

FROM OUR } **Changing the Slope
PRESIDENT } of the Brachytherapy Curve**



Steven J. Frank, MD

"It is a pleasure to address the membership in my first President's column."

Your Board of Director's recently met for its winter meeting, adding on an additional day for a strategic planning retreat. Our overall theme was *Changing the Slope of the Brachytherapy Curve*. We are in an uncertain time with respect to the future of our nation's healthcare system, and we continue to experience decreased utilization of brachytherapy for cancer management. Over the course of our strategic retreat, we established a 5-year vision for the ABS and a strategic framework to increase patient access to brachytherapy. We examined both external and internal factors with respect to the ABS and our agenda items included a review of the Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses in several strategic areas:

Education and Training Programs

- ABS School educational offerings
- Partnering with other societies
- Residency training
- Brachytherapy certification

Socioeconomic Sphere

- Communicating ABS efforts to ABS members
- Legislative priorities and financial constraints
- RUC involvement
- Direct patient marketing/education
- Alternate payment models for brachytherapy

Membership Growth

- Ideas and methods of attracting new members, to return to our 2012 and 2013 levels of 1,500+, including the creation of a Sponsor Program for Residents and a Resident Committee
- Resident Member retention post-residency
- National and international potential
- Bringing past members back

ABS Management

- Management tools and data reporting
- Board member acclimation process
- Finances and future revenue streams

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Annual Conference

- Member and vendor satisfaction
- Vendor mergers and acquisitions
- Delivery of CME (SAMS, SNAP Orals, etc.)

Future Member Benefits and Needs

- Technology – webinars and educational videos
- Simulation and contouring opportunities
- Governance – analysis of Board and Committee structures and responsibilities; frequency of Board meetings; with term of office a consistent issue (not enough time!), the Board will recommend to the membership in 2017 the creation of a President-Elect position, which ascends automatically to the presidency, with the Vice President position automatically ascending into the President-Elect position. This will provide more time for the grooming of our key leaders while also allowing them more time in office to accomplish their main goals.

In each of these key strategic areas, we were able to identify a list of priorities. Your Board has much to do, and it will not all come overnight, but when we convene in Boston we will report on our strategic framework and plan, post-meeting assignments, activities and progress. One goal is to create a more vibrant and meaningful committee structure, so I would encourage all members to participate as we look to *Change the Slope of the Curve* together. Our discussions led to the confirmation /creation of the following standing committees, and if you have any interest in participating on these committees, please contact me at your convenience.

Education

- ABS Schools
- other educational offering mechanisms and platforms
- ABS HDR and LDR Fellowship Programs

External Relations

- consists of ABS President, President-Elect, Vice President and Chairman of the Board

Fellowship

- manages the annual ABS Fellowship (FABS) program

Industry Relations

- working with industry on specific needs and funding initiatives
- emerging technologies

International

- serves as conduit to ABS for international brachytherapy societies
- identifies international markets and opportunities for members and brachytherapy education
- works with industry to secure funding for committee-related international travel to assist those in financially-challenged countries

Membership

- works with ABS staff and committee members to build society membership

Nominating

- constructs the slate of candidates each year

Patient Safety

- focus on medical events and quality assurance

Physics

- medical physicist members conduit to the Board

Publications/Journal

- includes *Brachytherapy*, *BrachyNews* and *BrachyBlast*

Residents

- Residents conduit to the Board
- assist with social media communications
- assist on standing committee agendas

Socioeconomics

- works with ABS consultant on legislative priorities and external relations

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In addition, two Task Groups were formed:

- 1) **Bylaws** (an updating of our Bylaws is necessary)
- 2) **Website** (a newly designed, more interactive website is scheduled for 2017)

Our committees will be working on 2017 committee descriptions, objectives and budgets, along with finalizing committee members for the upcoming year and defining the roles of the committee chairs. Should you have a particular interest or expertise and wish to participate, please contact our Executive Director, **Rick Guggolz**, at rguggolz@drohanmgmt.com.

Your Board of Directors will be working on the strategic plan milestones, deliverables, resources, budgets, operations and implementation. Our society efforts are collective efforts and all members are encouraged to participate. Through our collective efforts, we can *Change the Slope of the Brachytherapy Curve*.

It is my privilege to serve as your President this year and I look forward to seeing you in Boston next April. We wish you and yours a Wonderful Holiday Season from the ABS.

Steven J. Frank, MD
President, ABS

2017 Medicare Rule Has Minimal Impact on Payments to Physicians and Freestanding Cancer Centers

The Centers for Medicare and Medicaid Services (CMS) recently released the 2017 Medicare Physician Fee Schedule (MPFS) final rule. All policies and payments are effective **January 1, 2017**. The MPFS specifies payment rates to physicians and freestanding cancer centers. It does not apply to hospital-based facilities. Facility payment to hospital outpatient departments is covered under a separate rule and those changes are described in a separate article.

The ABS was successful in persuading CMS to increase the physician work value for complex interstitial brachytherapy (77778) from 8.00 to 8.78 relative value units (RVUs). CMS states that they "were persuaded that the RUC-recommended work RVUs for this service are appropriate, particularly because the work includes the supervision, handling and loading of radiations seeds, and it reflects the bundling with CPT 77790."

