XXXIII CONGRESSO NAZIONALE AIRO

AIRO2023

BOLOGNA,
27-29 OTTOBRE 2023

PALAZZO DEI CONGRESSI

Radioterapia Oncologica: l'evoluzione al servizio dei pazienti

Associazione Italiana
Radioterapia e Oncologia clinica

Comunicazioni orali selezionate 2

Discussant : C. Spatola

DICHIARAZIONE CONFLITTO DI INTERESSI

Relatore: CORRADO SPATOLA

Come da nuova regolamentazione della Commissione Nazionale per la Formazione Continua del Ministero della Salute, è richiesta la trasparenza delle fonti di finanziamento e dei rapporti con soggetti portatori di interessi commerciali in campo sanitario.

- Posizione di dipendente in aziende con interessi commerciali in campo sanitario (NIENTE DA DICHIARARE)
- Consulenza ad aziende con interessi commerciali in campo sanitario (NIENTE DA DICHIARARE)
- Fondi per la ricerca da aziende con interessi commerciali in campo sanitario (NIENTE DA DICHIARARE)
- Partecipazione ad Advisory Board (NIENTE DA DICHIARARE)
- Titolarietà di brevetti in compartecipazione ad aziende con interessi commerciali in campo sanitario (NIENTE DA DICHIARARE)
- Partecipazioni azionarie in aziende con interessi commerciali in campo sanitario (NIENTE DA DICHIARARE)

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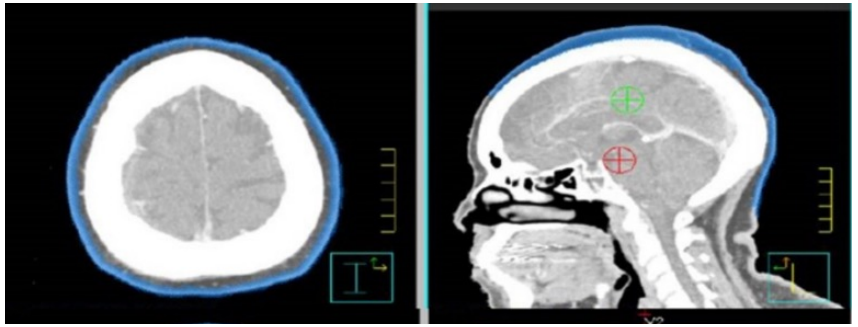
Abs B12 (471 di 6) 25. Tumori pediatrici

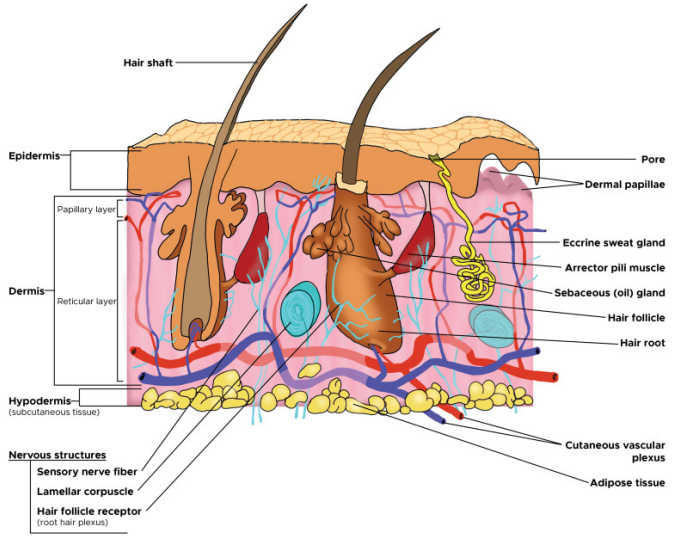
ALOPECIA PERMANENTE DOPO IRRADIAZIONE CRANIOSPINALE NEI PAZIENTI SOPRAVVISSUTI A TUMORE CEREBRALE IN ETÀ PEDIATRICA: ANALISI MULTI FATTORIALE

S. Campora[1], C. Satragno[2], F. Picichè[1], D. Esposito[1], M. Turazzi[1], F. Giannelli[3], C. Cavagnetto[4], D. Zefiro[4], N. Di Iorgi[5|6], A. Conte5|[7], A. Verrico[7], G. L Piccolo5|[7], L. Belgioia[1|3], S. Barra[2].

1. Dipartimento di Scienze della Salute (DISSAL) Università degli Studi di Genova;
2. Dipartimento di Medicina Sperimentale (DIMES) Università degli Studi di Genova
3. Radioterapia Oncologica, Ospedale Policlinico San Martino;
4. Fisica Medica, Ospedale Policlinico San Martino;
5. Dipartimento di Neuroscienze, Riabilitazione, Oftalmologia, Genetica, Salute del bambino e della mamma (DINOGMI) Università degli Studi di Genova
6. Dipartimento di Pediatria, Istituto di Ricovero e Cura a Carattere Scientifico Giannina Gaslini
7. Dipartimento di Neuro-Oncologia, Istituto di Ricovero e Cura a Carattere Scientifico Giannina Gaslini

Aims: To define the threshold doses to scalp for permanent alopecia onset combining endocrine, chemotherapy, and clinical data with radiotherapy data.





