East of England Radiotherapy Network:

Cervix Protocol V2

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1.0 Indications and patient population

This protocol covers treatment in the following situations:

a. **Curative Radiotherapy** of biopsy proven Squamous carcinoma, adenocarcinoma, or adeno-squamous carcinoma of the uterine cervix, FIGO Stage 1B, 2A, 2B ,3A, 3B, 3C, 4A [FIGO2018]

   This includes patients who are treated with chemo irradiation or radiotherapy as a single modality.

b. **Post –Operative Radiotherapy** of those patients who have had either:

   i. Previous radical surgical procedure-Hysterectomy or Trachelectomy
   ii. Incidental cervical cancer found in a hysterectomy for presumed benign disease
   iii. Cervical cancer in previous subtotal hysterectomy

   This includes patients treated with chemo irradiation or radiotherapy alone.

c. Brachytherapy following surgery & adjuvant chemo/radiation – at treating clinicians' discretion

d. Brachytherapy following definitive chemo/radiation

e. **Palliative Radiotherapy**

Please note: Departments delivering cervix radiotherapy using an online adaptive radiotherapy (OART) workflow must have appropriate local documentation in place describing the implementation and delivery of the adaptive pathway. This should include, as applicable, patient localisation and imaging, target volume and organ-at-risk definition, planning and adaptation processes and techniques, assessment of daily anatomy, target/OAR verification, plan selection and/or adaptation, and the roles and responsibilities for review and approval. Local documentation should be consistent with the principles and dose/volume requirements defined within this Network protocol.

1.1 Curative treatment eligibility

1.1.1 Inclusion criteria

Biopsy proven squamous carcinoma, adenocarcinoma, adeno-squamous carcinoma of the uterine cervix, **FIGO [2018]** stage IA [If surgery is considered inappropriate] to Stage IV A

1.1.2 Exclusion criteria

Contra-indications to pelvic radiotherapy, e.g., prior radiotherapy treatment, significant inflammatory bowel disease

1.1.3 Essential Pre-Radiotherapy investigations for curative patients

A. EBRT:

Bloods: FBC U&E LFT eGFR

Examination: Outpatient or Examination Under Anaesthesia [EUA] Biopsy and pathological confirmation

Imaging: MRI pelvis. Whole body imaging: PET CT or CT of chest abdomen and pelvis

B. Brachytherapy:

Examination: under anaesthesia/ Vaginal examination/speculum
MRI: to assess extent of soft tissue extension
History: Relevant histology and/or operation note

It is assumed that each centre will have imaging protocols developed for initial staging and post treatment imaging protocols.

2.0 Localisation

A. EBRT

Localisation		Notes
Position	Supine	
Arm position	Hands on chest Arm position as required if PA nodes being treated	
Immobilisation and supports	Knee wedge and ankle stocks	
Organ pre-requisites	Comfortably full bladder Empty bladder scan if using for ITV generation	Suggested drinking protocol if full: Void 1 hour before imaging and drink 300ml water/ clear fluid before CT/ treatment delivery
	Empty bowels	Bowels should be emptied before CT and treatment. Deflation or rescan should be considered if rectum diameter greater than 4cm. Bowel preparation may be given prior to radiotherapy planning scan and treatment to ensure empty rectum, individual department protocols may vary.
Contrast	IV Contrast	Unless contra-indicated

Localisation		Notes
CT acquisition	Slice thickness: 2-2.5mm Sup scanning limits: Top of L3 Inf scanning limits: 2cm below ischium	Will need to increase superior scan limit to T8/T9 if para aortics are involved
Examination	Gynaecological examination preferably with diagrammatic documentation.	
MRI	Planning MRI or use diagnostic MRI for planning (with or without co-registration)	

B. Brachytherapy

Radical treatment following EBRT

- The primary imaging modality is MRI with the applicator in situ which enables definition of the relevant volumes of interest directly on the images for treatment planning including applicator reconstruction [1]
- Contouring for both tumour and OAR is performed for each insertion of BT applicators by contouring the CTV on T2 weighted para transversal MRI sequences in a dedicated 3D Brachytherapy dose-planning system according to GEC ESTRO Recommendations (5). The MRI based target delineation can be reused by superimposition in the process of contouring on CT, if for subsequent fractions of brachytherapy only CT can be used with the applicator in place.[2]
- Contouring should be undertaken with reference to EUAs, diagnostic imaging at baseline and imaging undertaken at the end of EBRT prior to brachytherapy.
- CT imaging can also be used to delineate the organs at risk, registering the CT and MR images together for Image guided adaptive Brachytherapy of the cervix3.0 Dose prescription & chemotherapy

