WBRT plus SRS for Tumors in Eloquent Locations: But Why Give the WBRT?

doi:10.1017/cjn.2015.54 Can J Neurol Sci. 2015; 42: 283

This report is to be commended for evaluating local control and overall survival outcomes for metastases in eloquent areas.[1] It is a valuable addition to the literature. What is interesting is that all patients were treated up front with whole brain radiation (WBRT) and stereotactic radiosurgery (SRS) versus SRS alone. The question is: Why was WBRT given? The rate of distant brain relapse was not reported in this report; therefore, it is difficult to understand the impact of WBRT in the population under study, especially because this study did not report neurocognitive or quality of life outcomes. These outcomes are of great importance for patients at the end of life.

Our professional societies are increasingly providing guidance for patients presenting with limited brain metastases. The American Society for Radiation Oncology recommends against routinely adding WBRT to SRS because of WBRT's known adverse effect profile.[2] Both the National Comprehensive Cancer Network and German Society for Radiation Oncology support SRS alone in patients with limited brain metastases.[3,4] Furthermore, it has been suggested recently that there is a subgroup of patients, those 50 years and younger, that may have a better survival by not being treated with WBRT and treated with SRS alone.[5] Therefore, despite eloquent versus noneloquent locations, the evolution in the treatment paradigm is to offer SRS alone to patients presenting with limited brain metastases.[6] WBRT can be reserved as one of many salvage therapies.

DISCLOSURES

The author has nothing to disclose.

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RECEIVED APRIL 5, 2015. FINAL REVISIONS SUBMITTED APRIL 8, 2014.