INTRODUCTION:

The incidence of non-Hodgkin's lymphoma (NHL) is 70,130 new cases in 2012, with 18,940 estimated deaths. The incidence of non-Hodgkin's lymphoma has increased substantially over the past few decades due to age-related disease. The majority of non-Hodgkin's lymphoma originates in B-lymphocytes (80-85%) with T-lymphocytes comprising 15-20%. Natural killer cell lymphomas are very rare. The classification of non-Hodgkin's lymphoma is based on the cell of origin (large B, large T, or large NK), precursor or mature lymphocytes, as well as genetic, immunophenotype, and clinical features. Radiation therapy is typically delivered to the involved field either alone or in consolidation following chemotherapy. CT-based simulation and 3-dimensional planning is typically advised.

GOAL OF THE GUIDELINE:

The goal of these guidelines is to delineate appropriate indications of the employment of radiation therapy in the treatment of non-Hodgkin's lymphoma and to define suitable methods of delivery of radiation therapy for these indications.

GENERAL CONSIDERATIONS:

CT-based simulation with 3-dimensional conformal treatment planning is recommended. The use of intensity modulated radiation therapy as well as stereotactic body radiotherapy would be unusual. If requested, this would require peer to peer review to determine medical necessity. For nodal sites, radiation therapy alone or consolidation following chemotherapy should treat the involved field in most cases. Regional/extended fields are typically not recommended. For extranodal sites, radiation treatment fields should include the involved organ alone. Radiation dose is typically 24-36 Gy in standard fractionation. Doses of 40-50 Gy are recommended for residual disease after chemotherapy for diffuse large B cell lymphoma.

MEDICALLY NECESSARY INDICATIONS FOR RADIATION THERAPY AND TREATMENT OPTIONS:

Three-dimensional conformal radiation therapy (3D-CRT) or Two dimensional (2D) radiation therapy (2D) is the appropriate technique for treatment of Non-Hodgkin's Lymphoma.

Radiation dose is typically 24-36 Gy in standard fractionation. The following include radiation dose guidelines for the following lymphomas:

- Follicular lymphoma (24-30 Gy, or 36 Gy if bulky)
• Mantle cell lymphoma (30-36 Gy)
• MALT lymphoma (24-30 Gy)
• Diffuse large B cell lymphoma (30-36 Gy for CR, 40-50 Gy for PR following chemotherapy)
• Palliative dose (up to 10 fractions) for symptom control

Unless otherwise indicated standard radiation fractionation consists of 1.8 Gy to 2.0 Gy per day

TREATMENT OPTIONS REQUIRING ADDITIONAL CLINICAL REVIEW:

Intensity modulated radiation therapy (IMRT)

IMRT is not indicated as a standard treatment option and should not be used routinely for the delivery of radiation therapy for non Hodgkin’s lymphoma. IMRT is strictly defined by the utilization of inverse planning modulation techniques. IMRT may be appropriate for limited circumstances in which radiation therapy is indicated and 3D conformal radiation therapy (3D-CRT) techniques cannot adequately deliver the radiation prescription without exceeding normal tissue radiation tolerance, the delivery is anticipated to contribute to potential late toxicity or tumor volume dose heterogeneity is such that unacceptable hot or cold spots are created.

Clinical rationale and documentation for performing IMRT rather than 2D or 3D-CRT treatment planning and delivery will need to:

• Demonstrate how 3D-CRT isodose planning cannot produce a satisfactory treatment plan (as stated above) via the use of patient specific dose volume histograms and isodose plans.

• Provide tissue constraints for both the target and affected critical structures.

Stereotactic Body Radiation Therapy

Stereotactic Body Radiation Therapy (SBRT) is not currently an approved treatment option for the treatment of Non Hodgkin’s Lymphoma. Recent studies comparing SBRT conventional radiation therapy are limited.
REFERENCES


