

Current and Emerging Treatment Landscape of Lung Cancer II: Radiation Oncology Perspective

Jeffrey Bradley, MD FACR FASTRO
Vice Chair for Protons and Technology Development
Department of Radiation Oncology
University of Pennsylvania
Philadelphia, Pennsylvania, USA

May 9, 2025



Penn Medicine



Overview of the role of Radiation Oncology in lung cancer

- ▶ Make a decision: Curative vs Palliative
- ▶ Curative
 - Early stage unresectable (Stage I-II NSCLC)
 - Locally-advanced unresectable NSCLC
 - Post op NSCLC
 - Limited-stage SCLC
 - Oligo-categories (oligometastatic and oligoprogressive)
- ▶ Palliative principles
 - Improve symptoms, prevention of symptoms (i.e. fractures or obstruction), and/or durable local control
 - Often the most difficult of decisions we make
 - Treat vs not treat; what to treat; dose/fractionation; coordination with systemic therapy
 - Brain mets – few vs multiple

Radiation Oncology Tools (current and upcoming)

► Photons (alphabet soup!):

- Linear Accelerator – traditional linac; CT-based Halcyon; MRI-based Unity or ViewRay; PET-based Reflexxion
- Intensity-modulated RT (IMRT); Volumetric modulated arc therapy (VMAT); Image-guided RT (IGRT); 3 dimensional conformal (3DCRT); hypofractionated RT (i.e. 6-20 fractions); stereotactic RT; radiosurgery (1 fraction)
- Special equipment – 6 DoF couches; Hypersight (near diagnostic CT quality images); camera-based body surface imaging (for breath hold delivery)

► Protons

- Passive scattering (older systems; most have been upgraded)(similar to 3DCRT)
- Pencil-beam scanning (also called intensity-modulated proton therapy or IMPT)
- Volumetric arc proton therapy (not yet FDA approved)
- FLASH therapy – currently research only

► Brachytherapy – not used much in lung cancer setting

Any images of technology are supposed to be instructive only

- There are multiple vendors of these technologies
- Selected images are examples, not intended to favor one or the other

