamous cell carcinoma of the tonsil in an N0 neck or with one involved ipsilateral neck node.

- ◯ Complete adoption > Q24
- ◯ Non or partial adoption > Q23

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

23. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

24. Consider unilateral curative radiotherapy for lateralised T1-2 squamous cell carcinoma of the tonsil with involved ipsilateral nodes but without significant nodal burden after discussing the benefit of reduced toxicity versus the possible risk of a contralateral neck recurrence with the patient.

- ◯ Complete adoption > Q26
- ◯ Non or partial adoption > Q25

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

25. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Reducing the CTV to improve organ sparing

26. Consider omitting the high level II lymph nodes from the elective target volume in an uninvolved contralateral neck when delivering radical or adjuvant radiotherapy for nonnasopharyngeal head and neck squamous cell carcinoma.

- ◯ Complete adoption > Q28
- ◯ Non or partial adoption > Q27

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

27. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

28. Omit the contralateral retropharyngeal lymph nodes from the elective target volume when delivering radical radiotherapy for oropharynx cancer if all the following apply:
– No involved nodes in the contralateral neck
– No ipsilateral involved retropharyngeal lymph nodes
– GTVp does not involve the soft palate or posterior pharyngeal wall.

- ◯ Complete adoption > Q30
- ◯ Non or partial adoption > Q29

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

29. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Adjuvant RT following surgery

30. Offer contralateral neck radiotherapy for patients having adjuvant ipsilateral radiotherapy for oral tongue squamous cell carcinoma who have had surgery to the primary site and an ipsilateral neck dissection if any of the following apply:
– T3 or T4 tumour
– Primary is within 10 mm of the midline
– Two or more pathological lymph nodes in the ipsilateral neck
– Extranodal extension (ENE) is present in the ipsilateral neck.

- ◯ Complete adoption > Q32
- ◯ Non or partial adoption > Q31

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

31. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

32. Consider contralateral neck radiotherapy for patients having ipsilateral adjuvant radiotherapy for oral tongue squamous cell carcinoma who have had surgery to the primary site and an ipsilateral neck dissection if there is a single involved lymph node with no ENE in the ipsilateral neck.

- ◯ Complete adoption > Q34
- ◯ Non or partial adoption > Q33

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

33. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Induction chemotherapy

Non-nasopharyngeal head and neck squamous cell cancer excluding sinonasal tumours

34. Do not offer induction chemotherapy prior to definitive (chemo-) radiotherapy unless:
– There is an urgent need for a rapid response in advanced and symptomatic local disease or
– as part of a protocol for organ preservation.

- ◯ Complete adoption > Q36
- ◯ Non or partial adoption > Q35

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

35. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Nasopharyngeal cancer

36. Consider induction chemotherapy for locoregionally advanced, node-positive nasopharyngeal cancer in suitably fit patients.

- ◯ Complete adoption > Q38
- ◯ Non or partial adoption > Q37

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

37. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Radical reirradiation in head and neck cancer

38. The risk–benefit ratio of radical reirradiation changes with time. Avoid reirradiation in patients who have recurrence with a short latency period (eg within 6–12 months of completing radiotherapy) or with significant late effects.

- ◯ Complete adoption > Q40
- ◯ Non or partial adoption > Q39

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

39. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

40. Treat the GTV with small margins (maximum GTV to CTV expansion of 5 mm). The reirradiated CTV should ideally be less than 50 cm^3.

- ◯ Complete adoption > Q42
- ◯ Non or partial adoption > Q41

Consensus statement implementation v5

41. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

42. Do not include elective nodal areas within reirradiation treatment volumes.

- ◯ Complete adoption > Q44
- ◯ Non or partial adoption > Q43

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

43. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

44. Keep the cumulative spinal cord and other important organs at risk (OAR) doses as low as possible. Ensure a thorough radiobiology evaluation with advice from physicists has taken place with risks considered, discussed with patient and documented.

- ◯ Complete adoption > Q46
- ◯ Non or partial adoption > Q45

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

45. Reasons of non or partial adoption

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

Wish list

* 46. Please provide a wish list of resource or guidance

Vital	
Must have	
Enhancing	
Nice to have	

Clinical Oncology
The Royal College of Radiologists

Consensus statement implementation v5

47. Textbox for clarification of answers/comments

Thank you for completing the audit questionnaire.

All audit data will be held in accordance with the General Data Protection Regulation (2018). You can find out more about our data protection policy and procedures at https://www.rcr.ac.uk/data-protection-policy-and-procedures