CMS establishes values for new moderate sedation codes and implements a uniform methodology for valuation of the procedural codes that currently

include moderate sedation as part of the procedure. Specifically, CMS reduces the work RVU for breast brachytherapy button & tube catheter code 19298 and insertion of uterine tandem and/or vaginal ovoids code 57155 by 0.25 RVUs. The reduction in work RVUs will be offset by the physician work of the new moderate sedation codes, when it is provided.

CMS modified their proposal for claims-based reporting of procedures with a 10- or 90-day global period by significantly reducing the number of providers required to report in 2017 and limiting the number of global surgical codes required for reporting.

Overall, the final rule has minimal impact on payments to radiation oncologists and freestanding cancer centers in 2017.

To read a complete summary of the final rule and to review 2017 payment and impact tables go to:

<http://www.americanbrachytherapy.org/login/>

Wendy Smith Fuss
ABS Socioeconomics Consultant

CMS Expands Comprehensive APCs Without Addressing Data Concerns

The Centers for Medicare and Medicaid Services (CMS) recently released the 2017 Hospital Outpatient Prospective Payment System (HOPPS) final rule with an effective date of **January 1, 2017**.

CMS finalized their proposal to create 25 new Comprehensive APCs, many which include brachytherapy related surgical procedures (20555, 41019, 55920, 57155, 58346), which are converted from a clinical APC to a Comprehensive APC in 2017. This may have implications for brachytherapy treatment delivery since Comprehensive APCs make a single payment for the primary surgical procedure and bundle all other costs on the same claim, including radiation treatment planning and delivery codes.

ABS conducted an economic analysis of the new Comprehensive APC claims data and determined that all costs of associated radiation therapy services, including

brachytherapy treatment delivery, were not captured in the bundled payment. CMS replied that they rely on hospitals to bill all codes accurately in accordance with their code descriptors and CPT and CMS instructions, as applicable, and to report charges on claims and charges and costs on their Medicare hospital cost reports appropriately. Moreover, CMS stated that they do not remove claims from the claims accounting when stakeholders believe that hospitals included incorrect information on some claims. CMS may examine the claims for these brachytherapy insertion codes and determine if any future adjustment to the methodology (or possibly code edits) would be appropriate.

Of note, CMS reassigns the breast brachytherapy button & tube catheter code 19298 to lower paying **Level 2 Breast Surgery** Comprehensive APC that results in a

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significant 41.5% payment decrease. CMS maintains breast brachytherapy balloon catheter code 19296 in the same **Level 3 Breast Surgery** Comprehensive APC but with a 14% payment decrease in 2017.

CMS did not propose reassignment of any LDR or HDR brachytherapy treatment delivery codes but the 2017 payments have minor increases and decreases based on 2015 hospital claims:

- ▶ LDR intracavitary codes 77761 and 77762 are assigned to APC 5623 Level 3 Radiation Therapy with a slight payment decrease of 2.2%.
- ▶ LDR intracavitary code 77763 is assigned to APC 5624 Level 4 Radiation Therapy with a payment increase of 6.0%.
- ▶ HDR brachytherapy codes 77770, 77771 and 77772 and Category III code 0395T are assigned to APC 5624 Level 4 Radiation Therapy with a 6.0% payment increase.
- ▶ HDR brachytherapy skin surface codes 77767 and 77768 and Category III code 0394T are assigned to APC 5622 Level 2 Radiation Therapy with a 5.2% payment increase.

- ▶ The LDR Prostate Composite APC 8001 that includes 77778 and 57155 provided on the same day has 3.3% payment increase in 2017.

In addition, CMS is implementing site neutral payments required under the Bipartisan Budget Act of 2015, which requires that items and services furnished in certain off-campus provider-based departments will not be covered or paid under the HOPPS. Those items and services will instead be paid “under the applicable payment system” beginning January 1, 2017, which CMS designates as the Medicare Physician Fee Schedule. CMS reports that payment to these effected off-campus provider-based departments will be approximately 40 percent of the HOPPS payment.

To read a complete summary of the final rule and to review 2017 payment and impact tables go to:

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Wendy Smith Fuss
ABS Socioeconomics Consultant

Trump Announces Picks for HHS Secretary & CMS Administrator

President-elect **Donald Trump** has tapped House Representative **Tom Price** (R-GA) to lead the Department of Health and Human Services (HHS). Rep. Price, an orthopedic surgeon, has been a longtime opponent of the Affordable Care Act (ACA), was one of the first Republicans to introduce an alternative to the law when Democrats were debating health care reform in 2009 and 2010. The current Chairman of the House Budget Committee, many expect that Price will be a key player in helping the House pass an ACA replacement plan. Price also shares a close relationship with Vice President-elect **Mike Pence**—both former chairmen of the House’s Republican Study Committee.

Additionally, Trump announced that he will nominate Indiana-based healthcare consultant **Seema Verma** as the next administrator of CMS. Verma may be best known for her work on Medicaid issues and her close ties to Mike Pence. She designed Pence’s Medicaid expansion model—known as **Healthy Indiana Plan 2.0**—and has advised several Republican states on how to add conservative elements to their programs, such as health savings accounts and employment requirements.

