

Optimal allocation of proton therapy slots in combined proton-photon radiotherapy

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Title:

Optimal allocation of proton therapy slots in combined proton-photon radiotherapy

Short title:

Optimal allocation of limited proton resources

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Conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Data sharing statement

This study is based on the mean dose values in the contralateral parotid gland, oral cavity, and superior pharyngeal constrictor muscle from IMRT and IMPT plans for a cohort of 45 patients, which are made available at the following link [10.6084/m9.figshare.12977765](https://doi.org/10.6084/m9.figshare.12977765). All the results in this paper can be reproduced using the mean dose values as input parameters for the different NTCP models.

Abstract

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4 Purpose: Proton therapy is a limited resource, which is not available to all patients
5 who may benefit from it. We investigate combined proton-photon treatments, in which
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7 some fractions are delivered with protons and the remaining fractions with photons,
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9 as an approach to maximize the benefit of limited proton therapy resources at a
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11 population level.
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19 Methods: To quantify differences in normal tissue complication probability (NTCP)
20
21 between protons and photons, we consider a cohort of 45 head-and-neck cancer
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23 patients for which IMRT and IMPT plans were previously created, in combination with
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25 NTCP models for xerostomia and dysphagia considered in the Netherlands for proton
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27 patient selection. Assuming limited availability of proton slots, we develop methods to
28
29 optimally assign proton fractions in combined proton-photon treatments to minimize
30
31 the average NTCP on a population level. Such combined treatments are compared to
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33 patient selection strategies in which patients are assigned to single-modality proton
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35 or photon treatments.
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43 Results: There is a benefit of combined proton-photon treatments over patient
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45 selection due to the nonlinearity of NTCP functions, i.e. the initial proton fractions are
46
47 the most beneficial whereas additional proton fractions have a decreasing benefit
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49 when a flatter part of the NTCP curve is reached. This effect was small for the patient
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51 cohort and NTCP models considered, but may be larger if dose-response
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53 relationships are better known. In addition, when proton slots are limited, patient
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55 selection methods face a tradeoff between leaving slots unused and blocking slots
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1 for future patients who may have a larger benefit. Combined proton-photon
2 treatments with flexible proton slot assignment provide a method to make optimal use
3 of all available resources.
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9 Conclusions: Combined proton-photon treatments allow for a better utilization of
10 limited proton therapy resources. The benefit over patient selection schemes
11 depends on the NTCP models and the dose differences between protons and
12 photons.
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24 **Introduction**

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28 Proton therapy is widely considered a superior treatment modality in terms of the
29 dose distribution compared to conventional photon-based radiotherapy and its clinical
30 value is being investigated in the context of clinical studies [1]. As a rule of thumb,
31 protons allow reducing the integral dose to normal tissues by a factor of 2-3 [2], [3].
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33 However, proton therapy is not widely available. Currently, approximately 80 proton
34 therapy centers with a total of approximately 200 treatment rooms are in operation
35 worldwide [4]. This must be compared to more than 12'000 conventional
36 radiotherapy units [5]. Consequently, only a small percentage of patients with an
37 indication for radiotherapy is treated with protons [6] and not all patients who may
38 benefit from proton therapy have access to it.
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56 Strategies for selecting patients for proton therapy varies between institutions,
57 countries, and health care systems. In most countries, several treatments are
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1 considered standard indications for proton therapy, including pediatric patients and
2 tumors in proximity of the base of skull or spinal cord, e.g., chordoma and
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4 chondrosarcoma. In addition, there are treatment sites that are not routinely referred
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6 to proton therapy, but planning studies comparing intensity-modulated proton therapy
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8 (IMPT) to photon-based intensity-modulated radiotherapy (IMRT) or volumetric
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10 modulated arc therapy (VMAT) have demonstrated a potential advantage of proton
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12 therapy. One such treatment site is head and neck cancer squamous cell carcinoma
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14 (HNSCC). In HNSCC, several planning studies have found dose reductions through
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16 IMPT in critical organs such as the parotid glands, the pharyngeal constrictor
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18 muscles, and the oral cavity [7]–[9]. Dose reduction is expected to lower normal
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20 tissue complication probabilities (NTCP) for common side effects such as xerostomia
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22 and dysphagia [10]–[12].
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31 However, the incidence of HNSCC is too high to refer all patients to proton therapy.
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33 Currently, patient selection schemes based on NTCP models are being developed
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35 and promoted especially in the Netherlands as a forward-looking concept for
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37 selecting patients for proton therapy [13], [14]. In this approach, both photon and
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39 proton treatment plans are created and the dose difference between the two
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41 modalities is translated into an expected NTCP difference using agreed-upon NTCP
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43 models. Subsequently, patients in whom the NTCP reduction through protons
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45 exceeds a threshold are referred to proton therapy while the remaining patients
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47 receive photon therapy. This can be understood as an approach to maximize the
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49 benefit of limited proton therapy resources for the health care system as a whole.
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In this work, we further investigated how a limited number of proton therapy slots can be used optimally to maximize the benefit of proton therapy for a population of HNSCC patients. As the measure of benefit, we aimed to minimize the expected total number of complications in a patient population. To that end, we investigated if there is a role for combined proton-photon treatments where several fractions are delivered with IMPT and the remaining fractions with IMRT/VMAT.

