PRINCIPLES and PRACTICE of RADIATION ONCOLOGY

Matthew B. Podgorsak, PhD, FAAPM
Department of Radiation Oncology

OUTLINE

- Physical basis
- History of radiation therapy
- Treatment planning
- Technology of treatment delivery

Radiation

Non-ionizing

visible light
IR, UV

Ionizing

Directly

Charged
Particles

Indirectly

x-rays,
gamma,
neutrons

Ionizing Radiation: X-rays

- Result from extranuclear processes

  - characteristic radiation

  - bremsstrahlung radiation

Ionizing Radiation: Gamma Rays

- Intra nuclear process (RADIOISOTOPE)

  - unstable (radioactive) nucleus decays towards ground state

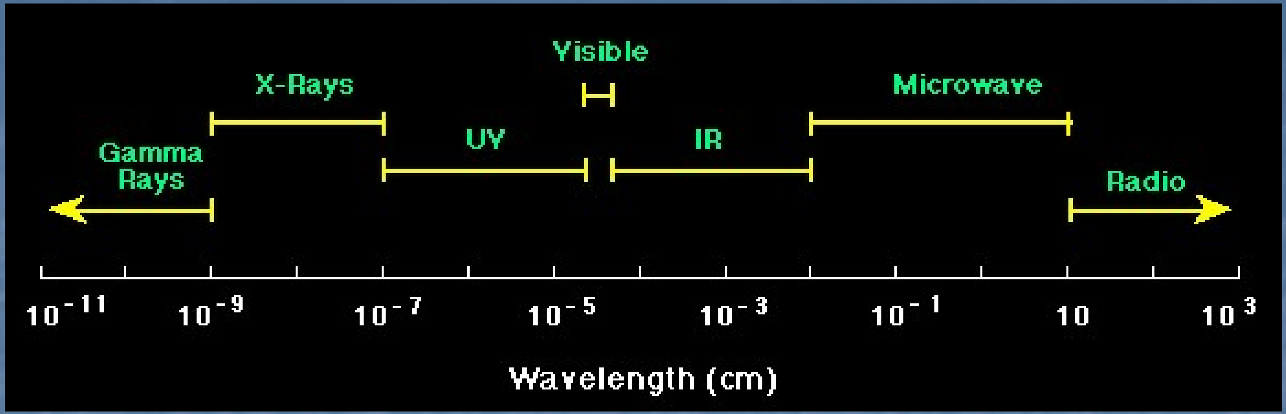
  - parameters characterizing decay:

    $t_{1/2}$, decay constant, specific activity

Common Radioisotopes

Isotope	Half-Life	Energy
Co-60	5.26 yr	1.25 MeV
Cs-137	30 yr	0.661 MeV
I-125	60 d	28 keV
Pd-103	17 d	21 keV

X Rays (photons)



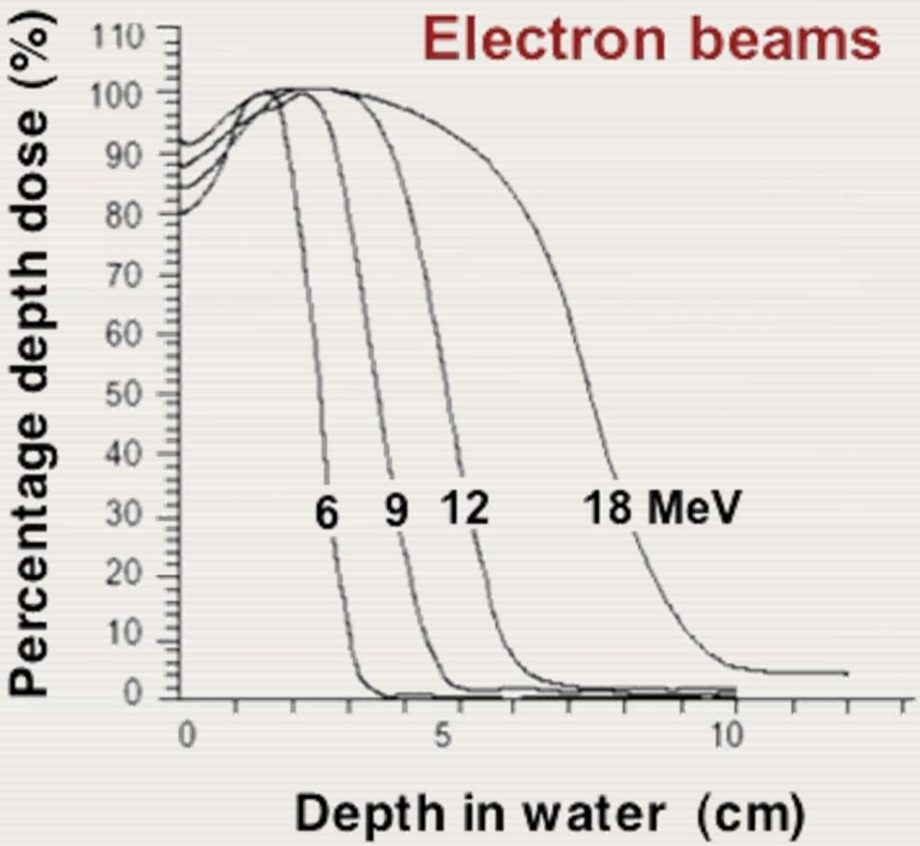
- Interact with matter in well characterized processes:
  - photoelectric interaction
  - Compton interaction
  - pair production
- Infinite range, probability-based interactions

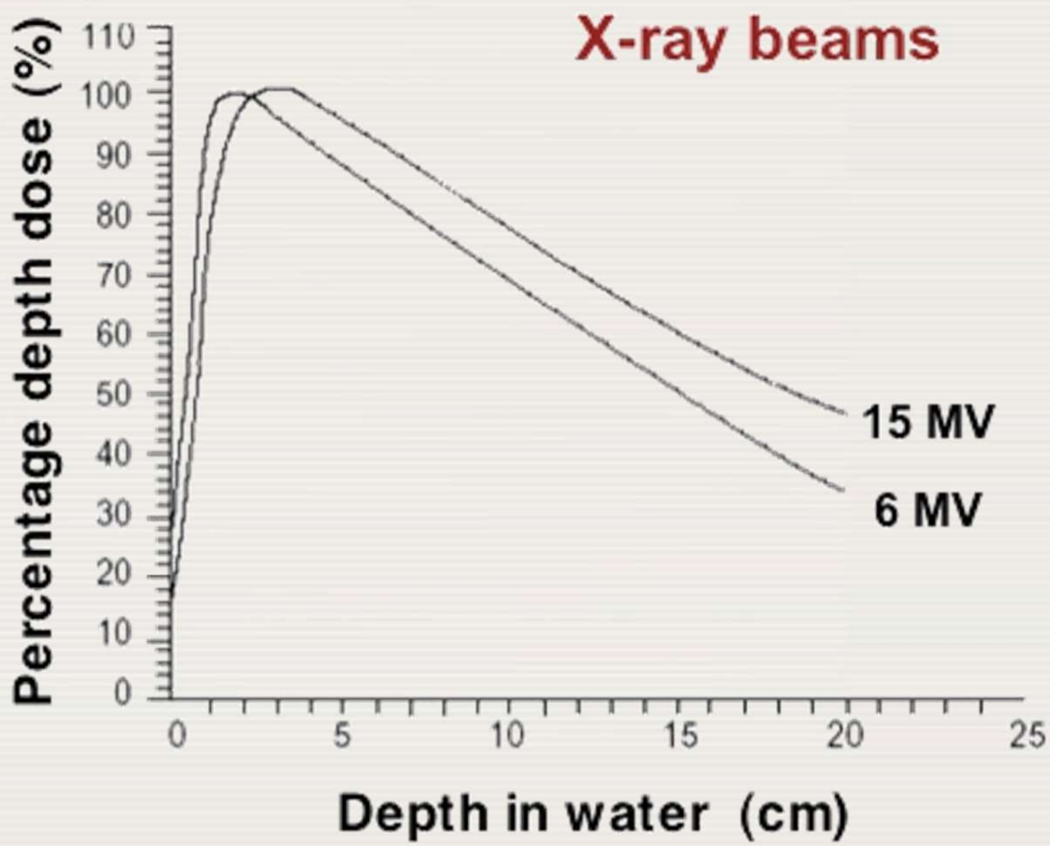
Charged Particles

- Interact via collisional and radiative mechanisms
- Predictable finite range

CENTRAL AXIS DEPTH DOSE DISTRIBUTIONS

- The general shape of the central axis depth dose curve for electron beams differs from that of photon beams.