3.0 Dose prescription & chemotherapy

Intent	Dose (Gy)/#	#/week	Chemo/ comments
a. Curative Radiotherapy	45Gy/25#	5	EBRT + concomitant cisplatin + HDR brachytherapy boost (as per EMBRACE II) Or EBRT 45Gy/ 25# + Vault HDR brachytherapy boost
b. Post-operative Radiotherapy	45Gy/25# with integrated boost of 57.5Gy to involved nodes outside true pelvis)	5	EBRT + concomitant cisplatin + HDR brachytherapy boost (as per EMBRACE II) Or EBRT 45Gy/ 25# + Vault HDR brachytherapy boost
	45Gy/25# with integrated boost of 55Gy to involved nodes inside true pelvis)	5	
	45Gy/25#	5	If unable/unsuitable to receive brachytherapy EBRT + concomitant cisplatin
	45Gy/25# with integrated boost of 60Gy to involved nodes	5	
	45Gy/25# + PH2 20Gy/10#	5	EBRT + concomitant cisplatin Sequential EBRT boost to primary target following 45Gy/25# e.g. when brachytherapy fails. Boost may be reduced within the range 10-20Gy/5-10# to spare OARs
	50.4Gy/28#	5	If unable/unsuitable to receive brachytherapy EBRT + concomitant cisplatin
	50.4Gy/28# with integrated boost of 60Gy to involved nodes	5	
	45Gy/25# + PH2 5.4Gy/3#	5	
	64Gy/32# to high dose primary disease, 60Gy to involved nodes, 50Gy to low dose primary and elective nodes	5	If unable to receive brachytherapy or chemotherapy

Intent	Dose (Gy)/#		#/week	Chemo/ comments
c. Radical Brachytherapy treatment following EBRT	Intracavity IGBT +_ interstitial	28 – 28.6Gy / 4#	2-4	As per EMBRACE 2 [1, 11]
		21 – 26.5Gy /3#	3	
e. Palliative Radiotherapy	8Gy/1#		1	
	20Gy/5#		5	
	30Gy/10#		5	

N.B For recurrence: dose should be considered as appropriate on a patient-by-patient basis, taking into consideration previous treatment delivered. This should be discussed at MDT.

4.0 Target volumes

XXXX is prescription in cGy

Target volumes should match agreed naming conventions unless there are operational reasons for use of other naming. PTV ProKnow nomenclature should be used for NHSE ProKnow Collections and Scorecard Templates for upload.

4.1 Primary target volumes

GTVp_XXXX - Gross Tumour Volume of the primary tumour e.g. GTV inside and outside the cervix and as a minimum the whole cervix
GTVn_XXXX - Gross Tumour Volume of individual pathological involved lymph node

CTVp_XXXX - GTV (if present) + paracervical and parametrial tissues.

CTVn_XXXX - GTVn + 0-3 mm - Clinical Target Volume of individual pathologic lymph nodes.

4.2 Elective Nodal target volumes

CTVe_XXXX = Clinical Target Volume of the elective nodal region, including pathological lymph nodes if present. Contour according to the assumed risk of microscopic nodal involvement as per the Table below. If there are meso-rectal lymph nodes present, then whole of the meso-rectum should be included as part of the CTV_E.
if lower 1/3 of vagina is involved include the inguinal nodes, these may be contoured separately.

Risk Group IN	Definition	EBRT Lymph node regions
Low Risk (LR LN)	Tumour size <4cm AND Stage 1A/1B1/11A2 AND N0 AND Squamous cell carcinoma AND no uterine invasion	**"Small Pelvis"** Internal Iliac External Iliac Obturator Pre-sacral
Intermediate Risk (IR LN)	Not low risk No high-risk features	**"Large Pelvis"** Nodes included in "Small Pelvis" and common iliac region (including the aortic bifurcation). In addition: • inguinal in case of distal vaginal involvement.