- *Esperienze derivate dalla Hippocampal-scalp sparing cranial irradiation*
- *Scarsità di lavori in letteratura (1 retrospettivo, 2 prospettici)*
- *Definizione di "scalp", tecniche applicate e limiti di dose differenti*
- *Diversi metodi di valutazione della QoL*

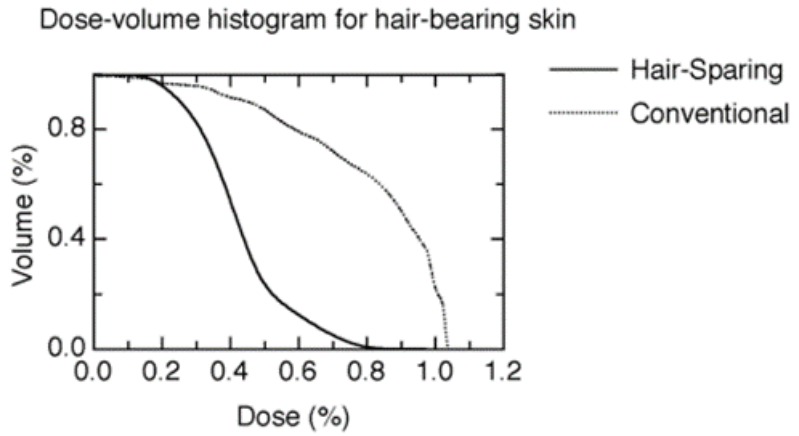
Radiation-induced alopecia

Technology in Cancer Research & Treatment
ISSN 1533-0346
Volume 4, Number 5, October (2005)

Treating the Contents and Not the Container: Dosimetric Study of Hair-sparing Whole Brain Intensity Modulated Radiation Therapy

David Roberge, M.D.[1,*]
William Parker, M.Sc.[2]
Tamim M. Niazi, M.D.[1]
Marina Olivares, M.Sc.[1]

www.tcrt.org



"The average measured dose at five surface points was reduced by 53% – from 95% of the prescription dose with the conventional plan, to 44%, with the IMRT plan"

"We would not expect that even a 53% reduction in dose would prevent acute alopecia in most patients. The tolerance of the hair follicle may be as low as 2-3 Gy (in a single fraction). However, the severity and duration of acute alopecia is dose dependent, thus a lower dose may mean shorter-lived partial alopecia"

De Puysseleyr *et al. Radiation Oncology* 2014, **9**:170
http://www.ro-journal.com/content/9/1/170

RADIATION ONCOLOGY

RESEARCH Open Access

Hair-sparing whole brain radiotherapy with volumetric arc therapy in patients treated for brain metastases: dosimetric and clinical results of a phase II trial

Annemieke De Puysseleyr[1], Joris Van De Velde[2], Bruno Speleers[1], Tom Vercauteren[3], Anneleen Goedgebeur[1], Tom Van Hoof[2], Tom Boterberg[1,3], Wilfried De Neve[1,3], Carlos De Wagter[1,3] and Piet Ost[1,3*]

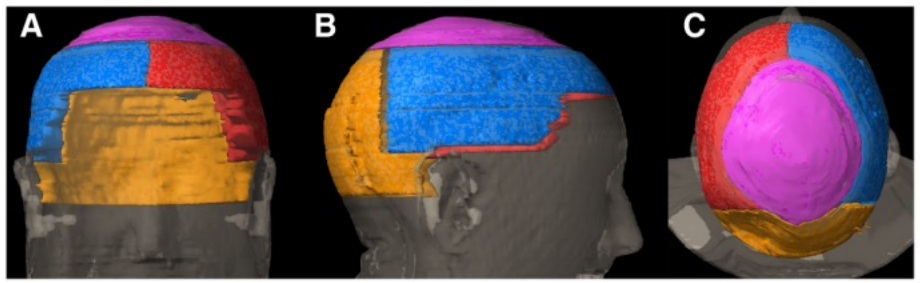
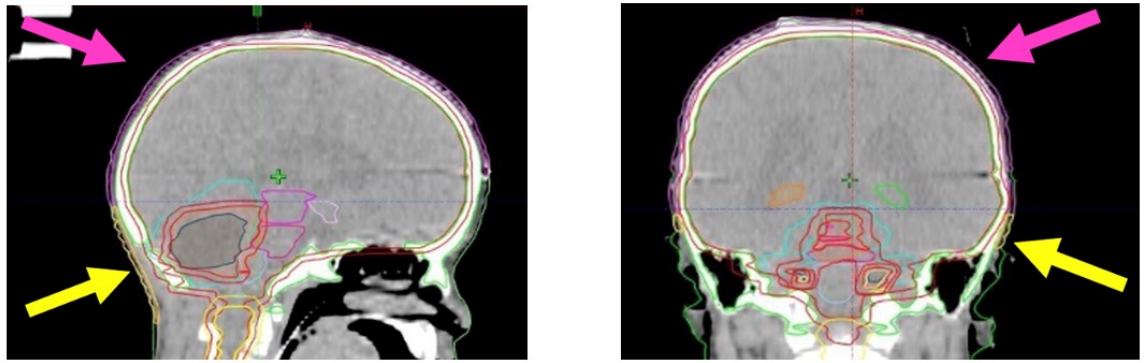


Figure 1 The hair follicle volume was defined as the tissue underlying the skin up to the outer table of the skull. An automated script was written in Pinnacle, version 9.0 (Philips Medical Systems, Andover, MA, US), to automatically contour this volume with the creation of 4 subvolumes representing the different areas of the scalp: top (vertex, pink), back (posterior aspect of the scalp, orange), left (left profile of the scalp, blue) and right (right profile of the scalp, red). **Panel A**: frontal view, **panel B**, lateral view, **panel C**: cranial view.

"In the phase II trial, a total of 10 patients were included before the trial was halted due to futility.

