



FUNDACION
M A R I E C U R I E
Córdoba - Argentina



Congreso sobre Avances Integrados en Oncología, Radiocirugía y Física Médica: Innovación y Precisión en el tratamiento del cáncer

Carcinoma ductal in situ: *Cuándo se puede omitir cirugía y/o radioterapia*



Philip Poortmans, MD, PhD

Iridium Network & Antwerp University, Antwerpen (B)



The future of cancer therapy



Former President



Conflict of interest

Affidea – medical advisor

MSD - consultant

And I worry about the future...

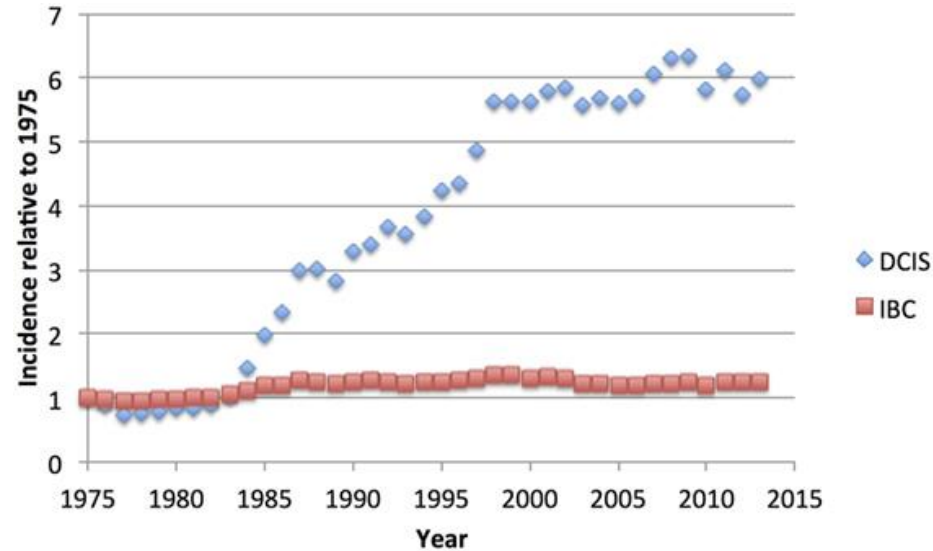
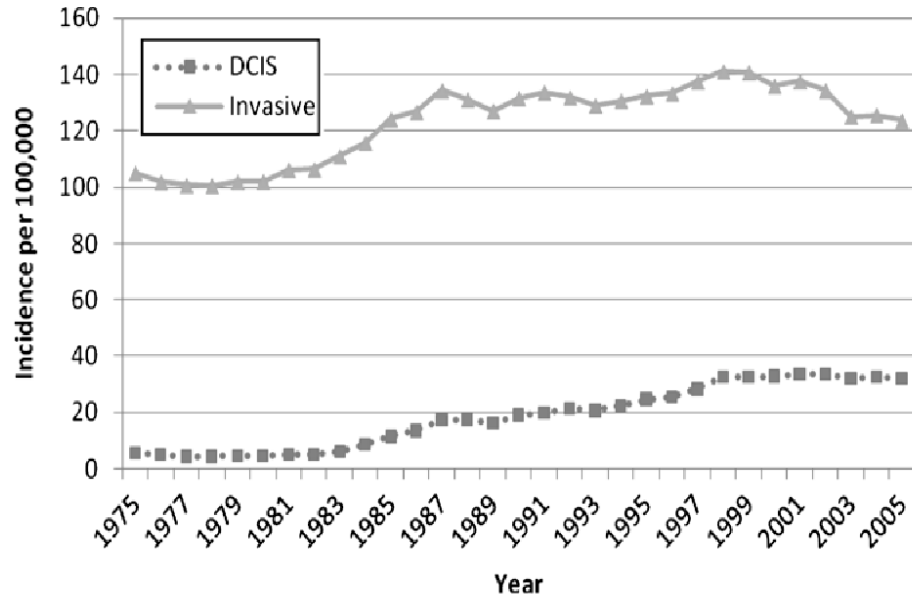


Radiation therapy for DCIS

- Introduction
- Evidence from the past
- Recent additions
- Discussion
- Conclusions

RT for DCIS: *Introduction*

Increasing breast cancer incidence, even (much) more for DCIS



RT for DCIS: *Introduction*

Old thoughts & habits:

- Rarely events after mastectomy
- Considered as pre-malignant disease
- Doubts about radiosensitivity
- Introduction of BCT followed later

Radiation therapy for DCIS

- Introduction
- Evidence from the past
- Recent additions
- Discussion
- Conclusions

RT for DCIS: *Evidence from the past*

Lumpectomy alone

Prospective, single-arm, multi-institution study:

- DCIS of predominant grade 1 or 2
- Mammographic extent ≤ 2.5 cm
- Final resection margins ≥ 1 cm
- No tamoxifen

RT for DCIS: *Evidence from the past*

Lumpectomy alone

Prospective, single-arm, multi-institution study:

- DCIS of predominant grade 1 or 2
- Mammographic extent ≤ 2.5 cm
- Final resection margins ≥ 1 cm
- No tamoxifen

July 2002: preliminary closure (157/200) of study

- Median FU of 40 months: 13 local recurrences
- 2.4% per patient-year (95% CI, 1.3% to 4.1%)
- 5-year rate of 12.5%
- 4/13 = invasive disease

RT for DCIS: *Evidence from the past*

Lumpectomy alone – ECOG trial

Prospective registration trial; median FU 6.5 years

- Eligible:
- $G1-2 \leq 2.5$ cm
 - $G3 \leq 1.0$ cm
 - margins ≥ 3 mm
 - no residual microcalcifications post-op

RT for DCIS: *Evidence from the past*

Lumpectomy alone – ECOG trial

Prospective registration trial; median FU 6.5 years

Eligible: - G1-2 ≤ 2.5 cm

- G3 ≤ 1.0 cm

- margins ≥ 3 mm

- no residual microcalcifications post-op

Included: - G1-2 median 6 mm (77% < 10 mm): n=565

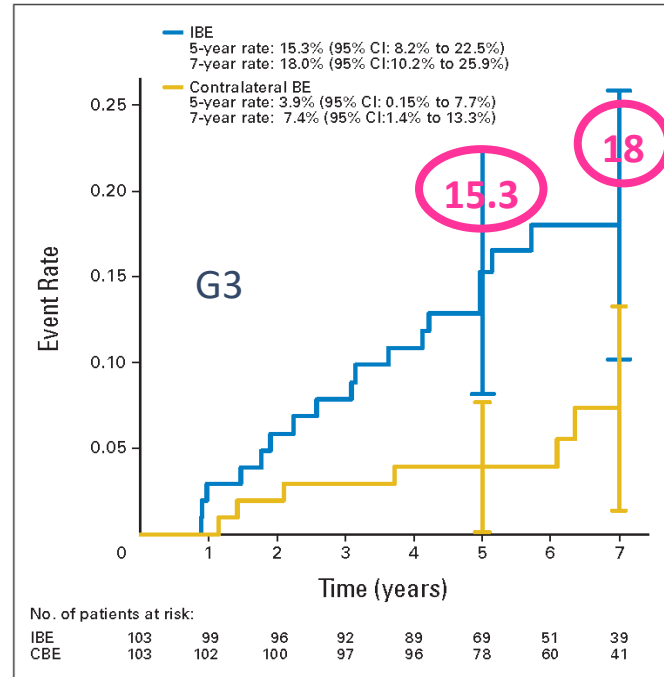
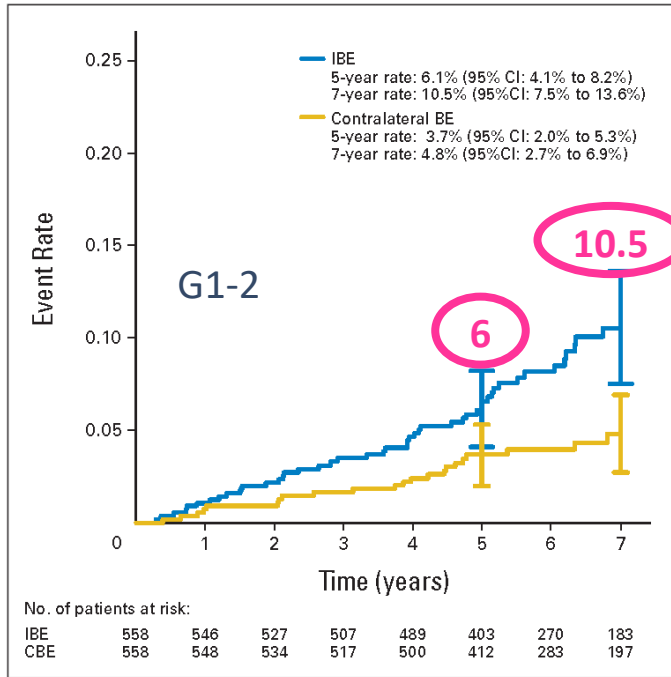
- G3 median 5 mm (88% < 10 mm): n=105

- margins ≥ 5 mm: 83%; ≥ 10 mm: 53%

- $\geq 30\%$ received Tamoxifen (from 2000 on)

RT for DCIS: *Evidence from the past*

Lumpectomy alone – ECOG trial



Ipsilateral vs contralateral breast events. 53% of IBE were invasive.