Price’s Healthcare Background

The healthcare plan introduced by Price has similarities to both the “Better Way” plan put forward this year by House Speaker **Paul Ryan** (R-WI) and the plan Trump outlined during his campaign. Price’s bill—which also includes traditional GOP ideas such as health savings

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accounts, high-risk insurance pools, and allowing interstate insurance sales—also happens to be the most detailed, and is the only one that has been put into legislative language.

As HHS Secretary, Price would have opportunities to significantly change the ACA through the regulatory process, such as loosening restrictions for the states on Medicaid or not enforcing the individual mandate. Price and his team would have to decide how aggressively to peel back the health law through the regulatory process while Congress works on repeal legislation. Price has also been a leading voice on health IT issues in Congress, fighting for a more provider-friendly version of the meaningful use EHR incentive program. Last year, he helped collect 116 House signatures supporting a slowdown in the process.

Leading Democrats, meanwhile, have indicated that Price could face a nomination fight in the Senate next year.

Verma's Healthcare Background

Through her consulting firm SVC Inc., Verma has worked on several high-profile Medicaid expansion proposals for Republican governors. Prior to consulting, Verma worked for the Health and Hospital Corporation of Marion County, Indiana and the Association of State and Territorial Health Officials in Washington, D.C.

Verma's selection could signal an interest from the Trump Administration in offering more flexibility for states to pursue "private option" models, impose work requirements, and add other conservative elements to the ACA.

Wendy Smith Fuss

ABS Socioeconomics Consultant

Brachytherapy Training Course by the IAEA in Vienna, Austria

This past month (October 2016), as part of the effort of the ABS International group chaired by **Dr. Beth Erickson**, the ABS participated in the IAEA Patient Safety Workshop that took in place in Vienna, Austria. The ABS was represented by **Zoubir Ouhib**, Medical Physicist. The course was attended by 30 students (Radiation Oncologists, Medical Physicists, Radiation Therapy Technologists) from 22 countries. Speakers from the ABS, AAPM, ESTRO, COCIR (ELEKTA), ISRTT from Indonesia, ASN (France) and IAEA were part of the agenda. In addition, a site visit to The General Hospital of Vienna (AKH) was provided where attendees were able to appreciate a world-renowned center with a first class brachytherapy program and all their safety procedures.

The topics were focused on the safety aspect of brachytherapy use: treatment delivery, facility, treatment planning, sources and calibration, HDR information exchange, end of life for devices and equipment, the use of Fault Tree analysis, Failure Mode Effects Analysis (FMEA), Root Cause Analysis, Incident Reporting and Learning. Attendees had an opportunity



to work in groups on prevention of medical events using AAPM TG100 recommendations.

The ABS contribution to this program was on the following topics: Safety in Facilities and Equipment, Safety in Treatment Planning, End of Life of brachytherapy and patient safety, and a general presentation on the ABS structure, goals, education and guidelines, committees, publication (*Brachytherapy Journal*), and all its valuable services provided to the membership.

It appears that more HDR units will be installed in other part of the world and good training and mentoring is very essential. The IAEA is working with organizations, including the ABS, to ensure that brachytherapy is used safely and that patients are provided the best care possible.

Zoubir Ouhib, MS, FACR

ABS Director-at-Large

To ProtecT or Pivot: Proceeding with Evidence Based Strategies in the Management of Prostate Cancer

10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer

N Engl J Med 2016; 375:1415-1424 October 13, 2016 DOI: 10.1056/NEJMoa1606220

Patient-Reported Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer

N Engl J Med 2016; 375:1425-1437 October 13, 2016 DOI: 10.1056/NEJMoa1606221

Treatment or Monitoring for Early Prostate Cancer

N Engl J Med 2016; 375:1482-1483 October 13, 2016 DOI: 10.1056/NEJMe1610395

Since the results of the *ProtecT Trial* were published 3 months ago, we have all had time to reflect on these results and hopefully, incorporate into our discussions with colleagues and patients. Interestingly, the day it went public one of our physician-administrators disseminated the 2 publications, editorial by **Anthony D'Amico**, and press releases to nearly 100 primary care providers. I immediately wrote my pre-ABS editorial to the group with this e mail:

Dear Dr. X and to all:

Thank you for sharing these articles earlier today. To read only the interpretations from the media or just the conclusion from the abstract would potentially lead one to believe there may be no role for treating prostate cancer patients as there was no difference in survival at 10 years when comparing observation to treatment (*surgery or radiation*). I often hear this comment in the doctors' lounge from males, "I see no value getting my PSA checked since the test is not that accurate

and most guys who have prostate cancer, die with it, but not from it". While there are truths to these statements, there are a few irrefutable facts:

1. Prostate cancer is the second leading cause of cancer deaths in males.
2. A reduction in metastatic disease was demonstrated at 10 years for those randomized to treatment vs observation in the *ProtecT Trial*— 2.4% vs 6.3% This difference is likely to increase with longer follow-up and may actually demonstrate an improvement in survival for those with live 15 years.
3. The quality of life portion of this study established quality of life differences between surgery and radiation: patient who underwent surgery had much higher rates of urinary leakage and impotency at 6 years, while those who received radiation had slightly worse bowel function.

