Leids Universitair Medisch Centrum

Palliatieve spoed in de longoncologie & radiotherapie

op zoek naar de inviduele balans

Prof. Dr. Yvette van der Linden
Radiotherapeut-oncoloog
Hoofd Expertisecentrum Palliatieve Zorg

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Leids Universitair Medisch Centrum

(potentiële) Belangenverstrengeling	Consulent Palliatieve Zorg
Voor bijeenkomst mogelijk relevante relaties met bedrijven	-
•Sponsoring of onderzoeksgeld •Honorarium of andere (financiële) vergoeding •Aandeelhouder •Andere relatie, namelijk…	• • • •

integraal kankercentrum Nederland

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Inhoud

Achtergrond radiotherapie

Spoedindicaties

- *Hemoptoe*
- *Vena cava superior syndroom*
- *Dreigende fractuur*
- *Dreigende dwarslaesie*
- *Hersenmetastasen*
- *Overig*

Uitkomsten

Overwegingen wel / niet behandelen

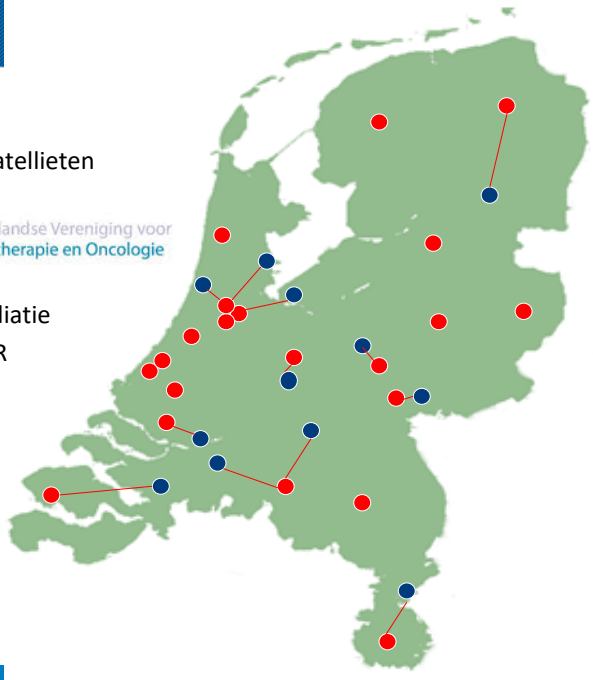
Wat handig is te weten over palliatieve radiotherapie…

- Effectieve behandeling bij kanker → respons 70%
  - pijn
  - bloedingen
  - stenoses
  - etc.
- Primaire tumor en metastasen
- Eénmalige of kortdurende bestraling
- Response niet direct -> na dagen / weken
- Indien nodig herbehandelingen mogelijk
- Ip weinig belastend voor patient
  - voorlichting/begeleiding
- Indicatiestelling, samenwerking essentieel

21 radiotherapiecentra
in Nederland + aantal satellieten

NVRO Nederlandse Vereniging voor Radiotherapie en Oncologie

+ Landelijk Platform Palliatie
& Radiotherapie -> LPPR



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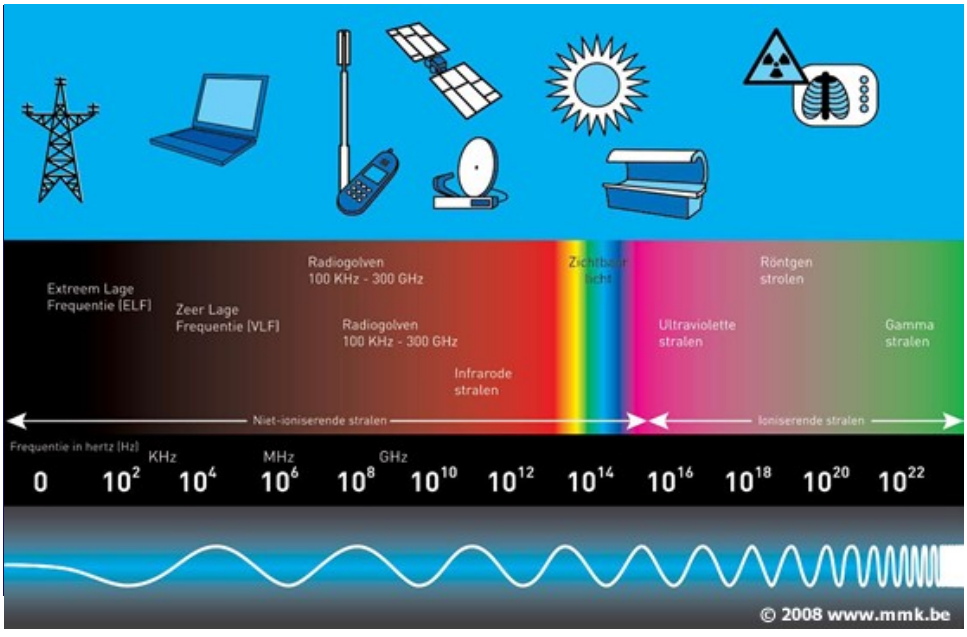
Verschillende soorten straling



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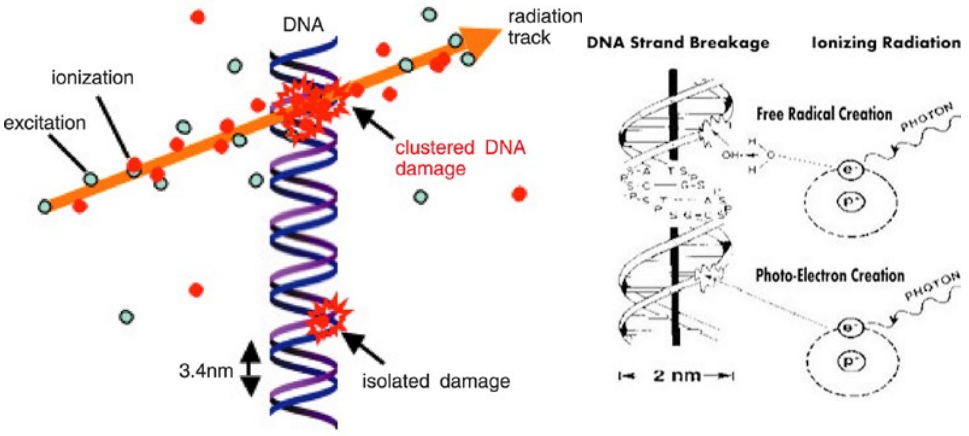
Effecten op DNA niveau



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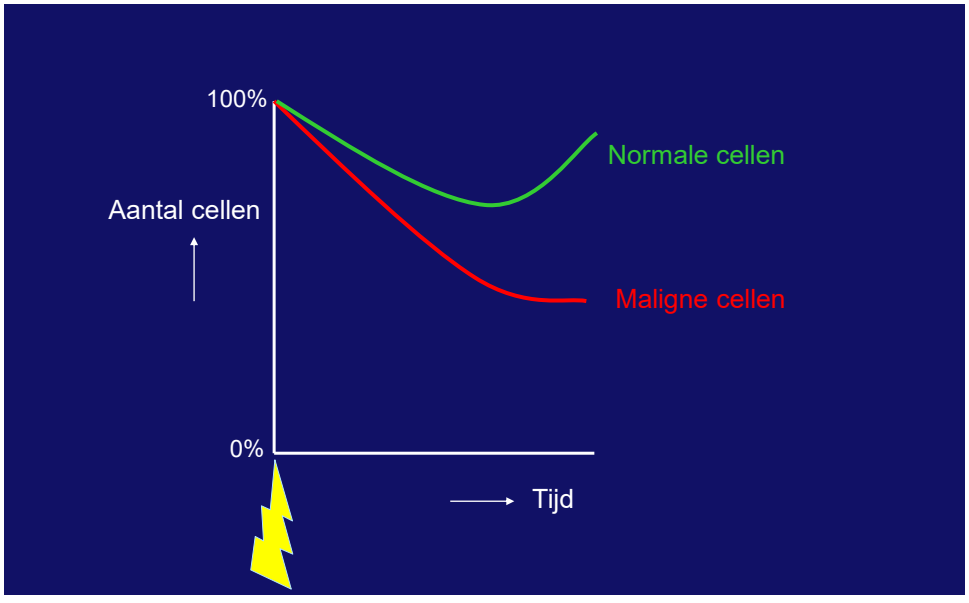
Cel overlevings curve -> doel palliatie



