Endobronchial Brachytherapy

Policy Number: 8.03.11  Last Review: 9/2017
Origination: 2/2002  Next Review: 9/2018

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for Endobronchial Brachytherapy when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered
Endobronchial brachytherapy may be considered medically necessary in the following clinical situations:
- In patients with primary endobronchial tumors who are not otherwise candidates for surgical resection or external beam radiation therapy due to co-morbidities or location of the tumor
- As a palliative therapy for airway obstruction or severe hemoptysis in patients with primary, metastatic, or recurrent endobronchial tumors

When Policy Topic is not covered
Other applications of endobronchial brachytherapy are investigational including, but not limited to, its use as a radiation “boost” to curative external-beam radiotherapy, as treatment for asymptomatic recurrences of non-small-cell lung cancer, or in the treatment of hyperplastic granulation tissue.

Considerations
Endobronchial brachytherapy is a multistep procedure requiring a series of radiation oncology CPT codes for radiation treatment planning, radiation physics, treatment delivery, and clinical treatment management. CPT codes 77761-77787 describe various types of radiation source application; these codes are used to describe the brachytherapy delivery. In contrast to other types of radiation therapy, endobronchial brachytherapy requires the services of a radiation oncologist and a pulmonologist or other physician to perform the bronchoscopy and insert the catheter.

Description of Procedure or Service

<table>
<thead>
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<th>Populations</th>
<th>Interventions</th>
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<tr>
<td>Individuals:</td>
<td>Interventions of interest are:</td>
<td>Comparators of interest are:</td>
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<tr>
<td>▪ With non-small-cell lung cancer</td>
<td>▪ Endobronchial</td>
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<td>▪ Overall survival</td>
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Endobronchial brachytherapy is the delivery of radiotherapy directly to endobronchial lesions, either intraluminally or interstitially, using permanently implanted radioactive seeds or a temporary afterloading implant. The technique permits targeted radiation while minimizing exposure to surrounding radiosensitive structures, such as normal lung, heart, and spinal cord.

For individuals with non-small-cell lung cancer (NSCLC) with airway obstruction or severe hemoptysis who receive endobronchial brachytherapy as palliative treatment, the evidence includes single-arm series and randomized controlled trials (RCTs) summarized in systematic reviews. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. Overall, the RCTs were assessed as low quality, and there is no evidence that endobronchial brachytherapy improves survival. However, the single-arm studies have suggested that endobronchial brachytherapy improves symptoms (pulmonary obstruction, hemoptysis), particularly in patients who are not candidates for external-beam radiotherapy (EBRT). If symptoms persist after EBRT, endobronchial brachytherapy is well-accepted as short-term palliation for symptoms such as hemoptysis, cough and dyspnea, and resolution of obstructive atelectasis or pneumonitis. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with NSCLC who receive endobronchial brachytherapy as primary treatment, the evidence includes single-arm series. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. For primary treatment (ie, with intent to improve survival outcomes), the effects of endobronchial brachytherapy on survival outcomes compared to alternative therapies are not well-defined. Additional comparative data are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with endobronchial hyperplastic granulation tissue who receive endobronchial brachytherapy, the evidence includes case series. Relevant
outcomes are symptoms, morbid events, and treatment-related morbidity. The evidence for endobronchial brachytherapy for hyperplastic granulation tissue is limited. The available case series typically include endobronchial brachytherapy as part of multimodal management, making it difficult to assess the specific contribution of brachytherapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Background**
Endobronchial brachytherapy has been most investigated as a palliative treatment of obstructing primary or metastatic tumors, particularly in NSCLC. There is also experience using endobronchial brachytherapy as a tool in curative treatment for some primary bronchial and tracheal tumors. Two to 4 fractions delivered weekly is a typical schedule. The most serious complications described for endobronchial brachytherapy are massive hemoptysis, formation of tracheoesophageal fistulas, bronchospasm, bronchial stenosis, and radiation bronchitis.(1)

In the outpatient setting, the patient receives local anesthesia and monitored sedation. A flexible bronchoscope is passed transnasally; a separate port on the bronchoscope allows passage of the afterloading catheter to the target lesion. Once the catheter is placed, the radioisotope can be administered by the high-dose radiotherapy afterloading machine. Patients with potential airway compromise due to bleeding may require treatment with a rigid bronchoscope, which requires general anesthesia and frequently an overnight stay.