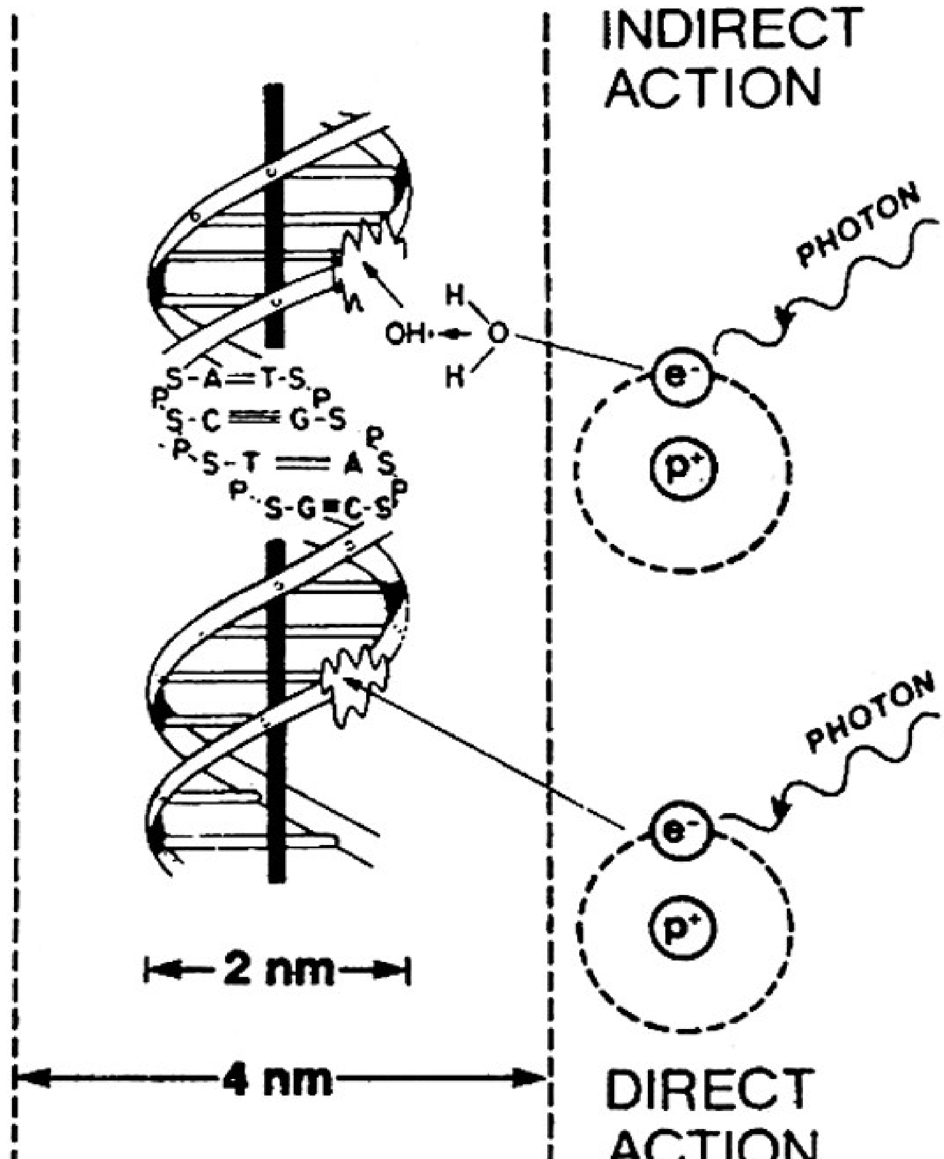
Radiobiology

- Physical deposition of energy leads to chain of reactions which ultimately lead to the observed clinical effect.
- Final energy transfer to material is via energetic electrons and positrons produced in a photon interaction.

Target Theory

- Cell killing is a multi-step process
- Absorption of energy in some critical volume is first step
- Deposition of energy as ionization or excitation in the critical volume leads to molecular damage
- Damage prevents normal DNA replication and cell division

The two mechanisms of cell Kill



Cellular Response

- Loss of function
  - mutation and carcinogenesis
  - interphase cell death (apoptosis)
- Loss of reproductive ability

Tumor Response

- Repair
- Repopulation
- Reoxygenation
- Reassortment

→ 4 R's of Radiobiology

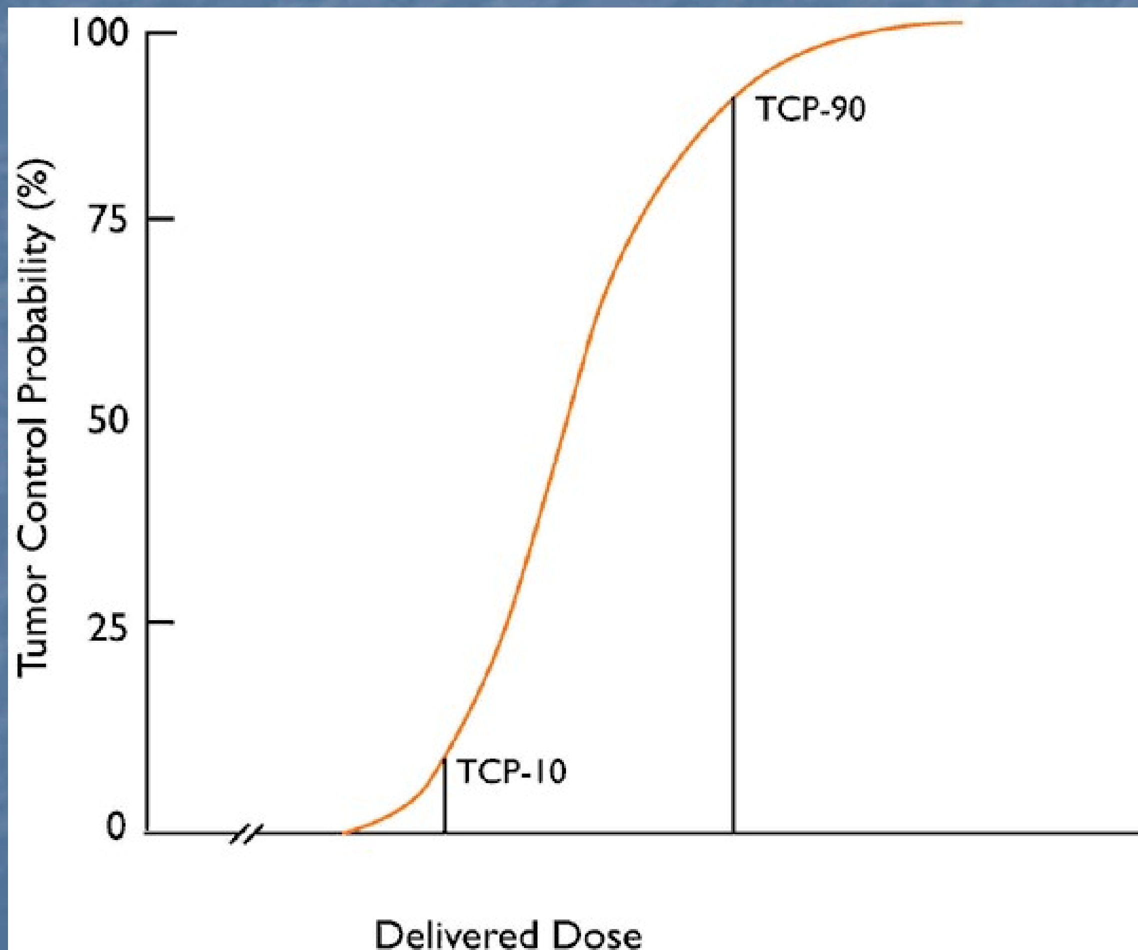
Dose Fractionation

- Dividing a dose into a number of fractions
  - spares normal tissues
    - repair of sublethal damage
    - repopulation of normal cells
  - increases damage to tumor cells
    - reoxygenation can occur
    - reassortment into radiosensitive phases of cell cycle