The rationale why combined proton-photon treatments with optimal allocation of proton fractions may outperform single-modality treatments with optimal proton patient selection is two-fold:

1. On the convex part of the NTCP curve, the first proton fractions are the most beneficial, i.e. the patient is on a steeper section of the NTCP curve. For an increasing number of proton fractions, the benefit of any additional proton fraction decreases. Thus, there may be a point of diminishing return and it may be more beneficial to give proton fractions to other patients.
2. Assume there is a given number of proton slots available each day to treat HNSCC patients. Then, any single-modality patient selection strategy faces a tradeoff between leaving a proton slot unused and blocking a proton slot for future patients who may have a larger benefit. Instead, flexible allocation of proton fractions in combined proton-photon treatments may make optimal use of all available proton slots.

Here, we present a methodology to optimally distribute a limited number of IMPT slots over a patient population to answer the question "How many proton fractions

1 should each patient receive?" rather than "Which patient should receive IMPT only
2 and which IMRT only?". The methods benefit in a HNSCC population is compared to
3
4 a patient-wise selection for single-modality treatment based on a $\Delta NTCP$ threshold.
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10 11 **Materials and Methods**

12 13 *Patient cohort and treatment plans*

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17 To quantify the dosimetric differences of proton and photon treatments, we consider
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19 a cohort of 45 patients with locally advanced HNSCC in different locations. This
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21 patient cohort was previously studied by Jakobi et al. [2] in the context of proton
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23 patient selection [2] and the dose escalation potential of proton therapy [15]. For all
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25 patients, IMPT and IMRT plans for a simultaneous integrated boost (SIB) treatment
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27 are available, which deliver 70 Gy(RBE) to a boost volume (GTV_{SIB}) and 54 Gy(RBE)
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29 to the remaining target volumes (PTV_{all}) in 30 fractions (see further details in
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31 Appendix A).
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44 *NTCP modeling*

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46 To calculate NTCP values for IMRT, IMPT, and combined treatments, we apply the
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48 NTCP models that have been agreed upon in the Netherlands for selecting patients
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50 for proton [16]. We consider NTCP models for xerostomia and dysphagia as
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52 described in [17], [18] but with updated parameters according to [16]. The general
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54 form of the NTCP model is the following:
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$$57 \quad NTCP = (1 + e^{(a-b*d)})^{-1} \quad (1)$$

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10 For xerostomia, the model parameters are

- 11 - $a = 1.507, b = 0.052;$
- 12 - d is the mean dose to the contralateral parotid gland.

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21 For dysphagia, the model parameters are

- 22 - $a = 3.303, b = 0.024;$
- 23 - d is the sum of the mean doses in the oral cavity and in the superior
24 pharyngeal constrictor muscle (PCM).

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27 Let d_j^γ and d_j^p denote the photon and proton mean doses per fraction for patient j for
28 a given organ. In a combined photon-proton treatment with n_j^p proton fractions and
29 n_j^γ photon fractions, the cumulative mean dose d_j in the organ is given by the sum of
30 photon and proton doses:

$$31 \quad d_j = n_j^\gamma d_j^\gamma + n_j^p d_j^p \quad (2)$$

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33 where $n_j^p \in \{0,1,2,\dots,30\}$ and $n_j^\gamma = 30 - n_j^p$ throughout this work. In this formulation,
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37 the proton dose d_j^p includes a constant RBE of 1.1.

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42 Let $NTCP_j(n_j^p)$ denote the NTCP value for patient j as a function of the number of
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44 proton fractions n_j^p . Let further $NTCP_{jk} = NTCP_j(n_j^p = k)$ denote the NTCP value for
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46 patient j if the patient receives exactly k proton fractions and $30 - k$ photon fractions.

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49 In this work, the NTCP values refer to either xerostomia ($NTCP^{Xero}$) or dysphagia
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51 ($NTCP^{Dys}$), or to an equally weighted sum of both complication risks ($NTCP^{Sum} =$
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 $NTCP^{Xero} + NTCP^{Dys}$). The mean doses in the contralateral parotid gland, the
superior PCM, and the oral cavity for IMRT and IMPT plans for each of the 45
patients are provided in the supplementary materials, Appendix I.

To quantify the benefit of proton therapy at a population level, we consider the average NTCP over a patient cohort:

$$\langle NTCP \rangle = \frac{1}{M} \sum_{j=1}^M NTCP_j(n_j^p) \quad (3)$$

where M is the number of patients in the cohort.

Optimal proton slot allocation for a given patient cohort

First, we consider an idealized scenario, in which all the 45 HNSCC patients are known at the time of distributing the proton slots. Although this is a hypothetical situation, it allows us to investigate if there is a benefit of combined proton-photon treatments that originates from a decreasing benefit of additional proton fractions on the convex part of the NTCP curve. We assume that, due to limited resources, only a percentage of the total number of fractions can be delivered with protons, i.e. a total number of N_{avail} proton slots are available, which is smaller than the total number of fractions needed to treat all 45 patients with protons.

