

Editor's note:

In the era of personalized medicine, a critical appraisal new developments and controversies are essential in order to derived tailored approaches. In addition to its educative aspect, we expect these discussions to help younger researchers to refine their own research strategies.

Controversies on Lung Cancer: Pros and Cons

Rebuttal from Dr Nestle and Dr Belderbos

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We fully agree that in a case when a patient with a T2N0M0 NSCLC central in the hilum has no other curative treatment option and is not eligible for conventionally fractionated radiotherapy, we can discuss with him/her the potential risk of SBRT and the weakness of the available data and may offer this treatment when the patient agrees to bear this risk.

However, this discussion should clearly be aware of the fact that most populations published so far are retrospective and therefore highly selected concerning the location of the tumor and that the idea that the risk is somewhere in the order of magnitude of resection may just be a consequence from this selection. Furthermore it should be kept in mind, that the toxicity in cases of “ultra-central” tumors might be much higher with hypofractionated regimens as compared to conventional fractionation.

When we focus our literature reviews to central tumors treated with high SBRT doses, we neglect the fact that due to toxicity concerns, patients treated outside of clinical trials may receive “SBRT” with insufficient dose. These patients will likely have worse tumor control, as it was seen in the German database analysis (1).

To safely define the therapeutic bandwidth between tumor control and normal tissue toxicity for patients with central tumors profound prospective data are urgently needed. Furthermore, if we aim to further establish SBRT

in the future as an alternative to resection also for central and “ultra-central” tumors, we will have problems without prospectively collected outcome and toxicity data. These data can only be obtained by prospective trials or at least from prospective databases including standardized follow up performed by the treating radiation oncologist.

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Footnote

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References

1. Schanne DH, Nestle U, Allgäuer M, et al. Stereotactic body radiotherapy for centrally located stage I NSCLC: a multicenter analysis. *Strahlenther Onkol* 2015;191:125-32.

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