So, let's dive into both studies in detail. The *Prostate Testing for Cancer and Treatment (ProtecT)* trial recruited men between 50-69 years of age in the United Kingdom. From 1999 to 2009, a total of 82,429 men underwent PSA screening in which 2,664 were diagnosed with localized prostate cancer and 1,643 were randomized to active monitoring or treatment: radical prostatectomy (open, nerve sparing approach) or EBRT 74 Gy via 3D with 3-6 months of ADT. "Triggers" to re-consider management in the observation group were based primarily on PSA results. Nearly 55% of men assigned to active monitoring received "radical" treatment: 49% surgery, 33% EBRT, 8% BT.

While prostate cancer survival was 98.8% at 10 years and was not significantly different among the 3 groups, the clinical progression rates were

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23% for those who underwent monitoring and about 9% for those who underwent treatment (similar for surgery and radiation). In addition, the rates of metastatic disease were significant at 6.3% for those observed vs 2.4% for those treated.

Number needed to treat—27 men would need to undergo surgery and 33 men would need to undergo radiation to prevent 1 from developing metastatic disease. Nine patients would need to undergo surgery or radiation to 1 prevent from developing clinical progression. These numbers were similar for the *PIVOT (Prostate Cancer Intervention versus Observation Trial)* trial in which surgery did not lower the all-cause or prostate-cancer-specific mortality compared to observation at 12 years. However, surgery was associated with a reduction in all cause mortality among men with a PSA > 10 ($p=0.04$ for interaction) and possibly those with intermediate or high-risk tumors ($p=0.07$ for interaction).

Now, let's get into the patient reported outcomes—quality of life. By year 6, 17% of the surgical group required pads for urinary leakage, compared to 8% in the surveillance group, and 4% for those radiated. Sexual function was also worse at 6 years in the surgical group as only 17% had erections adequate for intercourse compared to 27% for the radiation group and 52% for the surveillance group. Bowel function was a "little worse" with radiation compared to the other groups.

A few more observations: a near significant interaction was observed for men older than 65 randomized to surveillance vs treatment. D'Amico postulates that advancing age may have been associated with higher-grade disease. Finally, there was a trend favoring radiation over surgery.

So, to summarize these results:


1. No difference in survival at 10 years among the 3 groups.
2. Higher rates of developing metastatic disease for those observed.
3. Worse urinary and sexual function for those who underwent surgery.
4. Slightly worse bowel function for those who underwent radiation therapy.
5. For those who underwent surveillance, 55% were treated. So, was this actually a study of treatment vs delayed treatment?
6. About 30% of surgical patients had pT3 disease.
7. Radiation doses were on the lower side at 74 Gy—with a suggestion that radiated patients did better compared to those who underwent surgery.

Question to consider:

1. Would patients randomized to radiation have done better with brachytherapy?
2. What is the financial and late toxicity burden when comparing surgery and salvage radiation compared to radiation alone?

Although discussed in previous ABS Blasts and Newsletters, the controversies in screening for prostate cancer are also relevant to this discussion. Many in the medical community take issue with the *USPTF (US Preventive Task Force)* recommending against prostate screening for almost all males based upon the *PLCO (prostate, lung, colorectal, ovarian)* screening trial in which more than half of patients randomized to no screening were actually screened. In the *European Randomized Study of Screening for Prostate Cancer*

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(ERSPC) there was a difference in survival at 15 years when comparing screening with subsequent treatment to no screening.

While it is true that we have been non-selectively screening, diagnosing and treating too many patients who could have undergone active surveillance as supported by the *Protect Trial*, we certainly have data supporting the premise that treatment has the potential to improve survival for appropriately selected patients (*PIVOT, ASCENDE-RT and SWOG 8794 -adjuvant radiation study*). A critical message to the public is

as follows: **if you screen and treat appropriately, there is no doubt you will save lives.**

In closing, as radiation oncologists we have a moral obligation to inform our patients about their treatment options, and the true value of brachytherapy. We predict 2017 will be the year we “bend the curve” or PIVOT through public awareness and physician education.

Daniel G. Petereit, MD
ABS Director-at-Large

Steven J. Frank, MD
ABS President

ABS International Committee

The International Committee continues to move forward with significant enthusiasm.

We met as a committee at the **World Congress** and at **ASTRO**. Our work is broad and includes formation of task groups which include:

1. National and International Resident Rotations.
2. National and International Post-Graduate Observerships.
3. International/Community Outreach for the Underserved. We are welcoming members to the International Committee and any of these tasks groups.


We are very happy to learn that the **Elekta Corporate Giving Committee has approved a number of educational grants to support international speakers traveling to international meetings for brachytherapy educational advancement.** We are very appreciative of this generous donation to further global brachytherapy advancement. A special thank you to **Susan Springer** and **Ben Pais** for all of their efforts on our behalf.

