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Editorial

ABS brachytherapy consensus guidelines

Queen Elizabeth II called 1992, an "annus horribilis" or terrible year for the Royal Family. For the brachytherapy world, 2009 was our horrible year. It was on June 30, 2009 that events at the Philadelphia VA Medical Center were made public by the *New York Times* ("At V.A. Hospital, a Rogue Cancer Unit" by Walt Bogdanich). The impact from these events continues to reverberate throughout our specialty and community. As has been well documented by the Department of Veteran Affairs Office of the Inspector General, problems identified by the government included using the wrong strength seeds, no postimplant dosimetry, no peer review, and no quality assessments (1).

This incident highlighted the need by our specialty to make sure that the latest information available is widely distributed to the practitioners of brachytherapy. Beginning in 1999, Nag *et al.* (2–8) began publishing guidelines for brachytherapy under the purview of the American Brachytherapy Society (ABS). These papers remain some of the most widely read and heavily referenced articles of the last 10 years in radiation oncology. They introduced the expectation of postimplant dosimetric assessment, standardized indications and contraindications for treatment, and discussed areas of controversy. The prostate recommendations were published first, but guidelines for sarcomas, gynecologic, and head and neck malignancies quickly followed. Since the publication of the guidelines in the late 1990s and early 2000s however, there have been many changes in our specialty involving brachytherapy including the introduction of sophisticated treatment planning and imaging systems and technology, a much greater clinical experience with much longer follow-up and a much greater awareness and emphasis on patient safety and quality assurance.

In late 2009, members of the board of Directors of the ABS began discussions regarding the need to update these guidelines and expand their scope, especially in the context of the shortcomings identified at the Philadelphia VA and the belief that the most current information regarding brachytherapy needed to be disseminated as widely as possible. The ABS Board believed that these events provided us an opportunity to learn from these events and improve the knowledge and quality of implants. The original articles focused only on low-dose-rate prostate brachytherapy and some gynecologic malignancies, sarcomas, and head and neck cancers. The current Board of the ABS felt that now was the time to include all the relevant sites in which brachytherapy is a principal treatment modality. It was especially important to provide information on proper dosimetric analysis and quality assurance.

With the greater information available, specific guidelines include low-dose-rate prostate, high-dose-rate prostate, general principles in cervical cancer brachytherapy, low-dose-rate brachytherapy for cervical cancer, high-dose-rate brachytherapy for cervical cancer, vaginal cuff brachytherapy for endometrial cancer, and interstitial brachytherapy for vaginal cancer. Criterion used for each guideline included prior published guidelines, results from clinical trials, published peer-reviewed literature, and clinical experience of the committee members. The guidelines include information on (*1*) patient evaluation, (*2*) patient selection, (*3*) contraindications to the procedures, (*4*) planning, postimplant dosimetry and management, and (*5*) continuing areas of controversy.

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