Spine SBRT – QUESTIONS

Clinical Case Conference
UCSD Radiation Oncology
SA-CME

1. Which of the following is true regarding radiation dose strategies for spine metastases?
   A) 30 Gy in 10 fractions gives better pain relief than 8 Gy in 1 fraction.
   B) 30 Gy in 10 fractions gives less acute toxicity than 8 Gy in 1 fraction.
   C) SBRT 16 Gy in 1 fraction has been reported to have pain control rates >80% at one year.
   D) 20 Gy in 5 fractions gives better pain relief than 8 Gy in 1 fraction.

2. From a local control perspective, which of the following is **least** important to electively cover with RT fields when treating a vertebral body lesion with SBRT?
   A) Epidural space adjacent to the spinal cord.
   B) The vertebral body immediately superior to the treated vertebral body.
   C) Pedicles of the treated vertebral body.
   D) Posterior elements of the treated vertebral body.

3. Which of the following is true concerning management of spinal metastases in the presence of symptomatic compression fracture?
   A) If there is cord compression, SBRT is the safest and most efficacious approach.
   B) Surgical decompression gives improved overall survival compared to radiotherapy for patients who do **not** have cord compression.
   C) SBRT is not safe for patients with compression fracture.
   D) Kyphoplasty followed by SBRT has been reported to give excellent pain control.

4. Which of the following is a contraindication for spine SBRT according to ASTRO consensus guidelines?
   A) MRI not available due to patient pacemaker.
   B) Paraspinal extension of metastasis.
   C) 2 contiguous spine segments involved.
   D) Area previously received 30 Gy with fractionated radiotherapy.

5. Which of the following has been reported as a reasonable spinal cord dose constraint for spine SBRT?
   A) 10 Gy to 2 mL.
   B) 20 Gy to 1 mL.
   C) 30 Gy to 0.03 mL.
   D) Volume receiving 10 Gy less than 10% of spinal cord extending 6 mm above and below the target.