The average median dose to the hair follicle volume was 12.6 Gy, corresponding to a 37% dose reduction compared to the prescribed dose.
This resulted in a mean SALT-score of 75."
(Severity of Alopecia Tool is a scale ranging between 0 (no hair loss) to 100 (complete alopecia)

Results



Considering the work done by the atlas is in background,
this resulted in a time savings of 80% for the operator.

Results: Factors associated to Alopecia WS

otal dose to PCF tumor bed	4749.4 ± 1522.27	5797.8 ± 927.03	0.004*
Volume WS	182.1 ± 60.21	161.3 ± 50.35	0.26
Average Dose WS	2428.5 ± 519.11	2774.9 ± 549.38	0.045*
D50% WS	2406.7 ± 514.43	2752.4 ± 608.26	0.037*
D0.03cc WS	4342.9 ± 1100.85	5255.9 ± 1003.29	0.002*
V2000cGy WS	70.5 ± 23.13	78.3 ± 18.24	0.28
V1600cGy WS	88.4 ± 10.50	90.5 ± 6.14	0.98
V2500cGy WS	40.7 ± 34.58	57.7 ± 31.02	0.10
V3000cGy WS	23.9 ± 26.02	43.1 ± 29.23	0.019*
V3500cGy WS	9.7 ± 13.39	24.4 ± 20.18	0.003*
V4000cGy WS	4.1 ± 6.92	10.7 ± 9.42	0.003*
V4300cGy WS	2.6 ± 5.16	6.9 ± 7.45	0.004*
D0.01cc WS	4383.6 ± 1113.59	5306.7 ± 1006.25	0.004*
D98% WS	883.9 ± 736.80	590.8 ± 758.13	0.08
D2% WS	3759.4 ± 928.08	4545.5 ± 839.55	0.003*

Conclusion

- Atlas-based self-segmentation and the Alopecia_Hope protocol offer a more efficient and accurate method to identify the scalp.
- This study demonstrates the effectiveness and efficiency in reducing radiotherapy workload and improving accuracy.
- The identified dose cutoffs can be a guide for scalp-sparing in craniospinal irradiation in paediatric patients.
- Endocrinological damage and surgery do not seem to affect this toxicity as much as radiotherapy and high doses of chemotherapy.
- The combination with Thiotepa and bifraction radiotherapy probably affects the radiosensitivity of the scalp.
- Implementation of the DVH also on the basis of these factors will probably be a simple indication to prevent this toxicity
- Retrospective and prospective studies on larger cohorts are needed for better stratification of identified risk factors and to confirm threshold doses.

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Abs B11 (303 di 6) 21. Malattia oligometastatica

OUTCOME E FATTORI PREDITTIVI DI RISPOSTA IN PAZIENTI OLIGOMETASTATICI AFFETTI DA CANCRO DEL COLON-RETTO TRATTATI CON RADIOTERAPIA STEREOTASSICA (SBRT): L'IMPORTANZA DEL VOLUME TUMORALE

B. Marini[1|2], C. Franzese[1|2], T. Comito[1], M. Massaro[1], A. Teriaca[1], M. Badalamenti[1], C. Galdieri[1], S. Tomatis[1], M. Scorsetti[1|2].
[1] IRCCS Humanitas Research Hospital
[2] Department of Biomedical Sciences, Humanitas University

AIM: Understanding and identifying predictive factors is strongly necessary for a successful treatment strategy of oligometastatic colorectal cancer (CRC) patients. The aim of our study is to describe clinical outcomes and predictive factors of a large cohort of oligometastatic patients affected by CRC treated with Stereotactic body radiation therapy (SBRT).

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RESULTS: 347 patients for a total of 516 oligometastases

Characteristics	n°	%
Gender		
Female	125	36%
Male	222	64%
Performance Status		
0	231	66,60%
1	80	23%
2	36	10,40%
Primary site		
Colon	236	68%
Rectum	89	25,60%
Sigma	22	6,40%
Treated metastases		
1	207	59,60%
2	85	24,50%
3	44	12,70%
4	5	1,44%
5	6	1,73%

Characteristics	n°	%
Treated organs		
1	307	88,40%
2	36	10,37%
3	4	1,15%
Untreated lesions		
No	199	57,51%
Yes	147	42,49%
Systemic therapy before SBRT		
No	86	24,78%
Yes	261	75,22%
Median time to metastases: 21.2 months (0 - 167.9)		
Total delivered dose: 48 Gy (25 – 75)		
Number of fractions: 4 (1-10)		
BED minimum: 105.6 Gy (35.7 - 262.5)		
Tumor volume, median in cc: 14.1 (0.4 - 596.9)		

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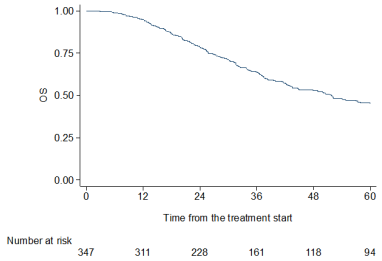
MEDIAN OS: 51,6 MONTHS



1-year OS: **94.9%** (95%CI 91.9 – 96.8)
3-year OS **63.8%** (95%CI 58.0 – 69.1)
5-year OS **45.1%** (95%CI 38.9 – 51.2)

WORSE OS:
- **worse PS** (HR 1.83, 95%CI 1.21 – 2.78; p=0.004)
- **tumor volume > 14.1 cc** (HR 1.51, 95%CI 1.12 – 2.04; p=0.006)
- **in-field progression** (HR 1.58, 95%CI 1.16 – 2.16; p=0.004)