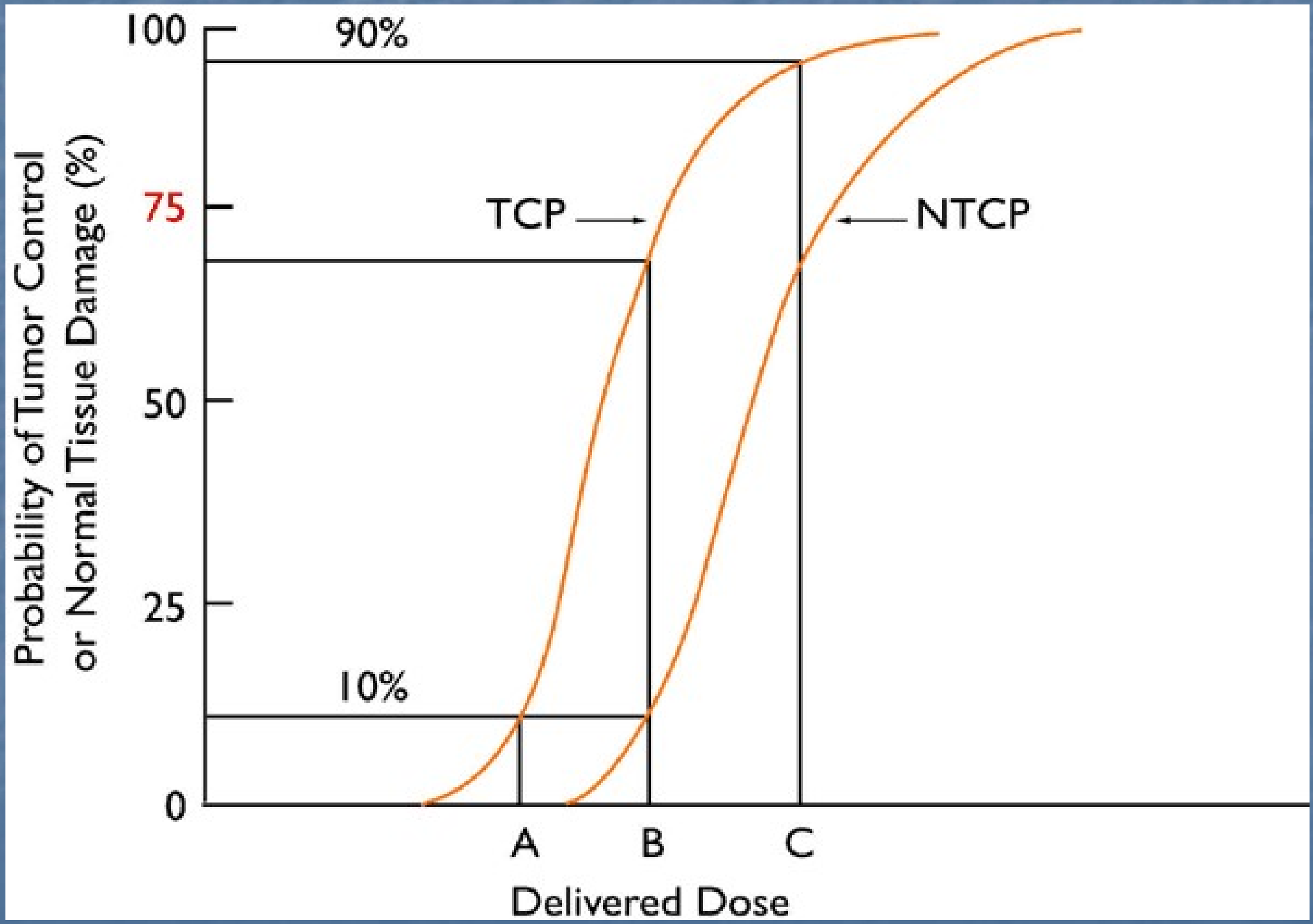
Tissue and Organ Response

- TCP – Tumor Control Probability
  - likelihood of controlling tumor growth
- NTCP – Normal Tissue Complication Probability
  - likelihood of normal tissue complications

Tumor Control Probability (TCP)



TCP vs. NTCP

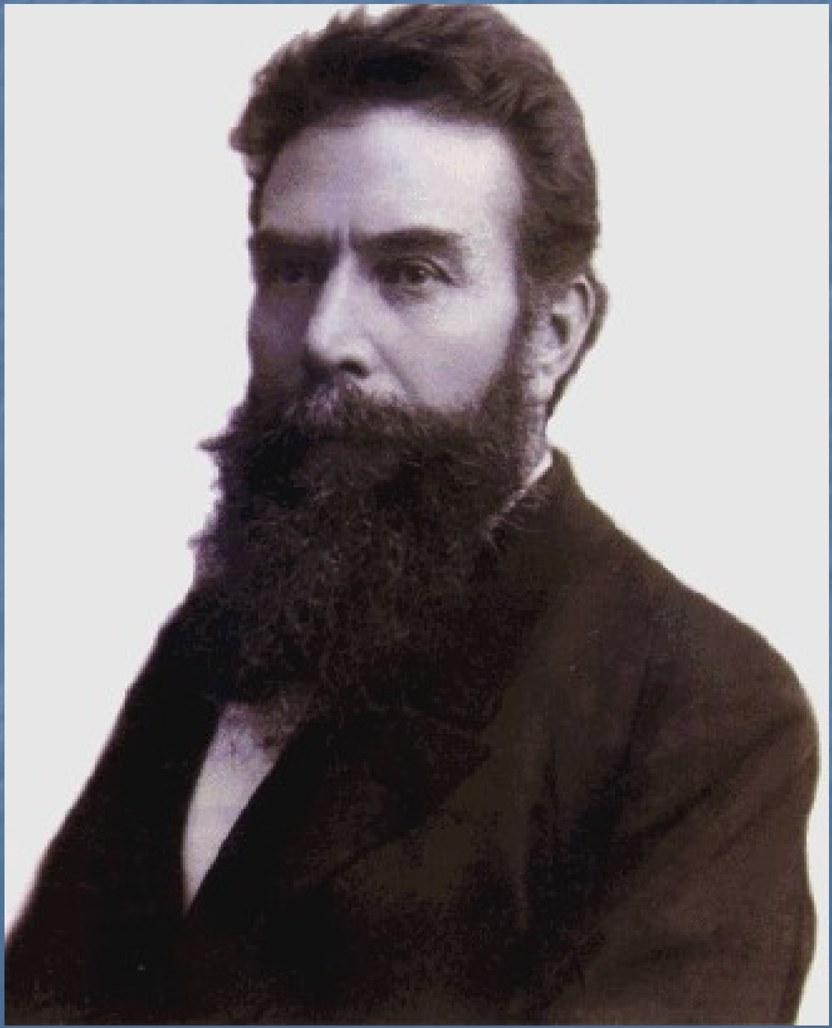

100
90%
75
TCP
NTCP
50
25
10%
0
A
B
C
Delivered Dose
Probability of Tumor Control
or Normal Tissue Damage (%)

Radiation Therapy History

- 1895 Roentgen discovers x-rays
- 1896 Becquerel discovers radioactivity (uranium)
- 1898 Marie Curie discovers Ra-226
- 1901 Pierre Curie self-induced radium burn on arm
- Biological effect of radiation exposure evident almost immediately
- Early radiation therapy using radium (interstitial, intracavitary, surface applicators)

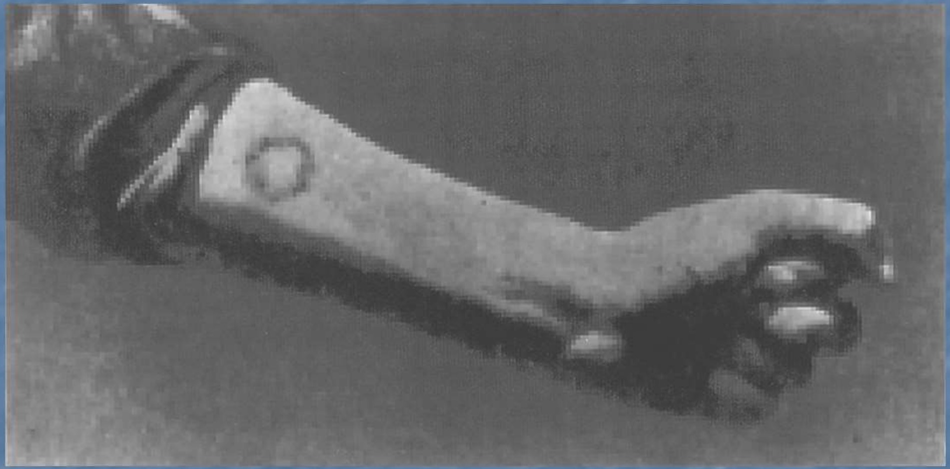
Discovery of X-rays

On 8 Nov 1895, Wilhelm Conrad Röntgen (accidentally) discovered an image cast from his cathode ray generator.



- The study and use of ionizing radiation in medicine started with three important discoveries:
  - X rays by Wilhelm Roentgen in 1895.
  - Natural radioactivity by Henri Becquerel in 1896.
  - Radium-226 by Pierre and Marie Curie in 1898.

Guinea Pig Physicist!

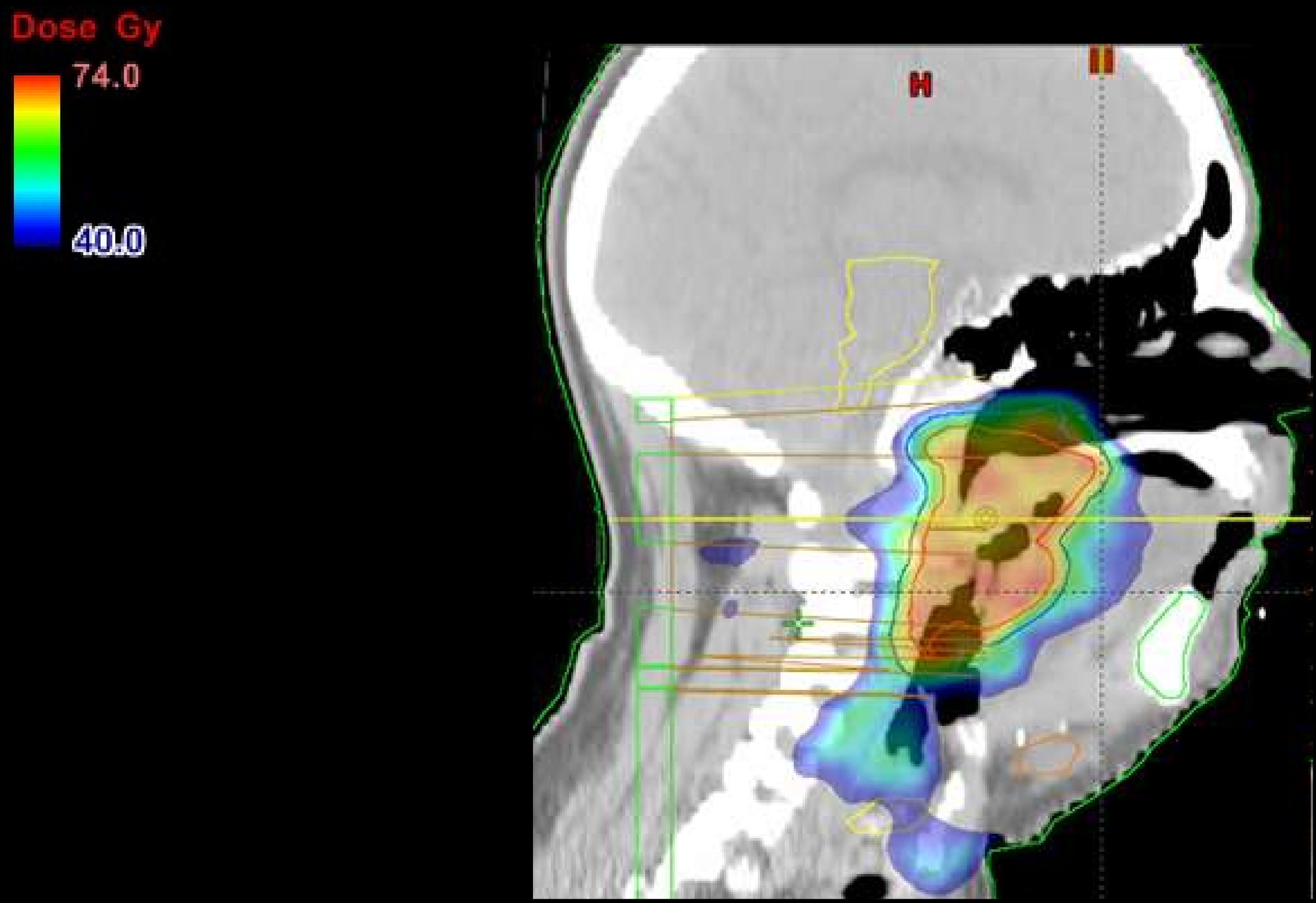


- Self induced radiation burn on Pierre Curie’s arm, 1901
- Experiment with biological application of radioactivity…first indication of biological effect?