The goal is to maximize the benefit of protons by optimally distributing the available proton fractions over the patient cohort, allowing for combined proton-photon treatments as well as single-modality proton and photon treatments as a special case thereof. To that end, we determine the number of proton fractions per patient n_j^p such that the average number of complications is minimized. Formally, this can be stated as the following optimization problem:

$$\underset{n_j^p}{\text{minimize}} \quad \frac{1}{M} \sum_{j=1}^M NTCP_j(n_j^p) \quad (4)$$

1 subject to
$$\sum_{j=1}^M n_j^p \leq N_{avail} \quad (5)$$

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$$n_j^p \in \{0, 1, 2, \dots, 30\} \forall j \quad (6)$$

5 This optimization problem can be solved to optimality by reformulating the problem as
6 a linear binary integer programming problem as described in supplementary
7 materials, Appendix B.
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15 Combined proton-photon treatments with optimal allocation of proton fractions are
16 compared to an optimal patient selection strategy for single modality treatments
17 (either pure IMPT or pure IMRT) based on the difference in NTCP values. To that
18 end, we calculate the NTCP difference for each patient
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$$\Delta NTCP_j = NTCP_j(n_j^p = 0) - NTCP_j(n_j^p = 30).$$

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27 Patients with the highest $\Delta NTCP$ are assigned to pure IMPT until the number of
28 proton slots is depleted. The rest of the patients receive pure IMRT.
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37 *Proton slot allocation during the continuous operation of a department*

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39 In reality, newly diagnosed HNSCC patients continuously start radiotherapy
40 throughout the year. Instead of allocating a total number of proton fractions over a
41 given patient cohort, one has to decide for every incoming patient whether the patient
42 receives protons or photons. We now consider a radiotherapy department in which
43 both protons and photons are available, but the number of proton slots available for
44 the treatment of HNSCC patients is smaller than the average number of HNSCC
45 patients under treatment at a given time.
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2 For this situation, we compare combined proton-photon treatments to a threshold-
3 based proton patient selection strategy. More specifically, we compare the following
4 two strategies:
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9 *1. Combined proton-photon treatments with daily proton slot reassignment*
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12 In this strategy, the available proton slots are assigned on a daily basis among the
13 patients currently under treatment. In this case, a patient may receive proton fractions
14 on some days and photon fractions on other days, depending on the other patients
15 that are under treatment. To assign proton slots on a given day, we determine the
16 patients under treatment which benefit the most from receiving one additional proton
17 fraction. Assuming that a patient j has so far received k proton fractions, we consider
18 the incremental NTCP difference:
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$$\Delta NTCP_{kj} = NTCP_{kj} - NTCP_{(k+1)j} \quad (7)$$

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32 which quantifies the benefit of receiving an additional proton fraction today, while
33 assuming that the remaining fractions will be delivered with photons. On each day,
34 the available proton slots are assigned to the patients with the highest $\Delta NTCP_{kj}$. The
35 remaining patients receive a photon fraction on that day.
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45 *2. Single modality treatments with threshold-based patient selection*
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49 The above daily proton slot reassignment strategy is compared to threshold-based
50 patient selection. In this case, an incoming patient is assigned to IMPT for the whole
51 treatment if both of the following conditions hold:
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- The NTCP improvement of pure IMPT over pure IMRT ($\Delta NTCP_j$) of the incoming patient j exceeds a threshold (e.g. 5%, 10%, 15%);
- A proton slot is available on the day the patient arrives.

Once patients are assigned to IMPT, the proton slots are blocked for the next 30 days. If one of the two conditions is not fulfilled, patients are assigned to IMRT.

To evaluate and compare both strategies, we calculate the average NTCP value by simulating the operation of a radiotherapy department over a long period of time. As an example, we assume that the department treats on average 100 head & neck cancer patients per year, meaning that on average 2 newly diagnosed patients per week start treatment. For a 30-fraction treatment scheme, patients are under treatment for 6 weeks, meaning that on average 12 patients are under treatment on any given day. We assume here that a constant number of proton slots is available each day, which is smaller than what would be needed to treat all patients with protons.

Each iteration of the simulation corresponds to one working day and the following steps are executed:

1. We randomly decide if a new patient starts treatment on that day. In this work, we assume a 40% probability for a new HNSCC patient every day (corresponding to an average of 2 patients per week).

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2. If a new patient starts treatment, the proton and photon mean doses in the contralateral parotid gland, the oral cavity, and the superior PCM are sampled from a 6D gaussian distribution function¹. The mean and covariance matrix of the Gaussian are calculated from the doses of the 45 HNSCC patients. The new patient is considered to be under treatment from now on.

3.1. For the daily slot reallocation strategy, the available proton slots are distributed among the patients under treatment as described above.

3.2. For the threshold-based single-modality patient selection, it is decided whether or not a new patient (if present) is assigned a proton slot for the next 30 days (if available today).

4. All patients under treatment receive one fraction.

Simulations are carried out for a period of 12'000 days, corresponding to approximately 4800 patients. The patients treated in the first and last 400 days are discarded to avoid any effects resulting from initial and ending conditions. Based on the remaining patients, the average NTCP value $\langle NTCP \rangle$ is calculated.

Results

Optimal proton slot allocation for the given patient cohort

¹ Samples in which the mean dose in one organ exceeds the GTV_{SIB} prescription dose of 70 Gy(RBE) and/or in which the proton dose exceeds the photon dose in one of the organs are discarded.

1 For the patient cohort considered, IMPT reduces the NTCP values compared to
2 IMRT for both xerostomia and dysphagia for all 45 HNSCC patients (Figure 1a), i.e.
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4 for every single patient a single modality IMPT treatment would have been optimal.
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6 The average NTCP values for xerostomia/dysphagia are reduced from 43.6%/26.2%
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8 for IMRT to 32.3%/22.0% for IMPT. If all patients are treated with IMPT instead of
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10 for IMRT, an average reduction of 15.5% of the sum of both toxicities ($\Delta NTCP^{Sum}$) is
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12 expected. The individual $\Delta NTCP^{Sum}$ values vary between 4.8% and 23.8% (Figure
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17 1b).