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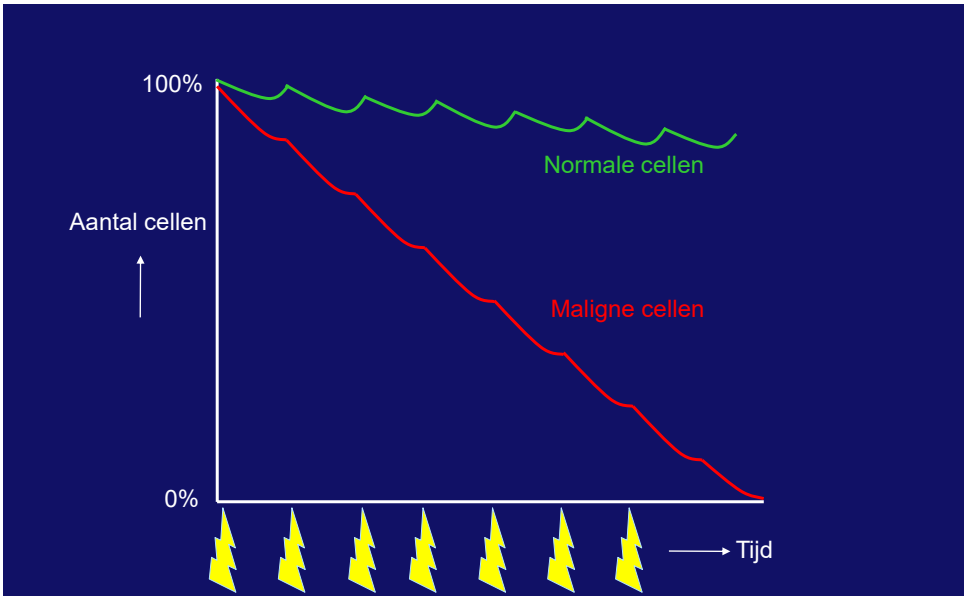
Cel overlevings curve -> doel curatie



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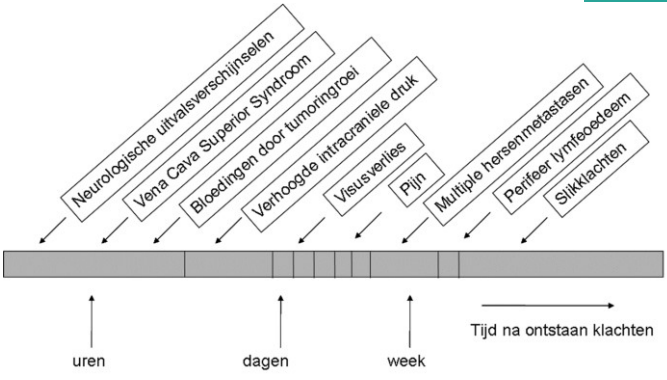
Spoedindicaties longoncologie

Spoed bij radiotherapie is relatief



10 Leerboek Oncologie, hoofdstuk Spoedeisende Oncologie, 2020- Bohn Stafleu 4-jun-23

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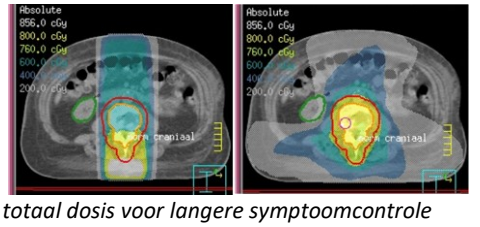
Palliatieve radiotherapie = voortdurend op zoek naar balans

Veranderende mogelijkheden bij patienten in de palliatieve fase

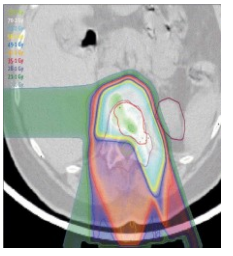
Short Course

- *Simpel, effectief*
- *Tijd & kostenefficient*



Radicaal

- *Meer fracties, hogere totaal dosis voor langere symptoomcontrole*
- *High dose hypofractionation met gebruik van nieuwe technieken*



Prophylactisch

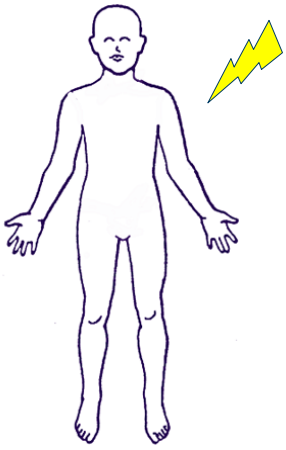
- *Behandelen van asymptomatische patienten met doel voorkomen klachten, verlengen levensduur, curatie?*
- *OLIGOMETASTASEN !*

Longoncologie
-> indicaties, uitkomsten, overwegingen

- Hemoptoe
- Vena cava superior syndroom

- Dreigende fractuur
- Dreigende dwarslaesie

- Hersenmetastasen
- Overig



Hemoptoe

N= 125 RO (34%)

Keuzes obv

- Performance status
- Prognosis
- Patient wensen

Niet -> expected late toxicity

Contents lists available at ScienceDirect

Clinical and Translational Radiation Oncology

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

Original Research Article

Patterns of practice in palliative radiotherapy for bleeding tumours in the Netherlands; a survey study among radiation oncologists

Jennifer Strijbos [a], Yvette M. van der Linden [b], Hanneke Vos-Westerman [c], Angela van Baardwijk [a,*], for the Dutch Platform Palliation, Radiotherapy

[a] MAASTRO Clinic, Department of Radiation Oncology, GROW – School for Oncology and Developmental Biology, Maastricht University Medical Centre, Maastricht, The Netherlands
[b] Leiden University Medical Centre, Department of Radiotherapy, Leiden, The Netherlands
[c] Isala, Department of Radiotherapy, Zwolle, The Netherlands

Table 1
Review of literature.