BETTER OS:
- **prior systemic therapy before SBRT** (HR 0.70, 95%CI 0.51 – 0.96; p=0.030)

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Tumor volume <= 14.1 cc correlated with a median OS of 68.5 months

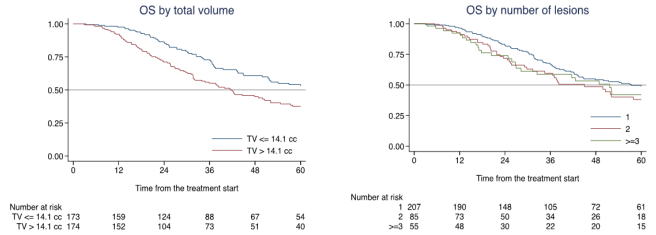

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Table 1 Randomized trials of metastasis-directed therapy (MDT) for patients with oligometastatic disease

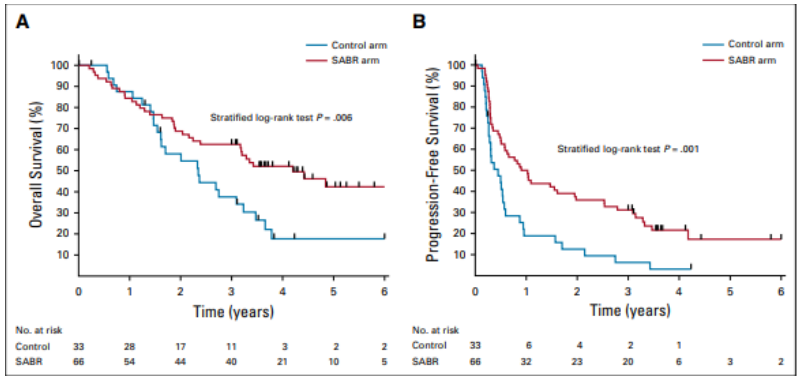
Study	Histology [%]	No. Patients	No. metastases		Median follow-up	MDT techniques used	RT dose (Gy)	RT No. fractions	PFS (median), month		OS (median), month		Grade 3+ toxicity (%)	
			Eligible	Included					MDT arm	Control arm	MDT arm	Control arm	MDT arm	Control arm
SABR-COMET (7)	Breast [18]; CRC [18]; lung [18]; prostate [16]; other [29]	99	1–5	1: 42 (42%); 2: 32 (32%); 3: 18 (18%); 4: 4 (4%); 5: 3 (3%)	25 months	HIGRT	16–60	1–8	12	6	41	28	N/A G2+: 3 (9%)	N/A G2+: 19 (29%)
MDACC (11)	NSCLC	49	0–3	0–1: 32 (65%); 2–3: 17 (35%)	38.8 months	Surgery and/or HIGRT	15–70	1–33	14.2	4.4	41.2	17	5 (20%)	2 (8%)
UTSW (12)	NSCLC	29	1–6	1: 6 (21%); 2: 14 (48%); 3: 8 (28%); 4: 1 (3%); 5–6: 0 (0%)	9.6 months	HIGRT	21–45	1–15	9.7	3.5	Not reached	17	4 (29%)	3 (20%)
EORTC 40004 (9)	CRC	119	1–9	1–2: 32 (27%); 3–4: 32 (27%); 5–6: 28 (24%); 7–9: 27 (23%)	9.7 years	RFA ± resection	N/A	N/A	16.8	9.9	45.6	40.5	51 (total, not by pt)	59 (total, not by pt)
STOMP (13)	Prostate	62	1–3	1: 27 (44%); 2: 16 (26%); 3: 19 (31%)	3 years	Surgery and/or HIGRT	30	3	ADT-free survival, median: 17	ADT-free survival, median: 13	N/A	N/A	0	0
ORIOLE (14)	Prostate	54	1–3	N/A	18.8 months	HIGRT	19.5–48	3–5	Not reached	5.8	N/A	N/A	0	0

RT, radiation therapy; PFS, progression-free survival; OS, overall survival; CRC, colorectal cancer; NSCLC, non-small cell lung cancer; HIGRT, hypofractionated image-guided radiation therapy; RFA, radiofrequency ablation; MDACC, MD Anderson Cancer Center; UTSW, University of Texas Southwestern.

Malattia oligometastatica
Malattia oligo-progressiva
Malattia oligo-ricorrente
Malattia oligometastatica-indotta

Stereotactic Ablative Radiotherapy for the Comprehensive Treatment of Oligometastatic Cancers: Long-Term Results of the SABR-COMET Phase II Randomized Trial

David A. Palma, MD, PhD[1]; Robert Olson, MD, MSc[2]; Stephen Harrow, MBChB, PhD[3]; Stewart Gaede, PhD[1]; Alexander V. Louie, MD, PhD[4]; Cornelis Haasbeek, MD, PhD[5]; Liam Mulroy, MD[6]; Michael Lock, MD[1]; George B. Rodrigues, MD, PhD[1]; Brian P. Yaremko, MD, PEng[1]; Devin Schellenberg, MD[7]; Belal Ahmad, MD[1]; Sashendra Senthi, MD, PhD[8]; Anand Swaminath, MD[9]; Neil Kopek, MD[10]; Mitchell Liu, MD[11]; Karen Moore, MSc[3]; Suzanne Currie, MSc[3]; Roel Schlijper, MD[2]; Glenn S. Bauman, MD[1]; Joanna Laba, MD[1]; X. Melody Qu, MD, MPH[1]; Andrew Warner, MSc[1]; and Suresh Senan, MBBS, PhD[5]