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22 Figure 1c shows the optimal distribution of proton fractions over the patient cohort
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24 that minimizes the sum of the NTCP values for xerostomia and dysphagia, assuming
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26 that only 20% of all fractions (270 out of 1350) can be delivered with protons. In this
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28 example, 4 patients receive only protons while 29 patients receive only photons. 12
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30 patients receive a combined proton-photon treatment. Patients with higher $\Delta NTCP^{Sum}$
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32 usually receive a larger number of proton fractions. However, there are small
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34 deviations from this general rule because the optimal number of proton fractions
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36 depends not only on the $\Delta NTCP^{Sum}$ but also on the local slope of the NTCP curve.
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38 For example, patient 17 has a slightly larger benefit than patient 16 from receiving 5
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40 proton fractions, even though, in a patient selection scheme, patient 16 would have a
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42 slightly larger benefit from receiving 30 proton fractions.
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51 When 20% of all fractions are delivered with protons, combined proton-photon
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53 treatments with optimal proton fraction allocation can reduce the average summed
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55 NTCP by 4.01% compared to treating all patients with photons (65.78% vs. 69.79%),
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57 as summarized in Table 1a. For the optimal patient selection strategy (where the 9
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1 patients with the highest $\Delta NTCP$ are treated with protons only and the remaining
2 patients with photons only), the average summed NTCP is 65.84%, only slightly
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4 higher than for combined treatments.
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9 To further put these numbers in perspective, the average NTCP reduction can be
10 expressed as percentage of the NTCP gain for treating all patients with protons only.
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13 If one randomly selected 20% of patients for proton therapy (without any NTCP
14 modeling), one would, in expectation, realize 20% of the 15.49% benefit of protons
15 over photons. Patient selection based on $\Delta NTCP$ increases this benefit to 25.5%
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((69.79-65.84)/(69.79-54.30)). Combined proton-photon treatments with optimal
proton fraction allocation increase the realized benefit to 25.9%. If 60% of all fractions
are delivered with protons, combined proton-photon therapy can realize 67.8% of the
possible benefit, compared to 67.7% for patient selection (Table 1a).

The optimal proton slot allocation for minimizing the average NTCP for xerostomia
and dysphagia individually rather than the sum is investigated in Appendix C. When
considering the two toxicities separately, proton slots may be given to different
patients because patients in whom IMPT lowers the contralateral parotid gland dose
may be different from the patients in whom the dose to the oral cavity and the PCM
may be lowered. However, in all cases, only a small improvement in average NTCP
is observed for combined proton-photon therapy over patient selection for single-
modality treatment.

Proton slot allocation during the continuous operation of a clinic

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Figure 2 illustrates the simulation of daily allocation of proton fractions assuming 3 available proton slots per day and a 40% probability that a new patient starts treatment on any given day. In this example, 6 patients receive IMPT only, 39 patients receive a combined proton and photon treatment, and 55 patients receive IMRT only. In total, 777 out of 3000 fractions are delivered with protons, reflecting that 3 proton slots per day are available while on average 12 patients are under treatment. Figure 2a illustrates several scenarios that may occur in the daily slot allocation strategy. Patients may receive proton therapy at the beginning of their treatment and switch to photons when other patients with a larger benefit from protons start treatment (e.g. patients 13, 15, 48, 55, 77). Similarly, patients may start with photons but switch to protons when patients with larger benefit finish treatment (e.g. patients 88, 94, 95). When two patients with very similar benefits from protons are under treatment at the same time, a proton slot may alternate between patients (e.g. patients 8, 9). Further details are provided in Appendix D.

For the threshold-based patient selection scheme (Figure 2c), 24 patients receive IMPT and 76 patients receive IMRT for a 14% $\Delta NTCP^{Sum}$ threshold. In this scenario, 115 proton fractions are unused as a result of waiting for a new patient in whom the benefit from protons exceeds the threshold of 14%. Also, 53 patients who exceed the threshold of 14% do not receive IMPT because all proton slots were blocked on the day they presented.

The daily slot allocation strategy for combined proton-photon treatments leads to a reduction of the average $NTCP^{Sum}$ values compared to the threshold-based patient selection for any number of available proton slots and for any threshold, as shown in

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Figure 3a. For the patient selection strategy and 3 available proton slots per day, a 14% threshold yields the smallest average $NTCP^{Sum}$ value (Figure 3b). For this optimal threshold, the patient selection reduces the average $NTCP^{Sum}$ to 64.22% compared to 68.06% for pure IMRT treatments for all patients. The daily slot allocation strategy lowers the average $NTCP^{Sum}$ to 63.16%. The main reason for this improvement is that the daily slot reallocation strategy makes use of all proton slots on every day, whereas some proton slots are unused in the patient selection scheme or are blocked by patients with less benefit. Treating all patients with protons would yields an average $NTCP^{Sum}$ of 52.35% (Table 1b). Further discussion on the patient selection threshold (Figure 3b) is provided in Appendix E.