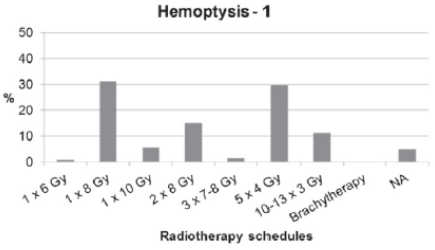
Author	Year	n	study type	symptoms	RT dose (Gy)/ fractions	Bleeding control rate	time to response	Duration of response
MRC Lung Cancer working party [2]	1991	369	RCT	Haemoptysis	17/2 vs 30/10 and 27/6	81% vs 86%	N/A	4.5 months for both groups
MRC Lung Cancer working party [3]	1992	235	RCT	Haemoptysis	17/2 vs 10/1	75% vs 72%	N/A	2.4 months for both groups
Asakura et al [4]	2011	30	Retrospective	Hematemesis	30/10	73%	N/A	3.3 months
Chaw et al [5]	2014	52	Review	Hematemesis	8/1 and 20/5	50%	<4 weeks	N/A
Lee [6]	2017	42	Retrospective	Hematemesis	Various	69%	2 weeks	3.4 months
Murakami et al [7]	2008	54	Review	Hematemesis and rectal bleeding	Various	Haematemesis: 54%, rectal bleeding: 64%	N/A	haematemesis: 4.6 months rectal bleeding: 10 months
Cameron et al [8]	2014	1759	Review	Rectal bleeding	Various	81%	N/A	N/A
Srinivasan et al [9]	1994	41	Retrospective	Hematuria	17/2 vs 45/12	59% (17/2) and 16% (45/12)	N/A	N/A
Duchesne et al [10]	2000	272	RCT	Hematuria	35/10 vs 21/3	89% vs 86%	50% <2 weeks	9 months
Lacarriere et al [11]	2013	32	Retrospective	Hematuria	30/10 and 20/5	54% (30/10) and 79% (20/5)	<2 weeks	3.6 months
Cameron et al [12]	2014	471	Review	Hematuria	Various	73%	N/A	N/A
Dirix [13]	2016	44	Retrospective	Hematuria	34.5/6	89%		13 months
Onsrud et al [14]	2001	46	Retrospective	Vaginal bleeding	10/1–30/3	88%	N/A	N/A
Mishra et al [15]	2005	69	Retrospective	Vaginal bleeding	10/1–30/3	100%	N/A	N/A
van Lonkhuijzen et al [16]	2011	596	Review	Vaginal bleeding	Various	45–100%	N/A	N/A
Chioric [17]	2012	62	Retrospective	Various	Various	87%	N/A	N/A
Sapienza et al [18]	2018	112	Retrospective	Various	Various	89%	N/A	at 3 months: 83% at 1 year 56%

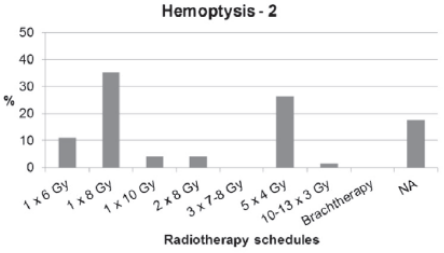
Year = year of publication, n = number of patients analyzed, RCT = randomized controlled trial, N/A = not analyzed.

Hemoptoe -> twee casus

Hemoptysis-1: Seventy year old woman, PS 2, non-small cell lung cancer (NSCLC) and chronic obstructive pulmonary disease. Haemoptysis for one month caused by a tumour in the main bronchus. Stereotactic RT four years ago in the right upper lobe (T1N0). Since three months loco-regional recurrence, adrenal and bone metastases. Patient suffers from haemoptysis and fatigue (Hemoglobin (Hb) 5.2 mmol/l).

Hemoptysis-2: In this case scenario, the patient had a T1N2 NSCLC in the right upper lobe with positive lymph nodes in station 4 right and 7, treated with concurrent chemo radiation to a total dose of 66 Gy, four years ago.





Effectiviteit op klachten veroorzaakt door longtumor

RCT -> 10x 3 Gy vs, 2x 8 Gy

N= 297

PROMS ->

Results of the Dutch National Study of the Palliative Effect of Irradiation Using Two Different Treatment Schemes for Non–Small-Cell Lung Cancer

Gijsbert W.P.M. Kramer, Stofferinus L. Wanders, Ed M. Noordijk, Ernest J.A. Vonk, Hans C. van Houwelingen, Wilbert B. van den Hout, Ronald B. Geskus, Mirjam Scholten, and Jan-Willem H. Leer

*To what extent during the past week have you been bothered by complaints that may arise from your disease?
Please put a cross by the answer that is most applicable to you.

Example: Have you been bothered, during the past week, by:

	Not At All	A Little	Quite A Bit	Very Much
Fatigue	☐	X	☐	☐

Have you been bothered, during the past week, by:

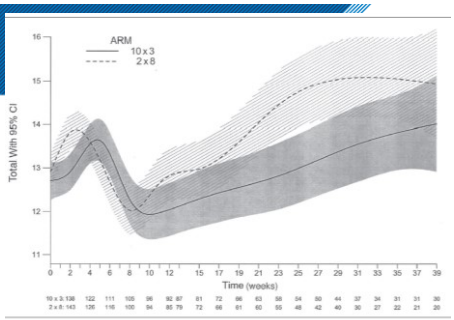
	Not At All	A Little	Quite A Bit	Very Much
Lack of appetite	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Pain in the chest	☐	☐	☐	☐
Coughing	☐	☐	☐	☐
Coughing up blood	☐	☐	☐	☐
Hoarseness	☐	☐	☐	☐

Effectiviteit op klachten veroorzaakt door longtumor

Resultaten

-> QoL=, maar, verloop verschilt

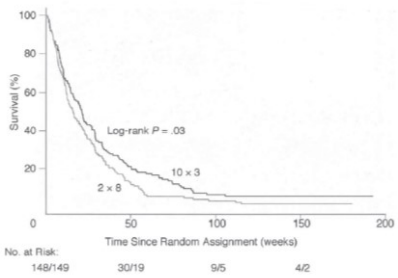
-> OS 1 jaar 19,6 % vs. 10,9 %



Conclusie

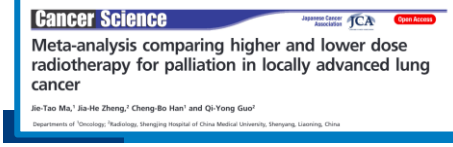
10x 3 Gy langduriger effect op klachten en overlevingsvoordeel

2x 8 Gy alternatief indien matige conditie



Richtlijn Longkanker 2020

- Geen verschil hoge vs. lage dosis effectiviteit
- Wel overlevingsvoordeel


Cancer Science

Meta-analysis comparing higher and lower dose radiotherapy for palliation in locally advanced lung cancer

Jie-Tao Ma,[1] Jia-He Zheng,[2] Cheng-Bo Han[1] and Qi-Yong Guo[2]

Departments of [1]Oncology, [2]Radiology, Shengjing Hospital of China Medical University, Shenyang, Liaoning, China

Kramer et al, JCO 2005

4-jun-23

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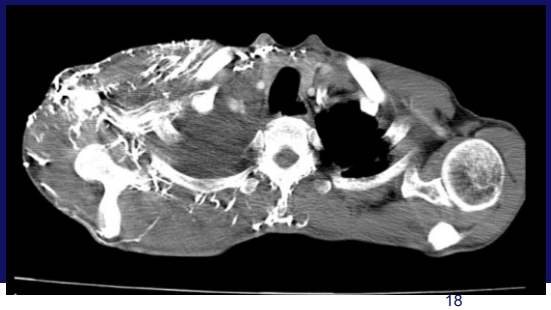
Vena Cava Superior Syndroom

- Compressie vena cava sup → flow vanuit hoofd en armen geblokkeerd
- Hevige benauwdheid, opgezwollen gelaat, gevoel te stikken
- dd bronchuscarcinoom, lymfoom (!)
- Radiotherapie i.c.m. dexamethason
- Plaatsen vasculaire stent



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Beperkte plaats voor RT ivm mogelijkheden interventie-radiologie

N = 54 studies
N= 2249 patienten

Cardiovasc Intervent Radiol (2022) 45:1236–1254
https://doi.org/10.1007/s00270-022-03178-z

CIRSE

REVIEW VENOUS INTERVENTIONS

Endovascular Stenting in Superior Vena Cava Syndrome: A Systematic Review and Meta-analysis

Eri Yin-Soe Aung[1] · Maha Khan[1] · Norman Williams[2] · Usman Raja[3] · Mohamad Hamady[4]

Technisch succesvol	97%
Klinisch succesvol	93%
Effectiviteit 1 jaar	90%

Voordeel van stenten= tijd kopen voor verkrijgen PA, afstemmen meest effectieve behandelplan