RT for DCIS: *Evidence from the past*

Nomogram for DCIS recurrence risks

Nomogram for Predicting the Risk of Local Recurrence After Breast-Conserving Surgery for Ductal Carcinoma In Situ

Udo Rudloff, Lindsay M. Jacks, Jessica I. Goldberg, Christine A. Wynveen, Edi Brogi, Sujata Patil, and Kimberly J. Van Zee

RT for DCIS: *Evidence from the past*

Nomogram for DCIS recurrence risks

Prospectively maintained DCIS database

All patients treated with BCT for DCIS

Between 1991 and 2006 → n = 1.868

Histopathologic data from original pathology reports;

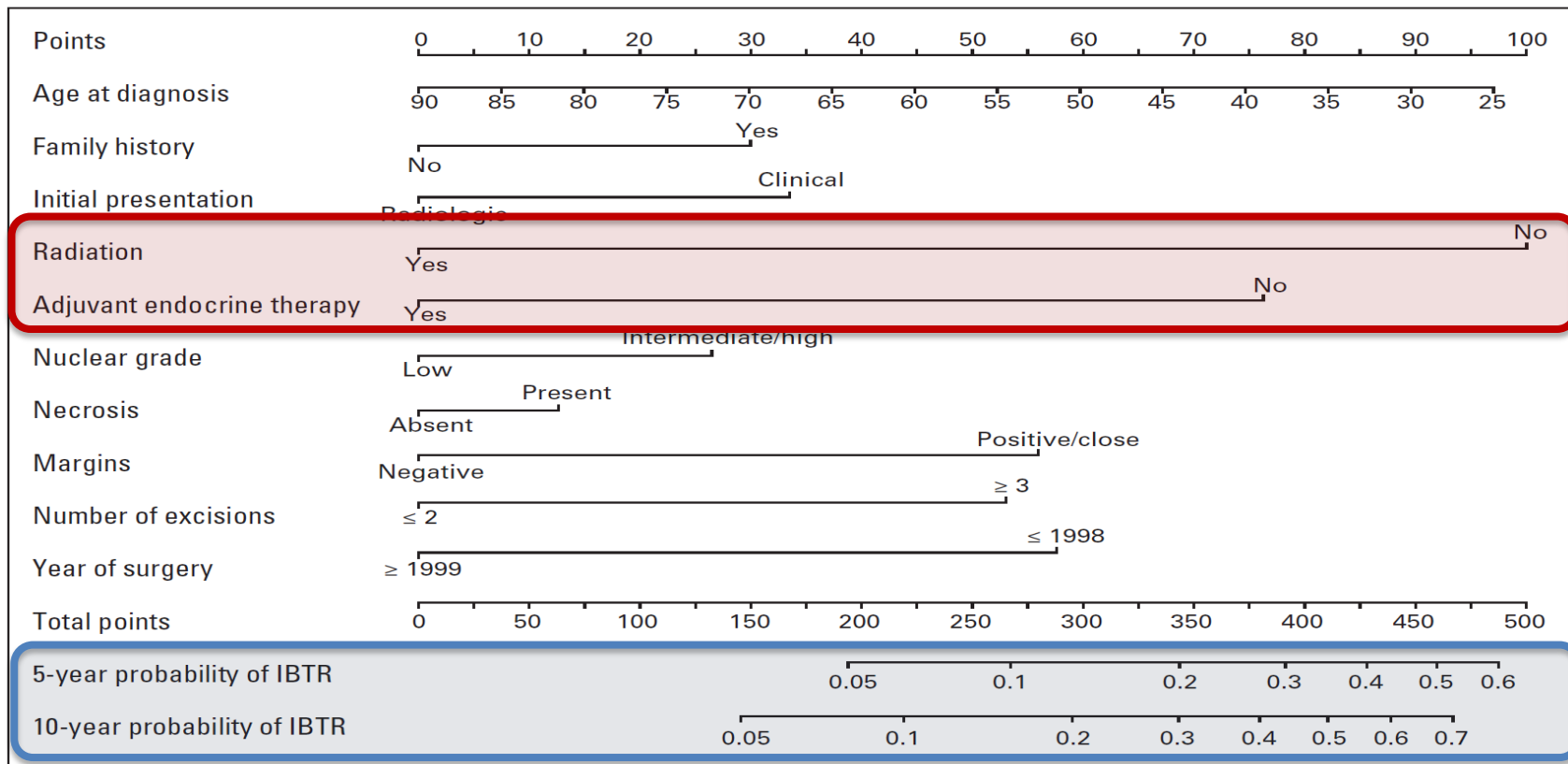
if incomplete → original slides reviewed

→ 360 of 1.868 cases; 19%

Data from 1.681 patients were complete and used

RT for DCIS: *Evidence from the past*

Nomogram for DCIS recurrence risks



RT for DCIS: *Evidence from the past*

Nomogram for DCIS recurrence risks

Limitations:

- Retrospective data
- Not randomized
- External validation required

RT for DCIS: *Evidence from the past*

Lumpectomy with/without RT

Overview of the Randomized Trials of Radiotherapy in Ductal Carcinoma In Situ of the Breast

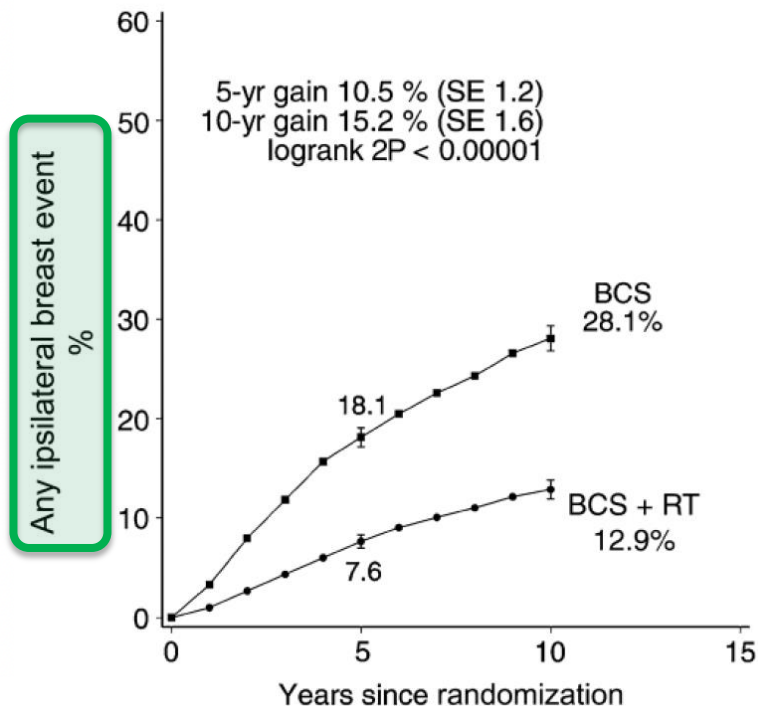
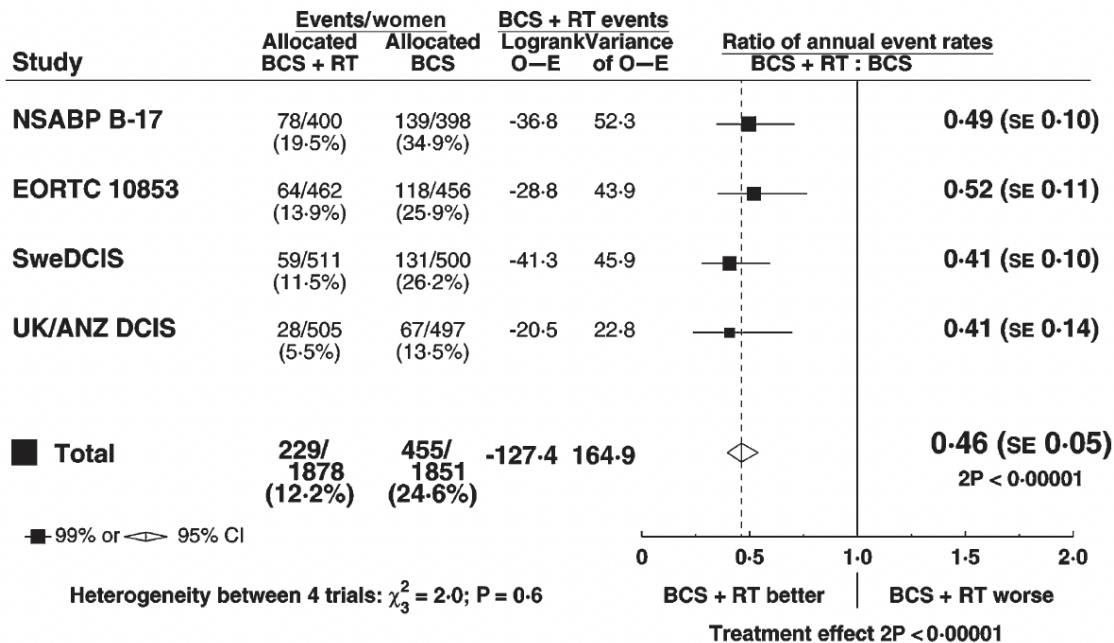
Early Breast Cancer Trialists' Collaborative Group (EBCTCG)

RT for DCIS: *Evidence from the past*

Year code, study name (reference)	Entry dates	No. of women randomized	No. of women eligible for analysis†	Median follow- up (yr)	Mammo- graphic detection (%)	Breast and axillary surgery	Negative surgical margins required	Central pathological review	Breast radiotherapy
Data available for overview									
NSABP B-17 (3, 4, 5)	1985–1990	818	798	16.5	80	Local excision (37% axillary dissection)	Yes (13% involved or unknown)‡	623 (76%)	50 Gy (2 Gy/f) 9% with boost
EORTC 10853 (6, 7, 8, 9)	1986–1996	1010	918	10.4	72	Local excision (20% axillary dissection)	Yes (16% “not free,” <1mm, involved or unknown)‡	824 (82%)	50 Gy (2 Gy/f) 5% with boost
SweDCIS (10, 11, 12)	1987–1999	1067	1011	8.4	79	Sector resection (17% axillary dissection)	No (11% positive, 9% unknown)‡	271 (25%)	50 Gy (2 Gy/f) (80%) or 48 Gy (2.4 Gy/f) (13%) or 54 Gy (2 Gy/f) then 2 wk gap (7%) Boost not recommended
UK/ANZ DCIS§(13)	1990–1998	1030	1002	4.8	100	Local excision (No axillary dissection)	Yes	0 (0%)	50 Gy (2 Gy/f) Boost not recommended
Data not yet available									
RTOG 9804	1999–2006	636	–	–	ns	Local excision (No axillary dissection)	Yes	0 (0%)	50.4 Gy (1.8 Gy/f) or 50 Gy (2 Gy/f) or 42.5 Gy (2.7 Gy/f) Boost not recommended

