Post
ESTRO
2025
AFRIQUE DU NORD

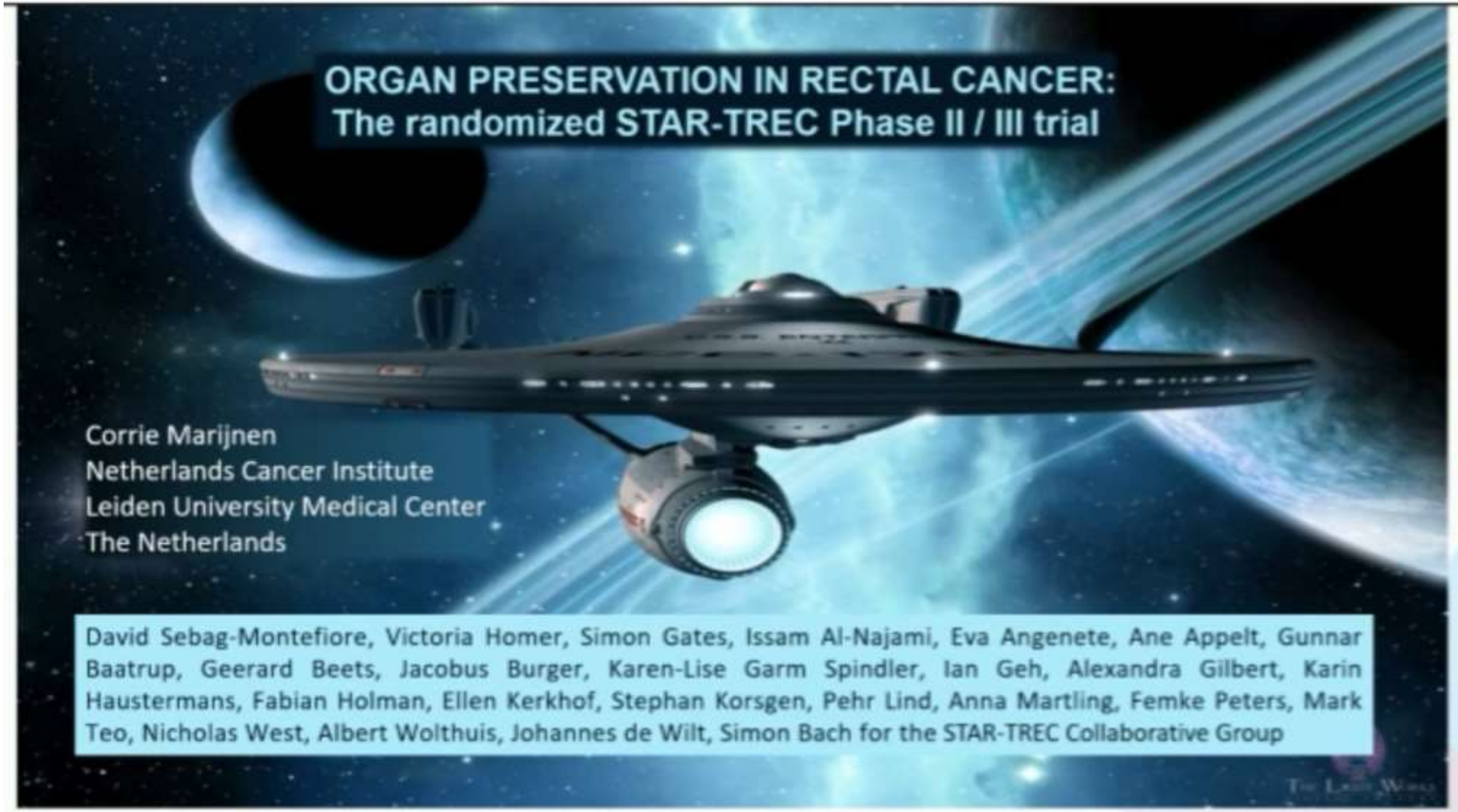
Société Marocaine de Cancérologie
الجمعية المغربية لداء السرطان

STOR
المعهد التونسي للأمراض الورمية والعلاج بالأشعة
Société Tunisienne d'Oncologie Radiothérapie

BY SMC/STOR
LE 28 MAI 2025 À 18H00 (GMT+1)
Evenement VIRTUEL

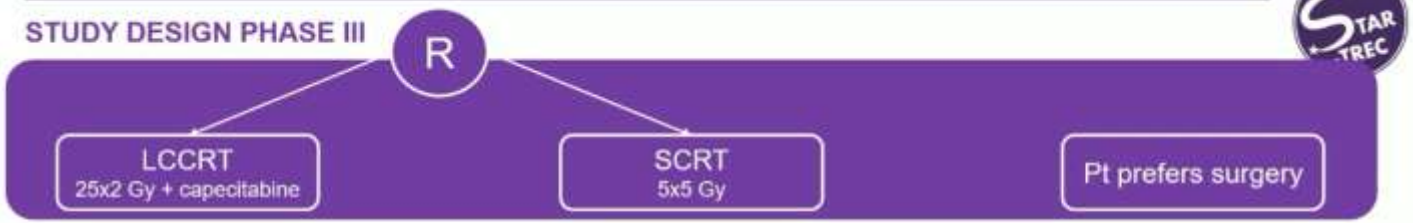
CANCERS DIGESTIFS

Zenab ALAMI



Corrie Marijnen
Netherlands

STUDY DESIGN PHASE III



AIMS:
Compare effectiveness of 2 radiotherapy schedules

PRIMARY ENDPOINT:
The proportion of patients with successful organ preservation at 30 months

TRIAL STEERING GROUP: ADVISED TO REPORT 12 MONTHS OUTCOMES

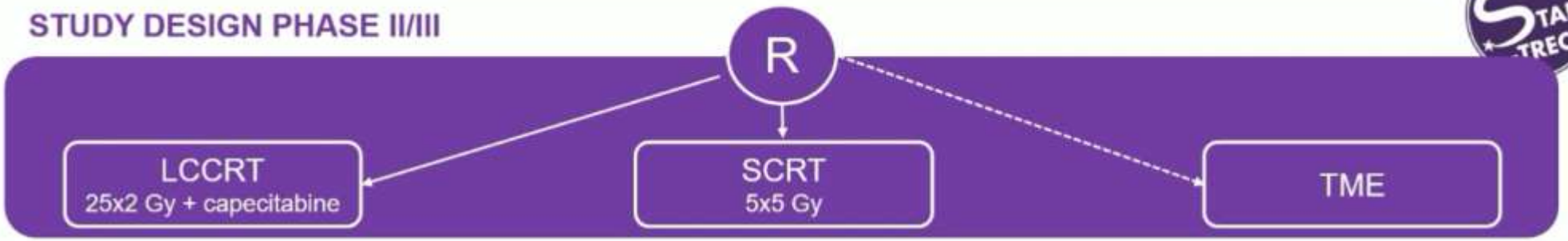
CURRENT ANALYSES ADVISED BY TRIAL STEERING GROUP

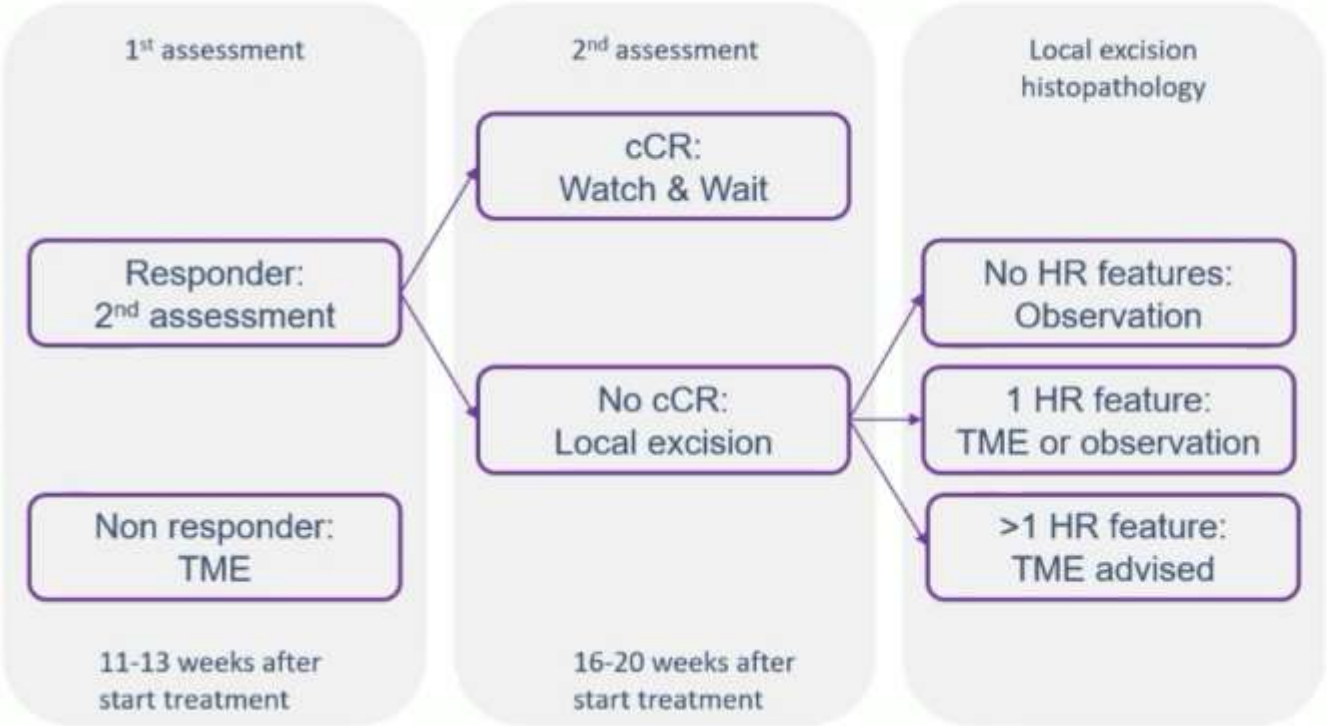
Only patients with 12 months* follow-up (or more) are included

TME free survival at 12 months
Post hoc analyses
- phase II and III separately
- tumors ≤3 cm vs >3 cm

Acute toxicity

STUDY DESIGN PHASE II/III





TME surgery

INCLUSION CRITERIA

Biopsy proven adenocarcinoma

mrT1-T3b (<= 5mm extramural spread) N0 CRM-ve

ECOG 0-1

Multidisciplinary team considers all treatment arms feasible

Minimum follow-up 12 months: 424/503 included*

INCLUSION OF PATIENTS: M-ITT

LCCRT
25x2 Gy + capecitabine

Did not start any trial treatment: 9

Started trial treatment: 163
- Received LCCRT: 161
- Received SCRT: 1
- Received TME: 1

Included in analyses: 163

SCRT
5x5 Gy

Did not start any trial treatment: 4

Started trial treatment: 168
- Received LCCRT: 0
- Received SCRT: 167
- Received TME: 1

Included in analyses: 168

TME

Did not start any trial treatment: 4

Started trial treatment: 78
- Received LCCRT: 0
- Received SCRT: 0
- Received TME: 78

Included in analyses: 78

PATIENT CHARACTERISTICS

	LCCRT (N=163)		SCRT (N=168)		TME (N=78)	
Recruitment phase						
Phase II (N)	38		40		36	
Phase III (N)	125		128		42	
Sex						
Male	115	71%	125	74%	53	68%
Median age (years)	67		67		67	
Tumor stage						
mrTX	2	1%	3	2%	2	3%
mrT1	15	9%	11	7%	2	3%
mrT2	114	70%	128	76%	49	63%
mrT3a	25	15%	18	11%	15	19%
mrT3b	7	4%	7	4%	10	13%
Tumor length (mm)	28		28		30	
Distance to anal verge (mm)	60		53		54	

PATHOLOGY RESULTS TME PATIENTS

Indication for the "real staging" of our organ preservation patients

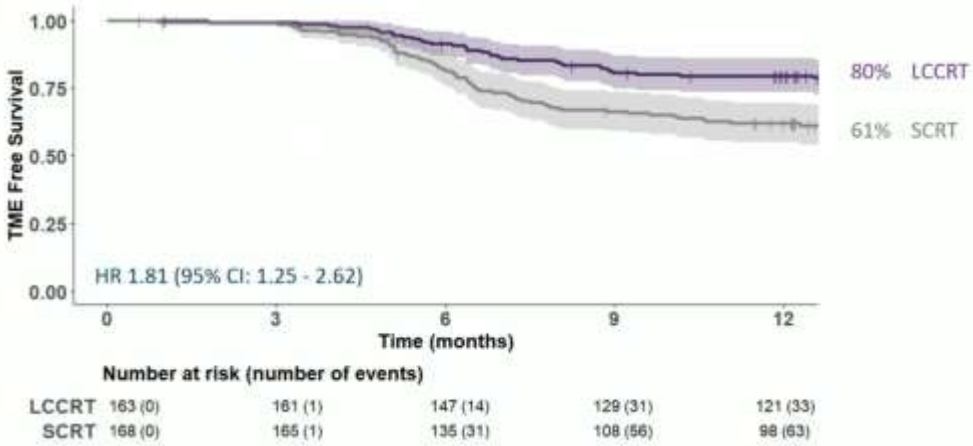
	MR-based (N=78)		Pathology (N=78)	
T-stage				
Tx	2	3%	1	1%
T1	2	3%	18	23%
T2	49	63%	39	50%
T3	25	32%	20	26%
N-stage				
N0	78	100%	58	74%
N+	0		18	23%
missing	0		2	3%

TOXICITY

No treatment-related deaths

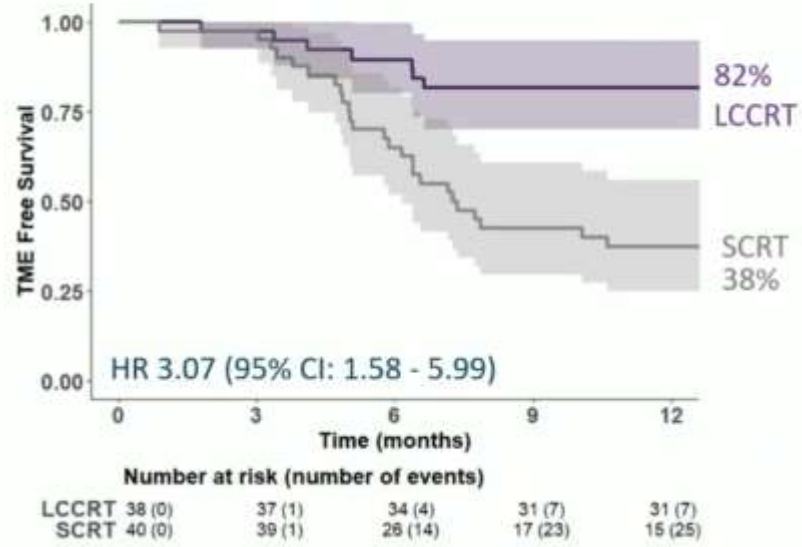
	LCCRT (N=163)		SCRT (N=168)	
SAE (including surgery)				
Number of SAEs	23		30	
Number of patients	21	12%	26	15%
Toxicity (only (C)RT)*				
None	12	7%	36	22%
Grade 1	89	55%	69	41%
Grade 2	55	34%	48	29%
Grade 3	6	4%	12	7%
Grade 4	0		0	
Grade 5	0		0	

TME FREE SURVIVAL AT 12 MONTHS
Better TME free survival after LCCRT

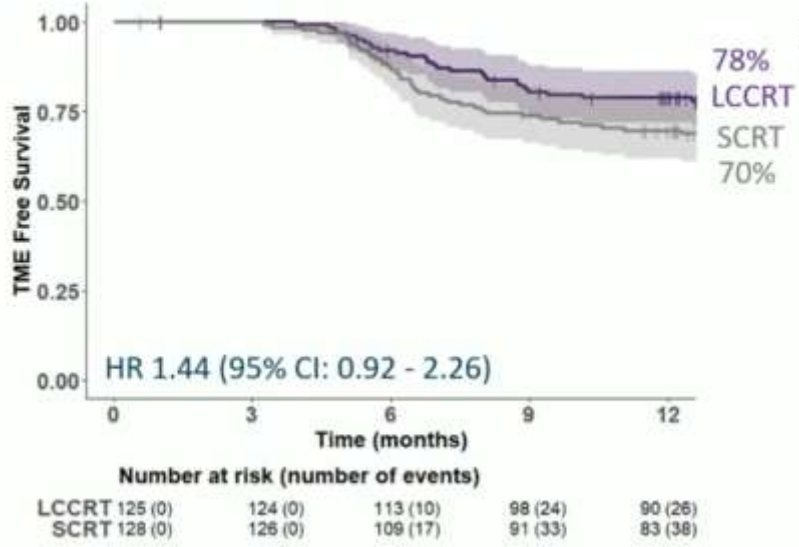


TME FREE SURVIVAL AT 12 MONTHS: TRIAL PHASE
Difference mainly seen in phase II

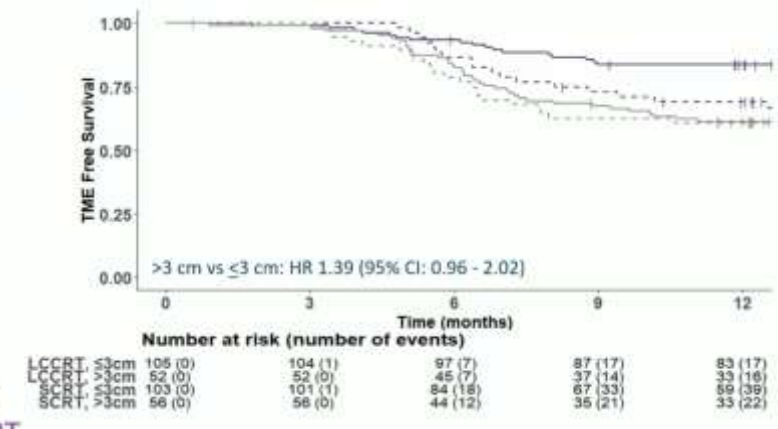
Phase II patients

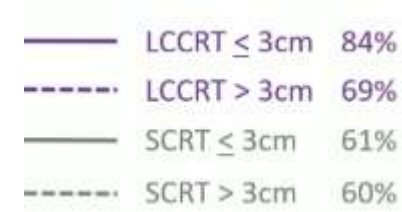


Phase III patients



TME FREE SURVIVAL AT 12 MONTHS: TUMOR SIZE
No difference in SCRT arm





DISCUSSION

For cT1-3b N0 rectal cancer

First study to include TME arm and compare two radiotherapy strategies

First study to include mesorectal-only target volume

Difference in phase II and III difficult to explain

SCRT dose may be less effective to achieve ypT0/1

Proof durability of outcomes with 30 months primary endpoint

Impact on HRQL evaluated at 24 months

IN CONCLUSION

For cT1-3b N0 rectal cancer

Excellent one year organ preservation rates

80% for LCCRT and 61% for SCRT

Little radiotherapy-associated toxicity with mesorectum only target volume

Organ preservation a very good option for early-intermediate risk rectal cancer

Short-term radiotherapy plus chemotherapy for locally advanced rectal cancer: 5-year outcomes of the phase III clinical trial

Presenter: Yuan Tang[1]

Co-first Authors: Yuan Tang[1], Haitao Zhou[2], Tongzhen Xu[1], Ning Li[3]

Corresponding Authors: Jing Jin[4,1], Chen Hu[5], Ye-Xiong Li[1], Yuan-Hong Gao[6], Shi-Xin Liu[7], Li-Chun Wei[8]

On behalf of the STELLAR study group

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NCT02533271

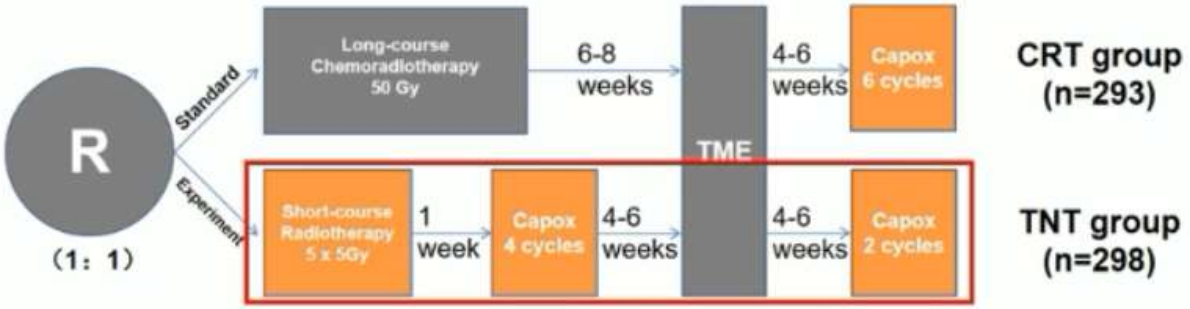
Yuan Tang
China

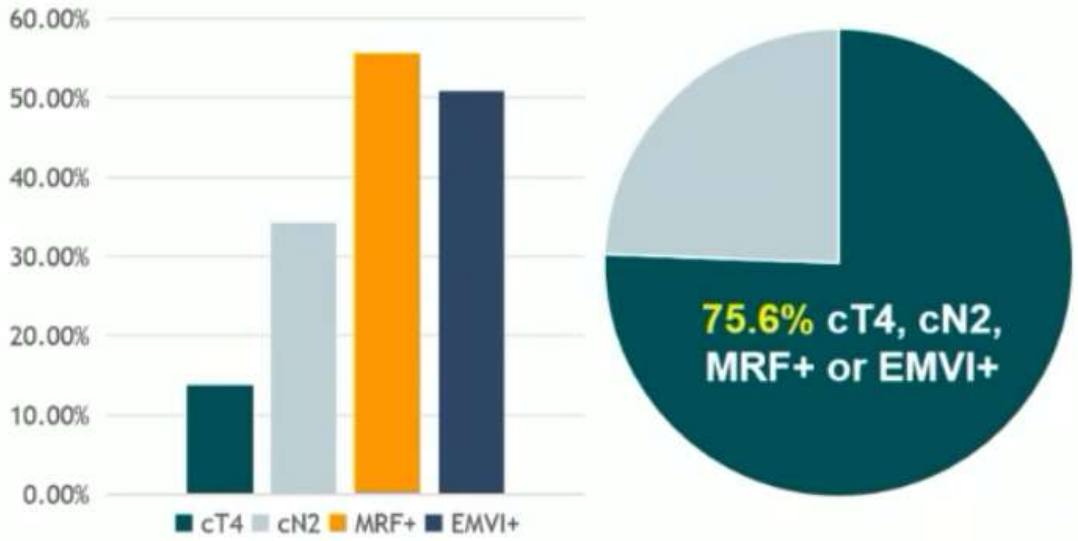
Background

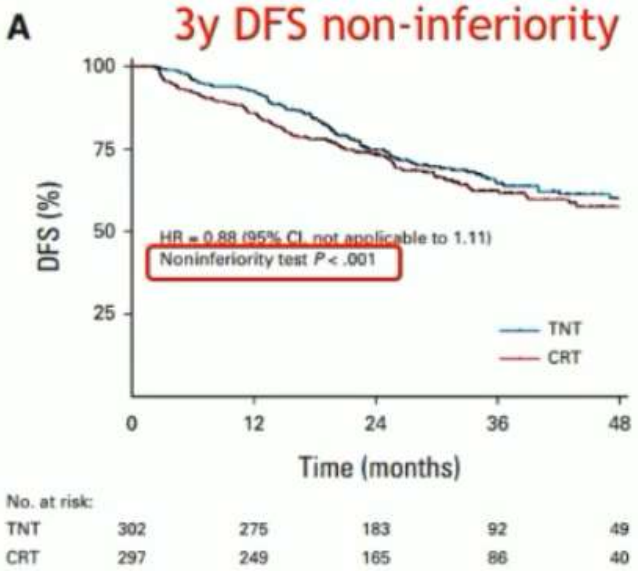
Primary endpoint: 3-year DFS

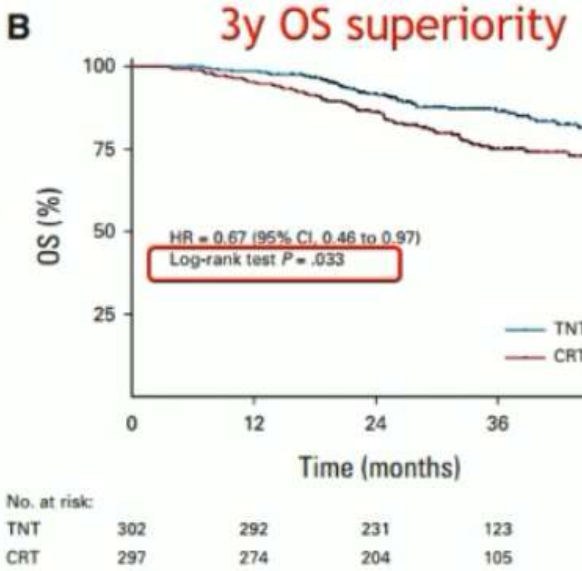
Primary hypothesis:

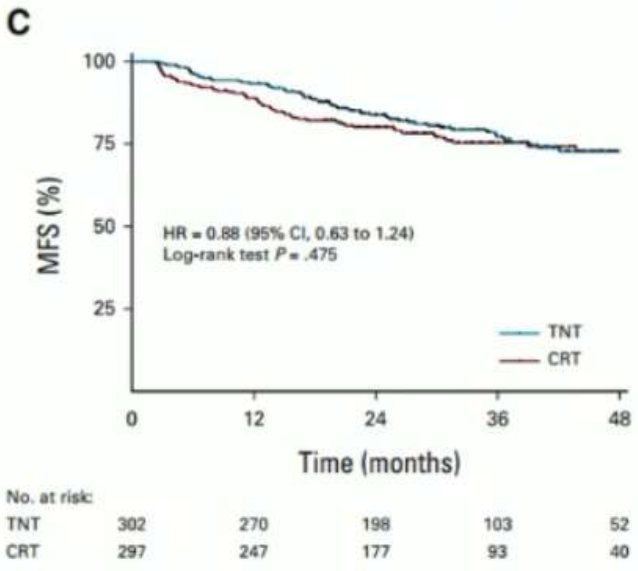
TNT is non-inferior to CRT in 3-year DFS

