PMB definition guideline for non-small cell lung cancer

Disclaimer:

The non-small cell lung cancer benefit definition has been developed for the majority of standard patients. These benefits may not be sufficient for outlier patients. Therefore regulation 15h and 15l may be applied for patients who are inadequately managed by the stated benefits. The procedure codes only serve as an indication of applicable procedure codes, and some significant procedure codes may not have been included. The benefit definition does not describe specific in-hospital management such as theatre, anaesthetists, anaesthetist drugs, supportive medication and nursing care. However, these interventions form part of care and are prescribed minimum benefits.

Table of contents

Abbreviations

CMS	-	Council for Medical Schemes
PMBS	-	Prescribed Minimum Benefits
DTPS	-	Diagnosis Treatment Pairs
NSCLC	-	Non-Small Cell Lung Cancer
AJCC	-	American Joint Committee on Cancer
SCLC	-	Small Cell Lung Cancer
FBC	-	Full Blood Count
LFTS	-	Liver Function Tests
U&E	-	Urea and Electrolytes
CT	-	Computed Tomography
MRI	-	Magnetic Resonance Imaging
PET	-	Positron Emission Tomography
SUVmax	-	Standardized Uptake Values
MTV	-	Metabolic Tumour Volume
TLG	-	Total Lesion Glycolysis
FDG PET	-	Fluorodeoxyglucose Positron Emission Tomography
EGFR	-	Epidermal Growth Factor Receptor
ALK	-	Anaplastic Lymphoma Kinase
FEV	-	Forced expiratory volume
FVC	-	Forced vital capacity
VATS	-	Video-Assisted Thoracoscopic Surgery
RFA	-	Radiofrequency Ablation

1. Introduction

1.1. The legislation governing the provision of the Prescribed Minimum Benefits (PMBs) is contained in the Regulations enacted under the Medical Schemes Act, No. 31 of 1998 (the Act). With regards to some of the Diagnosis Treatment Pairs (DTPs), medical scheme beneficiaries find it difficult to be fully aware of their entitlements in advance. In addition, medical schemes interpret these benefits differently, resulting in a lack of uniformity of benefit entitlements.

1.2. The benefit definition project is undertaken by the Council for Medical Schemes (CMS) with the aim of defining the PMB package, as well as to guide the interpretation of the PMB provisions by relevant stakeholders.

2. Scope and purpose

2.1. This is a recommendation for the diagnosis, treatment and care of individuals with non-small cell lung cancer (NSCLC) in any clinically appropriate setting as outlined in the Act.

2.2. The purpose is to provide detailed clarification in respect of benefit and entitlements to members and beneficiaries of medical schemes.

Table 1: Possible ICD 10 codes to identify non- small cell lung cancer

C33	Malignant neoplasm of trachea
C34.0	Malignant neoplasm, main bronchus
C34.1	Malignant neoplasm, upper lobe, bronchus or lung
C34.2	Malignant neoplasm, middle lobe, bronchus or lung
C34.3	Malignant neoplasm, lower lobe, bronchus or lung
C34.8	Malignant neoplasm, overlapping lesion of bronchus and lung
C34.9	Malignant neoplasm, bronchus or lung, unspecified
C38.1	Malignant neoplasm, anterior mediastinum
C38.2	Malignant neoplasm, posterior mediastinum
C38.3	Mediastinum, part unspecified
C76.1	Malignant neoplasm, thorax
D02.1	Carcinoma in situ, trachea
D02.2	Carcinoma in situ, bronchus and lung

D02.3	Carcinoma in situ, other parts of respiratory system
D02.4	Carcinoma in situ, respiratory system, unspecified

2.3. The CMS acknowledges that some patients will not qualify for PMB entitlements under the definition of treatable cancers as outlined in explanatory note 3, annexure A of the Act. In these instances, when the treatment intent is no longer curative, DTP 260S, may be applied depending on the clinical case.

Table 2: Applicable PMB code for a non-curative setting in NSCLC

PMB Code	PMB Description		ICD10 Code	ICD10 Description
260S	# Imminent death regardless of diagnosis	# Comfort care; pain relief; hydration	Z51.5	Palliative care

3. Epidemiology

3.1. Globally, non-small-cell lung cancer (NSCLC) accounts for the majority of lung cancers (85%-90%) while small cell lung cancer accounts for around 10%-15%. There are three major sub-types in NSCLC; the most prevalent is adenocarcinoma (40%) followed by squamous cell carcinoma (25-30%) and large cell carcinoma (10-15%). About 20% of NSCLC are NOS (Not Otherwise Specified) (Zappa & Mousa, 2016).