Early Radiation Therapy

- Early surface applicator, 1922
- Lack of rigorous quantitative dosimetry
- Disregard for radiation safety procedures

Dose distribution



Modern Radiation Therapy Team

- Radiation Oncologist / Resident
- Medical Physicist / Resident
- Dosimetrist
- Radiation Therapist
- Nurse
- Social Worker
- Administrator

Goal of radiation therapy

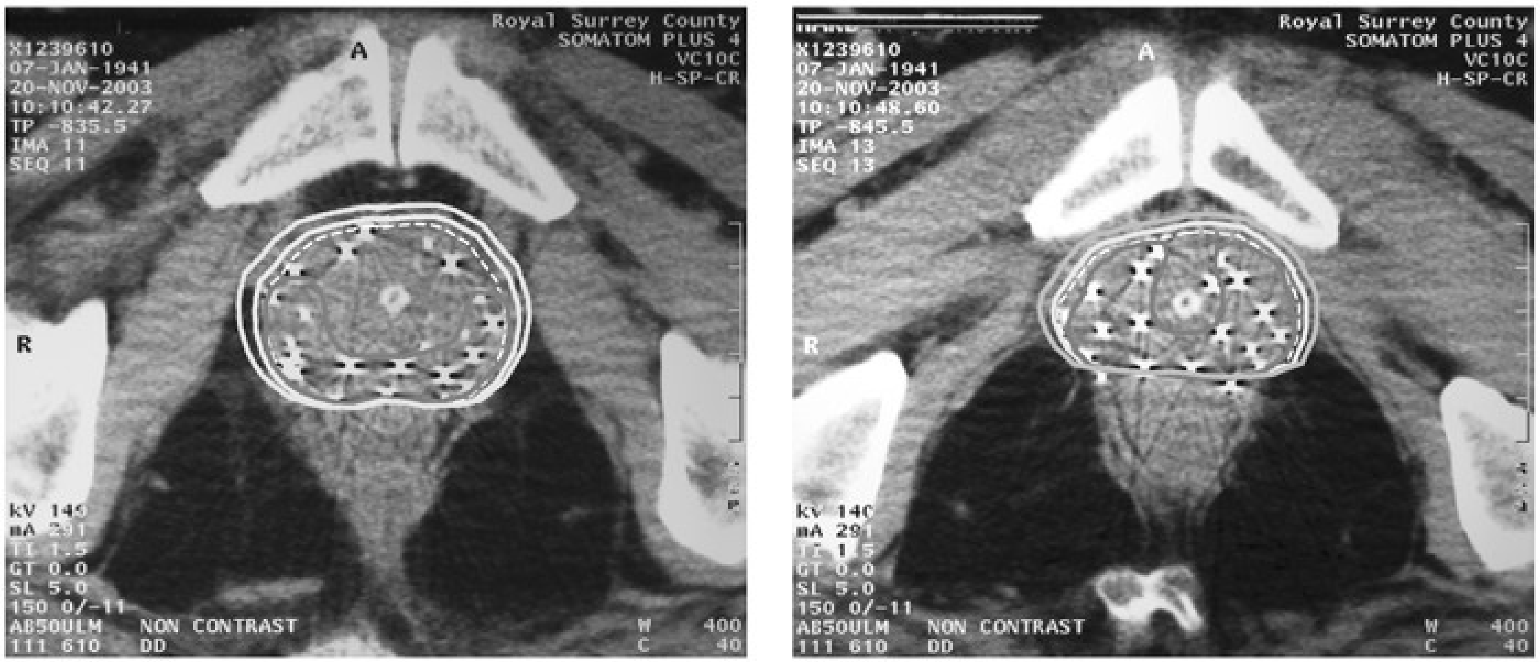
- “concentrate dose to target tissues and minimize dose to healthy tissues”

Radiation Therapy

- Brachytherapy – therapy at a short distance
  - sources placed directly into tumor volume
- Teletherapy – therapy at a large distance
  - source outside body

Review of Brachytherapy Principles

- Highly localized dose to target with sharp fall-off in surrounding tissues
- The ultimate conformal therapy?
- Inherent inhomogeneity and hot spots



Mid gland

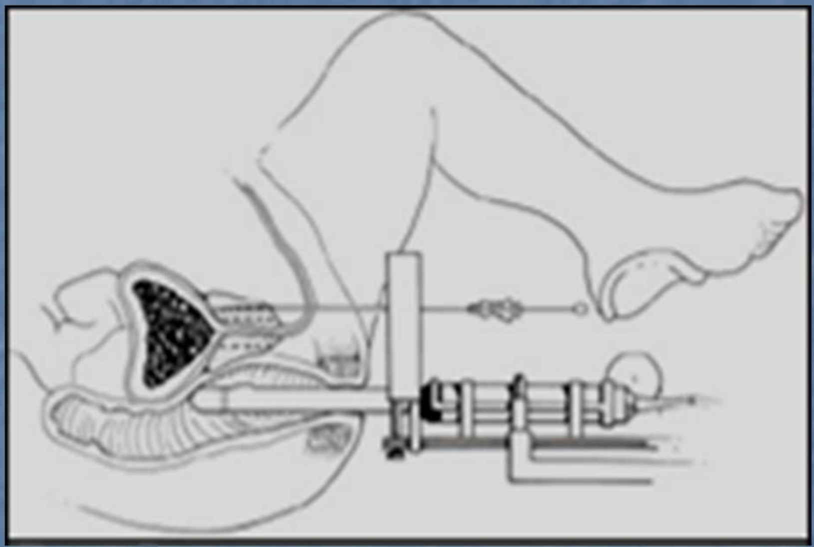
Apex of gland

Brachytherapy Clinical Applications

- Historically, brachytherapy has been applied clinically to many anatomical sites
- e.g., eye, head and neck, brain, skin, bronchus/lung, esophagus, breast, prostate, female pelvis (gyn), soft tissue (sarcoma), and others...

Prostate Brachytherapy

1970's MSKCC



TRUS-guidance (early '90's)

Post-Implant Dosimetry

Post-implant imaging for verification and dosimetry

Plane Film (2D)

CT (3D)

Other Brachytherapy

HDR esophagus

Typically 5 Gy/fx in 3-7 minutes

Other Brachytherapy

Base of tongue

Typically 1-4 day treatment

Teletherapy
Energy Categories

- Superficial (10 – 80 kVp)
- Orthovoltage (100 – 500 kVp)
- Megavoltage (Co-60 – 35 MV)