Endobronchial brachytherapy represents one approach to the local treatment of endobronchial lesions. Other technologies include electrocoagulation, cryosurgery, laser resection, endosurgery, and endobronchial stent placement. In some instances, the therapies may be used together, such as using laser therapy for initial debulking followed by brachytherapy.

**Rationale**
This evidence review was originally created in March 1999 and has been updated with searches of MEDLINE database. The most recent search covered the period through November 9, 2016.

Assessment of the efficacy for therapeutic interventions involves a determination of whether the intervention improves health outcomes. The optimal study design for a therapeutic intervention is a randomized controlled trial (RCT) that includes clinically relevant measures of health outcomes. Intermediate outcome measures, also known as surrogates, also may be adequate if there is an established link between the intermediate outcome and true health outcomes. Nonrandomized comparative studies and uncontrolled studies can sometimes provide useful information on health outcomes, but are prone to biases such as selection bias and observation bias.
Endobronchial brachytherapy is used as both palliative treatment and curative treatment; either alone or in combination with other modalities (eg, surgery, external-beam radiotherapy [EBRT]), or other endoscopic interventions.

Following is a review of the key literature to date.

**ENDOBRONCHIAL BRACHYTHERAPY AS PALLIATIVE TREATMENT**

Many patients with non-small-cell lung cancer (NSCLC) are initially treated with EBRT but ultimately experience local recurrence. Many are not candidates for further EBRT due to limited tolerance of normal tissue. If symptoms persist after EBRT, endobronchial brachytherapy is well-accepted as short-term palliation for such symptoms as hemoptysis, cough, and dyspnea, and for resolution of obstructive atelectasis or pneumonitis. A 2008 European prospective study reported on 270 patients who had previously received radiotherapy and subsequently were given high-dose brachytherapy. Total response rate was 80% for symptoms of dyspnea, cough, hemoptysis, and postobstructive pneumonia, with a median duration of palliation of 5 months (range, 2-14 months). In a summary of studies of palliative endobronchial brachytherapy between 1985 and 1994, Villanueva et al (1995) reported effective palliation in 60% to 100% of patients. Median overall survival (OS) of these patients is typically less than 9 months.

A 2008 Cochrane review (updated in 2012) of palliative endobronchial brachytherapy for NSCLC analyzed 13 RCTs but did not conduct meta-analysis because of heterogeneity in the doses of radiotherapy delivered, patient characteristics, and outcomes measured. Reviewers concluded that EBRT alone was more effective for palliation of symptoms than endobronchial brachytherapy alone. Findings did not provide conclusive evidence that endobronchial brachytherapy plus EBRT improved symptom relief, reduced complication rates, or extended survival compared with EBRT alone. In summary, reviewers did not find sufficient evidence to recommend endobronchial brachytherapy as an add-on to first-line EBRT, chemotherapy, or Nd-YAG laser palliative treatment. For patients previously treated by EBRT who remain symptomatic, endobronchial brachytherapy was considered an option.

A 2006 prospective randomized trial from India (N=45) also suggested that endobronchial brachytherapy alone and endobronchial brachytherapy plus EBRT had similar efficacy and safety profiles in the palliative management of NSCLC.

Ung et al (2006) conducted a systematic review of endobronchial brachytherapy for palliative treatment of NSCLC. Based on 29 studies, including 6 randomized trials, reviewers also concluded that EBRT alone was more effective than endobronchial brachytherapy alone for symptom palliation in previously untreated patients. Unlike the Cochrane review, however, the Ung review concluded that endobronchial brachytherapy with EBRT seems to provide better symptom relief than EBRT alone, yet their final recommendation was to only use endobronchial brachytherapy for symptomatic recurrent endobronchial obstruction after EBRT.
In 2015, Goldberg et al reported on a prospective, observational cohort study evaluating quality-of-life and symptom-related outcomes for 98 patients with locally advanced inoperable lung cancer receiving high-dose endobronchial brachytherapy.(7) Patients were followed every 3 months for 1 year. Most (78%) were treated for newly diagnosed disease that was inoperable at diagnosis. OS was 13.4% at 12 months. Endobronchial brachytherapy was not associated with OS or quality of life, compared with chemotherapy or EBRT, in multivariable analyses.