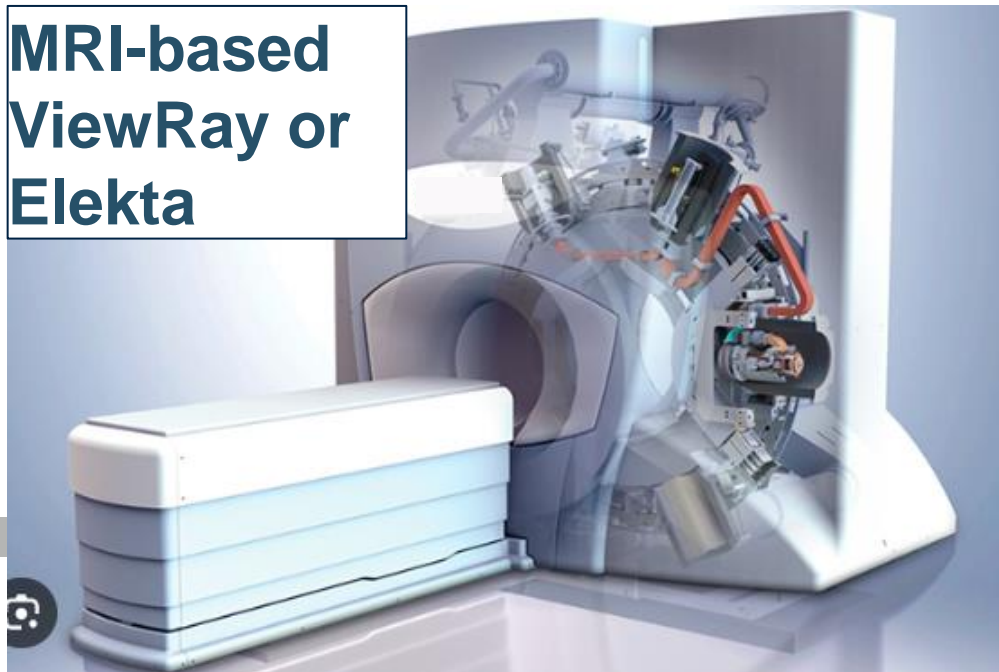
Linac



**CT-based
Halcyon / Ethos**



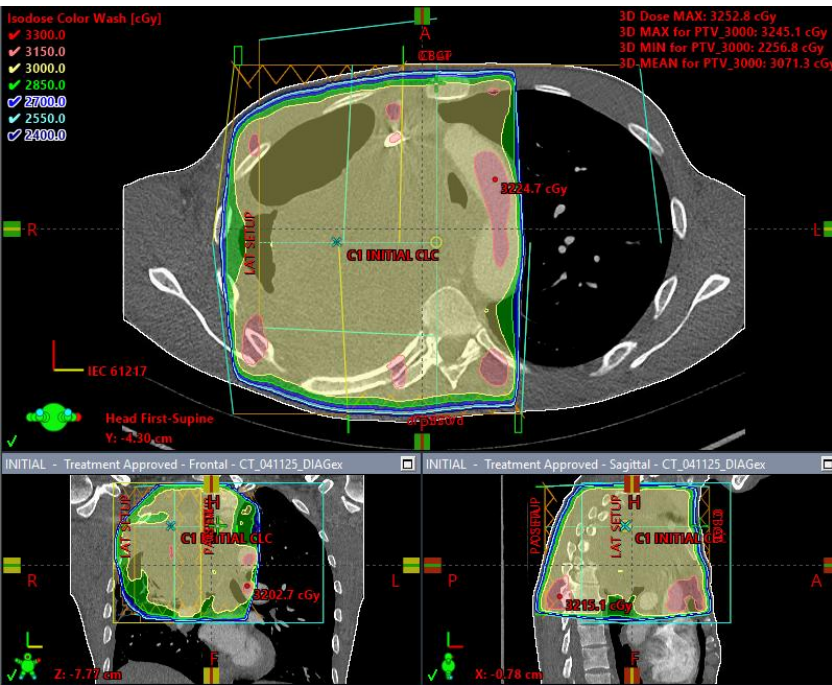
**MRI-based
ViewRay or
Elekta**



**PET-based
Reflexxion**

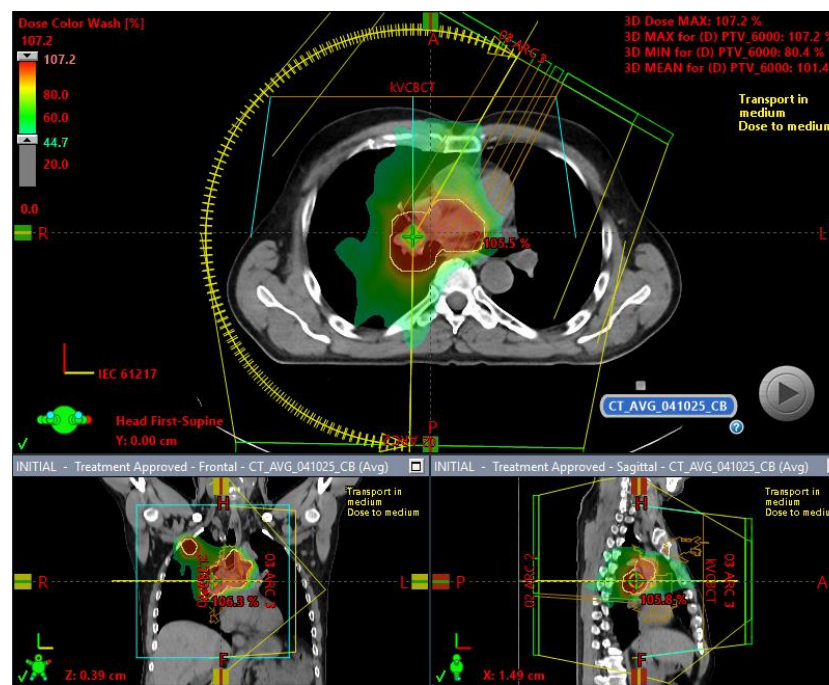


3DCRT - photons



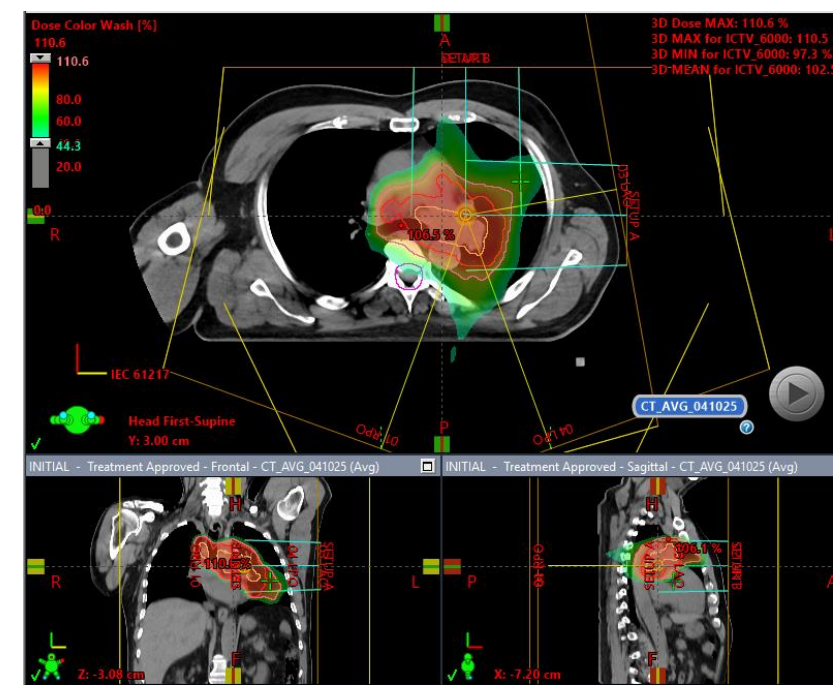
- Palliative RT
- Quick forward planning
- Commonly 30 Gy / 10 fractions or 20/5

VMAT IMRT - photons



- All OARs contoured
- Inverse planning (AI automated)
- Commonly 60-66 Gy in 30-33 fractions with chemo
- Can be hypofractionated (w/o chemo)
- Applies to adaptive RT equipment

IMPT - Protons



- All OARs contoured
- Forward planned
- Commonly 60-66 Gy in 30-33 fractions with chemo
- Can be hypofractionated (w/o chemo)

Radiosurgery options

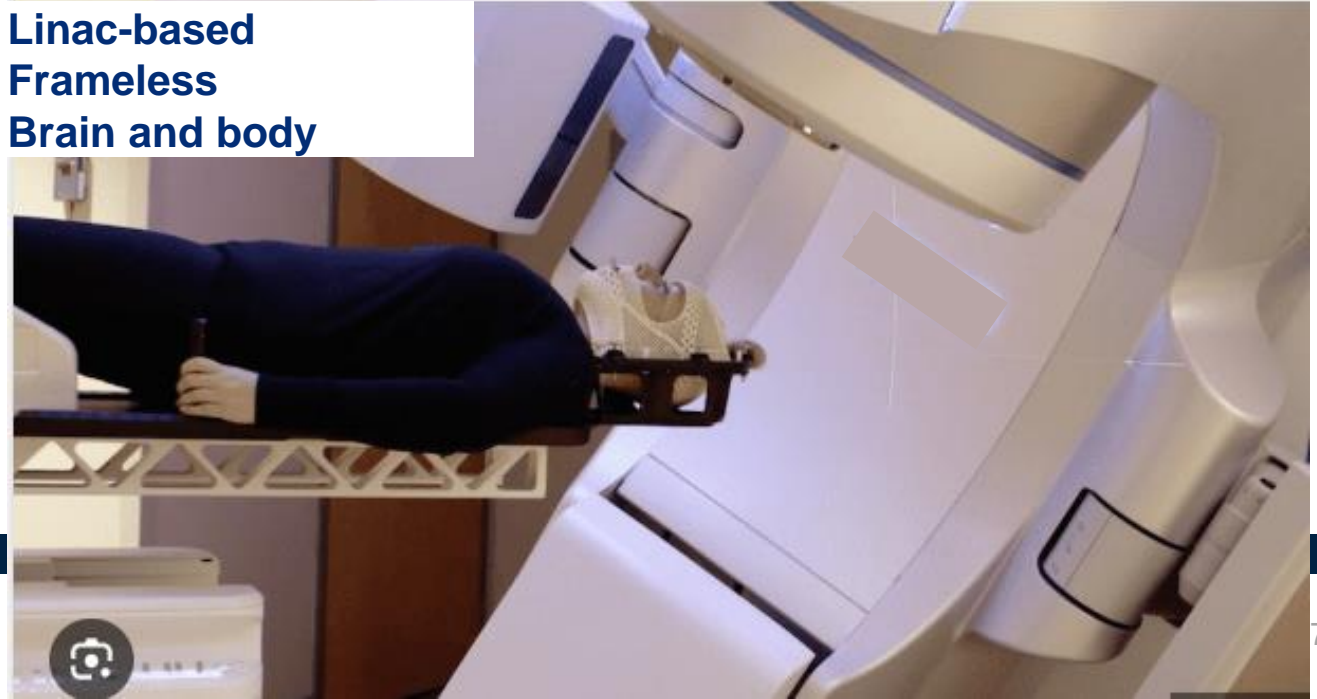
**Gamma knife –
Frame-based
Brain and BOS**



