Dear Colleagues,

In recent months, much attention has been devoted to a material presented firstly at San Antonio Breast Symposium (November 2011), published as an article on May 2, 2012 in the JAMA, entitled “Association between treatment with brachytherapy vs. whole-breast irradiation and subsequent mastectomy, complications, and survival among older women with invasive breast cancer”. Authors from the MD Anderson Cancer Center reported a small but statistically significant increase in the rate of mastectomies in elderly patients treated with APBI-brachytherapy as compared to conventional WBI. The rate of mastectomy was nonetheless very low in both groups (2.2% for WBI vs. 4% for APBI-brachytherapy). Authors concluded that “In a cohort of older women with breast cancer, treatment with brachytherapy compared with WBI was associated with worse long-term breast preservation and increased complications but no difference in survival”.

In American Brachytherapy Society response we can read that “there are several weaknesses in this article which need to be acknowledged. The report is based upon a review of Medicare claims data and, as such, is subject to limits in interpretation due to the retrospective nature and inherent selection bias. From prior analyses, we know that Medicare claims data are severely limited when it comes to extracting critically important prognostic factors such as the general medical condition of the patient and the extent of the tumor. Furthermore, critical details regarding other treatments that patients may have received such as the completeness of the initial breast tumor lumpectomy, the systemic therapy received, and the reason for subsequent mastectomy are often lacking. In short, the analysis presented in JAMA tells us very little. This is in stark contrast to the results of many carefully performed studies of APBI-brachytherapy accumulated over twenty years. Peer-reviewed randomized clinical trials are the gold standard of scientific evidence to establish the safety and efficacy of medical interventions. It is important to emphasize that two such studies are available that have demonstrated equivalence of APBI-brachytherapy in comparison to WBI for local control, complications, and cosmetic outcome”. Similar observations are published by Cuttinoto et al. (Int J Radiation Oncol Biol Phys 2012; 83: 1075-1077) who noted, as limitations of JAMA publications, “the use of surrogate metrics, treatment era bias, the retrospective nature of the analysis, selection bias, and incomplete treatment data”. Also “in the SEER-Medicare database, no information regarding proper dose delivery is available; (...) A critical piece of missing information in the MDACC abstract is patient selection criteria”. And one more important conclusion: “Because all the patients in the SEER-Medicare abstract were treated before the generation of ASTRO, ABS guidelines, it is not possible to judge whether the reported increased rate of mastectomy is a result of inappropriate patient selection for APBI during the period investigated or rather the result of APBI in general, as suggested by the authors”. Conclusions from Cuttinoto team are significant: “this abstract (paper) provides little meaningful information, in contrast to the results of many carefully performed prospective clinical trials of APBI accumulated over 20 years. In particular, we believe this abstract should be interpreted in the proper context of the entire APBI experience, to avoid undermining trial accrual and to avoid an unnecessary and improper reaction from the lay press and from the radiation oncology community”. Also the American Society of Breast Disease (ASBD, at www.ASBD.org) is concerned about misleading information in a recent study published in the journal of the American Medical Association (JAMA), comparing breast brachytherapy to whole breast irradiation (WBI). ASBD cautions that the study has several deficiencies that may unnecessarily deter women from choosing brachytherapy as a treatment option. The Society believes that brachytherapy remains a valuable method of treatment for appropriately selected patients, and that it should continue to be offered to appropriate women as a treatment choice. Potential benefits include less dose to healthy tissue, convenience (five days instead of six weeks for WBI), safety and effectiveness.


The question is whether the opinions and scientific arguments put forward by brachytherapists reach the environment of patients and physicians to the same degree as a critical news published widely in the press, not only of medical care. Bad news spreads very fast, and sensational medical portals publish and copy
you to read reports of experienced international teams of researchers. We wish you a pleasant reading!

In the educational corner an overview of guidelines for prostate cancer brachytherapy is published. We encourage average by PTV and isodose of 90% in 2D and 3D planning during endobronchial brachytherapy. We also publish a review article about physics aspects of dose accuracy in high dose rate (HDR) brachytherapy and three original investigations in physics. They concern such most interesting subjects like: 1. A novel method for analysis of post-brachytherapy prostate edema and its relevance to post-implant dosimetry. We further publish in the educational corner an overview of guidelines for prostate cancer brachytherapy. We encourage you to read reports of experienced international teams of researchers. We wish you a pleasant reading!

Sincerely yours,
Janusz Skowronek, MD, PhD, Ass. Prof.