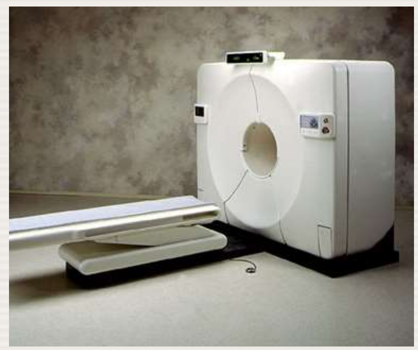
MEDICAL LINEAR ACCELERATOR

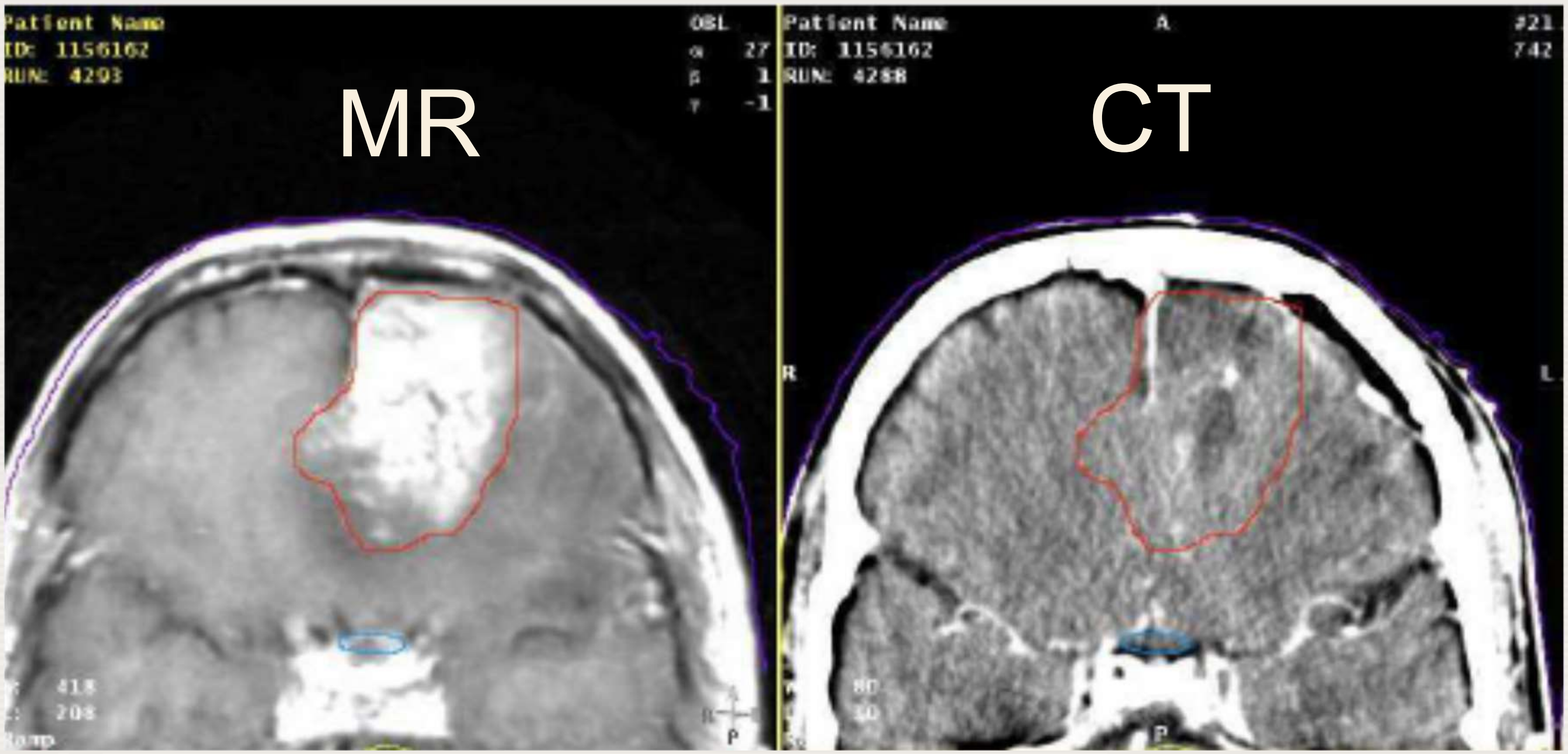
Patient flow in radiation therapy

- Consultation / Informed consent
- Treatment simulation
- Treatment planning
- Simulation check / port film
- *in vivo* dosimetry

Imaging for target localization

- **1970s CT scanner**
  - **Allan Cormack**
  - **Godfrey Hounsfield**
    - **Nobel Prize 1979**
- **1973 PET scanner**
  - **Edward J. Hoffman**
  - **Michael E. Phelps**
- **1980s MR scanner**
  - **Paul C. Lauterbur**
  - **Peter Mansfield**
    - **Nobel Prize 2003**





On the left is an MR image of a patient with a brain tumour. The target has been outlined and the result was superimposed on the patient's CT scan. Note that the particular target is clearly seen on the MR image but only portions of it are observed on the CT scan.

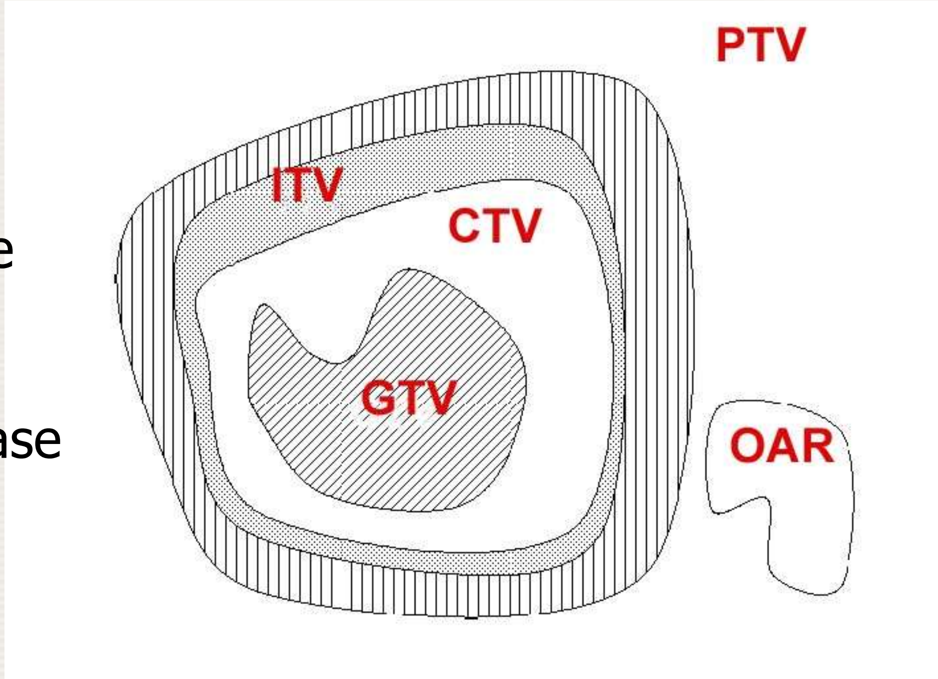
TREATMENT VOLUME DEFINITION

GTV – gross tumor volume
palpable or visible extent of disease

CTV - clinical target volume
GTV + subclinical microscopic disease

ITV - internal target volume
CTV + margin for organ motion
e.g., breathing

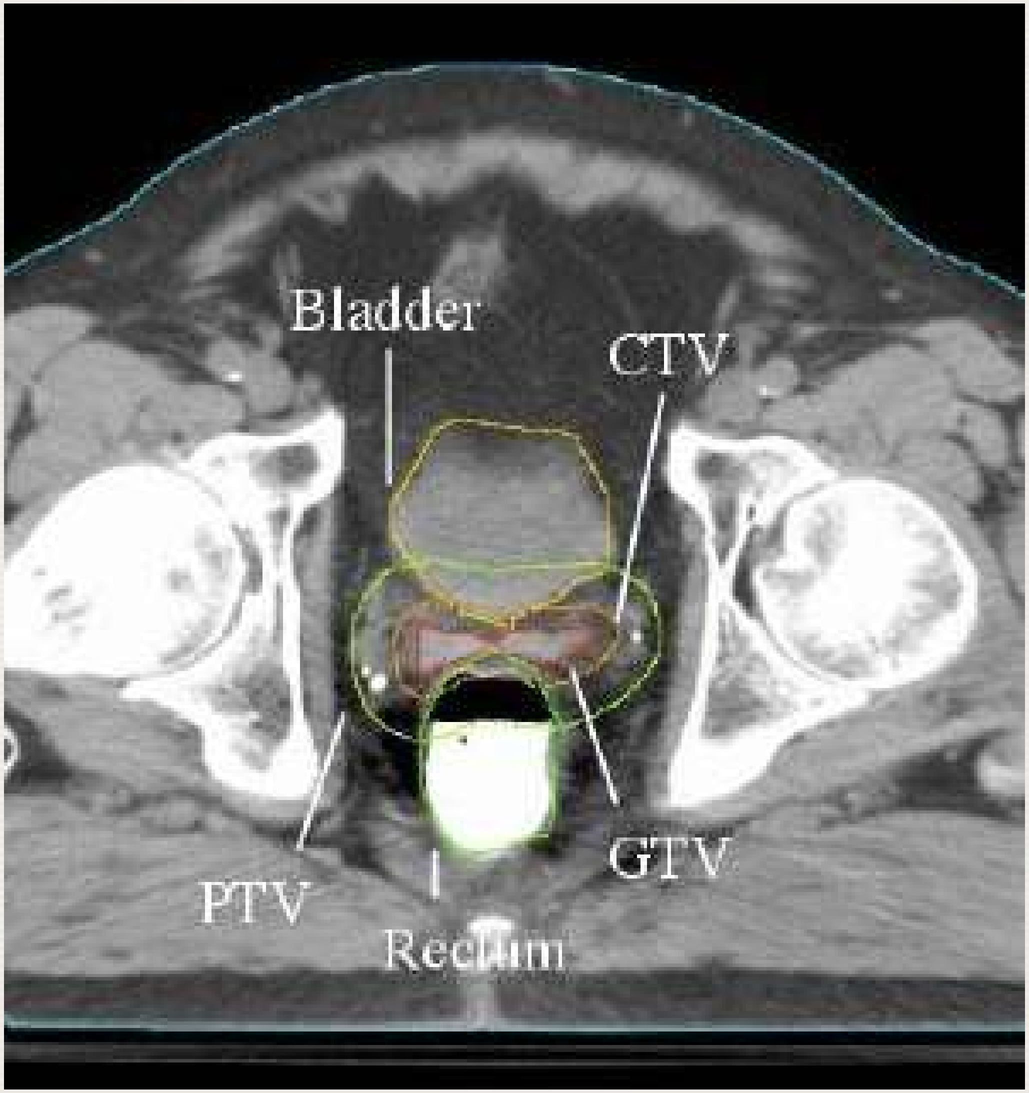
PTV - planning target volume
ITV + margin for setup errors and
treatment machine tolerances



