was significant decrease in WBC (median 6.2 vs. 4.9 10^3/ul; p-0.03), PLT (235 vs. 184 10^3/ul; p-0.01) before and after radiotherapy. RBC and Hb did not significantly decrease. The maximum Grade 3 early skin toxicity by the end of treatment was present only in two patients. No Grade 4 toxicities were observed. The maximum Grade 2 fatigue, Grade 1 dysphagia, Grade 1 pain with swallowing were recorded. The early skin toxicity resolved in all patients evaluated one month after finishing the treatment.

Conclusions: This 6-week course of definitive radiotherapy using SIB technique showed to be feasible and was associated with acceptable early skin toxicity. Long-term follow-up data are needed to assess late toxicity and clinical outcomes.

Electronic Poster: Clinical track: Gastrointestinal tumours (upper and lower GI)

EP-1195

Chemoradiotherapy for T4 and/or M1 lymph esophageal cancer - recent experience in a Japanese high-volume center

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Purpose/Objective: to review data for patients with stage T4 and/or M1 lym esophageal cancer who have been treated with definitive chemoradiotherapy since 2000 in an institution that is one of high volume centers in Japan.

Materials and Methods: We retrospectively reviewed data for all patients with T4 and/or M1 lym esophageal cancer who had been treated by definitive chemoradiotherapy between 2000 and 2013 in Tohoku University Hospital. The eligibility criteria included 1) histopathologically proven esophageal cancer, 2) T4 and/or M1 lymph (UICC 2002), 3) having undergone at least 1 cycle of concomitant chemotherapy, 4) having been irradiated with 50 or more Gy, and 5) no other active malignant tumor during treatment. Survival estimates were calculated from the first day of radiotherapy using the Kaplan-Meier method, and differences were evaluated by the log-rank test. Statistical significance was defined as a value of $p<0.05$ in the present study. SPSS software for Windows version 20.0 was used for all calculations. Toxicity was graded according to the Common Terminology Criteria for Adverse Events (CTCAE v3.0).

Results: Data for 86 patients were used for analysis in this study. Median age of the patients was 66 years. Primary sites were in the cervical, upper thoracic, middle thoracic, lower thoracic and abdominal esophagus in 9 patients, 20 patients, 49 patients, 7 patients and 1 patient, respectively. Clinical stages were III in 54 patients, IVa in 5 patients and IVb in 27 patients. Median total irradiation dose was 60 Gy (range, 50-70 Gy). CDDP+5-FU, CDGP+5-FU, CDDP+5-FU+DOC and CDGP+DOC were performed as concomitant chemotherapy with radiotherapy in 47, 35, 2 and 2 patients, respectively. Median observation period for the survivors was 36.1 months. At the last observation date, there were 68 deaths including 5 intercurrent deaths. The 1-year and 3-year overall survival rates were 40.1% (95%CI=29.5-50.7%) and 22.4% (95%CI=13.0-31.8%), respectively. Three patients had grade 3 radiation pneumonitis and 1 patient developed grade 5 radiation pneumonitis. One patient showed grade 3 pleural effusion. The overall survival of patients without M1 lym was significantly better than that of patients with Ml lym (3-y, 32.3% (95%CI=19.0-45.6%) vs. 6.7% (95%CI=0-15.7%, p=0005). The overall survival in recent patients (2007-2013) was not improved from that in past patients (2000-2006) (3-y, 15.9% (95%CI=2.0-29.8%) vs. 26.0% (95%CI=13.8-38.2%), p=0.32). There was no significant difference of survival rate between patients treated with 60 Gy or less and patients treated with more than 60 Gy (3-y, 25.3% (95%CI=10.8-39.8%) vs. 20.0% (95%CI=7.8-32.2%), p=0.45).

Conclusions: We showed the results of definitive chemoradiotherapy for T4 and/or M1 lym esophageal cancer in a Japanese high-volume center after 2000. T4 patients without M1 lym showed a relatively good 3-year survival rate of about 30%; however, the results were not improved after 2000.

EP-1196

Surgical interval after neoadjuvant treatment in rectal cancer: impact on response and outcome

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Purpose/Objective: The optimal waiting period between completion of neoadjuvant therapy and surgery in locally advanced rectal cancer (LARC) is controversial. The recommended duration and its impact in surgical radicality is discussed. The specific purpose of this study is to evaluate the effect of surgical interval on cancer response: tumor regression grade (TRG), postoperative morbidity and long-term oncologic outcomes.

Materials and Methods: Retrospective data analysis from patients with clinical stage II-III treated with chemoradiation (CRT) followed by surgery and IORT, between February 1995 and December 2012 is reported. Two groups according to the interval between neoadjuvant therapy and surgery (< 6 and ≥ 6 weeks) are evaluated. Clinico-pathological data related to response patterns as well as survival were compared.

Results: Three hundred thirty-five patients were assessed, of which 59,4% underwent delayed surgery. Baseline characteristics of the study groups, showed a higher proportion of patients with increased oncologic risk factors in the delayed surgery group (cT4, 14,1% vs 18%; cN+, 64,1% vs 76,6%). Complete pathological response (ypT0N0) and TRG 3-4 categories incidence are not significantly different among groups (8,8% vs 12,1%, p = 0,348; 41% vs 50,8%, p = 0.082), respectively. The maximal dimension of residual tumor post-neoadjuvant treatment was influenced by surgical period (p = 0.006). Longer surgical interval did not affect incidence or severity of complications or length of hospital admission (9,50 vs 10 days; p = 0.093). After a median follow-up time of 71 months, delayed surgery had a significant impact on overall survival (55,9% vs 70,4%; p = 0,014), not observed in disease-free survival (69,9% vs 74,9%; p = 0,233) or local relapse-free survival (LRFS) (90,4% vs 94,5%; p = 0,123).