patients are inoperable due due medical co-morbidities: local tumor control is achieved in >90% of the patients resulting in improved overall survival (OS). Based on the promising experiences in primary lung cancer and other cancer sites, SBRT is currently explored in the setting of oligo-metastatic disease. In this rather rare clinical setting, patients with a limited number of metastases (maximum 3-5) in a limited number of organs (1-2) are treated locally aiming at prolongation of disease-free interval, treatment-free interval and eventually overall survival. Despite the value of any local treatment in the metastatic setting has not been proven in randomized clinical trials, surgery is the guideline-recommended treatment of choice in many cancers e.g. colorectal cancer or renal cell cancer. This presentation will outline the rational of using SBRT in the oligo-metastatic setting, give a summary of current evidence and compare SBRT with other local treatment options especially surgical resection.

SP-0344
Against the motion
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SABR for oligometastatic disease is a favourite pastime for radiation oncologists looking for application of high precision hypofractionated conformal radiotherapy. This is often fuelled by interests in technology of treatment delivery not infrequently vested in equipment suited for this technique. Yet SABR is just one of a spectrum of local therapies for small lesions (which include surgery and thermal ablation) and evidence for benefit of real value to the patient is weak.
There is reasonable consensus that SABR can achieve prolonged control of individual lesions with reasonable safety providing the lesions are small and the dose is delivered within radiation tolerance of the structure they are lodged in. However, evidence of real benefit for the patient in terms of prolonging survival and improving or maintaining quality of life is hard to come by. The problems include the lack of validated definition of oligometastatic disease, inevitable patient selection and the consequent reporting bias and the lack of randomised studies. In this setting, SABR for oligometastatic disease cannot be considered the standard of care.

SP-0345
For the motion
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SP-0346
Against the motion
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Few evidences are available to justify the integration of stereotactic ablative radiotherapy (SABR) with current systemic approaches in metastatic disease, especially in the first-line setting. The use of SABR is supported by low-level evidence due to retrospective nature of published experiences, heterogeneous group of patients treated across studies, different techniques adopted, different dose and fractionation chosen, different endpoints evaluated, short follow-up, little or no data regarding late and early late toxicity.
Although in most cases very good rate of local control are reported with good toxicity profile, no large studies demonstrated the significant impact of SABR for oligometastases on disease-free and overall survival of patients.
Prospective experience are strongly required to evaluate the potential impact of SABR in the context of standard systemic therapies in a homogeneous disease population, on improving progression-free survival, time to progression, and hopefully overall survival. An overview on the attractive challenge between technical innovation and clinical benefit.

Teaching Lecture: Regional nodes radiotherapy in early breast cancer

SP-0347
Regional nodes radiotherapy in early breast cancer
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Regional radiotherapy (RT) is generally offered to patients operated for node-positive early breast cancer (BC), in particular if >3 nodes are involved. Despite results from randomised trials indicating beneficial effect from regional RT in patients with 1-3 positive nodes (pN1) many of these patients are not offered regional RT routinely (Overgaard et al, NEJM 1997, Lancet 1999, R&O 2007, Ragaz et al, NEJM 1997). The reluctance may be due to a relatively high incidence of loco-regional recurrences (LRR) and poor overall survival (OS) in the trials compared to retrospective studies in the same type of patients treated without regional RT in the same period. Recently the randomised MA.20 trial, which included 1832 patients (85% of the patients had pN1 disease) treated with breast conservation 2000 to 2007, confirmed the beneficial effect of regional RT (Whelan et al, ASCO 2011, abstract). Even node-negative patients operated for a medial or centrally located BC may have a survival gain from irradiating the internal mammary nodes (IMN) and medial supraclavicular (MS) nodes as demonstrated in the EORTC 22922/10925 Trial (Poortmans et al, ECCO 2013, abstract). It is thus likely that the use of regional RT will increase with the publication of these 2 trials.
A new group of patients is now being proposed as candidate for regional RT based on the AMAROS study (Donker et al, Lancet Oncol 2014). In that trial patients diagnosed with T1-2 and sentinel node positive BC were randomised to axillary lymph node dissection (ALND) versus axillary RT. The 1425 patients had an excellent and comparable loco-regional and distant control, but significantly more lymph oedema was seen in the ALND group favouring regional RT.
There are several concerns when planning regional RT, and one is the decision on optimal target delineation. An ESTRO consensus for this is now published. Another concern is the decision about which lymph node levels are the relevant targets to be irradiated. The EORTC 22922/10925 Trial adressed this when randomising 4004 stage I-III patients to ± RT to the IMN and MS nodes, and showed a gain in 10 year DFS and MFS. The DBCG IMN study based on >3000 patients also showed an OS gain in node positive patients if the IMN were included in the RT fields (Thorsen et al, EBCC 2014, abstract). A third concern is dose and fractionation, because most studies have used 50 Gy/25 fr, but since the publication of a Canadian trial and the START Trial B more centres are now using hypofractionation based on 40-42,5 / 15-16 fr for regional RT despite only limited data support this. Of