3.2. In South Africa, the majority of patients with non-small cell lung cancer present with metastatic disease (around 70%) or locally advanced disease (around 20%) (Aubeelack, Koegelenberg, Bolliger, von Groote-Bidlingmaier & Irusen, 2013).

4. Diagnosis, staging and risk assessment of NSCLC

Diagnosis is essential for treatment planning, and tissue diagnosis is required to assess whether the tumour is a primary malignancy, a pulmonary metastasis from another site, or possibly a non-malignant growth (Midthun, 2017). The 8th edition of the American Joint Committee on Cancer (AJCC) / International Union for Cancer Control (UICC) system is now used for staging non-small cell lung cancer. The eighth edition includes new tumour stage groupings and refinements of the T and M descriptors as shown below (Detterbeck, Boffa, Kim &Tanoue 2017; Lin, Shidan, Yunyun, Sunny, Guanghua, Adi & Yang, 2017). A multi-disciplinary approach is recommended in the diagnosis and staging, as well as determination of optimal treatment and supportive care (Detterbeck, Lewis, Diekemper, Addrizzo-Harris & Alberts, 2013).

Table 3: T, N, and M descriptors for the eighth edition of the TNM classification for lung cancer

T: Primary tumour	
Tx	Primary tumour cannot be assessed or tumour proven by presence of malignant cells in sputum or bronchial washings but not visualized by imaging or bronchoscopy
TO	No evidence of primary tumour
Tis	Carcinoma in situ
T1	Tumour ≤3 cm in greatest dimension surrounded by lung or visceral pleura without bronchoscopic evidence of invasion more proximal than the lobar bronchus (i.e., not in the main bronchus)*
T1a (mi)	**Minimally invasive adenocarcinoma¶**
T1a	**Tumour ≤1 cm in greatest dimension***
T1b	**Tumour >1 cm but 2≤ cm in greatest dimension***
T1c	**Tumour >2 cm but ≤3 cm in greatest dimension***
T2	Tumour >3 cm **but ≤5 cm** or tumour with any of the following features: Δ ▪ **Involves main bronchus regardless of distance from the carina but without involvement of the carina** ▪ Invades visceral pleura ▪ **Associated with atelectasis or obstructive pneumonitis that extends to the hilar region, involving part or all of the lung**
T2a	**Tumour >3 cm but ≤4 cm in greatest dimension**
T2b	**Tumour >4 cm but ≤5 cm in greatest dimension**
T3	**Tumour >5 cm but ≤7 cm in greatest dimension** or associated with separate tumour nodule(s) in the same lobe as the primary tumour or directly invades any of the following structures: chest wall (including the parietal pleura and superior sulcus tumours), phrenic nerve, parietal pericardium
T4	**Tumour >7 cm in greatest dimension** or associated with separate tumour nodule(s) in a different ipsilateral lobe than that of the primary tumour or invades any of the following structures: **diaphragm,** mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, oesophagus, vertebral body and carina
N: Regional lymph node involvement	

Nx	Regional lymph nodes cannot be assessed	
N0	No regional lymph node metastasis	
N1	Metastasis in ipsilateral peribronchial and/or ipsilateral hilar lymph nodes and intrapulmonary nodes, including involvement by direct extension	
N2	Metastasis in ipsilateral mediastinal and/or subcarinal lymph node(s)	
N3	Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s)	
M: Distant metastasis		
M0	No distant metastasis	
M1	Distant metastasis present	
M1a	Separate tumour nodule(s) in a contralateral lobe; tumour with pleural or pericardial nodule(s) or malignant pleural or pericardial effusion◊	
M1b	**Single extrathoracic metastasis§**	
M1c	**Multiple extrathoracic metastases in one or more organs**	
Stage groupings		
Occult carcinoma	TX	N0
Stage 0	Tis	N0
Stage IA1	**T1a (mi)**	**N0**
	T1a	**N0**
Stage IA2	**T1b**	**N0**
Stage IA3	**T1c**	**N0**
Stage IB	T2a	N0
Stage IIA	T2b	N0
Stage IIB	**T1a to c**	**N1**
	T2a	N1
	T2b	N1
	T3	N0