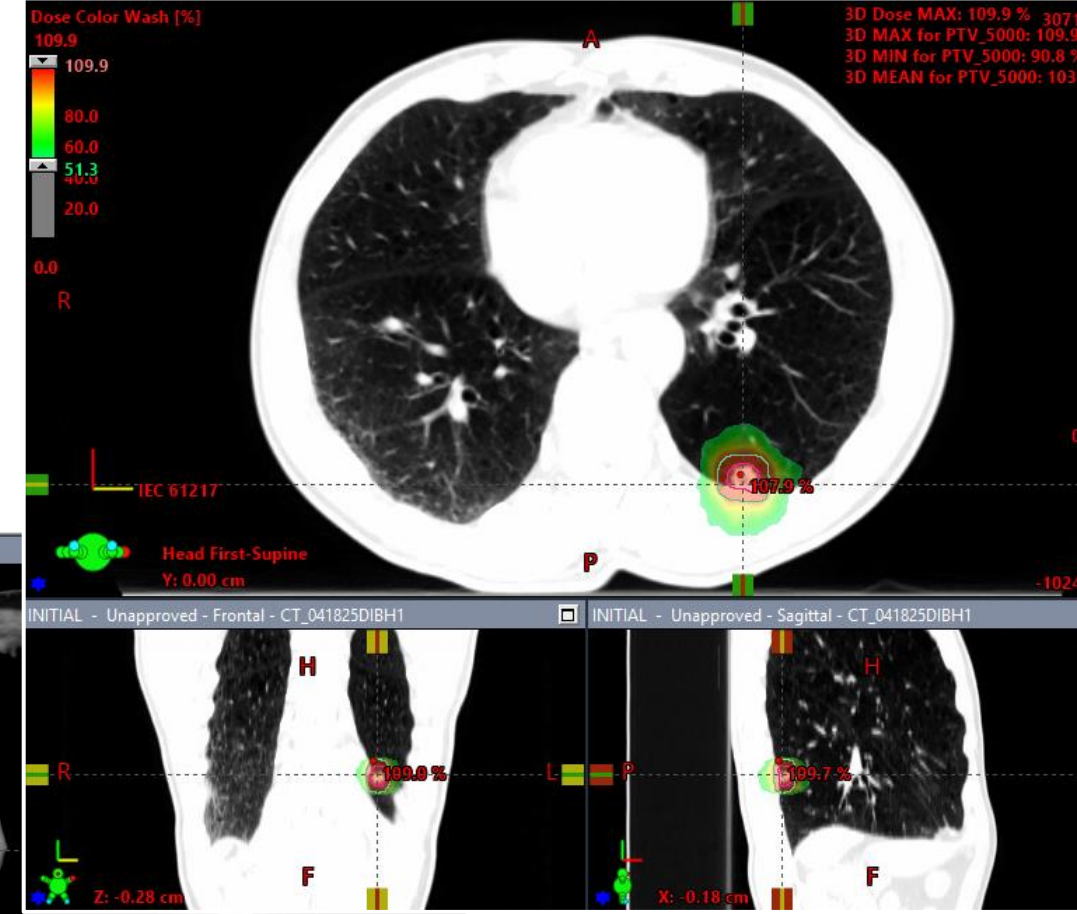
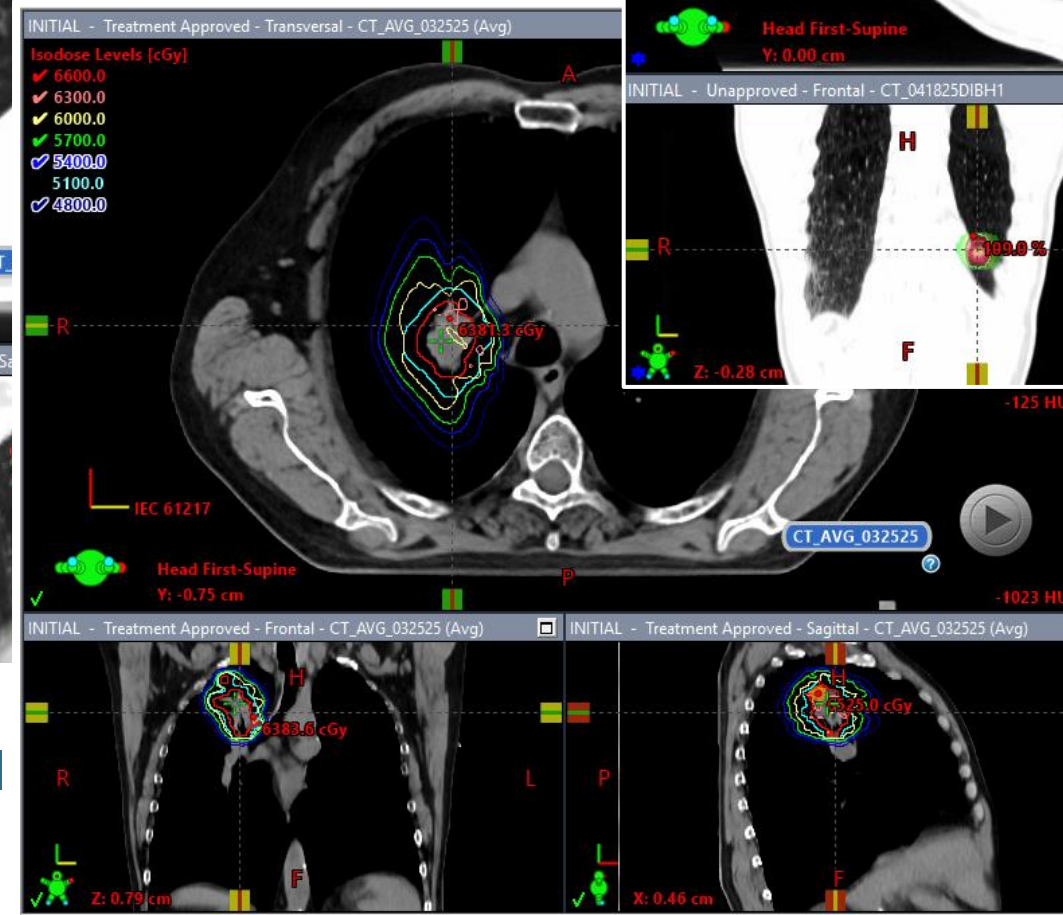
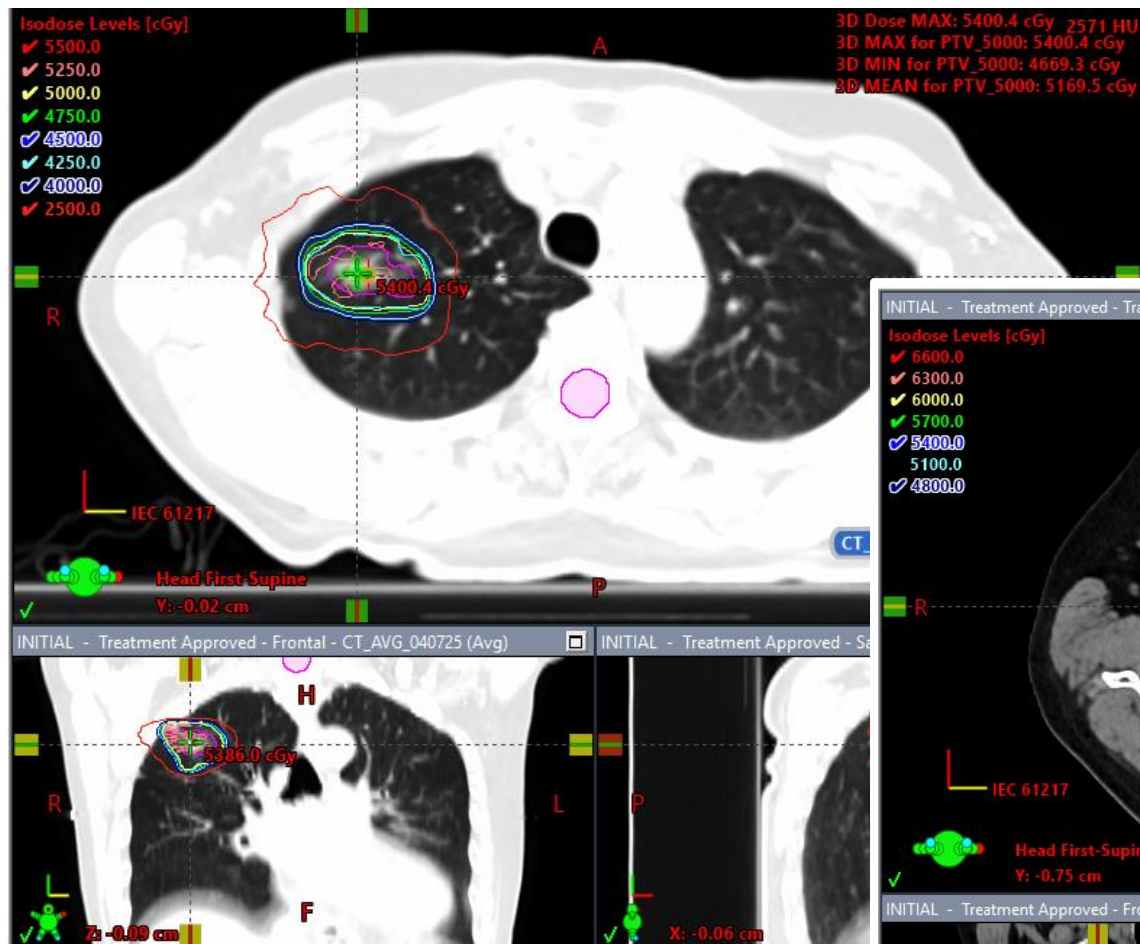
**Cyberknife-
Brain and body**



