Conclusion: Sequential chemotherapy and radiotherapy in adult medulloblastoma/PNET tumors is feasible with acceptable toxicity. High relapse rate in our patients indicate the need of treatment intensification with better coordination of combined therapy.

EP-1128
Outcome of high grade glioma patients: To prioritise dose to primary tumour or organs at risk?
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Purpose or Objective: Glioma is a primary brain tumour arising from the glial cells. High grade glioma, defined as grade III and IV, have poor survival rates. Glioblastoma multiforme is the commonest, but is also, the most aggressive type of glioma and is associated with a poor prognosis. Median survival of patients after treatment with debulking surgery followed by concurrent chemoradiotherapy and adjuvant chemotherapy is 14.6 months. Currently, post-operative fractionated radiotherapy is prescribed to a range of 54 to 60 Gy in fractions of 2 Gy. Organs at risk (OARs) including optic chiasm, optic nerves and the brain stem, may lie within, or in close proximity to the PTV. Neuropathy and/or necrosis has been shown to occur when the maximum dose exceeds 55Gy in the optic chiasm and 54Gy to the whole brainstem. The standard practice at Rosemere Cancer Centre is to prioritise the OARs at the expense of the total dose, therefore prescribing to a dose of 54Gy whenever the OARs is included in the PTV, which may have repercussions on tumour control and ultimately, overall survival.
This retrospective analysis aims to compare patient outcomes between the 54Gy/57Gy and 59.4Gy/60Gy regimes, to determine if compromising the dose to spare OARs is detrimental to tumour control and survival.
Material and Methods: The data of all glioma patients treated with radiotherapy between December 2012 and December 2014 at Rosemere Cancer Centre, were collected from our electronic databases. A total of 167 patients were identified. Patients with low grade glioma and those treated with a palliative intent were excluded. Fifty eight patients were included in the analysis.
Results: Twenty one patients were on a lower dose radiotherapy regime of 54Gy or 57Gy. The remaining 37 were on a higher dose regime of 59.4Gy or 60Gy. There was a statistically significant difference (p=0.05) in patients treated with the higher dose regime comparatively, of an additional 7.2 months median overall survival (mOS) benefit. The mortality hazard for the higher dose regime is 37% lower than the lower dose regime.
Conclusion: The outcome of patients treated with the 59.4/60Gy dose regime has shown to be statistically significant with a mOS benefit and lower mortality hazard. It is therefore clear that maintenance of the higher dose (59.4/60Gy) should be a priority, either at the expense of the OARs or to as much of the tumour volume as possible, whilst still observing the OARs constraints.

EP-1129
Pre- and post-irradiation hypothalamic-pituitary axis dysfunction in adults treated for brain tumours
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Purpose or Objective: Present and retrospectively evaluate our protocol of WBRT + SIB regarding radiation-induced alopecia.
Material and Methods: We use masks type 35764 / 2MA / M Orfit a subnet mask with eXaskin and compatible base resonance (eXaFrame). A similar number of slices is used in the images of CT and MRI, both acquisitions with identical position and immobilization and slice thickness of 1 mm. This is possible thanks to eXaFrame, resulting in excellent quality