Review of Patient Management Process and Recommendations in TG203

Moyed Miften, Ph.D.
Professor and Chief Physicist

Department of Radiation Oncology
University of Colorado School of Medicine
Acknowledgement

• TG203 members
Patient with CIED in RT clinic

Management Process

- Initial visit/consult
- Simulation
- Treatment planning
- Risk categorization and consultation
- Treatment
- Monitoring
- Follow up
Initial Visit Consult: Physician and Nurse

• Identify the CIED patient
• Place CIED alert in chart
• Place a copy of CIED identification card in chart
• CIED evaluation by cardiology/electrophysiology prior to treatment including checking for pacing dependence if needed
• Notify physics, dosimetry, and therapy
Simulation

- Studies have shown a small risk to CIED from CT irradiation.
- Most common effect observed was oversensing
- Effects were transient and were only observed during direct irradiation of the CIED generator
- Exclude the CIED from the scan when the anatomy in the CIED area is not needed for diagnosis, delineation, and dose calculations
Treatment Planning

• Avoid direction irradiation of CIED
• Beam energies ≤ 10 MV should be used
• TPS should be used in lieu of a measurement if CIED is within 3 cm (laterally) of the field edge or 5% isodose line for IMRT.
• Record the approximate distance from the field edge to the CIED and record distance in chart
• Perform in vivo dosimetry for the first fraction if CIED is > 3 cm and <10 cm from treatment fields.
• Adjust imaging fields to not irradiate CIED.
Physicist Role

- Contact manufacturer and place manufacturer guidelines in chart
- Perform in-vivo measurement if needed by placing detector on the nearest part of the CIED to the field
- Compare in-vivo measurement results to manufacturer guidelines
- Notify physician of in-vivo measurement results and document in chart
- Check plan and verify guidelines are being followed
Physician Role

- Consult physics/dosimetry to assess dose to the CIED
- Order in-vivo measurement when appropriate
- CIED should not fall directly within the radiation field
- Assess RT risk to CIED using TG203 and manufacturer guidelines
- Consult with cardiology/electrophysiology, and in conjunction, determine the risk level (low, medium, or high)
- On treatment orders will be based on risk level and electrophysiologist recommendations
- Follow TG203 or inhouse guidelines for monitoring during treatment
Recommendation to use ≤ 10 MV beams

• Reduce the risk of a Single Event Upset (SEU) in memory or logic circuits caused by neutrons (soft errors)
  • Changes in stored values in memory or transient changes in micro-processor circuitry
  • Reset of the device causing reversion to default parameters
  • Rare cases where reset may delay for hours or even weeks post-treatment
• There is some neutron production from 10 MV beams (and even at lower energies), however, the neutron flux increases dramatically above 10 MV
SEU Events and High Energy Beams

• Data from Grant et al (JAMA 2015)
  – 215 patients with ICPs and ICDs treated in various sites
  – CIED Median 0.50 Gy; range: 0–30.2 Gy
  – 15 SEU events (attributed to neutrons from > 10 MV beams), 2 unrecoverable, 3 transient noise events.

• Mouton et al (PMB 2002) reported changes in CIED output for an 18 MV beam
  – total doses was as low as 0.15 Gy,
  – changes are likely due to a SEU induced by neutrons
Risk Categories

- CIED malfunction mainly increases with
  - Cumulative dose
  - Neutrons present in the beam

<table>
<thead>
<tr>
<th>Cumulative dose</th>
<th>&lt; 2 Gy</th>
<th>2-5 Gy</th>
<th>&gt; 5 Gy or Neutrons</th>
</tr>
</thead>
<tbody>
<tr>
<td>pacing-independent</td>
<td>Low risk</td>
<td>Medium risk</td>
<td>High risk</td>
</tr>
<tr>
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<td>High risk</td>
</tr>
</tbody>
</table>

- Cumulative dose < 5 Gy
- Avoid high energy photons (>10MV), proton or neutron beams
## Low-Risk (< 2 Gy)