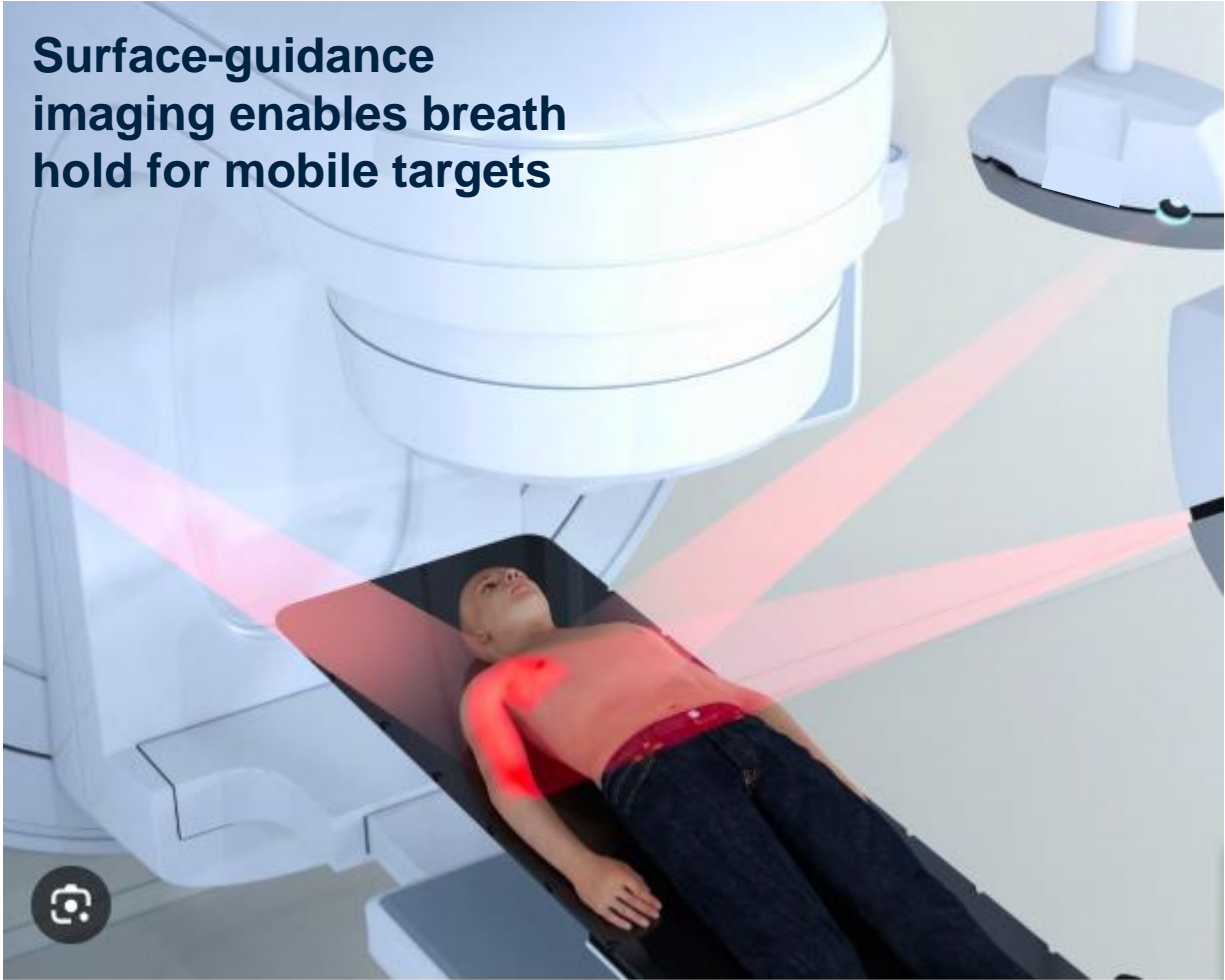
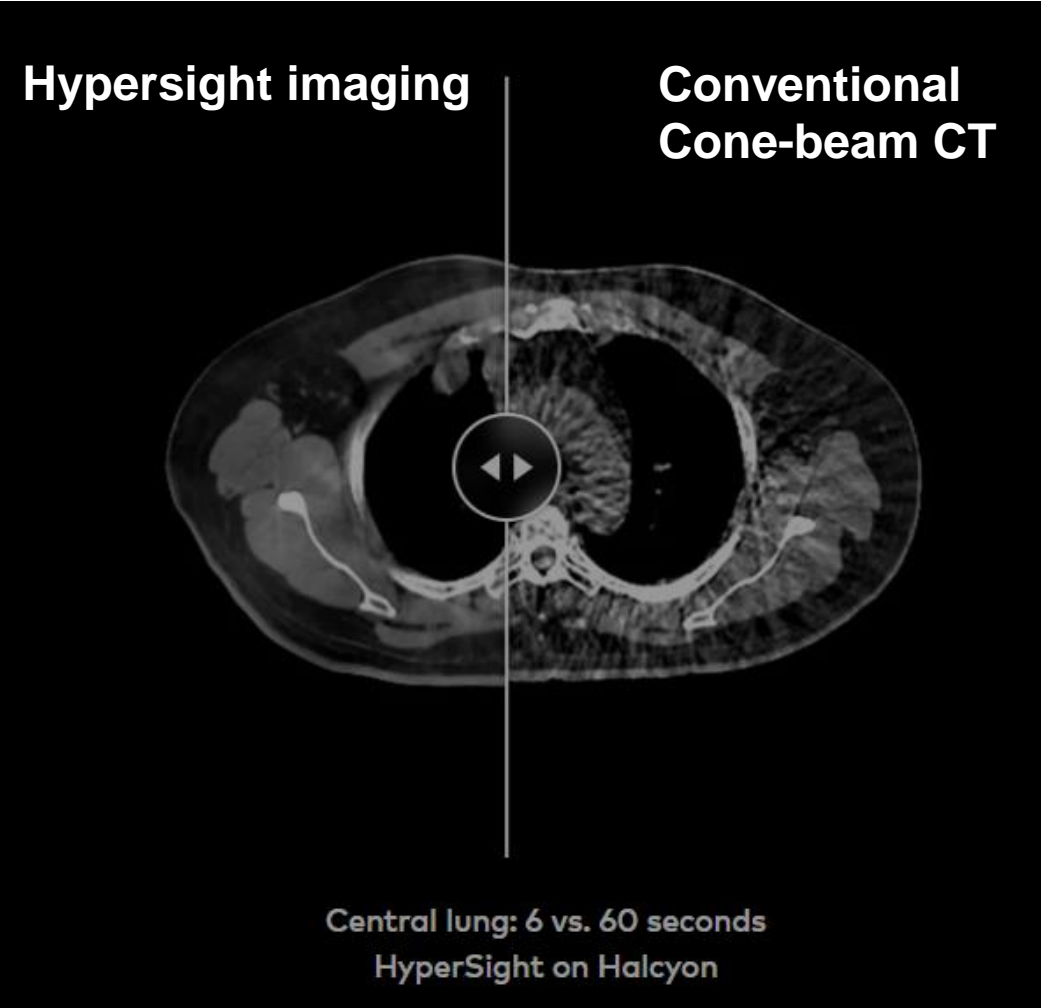
**Linac-based
Frameless
Brain and body**



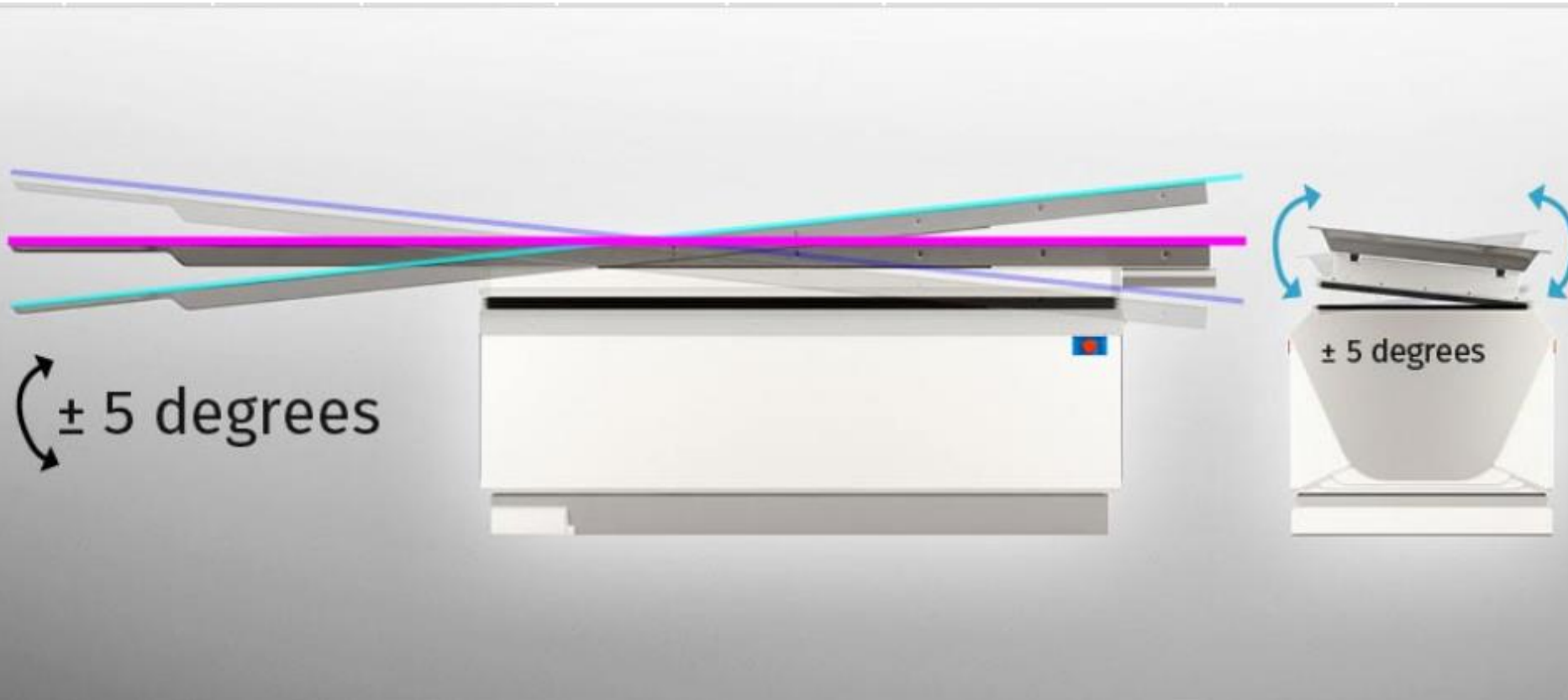
Size, location, and OARs



Special Features: On-board imaging and Surface guidance examples



What is a 6 DoF couch?