Medical Oncology (2022) 39:181
https://doi.org/10.1007/s12032-022-01788-8

REVIEW ARTICLE

A critical review on oligometastatic disease: a radiation oncologist's perspective

Pietro Pacifico[1,2] · Riccardo Ray Colciago[1,3] · Francesca De Felice[4] · Luca Boldrini[5] · Viola Salvestrini[6] · Valerio Nardone[7] · Isacco Desideri[8] · Carlo Greco[9] · Stefano Arcangeli[1,2]

Radiotherapy and Oncology 148 (2020) 157–166

Contents lists available at ScienceDirect

Radiotherapy and Oncology

journal homepage: www.thegreenjournal.com

Consensus

Defining oligometastatic disease from a radiation oncology perspective: An ESTRO-ASTRO consensus document

Yolande Lievens[a,*], Matthias Guckenberger[b], Daniel Gomez[c], Morten Hoyer[d], Puneeth Iyengar[e], Isabelle Kindts[f], Alejandra Méndez Romero[g], Daan Nevens[h], David Palma[i], Catherine Park[j], Umberto Ricardi[k], Marta Scorsetti[l], James Yu[m], Wendy A. Woodward[c]

Table 3 OMD on-going phase III randomized controlled trials

Study	Phase	Type of cancer	Intervention		
NCT05278052	III	NSCLC	Standard maintenance therapy + SBRT VS Standard maintenance therapy alone		
NCT05377047	III	Breast cancer	SBRT to all sites VS Standard first line systemic therapy	2027	3 year—OS
NCT04983095	III	Prostate cancer	SBRT to all sites + standard treatment VS Standard treatment	2029	Failure-free survival
NCT04498767	III	Solid tumors	SBRT to all sites VS Palliative RT	2030	OS
NCT04495309	III	Breast cancer	SBRT to all sites + Standard treatment VS Standard treatment	2025	PFS and QoL
NCT02417662	III	NSCLC	SBRT to all sites + Standard treatment VS Standard treatment alone	2022	3 year—OS
NCT04599686	III	Prostate cancer	SBRT to all sites VS ADT	2025	1 year—ADT-free survival
NCT04115007	III	Prostate Cancer	SBRT to all sites + Standard treatment VS Standard treatment	2027	Castration-resistant prostate cancer free survival
NCT04646564	III	Breast cancer	SBRT to all sites + Standard treatment VS Standard treatment	2026	2 year—PFS
NCT04646564	III				
NCT03862911	III				
NCT03784755	III				
			SBRT to primary tumor + Standard treatment		
NCT03721341	III	Solid tumors	SBRT to all sites + Standard treatment VS Standard treatment	2029	OS
NCT05209243	III	Prostate cancer	SBRT to all metastatic sites + ADT + Standard treatment + RT to primary tumor VS ADT + RT to primary tumor + Second generation hormonal treatment	2026	2 year—PFS
NCT03827577	III	NSCLC	SBRT to all sites + Lung resection + Standard treatment VS Standard treatment	2022	5 year—OS
NCT05352178	III	Prostate cancer	SBRT to all sites VS SBRT to all sites + ADT	2032	5 year—Poly metastatic free survival

NSCLC Non-Small Cell Lung Cancer, *PFS* Progression Free Survival, *OS* Overall Survival, *ADT* Androgen Deprivation Therapy, *RT* Radiation Therapy, *QoL* Quality of Life

What do we know

Safe treatment

There is no biological evidence supporting the maximal number of metastases, or the maximal lesion size, that can be treated to provide clinical benefit

Definition of OMD did not distinguish extracranial from intracranial metastases

Higher dose, greater control (BED ≥ 100)

Influence of prior and current systemic therapy, DFI, PS

Immunomodulation synergistic effects and Local control benefit

What needs to be clarified

Survival benefit

Correct timing undefined
(earlier treatment, better response?)

Standardization of techniques and schedules

Multidisciplinary management from diagnosis

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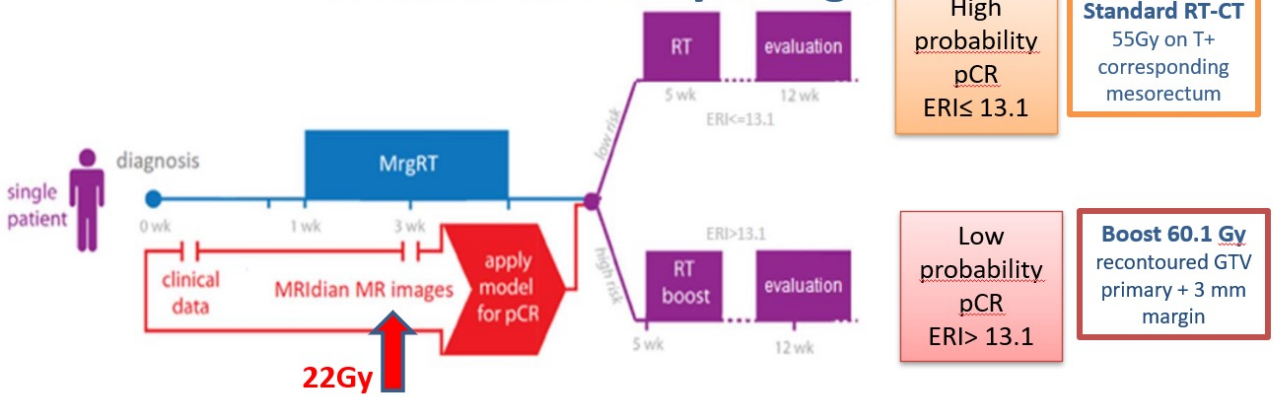
Abs B10 (161 di 6) 14. Tumori gastro-enterici

