

# Specialised Services clinical commissioning policy: Stereotactic radiosurgery/radiotherapy

## Clinical Commissioning Policies



### 1 Please indicate which clinical commissioning policy you would like to comment on:

Stereotactic radiosurgery/ radiotherapy for the treatment of pituitary adenomas [Adults]

## Clinical Commissioning Policies (continued)

### 2 Has all the relevant evidence been taken into account?

No

#### If you selected 'No', please give details:

The review has mainly focused on SRS/SRT and has not reviewed outcomes, including visual toxicity, for CRT series. It would be valuable to have more evidence on whether toxicity is truly lower with SRS/SRT than with modern fractionated radiotherapy techniques. Such an evidence review would distinguish obsolete techniques of CRT (e.g. some cited here were before 1991, probably CT based only) and modern state of the art IMRT and fractionated stereotactic radiotherapy techniques.

### 3 Does the impact assessment fairly reflect the likely activity, budget and service impact?

No

#### If you selected 'No', what is considered to be inaccurate?:

The numbers appear to be optimistic. In 2015/16 provider data showed 103 patients were treated using SRS/SRT and estimates indicate that in 2016/17 116 patients were treated using SRS/SRT. Previous 2013 commissioning policy stated: "It is estimated that about 22% of all previously operated patients (7% persisting and 15% recurring) will sooner or later need radiation treatment. This is equivalent to about 4 persons per one million inhabitants." If the figures of 1100 patients operated per year are fairly robust, this would translate to 22% of 1100 or approximately 240 patients per annum. The impact assessment estimates that up to 400 patients per year will be eligible for SRS/SRT, with the increase due to a clearer definition of the eligibility criteria and the patient pathway compared to the current commissioning statement.

The current criteria have been clarified to state that residual tumours should be growing or so close to the chiasm that SRS might become difficult if they did grow. This is helpful clarification, but it is doubtful it will translate to an almost doubling in numbers.

Many of these tumours are close to the chiasm, treatment of which can potentially result in long term toxicity. If numbers are to increase to the extent envisaged then there needs to be clearer data on toxicity of SRS/SRT relative to fractionated radiotherapy, especially visual toxicity and ideally also cranial vascular toxicity.

### 4 Does the policy proposition accurately describe the current patient pathway that patients experience?

Yes

#### If you selected 'No', what is considered to be different?:

**5 Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposed changes that have been described?**



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None

**6 Are there any changes or additions you think need to made to this document, and why?**

**Are there any changes or additions you think need to made to this document, and why? :**

1. Policy proposition: About this treatment. "The benefit of this treatment over further surgery or conventional radiotherapy is that it is possible to give the tumour cells a high dose of radiation while better protecting the surrounding healthy tissue." And on page 8 "As the radiation is precisely focused on the target area this reduces potential toxicity in the surrounding tissues e.g. the optic apparatus." This is a potentially misleading statement to patients. SRS/SRT may be more harmful than CRT to the optic apparatus if the dose is too high. Some more nuance is needed.
2. There is a possible case for these tumours to go to Tier 3 and 4 providers. The Policy proposition page 16 states : "The service specification states that patients with pituitary adenomas should be referred to designated Tier 1/2 SRS/SRT service providers ..... Clinically complex cases, such as those where the adenoma is close to the optic chiasm, may need to be treated in designated services with particular expertise." Anatomically most of these adenomas are very close to the optic chiasm and the policy clarification states the increased numbers for treatment will come from those whose tumours are "so close to the chiasm that SRS might become difficult if they did grow". A consensus what constitutes "close" to the optic apparatus to consider Tier 3 and 4 referral might be beneficial.
3. Previous commissioning policy stated "The relative risks and benefits of SRS/SRT over conventional fractionated radiotherapy should be discussed with patients on a case by case basis and documented in the case notes." Patients for whom either option is suitable should have the opportunity to discuss fractionated radiotherapy and SRS/SRT with clinicians who practice each (preferably both) of these, ideally in a joint clinic.
4. Audit should include the following data items in addition to those proposed:
  - a. If functioning, type of tumour (hormone secreted)
  - b. Previous surgeries (how many)
  - c. Indication for treatment: growing yes/no, close to chiasm such that future SRS may be difficult, hormone secretion etc.
  - d. Previous radiotherapy – dose, fractions, date completed
  - e. Visual acuity and fields at baseline before SRS/SRT and at follow up points when toxicity is determined
  - f. From radiotherapy planning: treatment technique, Gross Tumour Volume, any margin used to Planning Target Volume, Coverage (proportion of the target volume covered by the prescription isodose), Paddick Conformity Index, Gradient Index, Point max to optic chiasm, Dose to 0.01cc of optic chiasm
  - g. Treatment outcome at least 10 years post therapy also, if possible longer.

## **Final question**

**7 Before completing the survey you must declare any financial or other interests in any specialised services.**

**c:**

The RCR response was compiled with input from clinical oncologists who deliver Tier 1 and 2 SRS under contract to NHS England.