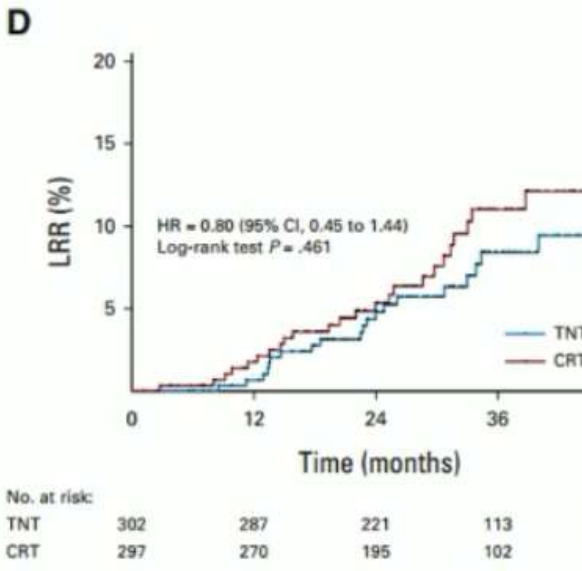












J Clin Oncol. 2022 May 20;40(15):1681-16

Objectives

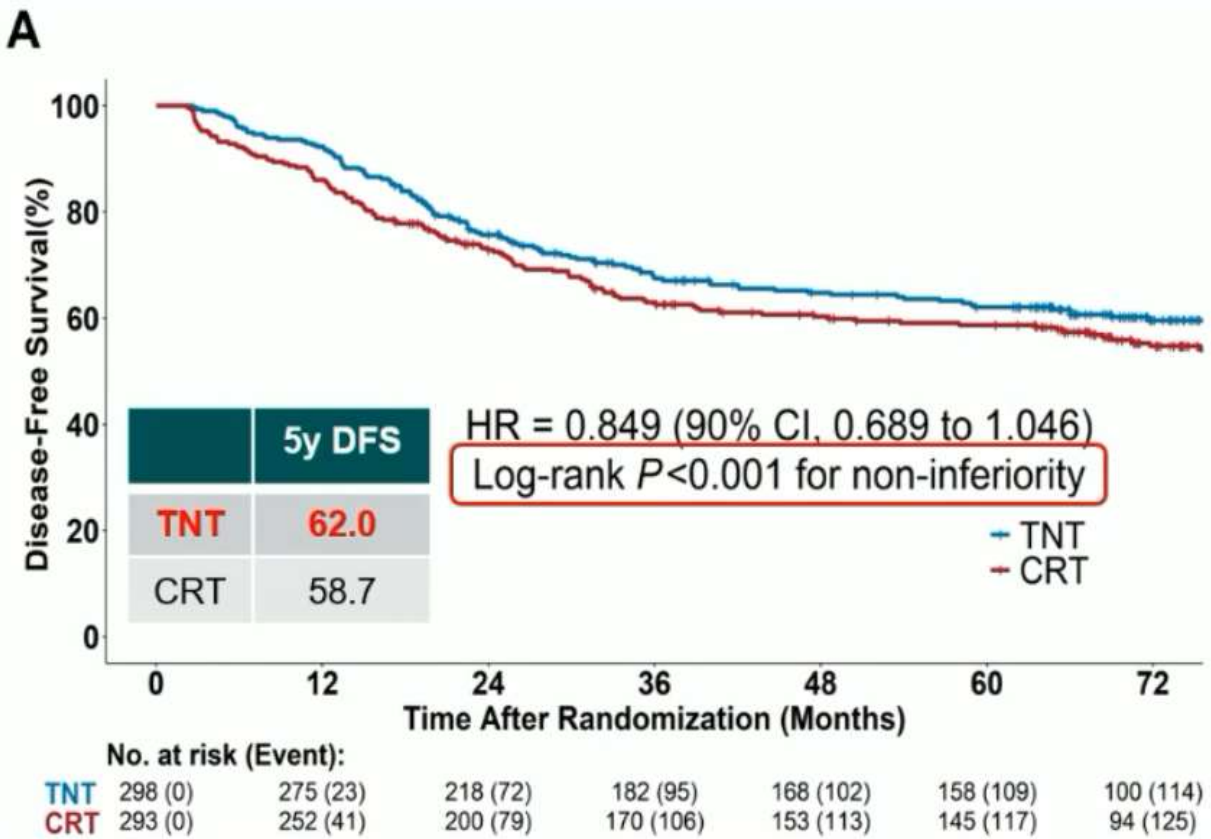
The STELLAR trial previously demonstrated that preoperative SCRT followed by chemotherapy (TNT) was **non-inferior** to standard CRT in terms of **3-year DFS** in LARC patients, and showed a **superior OS**.

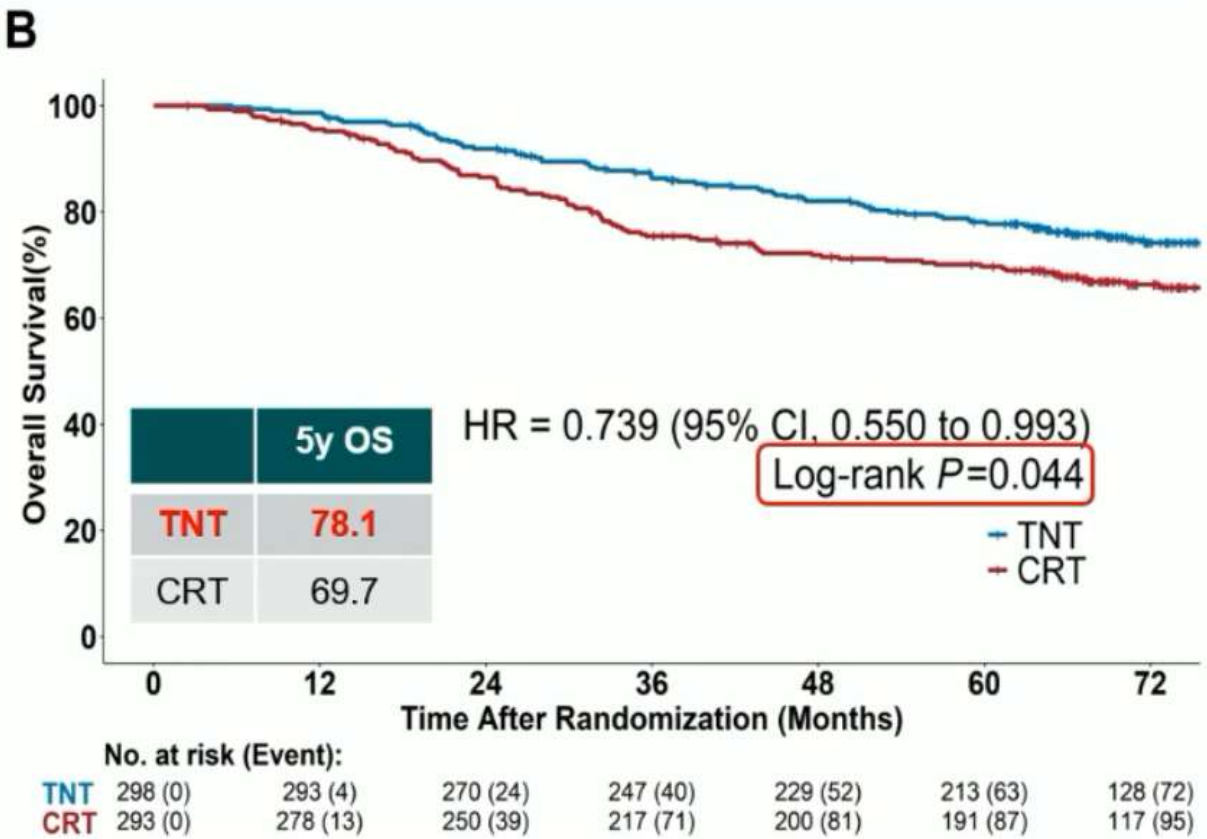
This presentation reports the updated 5-year follow-up results, including

- DFS and OS
- Distant metastasis (DM) and Locoregional Recurrence (LRR)
- QoL and anorectal function (EORTC QLQ-C30, Wexner fecal incontinence score)

5-year DFS and OS

Median follow-up of 68.7 months



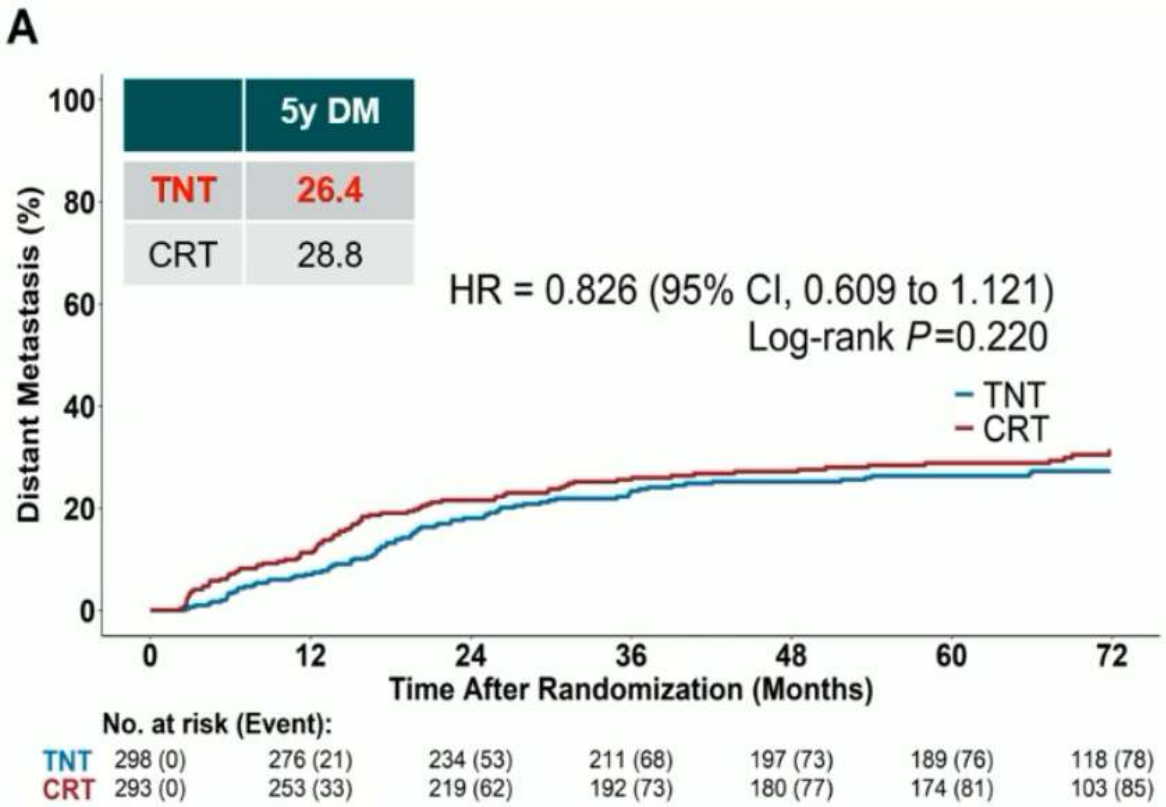


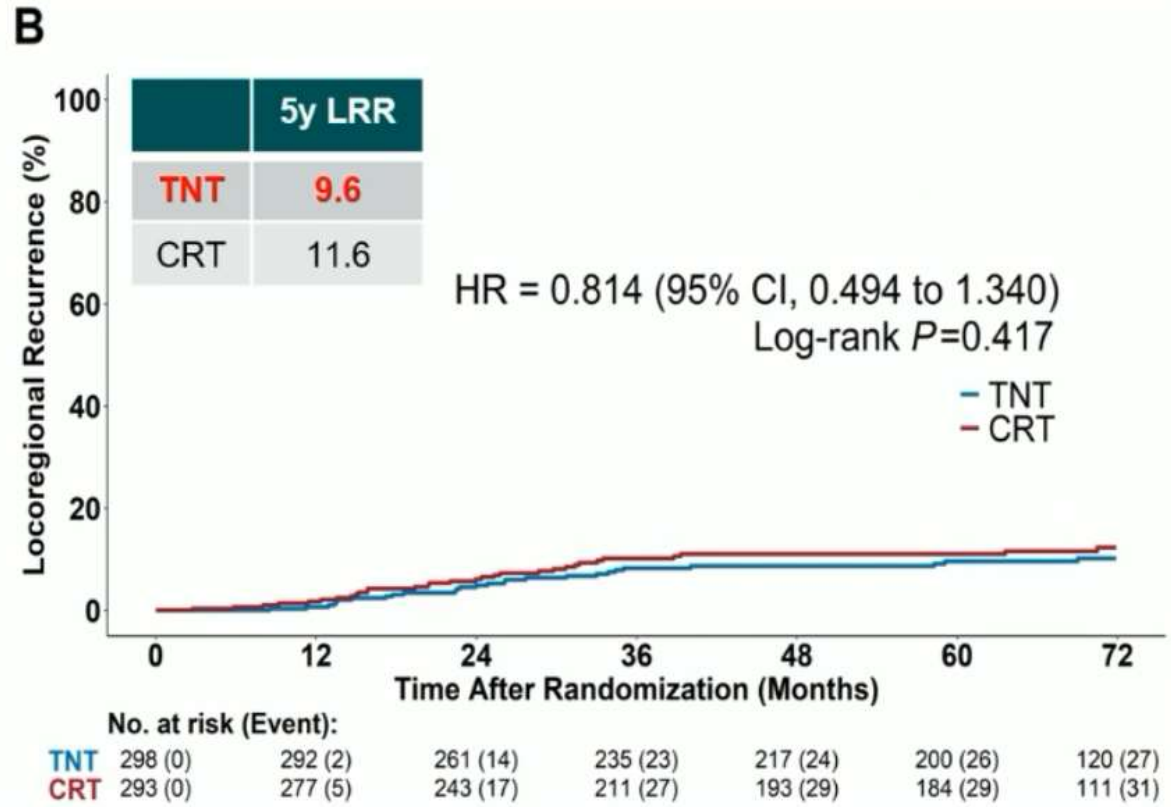
Absolute 5-year DFS difference: 3.3%

Absolute 5-year OS benefit: 8.4%

5-year DM and LRR

Median follow-up of 68.7 months



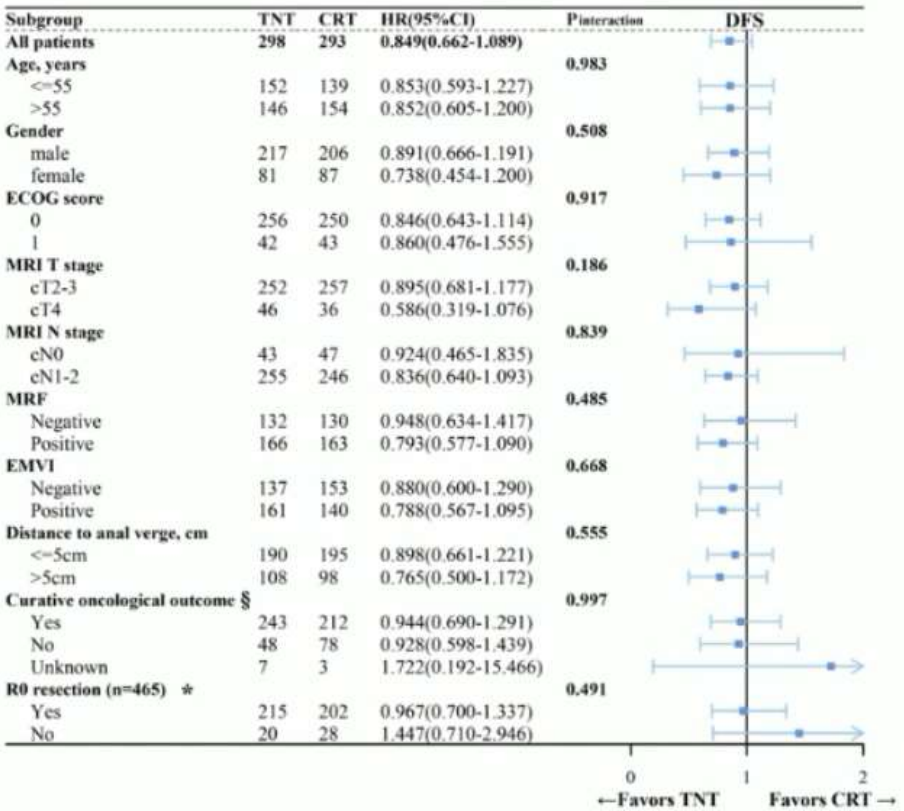


Absolute 5-year DM difference: 2.4%

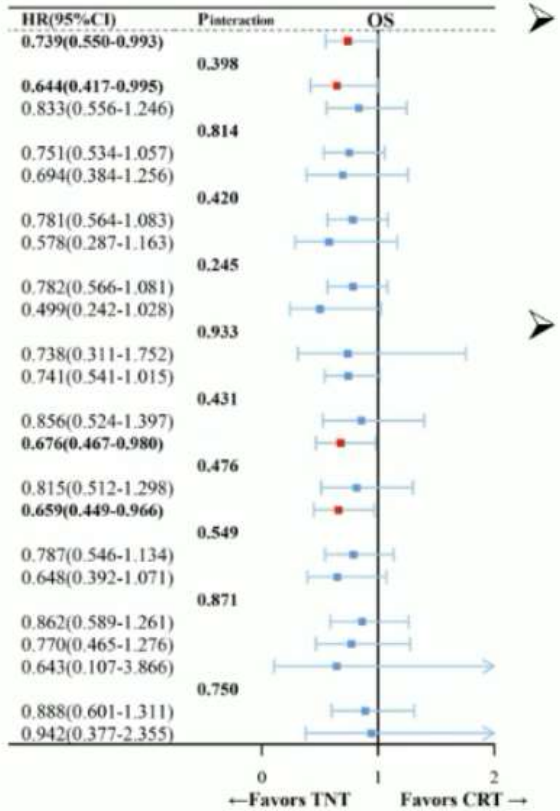
Absolute 5-year LRR difference: 2.0%

Forest Plots of DFS and OS across Subgroups

DFS



OS



- 5y DFS (TNT vs. CRT)

  TNT did not show a clear DFS advantage in any specific subgroup.

- 5y OS (TNT vs. CRT)

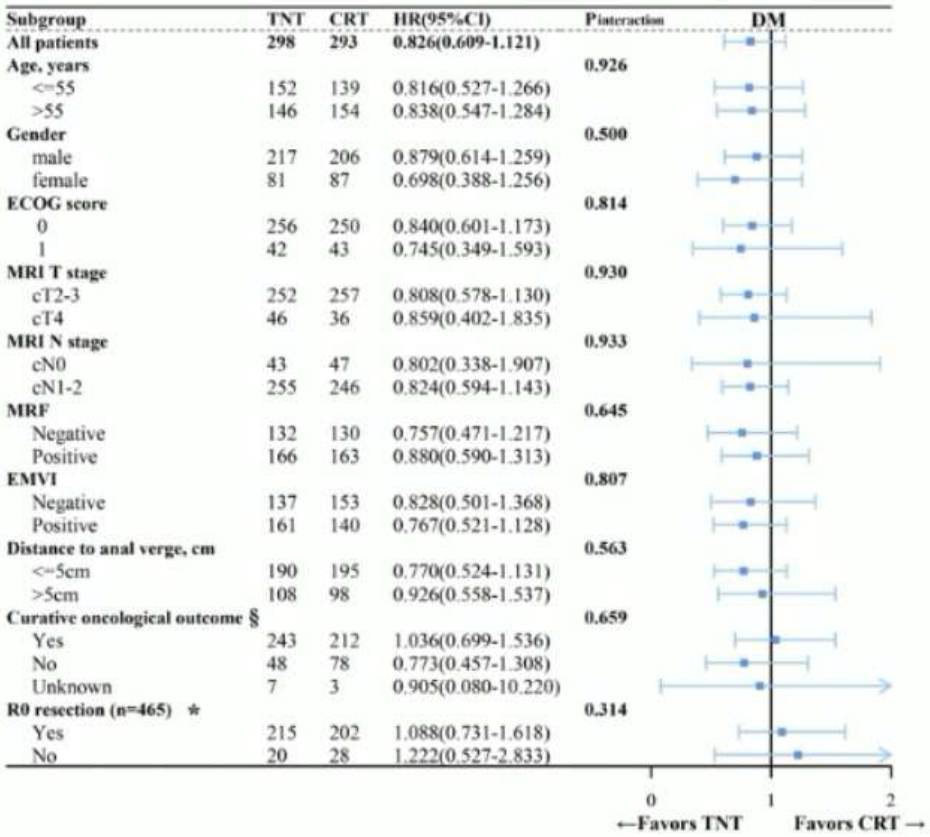
  TNT was superior to CRT in some subgroups.

  - Aged ≤55 years: 77.9% vs. 68.5%
  - MRF involvement: 76.8% vs. 63.2%
  - EMVI positive: 75.5% vs. 63.1%

  However, the interaction *P*-value was not significant.

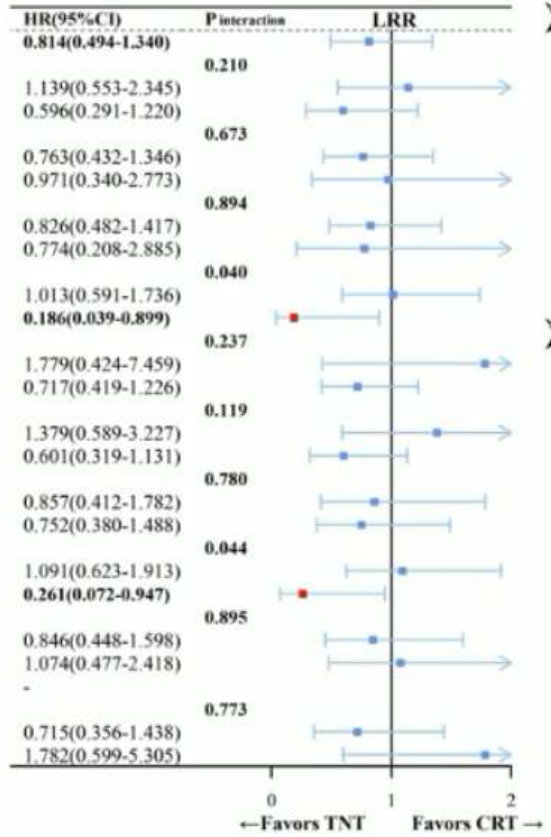
Forest Plots of DM and LRR across Subgroups

DM



Subgroup	TNT	CRT	HR(95%CI)	P interaction
All patients	**298**	**293**	**0.826(0.609-1.121)**	
Age, years				**0.926**
<=55	152	139	0.816(0.527-1.266)	
>55	146	154	0.838(0.547-1.284)	
Gender				**0.500**
male	217	206	0.879(0.614-1.259)	
female	81	87	0.698(0.388-1.256)	
ECOG score				**0.814**
0	256	250	0.840(0.601-1.173)	
1	42	43	0.745(0.349-1.593)	
MRI T stage				**0.930**
cT2-3	252	257	0.808(0.578-1.130)	
cT4	46	36	0.859(0.402-1.835)	
MRI N stage				**0.933**
cN0	43	47	0.802(0.338-1.907)	
cN1-2	255	246	0.824(0.594-1.143)	
MRF				**0.645**
Negative	132	130	0.757(0.471-1.217)	
Positive	166	163	0.880(0.590-1.313)	
EMVI				**0.807**
Negative	137	153	0.828(0.501-1.368)	
Positive	161	140	0.767(0.521-1.128)	
Distance to anal verge, cm				**0.563**
<=5cm	190	195	0.770(0.524-1.131)	
>5cm	108	98	0.926(0.558-1.537)	
Curative oncological outcome §				**0.659**
Yes	243	212	1.036(0.699-1.536)	
No	48	78	0.773(0.457-1.308)	
Unknown	7	3	0.905(0.080-10.220)	
R0 resection (n=465) ★				**0.314**
Yes	215	202	1.088(0.731-1.618)	
No	20	28	1.222(0.527-2.833)	

LRR



HR(95%CI)	P interaction
0.814(0.494-1.340)	
	0.210
1.139(0.553-2.345)	
0.596(0.291-1.220)	
	0.673
0.763(0.432-1.346)	
0.971(0.340-2.773)	
	0.894
0.826(0.482-1.417)	
0.774(0.208-2.885)	
	0.040
1.013(0.591-1.736)	
0.186(0.039-0.899)	
	0.237
1.779(0.424-7.459)	
0.717(0.419-1.226)	
	0.119
1.379(0.589-3.227)	
0.601(0.319-1.131)	
	0.780
0.857(0.412-1.782)	
0.752(0.380-1.488)	
	0.044
1.091(0.623-1.913)	
0.261(0.072-0.947)	
	0.895
0.846(0.448-1.598)	
1.074(0.477-2.418)	
-	
	0.773
0.715(0.356-1.438)	
1.782(0.599-5.305)	

- 5y DM (TNT vs. CRT)

  TNT did not reduce 5y DM compared with CRT in any subgroup.