Risk Group IN	Definition	EBRT Lymph node regions
		• Mesorectal space in case of mesorectal nodes and advanced local disease
High Risk (HR LN)	Based on nodal pathology • >1 pathologic node at common iliac or above • OR ≥3 pathologic nodes	"**Large Pelvis + Para-aortic"** Nodes included in "Large Pelvis" and para-aortic region with the upper border of CTV minimum at the level of renal veins (Usually INC 12) and at least 3cm cranial of the highest pathological node in case of para-aortic nodes)

*As per EMBRACE II

4.3 ITV

Use of an ITV is highly recommended for curative/adjuvant radiotherapy. There are several options for creation of ITV, "Basic ITV" using geometric expansion, "Intermediate ITV" using variable bladder filling planning CT/MR scans and diagnostic images or "Advanced ITV" using Plan of the Day. The strategy to derive ITV will be according to local protocols.

The "Basic ITV" method is detailed here.

- ITVp_XXXX= CTVp with following margins
  - 10 mm Ant-post
  - 10 mm Sup-Inf
  - 5 mm lateral
  - No additional margin, distal vagina [along vaginal axis] i.e., delete inferior slices of ITV up to CTV
  - Manual adaptation at muscle and bone
  - *An extra 5mm in all directions in area of uterine body involvement*
- **ITVpe_XXXX** = ITVp_XXXX + CTVe_XXXX

4.4 Curative / adjuvant radiotherapy PTV

ITV method

- PTVpe_XXXX = ITV_XXXX + 5 mm
- PTVn_XXXX = CTVn_XXXX + 5 mm

If no ITV generated

- PTVp_XXXX = CTVp_ XXXX + 10-15 mm
- PTVe_XXXX = CTVe_XXXX + 5-7 mm
- PTVn_XXXX = CTVn_XXXX + 5 mm

4.5 Image Guided Brachytherapy

Tumour volumes. The outlining follows the Embrace 1 trial protocol. No margins are added to the CTV in BT i.e., CTV=PTV

- **GTVres** = Macroscopic tumour (if present) at time of brachytherapy
- High Risk Target **HR-CTV** = Macroscopic tumour extension at time of brachytherapy. GTVres+whole cervix + presumed extra cervical tumour extension
- Intermediate risk target **IR-CTV** = HR-CTV + macroscopic tumour extension at diagnosis providing a minimal margin of 10mm to residual disease at time of brachytherapy in direction of potential spread. A reduced margin should be used towards an intact anatomical barrier. The GECESTRO recommendations suggest a 10mm margin in the lateral and cranio-caudal directions and 5mm in the anterior posterior direction. In some cases, the clinician may prefer to manually draw the IR-CTV but should pay attention to the suggested margins as guides.
- Unless OARs are involved in the disease, crop CTV-IR from all OARs

The HR-CTV and GTVres MRI (if present) should be outlined on MRI. If MRI is not available each fraction, a CT scan fused with fraction 1 MRI HR-CTV be copied across.

4.6 Palliative radiotherapy

VOI defined for Simple planning e.g. virtual simulation parallel opposed.

For 3D conformal/IMRT/VMAT contouring margins will depend on disease and technique used by treating centre. Suggested palliative margins are below or use as per local department protocol. Consider using radical contouring if appropriate.

GTVp_XXXX = All gross disease

PTVp_XXXX = GTVp_XXXX + 5-20 mm.

5.0 Organs at risk

- Aim for the use of standard nomenclature as per Global Harmonization Group consensus guidelines: https://www.thegreenjournal.com/action/showPdf?pii=S0167-8140%2820%2930294-2

A. EBRT

Structure name	Description
Bladder	Whole organ including the bladder neck
Rectum	From the ano-rectal sphincter to recto-sigmoid junction
Colon_Sigmoid	From recto-sigmoid junction to the left iliac fossa
Bowel	Outer contour of bowel loops including the peritoneum. Colon_Sigmoid may be included in Bowel if not reported separately
FemurHeadNeck_L and FemurHeadNeck_R	Both femoral head and neck to the level of the trochanter min
For para-aortic irradiation also include:	
Kidney_L and Kidney_R Kidneys	Outer contour excluding renal pelvis
SpinalCord	Outer contour
Optional (if para-aortic RT above L1 is applied):	
Duodenum	Whole organ
Ovary_L and Ovary_R (in cases of ovarian transposition)	Outer contour

B. Brachytherapy

The following organs at risk and dose points should be defined.