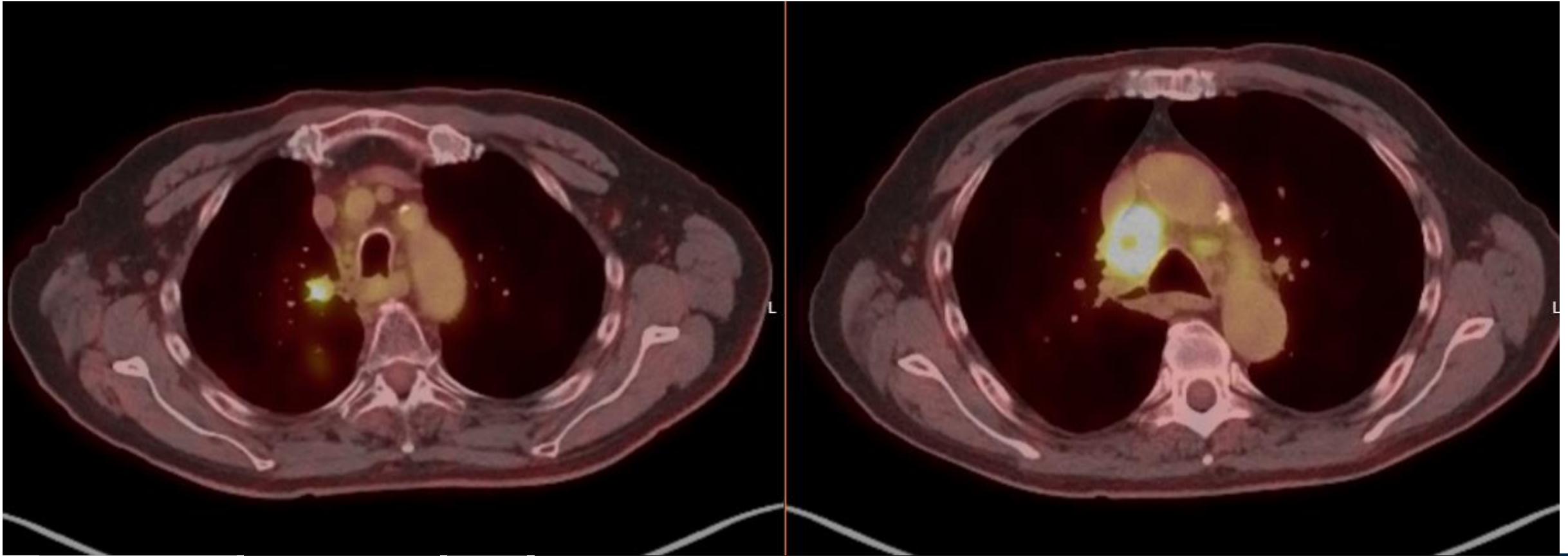


6 DoF couch:

Six degrees of freedom for more precise radiotherapy treatments.

Patient case

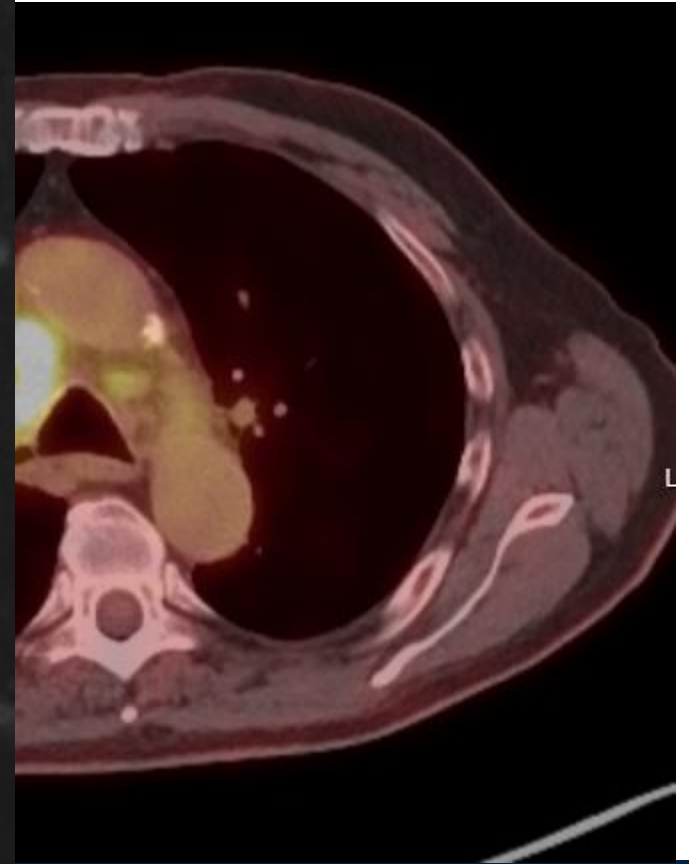
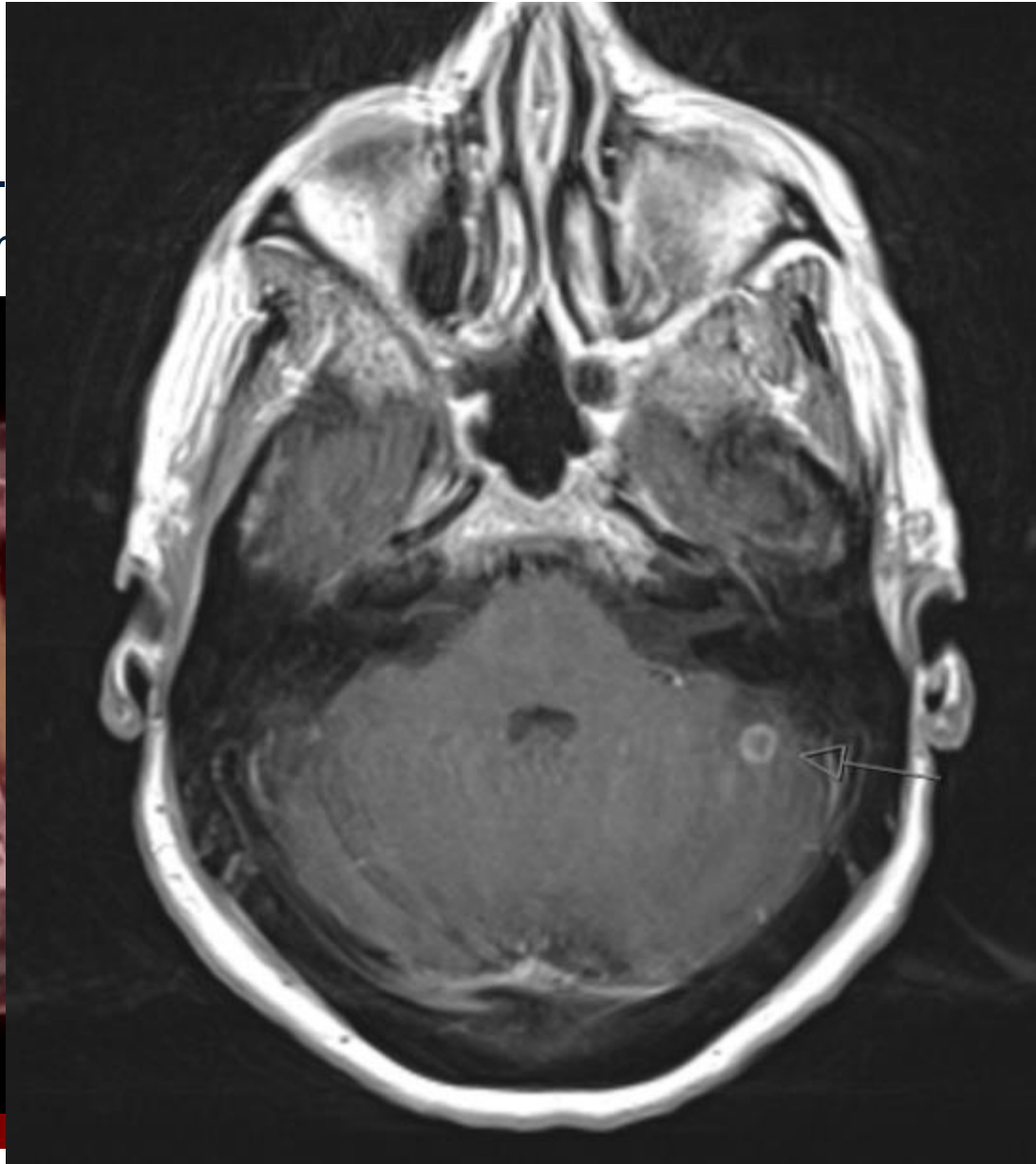
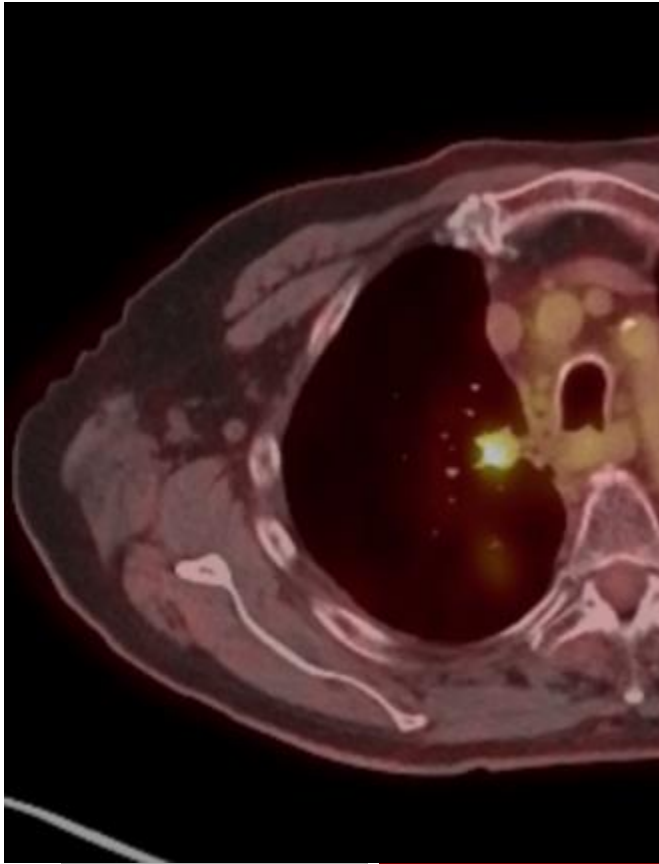
- ▶ 74 yo male with severe COPD with newly-diagnosed RUL squamous cell carcinoma involving R4 node. PDL1 is 20%. Has solitary brain metastasis.
- ▶ What do you recommend?