When sitting in on the **ABS International Committees**, one hears a **myriad of acronyms** that are used to describe various entities involved in international work. I would like to provide a few keys to the multitude of acronyms. Some of these include:

IAEA (International Atomic Energy Agency)

The IAEA's aim is to help build Member States' capacities and support them in establishing high-quality nuclear based technologies in health care world-wide. Since the IAEA began its work in human health over 50 years ago, the use of nuclear techniques in medicine has become one of the most widespread peaceful applications of atomic energy. The IAEA assists Member States with the coordination of research projects, expert guidance, equipment, the development of internationally harmonized guidelines, training and knowledge exchange in radiotherapy and radiodiagnosis. It supports cancer diagnosis and treatment (*radiotherapy*), quality assurance for the use of radiation in medicine for safe and accurate treatment of conditions such as cancer. It supports radiotherapy contouring, brachytherapy and teletherapy training and education and the implementation of projects in countries world-wide. IAEA

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supports medical physics in addition to radiotherapy, radio diagnosis and nuclear medicine. There is a dedicated dosimetry lab that has both teletherapy and brachytherapy equipment used for training and QA. The TLD audit program audits ~700 beams worldwide per year and does calibrations for secondary standard dosimetry labs.

The website for this organization is the Human Health Program:

<https://www.iaea.org/about/organizational-structure/department-of-nuclear-sciences-and-applications/division-of-human-health>

UICC (Union for International Cancer Control)

The UICC works closely with key international UN agencies including the World Health Organization (WHO), The International Agency for Research on Cancer (IARC), the Programme of Action for Cancer Therapy (PACT) and has consultative status with the UN Economic and Social Council (ECOSOC). The UICC unites the cancer community to reduce the global cancer burden, to promote greater equity, and to integrate cancer control into the world health and development agenda.

The website for this organization is:

www.uicc.org

Global RT—This is an initiative of **UICC** and **Global Task Force on Radiotherapy for Cancer Control (GTRFCC)**. GlobalRT is a movement to turn radiotherapy into a global health priority (<http://globalrt.org/>). As an initiative of the Young Leaders Program of the Global Task Force on Radiotherapy for Cancer Control (GTRFCC), it provides a virtual platform for education, exchange, and action around the essential nature of radiotherapy for cancer care. This organization helps to support the **Association of Residents in Radiation Oncology (ARRO) global resident rotations**.

In partnership with GlobalRT, ARRO's Global Health Rotation Initiative has centralized international rotation opportunities for residents. The program's mission is to expand the role of radiation oncologists in achieving more equitable care for all global

citizens through collaborative humanitarian outreach, education, and research. The Global Health Rotation Initiative currently lists 20 partner sites on globalrt.org, with hopefully many more to come in the next few months. The ARRO Global Health Committee also leads a mutual mentorship program and sponsors three residents annually through the ARRO Global Health Scholar Program. The global health committee is currently chaired by **Christopher Freese** of the University of Cincinnati.

Adam Olson is ARRO's contact for the ABS (adam.olson@duke.edu)

ICEC (International Cancer Expert Corp)

The ICEC is a pioneering mentorship model for establishing sustainable cancer care programs globally. The ICEC is pioneering a novel global mentorship-partnership model to address workforce capability and capacity within cancer disparities regions built under the requirement for local investment in personal and infrastructure. The goal for the ICEC center within these health disparities settings is to develop and retain a high quality sustainable workforce who can provide the best possible cancer care, conduct research, and become a regional center of excellence. ICEC is establishing teams of experts with expertise to mentor in the broad range of subjects required to establish and sustain cancer care programs.


The website for this organization is:

www.iceccancer.org

GCIIG (Gynecological Cancer Intergroup)

The Gynecological Cancer InterGroup (GCIIG) orchestrates the majority of current trials in gynecological malignancies. The GCIIG is an organization of international cooperative groups that perform gynecological cancer research. It is a nonprofit corporation that has structured governance, bylaws and standard operating procedures. GCIIG aims to promote and facilitate high quality clinical trials in order to improve outcomes for women with gynecological cancer. GCIIG

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was conceived in 1993 and formalized in 1997 and has 29 member groups including representation from North America, Europe, Asia and Australia. The GCIIG has a number of standing committees including cervix, endometrial, ovarian, rare tumors and a dedicated committee to accomplish phase 2 trials. The group has been very effective and has a history of successful collaboration and completion of randomized phase III trials, consensus conferences, brainstorming (*state-of-the-art*) initiatives, publications and reviews. International participation in trials has enabled achievement of rapid recruitment and international credibility for the results. Current GCIIG trials are looking at all aspects of gynecological cancer treatment including systemic, radiation and surgical questions. The group strongly supports the mission of providing access to relevant, high quality clinical trials in LMICs.

The website for this organization is:

<https://gciggroup.com>

CCRN (Cervix Cancer Research Network)

The Cervix Cancer Research Network (CCRN) developed within the Gynecologic Cancer Intergroup (GCIIG) out of a realization that cervical cancer trials were becoming scarce. While cervical cancer rates are declining in GCIIG countries, low- and middle-income countries are coping with large disease burdens. This led to extending trial development beyond GCIIG borders to involve a network of accredited, capable centers in other areas of the world. It was envisaged that this could harness local enthusiasm to raise standards of care. The CCRN would provide the infrastructure and support for high quality trials. (*Gaffney et al IJROBP 2015 92(3):506-508.*)

International Gynecologic Cancer Society (IGCS)

The mission of the International Gynecologic Cancer Society is to enhance the care of women with gynecologic cancer worldwide through education and training and public awareness.