Stage IIIA	**T1a to c**	N2
	T2a to b	N2
	T3	N1
	T4	N0
	T4	N1
Stage IIIB	**T1a to c**	**N3**
	T2a to b	N3
	T3	**N2**
	T4	N2
Stage IIIC	**T3**	**N3**
	T4	**N3**
Stage IVA	**Any T**	**Any N**
	Any T	**Any N**
Stage IVB	**Any T**	**Any N**

Note: Changes to the seventh edition are in bold.

TNM: tumor, node, metastasis; Tis: carcinoma in situ; T1a(mi): minimally invasive adenocarcinoma.
* The uncommon superficial spreading tumor of any size with its invasive component limited to the bronchial wall, which may extend proximal to the main bronchus, is also classified as T1a.
¶ Solitary adenocarcinoma, ≤3 cm with a predominately lepidic pattern and ≤5 mm invasion in any one focus.
Δ T2 tumors with these features are classified as T2a if ≤4 cm in greatest dimension or if size cannot be determined, and T2b if >4 cm but ≤5 cm in greatest dimension.
◇ Most pleural (pericardial) effusions with lung cancer are due to tumor. In a few patients, however, multiple microscopic examinations of pleural (pericardial) fluid are negative for tumor and the fluid is nonbloody and not an exudate. When these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging descriptor.
§ This includes involvement of a single distant (nonregional) lymph node.

There are several similarities between lab, histopathology and imaging investigations in small cell lung cancer (SCLC) and NSCLC.

4.1. **Lab investigations / point of care testing**

The initial evaluation of patients with newly diagnosed NSCLC consists of a complete medical history and physical examination, a pathologic review of biopsy specimens, and laboratory studies, including full blood count (FBC), serum electrolytes, serum calcium, renal and liver function tests (LFTs), and serum lactate dehydrogenase (Jett, Schild, Kesler & Kalemkerian, 2013). Sputum cytology might be requested pre-diagnostic to rule out tuberculosis (TB) or other infections. Sputum cytology is not recommended as a stand-alone diagnostic tool or after a diagnosis has been made.

The following laboratory investigations for NSCLC are recommended as PMB level of care for diagnosis and follow up (as clinically indicated):

- U&E and creatinine
- Serum calcium
- Serum lactate dehydrogenase
- LFTs
- Renal function tests
- FBC
- Platelets
- Blood gases

4.2. **Imaging radiology**

4.2.1. The common imaging modalities used for diagnosis and staging in patients with NSCLC include chest x-ray, computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) (Munden, Swisher, Stevens, & Stewart, 2005).

4.2.2. CT of the chest is the most common radiologic study performed after chest radiography to evaluate lung cancer in a patient.

4.2.3. PET is recommended only on motivation in selected patients (Vorster at al, 2016). A recent meta-analysis showed that patients with surgically resectable NSCLC with aggressive disease had high values of maximum standardized uptake values (SUVmax), metabolic tumour volume (MTV) and total lesion glycolysis (TLG). These patients have a high risk of disease recurrence with high mortality and FDG PET may identify these type of patients, who benefit from aggressive treatments (Liu et al., 2016).

4.2.4. A multi-variate analysis of pooled data from individual patients supports the evidence that a high SUV predicts poor prognosis in early stage disease. This study also showed that SUV has little or no prognostic value among patients with stage IV disease (Paesmans, Garcia, Wong, Patz Jr, Komaki, Eschmann, Govindan, Vansteenkiste, Meert, de Jong, Altorki, Higashi, Van Baardwijk, Borst, Ameye, Lafitte, Berghmans, Flamen, Rami-Porta & Sculier, 2015).