Structure name	Description
Bladder	Whole organ including the bladder neck. Outer wall contoured
Rectum	the outer rectal wall is contoured from the above the anal sphincter to the level of transition into the sigmoid
Sigmoid	the outer sigmoid wall is to be contoured from the recto-sigmoid flexure where it meets the Bowel
Bowel	Bowel – The bowel should be contoured to well above the parametria and the uterus (at least 2cm)

5.1 Planning structures

For patients being planned for external beam with a brachytherapy boost, extra planning structures are required.

CTV_HR - High Risk Clinical Target Volume of the primary tumour which will be boosted with HDR brachytherapy

CTV_HR_Eval – CTV_HR + 10mm cropped back 10-15mm from PTVn

OAR_Eval – OARs cropped back 10-15mm from PTVn

PTV_4500_Eval - PTV_4500 cropped back 10mm from PTVn

5.2 Planning Aims

A. EBRT

45Gy/ 25# without LN boost

	Structure Name	Hard planning aim	Soft planning aim
Targets	PTV_4500	V42.75Gy >95% D0.1cc <107%	V42.75Gy = 95%
	ITV_4500	D99.9% >95%	
Help contour	CTV_HR_10mm_Eval		D0.1cc <103%
OARs	Bowel	D0.1cc <105%	When no lymph node boosts: • V40Gy<250cm^3 • V30Gy<500cm^3
	Colon_Sigmoid	D0.1cc <105%	
	Bladder	D0.1cc <105%	V40Gy <60% V30Gy <80%
	Rectum	D0.1cc <105%	V40Gy <75% V30Gy <95%
	SpinalCord	D0.1cc <48Gy	
	FemurHeadNeck_L and FemurHeadNeck_R	D0.1cc <50Gy	
	Kidney	Dmean <15Gy	Dmean <10Gy
	Body	D0.1cc <107%	
Optional	Ovary_L or Ovary_R (in cases of ovarian transposition)	Dmean <5-8 Gy	
	Duodenum	V55<15cm^3	

Dmin = D99.9%, Dmax=D0.1cc

*Soft Planning aims can be used in the treatment plan optimisation. Values are based on the clinical data of EMBRACEII patients entered in the study before June 2017. The Soft Planning aims are not supposed to be fulfilled by all patients, but rather by ~70-80% of the patients.

45Gy/ 25# with LN boost

	Structure Name	Hard planning aim	Soft planning aim
Targets	PTV_4500_Eval	V42.75Gy>95%	V42.75Gy = 95% Dmax >107%
	ITV_4500	D99.9% >42.75Gy	
	PTVn_XXXX	D98% >90% of prescribed LN dose D0.1cc <107% of prescribed LN dose	D98%=90% of prescribed LN dose
	CTVn_XXXX	D98% >100% Of prescribed LN dose	D50% >102%
Help contour	CTV_HR_Eval		Dmax <103%
OARs	Bowel / Bowel_Eval	D0.1cc <105% (47.3Gy) *	When lymph node boost or para-aortic irradiation: • V40Gy<300cm^3 • V30Gy<650cm^3 D0.1cc <57.5Gy
	Colon_Sigmoid / Colon_Sigmoid_Eval	D0.1cc <105% (47.3Gy) *	D0.1cc <57.5Gy
	Bladder / Bladder_Eval	D0.1cc <105% (47.3Gy) *	V40Gy <60% V30Gy <80% D0.1cc <57.5Gy
	Rectum / Rectum_Eval	D0.1cc <105% (47.3Gy) *	V40Gy <75% V30Gy <95% D0.1cc <57.5Gy
	SpinalCord	D0.1cc <48Gy	
	FemurHeadNeck_L and FemurHeadNeck_R	D0.1cc <50Gy	
	Kidney_L and Kidney_R	Dmean <15Gy	Dmean <10Gy
	Body_Eval	D0.1cc <107%*	
Optional	Ovary_L or Ovary_R (in cases of ovarian transposition)	<5-8 Gy	
	Duodenum	V55<15cm^3	

Dmin = D99.9%, Dmax=D0.1cc

* Use OAR_Eval structure for Hard planning aim and report percentages of 45Gy unless otherwise stated. Soft planning aim applies to OAR

Soft Planning aims can be used in the treatment plan optimisation. Values are based on the clinicaldata of EMBRACEII patients entered in the study before June 2017. The Soft Planning aims are not supposed to be fulfilled by all patients, but rather by ~70-80% of the patients.

64Gy/32#

No available OAR tolerances for 64Gy/32# gynaecological cancers.

In lieu of tolerances – recommendation to keep OARs as low as reasonably practicable while achieving PTV V95%>=95% coverage.