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Complicated bone metastases

Radiotherapy and Oncology 173 (2022) 197–206
Contents lists available at ScienceDirect
Radiotherapy and Oncology
journal homepage: www.thegreenjournal.com

Guidelines

ESTRO ACROP guidelines for external beam radiotherapy of patients with uncomplicated bone metastases

Joanne van der Velden [a,1], Jonas Willmann [b,1], Mateusz Spałek [c], Eva Oldenburger [d], Stephanie Brown [e], Joanna Kazmierska [f,h], Nicolaus Andratschke [b], Johan Menten [d,i], Yvette van der Linden [a,j], Peter Hoskin [e,f,g,k]

Bone metastases – irrespective of size – should be regarded as uncomplicated if they are 1) painful; 2) without impending or existing pathologic fracture; and 3) without spinal cord or cauda equina compression,

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… so all other lesions are complicated

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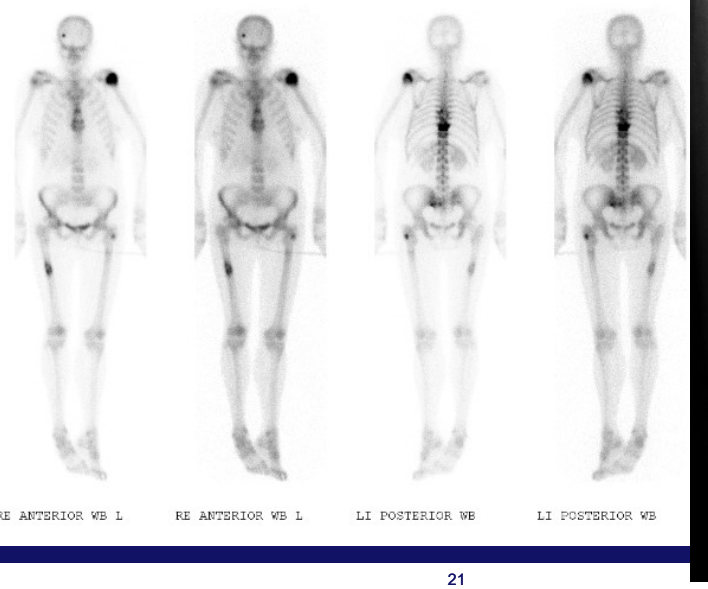
Femur metastasen



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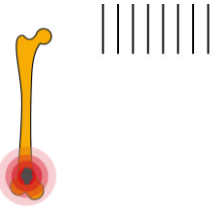
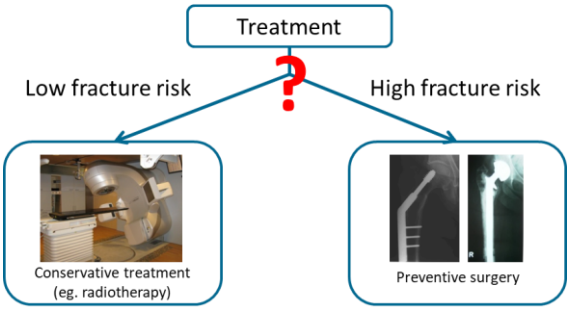
Fracture risk assessment in femoral metastases



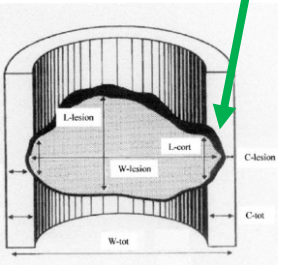


Methods

- clinical judgement
- Mirels scoring system

Variable	1 point	2 points	3 points
Site	Upper limb	Lower limb	Peritro-chanteric
Pain	Mild	Moderate	Functional
Lesion	Blastic	Mixed	Lytic
Lesion size/diameter of bone involved on any plain X-ray view	<1/3	1/3–2/3	>2/3

- lesional characteristics



Van der Linden, R&O 2003 / JBJS 2004, Van der Wal R&O 2020

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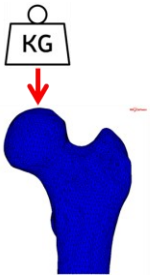
Improve fracture risk assessment using patient-specific finite element computer models

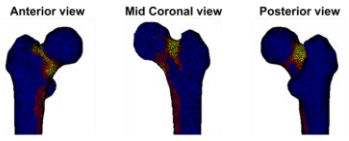
BOS -> Bone Strenght Score

Orthopedic Research Laboratory

Radboudumc

LUMC Leids Universitair Medisch Centrum





	PPV	NPV
3cm-rule	23	96
Mirels score	17	93
Clinical judgement	22	90
BOS-score	35%	97%

Eggermont et al Bone 2020 / NED TIJDSCHR ONCOL 2021 / Cancers (Basel) 2022
Bone Strength Score -> https://www.radboudumc.nl/onderzoeksprojecten/bos-score
Eggermont et al

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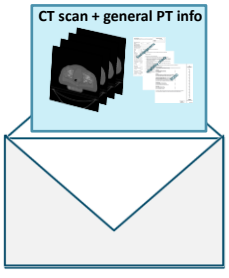
BOS in clinical practice

- Physicians can request BOS score

Radiotherapy



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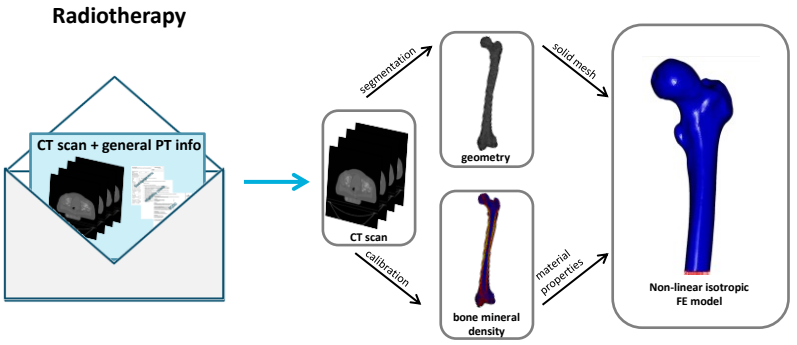
BOS in clinical practice

- Physicians can request BOS score



Eggermont et al., Bone 2020; Keyak et al., Clin Orthop Relat Res 2005

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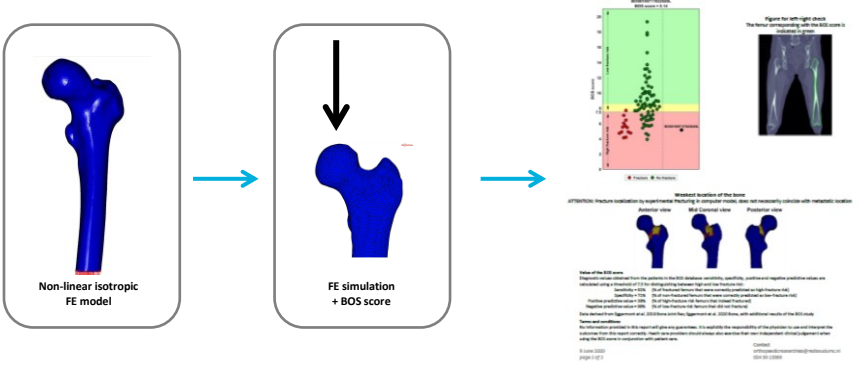
BOS in clinical practice

- Physicians can request BOS score



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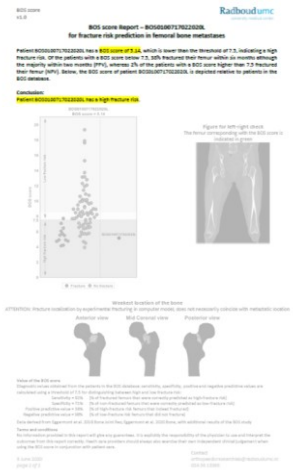
BOS report