Dependence of the benefit of combined proton-photon treatments on the NTCP model

The reduction of the average $NTCP$ for combined treatments compared to single-modality treatments depends on the shape of the $NTCP$ curve. To demonstrate this, we investigate three $NTCP$ models illustrated in Figure 4:

1. The Dutch xerostomia model described in section 2 (Dutch model),
2. The xerostomia model published by Houweling et al. [19] (Houweling model), which is described by $NTCP = \Phi((d^{mean} - D_{50})/(m \cdot D_{50}))$ with parameters $D_{50} = 39.9 \text{ Gy}$ and $m = 0.4$, where Φ is the cumulative distribution function of the standard normal distribution.

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3. A hypothetical model that shows a larger benefit of combined treatments (Favorable model), with the same functional representation as the Houweling model but with parameters $D_{50} = 28 \text{ Gy}$ and $m = 0.3$.

In Figure 5 we consider the allocation of limited proton fractions over the given cohort of 45 HCSCC patients based on the three models. For the dutch model, there is only a very small benefit of combined proton-photon treatments for any number of available proton slots. The reason for this is that the NTCP curve is approximately linear between a pure IMRT and a pure IMPT treatment. For a given patient, each additional proton fraction yields approximately the same incremental NTCP improvement, i.e. the benefit of additional proton fractions does not diminish. In fact, for a strictly linear dose-response relation, the solution to the optimal allocation of proton fractions in combined proton-photon treatments yields a patient selection scheme.

The parameters of the favorable model were chosen such that photon treatments are located in the steep part of the NTCP curve whereas proton treatments are located at lower values where the NTCP curve flattens. Therefore, the first proton fraction given to a patient has a larger benefit whereas a diminishing return is observed for later ones. In this case, there is a benefit of combined proton-photon treatments over patient selection that arises from the non-linearity of the NTCP curve. The benefit for the Houweling model is in between the dutch model and the favorable model.

The average NTCP reductions for treating all 45 patients with protons only instead of photons only are 11.3%, 10.5%, and 25.7% for the Dutch, Houweling, and favorable

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model, respectively. If 20% of all fractions are delivered with protons, 28.4%, 33.8%, 35.1% of that maximum improvement is realized through single-modality patient selection compared to 28.7%, 35.9%, 37.9 % for combined proton-photon treatments.

The favorable model also yields a larger improvement of combined proton-photon treatments over patient selection in the simulation of slot allocation during the continuous operation of a clinic (Appendix F). For example, for 3 available slots per day, combined treatments realize 38.0% of the maximum benefit of treating all patients with protons only, while patient selection with an optimal threshold realizes only 26.2%.

Discussion

Currently, concepts for selecting radiotherapy patients for proton therapy based on NTCP models are being developed, promoted, and implemented in individual countries [20], [21]. The goal of such patient selection schemes is to maximize the benefit of limited proton therapy resources for the healthcare system as a whole. In this work, we investigated if one can further increase the benefit of proton therapy for a population of patients via combined proton-photon treatments, in which some fractions are delivered with protons and others with photons.

Recently, several groups have investigated the optimization of combined proton-photon treatments [22]–[25]. The main difference in our work is that we consider the optimal use of limited proton resources for a population of patients. Previous works

1 have instead focused on the design of a combined proton-photon treatment for an
2 individual patient. A detailed discussion of how this work relates to other works on
3 combined proton-photon treatments is provided in Appendix G.
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9 First, we investigated if there is an advantage of combined treatments due to a
10 diminishing return of additional proton fractions on the convex part of the NTCP
11 curve. It turned out that the optimal use of limited proton fractions, which minimizes
12 the expected number of complications in a patient cohort, indeed contains combined
13 proton-photon treatments. However, the improvement over optimal patient selection
14 was small for the head & neck patient cohort considered in combination with the
15 NTCP models proposed in the Netherlands. However, the advantage of combined
16 proton-photon treatments would increase if the dose differences between proton and
17 photon plans spanned a larger, non-linear section of the NTCP curve. This may
18 become the case if a) dose-response relations become better known (e.g. by
19 discovering additional biomarkers), resulting in steeper NTCP curves, and b)
20 dosimetric differences between protons and photons become larger through further
21 improvements in IMPT planning and delivery. In this work, we used step&shoot IMRT
22 plans with 7 beams and IMPT plans with 3 beams. It can be expected that both plans
23 can be improved with VMAT and a larger number of beams.
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48 Second, we considered the real-world problem of proton slot allocation during the
49 continuous operation of a radiotherapy clinic assuming a limited number of available
50 proton slots for treating head & neck cancer patients. In that situation, an NTCP
51 threshold-based patient selection method faces the tradeoff between leaving proton
52 slots unused if the NTCP threshold is high or blocking slots with patients with
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1 mediocre benefit from proton therapy if the threshold is low. Combined proton-photon
2 treatments with daily slot allocation have the advantage that all proton slots are used
3 effectively. If a new patient starts treatment who has a larger benefit from proton
4 therapy than the other patients currently under treatment, a proton treatment slot can
5 be assigned to that patient.
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14 In a clinical setting, some conditions may differ from the assumptions made in this
15 work, and there are challenges in combined proton-photon treatments regarding
16 clinical workflow and patient scheduling. Further discussion on some of these
17 aspects is provided (due to word limitations) in Appendix H.
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26 In conclusion, from a global health system perspective, limited proton therapy
27 resources can be more efficiently used with combined proton-photon treatments and
28 daily proton slot allocation rather than single-modality treatments, even with optimal
29 patient selection.
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Figure captions