Table 4 : Imaging radiology for diagnosis and staging of non-small cell lung cancer recommended as PMB level of care

Description	Frequency	Comment
Chest X-ray	1	- Needs to be done initially. - Follow up chest x-ray only on motivation on a case by case basis if effusion has been drained and a chest drain inserted
CT chest , abdomen and pelvis with contrast	1	- CT scan should always be contrast for better definition. - CT scan is also done to follow up and monitoring treatment response
MRI brain	1	MRI brain is recommended over CT scans, especially for adenocarcinomas.
Ultrasound chest	1	- Only necessary if there is an effusion that needs drainage. - Ultrasound is appropriate to guide the procedure or to assist with therapeutic tap if repeated collection is required.
PET scan	On motivation	- Recommended on motivation for staging in patients with potentially curable disease (on CT staging) and who are fit for definitive therapy. - Not indicated if CT scan shows advanced stage or metastatic disease. - Not recommended for routine follow up.
Bone scan	On motivation	- Should be done in advanced disease characterised by pleural effusion, mediastinal, hilar nodes and bone symptoms. - To be approved only if a PET is not done.
Exclusions		
MRI chest	0	Not recommended as PMB level of care.
Ultrasound abdomen	0	Inappropriate to do an ultrasound abdomen. No place for ultrasound in early stage lung cancer.

4.3. **Histology**

4.3.1. Adenocarcinoma, squamous carcinoma, adenosquamous carcinoma, and large cell carcinoma are the four major histological sub-types of NSCLC. Patients with adenocarcinoma have a poorer prognosis than those with squamous cell carcinoma (Suzuki, Nagai,Yoshida, Nishimura, Takahashi & Yokose, 1999).However, the outcome of adenocarcinoma has improved with the availability of targeted treatment agents.

4.3.2. Adenocarcinoma more commonly manifests metastasis while, in contrast, squamous cell carcinoma metastases tend to occur later in the disease.

4.3.3. Two immunohistochemical stains (usually p63 + TTF1 or p63 + Napsin A) are recommended as PMB level of care, in addition to routine histology and cytology tests. The choice of stains might change in the future for example p63 may be replaced with p40, hence decisions should be made based on the current evidence based practices.

4.3.4. The routine histology and cytology tests that are done depends on the clinical context and the following can be used as a guide.

Table 4: Guidance to routine histology and cytology tests for SCLC

Cytology tests	• Pleural effusion cytology: if patient has an effusion (malignancy involving pleura is suspected) • Lung FNA: If sub-pleural mass • Transbronchial ultrasound guided FNA: If mass is in/near mediastinum • Bronchial brushing/lavage: If mass is in/around bronchus • Cytology stain: PAP. • Immunocytochemistry to confirm the diagnosis may be performed if material is suitable. If the sample of cells are submitted in fluid (e.g. pleural fluid), a cell block with additional immunocytochemistry is often performed (e.g. to exclude mesothelioma from adenocarcinoma)
Histology tests	• Pleural biopsy: If pleural mass • Trucut biopsy: if subpleural mass • Bronchial/transbronchial biopsy: If bronchial/peri-bronchial mass • Mediastinoscopy with biopsy: If mediastinal mass

4.3.5. CMS does not recommend both targeted treatment (e.g. erlotonib or crizotinib) and molecular testing for either the primary tumour, or for a metastasis.

4.3.6. Although both the tests and the targeted treatment are not recommended as PMB level of care, studies have shown improved outcomes in selected patients (Lindeman, Cagle, Beasley, Chitale, Dacic, Giaccone, Jenkins, Kwiatkowski, Saldivar, Squire, Thunnissen & Ladanyi, 2013, Leighl, Rekhtman, Biermann, Huang, Mino-Kenudson, Ramalingam, West, Whitlock & Somerfield, 2014). CMS recommends the consideration and application of scheme rules on a case by case basis.

4.4. Procedures for diagnosis and staging of non-small cell lung cancer

4.4.1. Surgery serves an important role in the diagnosis, staging, and management of NSCLC (Lackey & Donington, 2013)

4.4.2. Most patients with suspected lung cancer require a tissue-based diagnosis. The aims of tissue sampling include confirmation of diagnosis (e.g. adenocarcinoma vs squamous cell carcinoma) and molecular testing. The least invasive method of biopsy which yield sufficient tissue for genetic assessment is recommended. Fine needle aspirate is insufficient (Dietel, Bubendorf, Dingemans, Dooms, Elmberger, García, Kerr, Lim, López-Ríos, Thunnissen, Van Schil & von Laffert, 2016).

4.4.3. The following procedures are also recommended as PMB level of care:

- Transthoracic needle aspiration
- Bronchoscopy
- Lymph node biopsy
- Mediastinoscopy or mediastinotomy
- Oesophagoscopy
- Pulmonectomy
- Thoracentesis
- Bone marrow aspiration and biopsy - only where results of a bone scan or a PET scan are inconclusive.