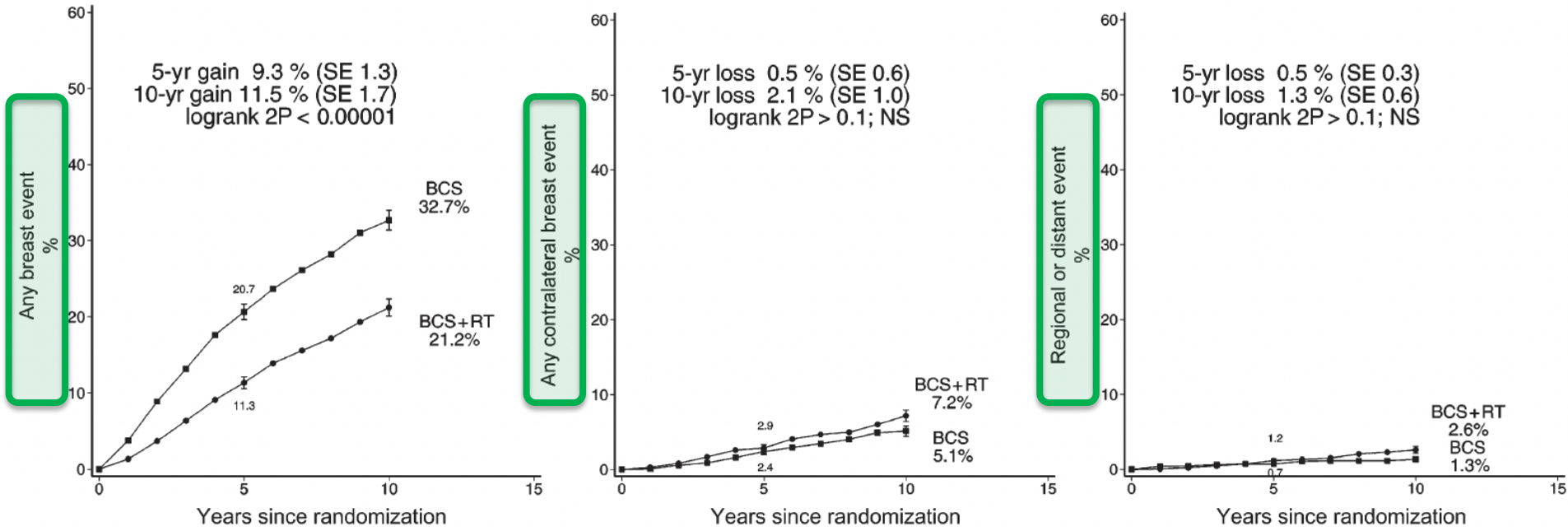
RT for DCIS: *Evidence from the past*

Lumpectomy with/without RT



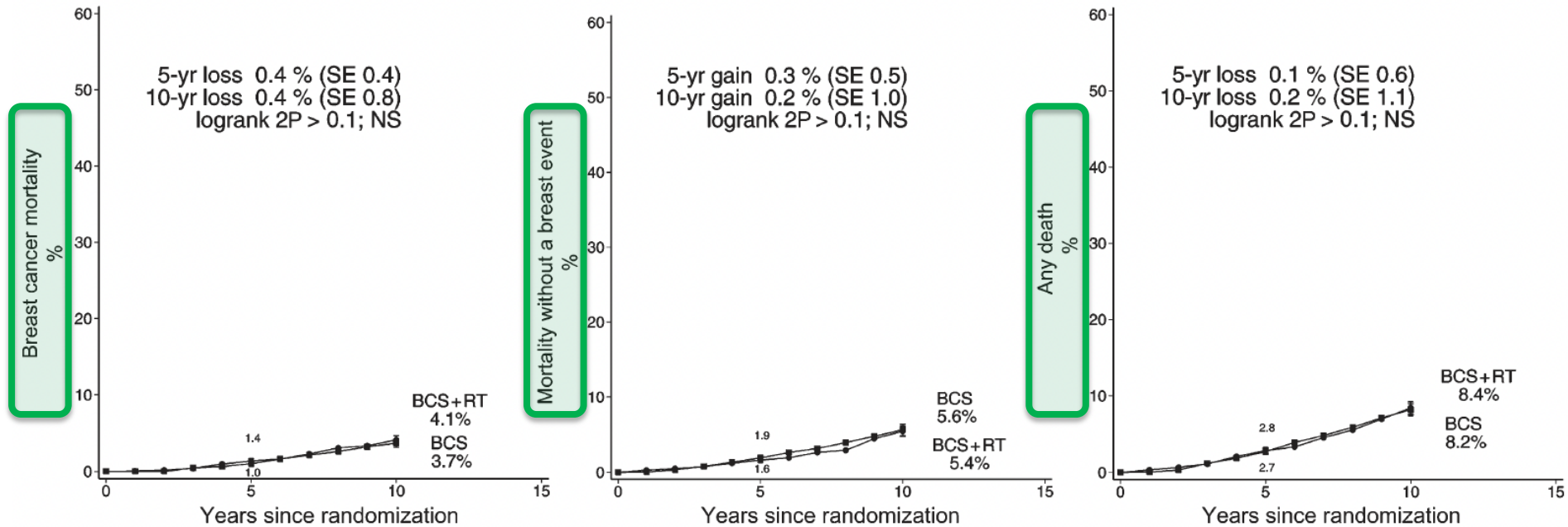
RT for DCIS: *Evidence from the past*

Lumpectomy with/without RT



RT for DCIS: *Evidence from the past*

Lumpectomy with/without RT



RT for DCIS: *Evidence from the past*

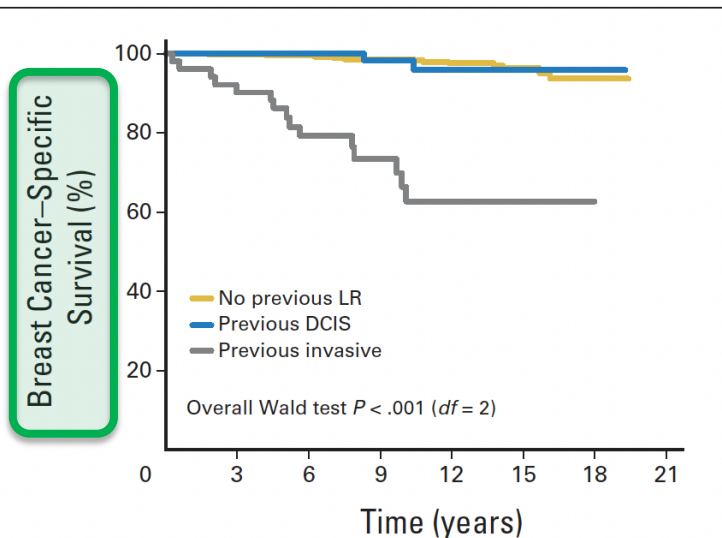
Lumpectomy with/without RT

Breast-Conserving Treatment With or Without Radiotherapy in Ductal Carcinoma In Situ: 15-Year Recurrence Rates and Outcome After a Recurrence, From the EORTC 10853 Randomized Phase III Trial

Mila Donker, Saskia Litière, Gustavo Werutsky, Jean-Pierre Julien, Ian S. Fentiman, Roberto Agresti, Philippe Rouanet, Christine Tunon de Lara, Harry Bartelink, Nicole Duez, Emiel J.T. Rutgers, and Nina Bijker

RT for DCIS: *Evidence from the past*

Lumpectomy with/without RT – after invasive recurrence



No. at risk	O	n						
No previous LR	18	832	781	668	554	291	101	27
Previous DCIS	2	70	68	63	52	34	14	2
Previous invasive	15	52	46	32	23	10	4	0

	FU (years)	Hazard ratio	
		Breast cancer mortality after invasive LR	All cause mortality after invasive LR
EORTC 10853	15.8	17.7	5.2
NSABP B17	17.3	7.1	1.8
NSABP B24	13.6		

RT for DCIS: *Evidence from the past*

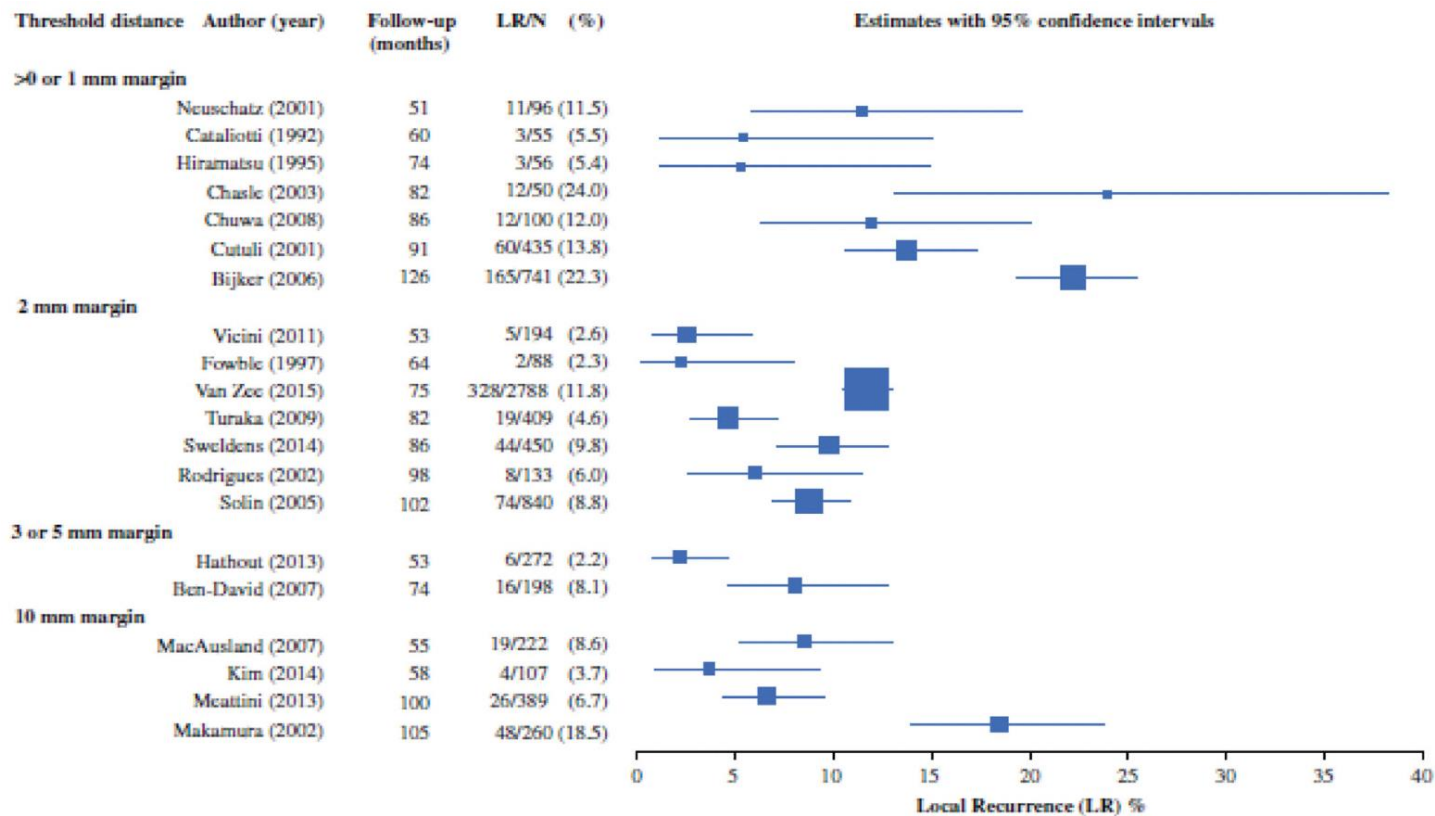
Optimal surgical margins

The Association of Surgical Margins and Local Recurrence in Women with Ductal Carcinoma *In Situ* Treated with Breast-Conserving Therapy: A Meta-Analysis

M. Luke Marinovich^{1,*}, Lamiae Azizi¹, Petra Macaskill¹, Les Irwig¹, Monica Morrow², Lawrence J Solin³, and Nehmat Houssami¹

RT for DCIS: *Evidence from the past*

Optimal surgical margins



RT for DCIS: *Evidence from the past*

Optimal surgical margins

Negative margins ➔ halved LR risk

RT for DCIS: *Evidence from the past*

Optimal surgical margins

Negative margins → halved LR risk

SSO-ASTRO-ASCO consensus guideline for BCS+WBI in DCIS

- ✓ 2 mm surgical margin → low LR rates without adverse cosmetic outcome
- ✓ Margin >2 mm → not significantly better
- ✓ Negative margin <2 mm → as such not an indication for mastectomy, further surgery should be guided by clinical judgment and patient preference