- Fracture risk information



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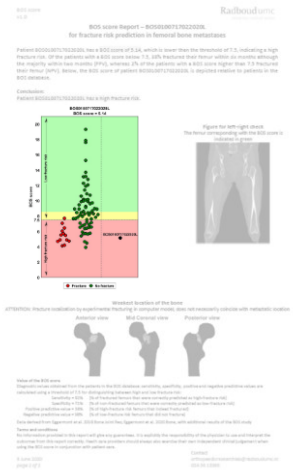
BOS report

- Fracture risk information
- BOS score relative to database



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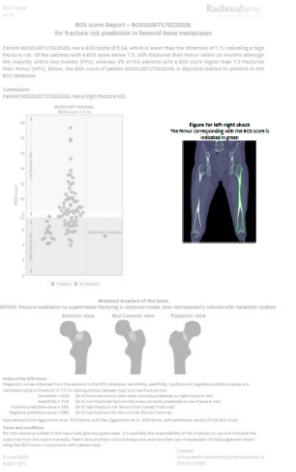
BOS report

- Fracture risk information
- BOS score relative to database
- Left-right check



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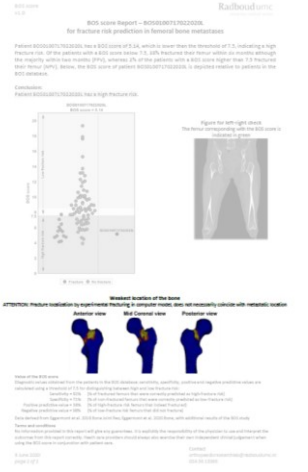
BOS report

- Fracture risk information
- BOS score relative to database
- Left-right check
- Weakest location of the bone



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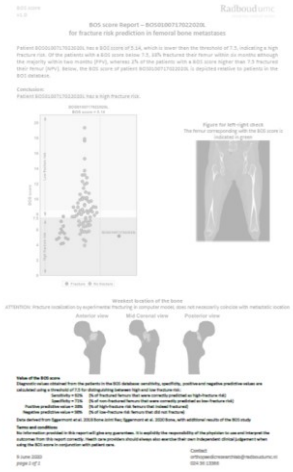
BOS report

- Fracture risk information
- BOS score relative to database
- Left-right check
- Weakest location of the bone
- General information



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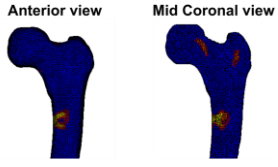
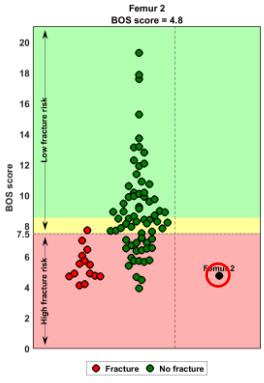
Results - case

- Patient at orthopaedic surgeon for high fracture risk but refused surgery
- Radiotherapy: CT scan and BOS score = 4.8
- Patient changed her mind
- Fracture one day prior to surgery





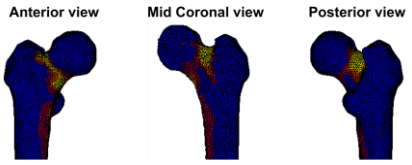
Eggermont et al. Cancers (Basel) 2022

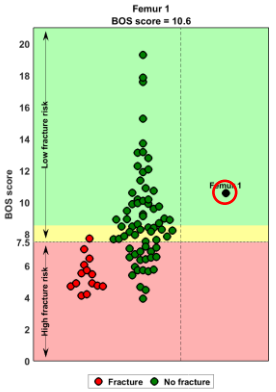
Radboudumc

32

Results - case

- Radiotherapy because of pain
- Initial estimation: low fracture risk
- BOS score = 10.6
- 1x8 Gy



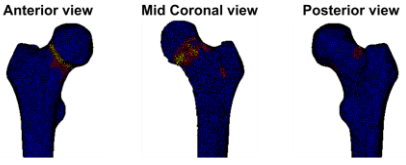


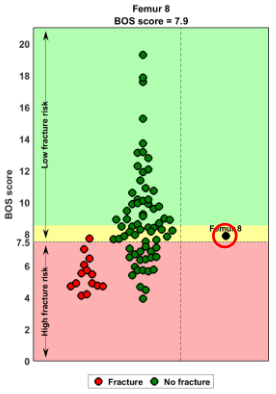
Radboudumc

33

Results - case

- Radiotherapy because of pain
- Initial estimation: low fracture risk
- BOS score = 7.9 → moderate risk
- 1x8 Gy → 2x8 Gy





Radboudumc

34

Results

- In case BOS ≠ initial estimation, 66% treatment plans were adapted
  - Low risk: single dose of RT
  - High risk: surgery or multiple fractions of RT
- Well substantiated treatment decision
- Multidisciplinary consultation between RT and ORTHO
- Patients
  - Extra confirmation of clinical estimation
  - Reassuring, patients feel more secure

Eggermont et al. Cancers (Basel) 2022

Radboudumc

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Mutatie mee in inschatten OS

N= 139 NSCLC met botmetastasen lange pijpbeenderen 2007-2014

Predictie model obv

15% EGFR -> OS 17,3 maand

34% kRAS -> OS 1,8 maand

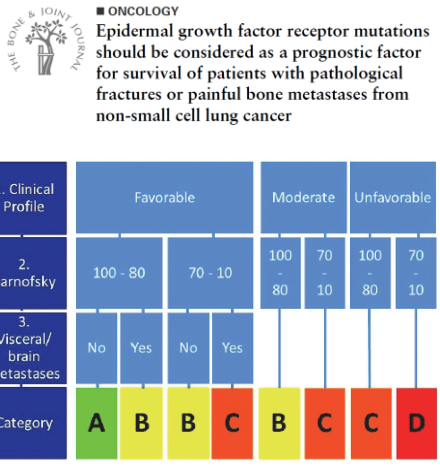


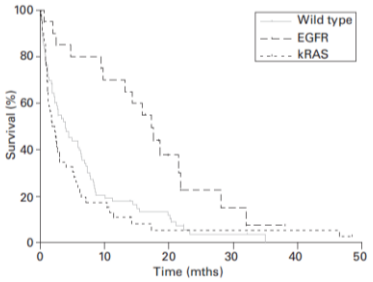
Fig. 1

Prognostic model for overall survival as developed by Bollen L, van der Linden YM, Pondaag W, et al. Prognostic factors associated with survival in patients with symptomatic spinal bone metastases: a retrospective cohort study of 1,043 patients. *Neuro Oncol* 2014;16:991-998 (reproduced by permission of Oxford University Press).[16] Categories (A-D) correlate with expected survival in months.