Patient case

- ▶ 74 yo male with severe
R4 node. PDL1 is 20%.
- ▶ What do you recommen

cell carcinoma involving



Patient Case

Major decisions to make

- ▶ Curative vs Palliative

- ▶ Operable vs inoperable
 - Brain
 - Lung

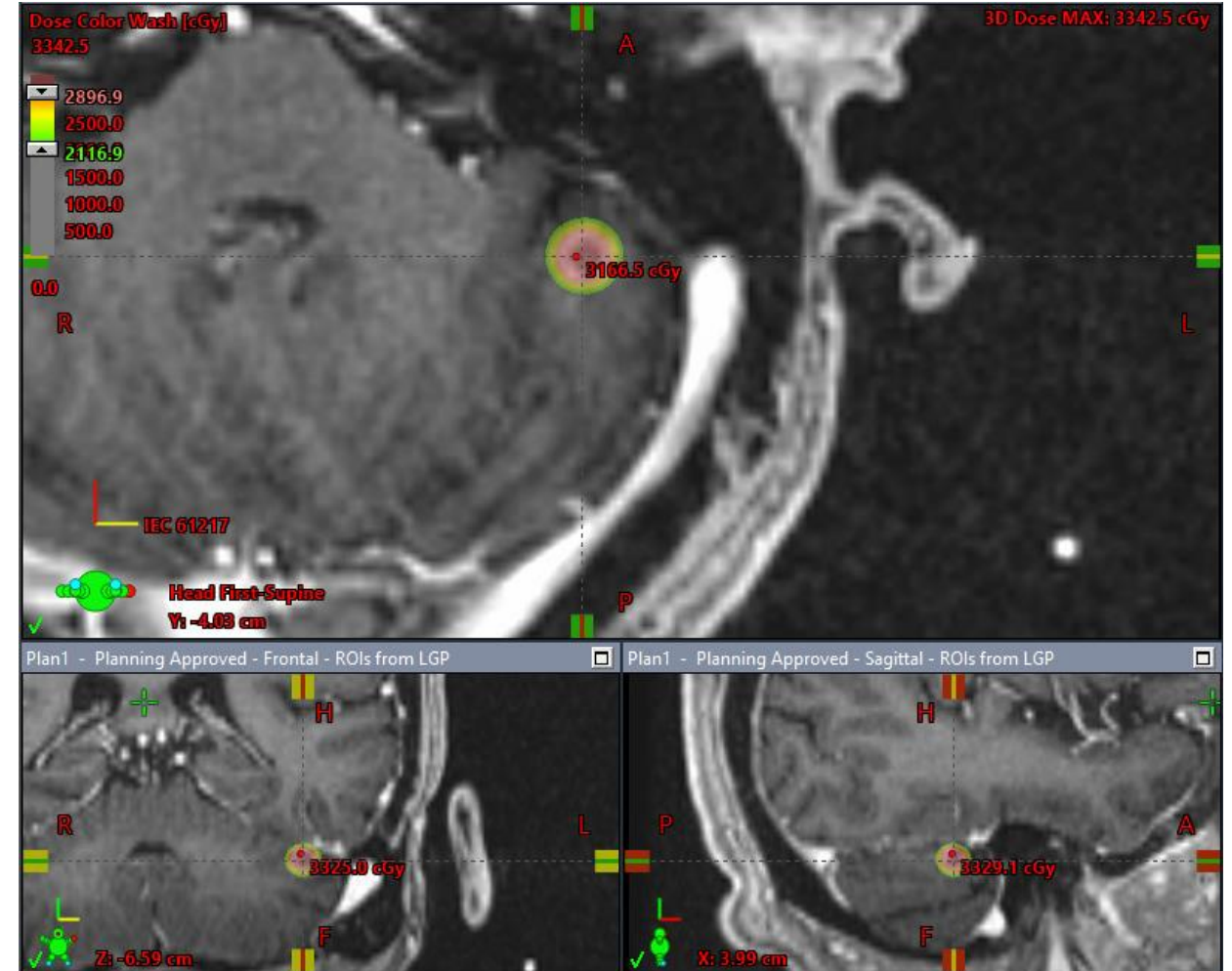
- ▶ Systemic therapy
 - Palliative setting - chemo vs. IO vs. both
 - Curative setting - sequential chemo vs. concurrent with RT
 - IO – when to add

- ▶ Radiation therapy
 - Radiation dose, fractionation, volume, method of delivery