Notes: Dutch protocol: re-excision rarely indicated
This is about pure DCIS, not about margins in associated DCIS
Also in DCIS, LR rates are decreasing

RT for DCIS: *Evidence from the past*

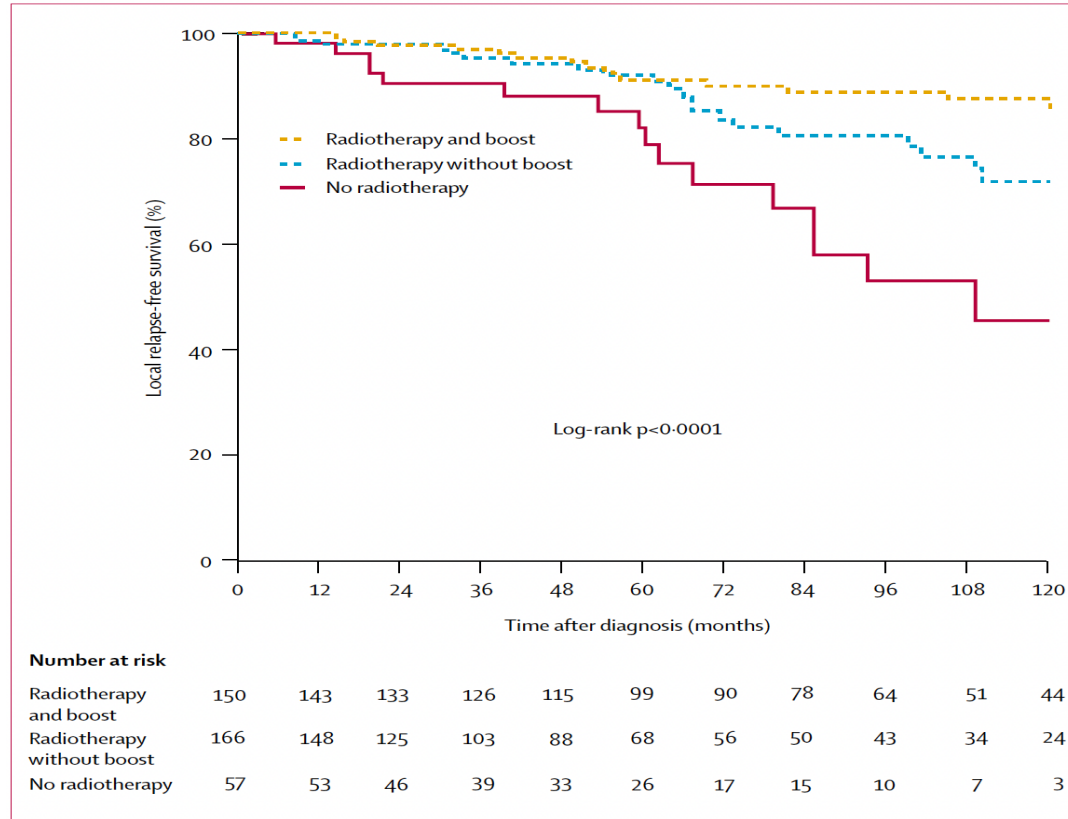
Boost after WBI

Boost radiotherapy in young women with ductal carcinoma in situ: a multicentre, retrospective study of the Rare Cancer Network

Aurelius Omlin, Maurizio Amichetti, David Azria, Bernard F Cole, Philippe Fournier, Philip Poortmans, Diana Naehrig, Robert C Miller, Marco Krengli, Cristina Gutierrez Miguelez, David Morgan, Hadassah Goldberg, Luciano Scandolaro, Pauline Gastelblum, Mahmut Ozsahin, Dagmar Dohr, David Christie, Ulrich Oppitz, Ufuk Abacioglu, Guenther Gruber

RT for DCIS: *Evidence from the past*

Boost after WBI



Radiation therapy for DCIS

- Introduction
- Evidence from the past
- Recent additions
- Discussion
- Conclusions

RT for DCIS: *Recent additions*

BIG 3–07/TROG 07.01: fractionation & boost in DCIS

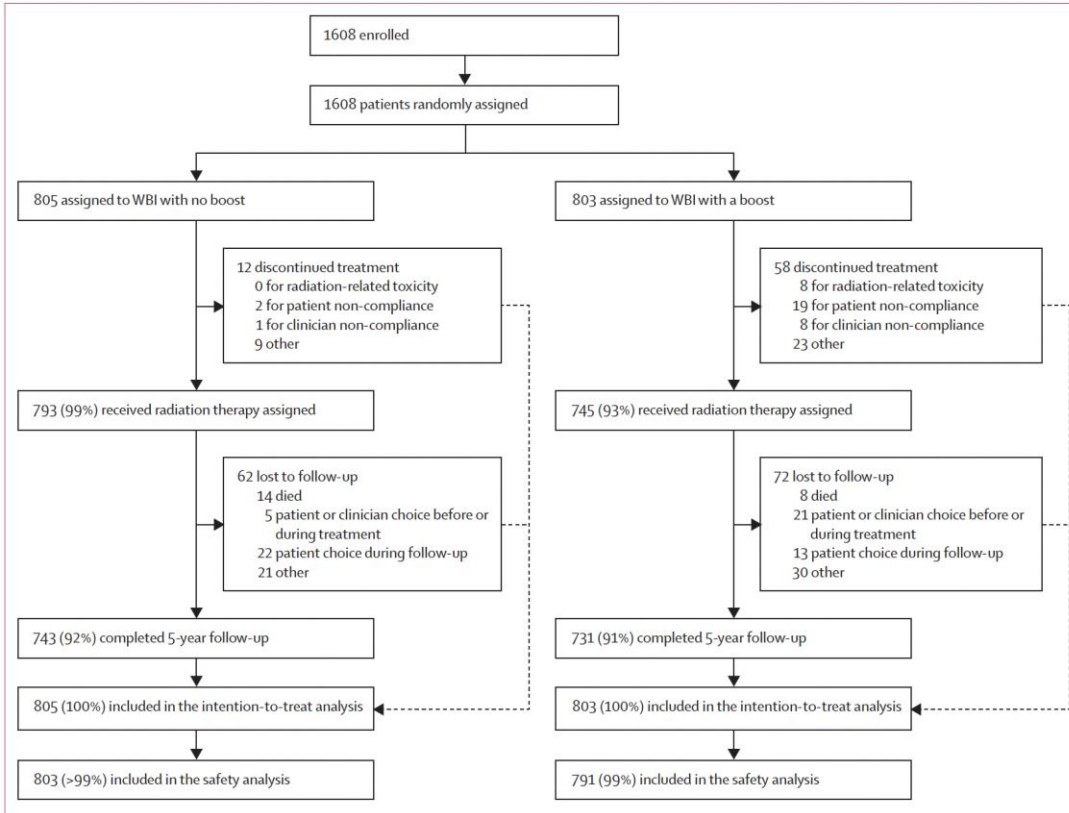
Radiation doses and fractionation schedules in non-low-risk ductal carcinoma in situ in the breast (BIG 3–07/TROG 07.01): a randomised, factorial, multicentre, open-label, phase 3 study



Boon H Chua, Emma K Link, Ian H Kunkler, Timothy J Whelan, A Helen Westenberg, Guenther Gruber, Guy Bryant, Verity Ahern, Kash Purohit, Peter H Graham, Mohamed Akra, Orla McArdle, Peter O'Brien, Jennifer A Harvey, Carine Kirkove, John H Maduro, Ian D Campbell, Geoff P Delaney, Joseph D Martin, T Trinh T Vu, Thierry M Muanza, Anthony Neal, Ivo A Olivotto, on behalf of the BIG 3–07/TROG 07.01 trial investigators*

RT for DCIS: *Recent additions*

BIG 3–07/TROG 07.01: fractionation & boost in DCIS



➤ 2007 - 2014

➤ N = 1608 patients

➤ Randomised:

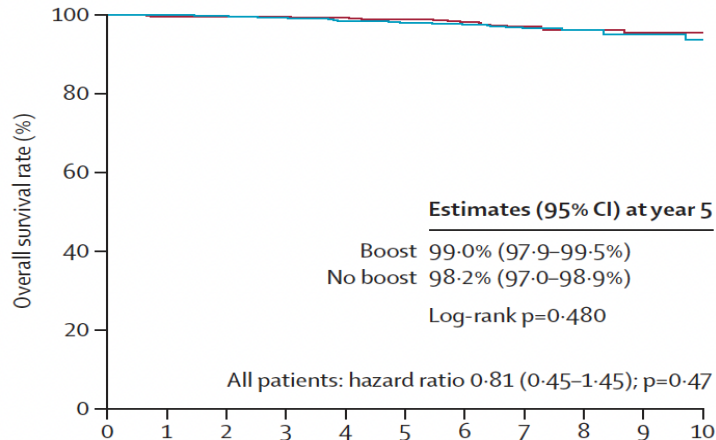
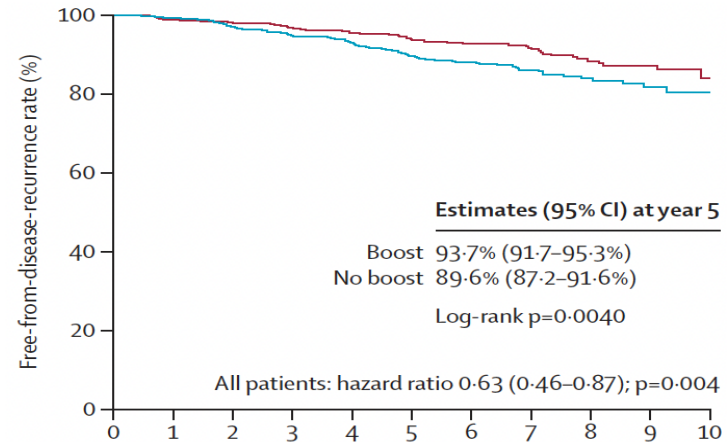
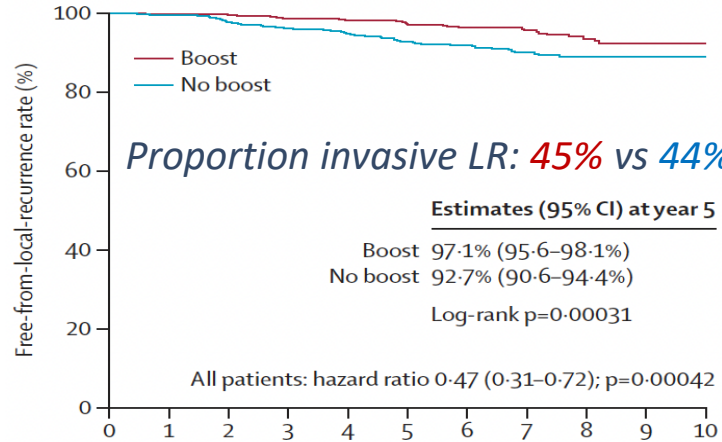
1. boost (n = 803) vs no boost (n = 805)

2. CF WBI (n = 831) & HF WBI (n = 777)

➤ Median FU 6.6 years.