APPROCCIO TERAGNOSTICO NELLE NEOPLASIE DEL RETTO TRATTATE CON RADIOTERAPIA IBRIDA GUIDATA DALLA RISONANZA MAGNETICA: ANALISI DI SICUREZZA AD INTERIM DELLO STUDIO DI FASE II THUNDER-2

G. Chiloiro[1], A. Romano[1], D. Cusumano[2], L. Boldrini[1], G. Panza[1], E. Meldolesi[1], L. Placidi[1], G. Meffe[1], M. Nardini[1], L. Indovina[1], M. A. Gambacorta[1].
1Fondazione Policlinico Universitario "A. Gemelli" IRCCS
2 Mater Olbia Hospital

Aims
Thunder 2 is a prospective clinical trial that focuses on exploring the potential therapeutic and diagnostic benefits of MRI-guided radiotherapy (MRIgRT) for locally advanced rectal cancer (LARC). Its primary aim is to assess the impact of escalating radiotherapy (RT) doses in LARC patients who have been identified as poor responders based on the Early Tumour Regression Index (ERI) on likelihood of achieving both pathological and clinical complete response. This interim analysis aims to evaluate the safety and feasibility of implementing the dose escalation MRIgRT strategy within the clinical trial.

Thunder 2: study design



High probability pCR
ERI≤ 13.1

Standard RT-CT
55Gy on T+ corresponding mesorectum

Low probability pCR
ERI> 13.1

Boost 60.1 Gy
recontoured GTV primary + 3 mm margin

CT with 5-FU or oral capecitabine (5-FU 225 mg/mq/day in c.i.; Capecitabine 1650 mg/m2/day chronomodulated)

Chiloiro G. et al, BMC 2022

Contents lists available at ScienceDirect
Radiotherapy and Oncology
journal homepage: www.thegreenjournal.com

Original article

A TCP-based early regression index predicts the pathological response in neo-adjuvant radio-chemotherapy of rectal cancer

Claudio Fiorino[a,*], Calogero Gumina[b], Paolo Passoni[b], Anna Palmisano[c], Sara Broggi[a], Giovanni M. Cattaneo[a], Alessandra Di Chiara[c], Antonio Esposito[c], Martina Mori[a], Roberta Raso[a], Monica Ronzoni[d], Riccardo Rosati[e], Najla Slim[b], Francesco De Cobelli[c], Riccardo Calandrino[a], Nadia G. Di Muzio[b]

[a] Medical Physics; [b] Radiotherapy; [c] Radiology; [d] Oncology; and [e] Gastroenterology Surgery, San Raffaele Scientific Institute, Milano, Italy

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Thunder 2: aims

- Increasing of **10%** of **CR** rate in *"not responder"* rectal cancer patients treated with MRI-LINAC hybrid machine
- Evaluating the **fea** models in MR-guic

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Thunder 2: interim analysis acute toxicity

32 Patients	Toxicity (CTCAE v 5.0) N (%)				
	G1	G2	G3	Total	*p value
	22 (68.8)	7 (21.9)	1 (3.2)	30 (93.8)	
16 boost	11 (34.4)	4 (12.5)	0	15 (46.9)	0.54
16 no boost	11 (34.4)	3 (9.4)	1 (3.2)	16 (50)	
Proctitis	7 (21.9)	1 (3.2)	1 (3.2)	9 (28.1)	
Diarrhoea	12 (37.5)	2 (6.3)	1 (3.2)	15 (46.9)	
Tenesmus	13 (40.7)	1 (3.2)		14 (43.9)	
Mucorrhoea	15 (46.9)	3 (9.4)		18 (56.3)	
Cystitis	8 (25)		1 (3.2)	9 (28.1)	
Fatigue	7 (21.9)	1 (3.2)		8 (25)	

CRT treatment was discontinued in 5 (15.6%) patients

CHT was discontinued in 2 other patients (overall 7 (21.9%))