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4 Figure 1: (a) Cumulative $NTCP$ and (b) $\Delta NTCP$ values for the 45 HNSCC patients for
5 the IMRT and IMPT plans, with indicated portions related to xerostomia and
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7 dysphagia. (c) Allocation of 270 proton fractions that minimizes the sum of the $NTCP$
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9 values for xerostomia and dysphagia in the whole population. The patients are
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11 ordered according to their $\Delta NTCP^{Sum}$.
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19 Figure 2: (a) Example for the allocation of 3 daily available proton slots to 100
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21 consecutive HNSCC patients for combined proton-photon treatments corresponding
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23 to the time period of approximately one year (281 working days), extracted randomly
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25 from the simulation. Each row corresponds to a patient and each column
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27 corresponds to the fraction number. If a patient receives a proton fraction, the
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29 corresponding element is filled with a color that encodes the total number of proton
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31 fractions received until that day. If the patient receives a photon fraction, the element
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33 is white.; (b) Number of proton fractions received by each patient; (c) patients
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35 selected for protons based on a $\Delta NTCP$ threshold of 14% for the same sequence of
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37 patients as in (a/b).
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46 Figure 3: (a) Average $NTCP^{Sum}$ as a function of the daily available proton slots for the
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48 combined treatments with daily slot reallocation (blue stars) and the single-modality
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50 treatment (patient selection) assuming different $\Delta NTCP^{Sum}$ thresholds. (b) Average
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52 $NTCP^{Sum}$ for threshold-based patient selection with 3 proton slots per day as function
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54 of the $\Delta NTCP^{Sum}$ threshold.
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Figure 4: Dutch (blue), Houweling (red), and favorable (yellow) NTCP models for xerostomia. The vertical lines show the mean of the contralateral mean doses ± 1 standard deviation for photons (black) and protons (green) over the 45 HNSCC patients.

Figure 5: Average NTCP values as a function of the number of available proton fractions N_{avail} for combined proton-photon treatments (x) and patient selection (+) treat all 45 patients with only protons.

Table caption

Table 1: Comparison of the average $NTCP^{Sum}$ values for the patient selection, combined proton-photon treatments, and the case that all patients are treated with photons and protons. Numbers in parentheses indicate the percentage of the benefit relative to what is achievable when treating all patients with protons. (a) for proton slot allocation over the given cohort of 45 patients; (b) for the simulation of the continuous operation of a department for 4499 patients.