Use of IMPART bladder cancer trial for 64Gy/32# Rectum and Bowel doses, POPs prostate bed trial for 66Gy/33# Bladder doses and INTERLACE trial for Kidney doses can be used as sensible start point for planning aims.

Organ	Lower priority Planning Aim	Higher priority Planning Aim
PTV	V0.1cc<105%	V95%>=95% V0.1cc<107%
PTVn		V98%>=90% V0.1cc<107%
Rectum	V65Gy <0.1cc	V30Gy <80% V50Gy <60% V60Gy <50% V65Gy <30%
Bowel (including Sigmoid)	V45Gy <139cc V50Gy <122cc V65Gy <0.1cc	V45Gy <209cc V50Gy <183cc V55Gy <105cc V60Gy <84cc V65Gy <26cc
Bladder	V50Gy <50% V60Gy <25% V65Gy <0.1cc	V65Gy<50%
Kidney_R and Kidney_L	V15Gy ≤ 25%	Mean <18Gy

B. Brachytherapy

Cervix Organ at Risk Planning Aims and Planning doses

Volume/OAR	Dose Limits			Planning Aims		
	Total EBRT + HDR EQD2$_{\alpha/\beta}$ dose (Gy)	***HDR Dose per # (Gy) 4# s***	***HDR Dose per # (Gy) 3# s***	***Total EBRT + HDR EQD2$_{\alpha/\beta}$ dose (Gy)***	***HDR Dose per # (Gy) 4#s***	***HDR Dose per # (Gy) 3# s***
D90 HR-CTV	≥ 85 <95	≥ 7.13 <8.31	>8.70 <9.42	≥90	≥7.74	≥9.42
D98 HR-CTV	≥ 75	≥5.83	≥7.17	≥ 80	≥6.50	≥7.96
D98 IR-CTV	-	-		≥ 60	≥3.50	≥4.38
D98 GTV	≥90	≥7.74	≥9.42	≥95	≥8.31	≥10.10
Bladder D2cc and ICRU Bladder Pt	< 90	<6.29	<7.46	< 80	<5.45	<6.47
Rectum D2cc	< 75	<4.98	<5.93	< 65	<3.93	<4.71
Recto-Vaginal point (ICRU 89)	< 75	<4.98	<5.93	< 65	<3.93	<4.71
Sigmoid D2cc	< 75	<4.98	<5.93	< 70	<4.48	<5.35
Bowel D2cc	< 75	<4.98	<5.93	<70 < 65 (ESGO)	<4.48 <3.93	<5.35 <4.71
Pt A	-	-		≥ 65	≥ 4.34	≥ 5.39

Priority

With MRI based IGRT, total EQD2$_{10}$ doses to HR-CTV D90 should be escalated to 90-95Gy while limiting dose to OAR. If required, to keep OAR doses within acceptable levels, EQD2 doses to HR-CTV D90 may be dropped to 85-90Gy. Recent data (ref to ESGO) suggests we should be achieving HR-CTV D90Gy > 90Gy in 70% of patients and >85Gy in 90% of patients.

The dose limits (hard planning aims) should be adhered to, deviations from these planning aims are only allowed in special cases with detailed explanation e.g., large tumour, unsuccessful implant.

6.0 Planning process/ technique

A. EBRT

- All EBRT treatment is IMRT/ VMAT/ Tomotherapy with inverse plan optimisation.
- Plan of the day may be used.
- Conformal or simple field arrangements can be used for palliative treatments.

For Patients who were intending to have brachytherapy, but brachytherapy was subsequently not been possible e.g. due to failed/unsuitable insertion or due to limited capacity of brachytherapy service.

- A 'replanning' CT scan must be performed expeditiously (after any applicators have been removed, if inserted) to minimise any gap from conclusion of delivered EBRT.
- It is expected that the planning CT will be done with intravenous contrast and follow all protocols defined in the initial PH1 planning scan

B. Brachytherapy

Due to the variation in brachytherapy modalities delivered across the network, implant and planning techniques are inherently varied. Recent guidance does not recommend superiority in one implant and planning technique. Consideration of the fact that implant and planning techniques may be dependent on service capability should be taken.

7.0 Peer Review/ Contour QA

A. EBRT

- All curative volumes should aim to be prospectively peer reviewed.
- A description of the contouring (planning note) and of the peer review process including changes made should be saved in the patient record.
- The peer review process and outcomes should be audited.

