

Spinal radiosurgery

The treatment of paraspinal and [spinal metastases](#) with spinal [radiosurgery](#) represents a natural extension of the principles of [intracranial stereotactic radiosurgery](#). However, spinal radiosurgery is a far more complicated process than intracranial radiosurgery. Larger treatment volumes, numerous organs at risk, and the inability to utilize rigid, frame-based immobilization all contribute to the substantially more complex process of spinal radiosurgery.

Beyond the convenience of a shorter duration of treatment for the patient, spinal radiosurgery affords a greater biological equivalent dose to a metastatic lesion than conventional radiotherapy fractionation schemes. This appears to translate into a high rate of tumor control and fast pain relief for patients. The minimally invasive nature of this approach is consistent with trends in open spinal surgery and helps to maintain or improve a patient's quality of life. Spinal radiosurgery has expanded the neurosurgical treatment armamentarium for patients with spinal and paraspinal metastasis.

Spinal radiosurgery is not considered in the domain of traditional [Gamma Knife radiosurgery](#) (GKRS) setup. The major obstacles in GKRS for [upper cervical spine](#) lesions remain in difficulty of frame fixation, avoiding collision and maintaining the integrity of the relative position of the lesion from image acquisition to treatment.

The supraorbital margin remains the standard lowest fixation point for [Leksell stereotactic system](#).

Tripathi et al., describe fixation at the [maxilla](#) to target and treat [upper cervical spine](#) lesions (up to C3 vertebra) with measures to ensure cervical immobilisation and precision of the GKRS treatment.

They have treated two patients at the upper cervical spine up to C3 vertebra by fixing anterior pillars of the Leksell stereotactic frame at the maxilla. To ensure cervical immobilisation and precision of treatment, the neck was immobilised with a [Philadelphia collar](#). The relative position between the head and sternum with the couch from image acquisition to the radiation delivery was kept constant. Docking angle was kept neutral (90 degrees) throughout the treatment (from image acquisition to actual treatment).

The maxilla is a potential alternative for stereotactic frame fixation. Measures to ensure cervical immobilisation with lower-down frame position permits treatment of lesions as low as C3 vertebra ¹⁾.

Local therapy to spine tumors has been shown to be effective in selected cases. Spinal [radiosurgery](#) (SRS) is an evolving radiotherapy regimen allowing for noninvasive, highly efficacious local treatment. The learning curve can compromise the results of any newly employed technology and should be studied to minimize its effects. In this paper the first 100 SRSs performed at several medical centers are presented and analyzed for the effects of the learning curve on outcome. METHODS A retrospective analysis was undertaken to evaluate data from patients treated with SRS at Sheba Medical Center and Assuta Medical Centers in the period from September 2011 to February 2016. Medical history, clinical and neurological findings, pathological diagnoses, SRS variables, complications, and follow-up data were collected and analyzed. Local control rates were calculated, and local treatment failure cases were qualitatively studied. RESULTS One hundred treatment sessions were performed for 118 lesions at 179 spinal levels in 80 patients. The complication rate was

low and did not correlate with a learning curve. Mean follow-up time was 302 days, and the overall local control rate was 95%. The local control rate was dose dependent and increased from 87% (among 35 patients receiving a dose of 16 Gy) to 97% (among 65 patients receiving a dose of 18 Gy). The 6 treatment failure cases are discussed in detail. CONCLUSIONS Spinal radiosurgery is a safe and effective treatment. Comprehensive education of the treating team and continuous communication are essential to limit the effects of the learning curve on outcome ²⁾.

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