Patient Case

Major decisions to make

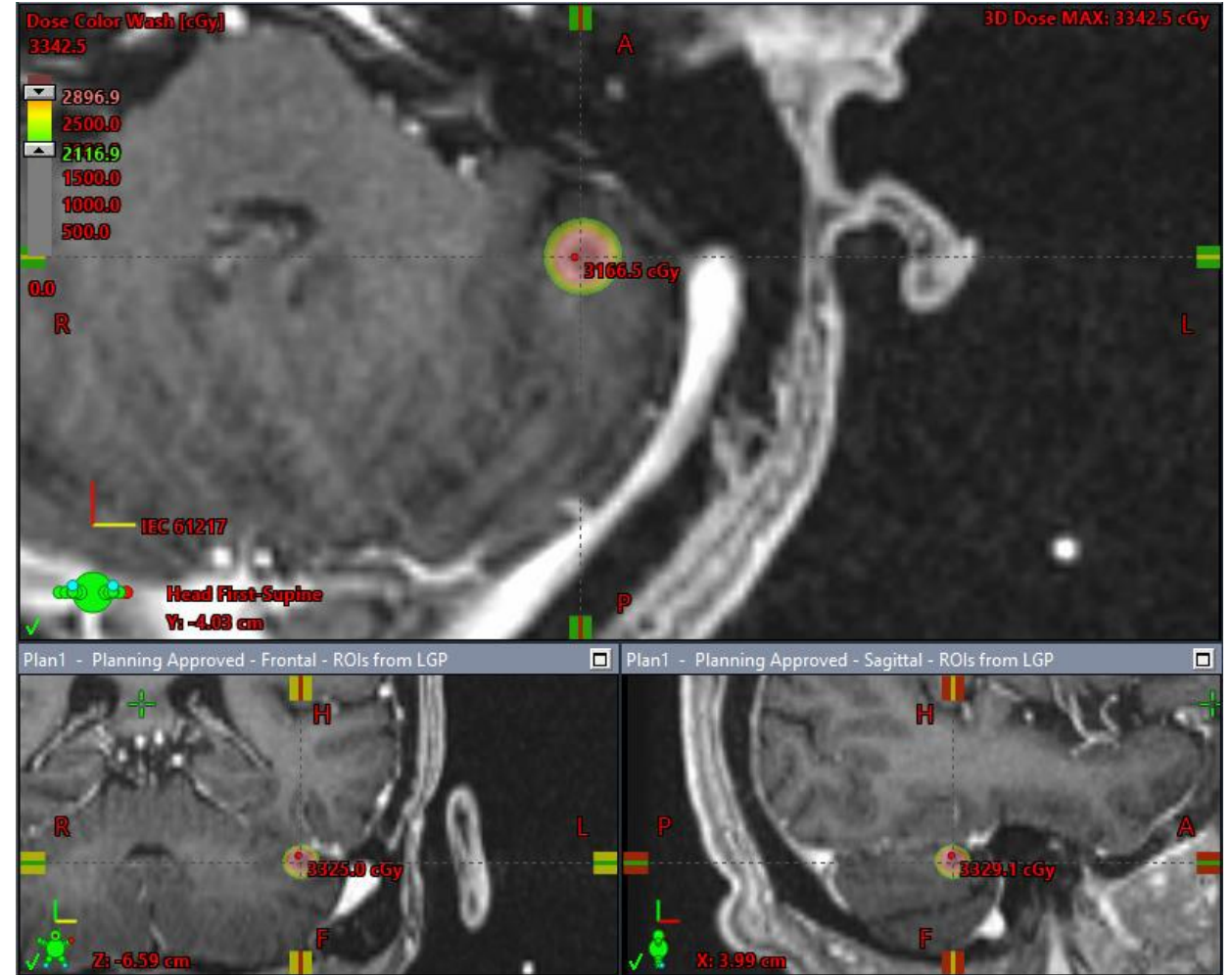
- ▶ Curative vs Palliative
 - Curative
- ▶ Operable vs inoperable
 - Brain – non-operative management w/ SRS
 - Lung
- ▶ Systemic therapy
 - Palliative setting - chemo vs. IO vs. both
 - Curative setting - sequential vs. concurrent
 - IO – when to add
- ▶ Radiation therapy
 - Radiation dose, fractionation, volume, method of delivery



Patient Case

Major decisions to make

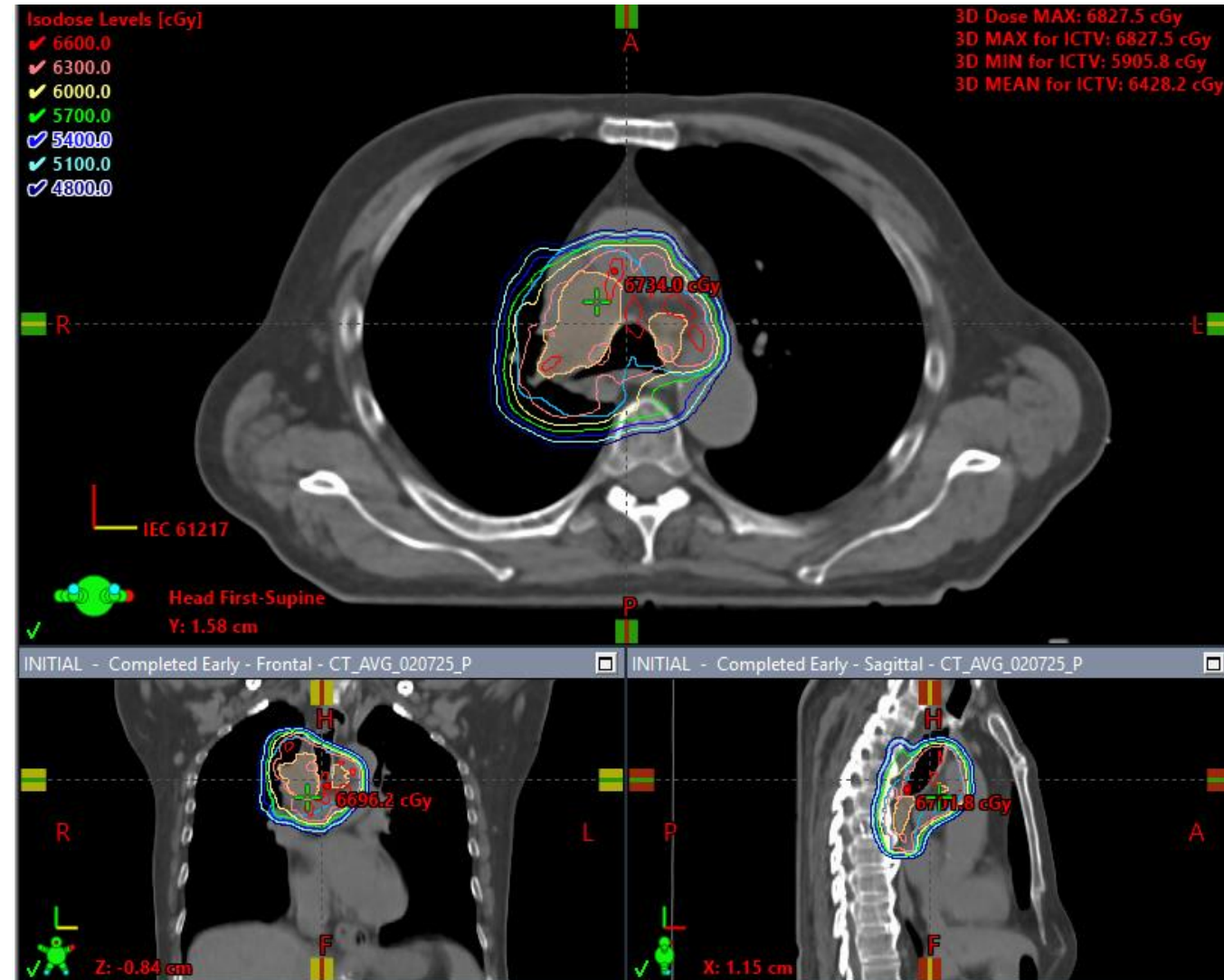
- ▶ Curative vs Palliative
 - Curative
- ▶ Operable vs inoperable
 - Brain – non-operative mgmt. w/ SRS
 - Lung – poor pulmonary function, so non-operative
- ▶ Systemic therapy
 - Palliative setting - chemo vs. IO vs. both
 - Curative setting - sequential vs. concurrent
 - IO – when to add
- ▶ Radiation therapy
 - Radiation dose, fractionation, volume, method of delivery



