

Dear Readers,

So, it happened, the World Congress of Brachytherapy has been postponed till May 2021 and moved to Madrid, Spain. I hope this time we will be able to meet as a brachytherapy community, fighting together for the proper management of our patients. I am sure all of you have already noticed plenty of COVID-19-related recommendations for currently proposed changes in the treatment regimens. Concerning my department, we have revised our habits and changed almost nothing in the workflow, paying attention to apply proper patients and staff safety principles. If some of you still consider difficult to cope with the time of pandemic, especially if it affects your nearest neighborhood, here you can find possible solutions and pathways in brachytherapy management of locally advanced cervical cancers, in particular. Please note the concisely written paper submitted by the Indian Brachytherapy Society published in the Educational Corner.



I am pleased to present the JCB 3/2020 issue that opens with a real crossbow shot, the manuscript, which title contains a BALESTRA acronym. An interesting work of the Italian group shares their analysis results, which proves again that HDR brachytherapy is a feasible treatment for a partial breast reirradiation. It offers an extremely low complication rate, it is a fast procedure, and saves patients' breasts. I would say, is like a shot from a crossbow straight into the tumor, isn't it?

The following five clinical investigations are quite different. Authors from Chicago (USA) report on the impact of implant interval in two-fraction definitive HDR prostate brachytherapy. They claim that the interval between treatments is not associated with differences in patient-reported quality of life or physician-graded toxicities. Representatives of Lanzhou University (China) investigated the efficacy of the combination of percutaneous transhepatic biliary drainage and ^{125}I stranded seeds for malignant bile duct obstruction treatment, and suggested that such an approach reduces bilirubin levels and prevents biliary obstruction; therefore, it promotes survival. Another Chinese group from Wuxi, based on their initial experience, reported that ^{125}I seed implantation for residual hepatocellular carcinoma or cholangiocellular carcinoma in challenging locations after transcatheter arterial chemoembolization is highly effective and safe. This is to be read and assessed in detail individually. The next is the first reported case series of HDR brachytherapy for isolated primary cutaneous B cell lymphoma (CBCL). Originated from Poznań (Poland), the paper by the Polish Brachytherapy Society group reveals that HDR-BT allows for achieving high local control of CBCLs, with relatively low late toxicity in the form of skin discoloration in most patients. The last clinical paper comes also from Poland (Warsaw) and is on the dosimetric evaluation of vaginal cuff brachytherapy planning in cervical and endometrial cancer patients. The authors emphasize the necessity of CT-based treatment planning, which is essential for optimal cylinder size selection, hot spots control in OARs, and reducing the occurrence of air gaps.

The next two papers are on BT physics. Peng Zhao *et al.* (China) investigated the clinical use of the ring applicator for combined intracavitary/interstitial image-guided brachytherapy treatment in patients with locally advanced cervical cancer. In a manuscript by Georgina Fröhlich *et al.* (Hungary) one can read about the biological dose summation of intensity-modulated arc therapy (IMAT) and image-guided HDR interstitial brachytherapy in intermediate- and high-risk prostate cancer. As the authors conclude, based on their biological dose summation method, the total dose of the prostate is higher using the BT boost, than the IMAT. BT boost yields lower rectum, bladder, and hip doses, but a higher dose to the urethra. When compared, uniform dose conception overestimates rectum and bladder dose and underestimates the dose to the urethra.

Gustavo Sarria *et al.* (Peru) submitted a case report on three conjunctival marginal zone B cell lymphomas of the fornix, treated with a novel single-shot scheme of low-energy electronic brachytherapy. In this small collective, the treatment was effective and safe, and could be considered amongst the therapeutic options for these rare malignancies. The second case submitted by Yoshiaki Ota *et al.* (Japan) is a report on a single-fraction of 10 Gy image-guided HDR-BT for head and neck cancer in a palliative setting, with promising results.

In a single technical note, Taylor J. Corriher *et al.* from Charlottesville (USA) present a comparison of initial CT-based target delineation and subsequent MRI-based target delineation for cervical cancer brachytherapy. Their most important conclusion was that MRI fusion is associated with target volume changes greater than 20% in over half of the treated patients.

Another productive group from China worked really hard to prepare an excellent systematic review paper on the 100 most cited articles concerning prostate cancer brachytherapy. After bibliometric analysis, a detailed list of the 100 most cited articles in prostate cancer brachytherapy was presented. We can clearly see the recommendations for the treatment of prostate cancer brachytherapy, which main goal is to improve long-term outcomes and patients' quality of life.

The JCB 3/2020 closes with an intriguing educational article from Japan. Naoya Murakami *et al.* present technical aspects of image-guided interstitial brachytherapy boost for nasopharyngeal carcinoma patients who responded poorly to the concurrent chemoradiotherapy with external beam radiotherapy.

I hope you all will enjoy reading this new issue of our Journal. Please, keep in mind the read articles and consider citing our contents in your current and future publications.

Lastly, you are all strongly invited to submit and improve scientific foundations of brachytherapy.

Yours sincerely,
Adam Chichef, MD, PhD
Editor-in-Chief
Journal of Contemporary Brachytherapy