The website for this organization is:

<https://igcs.org>

HVO (Health Volunteers Overseas)

HVO volunteers build local capacity by providing health care professionals in resource-scarce countries with the knowledge, skills and abilities they need to address the health care needs of their communities. HVO volunteers are trained health care professionals—physicians, nurses, dentists, physical therapists and others—willing to donate their time and expertise to work side-by-side with their colleagues overseas. The goal is not only to train new health care providers, but also to encourage and sustain current health workers so that they can continue to practice in their home countries. Through professional collaboration and personal connection, HVO's volunteers and supporters, along with the local health care providers they serve, build a global health community and work together to achieve the best health care possible for those who need it.

The website for this organization is:

<https://hvousa.org>


Radiating Hope 100% volunteer-run, mountain climbing, cancer-cure focused nonprofit 501(c)(3) organization. Their mission is to improve radiation oncology care, around the globe and particularly in low and middle income countries. The organization has active ongoing projects in Senegal, Tanzania and Kenya with future plans for collaborations in Guatemala, Honduras and Nepal. Radiation Hope continues to seek donations of radiation therapy equipment and donations of time from physicists and radiation oncologists—whether in or out of training.

The website for this organization is:

www.radiatinghope.org

A very interesting example of an **academic institution** contributing to global health is that of **Duke University Medical Center** (Courtesy of Junzo Chino, Adam Olson and Gita Suneja). Mulago Hospital in Kampala Uganda has had a long term relationship with Duke University Medical Center, which has included the Division of Gynecologic Oncology and

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the Department of Radiation Oncology. This relationship has included multiple visits by Duke Faculty, including Paula Lee (Gyn Oncology) and **Junzo Chino** (Radiation Oncology), working towards the development of a gynecologic oncology fellowship training program. Unfortunately the Co-60 teletherapy unit has been non-functional as of March of 2016, though there are plans to restore this service in 2017. There is however a functioning Co-60 brachytherapy unit, which is being used for palliation in the interim.

Gita Suneja recently joined the faculty at Duke and brought with her research collaboration in Botswana. The **Botswana Prospective Cohort Study** has now accrued over 2000 new cancer cases drawing from the three major centers in Botswana.

The analysis of cervix cancer patients was recently published (<http://ascopubs.org/doi/abs/10.1200/JCO.2016.67.9613>).

Cervical cancer screening initiatives are ongoing in Peru and Kenya, though no major radiotherapy collaborations in these countries have been established at this time.

The Duke Global Cancer Initiative has also developed a close relationship with Bugando Medical Center in Mwanza, Tanzania. Currently there are medical oncology and pediatric oncology services available with a reliable chemotherapy supply chain. The cancer center has built six treatment vaults for teletherapy machines and a Bhabhatron II Co-60 teletherapy unit has been installed. Commissioning is underway and they should be treating patients soon. A HDR brachytherapy unit was donated via **Radiating Hope** and should also be arriving shortly, so treatment for locally advanced cervical cancer can be delivered with curative intent. The Duke Global Health Institute has hired a pediatric neuro-oncologist that spends six months per year conducting research and caring for patients at Buganda Cancer Center. **Adam Olson**, a radiation oncology resident at Duke, will spend a year at Buganda Cancer Center as a Global

Health Fellow at the Duke Hubert Yeargan Center for Global Health. He will research the impact of radiation therapy access at Buganda on national referral patterns and test the feasibility of locally manufactured immobilization devices for breast cancer treatment.

Another very interesting example of an **academic institution** contributing to global health is that of the **University of Pennsylvania** (UPENN) which has been working with both the ministry of health (MOH) and the University of Botswana (UB) on broad issues of clinical care, education and research. **Dr. Surbhi Grover**, with support from **Department of Radiation Oncology at UPENN**, has been based in Botswana fulltime since December 2014. She has been focusing on clinical care, research, education and technical assistance to the MOH in development of several oncology initiatives in the public hospital.

Clinical care: Dr. Grover provides clinical care at Princess Marina Hospital (PMH) for 50% of her time. Working in collaboration with PMH, Dr. Grover was instrumental in establishing new patient clinics for teaching and established evidence-based care for all patients seen in clinic. Due to the high volume of gynecological and head and neck cancer patients, she also established multi-disciplinary clinics to streamline care. Most recently, she established a follow up clinic for gynecological cancer patients to help manage toxicities post oncological treatment. Such initiatives reduced delays in treatment by 50%. (*Grover et al. "Multidisciplinary gynecological oncology clinic in Botswana: a model for multidisciplinary oncology care in low and middle-income settings". Accepted to JGO Nov 2016*)

Research: UPENN Department of Radiation Oncology and UB have been awarded an NCI funded U54 consortia grant focusing on the natural history of cervical cancer and research capacity building in Botswana. This grant is a 5-year award and involves 3 sub-projects. In addition, there are several centers for AIDS and UICC funded grants in oncology lead by Dr. Grover and other UPENN and UB collaborators.