36 Willeumier et al Bone Joint J 2017 4-jun-23

36

15% EGFR -> OS 17,3 maand
34% kRAS -> OS 1,8 maand



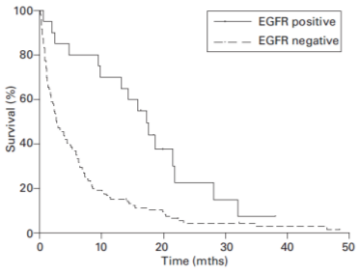


Table II. Median survival times before and after model adjustment for epidermal growth factor receptor mutation

Predictive category*	n (%)	Median OS (95% CI)	Hazard ratio	95% CI	p-value†
Before adjustment					
A	NA	NA	NA	NA	NA
B	NA	NA	NA	NA	NA
C	39	10.1 (3.0 to 17.2)	0.5	0.3 to 0.7	< 0.001
D	86	2.0 (1.3 to 2.7)	-	-	-
After adjustment					
A	NA	NA	NA	NA	NA
B	10	17.3 (12.3 to 22.3)	0.3	0.1 to 0.6	0.001
C	38	6.0 (2.4 to 9.6)	0.5	0.3 to 0.7	0.001
D	77	1.8 (0.9 to 2.8)	-	-	-

*categories A to D based on model in Figure 1[16]
†log rank test
OS, overall survival; CI, confidence interval; NA, not applicable (no patients in this category)

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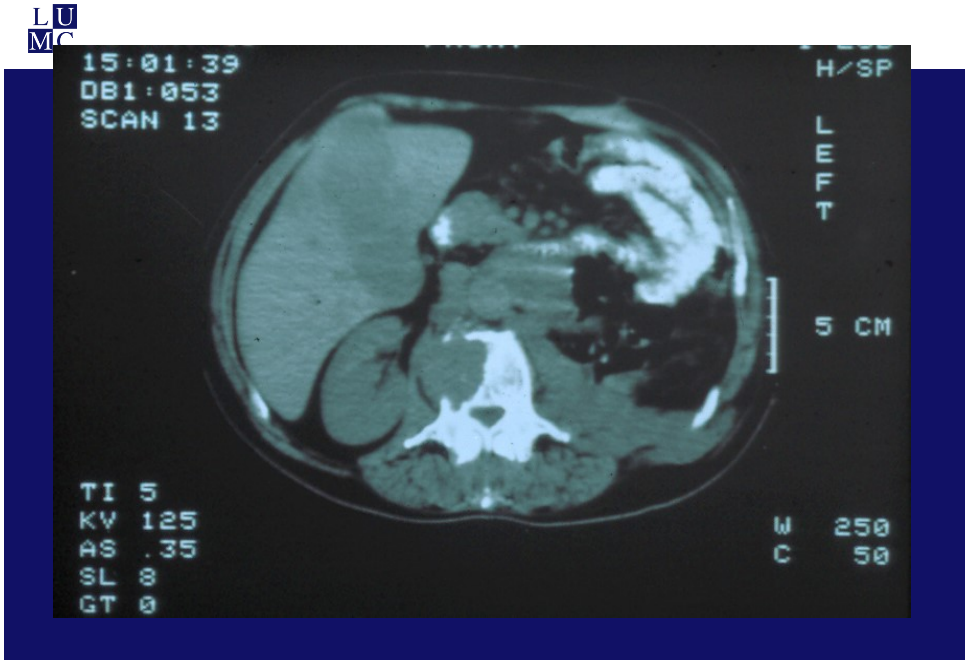

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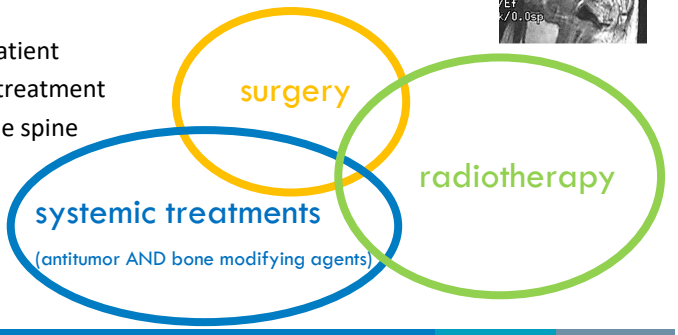
Goals of treatment in patients with spinal metastases

1. Durable pain relief
2. Remineralization and improvement of bone strength
3. Prevention of neurological symptoms
4. Restoration of neurological symptoms

Important factors when deciding on treatment are expected

- survival of the patient
- outcome of the treatment
- (in)stability of the spine



Inzet dexamethasone ter preventie van pijnflare

Dexamethasone for the Prevention of a Pain Flare After Palliative Radiation Therapy for Painful Bone Metastases: The Multicenter Double-Blind Placebo-Controlled 3-Armed Randomized Dutch DEXA Study

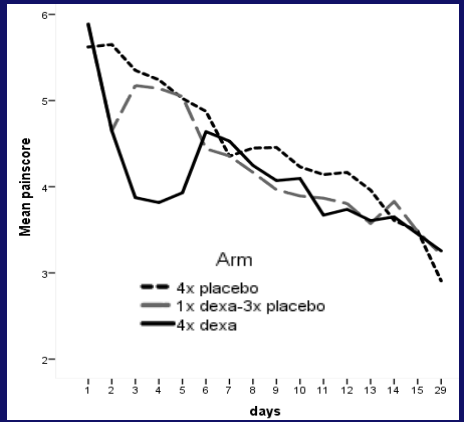
- RCT, n= 295
- 4x 8 mg, 1x 8 mg / 3x placebo, 4x placebo

- +/- 30% tijdelijke pijnflare
- geen effect dexa

-> effect dexamethasone op pijn

-> dexa als pijnmedicatie

van der Linden et al, IJROBP 2020



Inschatten instabiliteit

Gebruik SINS criteria

Table 8. Summary Table Including All Elements of the SINS

Element of SINS	Score
Location	
Junctional (occiput-C2, C7–T2, T11–L1, L5–S1)	3
Mobile spine (C3–C6, L2–L4)	2
Semi-rigid (T3–T10)	1
Rigid (S2–S5)	0
Pain relief with recumbency and/or pain with movement/loading of the spine	
Yes	3
No (occasional pain but not mechanical)	1
Pain free lesion	0
Bone lesion	
<50% collapse	2
No collapse with >50% body involved	1
None of the above	0
Posterolateral involvement of the spinal elements (facet, pedicle or CV joint fracture or replacement with tumor)	
Bilateral	3
Unilateral	1
None of the above	0

SINS score

0-6	7-12	13-18
Stable	Potentially unstable	Unstable

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The NOMS framework

Neurological	Current function & future threats Is decompression (in any form) needed and when?	ASIA / Bilsky
Oncological	Tumor behavior, both systemic and local Can we control the tumor for a meaningful time?	Local and systemic treatment options available
Mechanical	Contribution to pain & future threat to function Is stabilization (in any form) needed?	SINS
Systemical	Fitness of the patient Is the patient fit enough for (any of) your plans?	KPS / Bollen

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Courtesy prof. J.J. Verlaan and drs. N. Kasperts, UMCU

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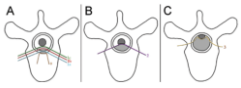
The NOMS framework



Neurological	ASIA E, Bilsky 1	Is decompression (in any form) needed and when?
Oncological	Lung cancer, stable disease, RT options available	Can we control the tumor for a meaningful time?
Mechanical	SINS 6, minimal mechanical pain	Is stabilization (in any form) needed?
Systemical	KPS 80-90, however frail patient	Is the patient fit enough for (any of) your plans?

A shared decision is reached to irradiate Th11 with 1x 8 Gy

Courtesy prof. J.J. Verlaan and drs. N. Kasperts, UMCU

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The NOMS framework
Case based discussion

Neurological	ASIA E, Bilsky 1	Is decompression (in any form) needed and when?
Oncological	Lung cancer, oligometastatic, RT options available	Can we control the tumor for a meaningful time?
Mechanical	SINS 6, minimal mechanical pain	Is stabilization (in any form) needed?
Systemical	KPS 80-90~~, however frail patient~~	Is the patient fit enough for (any of) your plans?