Ozkok et al (2008) published a case series from Turkey on the use of high-dose-rate endobronchial brachytherapy for palliation of symptoms in 158 patients with 3 profiles.(8) Group A comprised 43 patients with stage IIIA and IIIB NSCLC who received endobronchial brachytherapy plus EBRT; group B comprised 74 previously untreated patients with incurable, locally advanced lung cancer; and group C comprised 41 patients with symptomatic endobronchial recurrences who had previously received full-dose radiotherapy. Participants in group A were from a previously reported prospective trial(9); data from these participants were reanalyzed for symptom palliation in the Ozkok report. Not all patients received the intended number of fractions due to patient refusal or deterioration in performance status. A few patients required more than the prescribed doses due to repetitive obstructive symptoms. Response rates for cough, dyspnea, and hemoptysis were measured using the Speiser Symptom Index scoring system. Response rates in group A were 58% for cough (30% complete response [CR]), 77% for dyspnea (76% CR), and 100% for hemoptysis (92% CR). Groups B and C had CR rates of 57% and 55% for cough and 90% and 78% for dyspnea, respectively. Eighteen (11%) patients died of hemoptysis, with a median time to event of 7 months. Significant prognostic factors for fatal hemoptysis were use of brachytherapy intended as a treatment (as opposed to palliation, p<0.001), total radiobiologic equivalent dose (p<0.001), and the number of high-dose-rate endobronchial brachytherapy fractions (p<0.001). The authors concluded that high-dose-rate endobronchial brachytherapy was effective for palliation of symptoms related to inoperable lung cancer, either alone or in combination with EBRT. They cautioned that optimal dose, fractionation, and combination schedule with EBRT were unknown. Further, they stated that any benefit has to be weighed against potentially serious treatment-related morbidity or mortality.

Although endobronchial brachytherapy is often used to palliate hemoptysis, historically, there has been concern about an observed association between treatment with endobronchial brachytherapy and fatal hemoptysis. The largest study retrospectively reviewed 938 patients treated with external irradiation and/or endobronchial brachytherapy for inoperable NSCLC.(10) In this 1998 study, 101 (10.8%) patients died from massive hemoptysis; 78 (77%) of those who died had clinical or radiologic evidence of tumor progression while 23 (23%) did not. On multivariate analysis, intrabronchial tumor extension in the main bronchus, hemoptysis before radiotherapy, and tumor location in the upper bronchus were independently associated with massive hemoptysis. A dose-response relation between fraction dose and massive hemoptysis also was found; in all subgroups, higher incidence of massive hemoptysis was seen after fraction dose of 15 gray
(Gy). These data were largely consistent with data from Hennequin et al (1998) who reported that hemoptysis was most likely due to disease progression, with brachytherapy facilitating bleeding, rather than directly causing bleeding. However, for tumors located in the upper lobes, brachytherapy may be causal. Tumor location was cited as the most important factor in predicting pulmonary hemoptysis in a 1991 case series reported by Bedwinek et al, in which 32% of patients died of massive hemoptysis after brachytherapy.

Dagnault et al (2010) retrospectively reviewed 81 patients treated with brachytherapy for symptom palliation due to endobronchial primary lung tumors or metastases. Between 2002 and 2007, 81 patients who were not candidates for surgery or EBRT because of poor respiratory function, medical comorbidities, or previous treatment with thoracic radiation or surgery, were treated at a single institution. Mean patient age was 66 years (range, 39-87 years). Previous treatment comprised surgical resection of the primary tumor in 58% of patients, lung radiotherapy in 44%, and chemotherapy in 41%. After endobronchial brachytherapy, patients were followed until death or loss to follow-up. Patient characteristics included 59 (73%) with a lung primary and the remainder with metastatic disease, including primary colorectal cancer (13%), kidney, gynecologic, or head and neck cancers (4% each), and other cancers (2%). Presenting symptoms included dyspnea (66%), cough (47%), hemoptysis (28%), and no symptoms (6%). After brachytherapy, major symptomatic improvement was seen in most patients: dyspnea improved during or shortly after the end of treatment in 85% of patients; hemoptysis stopped in all 23 patients; cough improved in 77% of patients; and 18% remained stable. At 6-week follow-up, 72% of tumors were evaluable for bronchoscopic response. A visible bronchoscopic response was evident in 77 patients; for 42 (52%) of 81 patients, the tumor shrank significantly during treatment. Median survival was 14.7 months; local progression-free survival (PFS) was 77% at 12 months and 64% at 24 months. For comparison, authors stated that OS for most patients with inoperable endobronchial tumors or metastasis was less than 6 months. The incidence of complications was low, and all complications resolved.