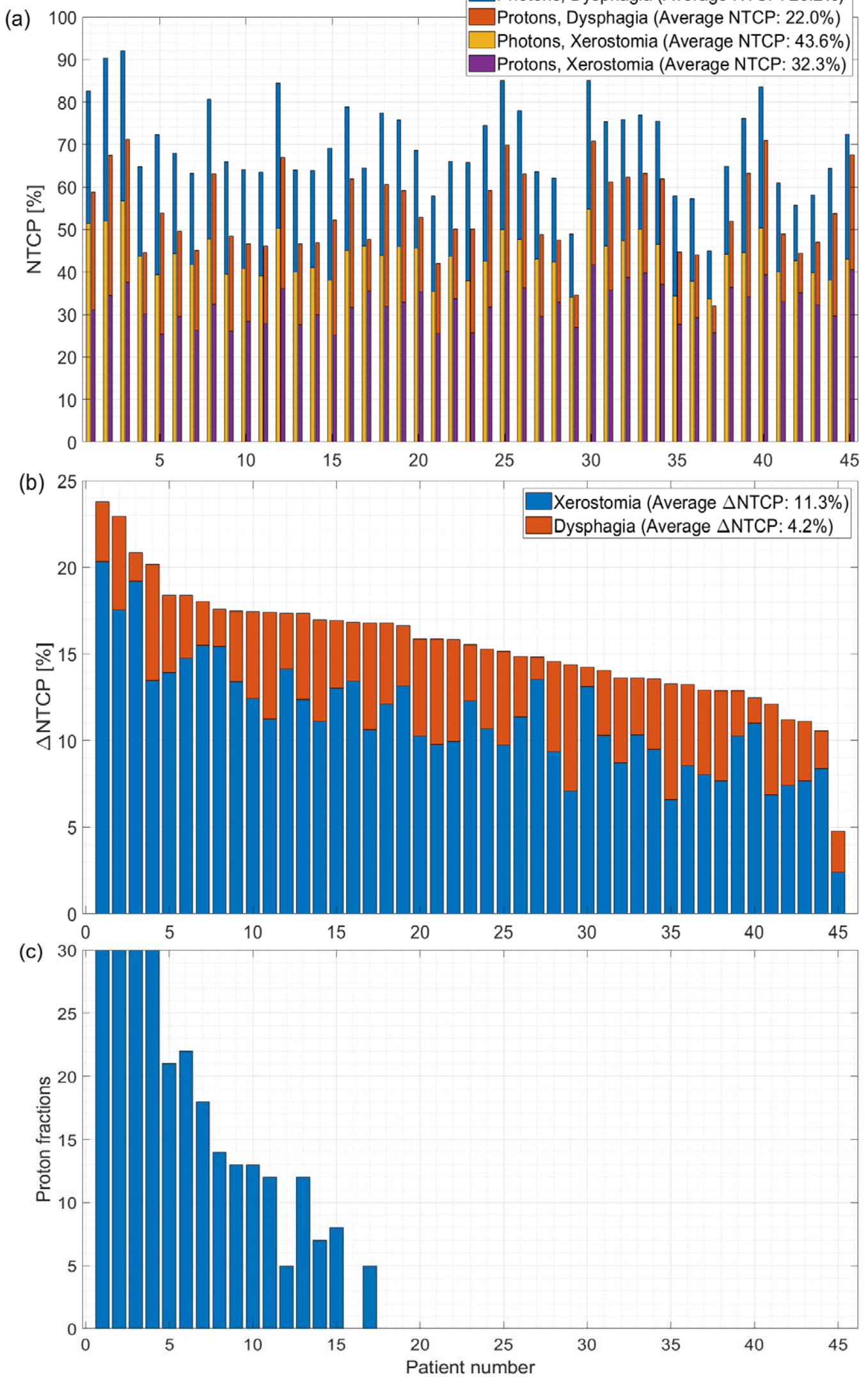
Table 1

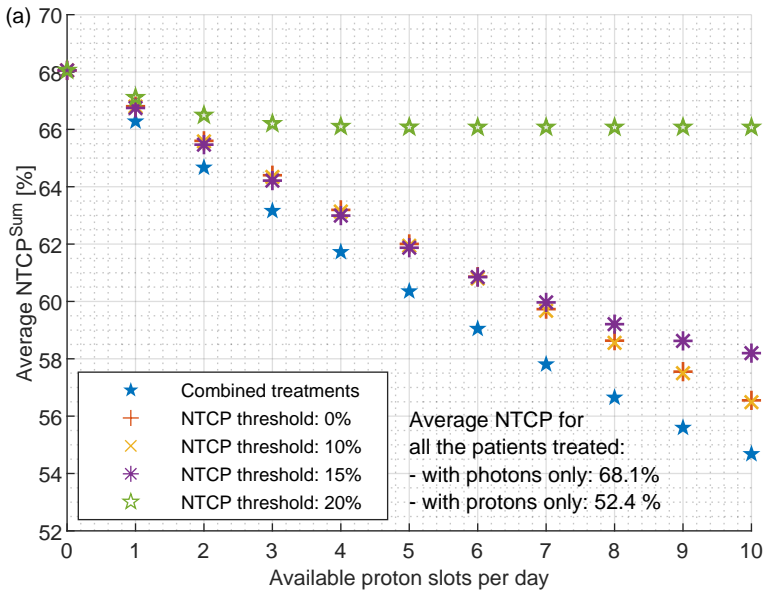
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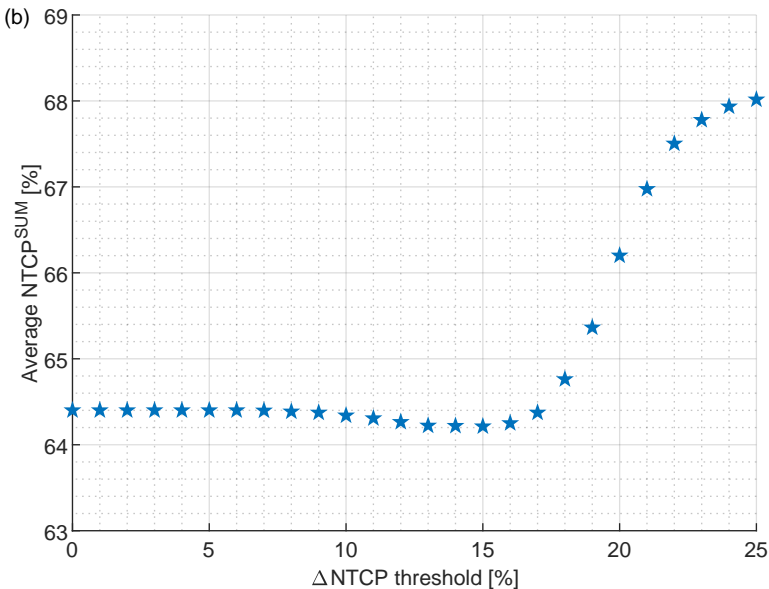
Only photons	Only protons	Patient selection		Combined proton-photon RT	
69.79%	54.30% (100%)	20% protons	60% protons	20% protons	60% protons
		65.84% (25.5%)	59.31% (67.7%)	65.78% (25.9%)	59.29% (67.8%)