- 5y LRR (TNT vs. CRT)

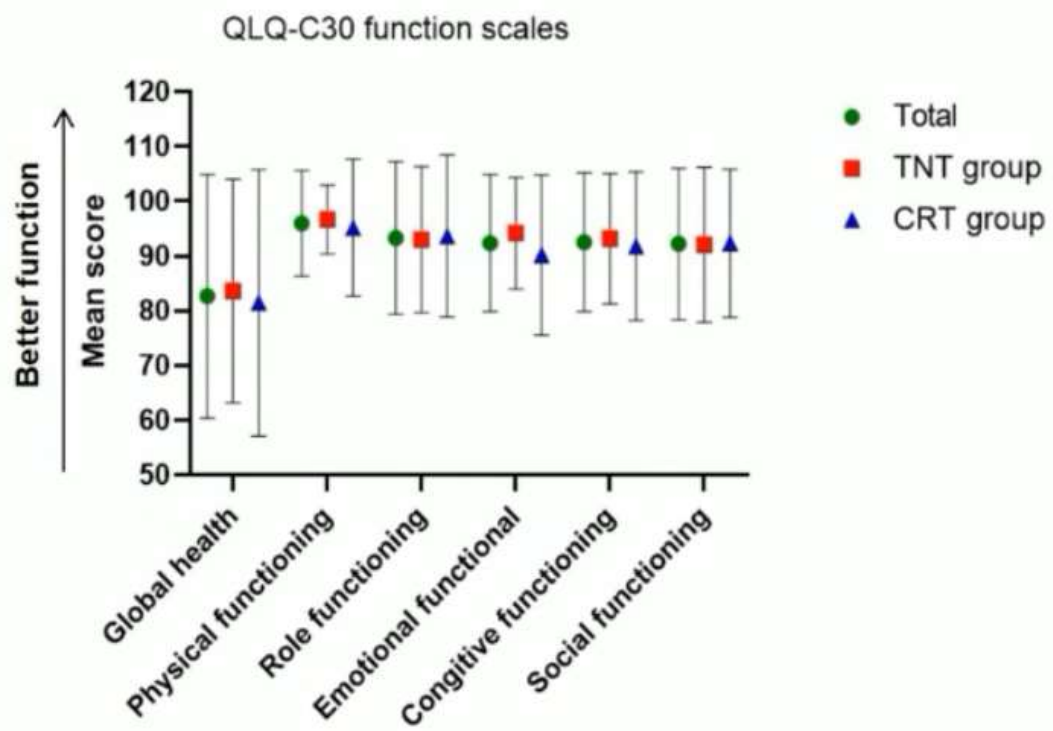
  TNT was superior to CRT in some subgroups.

  - cT4 stage: 5.6% vs. 23.6%
  - ＞5 cm to anal verge: 1.9% vs. 9.1%

  The interaction *P*-value was statistically significant in the above subgroups.

Quality of Life and Anorectal Function

	TNT	CRT	*P*
Surviving patients median follow-up（months）	77.1	77.6	-
rate of questionnaires completion	49.5	44.9	0.350
QLQ-C30			
Global health	83.5	81.4	0.511
Physical functioning	96.6	95.1	0.304
Role functioning	92.9	93.6	0.750
Emotional functioning	94.1	90.1	0.031
Congitive functioning	93.1	91.7	0.447
Social functioning	92.0	92.3	0.894
Wexner Score			
Wexner incontinence score	5	3	0.357



Comparable QoL and anorectal function

Treatment failure locations

Fewer regional-only recurrences in TNT group.

	TNT *N*=98 (%)	CRT *N*=104 (%)	P
LRR lesion			
Primary location alone	27 (27.6)	20 (19.2)	0.187
Regional lymphatic drainage area alone	1 (1.0)	10 (9.6)	**0.010**
Primary location together with Regional lymphatic drainage area	1 (1.0)	3 (2.9)	0.621
DM lesion			
Liver alone	19 (19.4)	24 (23.1)	0.607
Lung alone	24 (24.5)	21 (20.2)	0.502
Liver	35 (35.7)	45 (43.3)	0.314
Lung	37 (37.8)	39 (37.5)	0.999
Other distant organ (except for lung and liver)	17 (17.3)	9 (8.7)	0.092
Peritoneal metastasis	7 (7.1)	12 (11.5)	0.339
Non-regional lymphatic drainage area	3 (3.1)	5 (4.8)	0.721

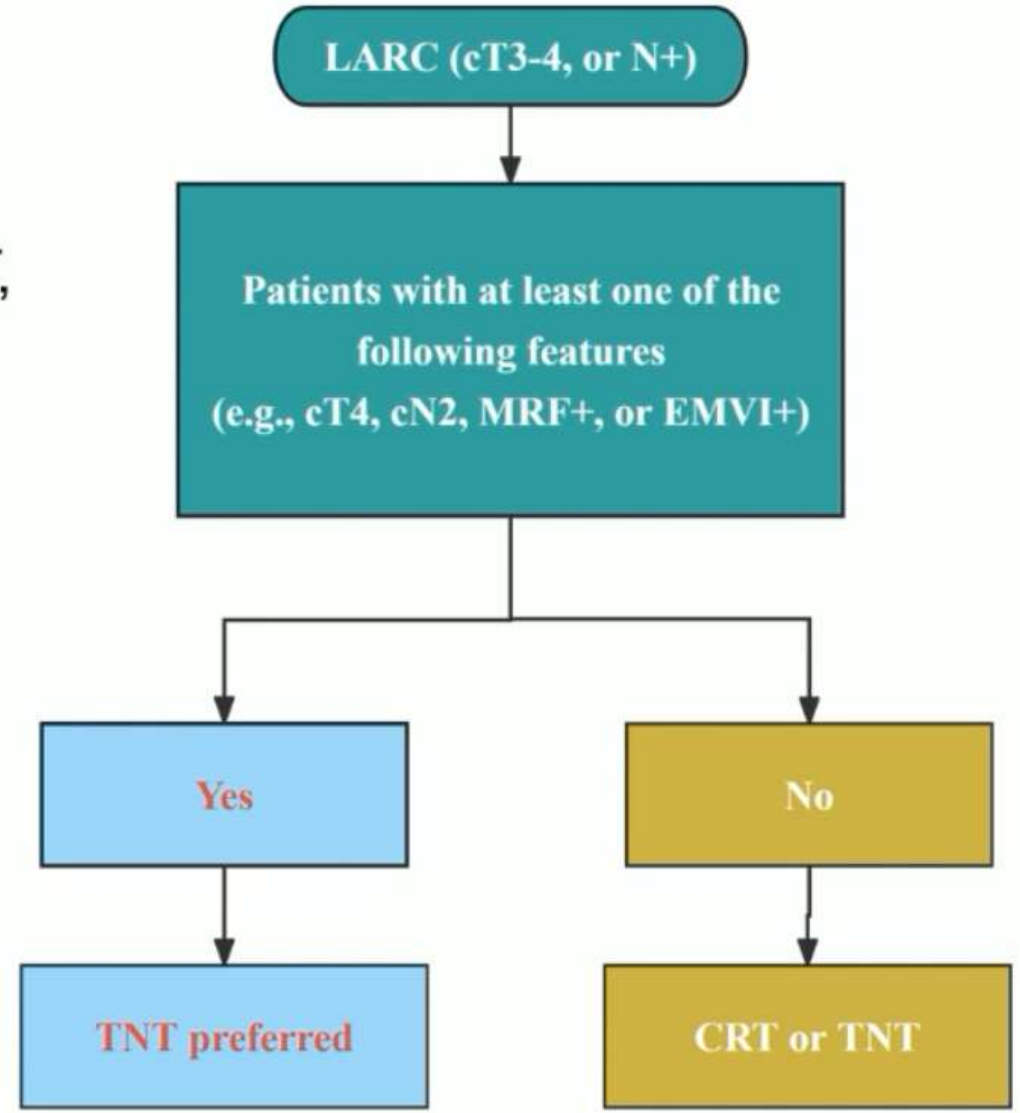
Key Findings

- **TNT maintains DFS non-inferiority and provides a sustained OS benefit** over CRT, **solidifying its long-term efficacy**

  --5y OS improved by 8.4% in the TNT group

- **No difference in QoL and anorectal function**

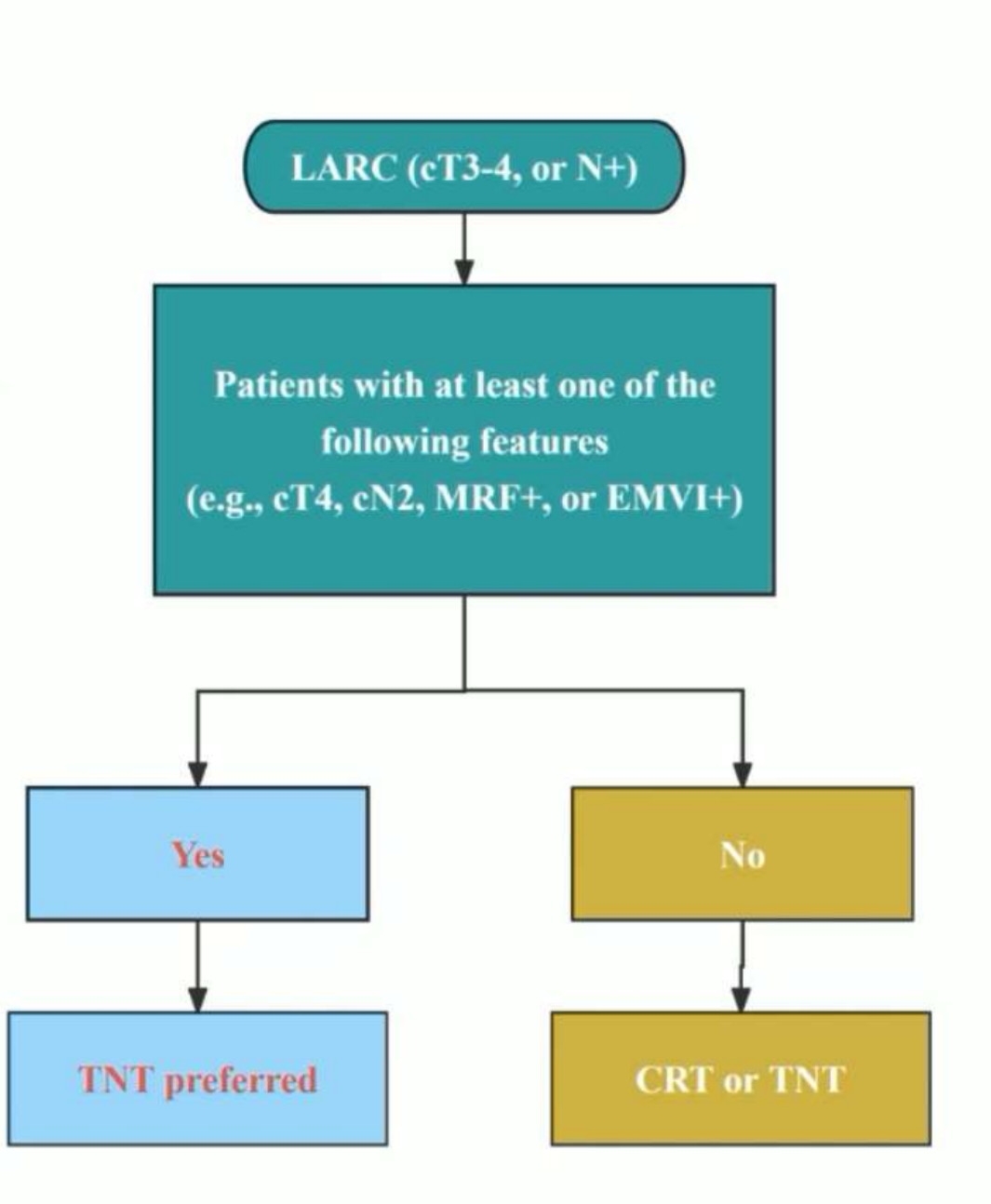
- **TNT should be recommended as a neoadjuvant option for LARC**



- Le TNT maintient la non-infériorité en termes de survie sans maladie (DFS) et offre un bénéfice durable en termes SG par rapport à la CRT, renforçant ainsi son efficacité à long terme.
  - SG à 5 ans améliorée de 8,4 % dans le groupe TNT

- Aucune différence dans la qualité de vie et la fonction anorectale

- Le TNT devrait être recommandé comme option néoadjuvante pour les LARC



Preoperative Short-course Radiotherapy Followed by Chemotherapy and PD-1 Inhibitor for Locally Advanced Rectal Cancer: Phase II Results of STELLAR II

Yuan Tang, Hao-Yue Li, Li-Chun We, Ning Li, Wen-Jue Zhang, Yu-Fei Lu, Fei-Yan Deng, Tong-Zhen Xu, Jia-Cheng Shuai, Zi-Fa Lei, Xian-Yu Meng, Shu-Nan Qi, Yong-Wen Song, Wen-Wen Zhang, Hao Jing, Gong Li, Shi-Xin Liu, Ying-Jie Wang, Zheng Liu, Hui-Ying Ma, Ning-Yu Wang, Bo Chen, Shu-Lian Wang, Ye-Xiong Li, Li-Na Zhao, Jian-Qiang Tang, Zheng Jiang, Ying-Gang Chen, Hai-Tao Zhou, Chen Hu, and **Jing Jin**

National Cancer Center/National Clinical Research Center for Cancer/Cancer Hospital, Chinese Academy of Medical Sciences and Peking Union Medical College, Beijing, China

中国医学科学院肿瘤医院
Cancer Hospital Chinese Academy of Medical Sciences

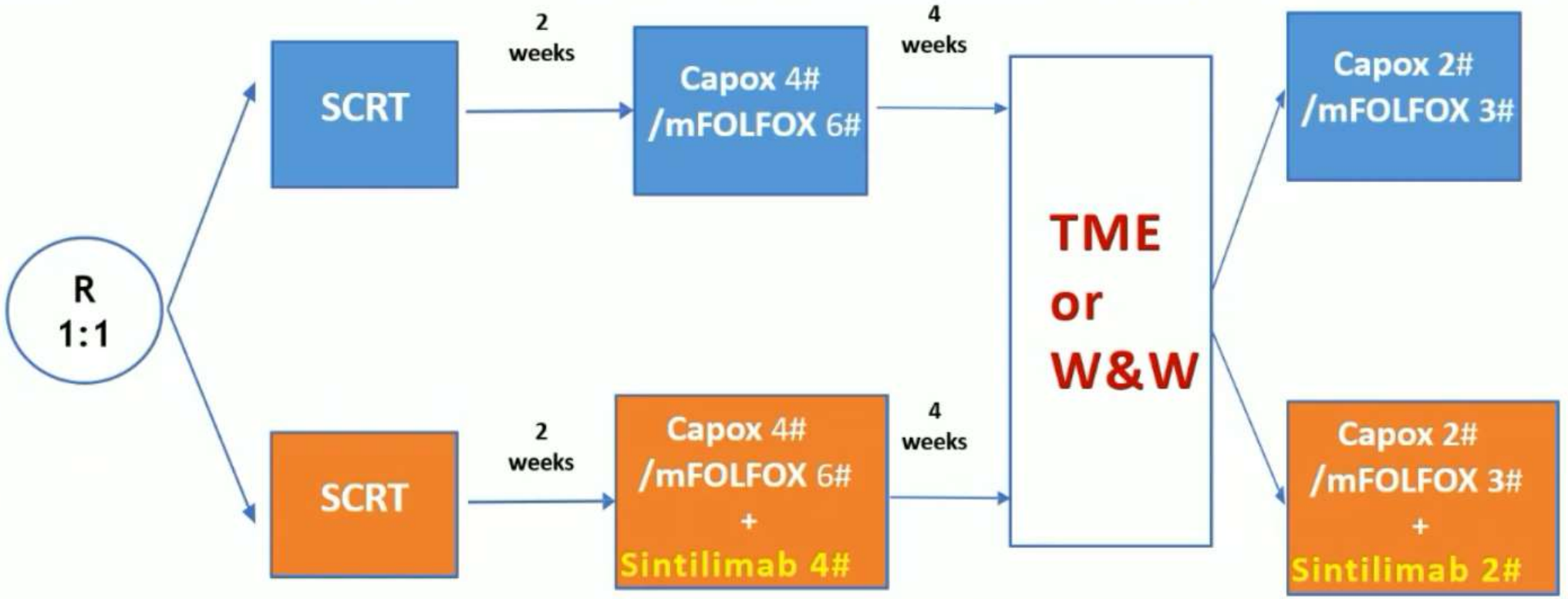
中国医学科学院肿瘤医院深圳医院
CANCER HOSPITAL CHINESE ACADEMY OF MEDICAL SCIENCES, SHENZHEN CENTER

Presented by : Jing Jin, email: jinjing@csco.org.cn

Jing Jin
China

Study design

- Multi-center, randomized controlled, seamless phase II/III study （NCT05484024）



W&W	a watch-and-wait (W&W) strategy was implemented if patients achieved cCR
SCRT	Pelvic radiotherapy, IMRT/VMAT 5Gy*5f
Sintilimab	Sintilimab 200mg, d1 Q21d*4

Capox	Capecitabine 2000 mg/m^2, d1-14 Oxaliplatin 130mg/m^2, d1 Q21d*4
mFOLFOX (selectable)	Oxaliplatin100 mg/m2 ivgtt(2h) d1 Calcium folinate 400 mg/m2 ivgtt (2h) d1 Fluorouracil 400 mg/m2 iv d1, 2400 mg/m2 ivgtt(46h) d1 Q14d*6

Presented by : Jing Jin, email: jinjing@csco.org.cn

Key eligibility criteria

- Patients aged from 18 to 75 years
- ECOG 0-1
- Rectal adenocarcinoma
- pMMR/MSS
- MRI-staged II-III: cT3-4N0 or cT2-4N+, M0
- ≤10cm from the anal verge

Endpoints

- Primary endpoints:

  Phase II—complete response rate (CR, cCR+pCR)

  Phase III—3-year disease free survival (DFS)

- Secondary endpoints:

  Grade 3–5 acute adverse events

  3-year local recurrence free survival

  3-year overall survival (OS)

  Surgical complications

  Quality of life (QoL)

Patients baseline characteristics

- Between August 2022 and November 2023, 218 patients were enrolled
- The median follow-up duration was 19.6 months (January 23, 2025)

	iTNT Group (n=110)	TNT Group (n=108)
Age, years, median (range)	59 (21-74)	59.5 (32-73)
Sex		
Male	81 (73·6)	72 (66·7)
Female	29 (26·4)	36 (33·3)
ECOG score		
0	40 (36·4)	41 (38·0)
1	70 (63·6)	67 (62·0)

Tumor characteristics

	iTNT Group (n=110)	TNT Group (n=108)
Clinical T category		
T2	5 (4·5)	6 (5·6)
T3	85 (77·3)	85 (78·7)
T4	20 (18·2)	17 (15·7)
T4a	11 (10·0)	12 (11·1)
T4b	9 (8·2)	5 (4·6)
Clinical N category		
N0	8 (7·3)	6 (5·5)
N1	33 (30·0)	30 (27·8)
N2	69 (62·7)	72 (66·7)
Clinical stage		
II	8 (7·3)	6 (5·6)
III	102 (92·7)	102 (94·4)

	iTNT Group (n=110)	TNT Group (n=108)
Distance to anal verge, cm		
≤ 5	83 (75·5)	81 (75·0)
5.1-10	27 (24·5)	27 (25·0)
MRF		
Positive	58 (52·7)	57 (52·8)
Negative	52 (47·3)	51 (47·2)
EMVI		
Positive	53 (48·2)	44 (40·7)
Negative	57 (51·8)	64 (59·3)
Risk group*		
Low-risk	18 (16·4)	19 (17·6)
High-risk	92 (83·6)	89 (82·4)

* Patients meeting any of the following criteria were defined as high-risk: cT4a/b, cN2, EMVI+, MRF+

Presented by : Jing Jin, email: jinjing@csco.org.cn

Treatment compliance

	iTNT Group (n=110)	TNT Group (n=108)	*P*
Compliance with neoadjuvant therapy			
4 cycles of chemotherapy	97 (88.2)	101 (93.5)	0.269
Full-dose of chemotherapy	85 (77.3)	90 (83.3)	0.261
Sintilimab			
≥2 cycles	109 (99.1)	-	
≥3 cycles	107 (97.3)	-	
≥4 cycles	97 (88.2)	-	
Compliance with adjuvant therapy			
full-cycle of chemotherapy	33 (45.8)	46 (56.1)	0.204
2 cycles of sintilimab	19 (26.4)	-	-

Toxicities

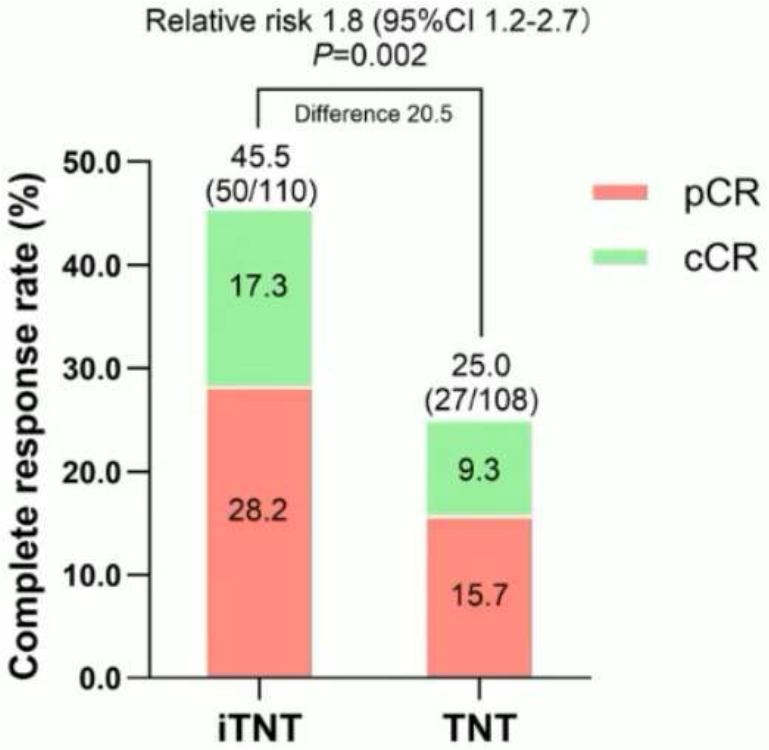
	iTNT Group			TNT Group		
Acute toxicity during SCRT						
Total No. of evaluable patients	110			108		
Overall grade 3 to 4 adverse events during SCRT	14 (12.7)			8 (7.4)		
Acute toxicity during chemotherapy ± PD-1 inhibitor						
Total No. of evaluable patients	109			105		
Overall grade 3 to 4 adverse events during chemotherapy ± PD-1 inhibitor*	30 (27·5)			14 (13·3)		
Overall grade 3 to 4 adverse events during neoadjuvant therapy*	38 (34·5)			21 (19.4)		
Postoperative complications						
	Grades 1-2	Grade 3	Grade 4	Grades 1-2	Grade 3	Grade 4
Total No. of evaluable patients	72			82		
Overall postoperative complications	**18 (25.0)**	**6 (8.3)**	**0 (0)**	**16 (19.5)**	**2 (2.4)**	**0 (0)**

Presented by : Jing Jin, email: jinjing@csco.org.cn

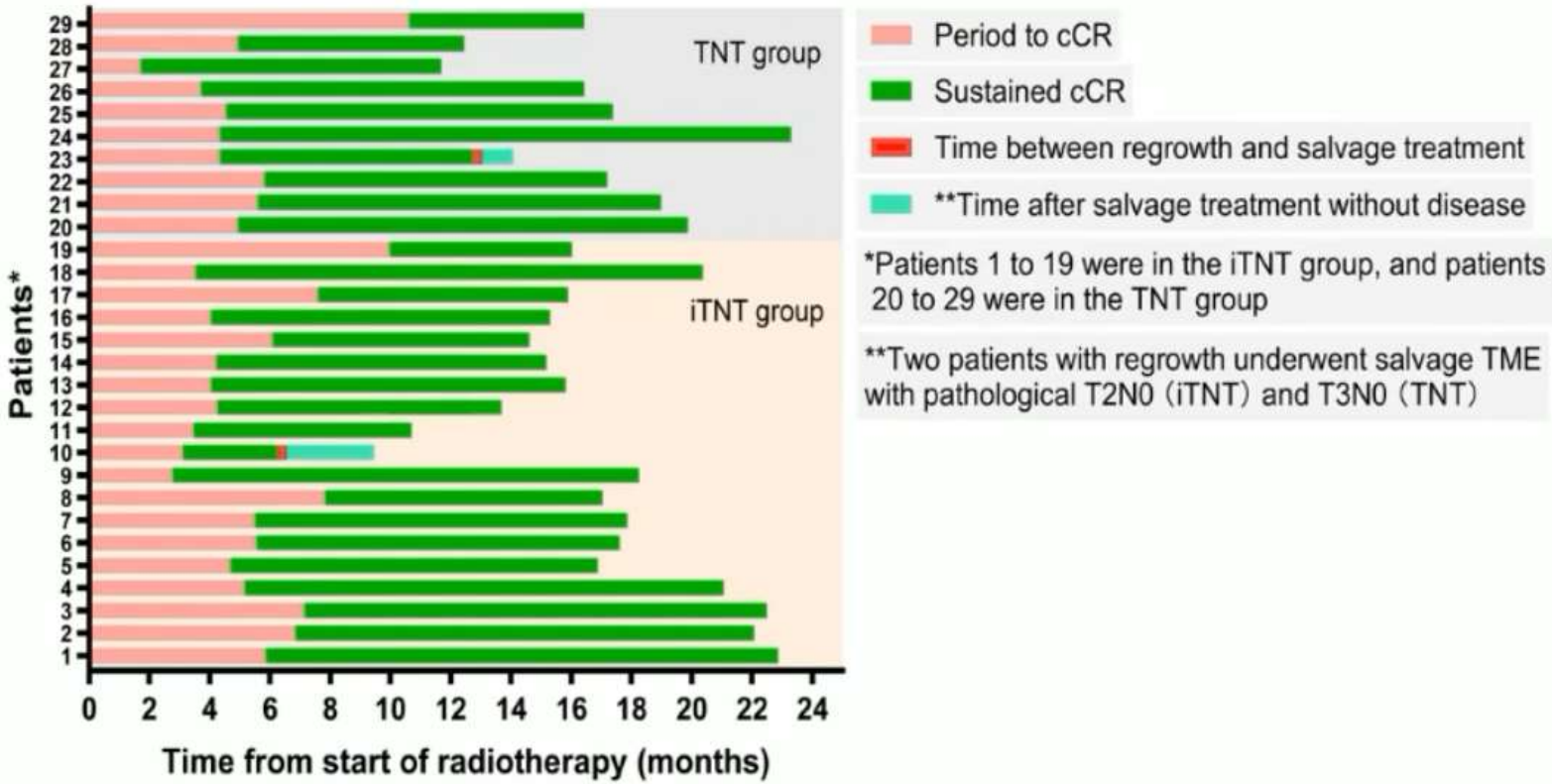
* $P<0.05$

CR rate

- **The iTNT regimen significantly improved CR rate: 45·5% versus 25·0% (difference 20·5%, 95%CI 12·4-28·6; P=0·002)**