Guarnaschelli et al (2010) reviewed treatment outcomes of 52 patients with recurrent endobronchial tumors who underwent palliative high-dose-rate endobronchial brachytherapy between 1995 and 2005 at 1 institution. Objective response was assessed by bronchoscopy and chest computed tomography, and subjective clinical response by patient reports. All patients had histologically proven bronchogenic carcinoma, recurrent or persistent symptoms (hemoptysis, cough, dyspnea, or postobstructive pneumonia), previous definitive EBRT, and bronchoscopic evidence of endobronchial obstruction. The mean patient age was 63 years (range, 41-83 years); 37% of patients were women. Tumor histology was non-small-cell in 77% of patients, small cell in 13%, adenoid cystic in 2%, and metastatic in 2%. Patient symptoms before brachytherapy included dyspnea on exertion (79%), cough (89%), hemoptysis (62%), wheezing (52%), dysphagia (8%), chest pain (15%), and shortness of breath (83%). Symptomatic improvement was defined as significant if there was improvement in 2 or more symptoms and mild if only 1 symptom improved. Forty-eight (92%) patients
showed symptomatic improvement. One patient had worsening hemoptysis, and 2 (4%) of 52 patients did not return for assessment. Median time to symptomatic relapse after the first fraction of brachytherapy was 6 months (range, 1 to >6 months). Complete or partial tumor regression was demonstrated in 44 (85%) patients on repeat bronchoscopy. For the entire cohort, median follow-up was 31 months, and median actuarial OS from the first brachytherapy session was 7 months (range, 0-55 months). Fifty (96%) patients tolerated treatment without acute, treatment-related complications. Significant treatment-related complications (grade 3 or 4) were reported as possibly occurring in 2 (4%) patients: 1 patient developed a pneumothorax 6 weeks after brachytherapy, and 1 patient died from hemoptysis 48 hours after treatment (it was unknown whether hemoptysis was due to brachytherapy or to erosion of tumor into a blood vessel).

A 2013 comparative effectiveness review prepared for the Agency for Healthcare Research and Quality assessed local nonsurgical therapies for symptomatic obstructive NSCLC.(15) For patients with obstruction due to inoperable NSCLC, 4 RCTs (268 patients) examined endobronchial brachytherapy alone or in combination with EBRT or Nd-YAG laser therapy for palliative or curative intent. All RCTs were determined to be of poor quality. Seven single-arm studies (740 patients) examined endobronchial brachytherapy alone or in combination with EBRT, stent placement, or chemotherapy plus photodynamic therapy for palliative or curative intent. The evidence was considered “insufficient to permit conclusions on the comparative effectiveness of local nonsurgical therapies for ... inoperable NSCLC patients with endoluminal tumor causing pulmonary symptoms.”

**Section Summary: Endobronchial Brachytherapy as Palliative Treatment**
Single-arm series and RCTs summarized in systematic reviews comprise the evidence base for endobronchial brachytherapy with palliative intent for NSCLC. Overall, the RCTs were assessed as low quality, and there is no evidence that endobronchial brachytherapy improves survival. However, the single-arm studies suggested that endobronchial brachytherapy improves symptoms (pulmonary obstruction, hemoptysis), particularly in patients who are not candidates for EBRT.

**ENDOBRONCHIAL BRACHYTHERAPY AS PRIMARY TREATMENT**
Candidates for primary treatment are principally patients with early-stage endobronchial tumors who are not candidates for surgical resection or EBRT due to comorbidities or tumor location. Most studies have been case series, which reported CR rates of 50% to 80%.(16-18)

There also have been investigations using brachytherapy to deliver a focused radiation boost to patients undergoing curative EBRT. Because patients usually present with surgically unresectable disease and because NSCLC is unresponsive to chemotherapy, primary treatment for most patients with NSCLC is typically EBRT.