B. Brachytherapy

Cross network peer review poses the following challenges:

- Time factor: Cross site peer review may hinder timely treatment and thus reduce treatment effectiveness
- Across the ODN there may be sites with limited numbers of Brachytherapy trained consultants/ARSAC licence holders.

The following has been agreed by the members of the ODN to mitigate these challenges

- On site peer review for contouring should be in place If possible
- Cross site routine plan review to be done via an annual audit*

*Cross site QA contouring may be required if large discrepancies in practice are found

- Possible Comparison of volumes via ProKnow

8.0 Target verification

Daily 3D CBCT and action for adaptive measures.

3D Soft tissue verification (daily if 3D CBCT) **

Modality	Frequency	Match point	Additional information
CBCT	Daily CBCT	Bony match using ROI/clipbox placed around the pelvis. Radiographers should perform a visual match of the structures within the PTVs and OAR check. Manual adjustments or subsequent soft tissue match to be made if required but ensuring nodal targets still sufficiently covered. The match should be verified on all planes.	Check external contour and report to physics if changes greater than 1cm. If all CTVs cannot be achieved within PTVs then plan must be referred for CBCT review and adaptive action may be taken if persists.

9.0 Side effects

9.1 Possible early or short-term side-effects	
Expected (50-100%)	**Initial Management (if appropriate)**
Tiredness	Rest when required Light exercise
Mild Pelvic Pain	Appropriate pain medication (paracetamol/ibuprofen)
Urinary Frequency	Decrease caffeine
Bowel Frequency	Low Fibre diet
Vaginal Itching, discharge, or light bleeding (spotting)	Emollient
Discomfort from prolonged bed rest	
Common (10-50%)	**Management (if appropriate)**
Cystitis/pain when you urinate	Drink plenty of fluids Paracetamol MSU
Urinary incontinence	Incontinence pads
Rectal Pain/discomfort	Instilagel Paracetamol
Less common (Less than 10%)	**Management (if appropriate)**
Looser Stools	Low fibre diet Loperamide Codeine phosphate
Skin Soreness, itching and redness	Moisturising Emollient
Bleeding from your Bladder or bowel	
Moderate pelvic pain	Appropriate pain medication (paracetamol/ibuprofen)
Rare (Less than 1%)	**Management (if appropriate)**
Heavy Bleeding	Tranexamic acid
Infection	Antibiotics
Risk of developing symptomatic blood clot	Completion of TRA
Risk of pressure sore	Appropriate dressings

9.2 Possible late or long-term side-effects	
Definite 100%	**Initial Management (if appropriate)**
Early menopause	
Infertility	
Expected 50%-100%	**Initial Management (if appropriate)**
Vaginal narrowing, shortening or dryness	Use of vaginal dilators
Common (10-50%)	**Initial Management (if appropriate)**
Urinary frequency	Pelvic floor exercises
Urinary incontinence	Incontinence pad Pelvic floor exercises
Bowel frequency	Low fibre diet
Looser Stools	Low fibre diet Loperamide Codeine phosphate
Less common (Less than 10%)	**Management (if appropriate)**
Cystitis/pain when you urinate	Drink plenty of fluids Paracetamol MSU
Rectal pain/discomfort	Instilagel Paracetamol
Bleeding from your bladder, bowel, or vagina	
Bowel/bladder damage which may require surgery	
Rare (Less than 1%)	**Management (if appropriate)**
A different cancer in the treatment area	

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12.0 Amendment History

A record of changes in this document

Date	Updated version number	Previous version number	Page Number/ Section (updated version)	Details
03.24	V1.0			New Document
11.26	V2.0	V1.0		Updated document issued with changes as outlined below:
			All	Brachytherapy information added throughout
			Section 1	Indications for c updated to include statement about treating clinicians' discretion
				Statement added about use of OART
			Section 2	Arm position information updated for PA nodes
			Section 3	Dose prescription table updated
			Section 4	Target volume information updated
			Section 4.5	GECESTRO recommendations added
			Section 5.2	Bladder V30Gy updated to <80% as per latest EMBRACE II guidance Clarified that Hard planning aims for Bladder/Rectum/Sigmoid/Bowel should be assessed on OAR_Eval but soft planning aims on OAR

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				Updated nomenclature to planning aims not constraints as per EMBRACE II
			Section 10	References updated
			Section 11	Membership updated