The primary endpoint (CR rate)



Swimmer plot of twenty-nine patients who achieved cCR, and adopted W&W strategy

Univariate and multivariate analyses

		Univariate Analyses		Multivariate Analyses	
	CR rate (%)	OR (95% CI)	P	OR (95% CI)	P
Group			0·002		0.000
iTNT (n=110)	45·5	2·500 (1·407 to 4·443)		4.194 (2·100 to 8·376)	
TNT (n=108)	25·0	Referent		Referent	
Age group, years			0·953		0·123
<60 (n=111)	35·1	0·984 (0·564 to 1·714)		0·588 (0·300 to 1·155)	
≥60 (n=107)	35·5	Referent		Referent	
Sex			0·120		0·102
Male (153)	32·0	0·623 (0·343 to 1·131)		0·552 (0·270 to 1·125)	
Female (n=65)	43·1	Referent		Referent	
ECOG score			0·115		0·058
0 (n=81)	42·0	1·581 (0·894 to 2·796)		1·971 (0·978 to 3·973)	
1 (n=137)	31·4	Referent		Referent	
Clinical T category			< 0·001		0.000
T2-3 (n=181)	41·4	12·382 (2·889 to 53·068)		19.328 (4·013 to 93.098)	
T4 (n=37)	5·4	Referent		Referent	
Clinical N category			0·544		0·721
N0 (n=14)	42·9	1·405 (0·469 to 4·208)		1·290 (0·318 to 5·233)	
N1-2 (n=204)	34·8	Referent		Referent	

		Univariate Analyses		Multivariate Analyses	
	CR rate (%)	OR (95% CI)	P	OR (95% CI)	P
Distance to anal verge, cm			0·338		0·094
≤5 (n=164)	33·5	0·734 (0·390 to 1·381)		0·514 (0·236 to 1·121)	
5.1-10 (n=54)	40·7	Referent		Referent	
MRF			0·112		0·266
Positive (n=115)	30·4	0·635 (0·363 to 1·111)		1·571 (0·709 to 3.484)	
Negative (n=103)	40·8	Referent		Referent	
EMVI			0·002		0·024
Positive (n=97)	23·7	Referent		Referent	
Negative (n=121)	44·6	2·593 (1·438 to 4·675)		2·414 (1·122 to 5·190)	
CEA, ng/ml			0·003		0·003
≤5 (n=123)	43·9	Referent		Referent	
>5 (n=95)	24·2	0·408 (0·226 to 0·736)		0·347 (0·171 to 0·704)	
Risk degree*			0.048		0.539
Low-risk (n=37)	48.6	Referent		Referent	
High-risk (n=181)	31.5	0.485 (0.237 to 0.994)		0.728 (0.264 to 2.006)	

STELLAR2: Conclusion

- **Pour le traitement par LARC pMMR/MSS, l'association SCRT suivie de quatre cycles de chimiothérapie plus un inhibiteur de PD-1 (sintilimab) a été bien tolérée, sans événements indésirables graves inattendus.**

- **Le taux de réponse complète a été significativement amélioré dans la stratégie iTNT (45,5 %).**

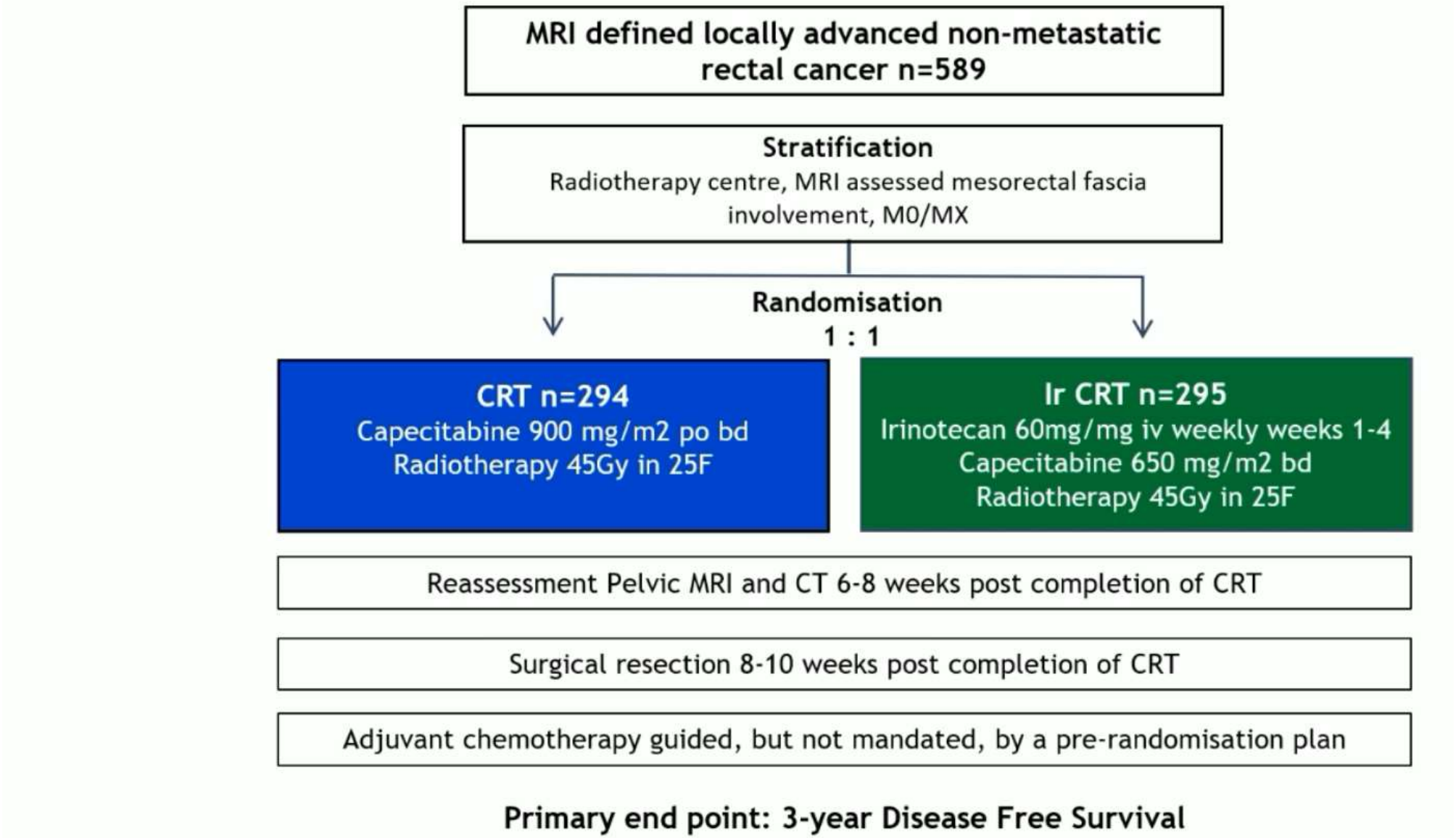
- **L'étude de phase III approche de la fin du recrutement et les résultats finaux de la survie sans maladie sont attendus**

Background

- The addition of neoadjuvant radiotherapy prior to surgical resection reduces local recurrence in rectal cancer
- Randomised phase III trials demonstrate that concurrent chemotherapy (CRT) is superior to long course radiotherapy alone, and is more effective and less toxic, when given pre-operatively
- Phase II, mainly single arm, clinical trials using doublet concurrent chemotherapy (oxaliplatin or irinotecan) with radiotherapy report higher pathological complete response rates (pCR) than using fluoropyrimidine CRT
- The phase II UK RICE study using concurrent irinotecan, capecitabine CRT reported 22% pCR, 64% three-year disease free and 88% overall survival with acceptable toxicity
- We planned a randomised phase III trial to evaluate the benefit of adding concurrent irinotecan and capecitabine to radiotherapy in MRI-defined locally advanced rectal cancer considered at high risk of loco-regional failure and distant relapse

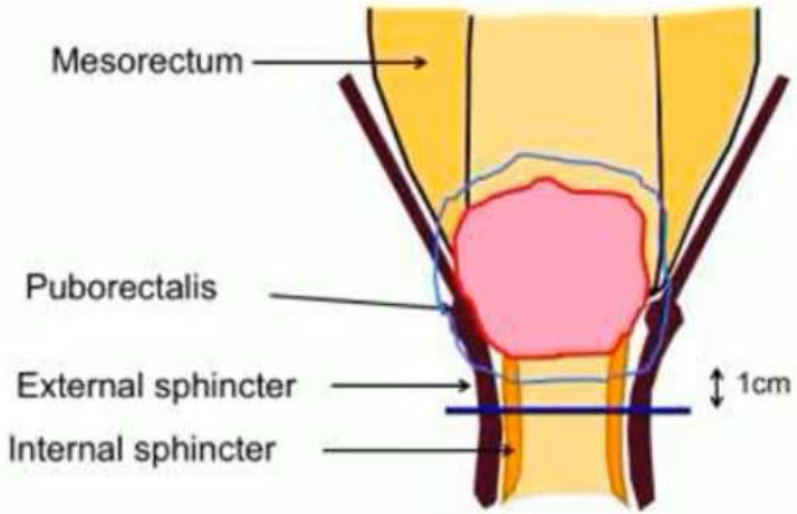
David Sebag-Montefore
United Kingdom

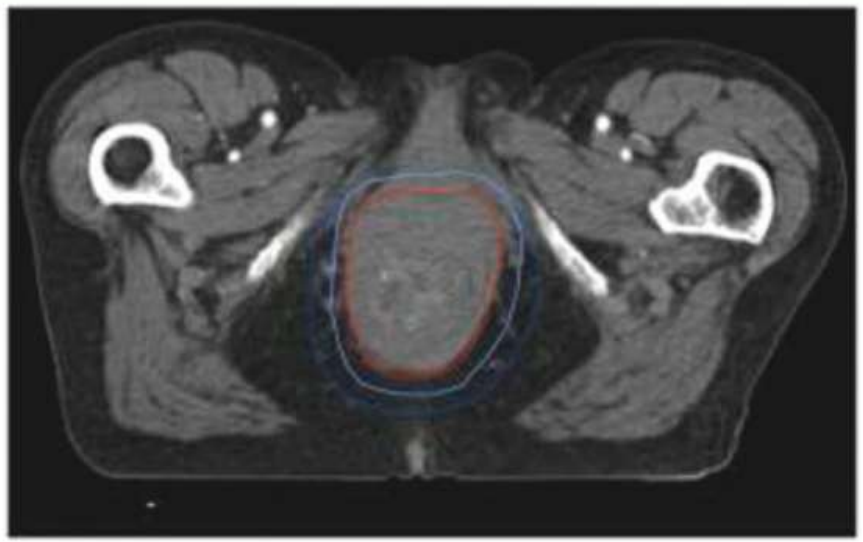
ARISTOLE Study Design



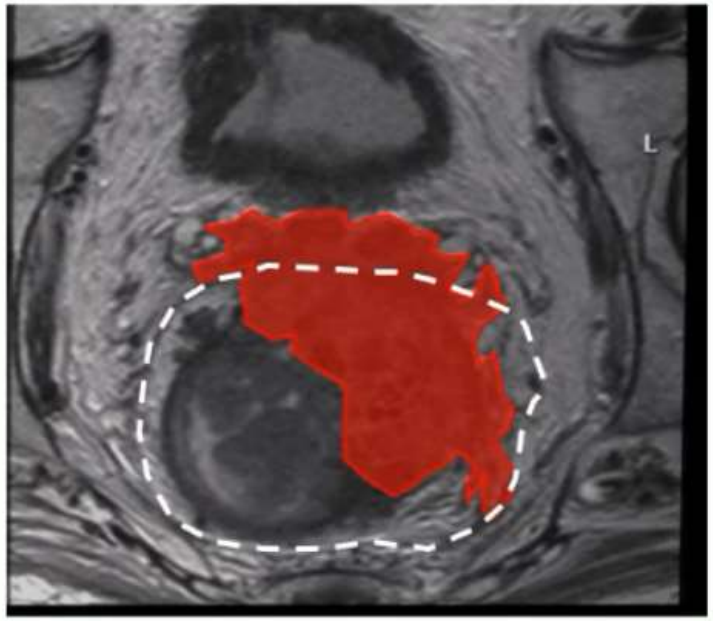
Trial conduct

- 75 UK sites - radiotherapy and surgery centres
- Pre-trial
  - Eight regional radiotherapy workshops
  - Detailed RT protocol
  - Real-time review first patient and review of 10% radiotherapy outlines and plans
- Recruitment
  - Oct 2011- July 2018
- Median follow-up
  - 76.4 months (95% CI 70.8-81.2)

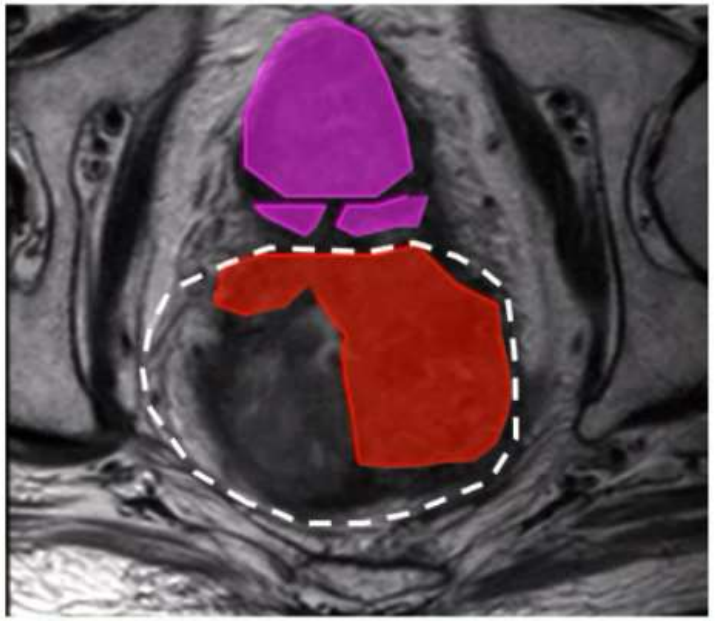




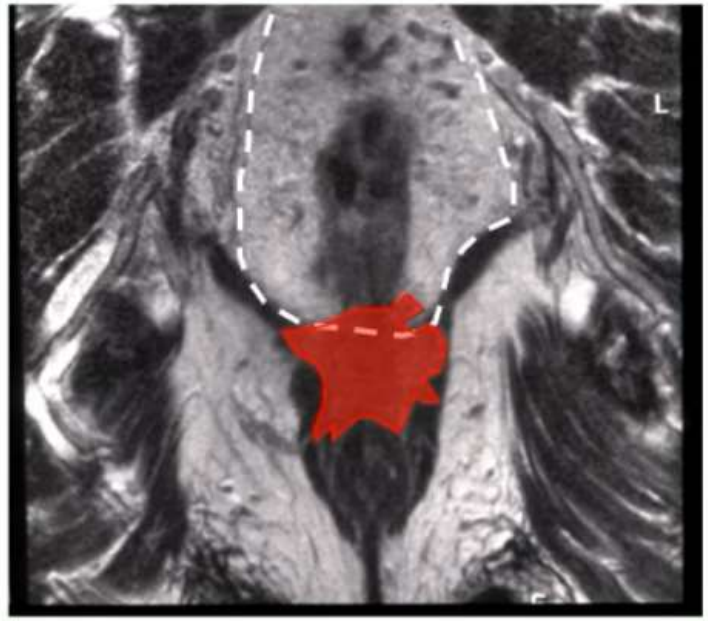
MRI defined locally advanced rectal cancer



Mesorectal fascia (MRF) involved or breached



MRF threatened:
tumour ≤ 1mm from MRF



Low tumours ≤ 1mm from the levator on two imaging planes; or full thickness of muscularis propria at the level of puborectalis or below; or tumour involving the inter-sphincteric plane or external anal sphincter

Patients with involved pelvic side wall nodes were only eligible if the primary tumour assessment met the above inclusion criteria

Patient Characteristics

	Ir CRT n=280*		CRT n=284*	
Age, years				
Median age (range)	60.5 (24.0-82.8)		60.9 (28.5-77.7)	
Sex				
Male	173	61.8	197	69.4
Female	107	38.2	87	30.6%
ECOG				
Fully active	217	77.5%	226	79.6%
Ambulatory (work able)	63	22.5%	58	20.4%
mrCRM				
Involved (0mm)	139	49.6%	138	48.6%
Threatened (</=1mm)	108	38.6%	109	38.4%
T stage (MRI defined)				
T2	17	6.1%	16	5.6%
T3	212	75.7%	223	78.5%
T4	45	16.1%	44	15.5%
N stage (MRI defined)				
N0	50	17.9%	81	28.5%
N1	141	50.4%	119	41.9%
N2	82	29.3%	83	29.2%
N3	1	0.4%	0	0%
Pre-treatment stoma				
No	174	62.1%	194	68.3%
Yes	39	13.9%	22	7.7%

Chemoradiotherapy compliance

Radiotherapy compliance

	Ir CRT n=276		CRT n=283	
Radiotherapy dose delivered				
RT as scheduled (45Gy/25fractions)	208	75.4%	251	88.7%
RT delivered >45Gy	15	5.4%	3	1.1%
Proportion of intended RT received				
Received ≥90% intended RT	260	94.2%	279	98.6%
Received <90% intended RT	16	5.8%	4	1.4%

Chemotherapy compliance

	Ir CRT n=276		CRT n=283	
Days on capecitabine				
Median (range)	35	4-58	35	7-47
Total % capecitabine dose delivered				
Median (range)	98	14-112	100	20-106
Capecitabine dose delivered				
Capecitabine as scheduled (100%)	129	46.7%	196	69.3%
Capecitabine delivered >100%	6	2.2%	7	2.5%
Received ≥90% intended capecitabine dose	187	67.8%	253	89.4%
Received <90% intended capecitabine dose	89	32.2%	30	10.6%
Irinotecan Compliance				
Received ≥90% intended irinotecan dose	205	74.3%		
Received <90% intended irinotecan dose	71	25.7%		

Worst Grade 3-5 acute adverse events

°	Ir CRT n=280*		CRT n=284*	
Blood disorders				
Anaemia	8	2.9%	4	1.4%
Lymphocytes decreased	**181**	**65.6%**	**100**	**35.3%**
Neutrophils decreased	**27**	**9.8%**	**3**	**1.1%**
Febrile neutropaenia	3	1.1%	1	0.4%
Platelets decreased	1	0.4%	1	0.4%
Infections and infestations				
Any infections	29	10.5%	27	9.5%
Gastrointestinal disorders				
Diarrhoea	**38**	**13.8%**	**10**	**3.5%**
Abdominal pain	13	4.7%	2	0.7%
Proctitis	8	2.9%	7	2.5%
General disorders				
Fatigue	17	6.2%	8	2.8%
Renal and urinary disorders				
Any renal and urinary disorders	5	1.8%	4	1.4%
Vascular disorders				
Any vascular disorders	13	4.7%	8	2.8%
Metabolism and nutrition				
Other metabolism and nutrition disorders	**34**	**12.3%**	**9**	**3.2%**
Dehydration	**10**	**3.6%**	**1**	**0.4%**
Anorexia	6	2.2%	2	0.7%

* Eligible patients

5 patients had a Gd 5 AE - 3 IrCRT and 2 CRT

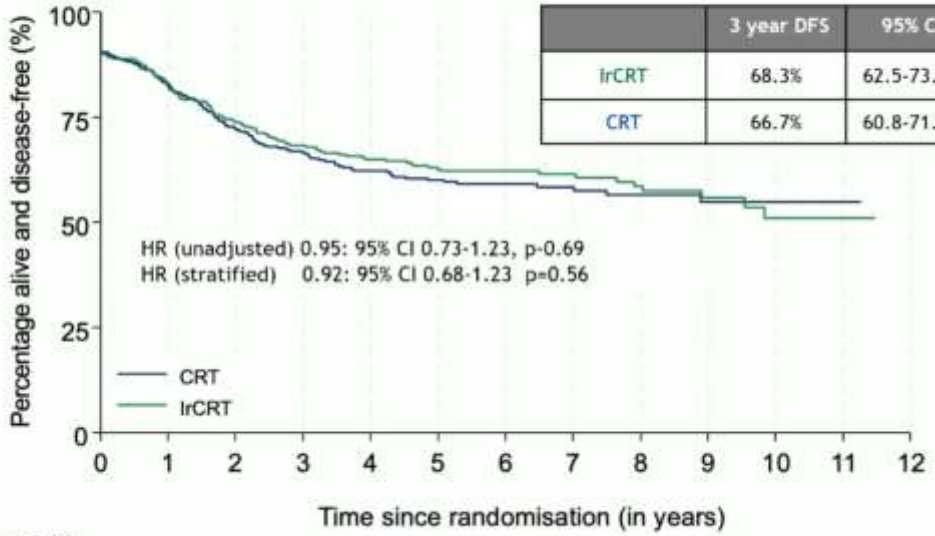
Radiological, pathological and surgical outcomes

	IrCRT n=280*		CRT n=284*	
MRI Tumour Regression Grade (mrTRG)				
TRG1	**38**	**13.6%**	**39**	**13.7%**
TRG2	90	32.1%	86	30.3%
TRG3	63	22.5%	68	23.9%
TRG4	49	17.5%	51	18.0%
TRG5	19	6.8%	24	8.5%
Time from CRT to surgical resection				
Median Weeks (Range)	10.6	(7.0 to 33.3)	10.6	(7.4 to 68.4)
Pathological TNM Stage	**n=238^**		**n=243^**	
Stage 0 (ypT0N0) - pCR	**46**	**19.3%**	**42**	**17.3%**
Stage I	63	27.3%	49	20.2%
Stage IIA	46	19.9%	64	26.3%
Stage IIB/C	8	3.5%	7	2.9%
Stage IIIA	12	5.2%	16	6.6%
Stage IIIB	55	23.8%	60	24.7%
Stage IIIIB	1	0.4%	1	0.4%
Pathological Resection Status			**1**	
R0 (>1mm)	**207**	**87.0%**	**212**	**87.2%**
R1 (0mm)	13	5.5%	13	5.3%
R1 (<+1mm)	10	4.2%	11	4.5%
R2	1	0.4%	2	0.8%

* Eligible patients
^ Patients who had surgery

>90% of the patients underwent surgical resection: APER 134 (55.1%) CRT and 130 (54.6%) IrCRT or anterior resection 94 (38.7%) CRT and 100 (42.0%) IrCRT