Aumont-le Guilcher et al (2011) reported on 226 patients with primary NSCLC (endobronchial only) who underwent high-dose-rate brachytherapy because of contraindications to surgery and EBRT.(19) The patient sample comprised 223
men and 3 women from 9 institutions; mean age was 62 years (range, 40-84 years). Tumor histology was squamous cell carcinoma (SCC) in 96%, adenocarcinoma in 2%, and other in 2%. Response to high-dose-rate brachytherapy at 2 to 3 months was classified as complete histologic response (disappearance of the lesion by bronchoscopy and negative biopsy), complete macroscopic response (disappearance of the lesion but no biopsy), partial response (>50% decrease in endobronchial tumor volume), or progression (increase in endobronchial tumor volume or tumor visible on computed tomography scan). At 3 months, complete local response was observed in 213 (94%) patients, and in 137 patients with biopsies, 126 (91%) had a CR. Seven patients had tumor progression, 5 had a partial response, and 1 had stable disease. OS was 57% at 2 years and 29% at 5 years. Median survival was 28.6 months. Cancer-specific survival was 81% at 2 years and 56% at 5 years. Complications led to treatment interruption in 4.5% of patients. Fatal complications (most commonly fatal hemoptysis) occurred in 6% of patients.

Skowronek et al (2013) reported on a small cohort of 34 patients in Poland who had stage IB-III lung cancer (74% SCC histology; all distant metastasis-free) who had undergone lobar resection. Thirteen (38%) patients developed postoperative recurrence in the bronchial stump, and 21 (72%) patients had histopathologically positive margins after nonradical resection. All patients had dyspnea and cough, and 8 (24%) patients had hemoptysis. Median patient age was 57 years (range, 47-73 years). Median time to recurrence after surgery was 11 months. It was not specified whether patients were candidates for reoperation. Nine patients received high-dose-rate endobronchial brachytherapy (total dose, 12 Gy) in combination with EBRT (total dose, 50 Gy), and 25 patients received brachytherapy alone (total dose, 30 Gy). At 1 month, complete local and radiologic response was observed in 25 (74%) patients, with 100% complete remission in the nonradical surgery group. All partial responses occurred in the recurrent tumor group (9 [69%] of 13 patients). Median OS for the entire cohort was 19 months. With a median follow-up of 2 years, 2-year OS was 15% in the group with recurrent tumor and 48% in the nonradical resection group (p=0.05). Adverse events were not reported.

Rochet et al (2013) reported on a cohort of 35 patients in Germany who had stage I, II, or III inoperable NSCLC (31% SCC histology; all distant metastasis-free) and received primary treatment with high-dose-rate endobronchial brachytherapy (median total dose, 15 Gy) in combination with EBRT (median total dose, 50 Gy). Mean age was 64 years (range, 45-75 years). With a median follow-up of 26 months, median OS was 39 months. One-, 2-, and 5-year OS rates were 76%, 61%, and 28%, respectively. Median PFS and local PFS were 17 months and 42 months, respectively. In patients without mediastinal node involvement, 5-year local PFS was 56% versus 11% with positive mediastinal nodes (p=0.008). Grade 3 adverse events were hemoptysis in 2 patients and necrosis in 1 patient. Fatal hemoptysis in 1 patient resulted from tumor recurrence.

In 2016, Hosni et al reported on a series of 10 patients with endobronchial tumors treated at a single center with endobronchial brachytherapy with curative intent.
with (n=8) or without (n=2) EBRT. Among the 10 patients treated with curative intent, median follow-up was 17 months. For these patients, the 2-year local control rate was 89% (95% confidence interval [CI], 79% to 99%) and the 2-year OS rate was 67% (95% CI, 51% to 83%). Given the high rate of combination therapy, it is difficult to draw conclusions about brachytherapy alone.

Section Summary: Endobronchial Brachytherapy as Primary Treatment
For primary treatment (ie, with intent to improve survival outcomes), the effects of endobronchial brachytherapy on survival outcomes compared to alternative therapies are not well-defined. Additional comparative data are needed.