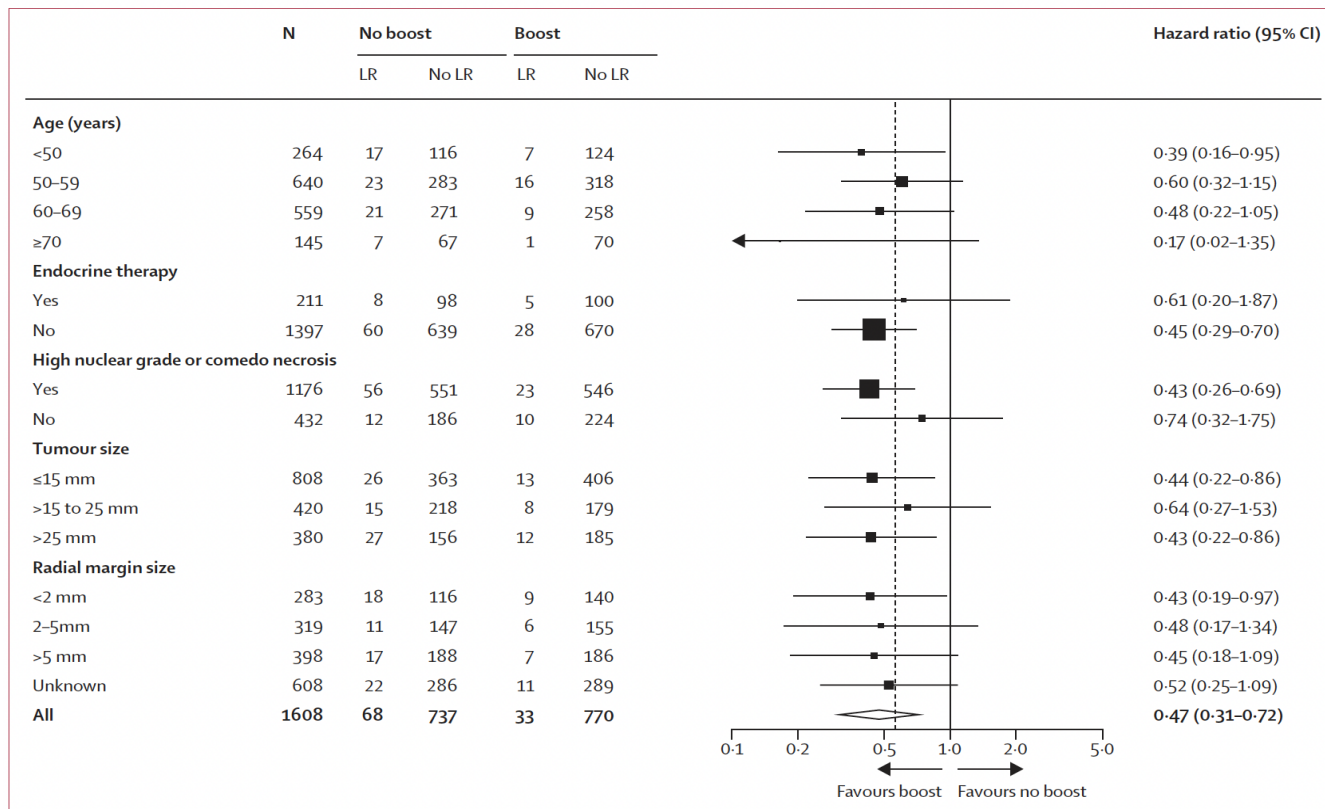
RT for DCIS: Recent additions

*BIG 3-07/TROG 07.01: fractionation & **boost** in DCIS*



RT for DCIS: *Recent additions*

*BIG 3–07/TROG 07.01: fractionation & **boost** in DCIS*



RT for DCIS: *Recent additions*

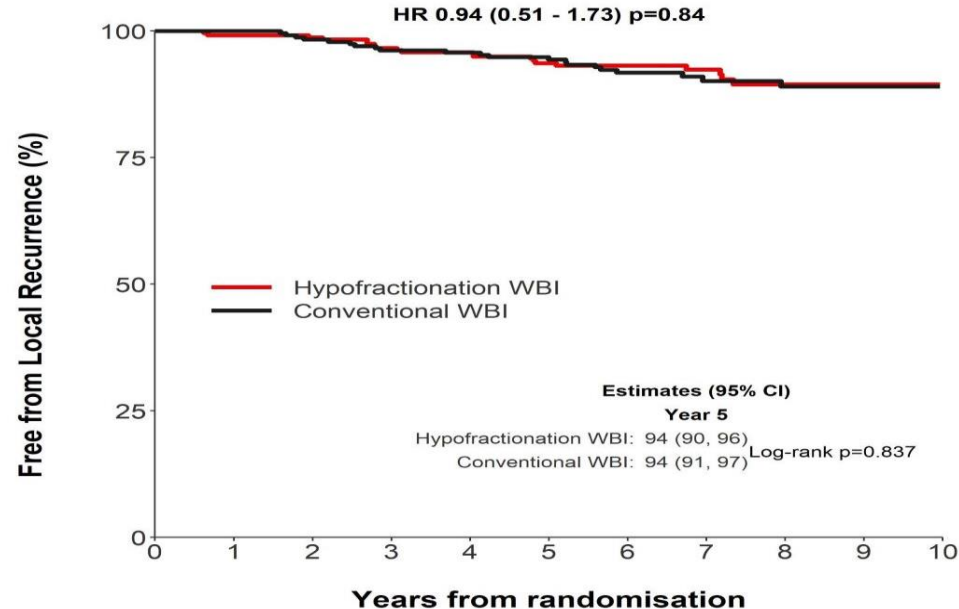
*BIG 3–07/TROG 07.01: fractionation & **boost** in DCIS – side effects*

Acute	No BOOST (N=805)			BOOST (N=803)			P
Grade	2	3	4	2	3	4	
Fatigue	112	7	0	131	11	1	0.25
Radiation dermatitis	227	8	0	338	23	1	0.006
Breast pain	90	8	0	116	10	1	0.49
Pneumonitis	0	1	0	1	1	0	>0.99
Late							
Breast pain	67	10	0	102	12	2	0.003
Induration or fibrosis	44	5	-	99	11	-	<0.0001
Telangiectasia	4	3	0	16	4	0	0.02
Pneumonitis	2	0	0	6	1	0	0.12
Cardiac	0	1	0	1	0	3	0.21
Second malignancy	-	2	2	-	0	0	>0.99

Boon HC, et al. Lancet 2022; 400: 431–4.

RT for DCIS: *Recent additions*

*BIG 3–07/TROG 07.01: **fractionation** & boost in DCIS*



No. at risk

Hypofractionation WBI	253	242	238	231	223	199	148	107	73	49	17
Conventional WBI	250	238	232	226	217	194	152	105	81	53	17

RT for DCIS: *Recent additions*

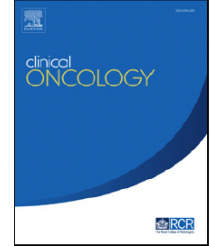
RT boost



Contents lists available at [ScienceDirect](#)

Clinical Oncology

journal homepage: www.clinicaloncologyonline.net



Original Article

Variation in the Use of Boost Irradiation in Breast-Conserving Therapy in the Netherlands: The Effect of a National Guideline and Confounding Factors[☆]

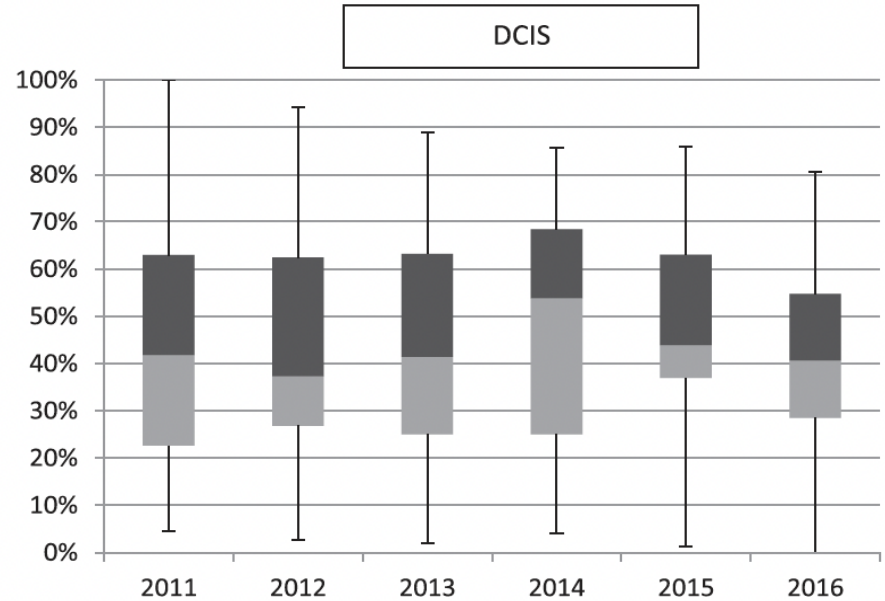
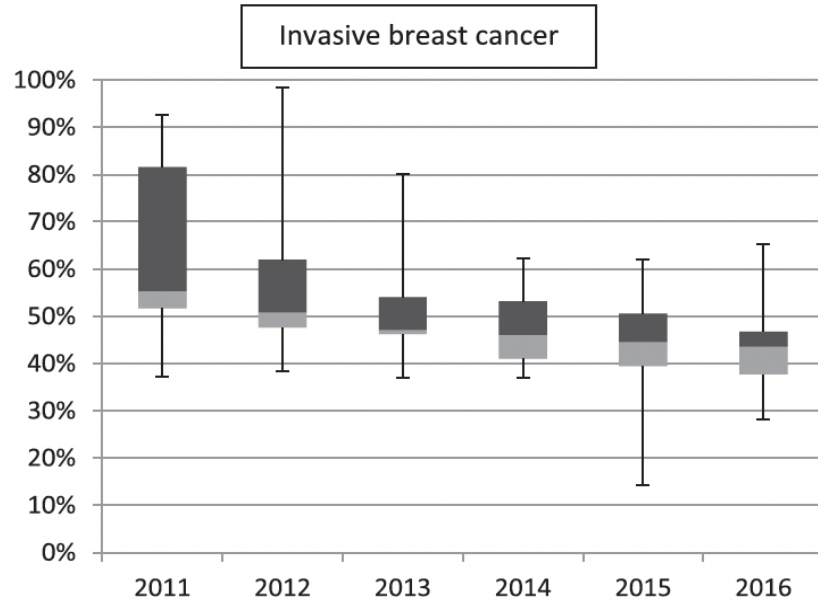


K. Schreuder^{*†‡}, J.H. Maduro^{‡§}, P.E.R. Spronk^{‡¶}, N. Bijker^{‡||}, P.M.P. Poortmans^{**}, T. van Dalen^{‡‡‡}, H. Struikmans^{‡‡‡}, S. Siesling^{*†‡}

Schreuder K, et al. Clinical Oncology 31 (2019) 250e259.

