

Correspondence

To the Editor:

Definition of *ABLATION*: the process of ablating; as *a*: surgical removal; *b*: loss of a part (as ice from a glacier or the outside of a nose cone) by melting or vaporization. (Online *Merriam-Webster Dictionary*).

Although we applaud the attempt of Loo et al¹ to remind their colleagues of the works of William Shakespeare in general, and the quote from *Romeo and Juliet* specifically (“What’s in a name? That which we call a rose by any other name would smell as sweet.”), we decry their attempt to use the Bard to introduce additional confusion and ambivalent terminology into the practice of radiation oncology. We also find it unfortunate that in their zeal to create more catchy or onomatopoeic acronyms, they have ignored over 30 years of history with regard to these therapies and missed a simple and salient feature of the interventions. Indeed, in their statement that “SBRT is basically descriptive of a treatment modality...” they seem to misunderstand that the purpose of the formally accepted CPT definitions of SRS and SBRT is exactly that—descriptive of 2 different generic processes of care of 2 different treatment regimens.

The only confusion that arises from the current definitions is secondary to an unfortunate quirk of history, in which the developer of the initial stereotactic radiation system was a neurosurgeon rather than a radiation oncologist, hence the term stereotactic radiosurgery (SRS). The problem was not at all use of the term “stereotactic,” which is universally understood, but of the term “radiosurgery.” Innumerable contentious battles with other surgical specialties desirous of hijacking the terminology of radiosurgery for other body sites ultimately led to a less than optimal, but workable, negotiated settlement several years ago that “SRS” would refer to the central nervous system (brain, spinal cord, and paraspinal) only, and “SBRT” would be used for all other body sites. Despite the contention by Loo et al, this terminology is now accepted by the Current Procedural Terminology Editorial Panel, AMA/Specialty Society Relative Value Scale Update Committee (RUC), Centers for Medicare &

Medicaid Services, and most commercial payers. Many of our colleagues in radiation oncology have added to the confusion by inappropriate utilization of terminology, even in our peer-reviewed literature, and vendors and physicians have adopted variations of the terms to suit their own marketing strategies.

We could find no reference to “ablation” in Shakespeare, but certainly could in *Merriam-Webster* (see above). In this regard, the term “ablation,” although perhaps lending itself to more seductive acronyms, would be extraordinarily misleading to most stakeholders. If a specific treatment regimen is “ablative,” then by definition are all other time/dose/fraction regimens “non-ablative?” What are the interpretive implications of this concept to patients, attorneys, or payers? What about SBRT that is clearly not ablative (eg, prostate)? Is that “nearly ablative?”

We would suggest consideration of another quote from Shakespeare with regard to the Loo et al proposal, this from Cassius in *Julius Caesar*—“The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings.” Any misunderstanding of the current terminology of SRS and SBRT relates to our insufficient adoption of correct utilization, strict adherence to terminology, and defense of the biological principles involved—not for lack of a catchy name or incertitude about the various devices used to deliver the treatments.

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Reference

1. Loo BW, Chang JY, Dawson LA, et al. Stereotactic ablative radiotherapy: what’s in a name? *Practical Radiat Oncol*. 2011;1:38-39.