A shared decision is reached to irradiate Th11 with 1x 18 Gy (SBRT)

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(Dreigende) dwarslaesie

(nachtelijke) rugpijn
- vaak eerste symptoom

Gevoels- krachtsverlies
- armen / benen

Blaasretentie, obstipatie

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Neurologische uitval -> dwarslaesie verschijnselen

Consult neuroloog / MRI

Indicatie voor spoedbestraling / spoedoperatie

- Redelijk resultaat -> 70% herstel van functie
  - indien patient nog ambulant
  - langzame progressie
- Matig resultaat bij complete parese > 24 uur

Moeilijke keuze; afwegen prognose en resultaat

Richtlijn wervelmetastasen -> www.oncoline.nl en beslisboom om www.oncoguide.nl

46 Rades, JCO 2005

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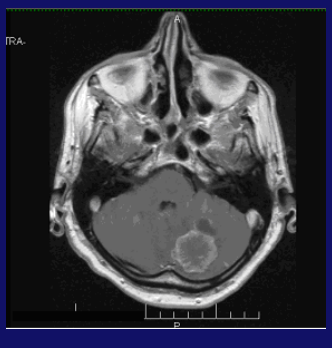
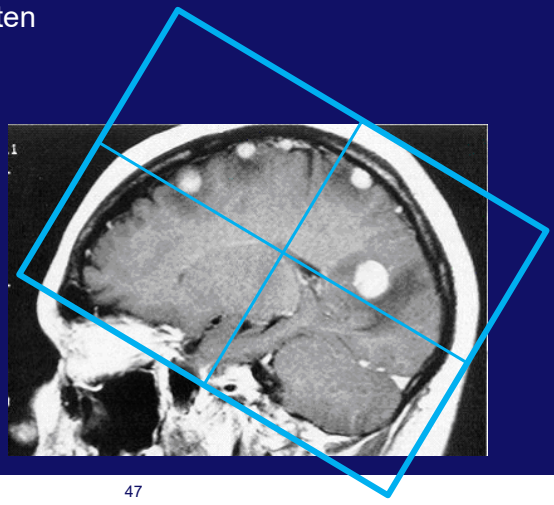
Hersenmetastasen

- M.n. bij mamma- en bronchuscarcinoom
- Hoofdpijn, misselijkheid/braken, neurologische uitval, epileptische insulten





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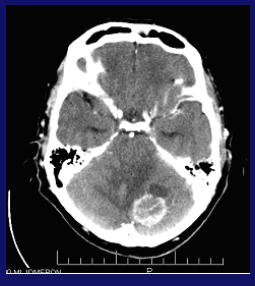
Hersenmetastasen

- Start dexamethason: neurologisch herstel ?
- Radiotherapie
  - Conventioneel → 5x 4 Gy (of 10x 3 Gy)
  - Stereotactie → bijv. 1x 20 Gy (klein volume), 3x 8 Gy (groter volume)

- Voorkomen verdere uitval
- Afname dexamethason-afhankelijkheid
- Toename overleving



- Alopecia totalis

2020 Richtlijn hersenmetastasen www.richtlijnendatabase.nl

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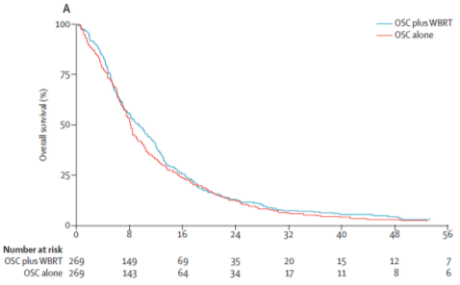
Quartz study in the Lancet Oncology 2016

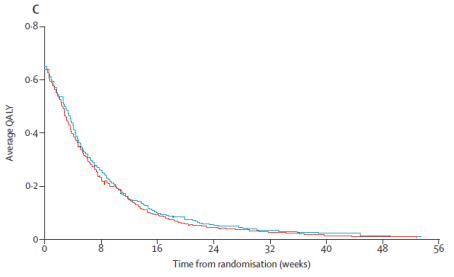
N= 538

20 Gy vs. Dexa + BSC

Dexamethasone and supportive care with or without whole brain radiotherapy in treating patients with non-small cell lung cancer with brain metastases unsuitable for resection or stereotactic radiotherapy (QUARTZ): results from a phase 3, non-inferiority, randomised trial

Paula Mulvenna, Matthew Nankivell, Rachael Barton, Corinne Faivre-Finn, Paula Wilson, Elaine McColl, Barbara Moore, Iona Brisbane, David Ardron, Tanya Holt, Sally Morgan, Caroline Lee, Kathryn Waite, Neil Bayman, Cheryl Pugh, Benjamin Sydes, Richard Stephens, Mahesh K Parmar, Ruth E Langley

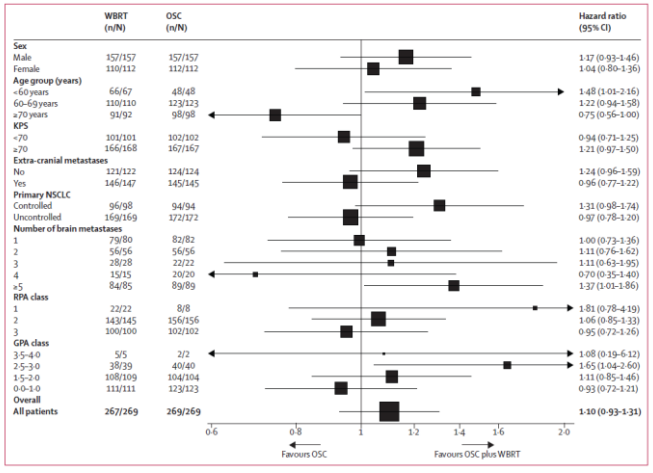




Subgroepen?

Wellicht

- Jongere patienten
- Geen overige ziekte
  - Primair
  - Op afstand



	WBRT (n/N)	OSC (n/N)	Hazard ratio (95% CI)
Sex			
Male	157/157	157/157	1·17 (0·93-1·46)
Female	110/112	112/112	1·04 (0·80-1·36)
Age group (years)			
<60 years	66/67	48/48	1·48 (1·01-2·16)
60-69 years	110/110	123/123	1·22 (0·94-1·58)
≥70 years	91/92	98/98	0·75 (0·56-1·00)
KPS			
<70	101/101	102/102	0·94 (0·71-1·25)
≥70	166/168	167/167	1·21 (0·97-1·50)
Extra-cranial metastases			
No	121/122	124/124	1·24 (0·96-1·59)
Yes	146/147	145/145	0·96 (0·77-1·22)
Primary NSCLC			
Controlled	96/98	94/94	1·31 (0·98-1·74)
Uncontrolled	169/169	172/172	0·97 (0·78-1·20)
Number of brain metastases			
1	79/80	82/82	1·00 (0·73-1·36)
2	56/56	56/56	1·11 (0·76-1·62)
3	28/28	22/22	1·11 (0·63-1·95)
4	15/15	20/20	0·70 (0·35-1·40)
≥5	84/85	89/89	1·37 (1·01-1·86)
RPA class			
1	22/22	8/8	1·81 (0·78-4·19)
2	143/145	156/156	1·06 (0·85-1·33)
3	100/100	102/102	0·95 (0·72-1·26)
GPA class			
3·5-4·0	5/5	2/2	1·08 (0·19-6·12)
2·5-3·0	38/39	40/40	1·65 (1·04-2·60)
1·5-2·0	108/109	104/104	1·11 (0·85-1·46)
0·0-1·0	111/111	123/123	0·93 (0·72-1·21)
Overall			
All patients	**267/269**	**269/269**	**1·10 (0·93-1·31)**

- Niet meegenomen mutatiestatus EGFR / KRAS

NL data RT en hersenmetastasen uitkomsten

N = 4363 NSCLC

OS mediaan 3 maanden

ACTA ONCOLOGICA, 2018
VOL. 57, NO. 5, 637–643
https://doi.org/10.1080/0284186X.2017.1418534