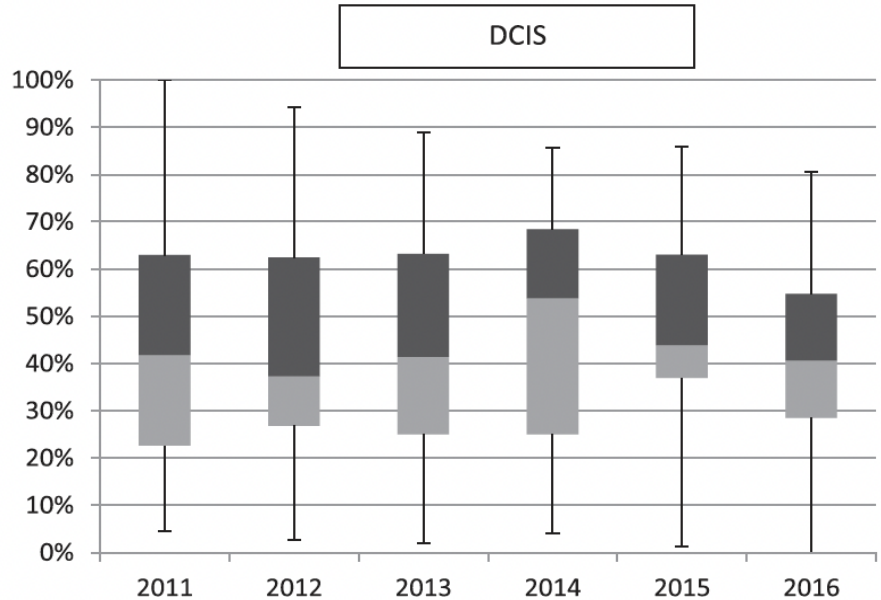
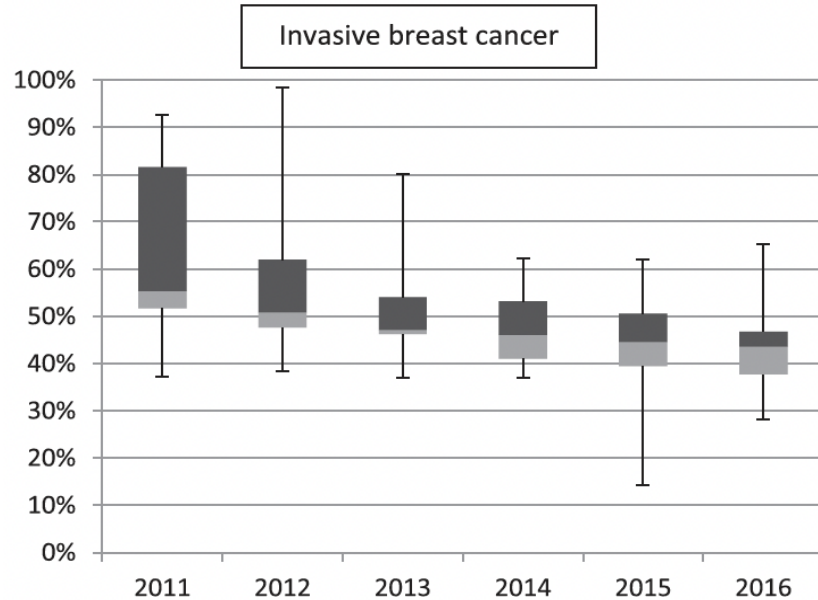
RT for DCIS: *Recent additions*

RT boost – NL, 2011-2016 after BCT



RT for DCIS: *Recent additions*

RT boost – NL, 2011-2016 after BCT



Evers J, et al Clin Oncol 2025 (2017-2022):

- Omission of surgery → 30%
- Decreased use of RT overall
- Decreased use of boost
- Introduction of PBI

RT for DCIS: *Recent additions*

What about PMRT?

Radiotherapy and Oncology 161 (2021) 177–182



Contents lists available at [ScienceDirect](#)

Radiotherapy and Oncology

journal homepage: www.thegreenjournal.com



Short Communication

Superficial margins in skin sparing and nipple sparing mastectomies for DCIS: A margin of potential concern



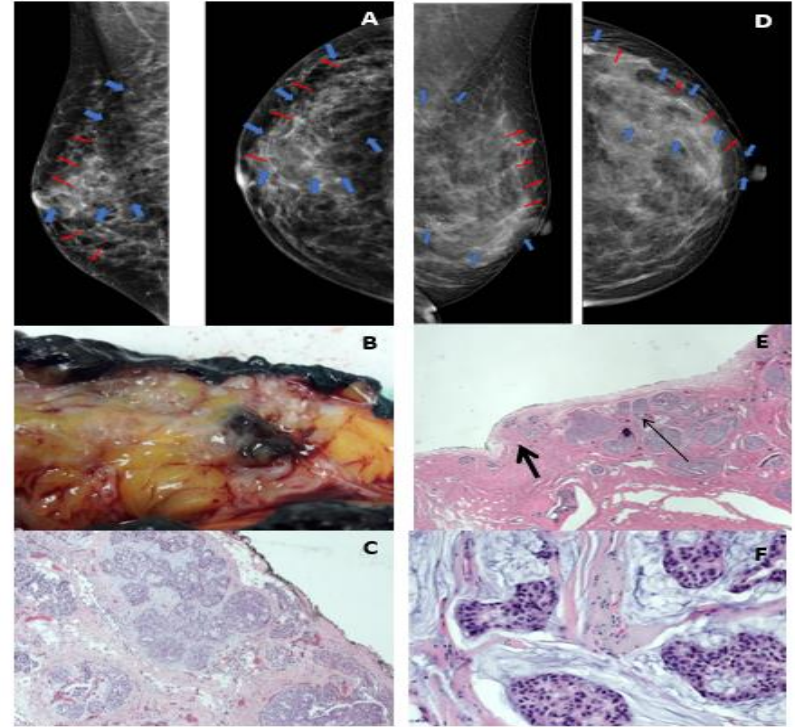
Trine Tramm ^{a,*}, Peer Christiansen ^b, Birgitte Vrou Offersen ^c, Karen Berenth Madsen ^d, Philip Poortmans ^{e,f}, Orit Kaidar-Person ^{g,h}

Tramm T, et al. Radiother Oncol. 2021;161:177-82.

RT for DCIS: *Recent additions*

What about PMRT?

- Even if the resection is done perfectly, the limits of anatomic extension of the fibroglandular tissue may be imprecise and show substantial variation
- Depending on the primary disease site within the breast, involved or close superficial margins in SSM/NSM may be underestimated



Extensive DCIS close to the margin

RT for DCIS: *Recent additions*

What about PMRT?

Critical Reviews in Oncology / Hematology 138 (2019) 207–213



ELSEVIER

Contents lists available at [ScienceDirect](#)

Critical Reviews in Oncology / Hematology

journal homepage: www.elsevier.com/locate/critrevonc



The Assisi Think Tank Meeting Survey of post-mastectomy radiation therapy in ductal carcinoma in situ: Suggestions for routine practice



A. Montero-Luis^{a,*}, C. Aristei^b, I. Meattini^c, M. Arenas^d, L. Boersma^e, C. Bourcier^f, C. Coles^g, B. Cutuli^h, L. Falcinelliⁱ, O. Kaidar-Person^j, M.C. Leonardi^k, B. Offersen^l, F. Marazzi^m, S. Riveraⁿ, L. Tagliaferri^o, V. Tombolini^p, C. Vidali^q, V. Valentini^r, P. Poortmans^s

Montero-Luis A, et al. CROG 2019;138:207-13.

RT for DCIS: *Recent additions*

Partial breast irradiation

COMMENTARY

WILEY *The Breast Journal*

Partial breast irradiation for ductal carcinoma in situ: The Goldilocks principle?

Icro Meattini¹ MD  | Philip Poortmans² MD, PhD | Lorenzo Livi¹ MD | Orit Kaidar Person³ MD  | Stefania Pallotta⁴ PhD | Carlotta Becherini¹ MD | Livia Marrazzo⁴ PhD

RT for DCIS: *Recent additions*

Partial breast irradiation

European Society for Radiotherapy and Oncology Advisory Committee in Radiation Oncology Practice consensus recommendations on patient selection and dose and fractionation for external beam radiotherapy in early breast cancer



Icro Meattini, Carlotta Becherini, Liesbeth Boersma, Orit Kaidar-Person, Gustavo Nader Marta, Angel Montero, Birgitte Vrou Offersen, Marianne C Aznar, Claus Belka, Adrian Murray Brunt, Samantha Dicuonzo, Pierfrancesco Franco, Mechthild Krause, Mairead MacKenzie, Tanja Marinko, Livia Marrazzo, Ivica Ratosa, Astrid Scholten, Elżbieta Senkus, Hilary Stobart, Philip Poortmans, Charlotte E Coles**

Meattini I, et al. Lancet Oncol 2022; 23: e21–31.

RT for DCIS: *Recent additions*

Partial breast irradiation

4. Partial breast irradiation–patient selection for external beam radiotherapy

Low risk-features suitable for partial breast irradiation are:
luminal-like subtypes small tumour (≤ 3 cm), absence of lymph
vascular space invasion, non-lobular invasive carcinoma, tumour
grade 1–2, low-to-intermediate grade DCIS (sized ≤ 2.5 cm with
clear surgical margins ≥ 3 mm), age at diagnosis 50 years or more,
unicentric or unifocal lesion, clear surgical margins (> 2 mm),
node negative (including isolated tumour cells), and no use of
primary systemic therapy and neoadjuvant chemotherapy

