

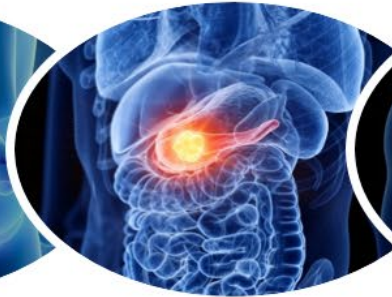
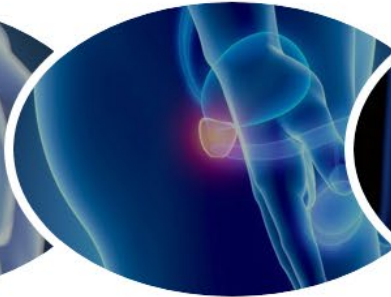
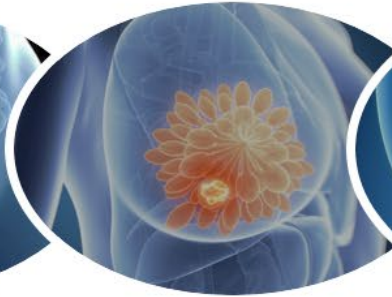
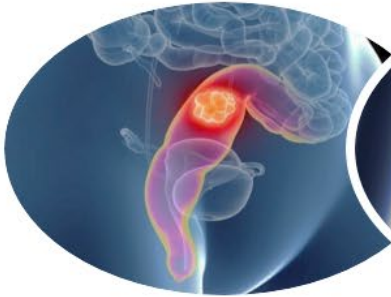
Rectal cancer

Breast cancer

Prostate cancer

**Pancreatic cancer**

Lung cancer



May 20<sup>th</sup>

May 27<sup>th</sup>

June 3<sup>rd</sup>

**June 10<sup>th</sup>**

June 17<sup>th</sup>

Keynote speaker:  
Prof. C. Rödel

Keynote speaker:  
Prof. M. Brunt

Keynote speaker:  
Dr. N. van As

**Keynote speaker:  
Prof. M. Hawkins**

Keynote speaker:  
Prof. S. Senan

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**Q & A**

## Questions

## Answers

<p>What would Dr. Hawkins recommend for motion management of pancreas cancer? Is it necessary and if yes is breath hold or compression preferred?</p>	<p>Respiratory motion management must be attempted in radiotherapy planning for pancreatic cancer SBRT. Abdominal compression might be better tolerated in elderly or less fit patients ( as patient is passive ) and breathhold is easier for fitter patients. If abdominal compression is used this has to be followed by a 4DCT scan to confirm the motion reduction.</p>
<p>5 x 5 Gy ist unter BED &lt; 90 Gy. Wäre 7 x 5 Gy nicht erstrebenswerter, um die BED&gt;90 Gy zu erreichen?</p>	<p>MP 5 x 5 Gy is indeed a low dose and we only give that dose for palliative aims. We try to achieve at least 5 x 6.6 Gy on the 80% Isodose when aiming for local control</p>
<p>Would you consider SABR or dose escalated RT outside of a clinical trial?</p>	<p>MP Whenever possible we try to treat pancreatic cancer with SBRT because of the advantages of its short treatment time. MH agree, but we should consider developing and enrolling all our patients in clinical trials</p>
<p>Why was Nelfinavir as radiosensitizer not further pursued?</p>	<p>The SCALOP 2 study is due to report soon and will clarify the role of Nelfinavir as a radiation sensitizer in pancreatic cancer. Also Roche has discontinued manufacturing the product.</p>
<p>What's your thing about the use of spacer between tumor and bowel for SBRT?</p>	<p>MP The idea behind a spacer is reasonable. However, we are cautious towards placement of any spacers in the abdomen because its demonstrated risk of toxicity, e.g. in retroperitoneal sarcoma. On these grounds, we will follow up on trial data coming up. MH there have been some data in abdomen with the use of laparoscopically placed spacers using materials similar to skin or allografts. The procedure is invasive, and until we know who are the patients that will benefit or radiation and we should investigate in a prospective clinical trial to show benefits,</p>
<p>Do you think should we manage oligometastatic pancreatic cancers like in the trial of SABR-COMET as radiation oncologists?</p>	<p>MP It is unclear if there is a true oligometastatic state in pancreatic cancer. We treat only very selected patients with pancreatic cancer as oligometastatic patients, e.g. patients that show a stable disease for several months without advent any new mets.</p>

## Questions

## Answers

	<p>MH I agree, the biology and metastatic rate in pancreatic cancers differ compared with breast colorectal or prostate cancer. As we do not have any biomarker selection we should consider randomized trials in pancreatic cancer with oligometastatic disease</p>
<p>In regards about the local failure, Do you change the GTV for SBRT?</p>	<p>MP The GTV corresponds to the visible tumor on diagnostic images. It is important to cover well the areas of vascular invasion</p>
<p>What margins would you use for palliative and what for curative SBRT-treatment? CTV? PTV? Would you make a difference?</p>	<p>MP We use for SBRT a PTV margin of 5 mm and no CTV, with daily MR-image guidance. In case of abutting of intestinal organs over a longer distance we switch to a SIB concept with 5 x 5 Gy on the areas with high risk of toxicity and 5 x 6.6 Gy on the 80% Isodose within the GTV</p> <p>MH Agree .The PTV margin is driven by the motion management and the setup accuracy. 5 mm 3D is accepted margin for set-up. In general CTV is not used for SBRT as the concept of including microscopic disease is not always accepted.</p>
<p>What would Dr. Hawkins recommend for motion management of pancreas cancer? Is it necessary and if yes is breath hold or compression preferred?</p>	<p>Respiratory motion management must be attempted in radiotherapy planning for pancreatic cancer SBRT. Abdominal compression might be better tolerated in elderly or less fit patients ( as patient is passive ) and breathhold is easier for fitter patients. If abdominal compression is used this has to be followed by a 4DCT scan to confirm the motion reduction.</p>
<p>Any specific biomarkers you use to select patients for RT?</p>	<p>This is an excellent question. We do not have any blood, imaging or tumour related biomarkers for patients selection.</p> <p>We think that in patients that have CA19-9 a response to chemotherapy (reduction in CA19-9 levels) accompanied by tumour reduction on imaging, and performance status 0-1 are good indicators that radiotherapy could be selected in that case.</p>

## Questions

## Answers

**Prof. Dr. M. Hawkins**

**Dr. M. Pavic**