Primary end point: Disease-free survival

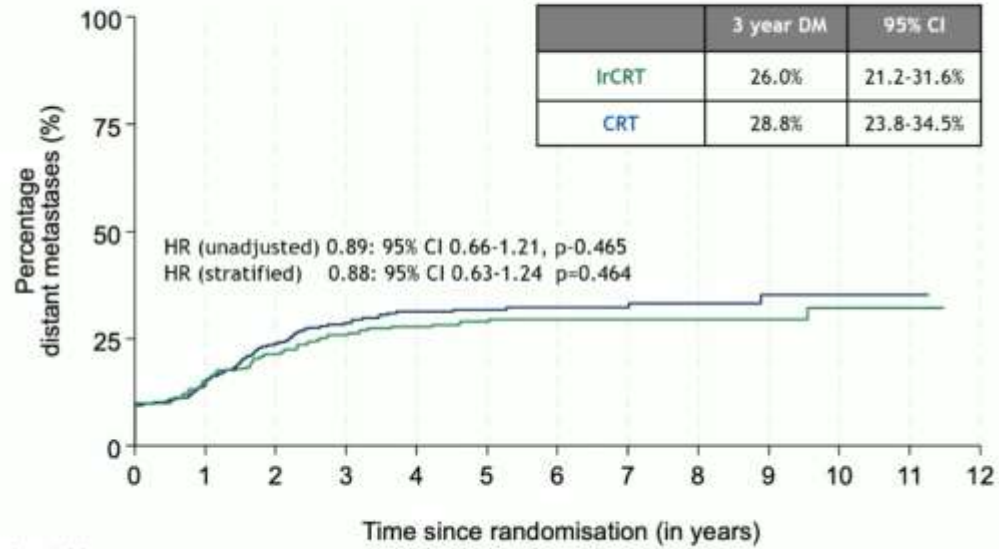


	3 year DFS	95% CI
IrCRT	68.3%	62.5-73.4%
CRT	66.7%	60.8-71.8%

Number at risk

CRT	284	233	202	186	171	153	87	67	51	33	17	3	0
IrCRT	280	230	204	187	175	156	91	70	54	34	19	3	0

Distant Metastases

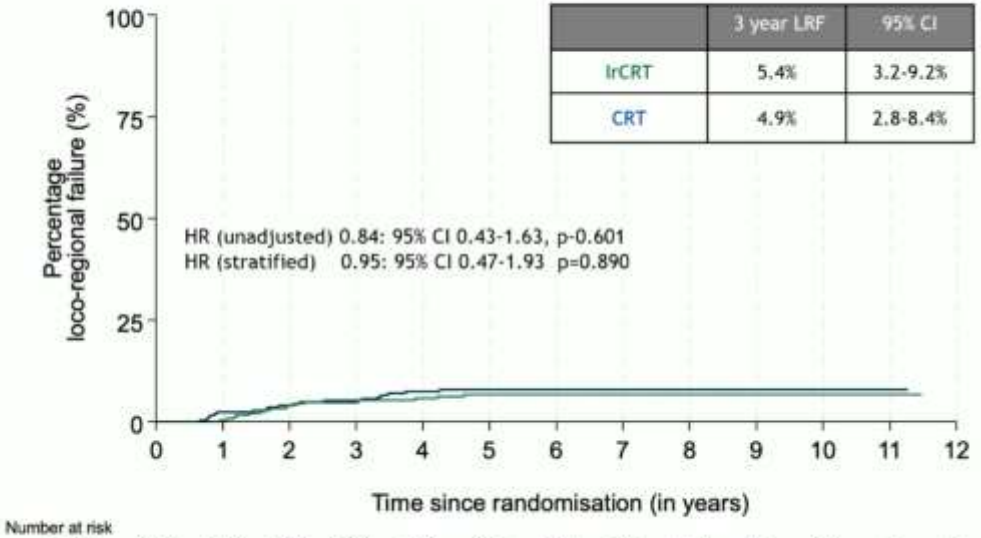


	3 year DM	95% CI
IrCRT	26.0%	21.2-31.6%
CRT	28.8%	23.8-34.5%

Number at risk

CRT	284	236	207	191	178	158	91	70	52	33	17	3	0
IrCRT	280	230	210	195	182	162	94	73	56	36	21	3	0

Loco-regional failure

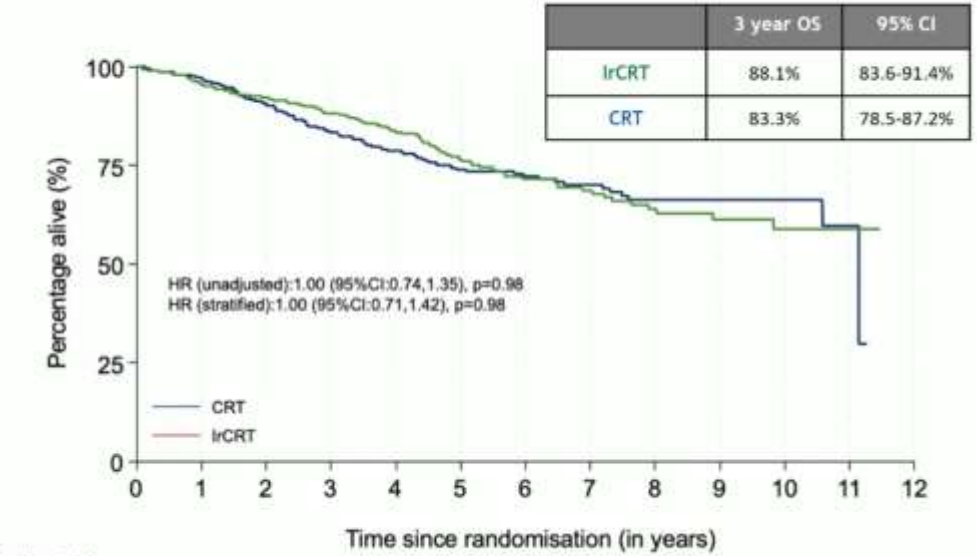


	3 year LRF	95% CI
IrCRT	5.4%	3.2-9.2%
CRT	4.9%	2.8-8.4%

Number at risk

CRT	257	243	230	217	198	175	100	77	59	36	20	4	0
IrCRT	252	242	229	219	209	179	103	79	56	36	21	3	0

Overall Survival



	3 year OS	95% CI
IrCRT	88.1%	83.6-91.4%
CRT	83.3%	78.5-87.2%

Number at risk

CRT	284	275	254	234	218	189	112	85	62	37	21	4	0
IrCRT	280	265	255	241	225	190	107	81	58	38	23	3	0

ARISTOTLE: CONCLUSION

- Il n'existe aucune différence en termes de pCR ou de DFS lorsque l'irinotécan concomitant est ajouté à la CRT par capécitabine en préopératoire.

- L'ajout d'irinotécan concomitant a entraîné un taux plus élevé de toxicité aiguë et une réduction de l'observance de la radiothérapie.

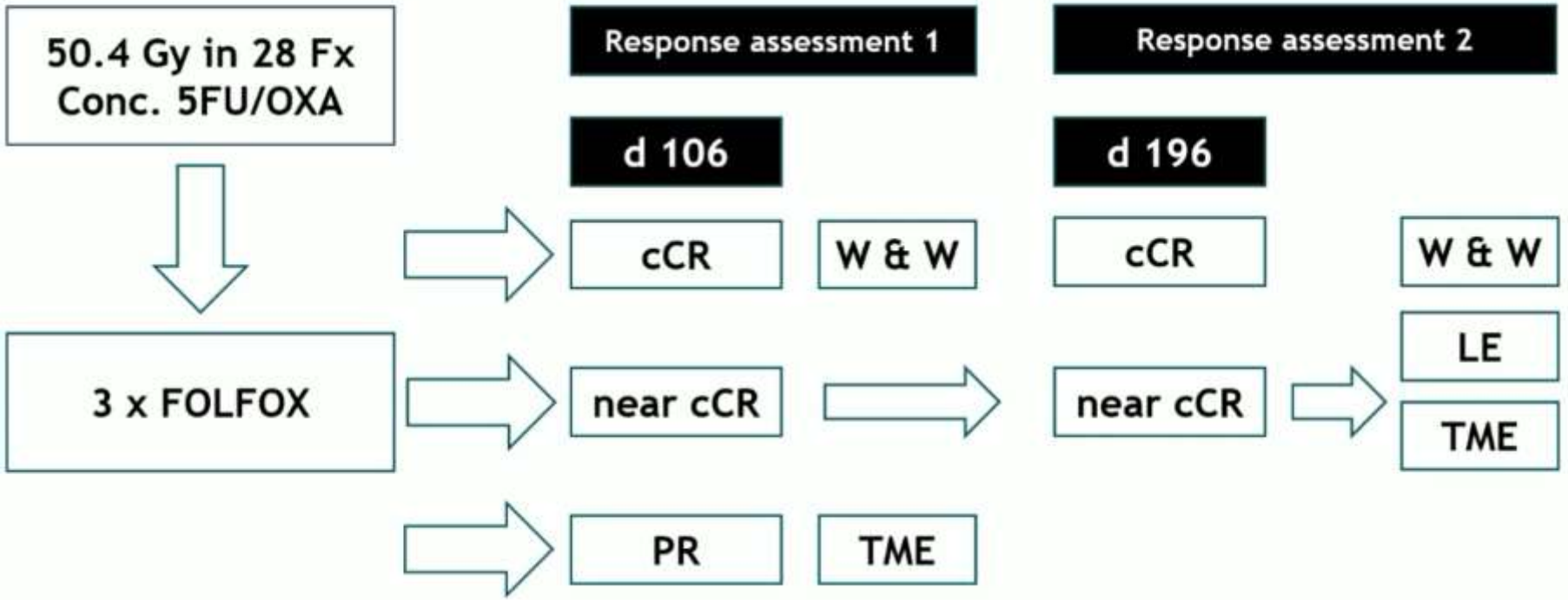
Cihan Gani
University Hospital Tübingen

Organ preservation and quality of life after TNT for locally advanced rectal cancer:

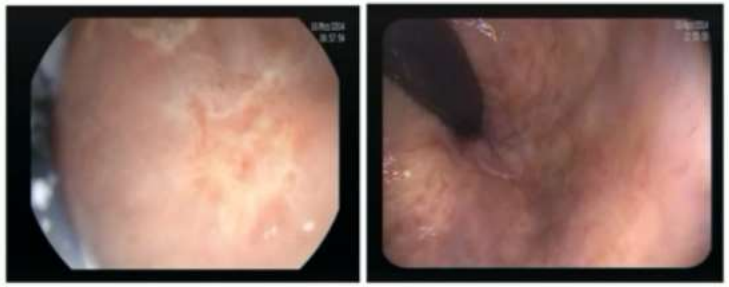
A study of the German Rectal Cancer Study Group (CAO/ARO/AIO-16)

ESTRO Vienna – May 5th 2025

Methods - Study flowchart



Examples for a clinical complete response:



Examples for a near clinical complete response:

Examples for residual tumor:

Methods

- **Single arm multicenter phase II trial** conducted at 4 centers in Germany (Tübingen, Frankfurt, Würzburg, Erlangen).
- **Primary endpoint: clinical complete response rate** on d106/196.
  Simon's optimal 2 stage design
  Goal: cCR rate 20% - 89 patients needed.
- Patients with **cT1-cT2 cN+** or **any cT3 tumor** of the mid and distal rectum were eligable (T4 excluded!)

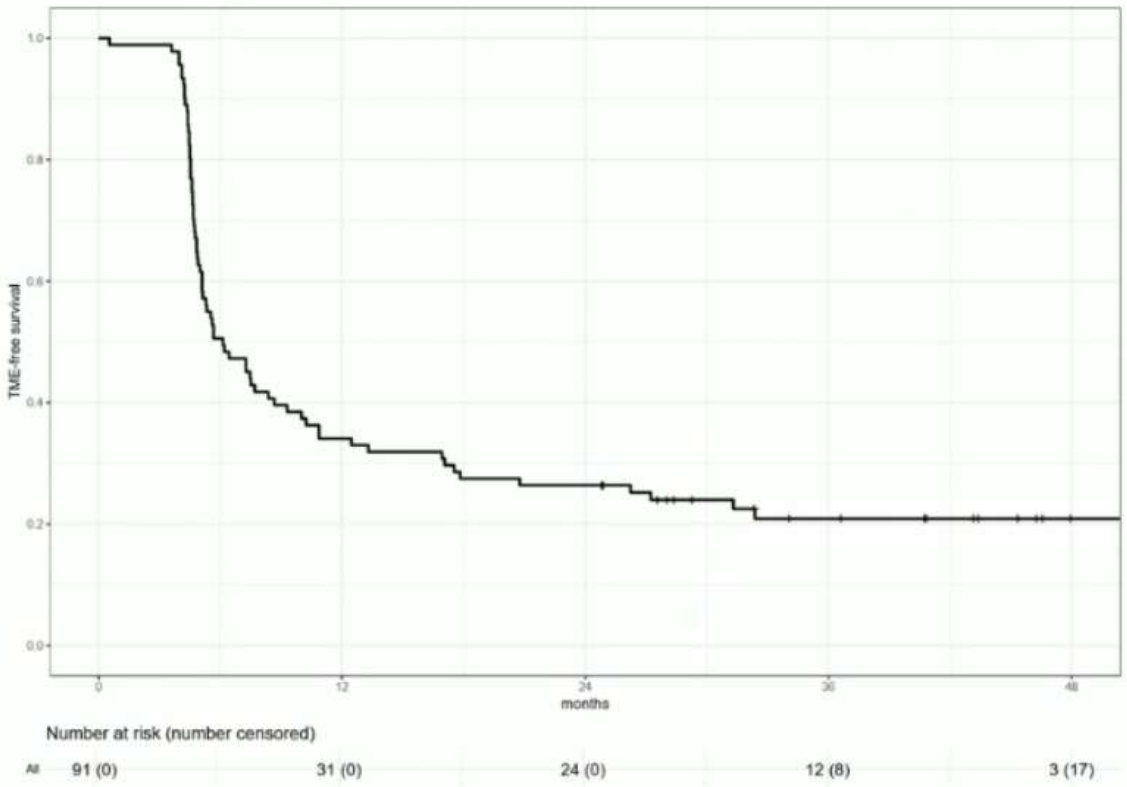
Results – Cohort

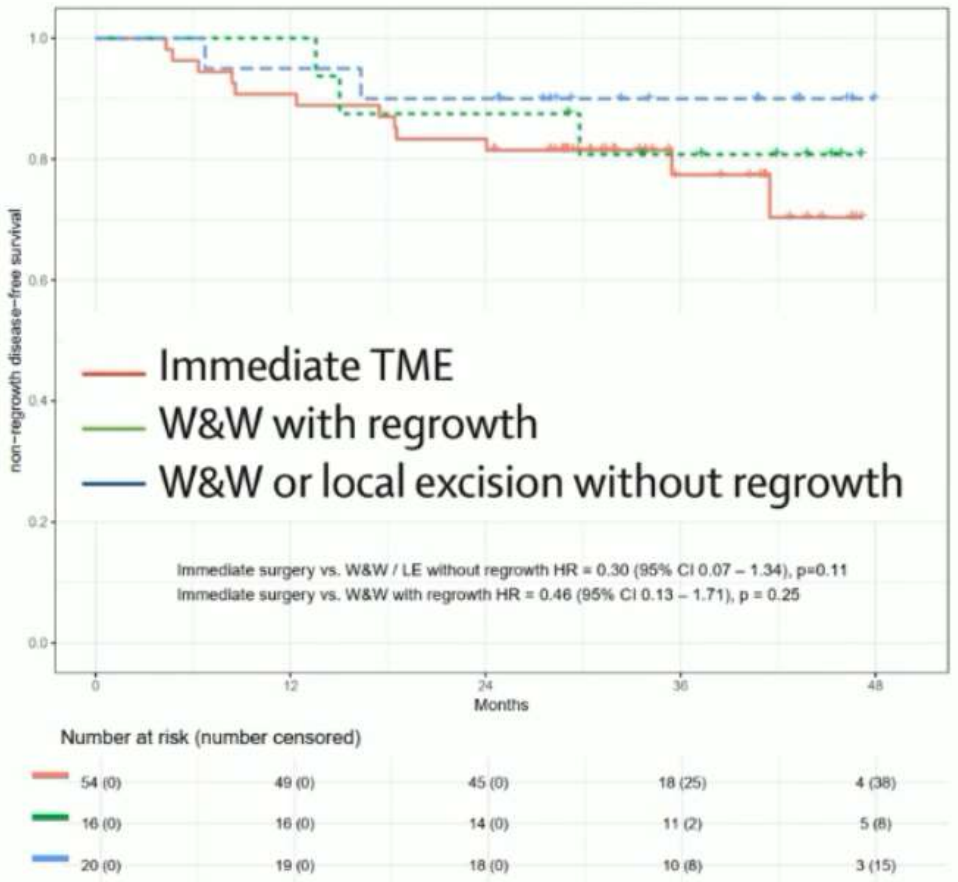
- 91 patients recruited between 2018 and 2020

		n	%
T-Stage	cTx	1	1%
	cT2	5	5%
	cT3a	28	31%
	cT3b	27	30%
	cT3c	24	26%
	cT3d	6	7%
MRF-status	MRF+	51	56%
	MRF-	38	42%
EMVI	EMVI negative	62	68%
	EMVI (minor vessels)	23	25%
	EMVI (large vessels)	2	2%
N-Stage	cN0	12	13%
	cN1	34	37%
	cN2	44	48%
	cNx	1	1%

Results - events during follow-up (median 39 months)

- During follow-up 16 / 36 patients had local regrowth (all intraluminal)
- R0 salvage surgery in all instances

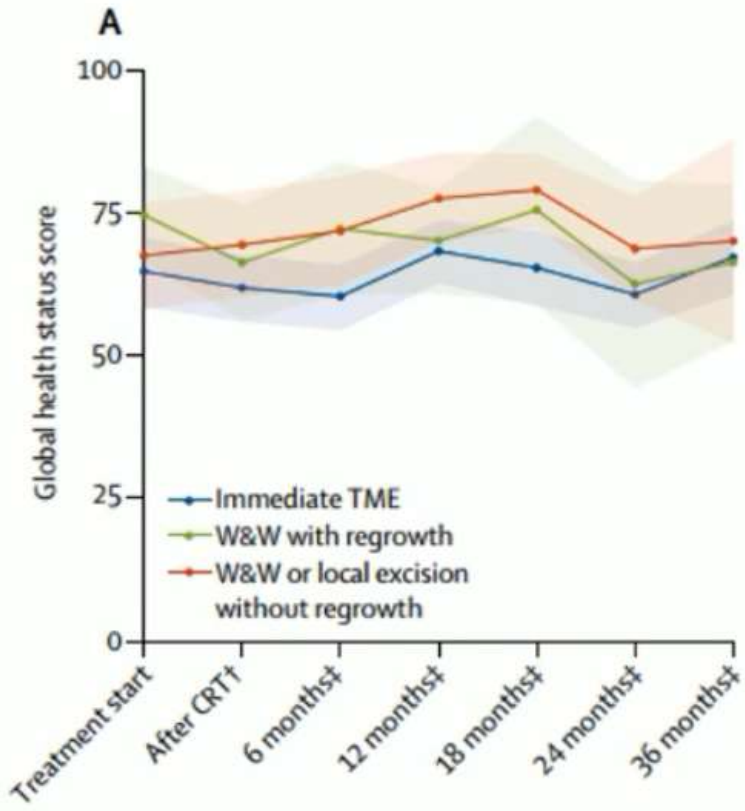




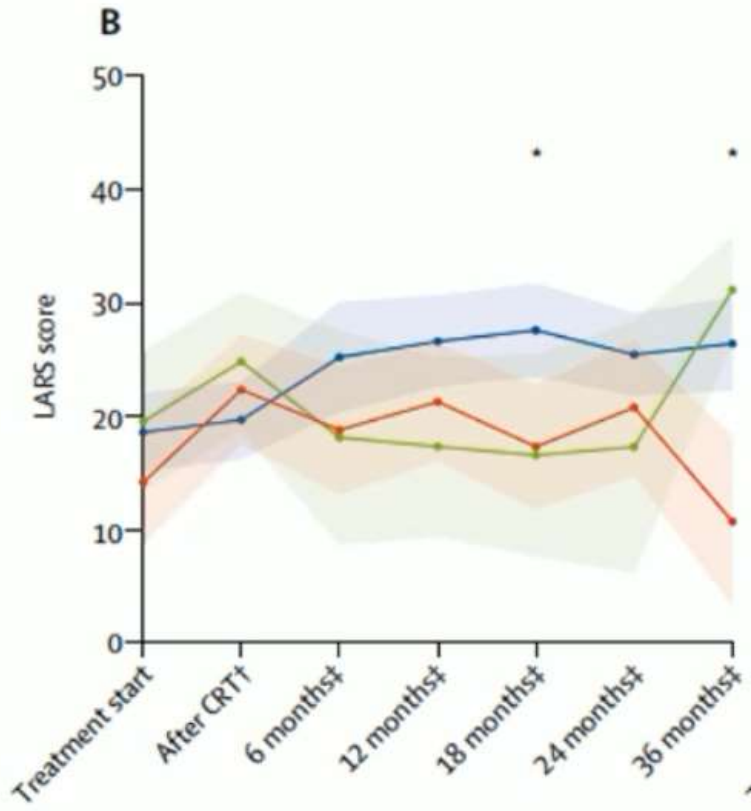
3y- TME-free survival: 21%

Results - Quality of life and organ function

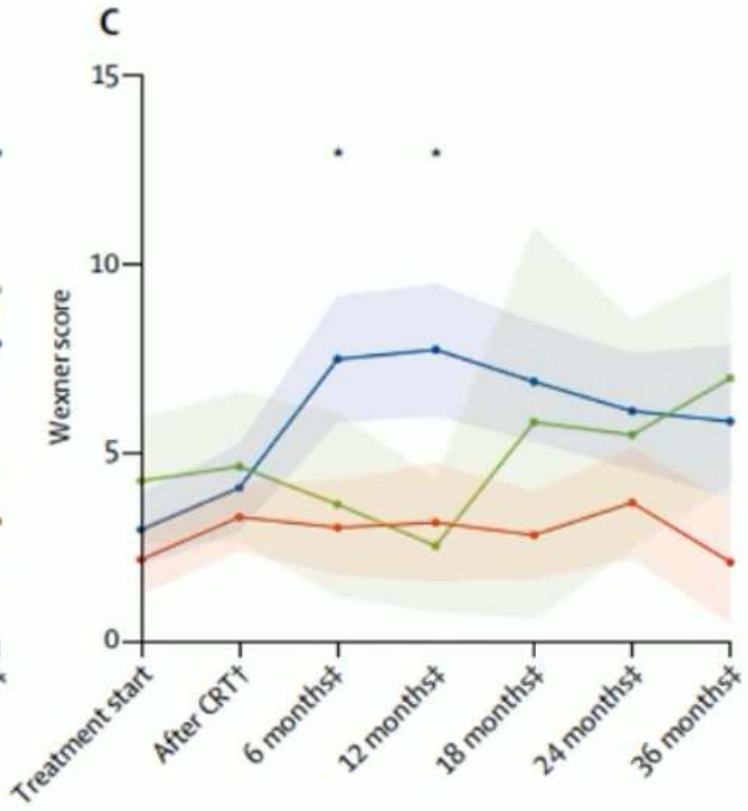
Global health



LARS score



Incontinence



Conclusion

- Les patients dont l'organe a été préservé avec succès ont une fonction rectale supérieure à celle des patients ayant subi une TME.

- La régression tumorale peut prendre du temps, comme en témoigne le fait qu'environ 2/3 des patients obtiennent une CCR après une deuxième évaluation de la réponse après une cCR initiale quasi complète.

- Les patients ayant eu une repousse locale et une chirurgie de sauvetage n'ont pas eu de résultats inférieurs en termes de survie sans maladie (DFS) par rapport aux patients ayant subi une chirurgie TME immédiate.

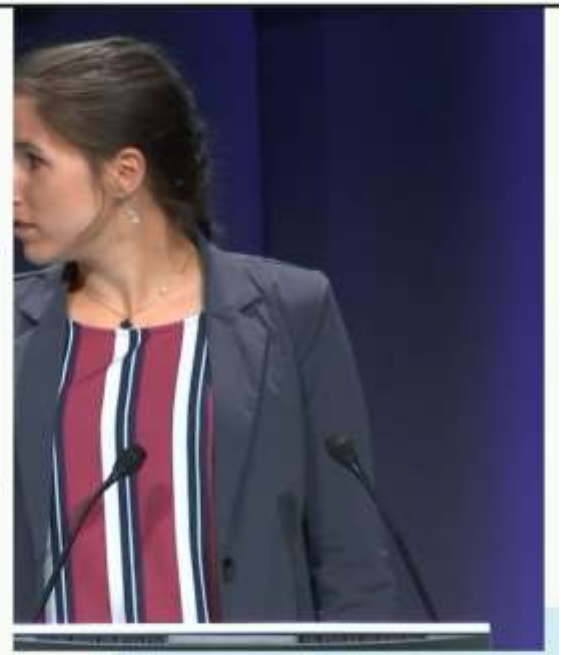
Conclusion - What we still don‘t know

- TME-free survival in CAO/ARO/AIO-16 (21%) is lower than in OPRA (54%)

Extensive biomaterial collection in CAO/ARO/AIO-16 (RNAseq, sequential MRI imaging, liquid biopsies)

Study accepted for publication in Lancet Gastroenterology Hepatology and to appear online on May 8th 2025.

Factors influencing locoregional recurrences in the RAPIDO trial



Ilaria Prata
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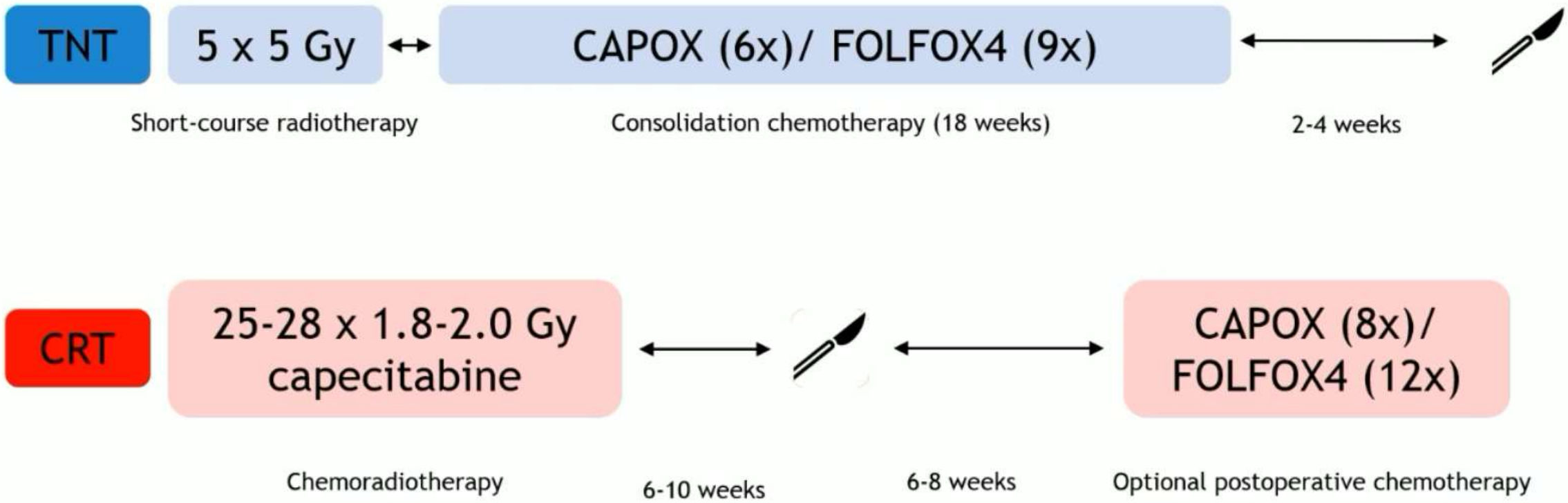
and collaborative investigators.

