any treatment was 23 weeks vs. 9 weeks in pts with BSC, p < 0.0001. In pts who received local treatment (8: surgery + 3: RT) median PPS was 51 vs. 21 weeks for CHT, p = 0.36. Median PPS for surgery was 51 weeks vs. 17 weeks for RT, p = 0.62. Pts with poor KPS (<60) at relapse did not benefit from local treatment as compared with CHT: median PPS for local treatment vs. CHT was 14 vs. 18 weeks, p = 0.81. Median PPS for poor KPS pts with BSC was 7 weeks. For the whole group of 84 pts, median OS from randomization was 35 weeks: 55 vs. 30 weeks in pts who received any treatment vs. BSC only, p < 0.0001.

Conclusions: Our results suggest that an active therapeutic approach may be beneficial for selected elderly and/or frail pts with rGBM, compared to BSC alone. Re-surgery seems to be the most efficacious therapeutic option for rGBM in elderly pts with high KPS; in poor KPS pts there is no benefit of local treatment (surgery and/or RT) over CHT.

PO-0812
Long-term outcomes and toxicity after proton beam radiotherapy of large non-peripapillary choroidal melanoma
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Purpose/Objective: To report on outcomes and toxicity after proton beam radiotherapy for large non-peripapillary choroidal melanoma considered unsuitable for other eye-sparing therapies in Canada.

Materials and Methods: We included patients with non-peripapillary tumors (>2mm from the optic disc) treated with proton therapy at TRIUMF, the only ocular proton therapy facility in Canada, from 1995-2013. A prospective database including patient, tumor, and treatment characteristics was updated with ocular complications and follow up status from chart reviews.

Results: In total, 77 patients were included in the analysis. The median age was 60 years and the median observation time 47 months (0-221 months). More than half of the patients (53%) had a tumor located anterior to the equator and 35% had involvement of the ciliary body. The median tumor diameter was 13.6 mm and the median thickness was 7.1 mm. The 5-(10) year actuarial rate was 85 (85)% for ocular tumor control, 72 (57)% for metastasis-free survival, 77 (63)% for overall survival, 22 (22)% for enucleation and 38 (38)% for complete blindness. 80% of patients with blindness had developed neovascular glaucoma.

Conclusions: Proton therapy resulted in acceptable local control and survival rates in patients with large anteriorly located tumors. The risk of complete blindness and severe toxicity requiring enucleation was low and a substantial proportion maintained a useful vision.

Poster: Clinical track: Early phase trials

PO-0813
Feasibility of using the ‘cohort multiple Randomized Controlled Trial’ design to conduct the RECTAL BOOST* study
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Purpose/Objective: * RECTAL BOOST = Randomized Controlled Trial for pre-operative dose-escalation boost in locally advanced rectal cancer.

Randomized controlled trials (RCTs) are the gold standard to evaluate effectiveness of new interventions. RCTs often experience difficulties in recruitment and generalizability.

We introduced the ‘cohort multiple Randomized Controlled Trial’ (cmRCT) to efficiently and simultaneously evaluate multiple oncologic interventions, while maintaining the highest level of evidence.

The RECTAL BOOST* study, which compares response rates after boost plus standard chemoradiation (CRT) (intervention arm) to standard chemoradiation alone (control arm) in patients with locally advanced rectal cancer (LARC), is the first clinical study according to cmRCT design. We evaluated feasibility of this design in terms of recruitment rates and boost-offer acceptance.

Materials and Methods: The basis of this ‘cohort multiple Randomized Controlled Trial’ (cmRCT) is a cohort consisting of all patients with rectal cancer. Patients consent to prospective collection of clinical, histological and quality-