RT for DCIS: *Recent additions*

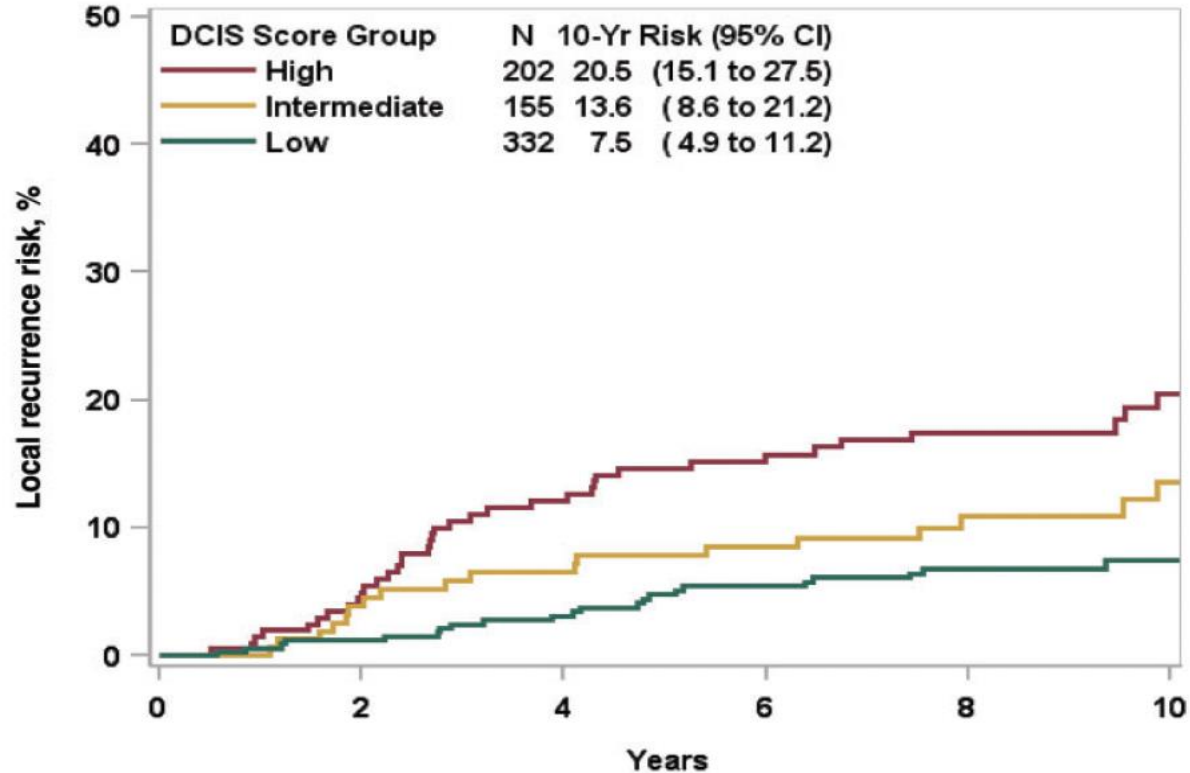
Molecular & genomic predictors

Multigene Expression Assay and Benefit of Radiotherapy After Breast Conservation in Ductal Carcinoma in Situ

Eileen Rakovitch, Sharon Nofech-Mozes, Wedad Hanna, Rinku Sutradhar, Frederick L. Baehner, Dave P. Miller, Cindy Fong, Sumei Gu, Alan Tuck, Sandip Sengupta, Leela Elavathil, Prashant A. Jani, Michel Bonin, Martin C. Chang, Elzbieta Slodkowska, Joseph M. Anderson, Diana B. Cherbavaz, Steven Shak, Lawrence Paszat

RT for DCIS: *Recent additions*

Molecular & genomic predictors



RT for DCIS: *Recent additions*

Molecular & genomic predictors

E4112 Schema & Eligibility

March 2015-Apr 2016

Inclusion

Women with core biopsy-proven unilateral DCIS within the past 4 months

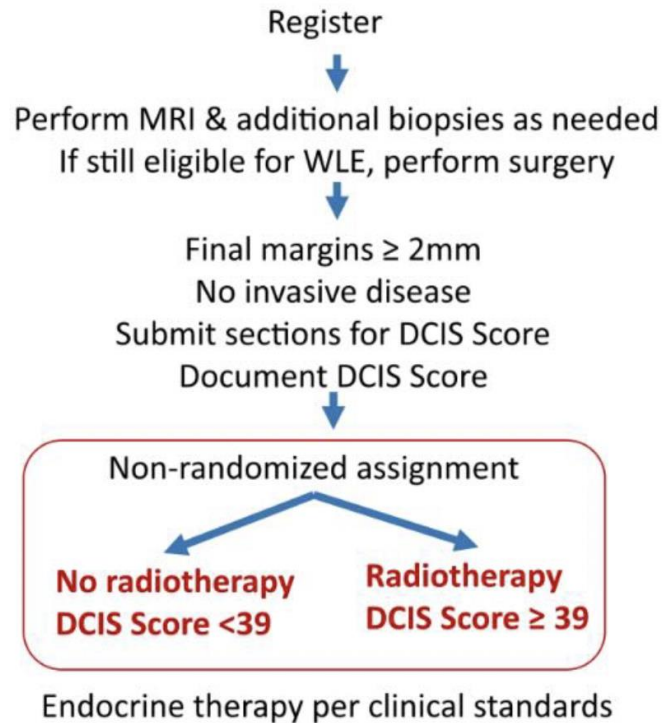
No microinvasion

Breast conservation was feasible based on conventional imaging

Disease resectable in a single specimen

No prior history of invasive breast cancer or DCIS

No use of anti-estrogens in prior 3 months



RT for DCIS: *Recent additions*

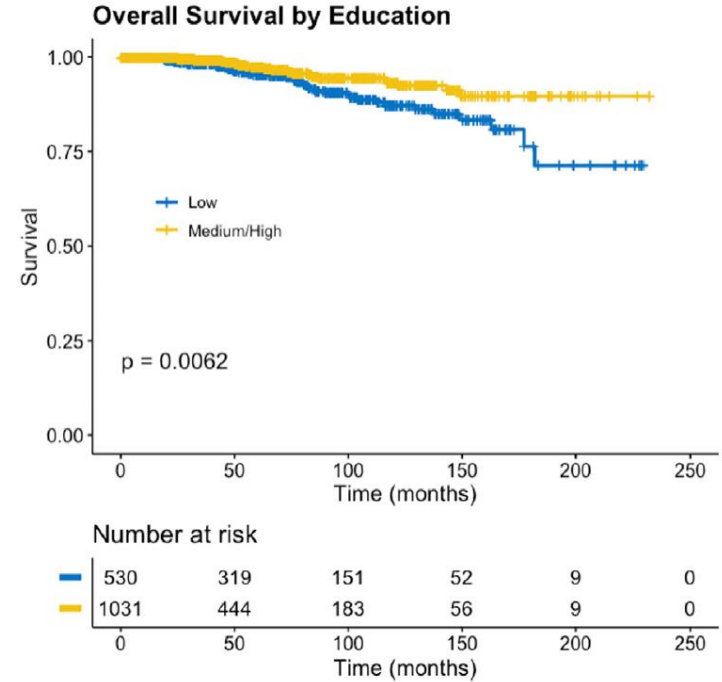
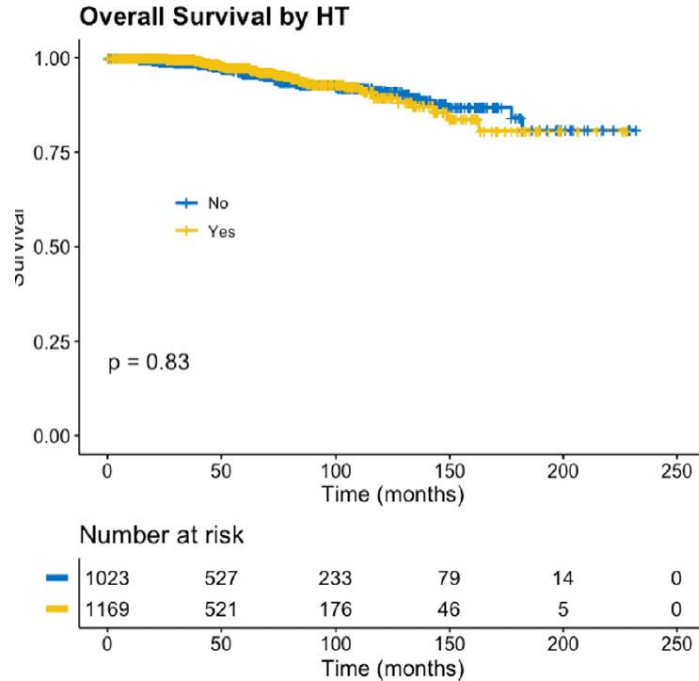
Molecular & genomic predictors

Conclusion

- DCIS Score identified ~50% as eligible for omission of radiation therapy following MRI and successful BCS.
 - Adherence to RT recommendations was 93% (159/171)
- Women with intermediate/high Score DCIS who received radiotherapy experienced an IBE rate that was approximately two-thirds lower than previously reported.
- When DCIS Score was low, 5-year IBE rate was ~5%, as in prior studies where RT omission was based on low-grade or low Score DCIS.
- Analysis of 10-year IBE outcomes from E4112 is planned, and larger prospective studies are under consideration.

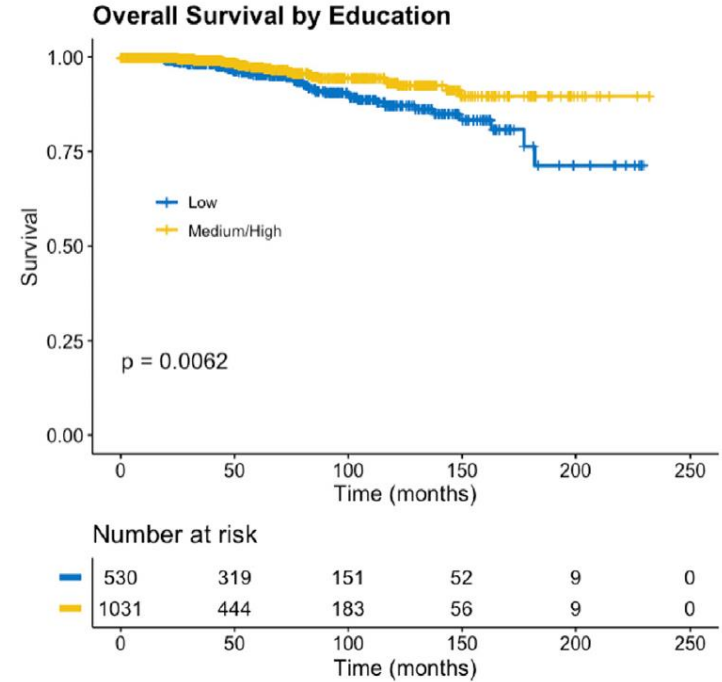
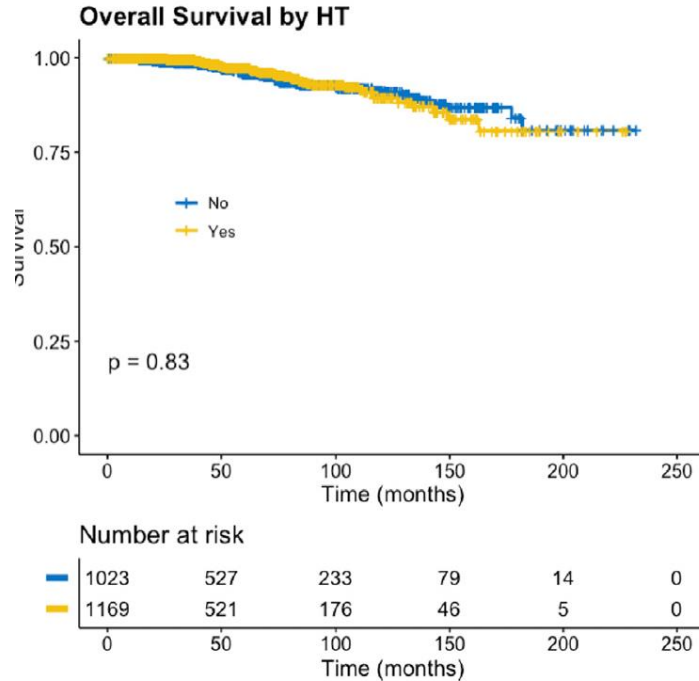
RT for DCIS: *Recent additions*

