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COMMENTS

Rapid Access Palliation

In Regard to Roos et al.

To the editor: We commend Roos et al on their survey documenting the limited uptake of Rapid Access Palliative Radiotherapy (RAPRT) clinics in Australia and New Zealand (ANZ).[1] The RAPRT concept was developed in Canada and successfully reduced waiting times for palliative radiation therapy (RT). However, since then, we have witnessed advances in RT planning and delivery, including deformable registration techniques, cone beam computed tomography (CT), image guidance, and, where appropriate, complex techniques such as stereotactic body RT.

We agree with Roos that in the ANZ setting, other novel strategies beyond "classical" RAPRT clinics are needed to ensure optimal RT service for palliative patients. They mention CT simulation avoidance, which we developed and introduced in our department in 2018.[2] We have previously published a prospective series after treating 160 patients on this pathway.[3] At present, these numbers have grown to 451 individual patients and 551 courses.

We would like to share updated descriptive statistics of our CT simulation avoidance program to provide further insights into this promising palliative RT paradigm:

- We have now treated 451 individual patients on this pathway, of whom 77 received >1 course.
- On average, 14.5 treatments were delivered per month since pathway start, comprising now 60% to 80% of total weekly palliative cases.
- The median time between consultation and first day of treatment was 5 days (interquartile range, 2−7 days).
- Most received an 8 Gy single fraction (53%). The next most common schedules were 20 Gy in 4 to 5 fractions (26%) and 25 Gy in 5 fractions (11%).
- Of the treatments, 51% were planned using an intensity modulated technique.
- Figure 1 illustrates the statistically[4] and clinically significant[5] pain response in evaluable patients, noting that some patients in cohort A were not treated for pain.

Palliative treatment avoiding CT simulation can deliver high-quality RT safely, conveniently, effectively, and in a timely manner. It also has comparatively less logistical impact, particularly on smaller departments that do not have the economies of scale that justify a dedicated RAPRT clinic. It addresses several RAPRT barriers identified by Roos et al[1] and is particularly attractive in the current COVID-19 climate.

We are actively investigating a variant of this approach in a randomized trial and are working on complementary supportive approaches using interdisciplinary and digital

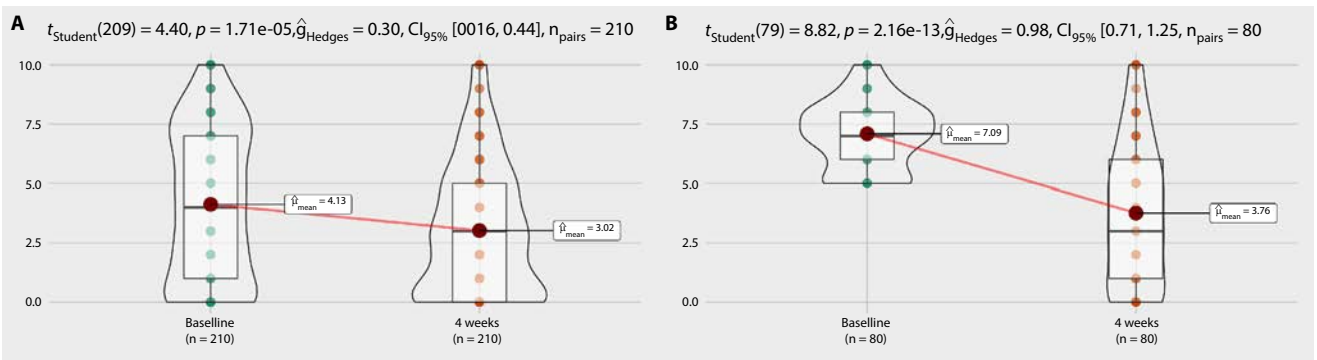

Fig. 1. Pain response in (A) all evaluable patients and (B) the subset with severe osseous pain at baseline (0 = no pain; 10 = maximum pain).

Disclosures: none.

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health strategies. We are looking forward to working together with the ANZ and international palliative RT communities to build the evidence around these modern approaches for the benefit of our patients.

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Nasopharyngeal Carcinoma Reirradiation

In Regard to Ng et al.

To the Editor: Our team of radiation oncologists reviewed the international guidelines on nasopharyngeal carcinoma (NPC) published in the July issue of *International Journal of Radiation Oncology, Biology, Physics.*[1] We find the concept behind this useful publication to be commendable and acknowledge and appreciate the efforts of the guideline's authors. Our team also has a special interest in this tumor site, and we have tried to address a few radiation treatment issues we have encountered in our Joint Commission International Accreditation –accredited tertiary referral university practice.[2]

Certainly, the guideline covers almost all practical areas of clinical issues pertaining to locally recurrent nasopharyngeal carcinoma treated by intensity modulated radiation treatment, but we ask that the authors kindly consider elaborating on the following points to further clarify inferences drawn from the results of their work. Our queries are not critical. In our opinion, further elaboration would enhance readers' understanding of the practical aspects of reirradiation of locally recurrent NPC.

First, with reference to disease-free interval, a new table with stratification of authors' opinions would enhance the understanding of practicing radiation oncologists.

Second, we ask the authors to correlate their findings on the spinal cord as an important organ at risk and further discuss its relationship with first and second total tumor doses delivered to the planning target volume. We also wish to read the authors views on the potential chances of adverse effects related to spinal cord cumulative doses.[3]

Third, for our own better understanding, we ask the authors to elaborate on their discussion of radiation therapy technique used in the first treatment of patients with NPC.[4]

In addition, given that the authors represent almost all regions of the world, we wish to know about the variation in reirradiation practices in endemic and nonendemic regions, and about varying opinions among teaching institutes and nonteaching institutes.

Disclosures: none.