<table>
<thead>
<tr>
<th>Department</th>
<th>Staff</th>
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<tbody>
<tr>
<td>• Resuscitation protocol</td>
<td>• CIED check before 1st fraction and after last fraction</td>
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<tr>
<td>• Pacemaker magnet, pulse oximetry, and AED available at treatment unit.</td>
<td>• Radiation oncologist and QMP available with sufficient knowledge in the management of CIED patients.</td>
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<tr>
<td>• Close monitoring of the CIED patient with an audio-visual system during treatment</td>
<td>• Therapists should be experienced in the management of CIED patients</td>
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<tr>
<td>• ICD patients: program tachycardia off or use magnet</td>
<td></td>
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<tr>
<td>• Communication with cardiology/electrophysiology</td>
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</table>
## Medium-Risk (2-5 Gy)

<table>
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<tr>
<th>Department</th>
<th>Staff</th>
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<tbody>
<tr>
<td><strong>Low-Risk requirements AND</strong></td>
<td><strong>Low-Risk requirements AND</strong></td>
</tr>
<tr>
<td>- Formal consultation with electrophysiology.</td>
<td>- CIED technologist to interrogate the device at mid-treatment.</td>
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<tr>
<td>- Pacing dependent: consult with electrophysiology on the use of magnet and pulse oximetry.</td>
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<tr>
<td>- Appropriate cardiac support available to manage complications from potential CIED malfunctions.</td>
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</table>
# High-Risk (> 5 Gy or Neutrons)

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<td>Medium-Risk requirements AND</td>
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<tr>
<td>• ECG monitoring weekly.</td>
<td>• Trained staff examines ECG.</td>
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<td></td>
<td>• CIED technologist should be available, if needed.</td>
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<tr>
<td></td>
<td>• Technologist to interrogate the device weekly once the device receives &gt; 5 Gy.</td>
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</table>
Other Recommendations

• Verify the CIED compatibility prior to MR simulating the patient and ensure device is MR conditional

• Contact the device manufacturer to ensure the device compatibility with the magnetic field strength used for simulation

• Low dose-rates of $< 0.01 \text{ Gy/min}$ to the device should be maintained (soft recommendation)
Use of Magnets During RT

• The use of a magnet over an ICD
  – temporarily inhibit defibrillation therapy while it is applied.
  – cardiology may require additional monitoring of the patient during treatment in case defibrillation is required.

• The use of a magnet over an ICP
  – turns the sensing function off and sets the pacer to a preprogrammed asynchronous mode (usually 70-90 bpm)
  – ignore any sensed activity and is therefore asynchronous to any intrinsic patient heart rhythm

• Cardiology/electrophysiology should be consulted
Magnet on ICP

native atrial beats

asynchronous atrial and ventricular pacer spikes

https://www.downeastem.org/downeastem/2017/12/18/v2tpxxht3x5trj8phtar2ts1nombb
Patient with Carcinoma of the Uterus

- 68 yo patient implanted with ICP, pacing dependent
- Whole pelvis treated to 40 Gy in 20 fractions Gy using 6MV VMAT followed by 8.5 Gy x 2 HDR to uterus
- ICP > 10 cm from treatment fields
- Patient was completely dependent on her pacemaker as her underlying rhythm during device interrogation showed complete heart block with no ventricular escape.
- Magnet on ICP during treatment
- Heart rate monitoring, to ensure proper magnet placement, is utilized during treatments
Patient with intimal sarcoma of the left atrium

- 68 yo patient implanted with ICP, pacing dependent
- Hypofractionated chemoradiation to 34.5 Gy in 15 fractions using 6MV VMAT
- ICP dose 42 cGy
- Managed following consultation with the device clinic as high risk with daily device checks
- Magnet on ICP with every treatment
Patient with left hilar mass encasing the left pulmonary artery

- 68 yo patient implanted with ICD
- Treated to 30 Gy in 10 fractions using 6MV 3DCRT
- ICD dose 428 cGy
- Patient is medium risk: checks at pre-, mid-, and post-treatment
- Magnet on ICD with every treatment
Summary

• Management of RT patients with a CIED is essential.
• Safe medical practice requires that the risk to patients CIED be reduced as much as possible.
• The risk of CIED malfunction should be weighed against other medical risks the patient may be subjected to.
• The quality of radiotherapy and the risk of tumor recurrence should not be comprised for the sake of reducing the risk to a CIED which is comparatively low.
Thank You