ENDOBRONCHIAL BRACHYTHERAPY TO TREAT HYPERPLASTIC GRANULATION TISSUE
Endobronchial brachytherapy has been investigated to treat hyperplastic granulation tissue causing recurrent airway stenosis after lung transplantation or stent placement. A 2008 case series reported on endobronchial brachytherapy in 8 patients after excision of obstructive granulation tissue; 6 (75%) patients had a good or excellent subjective early response for the first 6 months. A 2006 case series used endobronchial brachytherapy in 5 patients with benign, post-lung transplantation granulation tissue refractory to multiple other bronchoscopic interventions. After a median follow-up of 12 months, 3 (60%) of 5 patients had marked symptom improvement. While these case series reported positive outcomes, adequately powered trials are needed to fully evaluate the potential role of endobronchial brachytherapy in the treatment of granulation tissue.

Rahman et al (2010) reported long-term follow-up for 115 patients who underwent various flexible bronchoscopic therapeutic modalities for the management of benign tracheal stenosis between 2001 and 2009. High-dose-rate endobronchial brachytherapy was used in cases of refractory stent-related granulation tissue formation, defined as requiring 3 or more interventions within 6 months due to recurrent granulation tissue formation. All patients presented with signs and symptoms of upper airway obstruction, including shortness of breath, stridor, cough, dyspnea, and wheezing. Stents were placed in 33 patients to restore airway patency, and 28 of them underwent brachytherapy to prevent granulation tissue reformation. All 28 experienced a reduction in therapeutic bronchoscopic procedures after brachytherapy compared with the pretreatment period; no further details about response duration or other outcomes were reported. There were no treatment-related complications. Although this case series reported positive results, small sample size and concerns about outcomes reporting limit conclusions that can be drawn.

Section Summary: Endobronchial Brachytherapy to Treat Hyperplastic Granulation Tissue
The evidence for endobronchial brachytherapy for hyperplastic granulation tissue is limited by sample sizes. The available case series also typically included endobronchial brachytherapy as part of multimodal management, making it difficult to assess the specific contribution of brachytherapy.
SUMMARY OF EVIDENCE
For individuals with non-small-cell lung cancer (NSCLC) with airway obstruction or severe hemoptysis who receive endobronchial brachytherapy as palliative treatment, the evidence includes single-arm series and randomized controlled trials (RCTs) summarized in systematic reviews. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. Overall, the RCTs were assessed as low quality, and there is no evidence that endobronchial brachytherapy improves survival. However, the single-arm studies have suggested that endobronchial brachytherapy improves symptoms (pulmonary obstruction, hemoptysis), particularly in patients who are not candidates for external-beam radiotherapy (EBRT). If symptoms persist after EBRT, endobronchial brachytherapy is well-accepted as short-term palliation for symptoms such as hemoptysis, cough and dyspnea, and resolution of obstructive atelectasis or pneumonitis. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with NSCLC who receive endobronchial brachytherapy as primary treatment, the evidence includes single-arm series. Relevant outcomes are overall survival, symptoms, morbid events, and treatment-related morbidity. For primary treatment (ie, with intent to improve survival outcomes), the effects of endobronchial brachytherapy on survival outcomes compared to alternative therapies are not well-defined. Additional comparative data are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with endobronchial hyperplastic granulation tissue who receive endobronchial brachytherapy, the evidence includes case series. Relevant outcomes are symptoms, morbid events, and treatment-related morbidity. The evidence for endobronchial brachytherapy for hyperplastic granulation tissue is limited. The available case series typically include endobronchial brachytherapy as part of multimodal management, making it difficult to assess the specific contribution of brachytherapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

SUPPLEMENTAL INFORMATION

PRACTICE GUIDELINES AND POSITION STATEMENTS
Current National Comprehensive Cancer Network guidelines (v.2.2017) for non-small-cell lung cancer (NSCLC) recommend relief of airway obstruction with endobronchial brachytherapy for locoregional recurrence with (1) endobronchial obstruction or (2) severe hemoptysis (category 2A).(26)

American College of Radiology
American College of Radiology Appropriateness Criteria are developed by expert consensus and literature review. Several 2013 and 2014 publications have addressed radiotherapy and nonsurgical treatments of lung cancer.
• For nonsurgical treatment of NSCLC in patients with poor performance status or for palliative intent, the expert panel considered endobronchial brachytherapy “useful for patients with symptomatic endobronchial tumors.”(27)

• For nonsurgical treatment of NSCLC in patients with good performance status or for definitive intent (no distant metastases), the panel considered endobronchial brachytherapy not appropriate.(28) Endobronchial brachytherapy may be appropriate in combination with EBRT [external-beam radiotherapy] for patients who are symptomatic due to endoluminal obstruction, eg, postobstructive pneumonia.