Chiloiro G. et al, Radiation Oncology 2023

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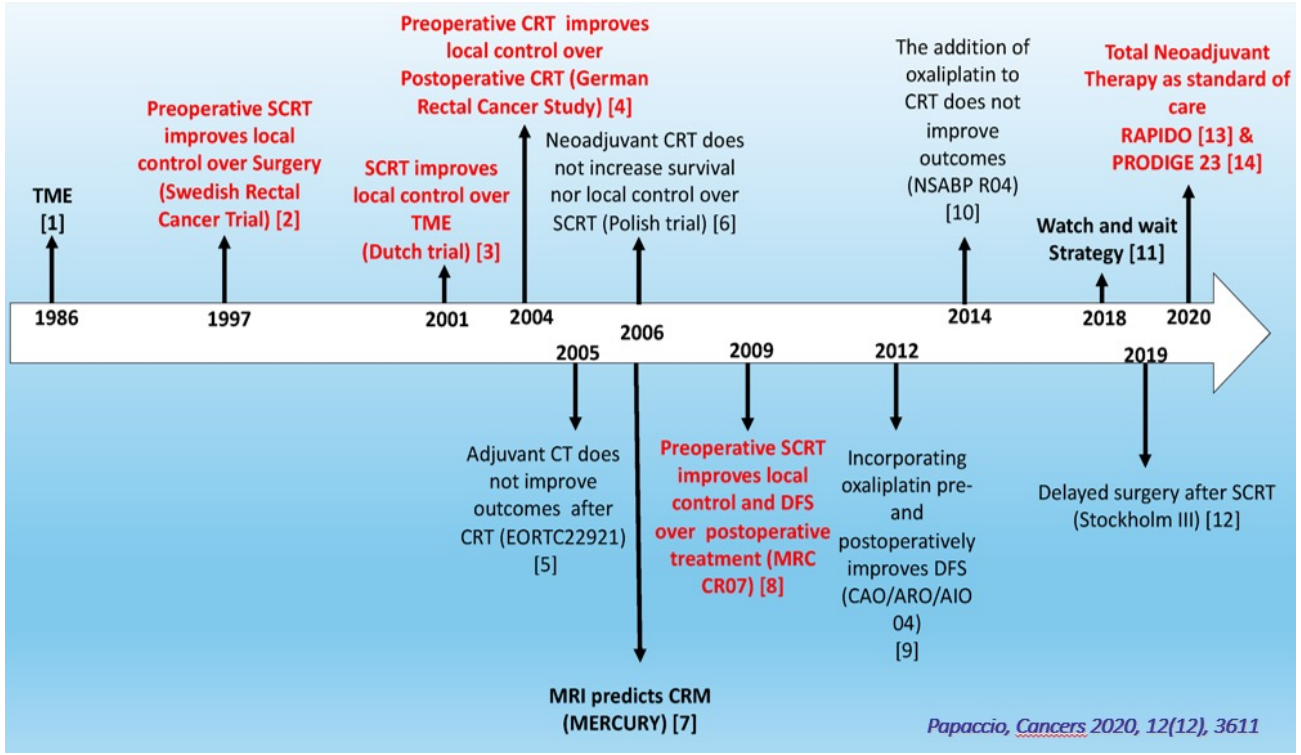
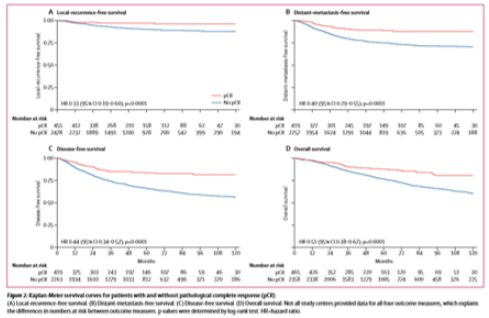
Associazione Italiana Radioterapia e Oncologia clinica

Intensificazione del trattamento neoadiuvante



Articles



Long-term outcome in patients with a pathological complete response after chemoradiation for rectal cancer: a pooled analysis of individual patient data

Monique Maas, Putzy J Nelemans, Vincenzo Valentini, Prajnan Das, Claus Rödel, Li-Jen Kuo, Felipe A Calvo, Julio García-Aguilar, Rob Glynne-Jones, Karin Haustermans, Mohammed Mohiuddin, Salvatore Pucciarelli, William Small Jr, Javier Suárez, George Theodoropoulos, Sebastiano Biondo, Regina G H Beets-Tan, Gerrard L Beets

Patients with pCR after chemoradiation have better long-term outcome than do those without pCR. pCR might be indicative of a prognostically favourable biological tumour profile with less propensity for local or distant recurrence and improved survival.

Dovuto a cosa?

- intensificazione RT
- intensificazione CT
- allungamento del timing per la chirurgia

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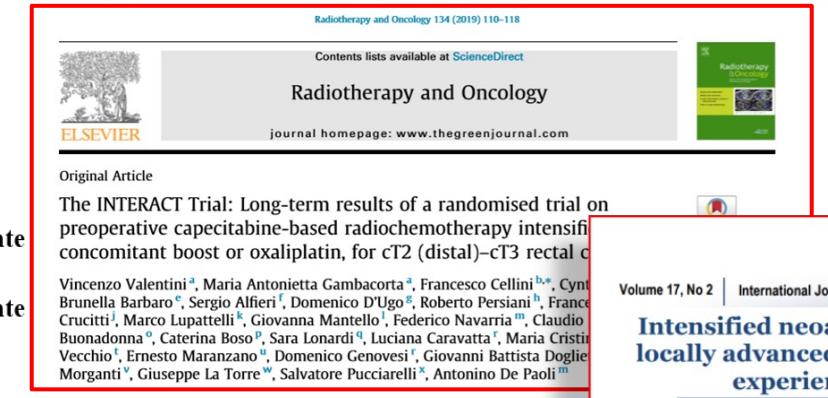
Radioterapia Oncologica:
l'evoluzione al servizio dei pazienti

Schemi TNT attualmente in uso

1. **Chemioradioterapia neoadiuvante (nCRT) seguita da chemioterapia di consolidamento (CONCT):**
2. **Chemioterapia di induzione (INCT) seguita da chemioradioterapia neoadiuvante (nCRT)**
3. **Chemioterapia di induzione (INCT) seguita da chemioradioterapia neoadiuvante (nCRT) seguita da chemioterapia di consolidamento (CONCT).**