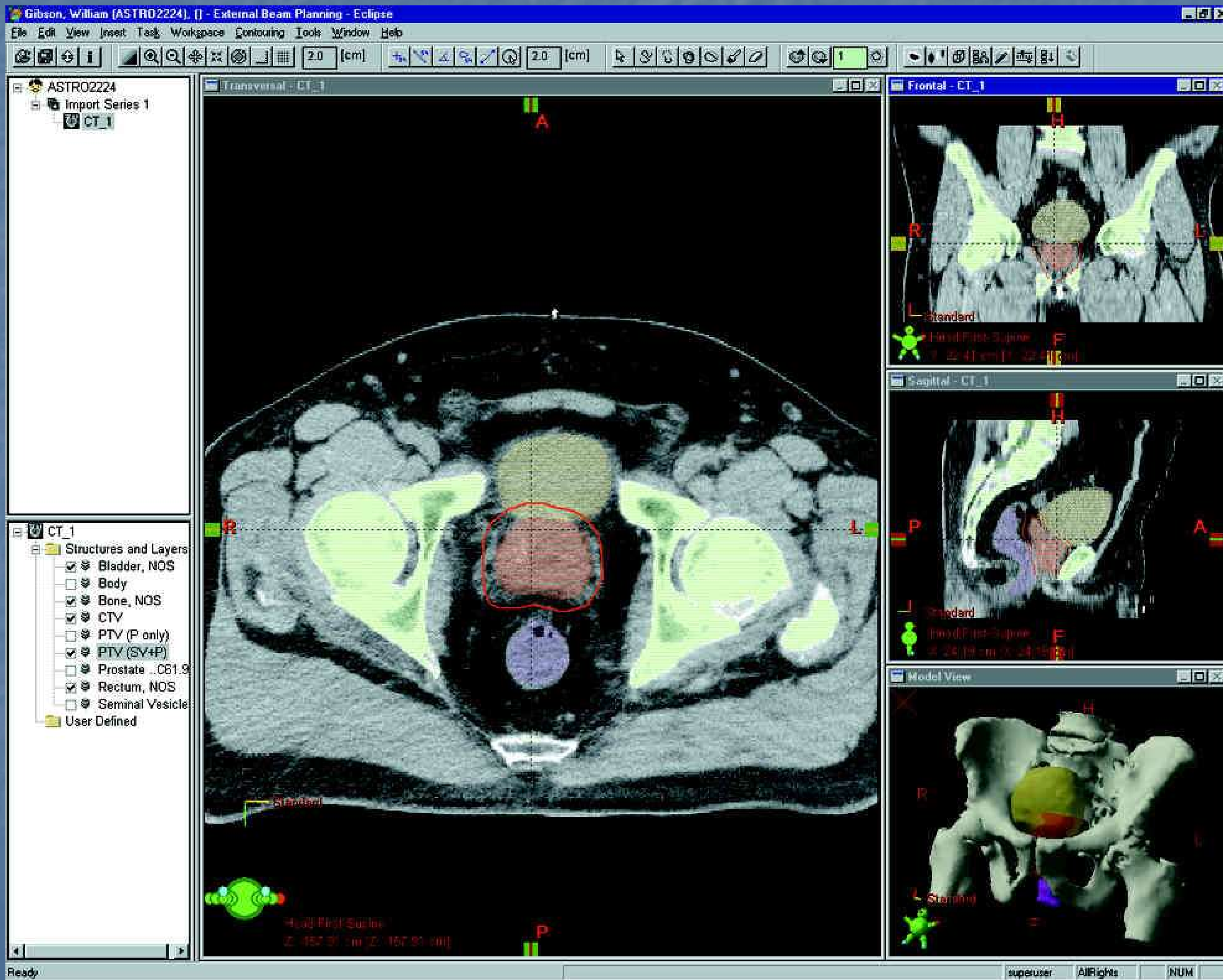
MALE PELVIC CONTOURING

Contours for different volumes have been drawn on this CT slice for a prostate treatment plan:

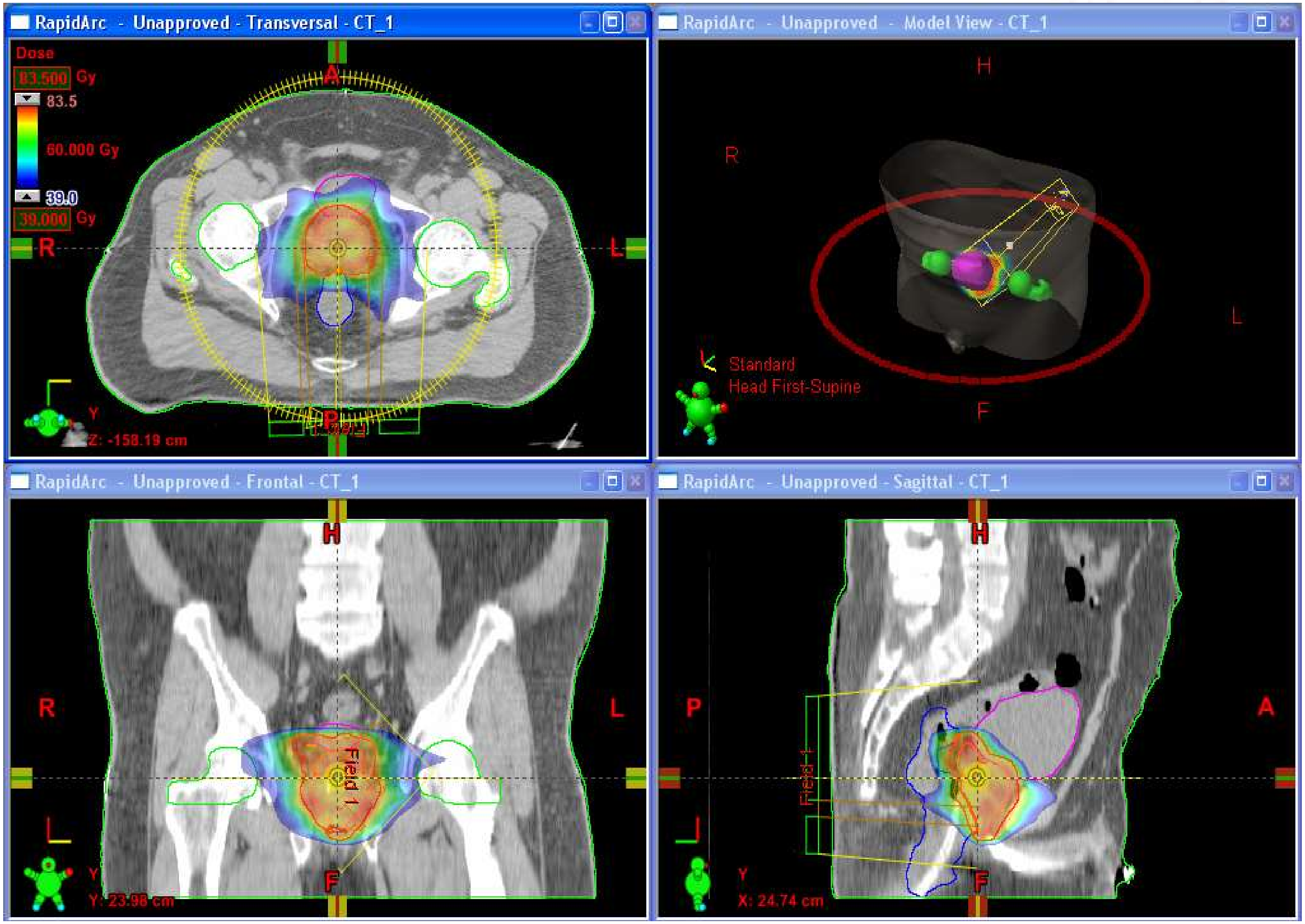
- GTV
- CTV
- PTV
- organs at risk (bladder and rectum).



