

## Stakeholder Response Form CRG Product Testing

Please complete one response form per consultation document that you wish to provide comments on.

Date	31/07/2017
Respondent's Name	Dr Jeanette Dickson, Vice-President, Clinical Oncology
Respondent's Organisation	The Royal College of Radiologists
Replying on behalf of organisation?	Yes
Document responding to:	Clinical Commissioning Policy Proposition for Stereotactic radiosurgery/ radiotherapy for the treatment of pituitary adenomas (Adults)
Relevant CRG	Radiotherapy CRG

**It is proposed that highly specialised products will go for period of public consultation.  
Please select the consultation level that you consider to be most appropriate.**

2 - up to 12 weeks consultation to include some additional proactive engagement activities during the live consultation period

**Do you have any further comments on the proposed changes to the document?**

1. YES

**If Yes, please describe below, in no more than 500 words, any further comments on the proposed changes to the document as part of this initial 'sense check'.**

Significant concerns around SRS and SRT being commissioned as the best option for treating pituitary adenomas have been received from clinicians experienced in the standard radiotherapeutic management of these tumours as well as in the delivery of SRT and SRS.

Survival and short term outcomes quoted in published evidence cannot be taken as sufficient evidence to implement this technique. Long term control and the potential late effects to optic and vascular structures resulting in disabling consequences need to be further investigated.

These are very slow growing tumours which are often very effectively controlled by surgery and medical treatments. Asymptomatic patients with residual tumour and normal pituitary function (especially those under 50 years) do not need radiation until progression which can be many years in most cases.

Non-functioning adenomas considered for radiation therapy are usually large and close to the chiasm. SRS and SRT are only appropriate for a very limited number of patients in whom optic chiasm and optic nerve, brainstem and cavernous sinus can all be spared. The biological advantages of fractionation with small doses per fraction reduces the risk of visual damage and very late vascular events compared with extremely hypofractionated SRS and SRT.

Functioning adenomas carry a high risk of cerebrovascular events, especially in those with patients with diabetes and hypertension. It is established that patients with pituitary tumours on long term hormone replacement have a 40 fold increased risk of death from cardiovascular and cerebrovascular events. Pituitary adenoma patients can survive a very long time and treating with SRS or SRT with a high dose per fraction will significantly add to this vascular risk.

Highly conformal treatment with longer fractionation is more appropriate in these tumours and adopting the SRS and SRT techniques for immobilisation to further reduce the volume irradiated needs more consideration. Current treatment offers good control with a historically good safety profile. SRS and SRT have not been proven to be more beneficial than standard treatment and should only be considered in very selective patients individually discussed in appropriate MDT, perhaps nationally.

There is minimal data on use of hypo-fractionated SRT. However, conventionally fractionated stereotactic radiotherapy using 25 fractions is the international gold standard and should be considered as the preferred option for long term patient safety for NHS England commissioning policy.

**Please declare any conflict of interests relating to this document or service area.**

n/a