Chemioradioterapia concomitante
5-FU o capecitabina

Chemioterapia di induzione o consolidamento
Folfox4 – Xelox - Folfirinox


Radiotherapy and Oncology 134 (2019) 110–118

Contents lists available at ScienceDirect

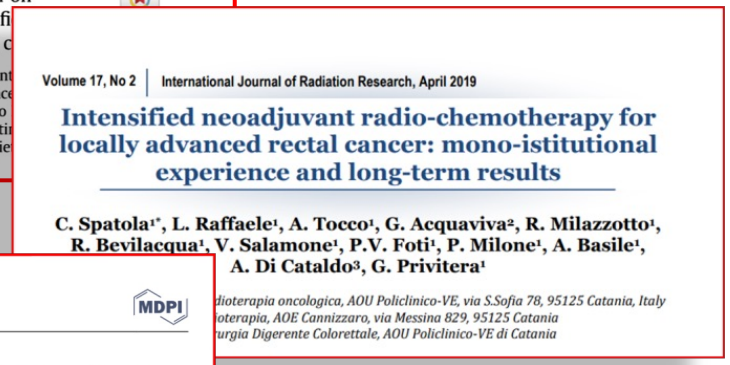
Radiotherapy and Oncology

journal homepage: www.thegreenjournal.com

Original Article

The INTERACT Trial: Long-term results of a randomised trial on preoperative capecitabine-based radiochemotherapy intensifi concomitant boost or oxaliplatin, for cT2 (distal)–cT3 rectal c

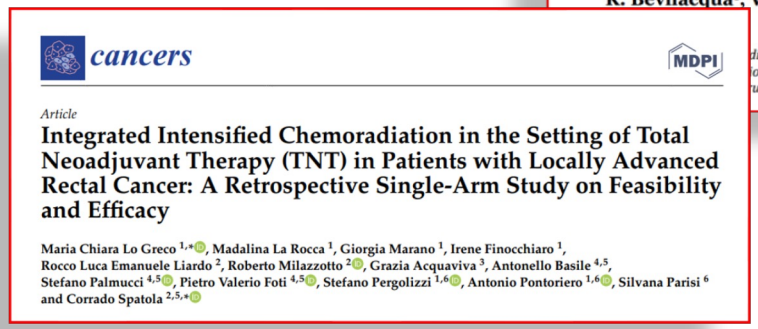
Vincenzo Valentini [a], Maria Antonietta Gambacorta [a], Francesco Cellini [b,*], Cynt Brunella Barbaro [c], Sergio Alfieri [f], Domenico D'Ugo [g], Roberto Persiani [h], Franc Crucitti [j], Marco Lupattelli [k], Giovanna Mantello [l], Federico Navarria [m], Claudio Buonadonna [o], Caterina Boso [p], Sara Lonardi [q], Luciana Caravatta [r], Maria Cristi Vecchio [t], Ernesto Maranzano [u], Domenico Genovesi [r], Giovanni Battista Doglie Morganti [v], Giuseppe La Torre [w], Salvatore Pucciarelli [x], Antonino De Paoli [m]


Volume 17, No 2 | International Journal of Radiation Research, April 2019

Intensified neoadjuvant radio-chemotherapy for locally advanced rectal cancer: mono-istitutional experience and long-term results

C. Spatola[1*], L. Raffaele[1], A. Tocco[1], G. Acquaviva[2], R. Milazzotto[1], R. Bevilacqua[1], V. Salamone[1], P.V. Foti[1], P. Milone[1], A. Basile[1], A. Di Cataldo[3], G. Privitera[1]

[1] Radioterapia oncologica, AOU Policlinico-VE, via S.Sofia 78, 95125 Catania, Italy
[2] Radioterapia, AOE Cannizzaro, via Messina 829, 95125 Catania
[3] Chirurgia Digerente Colorettale, AOU Policlinico-VE di Catania


cancers

MDPI

Article

Integrated Intensified Chemoradiation in the Setting of Total Neoadjuvant Therapy (TNT) in Patients with Locally Advanced Rectal Cancer: A Retrospective Single-Arm Study on Feasibility and Efficacy

Maria Chiara Lo Greco [1,*], Madalina La Rocca [1], Giorgia Marano [1], Irene Finocchiaro [1], Rocco Luca Emanuele Liardo [2], Roberto Milazzotto [2], Grazia Acquaviva [3], Antonello Basile [4,5], Stefano Palmucci [4,5], Pietro Valerio Foti [4,5], Stefano Pergolizzi [1,6], Antonio Pontoriero [1,6], Silvana Parisi [6] and Corrado Spatola [2,5,*]


Cancer Treatment Reviews 96 (2021) 102177

Contents lists available at ScienceDirect

Cancer Treatment Reviews

journal homepage: www.elsevier.com/locate/ctrv

Hot Topic

Total neoadjuvant therapy for rectal cancer: Making sense of the results from the RAPIDO and PRODIGE 23 trials

E.F. Giunta [a], G. Bregni [b], A. Pretta [b], A. [illegible]
T. Troiani [a], F. Ciardiello [a], A. Hendlisz [b]


SYSTEMATIC REVIEWS

Neoadjuvant radiotherapy dose escalation for locally advanced rectal cancers in the new era of radiotherapy: A review of literature

Durim Delishaj, Ilaria Costanza Fumagalli, Stefano Ursino, Agostino Cristaudo, Francesco Colangelo, Antonio Stefanelli, Alessandro Alghisi, Giuseppe De Nobili, Romerai D'Amico, Alessandra Cocchi, Antonio Ardizzoia, Carlo Pietro Soatti

Tasso di regrowth del 22.1%
(il 96% nei primi 3 anni di sorveglianza)
OPRA Trial

In case of cCR: **W&W or LE** approach could be followed

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Radioterapia Oncologica:
l'evoluzione al servizio dei pazienti

GRAZIE