RAPIDO TRIAL



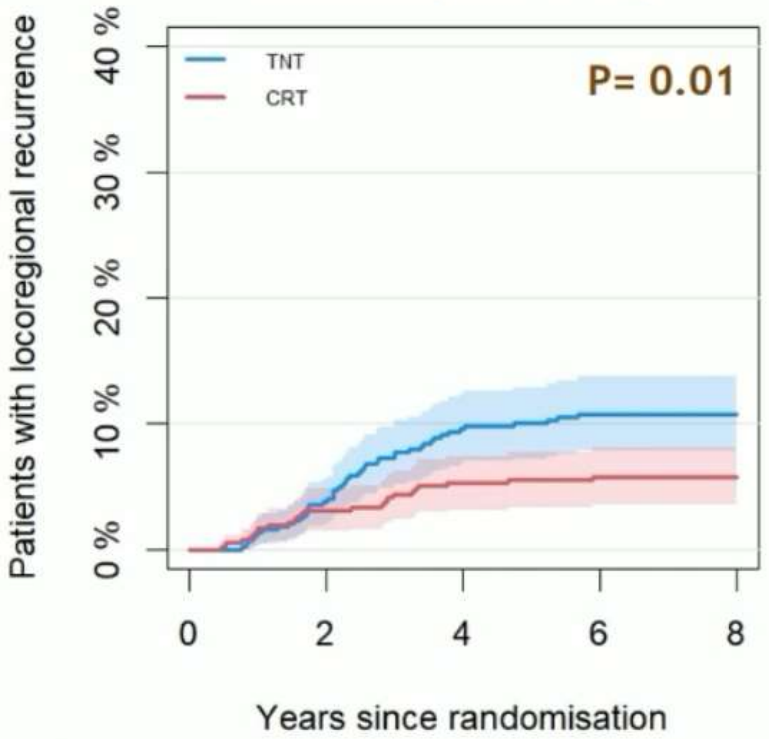
5-YEAR OUTCOMES

Outcome	TNT	CRT	
Disease-related Treatment Failure	28%	34%	P=0.048
Distant metastases	23%	30%	P=0.011
Pathological Complete response	28%	14%	P<0.0001

MORE LOCOREGIONAL RECURRENCES

Locoregional recurrences (LRR)

HR 1.91 (1.17-3.13)



Number at risk

TNT	430	392	350	278	189
CRT	419	391	348	282	153

11% TNT

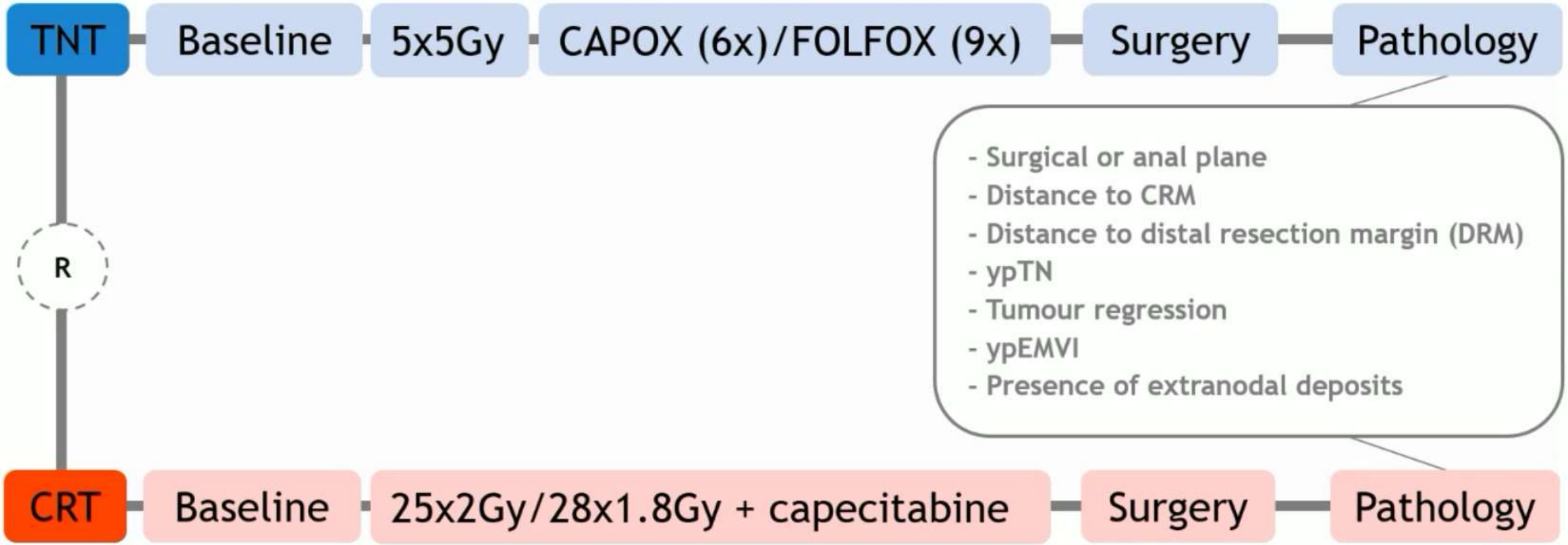
6% CRT

Which factors contributed to the difference in locoregional recurrences rates between TNT and CRT?

Inclusion criteria:
local R0 or R1 surgery

N=829

EVALUATED FACTORS

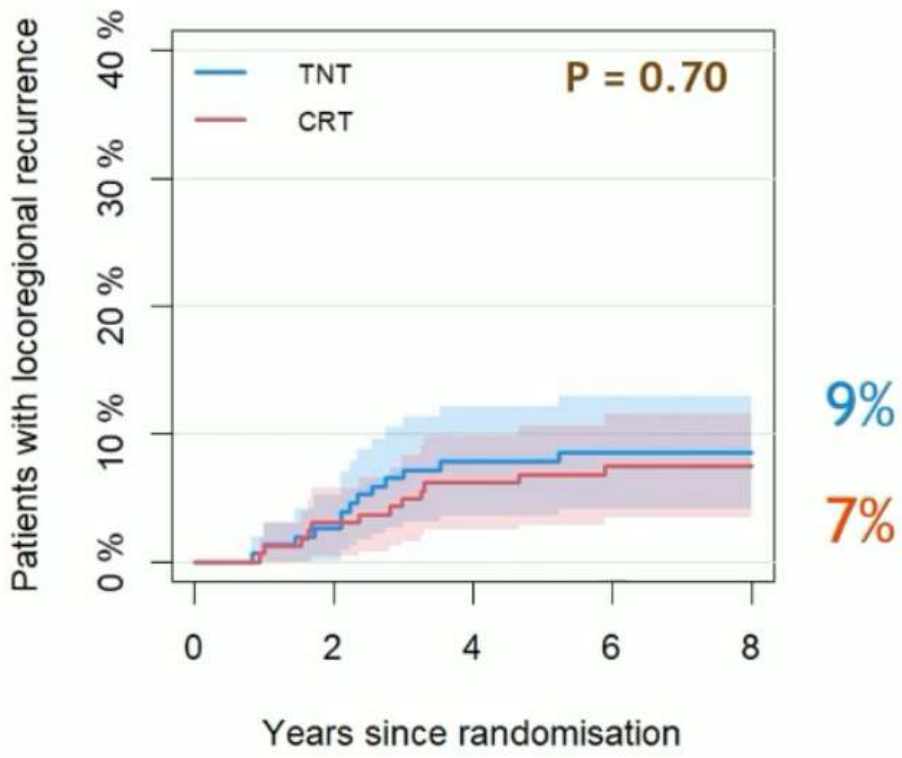


DIFFERENCE AFTER SPHINCTER PRESERVATION

Abdominoperineal resection

N = 316

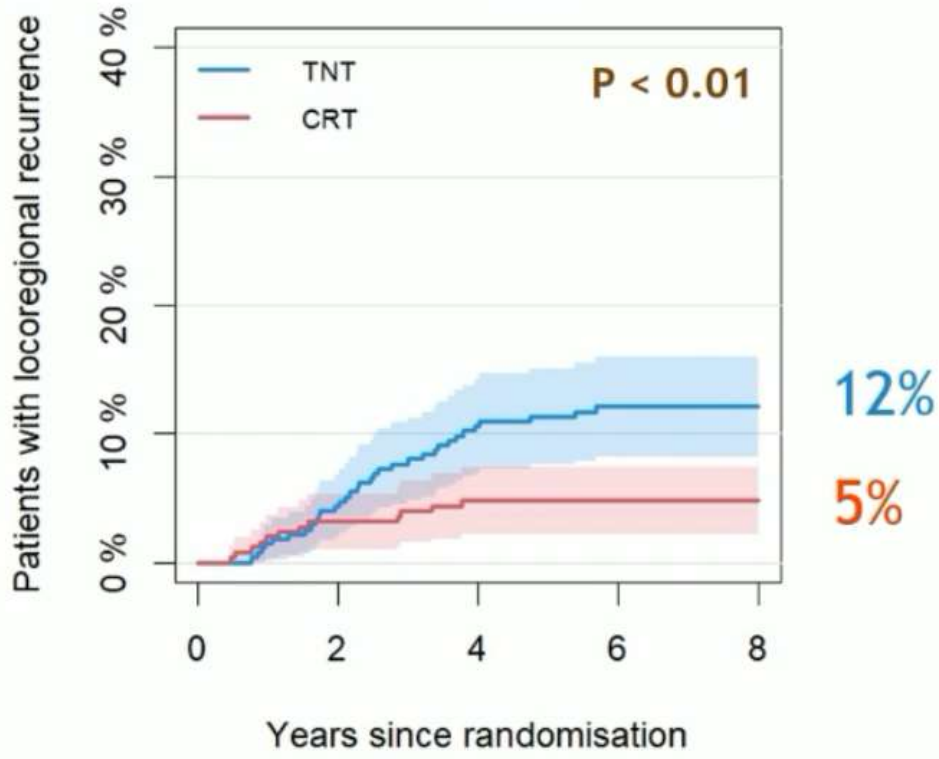
HR 1.17 (0.53-2.56)



Sphincter preserving surgery

N = 528

HR 2.60 (1.34-5.04)

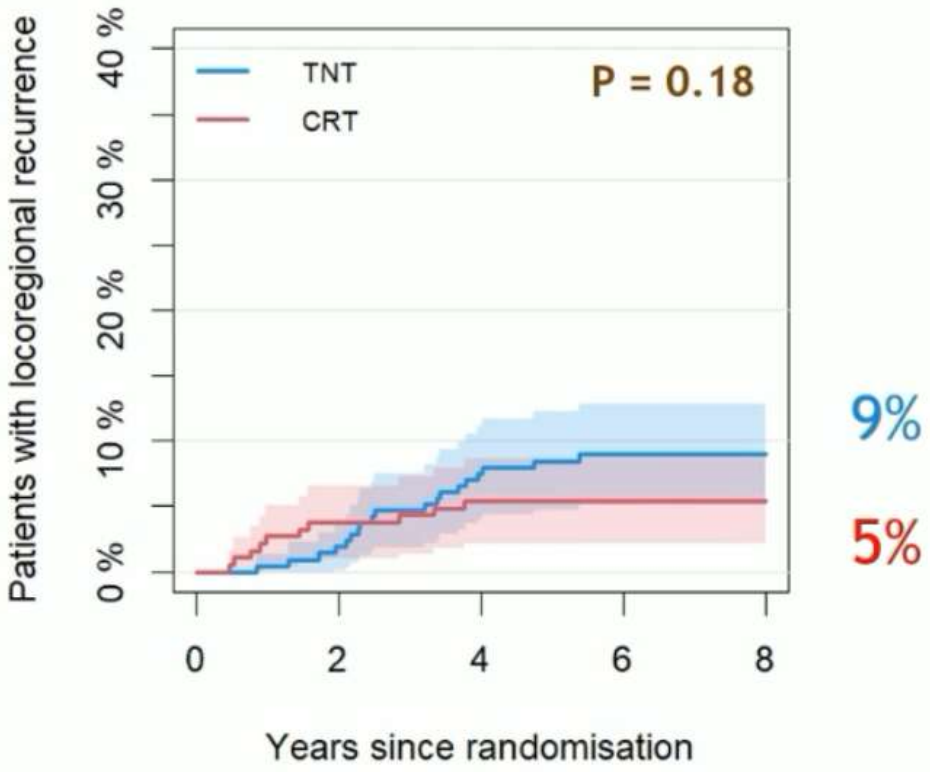


DIFFERENCE WITH DISTAL MARGIN ≤ 10 MM

DRM > 10 mm or pCR

N = 400

HR 1.67 (0.78-3.59)



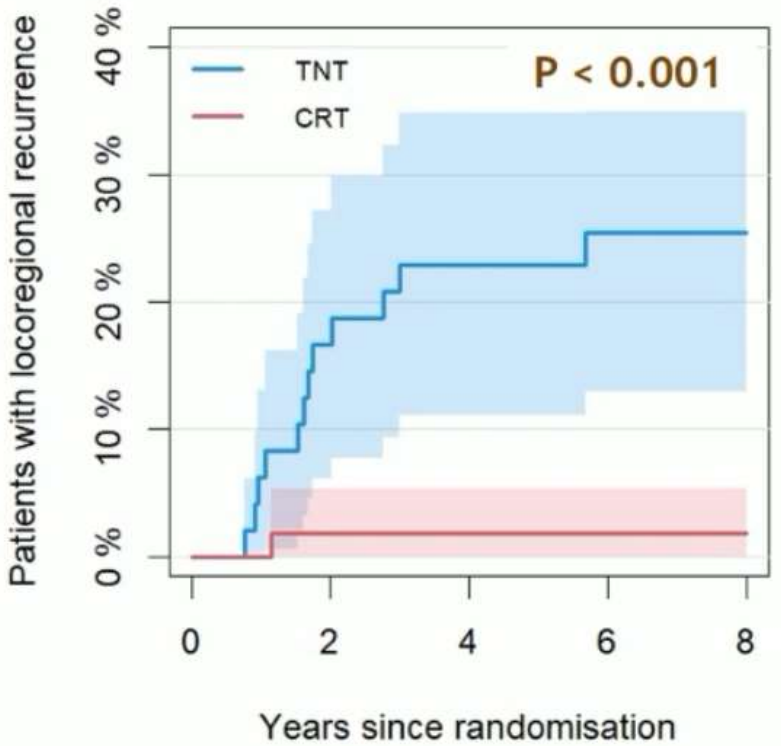
9%

5%

DRM ≤ 10 mm

N = 104

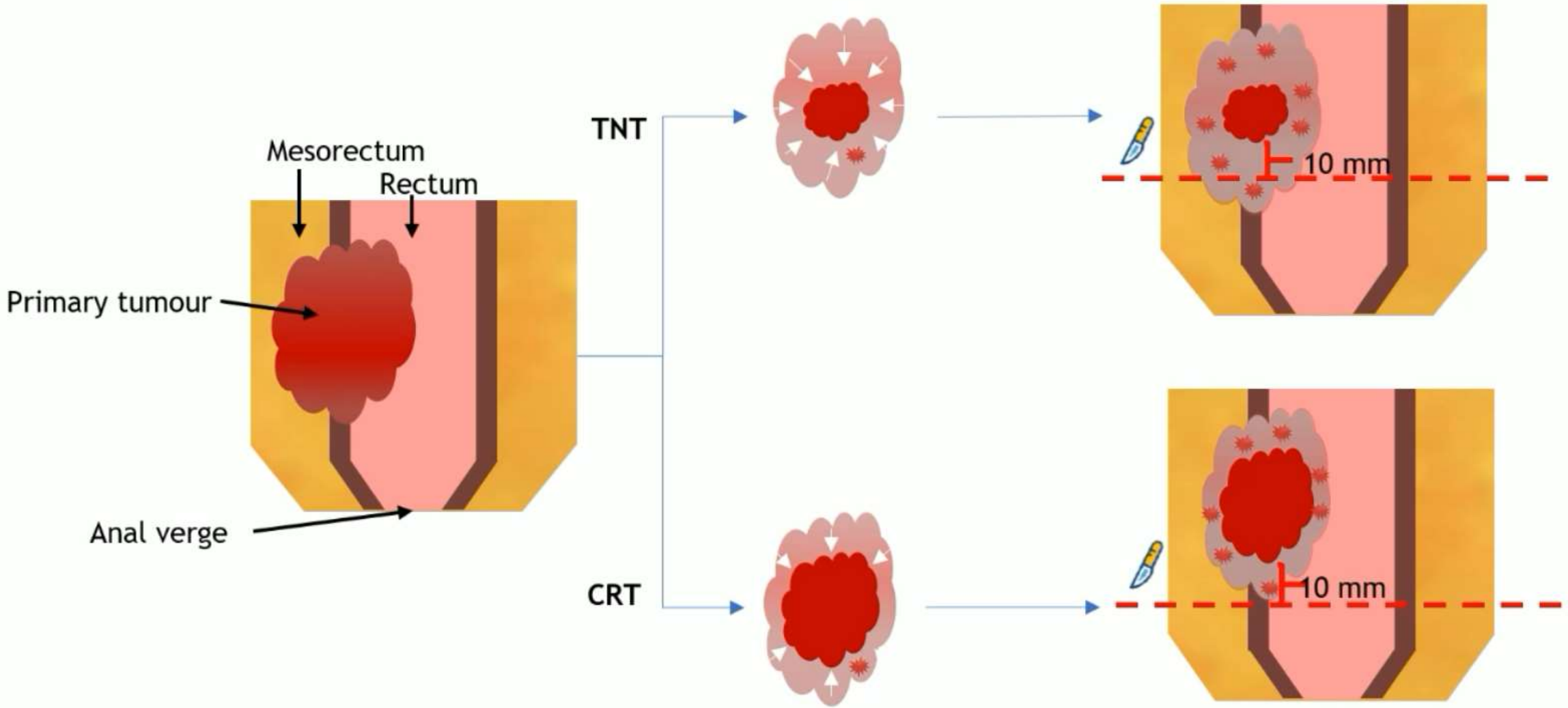
HR 15.51 (2.02 -119.35)



25%

2%

DRM ≤10 MM IS NOT SUFFICIENT AFTER TNT



TAKE HOME MESSAGES

- More locoregional recurrences after sphincter-preserving surgery with TNT
- A distal resection margin of 10 mm might not be sufficient after TNT
- DRM is probably important with all TNT schedules

ESTRO 2025

UNIKLINIK KÖLN

07h00 - 07h40

Strauss 1-2

PANEL DISCUSSION

Rectal cancer is the new anal cancer: Organ preservation in focus

Clinical

Organ preservation in rectal cancer:

For some, or will it be for all?

State-of-the-art and future perspectives

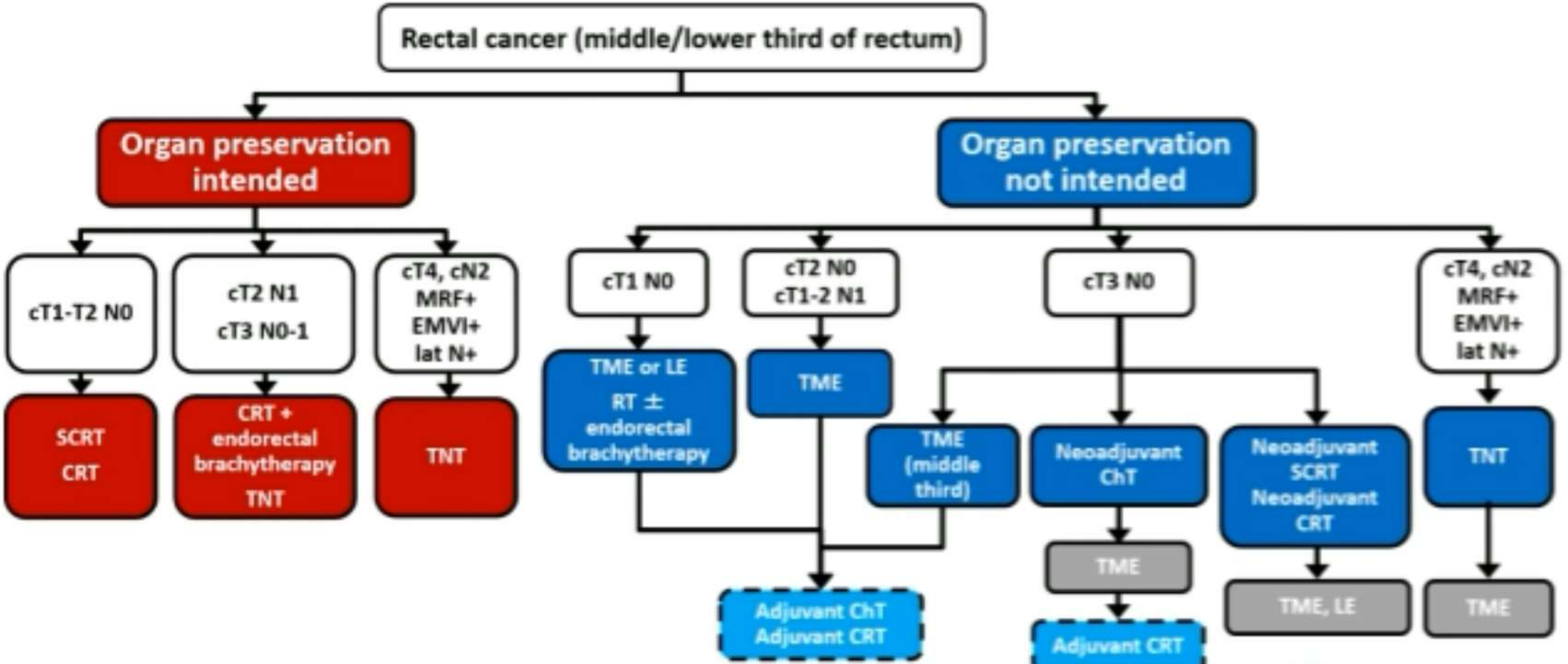
Emmanouil Fokas
Department of Radiotherapy, Cyberknife and Radiation Oncology
University of Cologne

the-art and future p...