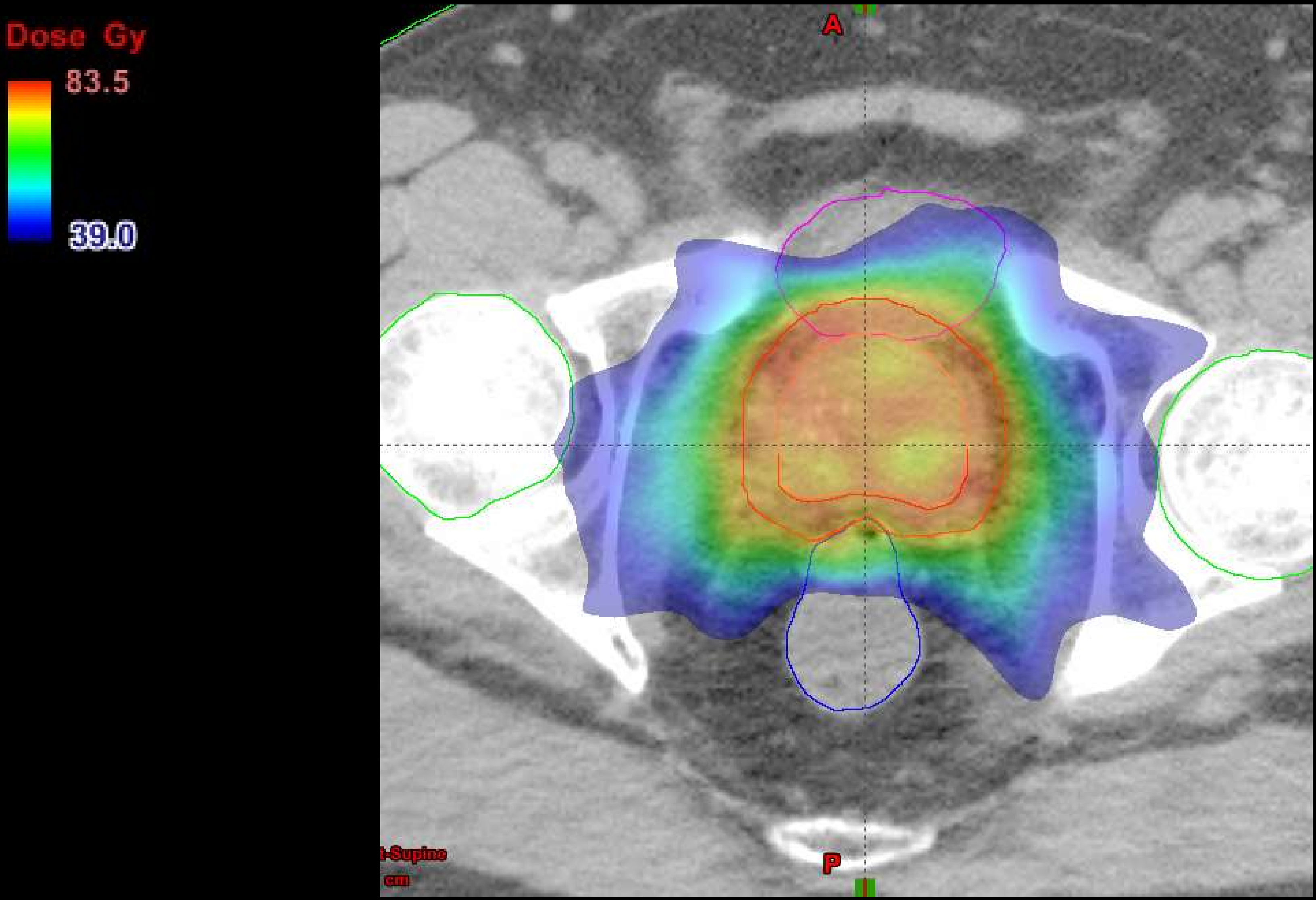
Treatment Planning



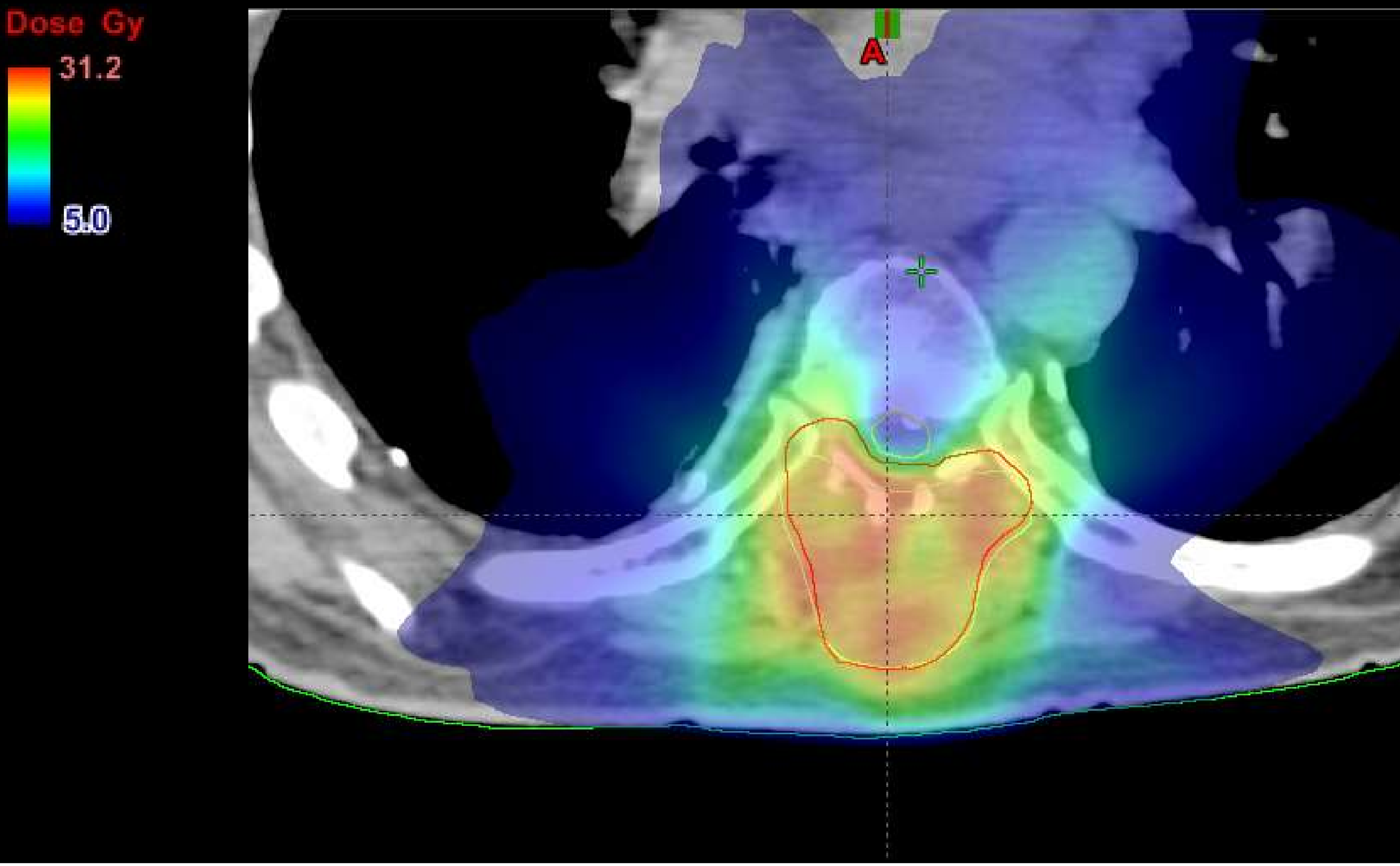
Dose distribution



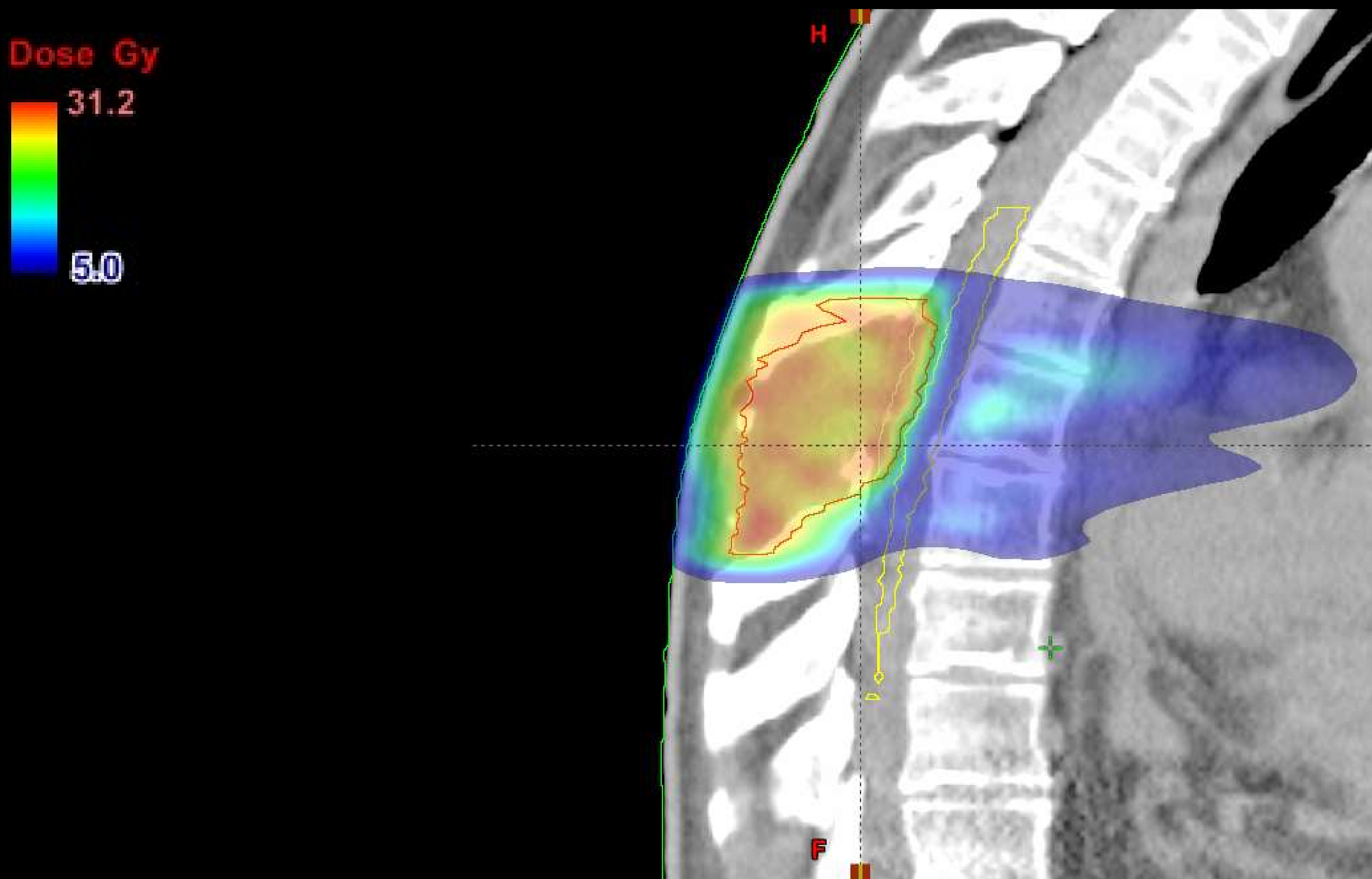
Dose distribution



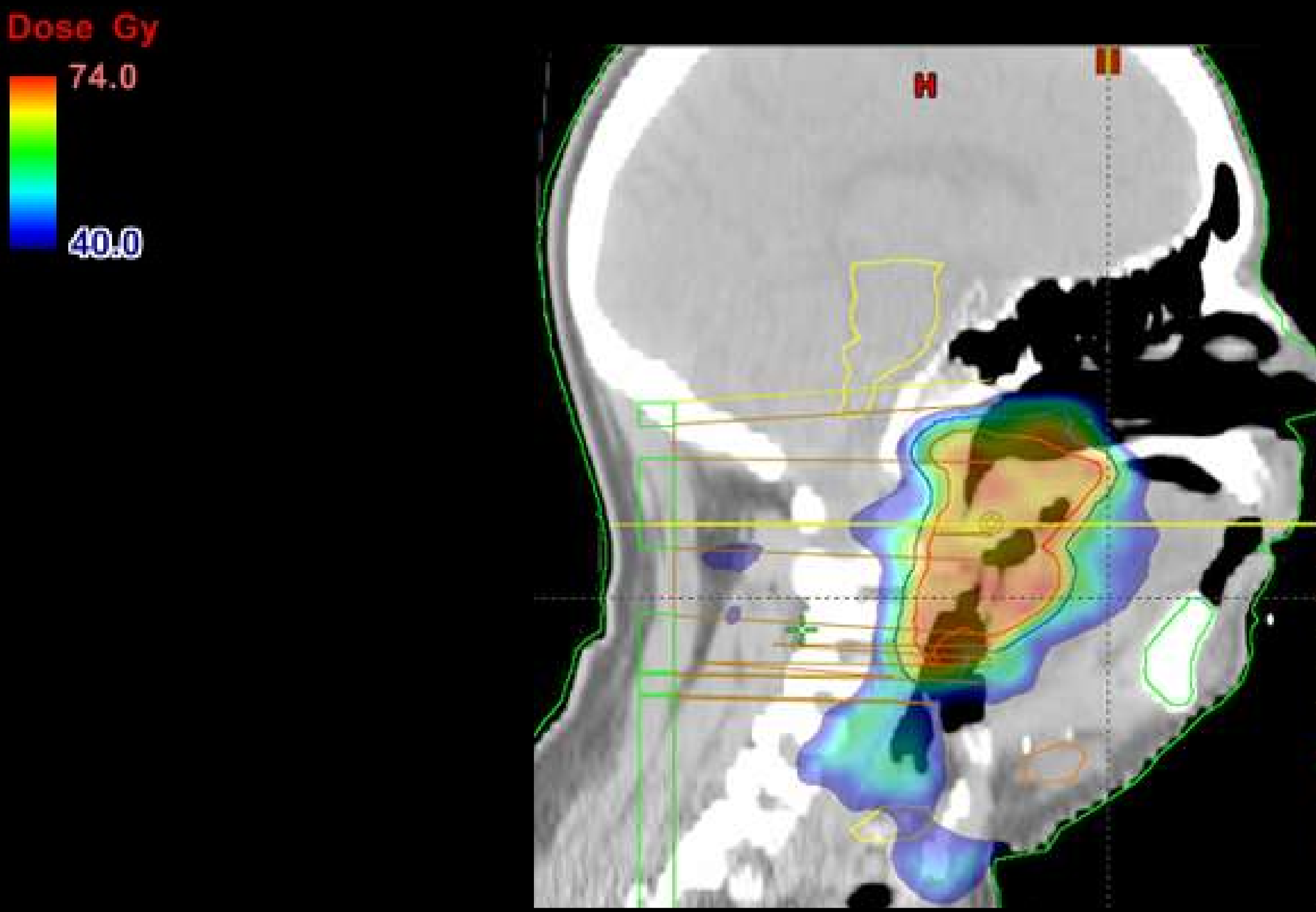
Dose distribution



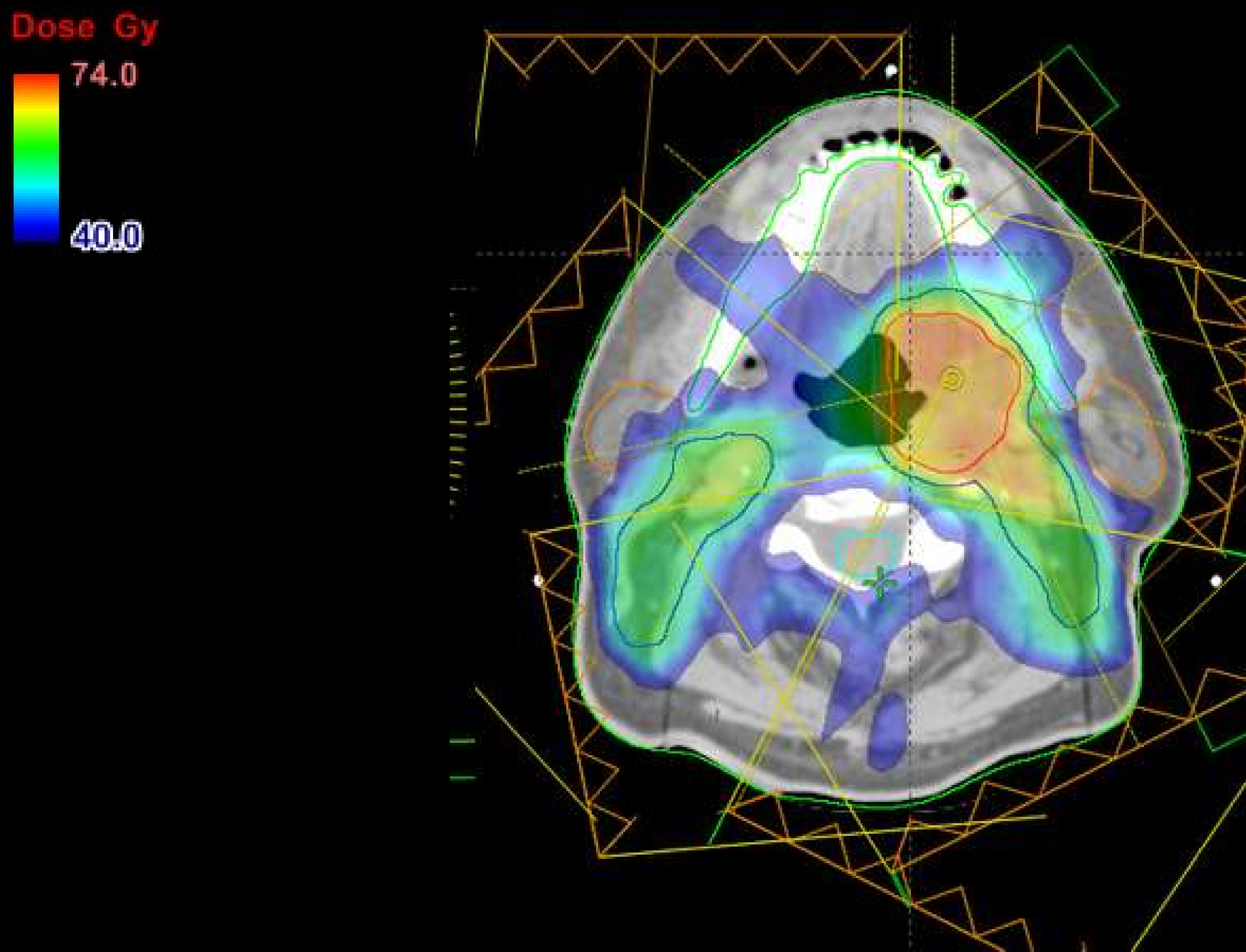
Dose distribution



Dose distribution



