Conclusions: Dose response for local control based on D90 of HR CTV is significant in a multicenter setting. Overall local control can be obtained in 95% of the patients when D90 of HR CTV>92 Gy. The analysis further points to FIGO stage, tumour width at diagnosis, volume of HR CTV and histology as important determinants for TCD90 analysis further points to FIGO stage, tumour width at diagnosis, obtained in 95% of the patients when D90 of HR CTV>92 Gy. The is significant in a multicenter setting. Overall local control can be permitted from UK centres. This will therefore require an advance in standards for centres wishing to participate in the INTERLACE trial: a phase III trial of weekly induction chemoradiation versus standard chemoradiation. The INTERLACE pre-trial questionnaire has revealed a wide variation in dose fractionation and treatment techniques being used in centres across the UK. Following our results new minimum dose requirement for the trial of 78 Gy, with values ranging from 68.3 to 83.9 Gy. The intended trial requirement for the overall treatment time of ≤ 50 days was also not met by 7 of the 22 centres. Out of 21 brachytherapy centres, 18 use 3D imaging for the planning of all treatment slots are at a premium.

PD-0267
A survey of UK practice in cervical cancer radiotherapy aimed at developing trial specific quality assurance
T. Simnor1, J. Conibear1, P. Diez1, E. Miles1, M. McCormack1
1Mount Vernon Hospital, Radiotherapy Physics, Northwood Middlesex, United Kingdom
2The Royal Marsden Hospital, Clinical Oncology, London, United Kingdom

Purpose/Objective: To determine the current variation in radiotherapy practice for the treatment of cervical cancer across the United Kingdom (UK) with the aim of developing a comprehensive radiotherapy quality assurance (QA) programme for both external beam radiotherapy (EBRT) and brachytherapy within the context of the INTERLACE trial: a phase III trial of weekly induction chemotherapy and chemoradiation versus standard chemoradiation. The data will also be used to help determine the need for a national brachytherapy dosimetry audit.

Materials and Methods: A pre-trial questionnaire was circulated to 31 radiotherapy centres that had expressed interest in participating in INTERLACE. In addition to external beam radiotherapy (EBRT) details, in depth information on brachytherapy technique and QA was collected.

Results: To date, 22 questionnaires have been completed and evaluated. Local practice was seen to vary significantly between centres with particular variation in brachytherapy techniques. For EBRT, all but 2 centres utilise 3D CT and MRI modalities, only 6 of these also utilise PET imaging. Seven out of 22 centres use 3D virtual simulation (Vsim) techniques for EBRT planning. With respect to total EQD2 dose, 9 out of 22 centres did not achieve the proposed minimum dose requirement for the trial of 78 Gy, with values ranging from 68.3 to 83.9 Gy. The intended trial requirement for the overall treatment time of ≤ 50 days was also not met by 7 of the 22 centres. Out of 21 brachytherapy centres, 18 use 3D imaging for the planning of all fractions. Twelve of these optimise their plans for each individual patient; 6 to the target volume and 6 to OAR volumes or ICRU points, while the remaining 9 use standard plans. Six out of 21 centres have not participated in any brachytherapy dosimetry audit to date.

Conclusions: The INTERLACE pre-trial questionnaire has revealed a wide variation in dose fractionation and treatment techniques being used in centres across the UK. Following our results new minimum standards for centres wishing to participate in the INTERLACE trial have been set. Now Vsim techniques for EBRT planning will not be permitted from UK centres. This will therefore require an advance in technique to 3D conformal planning for some centres. Several centres will be required to increase their total EQD2 dose for trial patients. The overall treatment time has now been amended to up to 56 days. Finally our results have highlighted the need for a national brachytherapy dosimetry audit which is now currently under development.

PD-0268
Using systematic CTC registration in the clinic to aid competent care of acute side-effects of radiotherapy
K. Oiling1, L. Holberg1, M. Hansen1, M.D. Lund2, A.L. Appelt2
1Vejle Hospital, Radiotherapy Dep. of Oncology, Vejle, Denmark
2Vejle Hospital, Medical Physics Dep. of Oncology, Vejle, Denmark

Purpose/Objective: This study examined the use of Systematic Common Terminology Criteria for Adverse Events v. 3.0 (CTC) registration to enable consistent patient care and prevention of acute side-effects from radiotherapy (RT). The goal was to enhance the ability of the radiation therapist nurses (RTN) to evaluate and act on acute side-effects. Hence we investigated whether performing CTC registration on specific weekdays compared to doing the registration on specific treatment fractions improved the quality of patient care as well as the toxicity data collection. Furthermore, we studied whether CTC registration combined with prior delegated medical actions and supplementary nurse prescribing reduced the need for physician consultations and interventions.

Materials and Methods: We randomly selected 20 patients treated with RT for rectal cancer during October 2011. At that time point, CTC registration was done on every fifth day of the patient’s treatment course. We evaluated the relative number of planned CTC registrations actually performed and all medical interventions. This was compared to similar data collected for 20 randomly selected rectal cancer patients treated during October 2012, where CTC