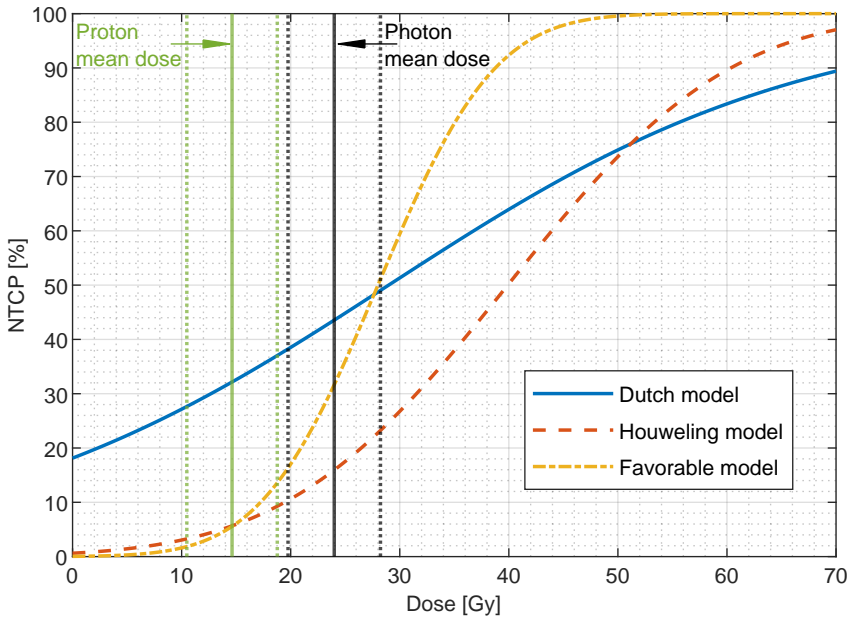
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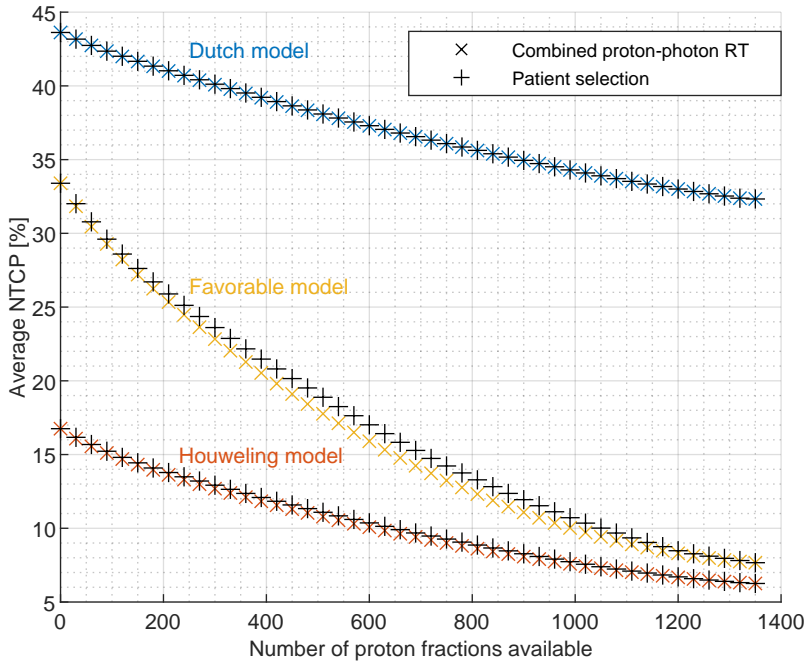
Only photons	Only protons	Patient selection with 14% threshold		Daily slot reallocation strategy	
68.06%	52.35% (100%)	3 proton slots per day	6 proton slots per day	3 proton slots per day	6 proton slots per day
		64.22% (24.4%)	60.67% (47.0%)	63.16% (31.2%)	59.05% (57.4%)

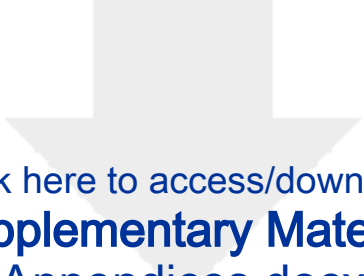




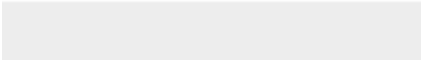


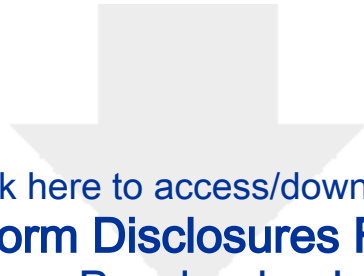




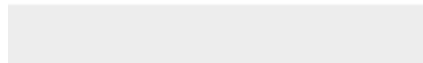


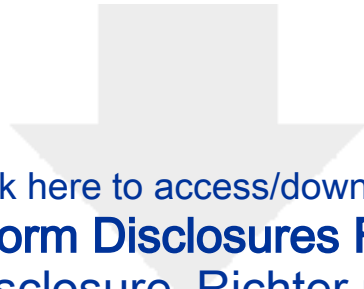
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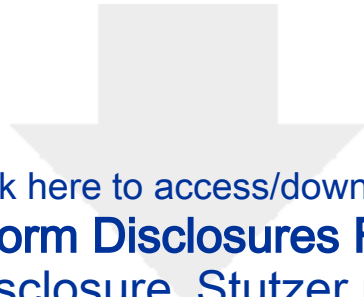
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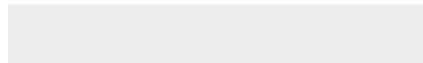


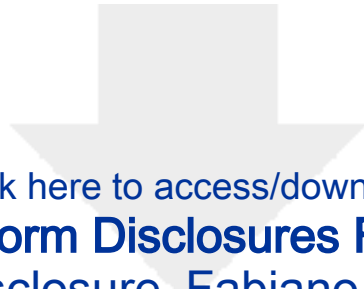
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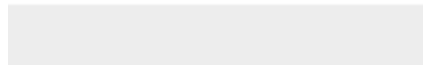


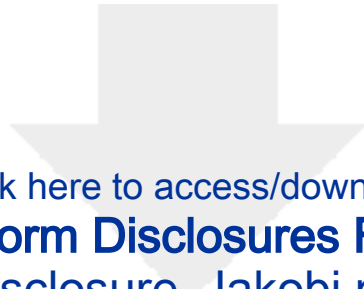
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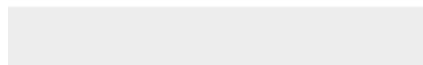


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