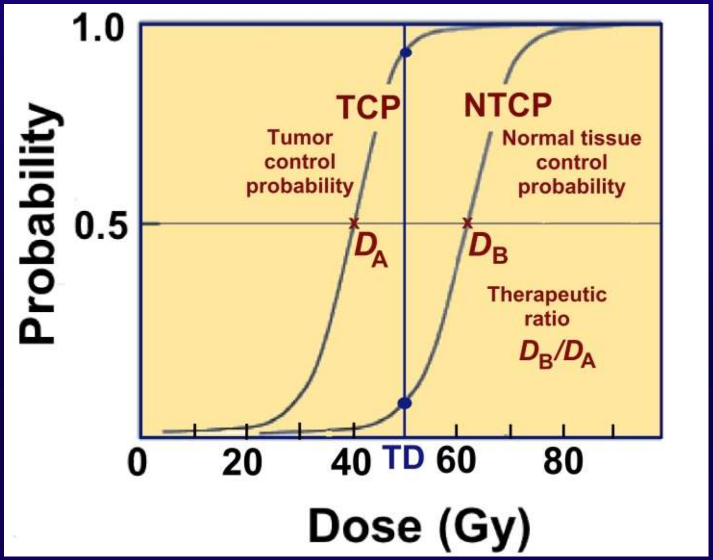
Dose distribution



GOALS of MODERN RADIOTHERAPY

To improve tumor control

through an increase in tumor dose,
i.e., through an increase in TCP



To reduce morbidity

through decreased dose to normal tissue,
i.e., through a decrease in NTCP

Using
(1) **More complex treatment techniques**
and
(2) **New technology**