• Endobronchial brachytherapy is not included in appropriateness criteria for radiotherapy of small cell lung cancer.(29)

Third International Lung Cancer Consensus Workshop
The 2012 Third International Lung Cancer Consensus Workshop generated consensus statements on palliative radiotherapy and symptom control. For endobronchial brachytherapy, experts concluded that there was no evidence to routinely recommend endobronchial brachytherapy alone or in combination with other palliative maneuvers in the initial palliative management of endobronchial obstruction resulting from lung cancer. However, for palliative management of patients with recurrent endobronchial obstruction after external radiotherapy or to treat a central obstruction before definitive radiotherapy to reestablish airway patency, endobronchial brachytherapy may be a reasonable option.(30)

American Brachytherapy Society
In 2016, the American Brachytherapy Society issued consensus guidelines on thoracic brachytherapy for lung cancer.(31) The guidelines included the following recommendations:
• As palliative care for patients with central obstructive lesions, particularly those who have previously received EBRT
• Alone or in combination with “endobronchial resection, laser therapy, stenting, and photodynamic therapy”
• As either “high dose rate or pulsed dose rate with the ability to optimize dose” (low dose rate not recommended).

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS
Not applicable.

MEDICARE NATIONAL COVERAGE
There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

ONGOING AND UNPUBLISHED CLINICAL TRIALS
Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

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A Phase III, Multi-centre, Randomized Trial to Evaluate the Symptomatic and Quality of Life Improvements in Lung Cancer Patients Receiving External Beam Radiation With or Without High Dose Rate Intraluminal Brachytherapy

NCT: national clinical trial.

References:


 Billing Coding/Physician Documentation Information

31643 Bronchoscopy, (rigid or flexible); with placement of catheter(s) for intracavitary radioelement application

77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)

77317 Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)

77318 Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12
channels), includes basic dosimetry calculation(s)

77761  Intracavitary radiation source application; simple
77762  Intracavitary radiation source application; intermediate
77763  Intracavitary radiation source application; complex
77770  Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel
77771  Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels
77772  Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels
77790  Supervision, handling, loading of radiation source

**ICD-10 Codes**

C34.00-  C34.00-C34.92 Malignant neoplasm of bronchus lung, code range
C34.92
C78.00-  Secondary malignant neoplasm of lung, code range
C78.02
D02.20-  Carcinoma in situ of bronchus and lung, code range
D02.22

Codes: 77326, 77327, 77328 deleted 1/1/2015
Codes: 77785, 77786, 77787 deleted 1/1/2016

**Additional Policy Key Words**

N/A

**Policy Implementation/Update Information**

2/1/02  New policy added to the Radiotherapy section. Included in comprehensive policy titled *Brachytherapy for Cancer.*
9/1/06  Policy updated to review Endobronchial Brachytherapy as a specific topic. Remains medically necessary. Final policy updated 2/1/07.
9/1/07  No policy statement changes.
9/1/08  No policy statement changes.
9/1/09  No policy statement changes. Coding updated. CPT codes 77781, 77782, 77783 and 77784 were deleted effective 12/31/2009.
11/1/09  Policy statements changed to add that use as palliative treatment for severe hemoptysis and in recurrent tumors may be considered medically necessary and that use in asymptomatic recurrent disease is considered investigational. This change is effective 10/6/09.
9/1/10  No policy statement changes.
9/1/11  No policy statement changes.
9/1/12  No policy statement changes.
9/1/13  No policy statement changes.
9/1/14  No policy statement changes.
9/1/15  No policy statement changes.
9/1/16  No policy statement changes.
9/1/17  No policy statement changes.

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