Strauss 1-2

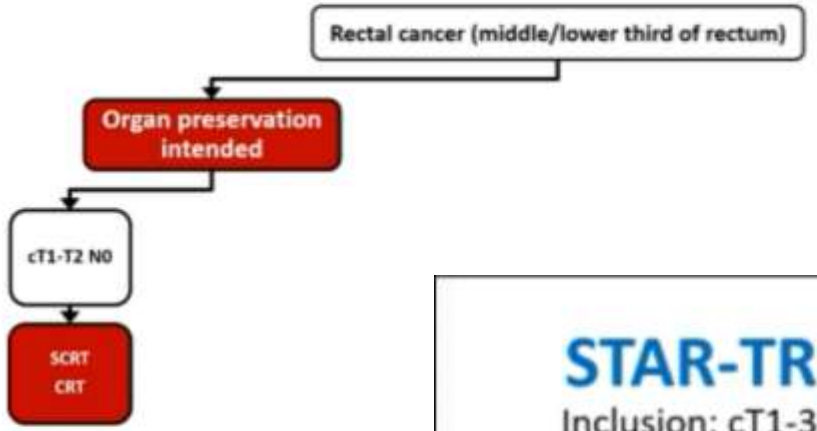
Emmanouil Fokas
Germany

New oncology guidelines - new era



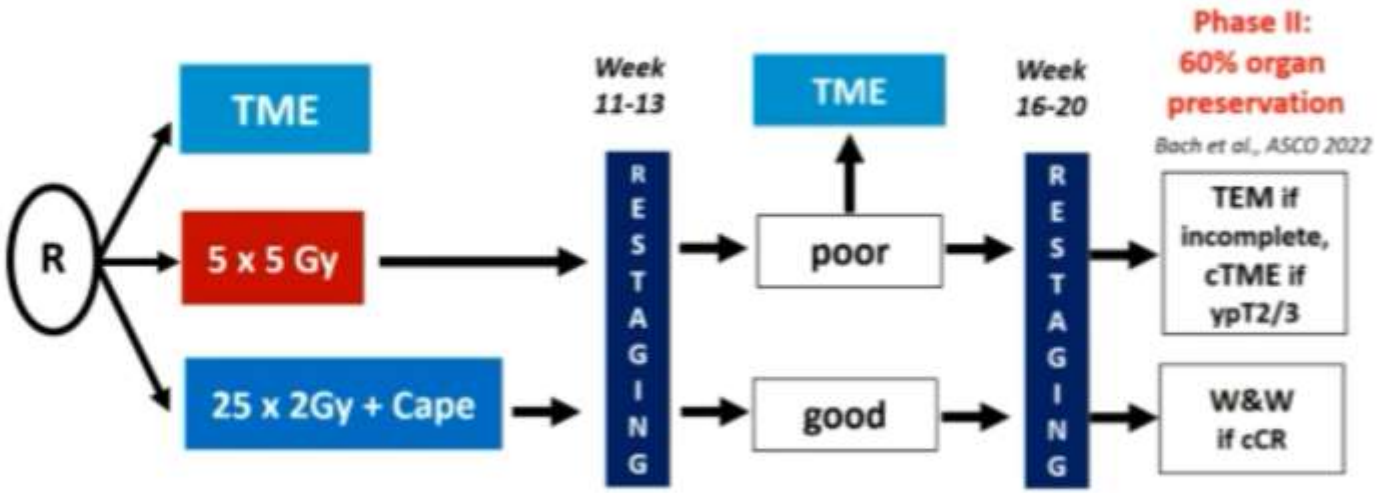
*Based on Onkopedia (German) guidelines

Treatment options for organ preservation



STAR-TREC phase II/III trial

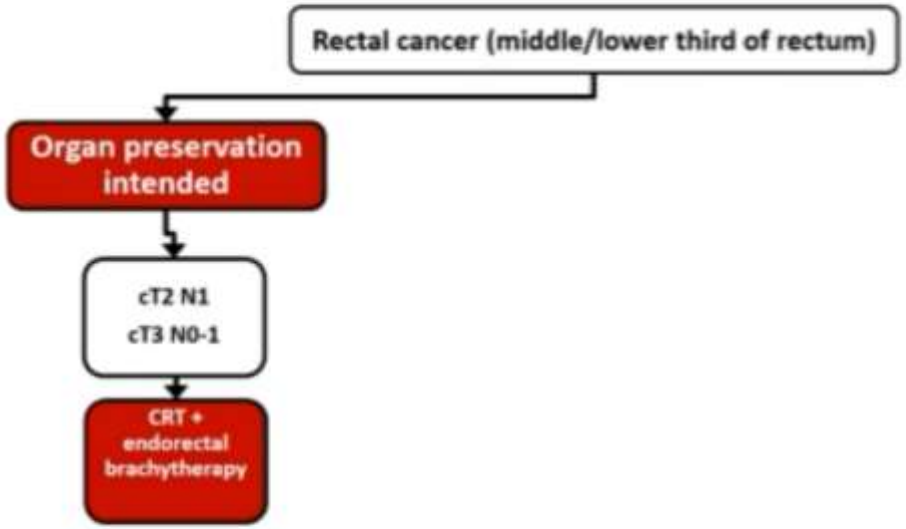
Inclusion: cT1-3b N0M0, < 4 cm



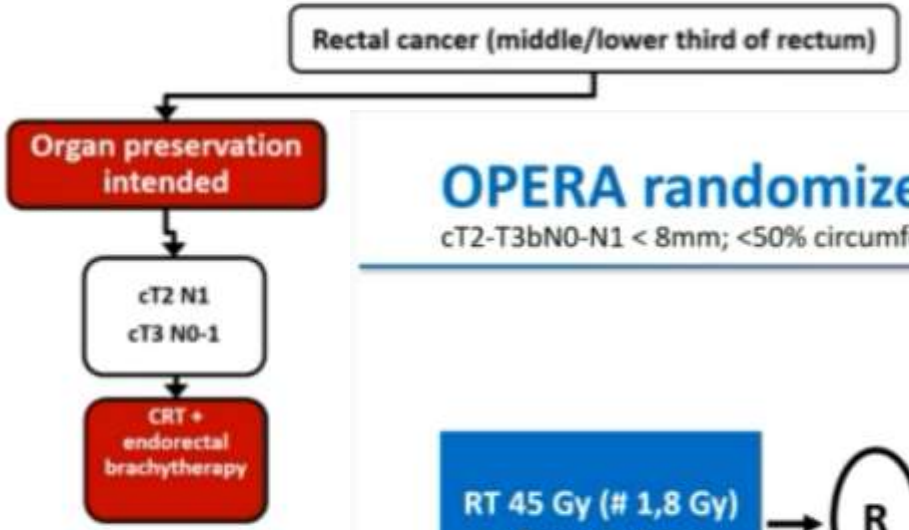
Primary endpoint: **recruitment (n=120, phase II), organ preservation (n=380, phase III; TME arm omitted)**

Marijnen et al. ESTRO2025 - Top clinical trials
Sunday, May 04, 11:40 - 12:45, Plenary Hall

Treatment options for organ preservation

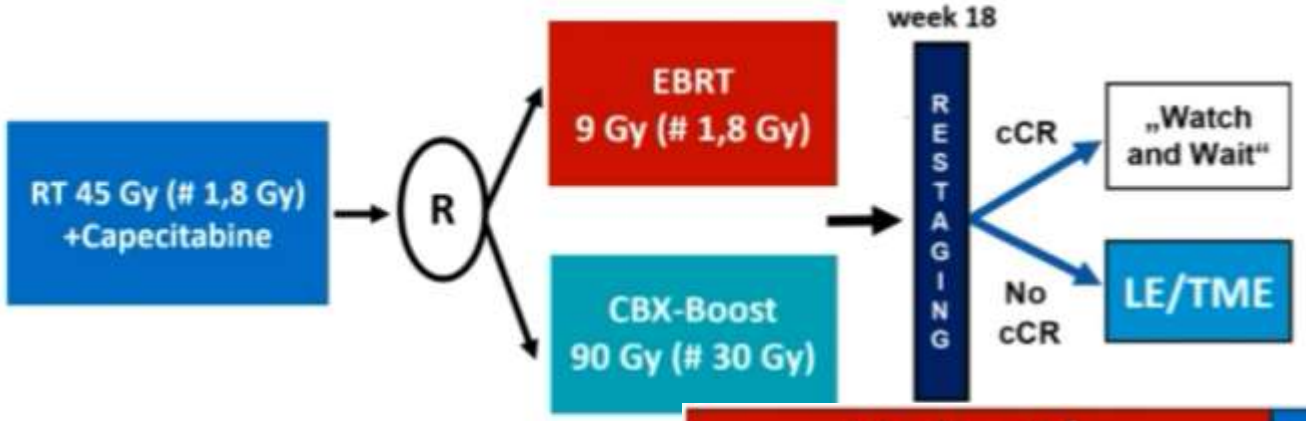


Treatment options for organ preservation



OPERA randomized phase III trial

cT2-T3bN0-N1 < 8mm; <50% circumference, <5 cm, < 10 cm from AV

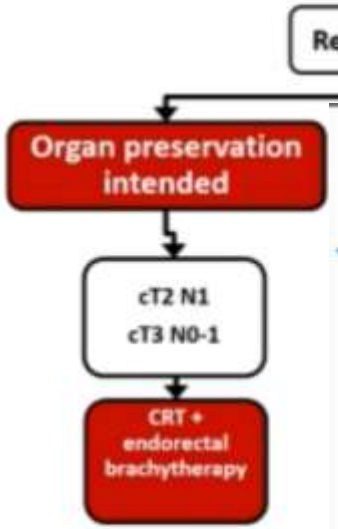


Primary endpoint: Organ preservation

CXB: Papillon 50 KV contact brachytherapy (3x30 Gy, ,

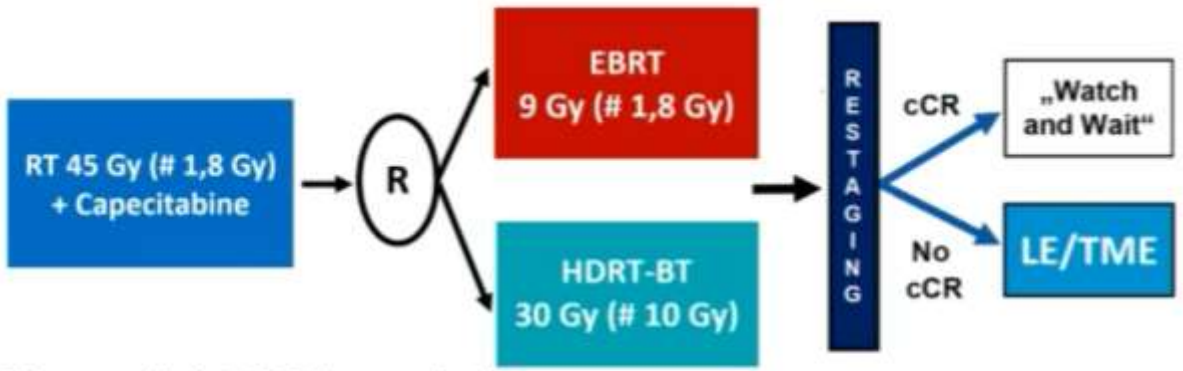
Median F/u: 61.1 months	CRT+EBRT N=69	CRT+CBX N=72	p-value
5-year organ preservation (all pts)	56%	79%	0.004
5-year organ preservation(T<3cm)	54%	93%	0.006
Acute proctitis Grade II-III	6%	13%	-
Poor LARS (incontinence score >30)	24%	17%	NS
Rectal bleeding (telangiectasia)	17%	64%	<0.001

Treatment options for organ preservation



MORPHEUS randomized phase III trial

cT2-T3bN0-N1 < 8mm; <50% circumference, <5 cm, < 10 cm from AV



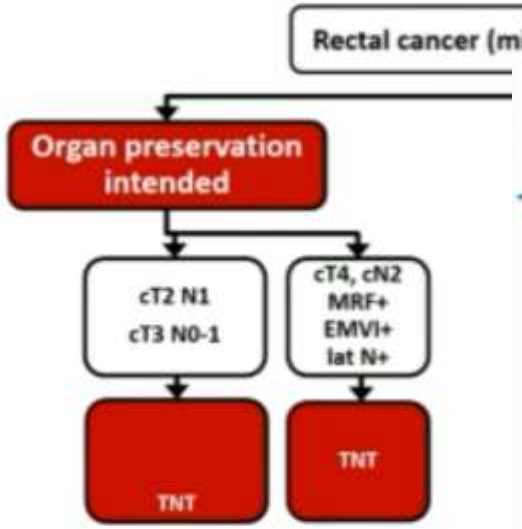
Primary endpoint: TME-free survival

HDR-BT: conventional afterloading brachytherapy (3x10 Gy

Median F/u: 26 months	CRT+EBRT N=20	CRT+Brachy N=20	p-value
2-year TME-free Survival	40%	85%	0.006
cCR	10/20 (50%)	18/20 (90%)	-
Local regrowth at 2 years	3/10 (30%)	3/18 (17%)	-
G3 proctitis	-	10%	-

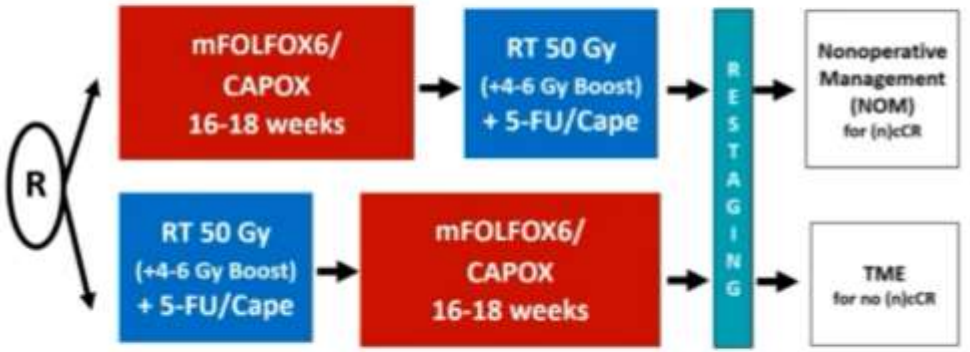
Vuong T et al., Cancers 2023

TNT when organ preservation is the main aim



OPRA phase II

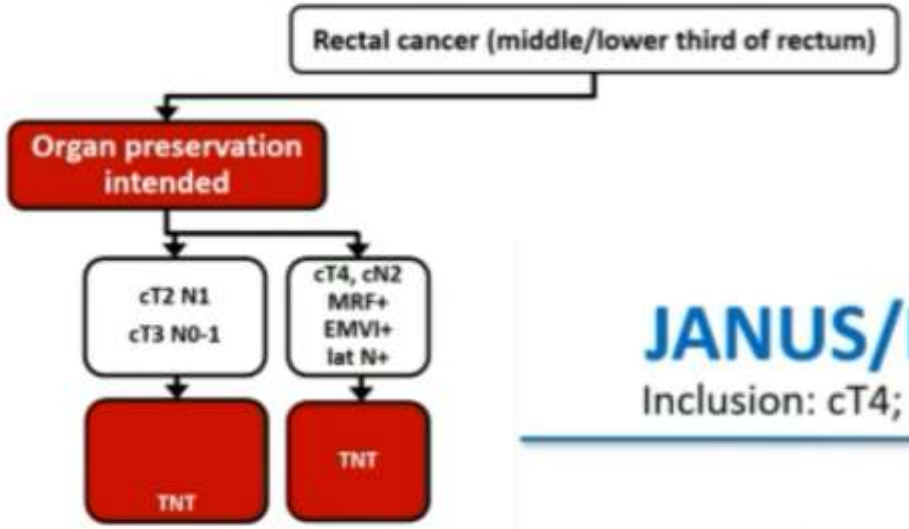
UICC stage II and III, distal RC (requiring APR or coloanal anastomosis)



Primary Endpoint: **3y-DFS,** n=322

5-year F/U	Induction chemo/CRT (N=158)	CRT/consolid chemo (N=166)	p-value
DFS	71 %	69 %	0.68
TME-free survival	39%	54%	0.01
G3/4 toxicity	34% / 11%	31% / 7%	0.18
DFS	TME after restaging: 64%	TME after regrowth: 64%	0.94

TNT when organ preservation is the main aim



JANUS/NRG GI010 phase II/III

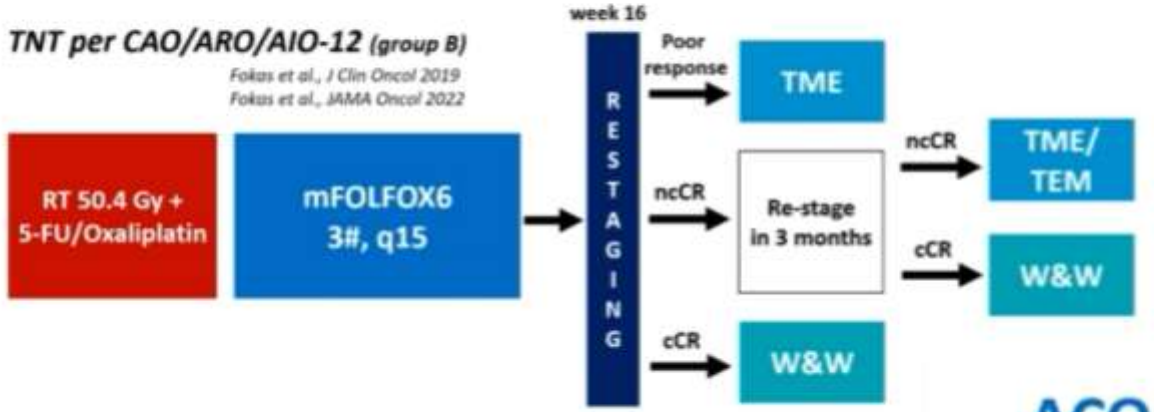
Inclusion: cT4; N+; any T3N0 requiring APR

Primary Endpoints: phase II **cCR (n=312)**; phase III **organ preservation-adapted DFS (n=700)**

NCT05610163

CAO/ARO/AIO-16 phase II

Inclusion: MRF+, EMVI+, any cT3 if low rectal third, cT3c/d, N+, mid rectal third



Primary endpoint: **cCR**, n=89

NCT03561142

Gani et al.
Monday, M

ACO/ARO/AIO-18.1 phase III

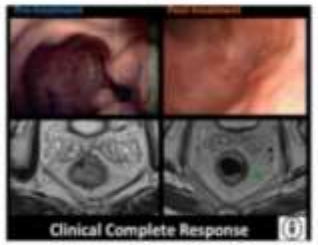
Inclusion: MRF+, EMVI+, any cT3 if low rectal third, cT3c/d, N+, T4 mid rectal third

Primary endpoint: 3-year organ preservation (OP) rate, N=702
Hypothesis: improvement in 3y-OP rate from **30%** (SCRT - TNT) to **40%** (LCRT - TNT)
Accrual completed September 2023; report scheduled for Q1/2026

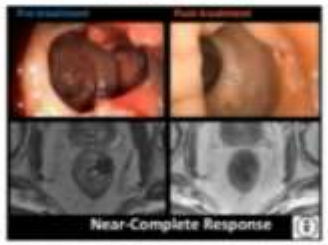
NCT04230759

Definition of tumor response

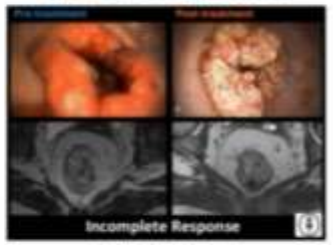
cCR



near cCR



poor response



cCR: clinical complete remission
ncCR: near cCR

Smith et al., BMC Cancer 2015
Martens et al. JNCI 2021
Fokas et al., Nature Rev Clin Oncol 2021

Follow-up methods and intervals for organ preservation

Year	Serum carcino-embryonic antigen	DRE	Endoscopy	Pelvic MRI	Chest and/or abdominal CT
1	4 months	3–4 months	3–4 months	3–4 months	6 months
2	4 months	3–4 months	3–4 months	3–4 months	Annually
3	4 months	6 months	6 months	6 months	Annually
4	6 months	6 months	6 months	6 months	Annually
5	6 months	6 months	6 months	6 months	Annually

Patients should be informed in advance by the physician about the surveillance programme for organ preservation strategies

Fokas et al., Nat Rev Clin Oncol 2021

Benefits of organ preservation compared to surgery

- high priority for patients
- avoidance of colostomy (deeply seated tumors)
- better physical and cognitive function
- better physical and emotional resilience
- better global state of health
- fewer problems with bowel movements
- fewer problems with sexual and urinary function

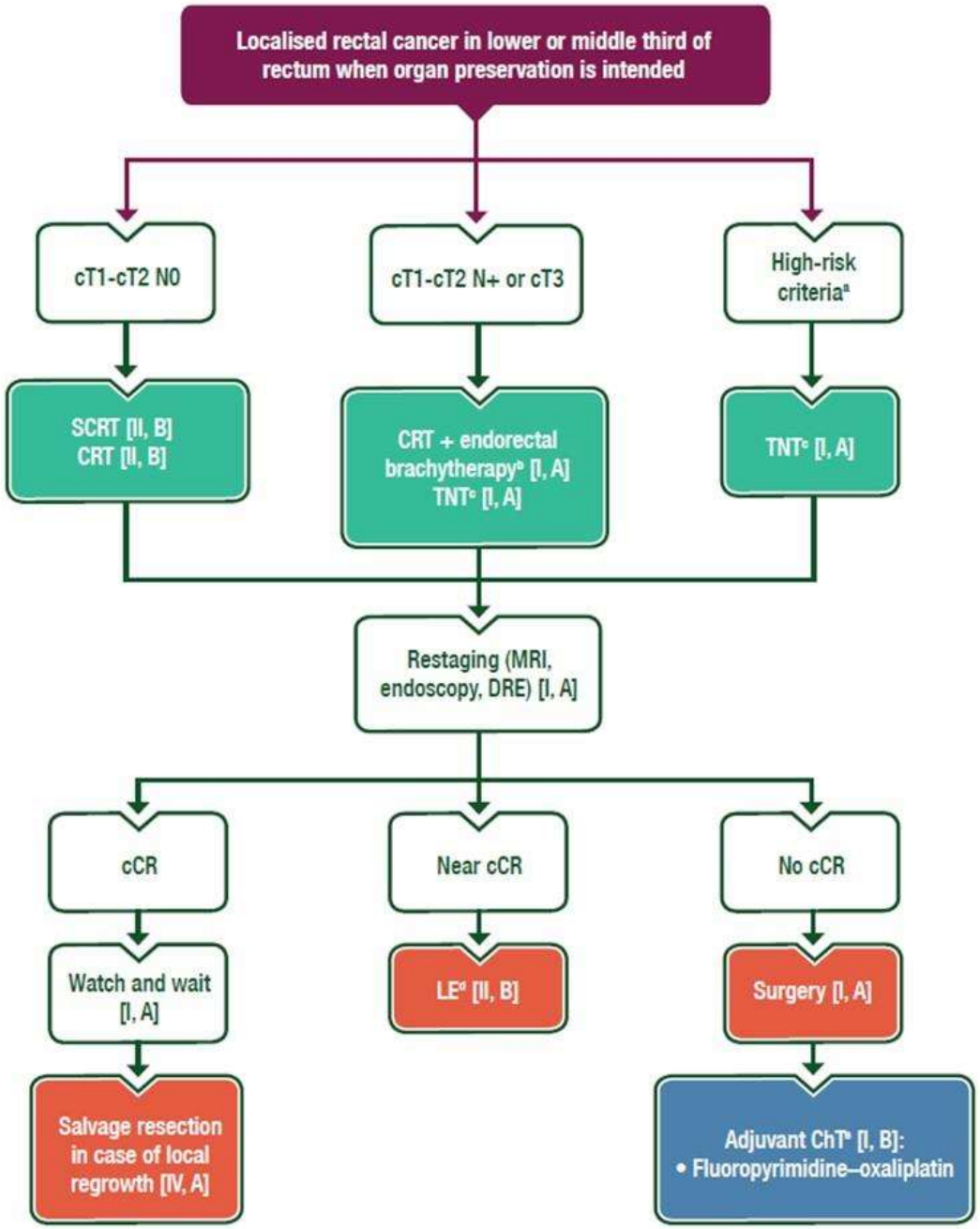
Hupkens B et al., Dis Colon Rectum 2017
Van de Sande M et al., Radiother Oncol 2019

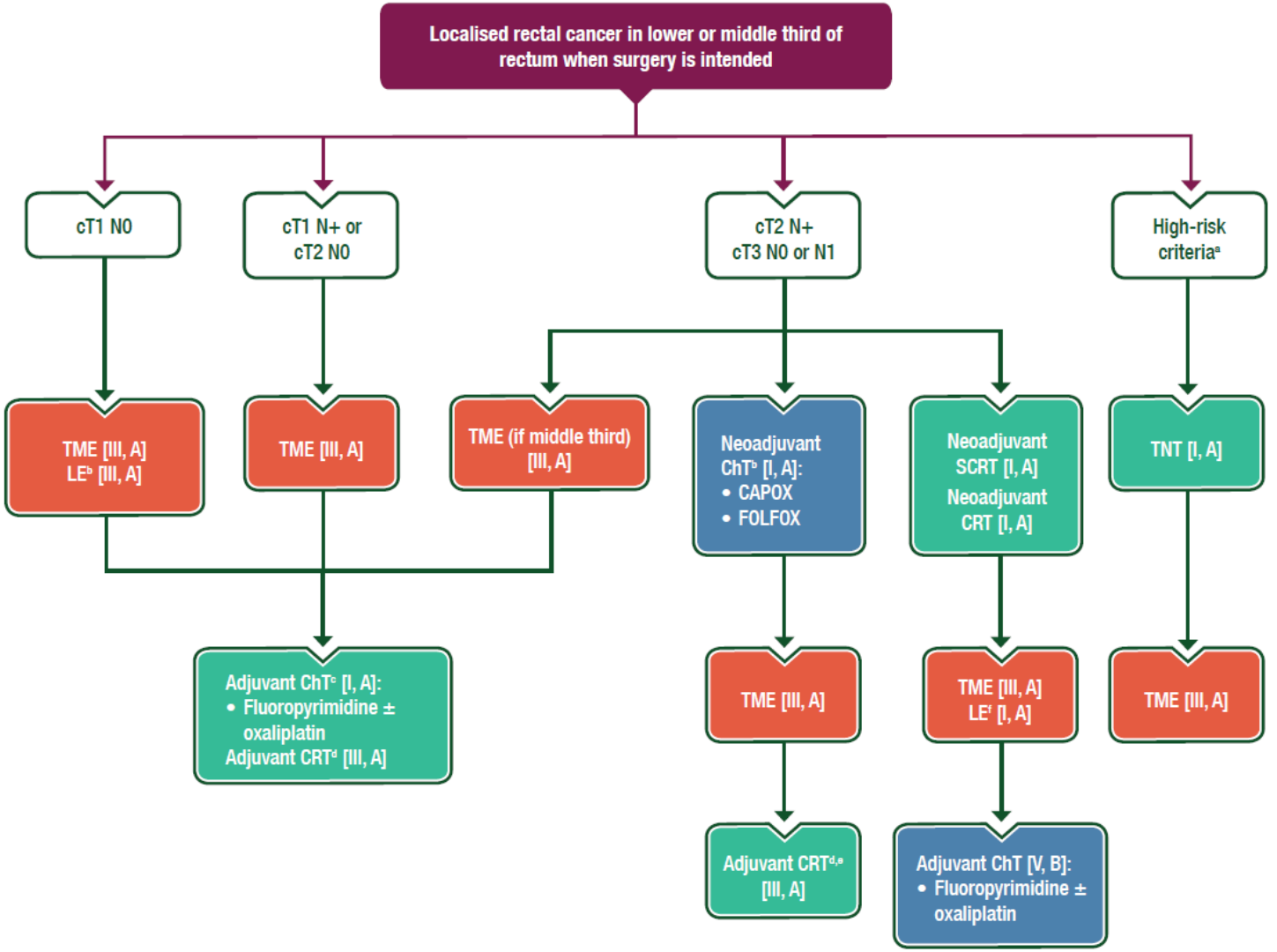
Gani C et al., Front Oncol 2019
Van der Valk et al., EJSO 2019

Bach S et al., Lancet Gastro Hep 2021
Fokas et al., Nat Rev Clin Oncol 2021

Préservation rectal: Conclusion

- La prise en charge du cancer du rectum s'est orientée vers la préservation d'organe : nouvelle ère, nouvelles lignes directrices ; **nécessité de développer une expertise nationale**
- Quelques points clés :
  - IRM de haute qualité pour une stratification précise du traitement basée sur le risque à l'inclusion
  - définition de la réponse tumorale ;
  - programme de surveillance intensif
- Le traitement multidisciplinaire intégrant la RT a placé la barre très haut en termes de taux de préservation des organes au stade précoce/intermédiaire
  - (par exemple, essais OPERA, STAR-TREC : 60-80 %)
  - et au stade avancé de la maladie (par exemple, essai OPRA : 50 %)
- La prise de décision partagée s'imposera progressivement comme un élément clé, en raison de la complexité accrue des stratégies thérapeutiques dans le cancer du rectum.