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Education: Through the U54 mentoring core, UPENN faculty are involved in research methods training for junior faculty at UB. Dr. Grover also has an adjunct position at the University of Botswana School of medicine and is involved with oncology teaching for medical students. In collaboration with **ARRO, Dr. Grover has also established a radiation oncology rotation in Botswana for residents in the US.** This allows for senior residents to provide clinical care in Botswana and explore opportunities to be involved in global health as their career in the future.

Technical Assistance to MOH: Dr. Grover is working closely with the head of the department of oncology at PMH and the MOH in developing cancer guidelines for the top 10 cancers in Botswana. She is also providing technical input for the establishment of the new radiation oncology facility at the UB. Finally, Dr. Grover was heavily involved in supporting MOH in development of the cancer symposium held in Botswana in 2014 and 2016 to establish goals for Botswana in regards to cancer screening and treatment.

At the **individual level**, Dr. Subir Nag, a member of the ABS International committee, is also very active in global Health. He gave a live demonstration of an interstitial cervical cancer brachytherapy procedure at the Rajiv Gandhi Cancer Institute, New Delhi, earlier this year. The procedure was televised live to the congress venue with the audience queries being clarified real-time on video during the procedure. This was followed by a seminar on Image-guided cervical cancer brachytherapy explaining the details. He will travel to Chittaranjan Cancer Hospital and Research Institute, Kolkata, India next month, giving a seminar on the *Recent Advances in Brachytherapy*.

Whether at the level of the organization, institution or individual, we appreciate the contributions made to improving cancer cure with the use of brachytherapy across our world. Please contact **Beth Erickson** (berickson@mcw.edu) if you would like to be involved with the work of this committee and also spread the word about the use of brachytherapy and contributions to global health.

Beth Erickson, MD
ABS International Committee Chair



What can YOU do for the ABS?

As a Member of ABS, what can YOU do to Support Your Association?

- Recruit new members both locally and at national meetings that you attend during the year
- Contact the national office with the names of potential corporate members, potential exhibitors and sponsors, based on the various vendors that you come into contact with on an annual basis
- Participate on an ABS committee
- Submit an article for publication in *Brachytherapy*, the official journal of the Society, or for *BrachyBlast*, or for the *BrachyNews*
- Renew your membership each year in a timely fashion
- Submit topics and speaker suggestions for the next Annual Meeting, or for a future ABS School

Membership Recruitment

For colleagues that may wish to join, refer them to the website to print out an application (www.americanbrachytherapy.org). Resident memberships are complimentary.

Membership Committee Participation

The ABS Membership Committee is looking for volunteers for regional membership recruitment efforts — if you are interested please contact the ABS committee chair, **Jarek Hepel** (jhepel@lifespan.org).

ABS Staff: Should you need assistance from the National Office staff, you may contact:

Rick Guggolz, Executive Director
rguggolz@drohanmgmt.com
extension 4070

Melissa Pomerene, Program Manager
mpomerene@drohanmgmt.com
extension 4085

Activities and Operations

Greetings—

our recent Society activities have included work in many important professional and collaborative areas, summarized below:

ABS and Boston in 2017

Drs. Dan Petereit and **Ann Klopp** are the Co-Scientific Chairs for the 2017 Annual Conference at the Seaport Hotel in Boston, and he and his committee have done a great job in bringing us a strong agenda with current topics. We have a special keynote speaker, **Professor Robert Kaplan** from the Harvard Business School, to address value-based healthcare, specifically relating to bundling for prostate brachytherapy.

We will have contouring sessions, a large brachytherapy-specific vendor presence for the viewing of products, physics workshops, proffered paper sessions, SNAP oral and SAMS sessions.

Other conference highlights include the awarding of the **ABS Ulrich Henschke Award**, the **Judith Stitt Awards** for the four best abstracts, our **Annual Membership Luncheon**, the **Resident's Luncheon**, an opening reception to renew old friendships, and the **Resident Travel Awards**. At the Membership Luncheon we will also be awarding the second **ABS Dr. Thom Shanahan Distinguished Brachytherapy Educator Award**, which was presented to **Dr. Juanita Crook** this year. The ABS Dr. Thom Shanahan Distinguished Brachytherapy Educa-

tor Award was created in memory of **Dr. Thomas Shanahan**, and is to be awarded at the President's discretion to an ABS member that has had a sustained and significant impact on brachytherapy education.

Note this year the addition of a simulator workshop on Saturday afternoon. Basic principles of LDR brachytherapy physics, treatment planning, treatment outcomes and quality assurance procedures will be taught to participants. A major focus of the course was the actual "hands on" simulation instruction and practice in pre-implant ultrasound and post-implant CT and MRI contouring using planning systems. Participants also implant prostate phantoms using "dummy seeds" through pre-plan as well as intra-operative techniques.

Before or after the conference, take advantage of all that Boston has to offer, from its waterfront to its great dining options to its variety of historical sites to be explored and enjoyed.

ABS Upcoming 2017 Elections

Look soon for a communique' with the ABS 2017 slate of candidates. Voting will go Live on-line at the end of February.

continued ➔

Board of Director's Strategic Planning Meeting in Chicago

On December 1st the ABS Board of Directors held a comprehensive strategic planning meeting in Chicago, see more details in our President's message.