5. Treatment options for NSCLC

The decision of the physician treatment choice depends on many variables including but not limited to patient condition, extent of radiotherapy field, surgery or residual lung function.

5.1. Surgery

5.1.1. Baseline pulmonary function is PMB level of care as part of pre-operative work up.

5.1.2. Surgical resection offers the best opportunity for long-term survival and cure in patients with resectable NSCLC and patients with stage I or II NSCLC should be treated with complete surgical resection whenever possible (West, Vallières & Schild, 2017).

5.1.3. Lobectomy, the surgical resection of a single lobe, is generally accepted as the optimal procedure for early stage NSCLC. Limited resection is associated with worse survival rates compared with lobectomy. The introduction of video-assisted thoracoscopic surgery (VATS) may facilitate the use of limited resections in selected high-risk patients (West et al., 2017).

5.1.4. Video-assisted thoracoscopic surgery (VATS) is recommended as PMB level of care for segmental resections and mediastinal lymph node biopsy not accessible on mediastinoscopy and pleural biopsy.

5.1.5. Segmentectomy (or wedge resection) are also recommended as PMB level of care if a complete resection can be achieved in selected patients with limited disease. This form of surgery may also be preferred for some people who could not tolerate conventional lobectomy, for example, in the case of a person whose lungs do not work well as confirmed by lung function tests (NICE guidelines, 2011).

5.1.6. Surgery is not recommended in metastatic disease with the possible exception of surgery for limited brain metastases (Ettinger, Akerley, Bauman, Chirieac, D'Amico, DeCamp, Dilling, Dobelbower, Doebele, Govindan, Gubens, Hennon, Horn, Komaki, Lackner, Lanuti, Leal, Leisch, Lilenbaum, Lin, Loo, Martins, Otterson, Riely, Schild, Shapiro, Stevenson, Swanson, Tauer, Yang,Gregory & Hughes, 2017b).

5.1.7. The following surgical interventions are the recommended PMB level of care:

- Lobectomy
- Segmental / wedge resection
- Lymph node dissection

5.1.8. Robotic surgery is not PMB level of care.

5.2. **Chemotherapy**

5.2.1. Patients with stage I and II disease who have undergone surgery can receive adjuvant chemotherapy or adjuvant radiotherapy.

5.2.2. Stage III is now divided into categories A, B and C.

5.2.2.1. For pathological Stage III diagnosed postoperatively, the recommended treatment includes (Bezjak, Temin, Franklin, Giaccone, Govindan, Johnson, Rimner, Schneider, Strawn , Azzoli, 2015) :

- Radiotherapy to mediastinum if nodes were involved.

- Radiotherapy to tumour bed if resection margins clear.
- Adjuvant chemotherapy.
- Chemotherapy followed by radiotherapy is the preferred sequence if radiotherapy is to be included. Concurrent chemotherapy with RT is of uncertain benefit.

5.2.2.2. Patients with operable stage III (includes T3N1 and T4 N0-1) can undergo surgery followed by chemotherapy.

5.2.2.3. For patients with stage III inoperable (medically) or superior sulcus tumours, the recommended treatment is chemoradiotherapy with adjuvant chemotherapy. Superior sulcus tumours are candidates for surgery after chemoradiotherapy (Rusch, Giroux, Kraut, Crowley, Hazuka, Johnson, Goldberg, Detterbeck, Shepherd, Burkes, Winton, Deschamps , Livingston , Gandara , 2001).

5.2.2.4. For patients with N2 disease, although chemoradiation is a standard option for patients with known mediastinal involvement, the role of surgery after induction chemotherapy or chemoradiation in certain settings is extensively debated. There is a variation in the threshold to offer surgery after induction therapy, given that, while local control may be improved, no randomized studies have demonstrated a survival benefit to this approach. In the setting of limited data, some experts treat essentially all stage III N2 disease with definitive chemoradiation (Pless , Stupp , Ris, Stahel, Weder , Thierstein , Gerard , Xyrafas , Früh , Cathomas , Zippelius , Roth , Bijelovic , Ochsenbein , Meier , Mamot , Rauch , Gautschi , Betticher , Mirimanoff , Peters , 2015).

