The Radiological Physics Center's Experience with IMRT



ACMP May 2007 Geoffrey S. Ibbott THE PHEREDY OF TEXAS

Making Cancer History*

CANCER CENTER

Purposes of Credentialing for IMRT Clinical Trials

Education

•Evaluate ability to deliver dose

 Improve understanding of protocol

Reduce deviation rate



General Credentialing Process

- Previous patients treated with technique
- Facility Questionnaire
- Knowledge Assessment Questionnaire
- Benchmark case or phantom
- Electronic data submission
- RPC QA & dosimetry review
- Clinical review by radiation oncologist

Feedback to Institution





prostate IMRT: 4, incl. prosthesis

RPC Phantoms





thorax IMRT/SBRT: 3 phantoms, 6 constr., motion





H&N IMRT: 20 in service, 5 under constr.

SRS: 2 in service, others sent by RDS

liver SBRT: 3, incl. motion

IMRT Credentialing

.250+ institutions have successfully irradiated an RPC IMRT phantom





Scan, Plan, Treat a phantom



Plan vs. Treatment



Number of Phantom Mailings





Phantom Results

Comparison between institution's plan and delivered dose.

Criteria for agreement: 7% or 4 mm DTA

Phantom	H&N	Prostate	Thorax	Liver
Irradiations	254	73	30	6
Pass	179*	55	17	3
Fail	71	9	7	1
Under analysis or at institution	30	6	6	1

Year introduced 2001 2004 2004 2005 * 30% of institutions failed H&N phantom on the first attempt

QA for Advanced Technology, Dallas, February 2007

Explanations for Failures

Explanation	Minimum # of occurrences
incorrect output factors in TPS	1
incorrect PDD in TPS	1
Software error	1
inadequacies in beam modeling at leaf ends (Cadman, et al; PMB 2002)	14
not adjusting MU to account for dose differences measured with ion chamber	3
errors in couch indexing with Peacock system	3
2 mm tolerence on MLC leaf position	1
setup errors	7
target malfunction	1
Incomplete delivery	1

Examples of Failures







Physicists per machine





Learning from **Errors**

Analysis IAEA update, someone else? Reporting ation Oncology Safety Information S ROSIS database EGISTER CLINIC

Risk of identification & litigation

Limitations on discussion

- NRC
- Barriers

Welcome to ROSIS

a voluntary safety reporting system for Radiation Oncology

ROSIS is short for "Radiation Oncology Safety Information System" and it is a voluntary web-based safety information database for Radiotherapy. The system is based on professional front-line staff in radiotherapy clinics reporting incidents and corrective actions over the Internet to a database.



LINKS

RESOURCES





Thank you!