Inaugural ABS Fellow Program

The Board of Directors is pleased to announce the inaugural class of **Fellows** for the ABS, to receive the designation **FABS** at the 2017 Annual Conference in Boston:

Douglas Arthur	Brian Davis
Beth Erickson	Basil Hilaris
Eric Horwitz	Robert Lee
Alvaro Martinez	Gregory Merrick
Subir Nag	Bradley Prestidge
Frank Vicini	David Wazer

The ABS views this as a significant accomplishment and the Fellowship program celebrates the career contributions of these individuals to both the ABS and to the field of brachytherapy. *Congratulations to all*, and our appreciation to the committee for the establishment of the Fellow criteria and the review of candidate submissions.

ABS Socioeconomic Committee Active

The ABS Socioeconomic Committee remains active on the valuing of brachytherapy codes. **ASTRO, ACR, AAPM** and **ABS** staff had a conference call about the 2017 HOPPS and MPFS final rules. From our perspective, CMS was not responsive to any of our comments on the HOPPS proposed rule. We think that it would be useful to have a face-to-face meeting with CMS to raise our issues, where there are flaws in CMS'

methodologies and data and our proposed remedies. We plan on scheduling a meeting in late February or early March.

ABS Journal

The ABS leadership is evaluating a contract renewal proposal from Elsevier, the current publisher of the ABS Journal, *Brachytherapy*.

ABS 2017 Prostate School

For more CME opportunities, the ABS Prostate School will be held next **February 24-25** at the **Hyatt Pier 66** in **Ft. Lauderdale**.

ABS Returns to San Francisco in 2018

The **2018 Annual Conference** will return to the **Hilton San Francisco Union Square**, site of the 2016 World Congress. The conference will be **June 7-9**.

Consensus Statements

The ABS Consensus Statements are now centralized at: <http://www.brachyjournal.com/>

The completion of these Consensus Statements represents a tremendous effort by the Society over the past decade and we are proud to direct our members to this important, ongoing resource. There are approximately six Consensus Statements currently in production that, once completed, will also join this section of the Journal website.

FY 2015 Financial Review

The ABS FY 2015 financial review has been completed by an outside CPA firm, as is the annual practice. The FY 2017 budget will be approved by the Board's at its next meeting.

Rick Guggolz

Executive Director, ABS

ABS MEETINGS

FUTURE



2017

February 24–25 | Prostate School
Hyatt Regency Pier 66 | Ft. Lauderdale, Florida

April 20–22 | Annual Conference
Seaport Hotel | Boston, Massachusetts

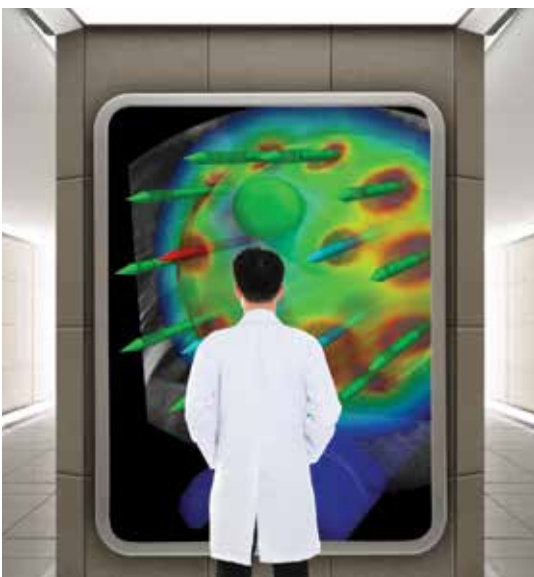
2018

February 23–24 | GYN School
Hyatt Regency Pier 66 | Ft. Lauderdale, Florida

June 7–9 | Annual Conference
San Francisco Hilton Union Square | San Francisco, California



DISCOVER THE FUTURE OF HDR PLANNING TODAY



At Varian, we believe that one of the most powerful tools to fight cancer is collaboration. Let us partner with you as we deploy a new software release for Vitesse™ real-time planning for HDR brachytherapy*. Vitesse 4.0 offers enhanced workflow and contouring capabilities, as well as the ability to pre-plan on multimodality images. The new software allows users to import DICOM structures into Vitesse from the VariSeed™ LDR treatment planning system's VariPath™ biopsy module, as well as other contouring systems. With Vitesse, users go from image capture to approved treatment plan in one integrated real-time experience. Together, we can draw on our collective energy to fight cancer and build a better future.

Join us at the 2017 ABS School of Prostate Brachytherapy in Fort Lauderdale, Florida.

To learn more, visit varian.com/brachytherapy

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Radiation treatments may cause side effects that can vary depending on the part of the body being treated. The most frequent ones are typically temporary and may include, but are not limited to, irritation to the respiratory, digestive, urinary or reproductive systems, fatigue, nausea, skin irritation, and hair loss. In some patients, they can be severe. Radiation treatment is not appropriate for all cancers. See <http://www.varian.com/use-and-safety> for more information. *Devices or features presented may not be available for sale in all markets.

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