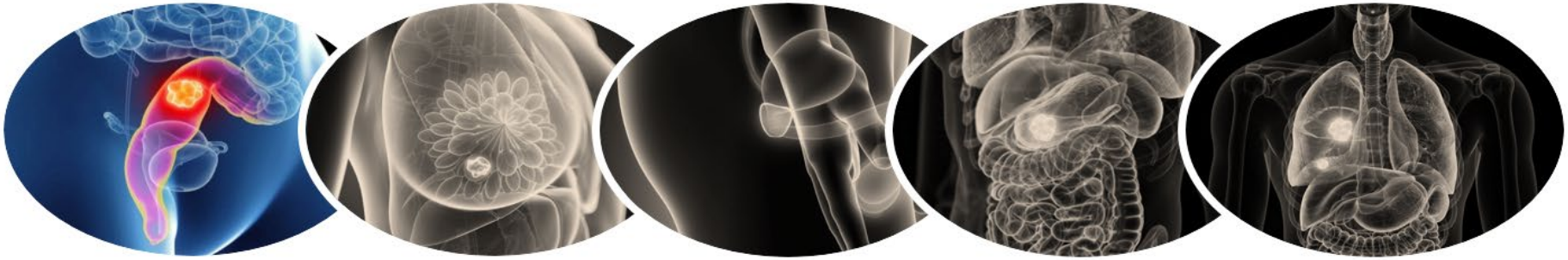
Rectal cancer | Breast cancer | Prostate cancer | Pancreatic cancer | Lung cancer



May 20th	May 27th	June 3rd	June 10th	June 17th
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

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Questions	Answers
5*5 --which radiation technique is used--3DCRT/IMRT/VMAT?	In the trials that established 5*5 only old 2D/3D techniques were used. In the current trials, including the ongoing German ARO-trial IMRT/VMAT is mandatory and also strongly recommended for treatment outside of trials
pCR in standard arm at 14 % is low any biological factors responsible	Please note that the pCR-rates should not be confused between different concepts: 14% is usual in the case of “accidental” pCR, following simple neoadjuvant radiotherapy and waiting interval of 6 weeks
Would you apply TNT for patients with oligo M1? Would you prefer Rapido or Prodige? Is there any evidence which support such a procedure?	TNT for oligometastatic patients is an excellent option, already used in clinical routine in large centers, but with scarce evidence so far. The “Rapido” concept seems to be reasonable in order to avoid long-course RT for these patients and is used both in Frankfurt and Zurich
In anal cancer, we treat the lower rectum with 60 Gy without big problems, why do we not treat that high for lower rectum to achieve higher pcr?	60 Gy in anal cancer is almost an overtreatment for most tumor stages and the patients also experience some not negligible late effects. However, in the case of the not so radiosensitive rectal cancer 60 Gy is an option and already used in rectal preservation trials, e.g. in the DANISH trial, but also with not negligible late toxicity, especially for patients receiving salvage surgery
Talking about contouring, when you prescribe 5x5, do you contour as the same way 25 x 2 vs 5 x 5?	Yes, the contours regarding CTV and OARs are the same for both cases
In the last presented Study design is the radiotherapy ad 54 Gy applied as simultaneous integrated boost?	Unfortunately is not clear, which trial do you mean, but both options are possible and tested.
Which should be the minimum technology required to use 5x5 ?	The minimum technology is 2D as in the historical trials, but nowadays IMRT/VMAT is the standard requirement

Questions	Answers
	for every patient with rectal cancer, regardless of the fractionation regimen.
What radiation technique do you use for these patients, 3 D vs IMRT?	See above: IMRT/VMAT
In which patients we can omit nodal stations from CTV in 5 x 5 regimen	In both regimens, patients with cN0 category can be irradiated “only” up to the sacroiliacal joint (S2) and spare the higher iliacal nodes
What is the best time for the first reassessment (during neoadj treatment at the end or longer? What modality?	According to the current knowledge and practice, the first assessment should be done 6-10 weeks after neoadjuvant radiotherapy, always including multimodality examination consisting of DRE, MRI and endoscopical evaluation
What was the radiation dose used in OPRA trial?	50 Gy + 4-6 Gy boost were used in the OPRA-trial
Thank you, very informative. Outside of the current ACO/ARO trial, what should be recommended for a cT3 cN+ cancer in the lower third of the rectum in elderly patients?	5x 5 Gy (followed or not by chemotherapy depending on comorbidity) should be used for elderly and frail patients. Please note: biologically younger patients with tumor adjacent to the sphincter might benefit from a long course chemoradiotherapy and/or a TNT concept.
What target volume do you recommend for 5*5 radiotherapy?	The target volumes should not differ between regimens
Is the classical T3 N+ without high-risk features like lateral LN or CRM+ a good Rapido patient?	This remains unclear at the moment. If no high-risk criteria according to RAPIDO are seen in a patient, standard CRT or 5x5 Gy with delayed surgery remain excellent options. So, if you see a patients with, e.g.,

Questions	Answers
	T3a/b in the mid of the rectum with limited (or only suspected) N+, TNT rather be an overtreatment.
Do you have an explanation for the very high pCR rate in the OPRA Trial?	The TNT and the radiotherapy boost used, which are both an intensification compared to “accidental” neoadjuvant data, as well as the longer waiting interval are the reasons for the good pCR rates in the OPRA trial. Moreover, it may well be that many early T3 tumors have been included. As by now, we do not have adequate patients characteristics and need top wait for the full-length paper of OPRA
Do you think radiation dose-escalation could have similar results as polychemotherapy plus radiation?	This could be indeed be the case, if we compare the DANISH trial (RT-dose escalation) with the OPRA-trial (polychemotherapy). Both comes with a price!
Including lymph-nodes?	If you mean including lymph nodes in the standard CTV: this I always the case. If clinically involved lymph nodes should be included in a possible dose-escalation boost is not clear yet.
what consensus of delineation of target volume do you use if you treat with hypofractionation? can we lower the cranial border of CTV? in which cases	The guidelines and consensus used for delineation for 5x 5 Gy is the same with standard fractionation. In case of cN0, we can indeed limit the CTV to a lower cranial border: the ileosacral joint / S2
If chemotherapy is not feasible for comorbidities, for which patients could be reasonable to propose long-course RT alone instead of 5x5? Thank you	In case of patients with the goal of rectal preservation and limited feasibility of chemotherapy a boost-escalated ling-course RT might be reasonable as individual regimen
Would you recommend dose escalation w/o brachytherapy and a long term Wait and See strategy before TME (increased fibrosis?)	As we have seen from the results of the DANISH-trial this option is possible, but the goal should be clearly organ preservation. Salvage-TME after such regimens may be associated with a higher risk of increased morbitidy

Questions	Answers
What target volume do you recommend for 5*5 radiotherapy?	The same target volumes as for long-course regimens. See also answers above.

Prof. Dr. C. Rödel

PD Dr. P. Balermpas