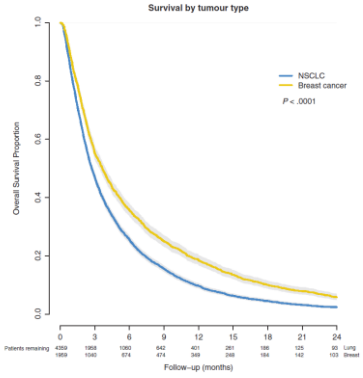
Taylor & Francis
Taylor & Francis Group

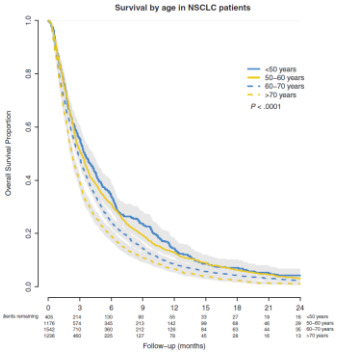
ORIGINAL ARTICLE

Check for updates

Survival after whole brain radiotherapy for brain metastases from lung cancer and breast cancer is poor in 6325 Dutch patients treated between 2000 and 2014

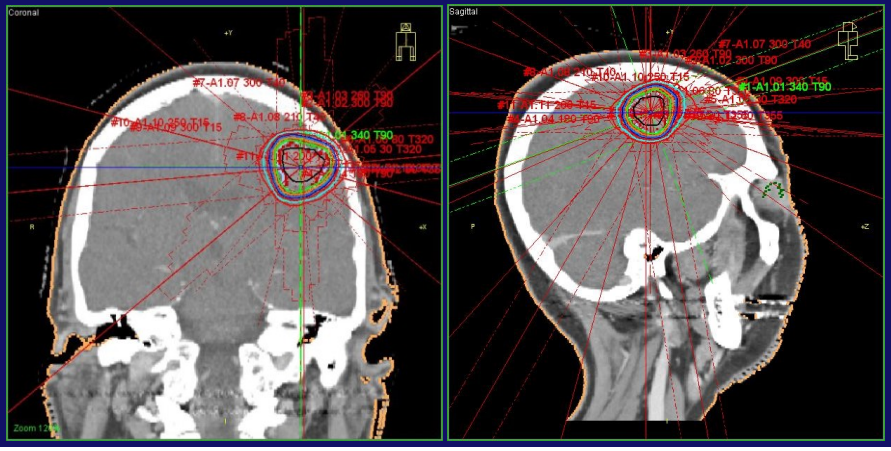
Paul M. Jeene[a,b], Kim C. de Vries[c,d], Johanna G. H. van Nes[e], Johannes J. M. Kwakman[a], Gerda Wester[f], Tom Rozema[g], Pètra M. Braam[h], Jaap D. Zindler[i], Peter Koper[j], Joost J. Nuyttens[d], Hanneke A. Vos-Westerman[k], Ilona Schmeets[l], Charles G. H. J. Niël[b], Stefan Hutschemaekers[m], Yvette M. van der Linden[n], Joost J. C. Verhoeff[o] and Lukas J. A. Stalpers[a]





Stereotactie hersenmetastasen -> veel minder bijwerkingen, veel effectiever

- Max. 10 metastasen of totale volume <= 30cm3
- Meeste patienten hebben 1-4 meta's en geen / weinig ziekteactiviteit elders



Overig -> NSCLC- incisie huisarts -> huidmetastase

5x 4 Gy -> na 8 weken

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Conclusies longoncologie & palliatie

RT effectieve behandeling in 70-80%
Spoed is relatief ivm niet directe werking

Laagdrempelig overleg
-> ad hoc
-> MDO -> proactief bespreken behandelopties en timing

,Borrelze & Eetze

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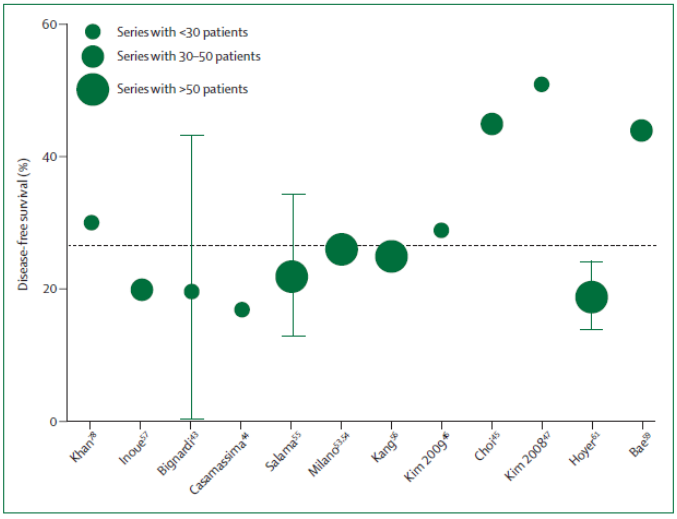
Only 20-40% of oligometastatic patients remain disease-free at maximum 5 yrs FUP



Tree et al, Lancet 2013

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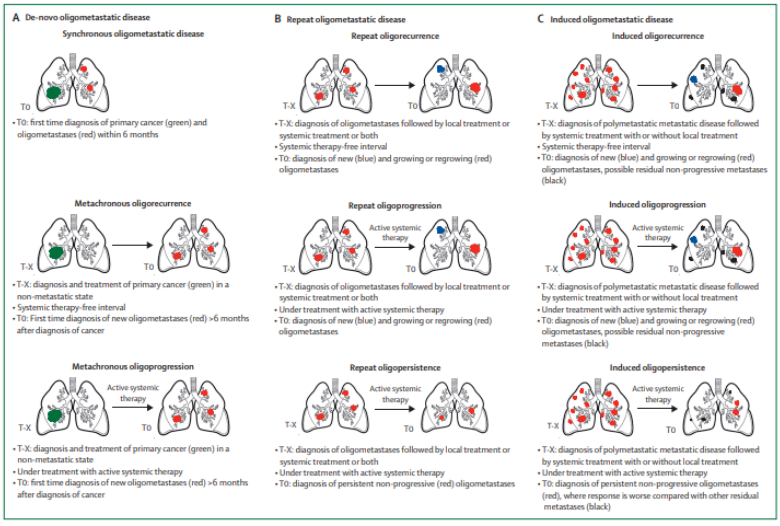
ESTRO/EORTC consensus recommendation on oligometastatic disease

Guckenberger et al. Lancet Oncol 2020



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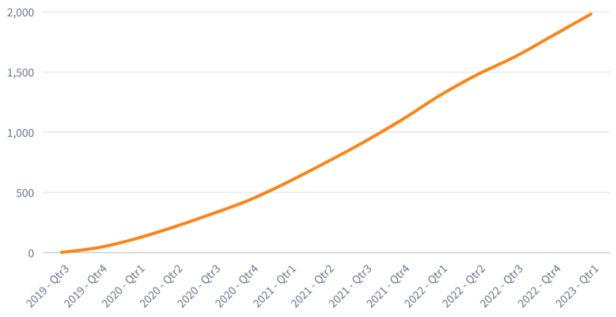
OligoCare prospective international study

Doel -> evalueren radicale radiotherapie bij longca, mammaca, prostaatca
Effectiviteit, overleving



https://www.estro.org/Science/E2RADIATE
https://project.eortc.org/e2-radiate/cohorts/

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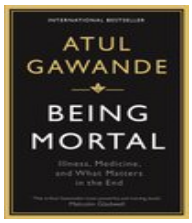
Easier way to get to know the patient's perspective

Short assessment -> 5 questions

1. *What do you know of your illness and how far advanced it is?*
2. *What are your fears and uncertainties regarding your future?*
3. *What are your goals and priorities in life?*
4. *What are you willing to give up or not , and what will you accept?*
5. *What makes a day a good day for you?*



Always also ask carers
How are you? What are your concerns?
What can we do for you?

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