Localised rectal cancer in lower or middle third of rectum when organ preservation is intended
cT1-cT2 N0
cT1-cT2 N+ or cT3
High-risk criteria[a]
SCRT [II, B]
CRT [II, B]
CRT + endorectal brachytherapy[b] [I, A]
TNT[c] [I, A]
TNT[c] [I, A]
Restaging (MRI, endoscopy, DRE) [I, A]
cCR
Near cCR
No cCR
Watch and wait [I, A]
LE[d] [II, B]
Surgery [I, A]
Salvage resection in case of local regrowth [IV, A]
Adjuvant ChT[a] [I, B]:
• Fluoropyrimidine–oxaliplatin


Localised rectal cancer in lower or middle third of rectum when surgery is intended
cT1 N0
cT1 N+ or cT2 N0
cT2 N+ cT3 N0 or N1
High-risk criteria[a]
TME [III, A]
LE[b] [III, A]
TME [III, A]
TME (if middle third) [III, A]
Neoadjuvant ChT[b] [I, A]:
• CAPOX
• FOLFOX
Neoadjuvant SCRT [I, A]
Neoadjuvant CRT [I, A]
TNT [I, A]
Adjuvant ChT[c] [I, A]:
• Fluoropyrimidine ± oxaliplatin
Adjuvant CRT[d] [III, A]
TME [III, A]
TME [III, A]
LE[f] [I, A]
TME [III, A]
Adjuvant CRT[d,e] [III, A]
Adjuvant ChT [V, B]:
• Fluoropyrimidine ± oxaliplatin

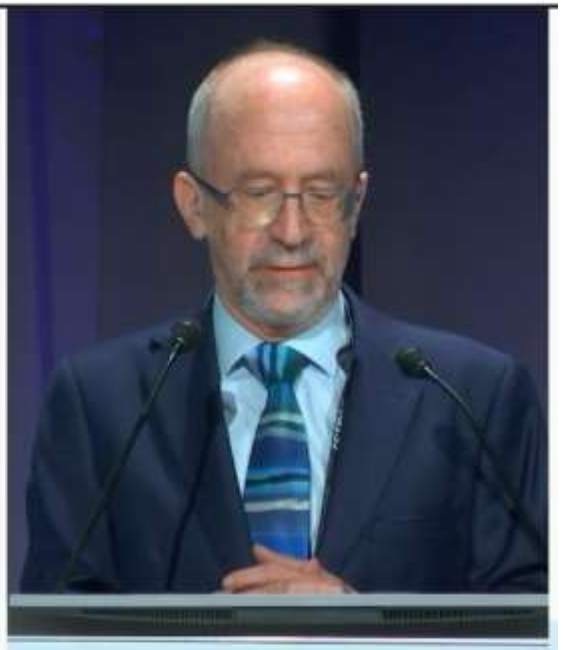

ESMO
ANNALS OF ONCOLOGY
DRIVING INNOVATION IN ONCOLOGY

PLATO ACT 4

Long term results of a randomised trial evaluating reduced dose and standard dose chemoradiotherapy in early-stage anal cancer

Sebag-Montefiore D[1], Harrison M[2], Gilbert A[1], Abbott N[3], Berkman L[4], Copeland J[1], Gilbert D[5], Gaul C[1], Glynne-Jones R[2], Goh V[6], Hawkins M[7], Muirhead R[8], Rao S[9], Renehan A[10], Ruddock S[1], Smith A[1], Webster J[1], Brown S[1], Adams R[11]
on behalf the PLATO Trial Management Group

[1]**University of Leeds**, [2]Mount Vernon Hospital, [3]RTTQA Group, [4]Patient advocate
[5]Royal Sussex County Hospital, [6]Kings College London, [7]University College London, [8]Churchill Hospital Oxford,
[9]Institute of Cancer Research, Royal Marsden London, [10]University of Manchester, [11]Cardiff University



David Sebag-Montefore
United Kingdom

ACT4 Study Design

T1,T2<4cm N0/X
162 required, 163 randomised **mITT**
population n=160

Minimisation factors
T-Stage (T1, T2), N-stage (N0, NX), Sex (M,F)
HIV Status (Positive, negative),Randomising Centre

Randomisation
2 : 1

rd-IMRT

Reduced dose IMRT
n=105
GTV - 41.4Gy in 23F
CTV - 34.5Gy in 23F

sd-IMRT

Standard dose IMRT
n=55
GTV - 50.4Gy in 28F
CTV - 40Gy in 28F

Chemotherapy: MMC IV 12mg/m^2 D1 Capecitabine 825mg /m^2 BD PO RT days
Radiotherapy: IMRT/VMAT, Trial specific guidelines, RTTQA

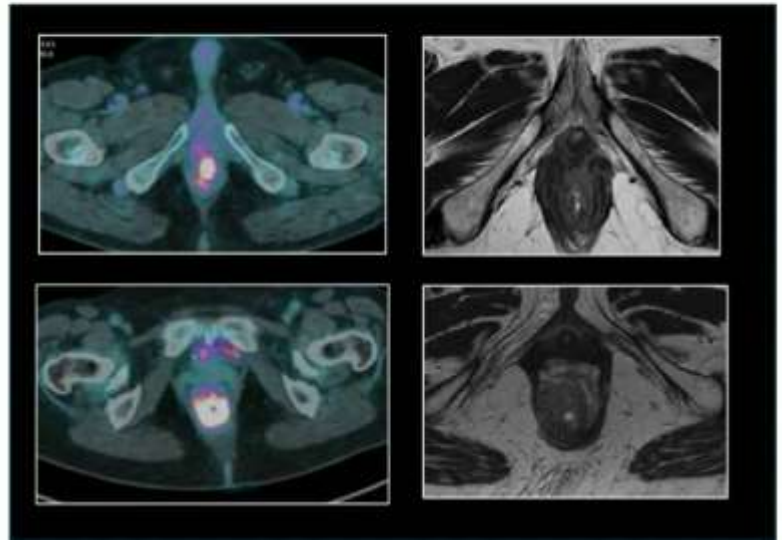
STUDY AIM

to determine if rd-IMRT results in an acceptably **low rate of LRF** and **reduced toxicity**

rd-IMRT

lower limit of 90% CI >80% for 3-year LRF free rate with rd-IMRT

T1,T2<4cm N0/X



Patient Characteristics

	Standard dose IMRT N (%) n=55		Reduced dose IMRT N (%) N=105		Total N (%) n=160	
Gender						
Male	14	25.5%	29	27.6%	43	26.9%
Female	41	74.5%	76	72.4%	117	73.1%
Age (years)						
Median (Range)	64.0 (38.0 - 87.0)		68.0 (35.0 - 84.0)		66.0 (35.0 - 87.0)	
Tumour site						
Anal margin	11	20.0%	24	22.9%	35	21.9%
Anal canal	44	80.0%	81	77.1%	125	78.1%
T stage						
T1	10	18.2%	19	18.1%	29	18.1%
T2	45	81.8%	86	81.9%	131	81.9%
N Stage						
N0	55	100.0%	104	99.0%	159	99.4%
Nx	0	0.0%	1	1.0%	1	0.6%
ECOG						
0	48	87.3%	90	85.7%	138	86.3%
1	7	12.7%	15	14.3%	22	13.8%
HIV status						
Positive	1	1.8%	4	3.8%	5	3.1%
Negative	54	98.2%	101	96.2%	155	96.9%
p16 Status						
Positive	45	90%	84	95.5%	129	93.5%
Negative	5	10%	4	4.5%	9	6.5%

Treatment Compliance

	Standard dose IMRT N=55		Reduced dose IMRT N=105		Total N=160	
RADIOTHERAPY						
Total radiotherapy dose received	50.4Gy	28.8-50.4	41.4GY	23.4-50.4		
Median Treatment duration (days, range)	38 days	30-40	31 days	17-30		
Radiotherapy Interruption*	14	25.5%	16	15.2%	30	18.8%
CHEMOTHERAPY						
Chemotherapy as per protocol	28	50.9%	66	62.9%	94	58.8%
Capecitabine delay	3	5.5%	5	4.8%	8	5.0%
Capecitabine reduction	4	7.3%	12	11.4%	16	10.0%
Capecitabine omission	25	45.5%	33	31.4%	58	36.3%

*All participants adhered to the radiotherapy schedule and completed the scheduled course without more than 3 days delay due to toxicity

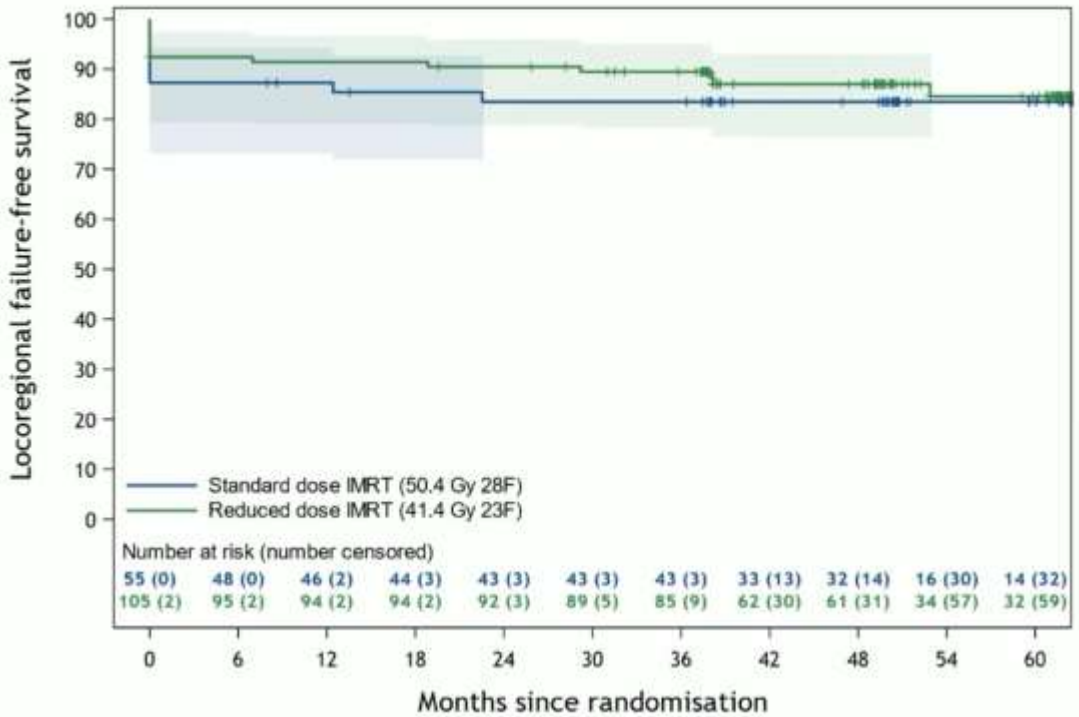
Primary end point – 3-year loco-regional failure rate

- The 3-year locoregional failure-free rate is:
  - **Reduced dose IMRT** **87.6% (90% CI 81.04-92.52)**
  - Standard dose IMRT 83.6% (90% CI 73.18-91.19)

- We reject the null hypothesis as the lower bound of the 90% confidence interval in the reduced dose arm is above 80%

- **The primary end-point is met**

Primary end point: 3 year loco-regional failure free rate

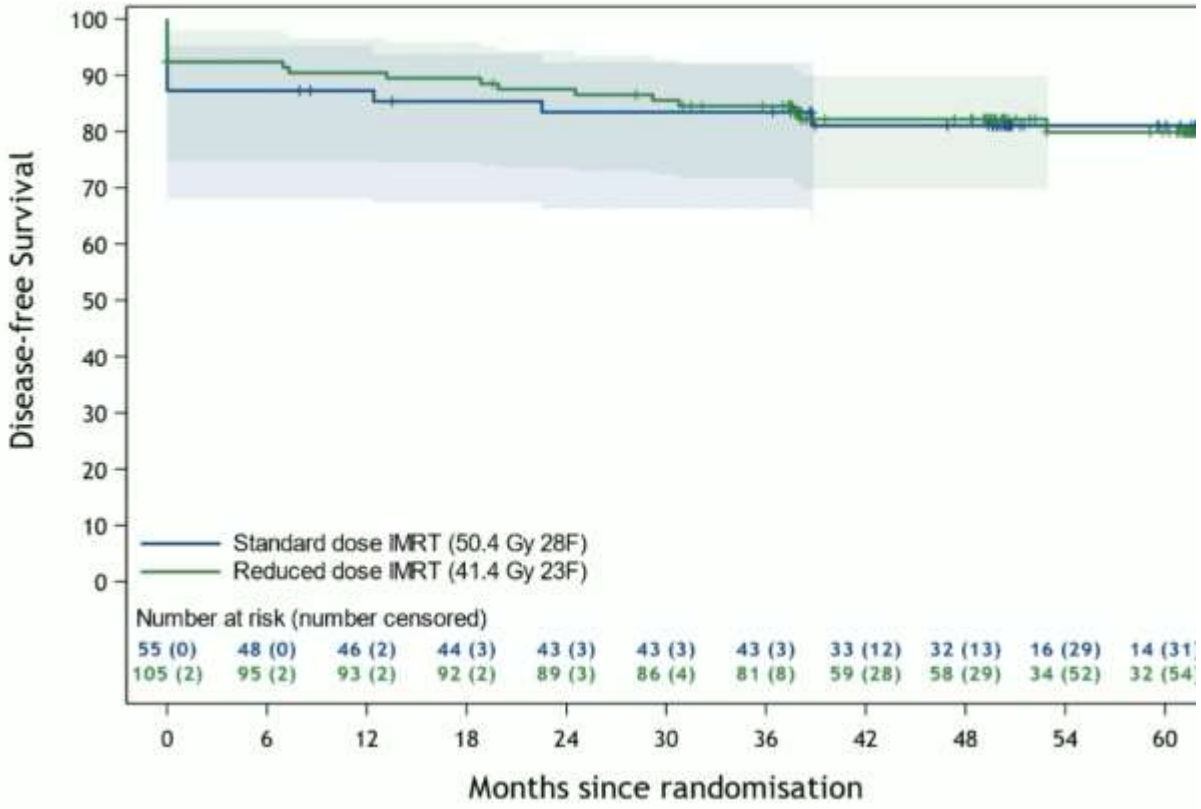


	3-year LRFF	90% CI
Reduced dose IMRT	89.4%	78.19-95.06
Standard dose IMRT	83.4%	70.58-91.02

Pattern of loco-regional failure

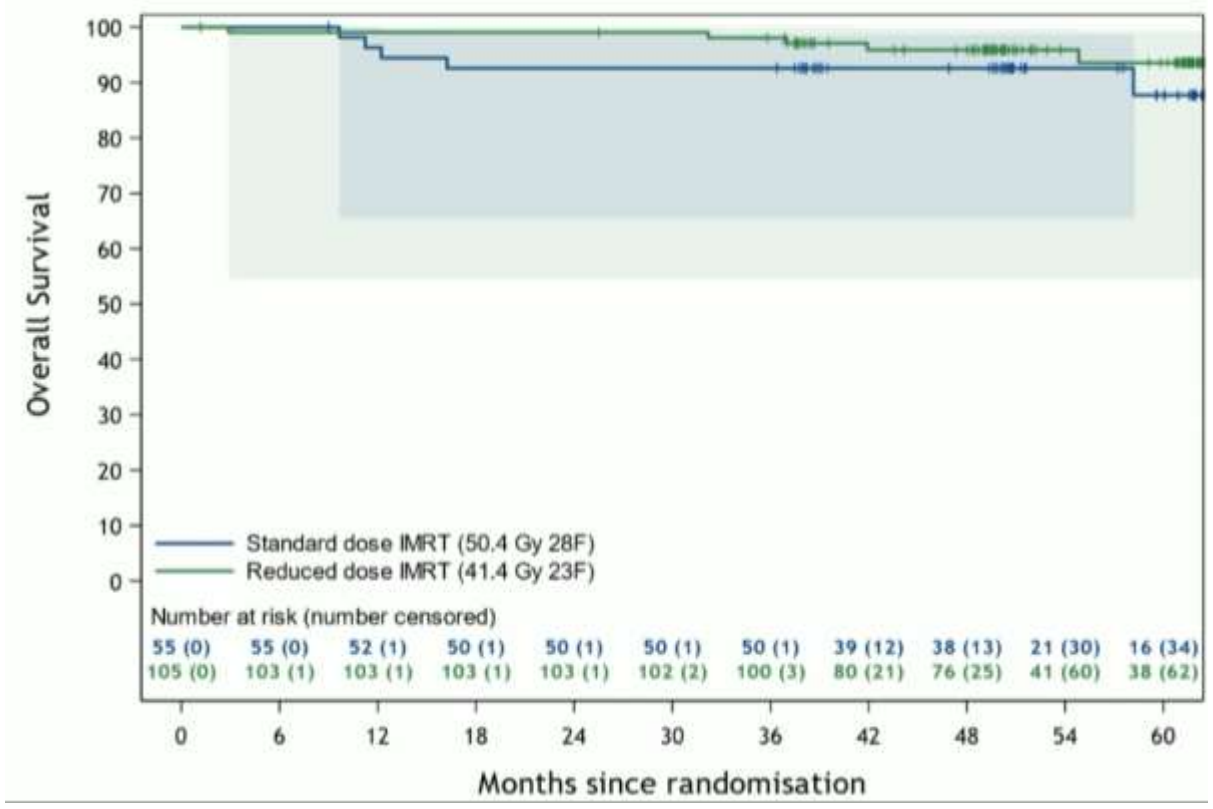
	Standard dose IMRT N=55		Reduced dose IMRT N=105		Total N=160	
Complete response at 6 months						
Primary site only	2	3.6%	4	3.7%	6	3.7%
Primary and nodal	0	0%	1	0.9%	1	0.09%
Nodal only	0	0%	0	0%	0	0%
Incomplete response at 6 months						
Primary site only	2	3.6%	4	3.7%	6	3.7%
Primary and nodal	1	1.8%	0	0%	1	0.06%
Nodal only	0	0%	0	0%	0	0%
Total	5	9.0%	9	8.3%	14	8.6%

Disease-Free Survival



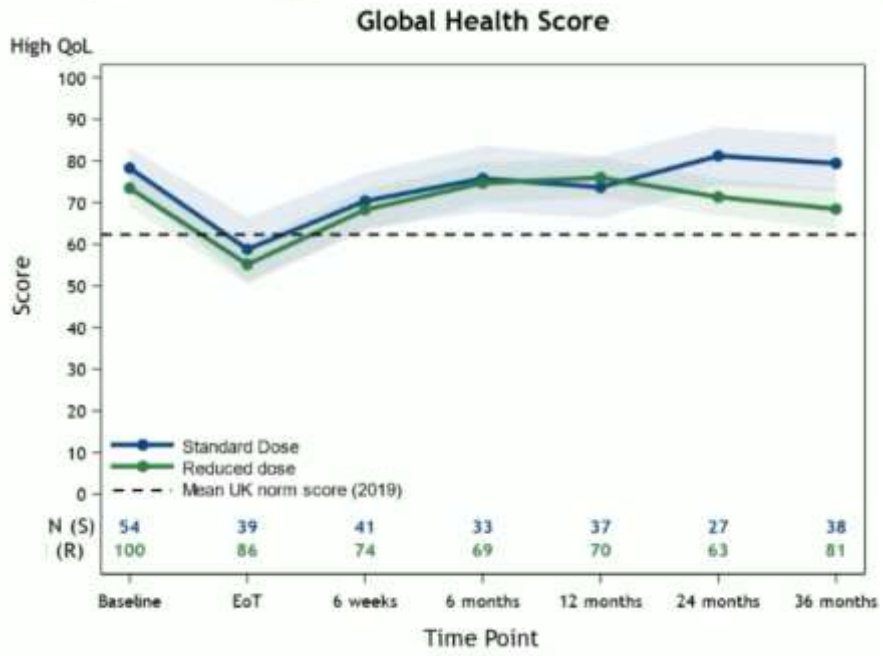
	3-year DFS	95% CI
Reduced dose IMRT	84.5%	71.66-91.88
Standard dose IMRT	83.4%	66.31-92.33

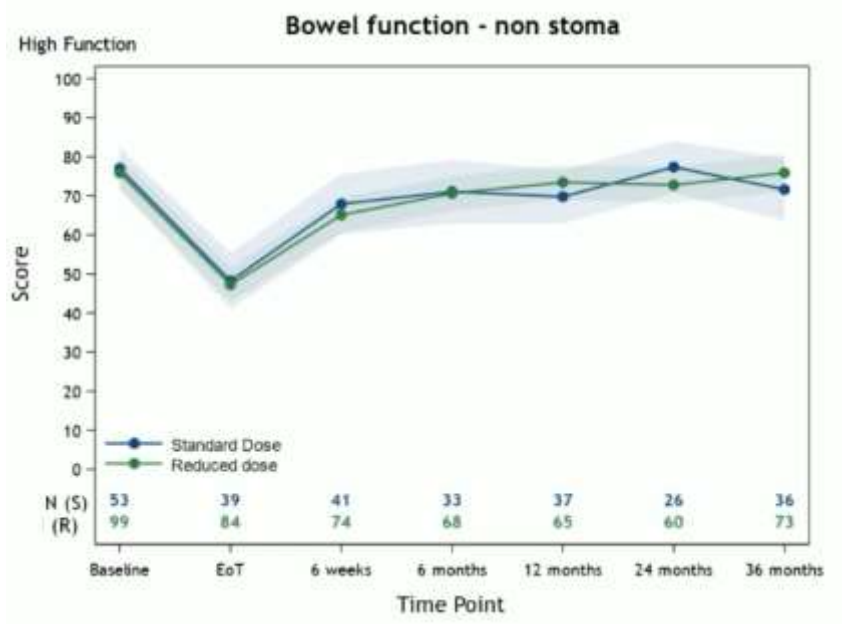
Overall Survival



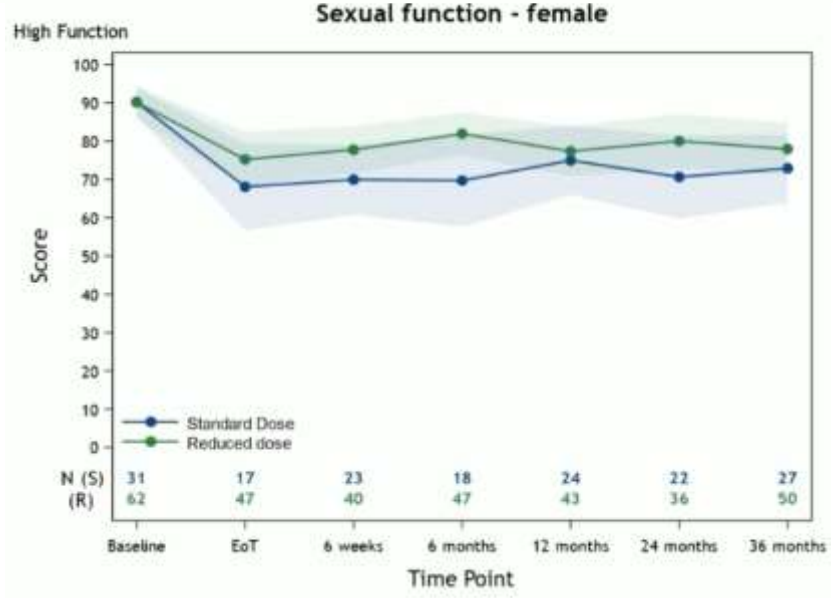
	3-year OS	90% CI
Reduced dose IMRT	98.1%	54.57-100
Standard dose IMRT	92.6%	65.49-98.66

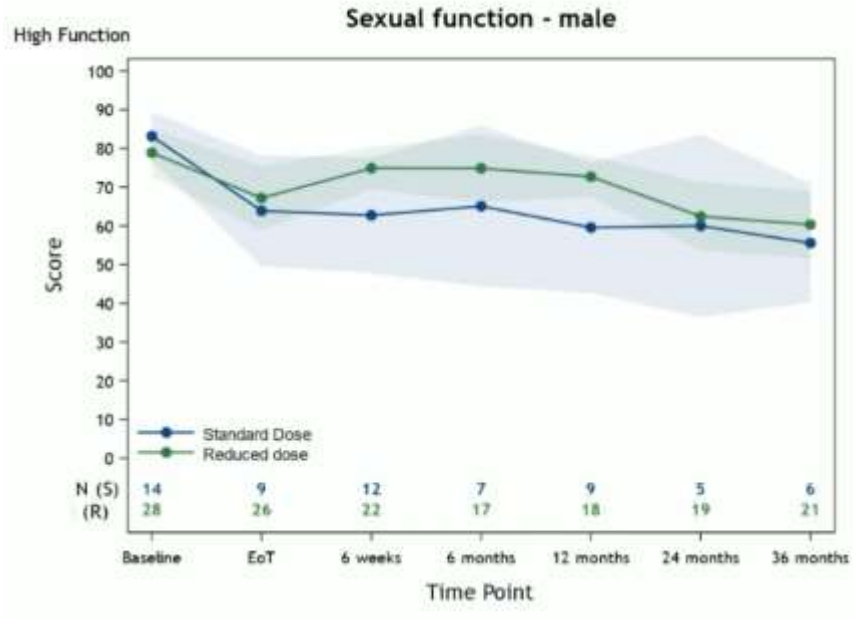
EORTC QLQ Patient Reported Outcomes





EORTC QLQ-ANL27 Patient Reported Outcomes - Sexual Functio





Conclusions

- Reduced dose IMRT with concurrent MMC and capecitabine resulted in a:
  - **87.6% loco-regional failure free rate at 3 years** - **the primary end point is met**
  - 84.5% disease free survival at 3 years
  - 98.1% overall survival at 3 years

- There were no isolated nodal failures

- Patient reported outcomes measuring late toxicity were similar

- **The shorter, reduced dose IMRT regimen offers major advantages to patients, their carers, and health care systems and should be considered as a new treatment option for patients with early-stage anal cancer**

Société Marocaine de Cancérologie
الجمعية المغربية لداء السرطان

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الجمعية التونسية للأمراض الورمية والعلاج بالأشعة
Société Tunisienne d'Oncologie Radiothérapie

Post ESTRO 2025 AFRIQUE DU NORD

BY SMC/STOR

LE 28 MAI 2025 À 18H00 (GMT+1)

Evenement VIRTUEL

MEROS