Patient Case

Major decisions to make

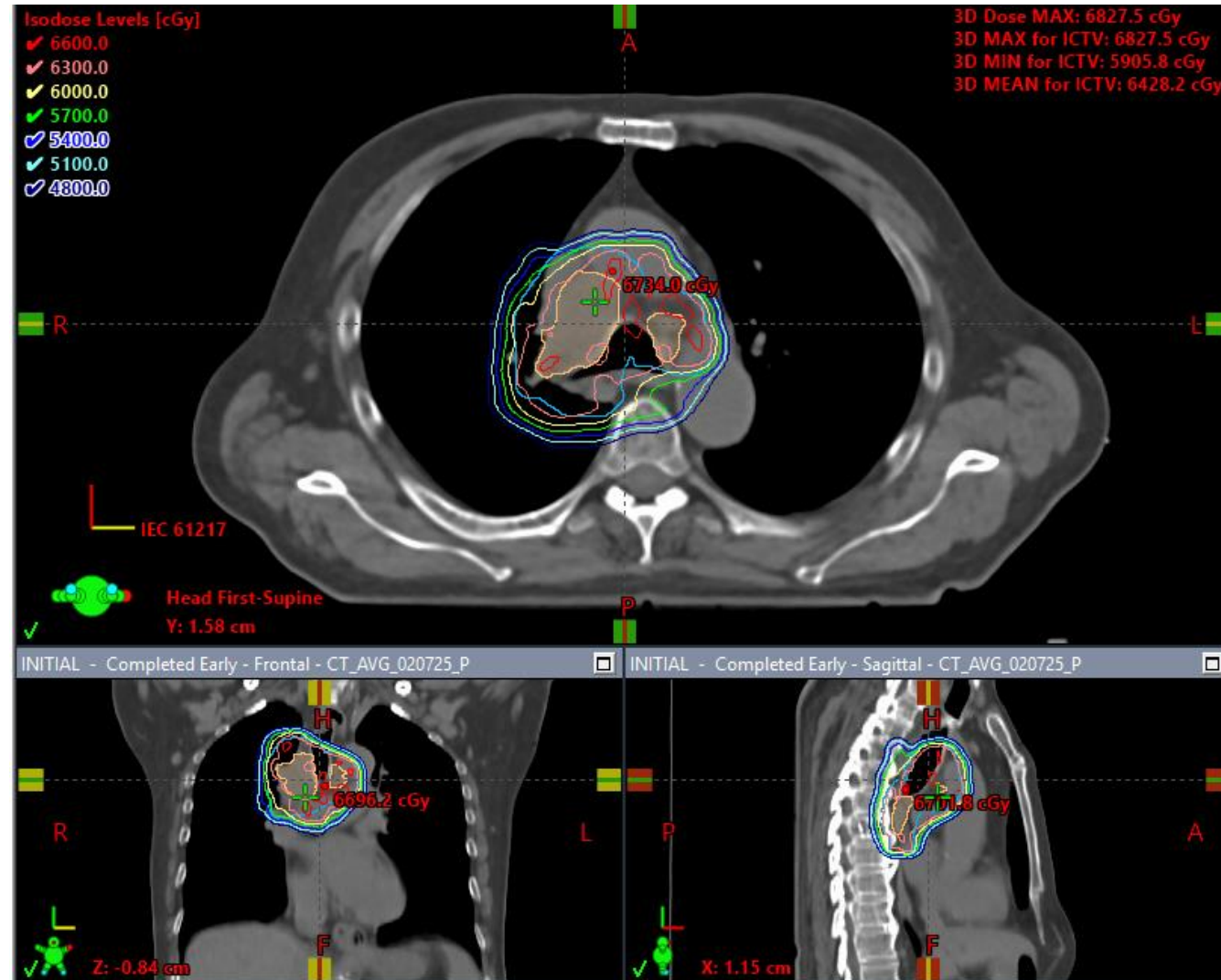
- ▶ Curative vs Palliative
 - Curative
- ▶ Operable vs inoperable
 - Brain – non-operative mgmt. w/ SRS
 - Lung – poor pulmonary function, so non-operative
- ▶ Systemic therapy
 - ~~Palliative setting - chemo vs. IO vs. both~~
 - Curative setting - ~~sequential vs. concurrent~~
 - IO – ~~when to add~~ after CRT per PACIFIC
- ▶ Radiation therapy
 - Radiation dose, fractionation, volume, method of delivery



Patient Case

Major decisions to make

- ▶ Curative vs Palliative
 - Curative
- ▶ Operable vs inoperable
 - Brain – non-operative mgmt. w/ SRS
 - Lung – poor pulmonary function, so non-operative
- ▶ Systemic therapy
 - ~~Palliative setting – chemo vs. IO vs. both~~
 - Curative setting - ~~sequential vs. concurrent~~
 - IO – ~~when to add~~ after CRT per PACIFIC
- ▶ Radiation therapy
 - Radiation dose, fractionation, volume, method of delivery

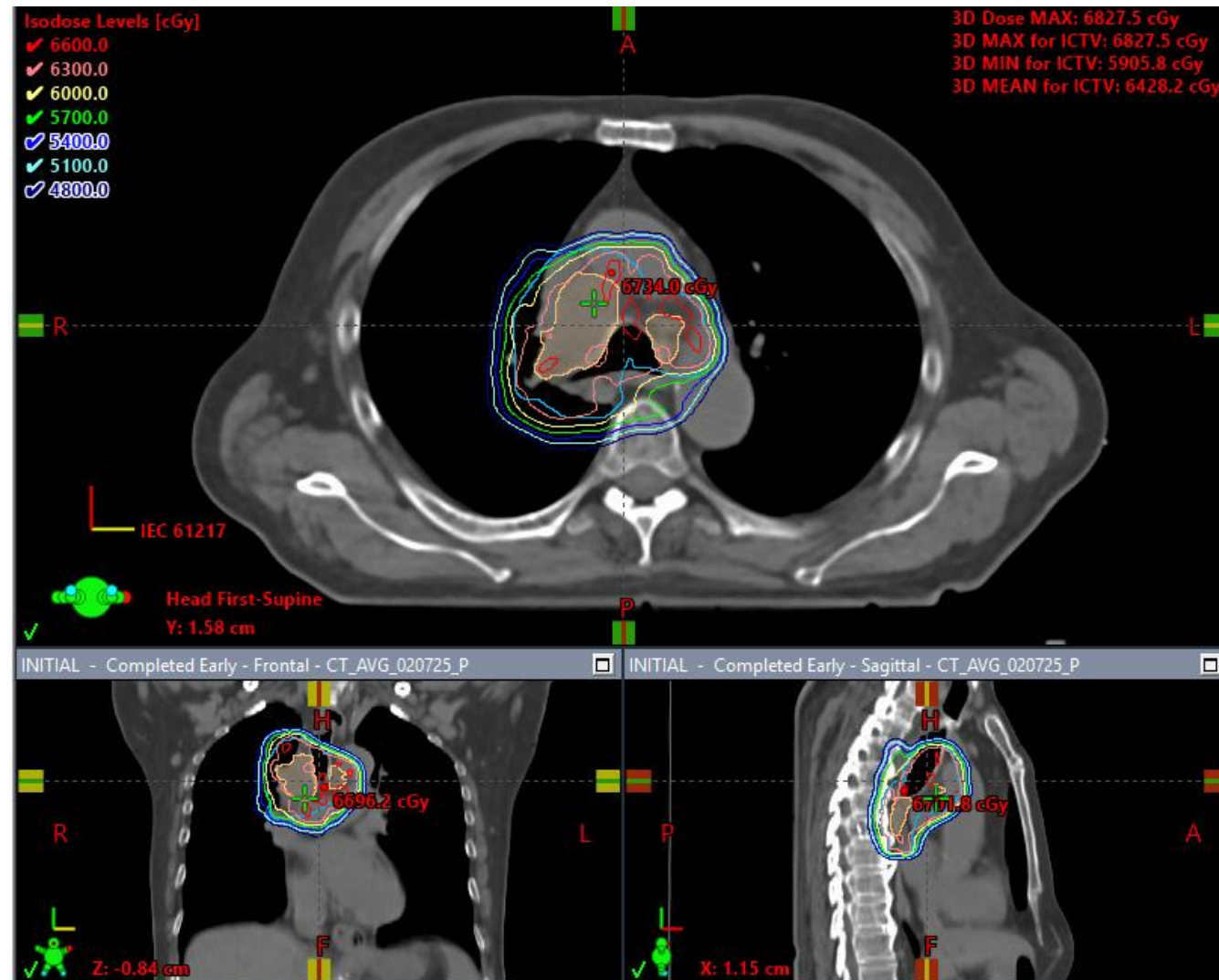


Patient Case

Radiation Decisions and why

- ▶ 60 Gy in 2 Gy daily fractions
 - SOC per RTOG 0617 and PACIFIC trials
- ▶ IMRT delivery
 - Target volume is above the heart, and IMRT does a good job there.
- ▶ Daily CBCT for alignment
 - Daily tumor imaging helps with accurate delivery and monitoring response
- ▶ Expectations: Esophagitis
 - No great prevention strategy

▶ If chemo was not concurrent delivery, would consider hypofractionation with 20 fx
Example: 50-55 Gy in 20 fractions using $\alpha/\beta = 3$



Open for discussion