5.2.2.5. There are many permutations that may lead to diagnosis of N2 disease and the treatment decision will be determined by the patient presentation.

5.2.3. Cisplatin combinations (including gemcitabine or vinorelbine or taxanes) are recommended as first-line in metastatic disease with poorer outcomes shown with carboplatin. Carboplatin use is recommended in patients where cisplatin is contraindicated, for example patients with renal failure (Novello, Barlesi, Califano, Cufer, Ekman, Levra, Kerr, Popat, Reck, Senan, Simo, Vansteenkiste & Peters, 2016).

5.2.4. Gemcitabine should be considered only in patients who are intolerant to taxanes.

5.2.5. Only the intravenous formulation of vinorelbine is considered PMB level of care for NSCLC. Oral vinorelbine can be considered on a case by case basis especially for elderly patients.

5.2.6. In patients with metastatic disease with performance status of 2 or beyond, alternative treatment with carboplatin doublets or gemcitabine / vinorelbine / taxanes as monotherapy may be considered (Novello et al., 2016; Masters, Temin, Azzoli, Giaccone, Baker, Brahmer, Ellis, Gajra, Rackear, Schiller, Smith, Strawn, Trent & Johnson, 2015).

5.2.7. Clinical evidence does not support recommendations for third-line treatment (Masters et al., 2015).

Table 5: Chemotherapy recommended as PMB level of care for NSCLC

Indication	Medicine names	Comments
Adjuvant	Cisplatin / Carboplatin Vinorelbine - Intravenous Paclitaxel	Only for post resection
Neo-adjuvant (chemoradiation)	Cisplatin / Carboplatin Vinorelbine - Intravenous Paclitaxel Etoposide Docetaxel Gemcitabine	Gemcitabine is only for patients who are intolerant to paclitaxel or patients with neuropathies. Only IV vinorelbine is recommended as PMB. Oral vinorelbine to be approved on a case to case basis specifically for elderly patients
Metastatic	Vinorelbine – Intravenous Cisplatin / Carboplatin Paclitaxel Gemcitabine Etoposide Docetaxel	
EXCLUSIONS		
• Pemetrexed - Although it is now an international standard of care, it is not recommended as PMB level of care. • Erlotinib • Bevacizumab		

5.3. **Radiotherapy**

5.3.1. Some patients may have a surgically removable NSCLC, but may not be operable due to poor pulmonary function or comorbidities. Patients with stage I or II disease who are not candidates for surgical resection because of comorbities or refusal of surgery may be candidates for nonsurgical local therapy such as radiation (Ettinger, et al, 2017a; Munden et al, 2005).

5.3.2. All patients should undergo pulmonary function tests (including lung volumes) before having radical radiotherapy for NSCLC.

5.3.3. Chemoradiation is indicated in stage II or III patients who are not suitable for surgery if the potential benefit in survival outweighs the risk of additional toxicities (NICE guidelines, 2011).

5.3.4. IMRT is recommended as PMB level of care on motivation in selected patients with locally advanced disease receiving high dose radiotherapy.

5.3.5. Other image-guided ablative techniques such as cryoablation, radiofrequency ablation (RFA), laser ablation and microwave ablation have not been proven with adequate long-term data and none of these have an established role in the routine management of stage I or stage II NSCLCs and are not recommended as PMB level of care (West et al., 2017).

5.3.6. Whole brain radiotherapy for confirmed brain metastases is recommended as PMB level care.

5.3.7. Prophylactic radiotherapy has no basis for NSCLC and is therefore not PMB level of care.

5.3.8. Stereotactic radiation is not recommended as routine. It recommended as PMB level of care on motivation on a case by case basis for selected patients with limited metastases.

5.3.9. Extracranial stereotactic radiotherapy for metastatic disease or primary is not recommended as PMB level of care.

Table 6: PMB level of care for radiation therapy in NSCLC

Definitive Radiation therapy: 60Gy (30# x 2Gy) / 66Gy (33# x 2Gy) / 70Gy (35# x 2Gy) - any dose between 30 and 35# Palliative Radiation therapy: 3# to 15# to control pain

6. Best supportive care

Best supportive care guidelines are currently being developed, and a hyperlink will be added once the guidelines are finalised.

This guideline will be reviewed on 31 March 2020

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