Value of endocrine therapy & SES



RT for DCIS: *Recent additions*

Value of endocrine therapy & SES



*SES-effect also seen in Dutch
population-based study*

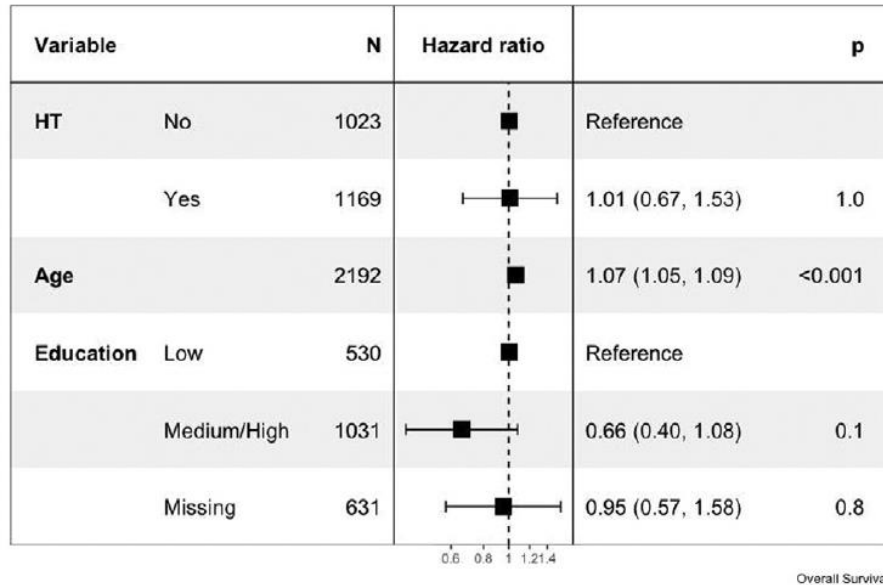
Schmitz R, et al IJC 2025.

RT for DCIS: *Recent additions*

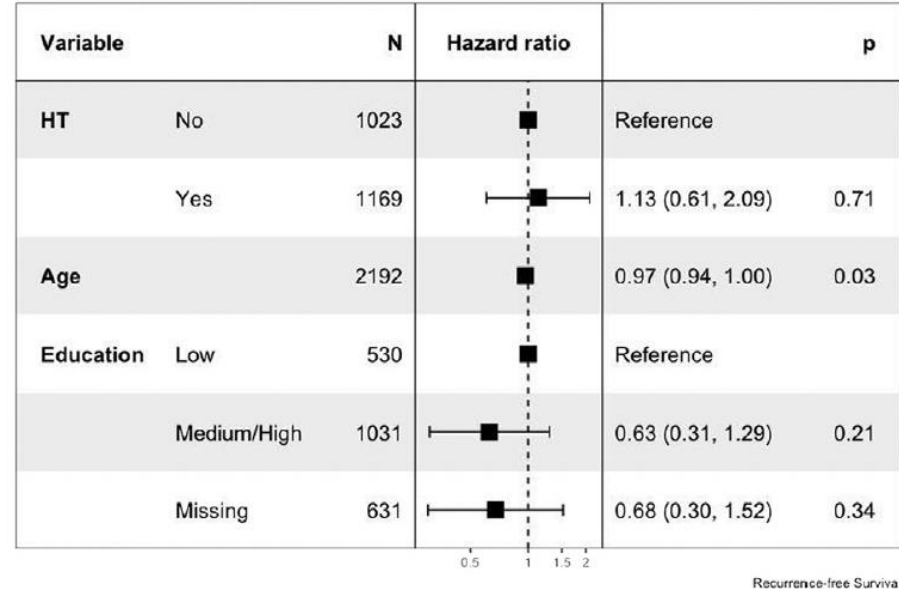
Value of endocrine therapy & SES

Multivariable analysis

OS



RFS



RT for DCIS: *Recent additions*

Omission of surgery

Study	N	Age	Eligibility	Endocrine therapy
LORIS (RCT)	932	≥48	Low-risk on central review	No
COMET (RCT)	1200	≥40	G1 or 2, ER/PR+	Optional
LORD (RCT → registry)	1240	≥45	G1 or 2	No
LORETTA (registry)	340	≥40	G1 or 2, ER/PR+, ≤25mm	Tamoxifen

Radiation therapy for DCIS

- Introduction
- Evidence from the past
- Recent additions
- Discussion
- Conclusions

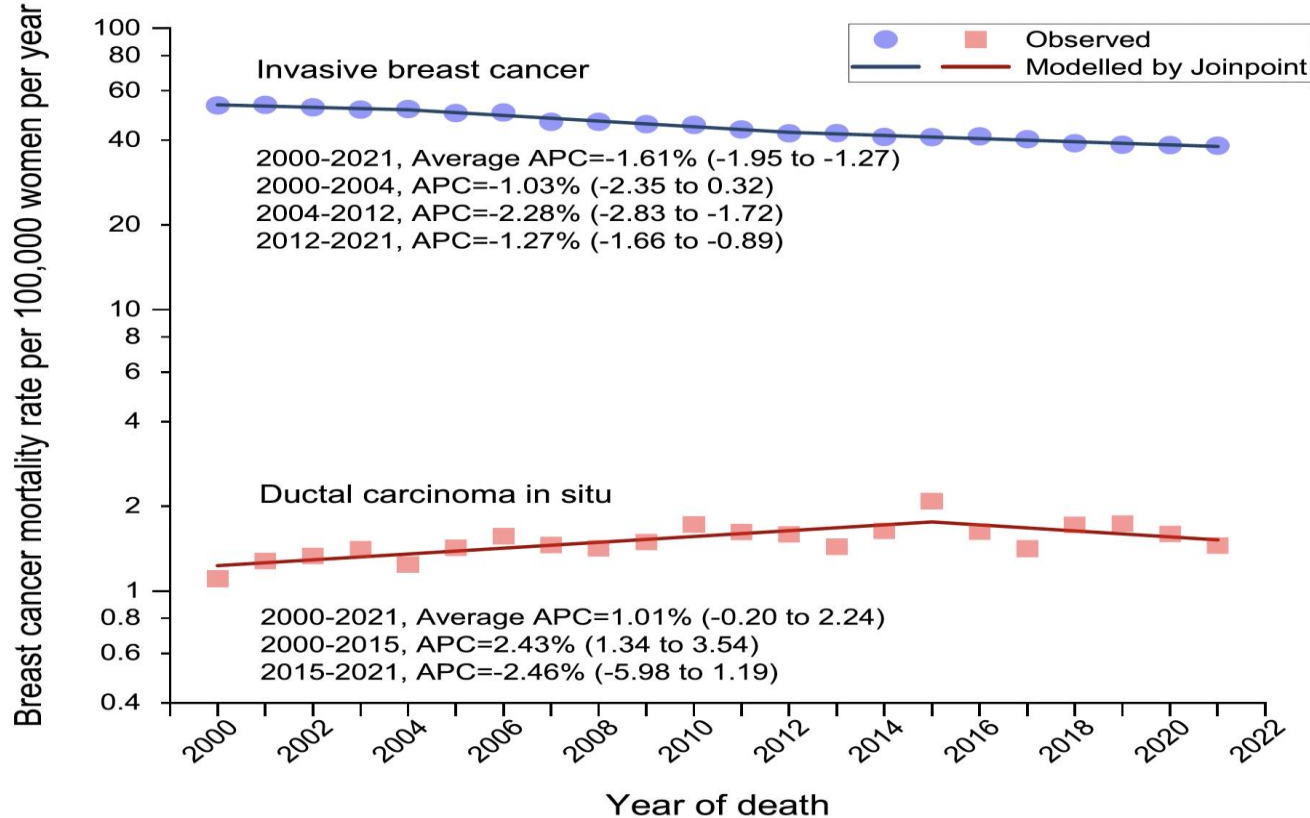
RT for DCIS: *Discussion*

Basis

- ✓ Low breast cancer mortality after DCIS diagnosis
- ✓ Increased mortality after invasive local recurrence (LR)
- ✓ Principal goal of treatment of DCIS is prevention of invasive LR
- ✓ Changing surgical extend → jeopardising safety?

RT for DCIS: *Discussion*

Trends in death rates from DCIS versus invasive BC in the United States



RT for DCIS: *Discussion*

Local treatments for DCIS

- ✓ No randomised comparison of mastectomy vs BCS/BCT
- ✓ Higher LR if no RT after BCS
- ✓ Observational cohort study (n=140,366) 15-year BC-mortality: BCT 1.7% vs BCS or mastectomy 2.3% (= *significant*)
- ✓ BCT or mastectomy both options for shared decision-making
- ✓ Mastectomy ± reconstruction if no adequate surgical margins or no good cosmetic outcome expected after conservative surgery

RT for DCIS: *Discussion*

Radiation therapy for DCIS

- Challenging to apply study results in practice:
 - Low-risk characteristics not well-defined
 - LR increases with follow-up
- Shared decision-making on omission of RT after BCS:
 - Patient preference
 - Competing causes of mortality
 - Side effects of RT

RT for DCIS: *Discussion*

Radiation therapy for DCIS spares breasts

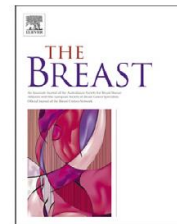
The Breast 37 (2018) 179–180



Contents lists available at ScienceDirect

The Breast

journal homepage: www.elsevier.com/brst



Editorial

Radiation therapy after breast conserving surgery increases long-term breast conservation for DCIS patients



Orit Kaidar-Person¹

*Oncology Institute, Radiation Oncology Unit, Rambam Medical Center,
Haifa, Israel*

Icro Meattini¹

*Oncology Unit, Oncology Department, Azienda Ospedaliero-
Universitaria Careggi, University of Florence, Florence, Italy*

Philip Poortmans*

Department of Radiation Oncology, Institut Curie, Paris, France

RT for DCIS: *Discussion*

Endocrine therapy for DCIS

Lack of consensus on adjuvant endocrine therapy for DCIS...

... but seems to add little more than “chemoprevention” of CL BC!

RT for DCIS: *Discussion*

Omission of surgery for low-risk DCIS

- ✓ Increased early detection
- ✓ Increasing controversy on over-diagnosis and over-treatment of DCIS
- ✓ Invasive progression highly variable

RT for DCIS: *Discussion*

Prognostic & predictive factors for DCIS

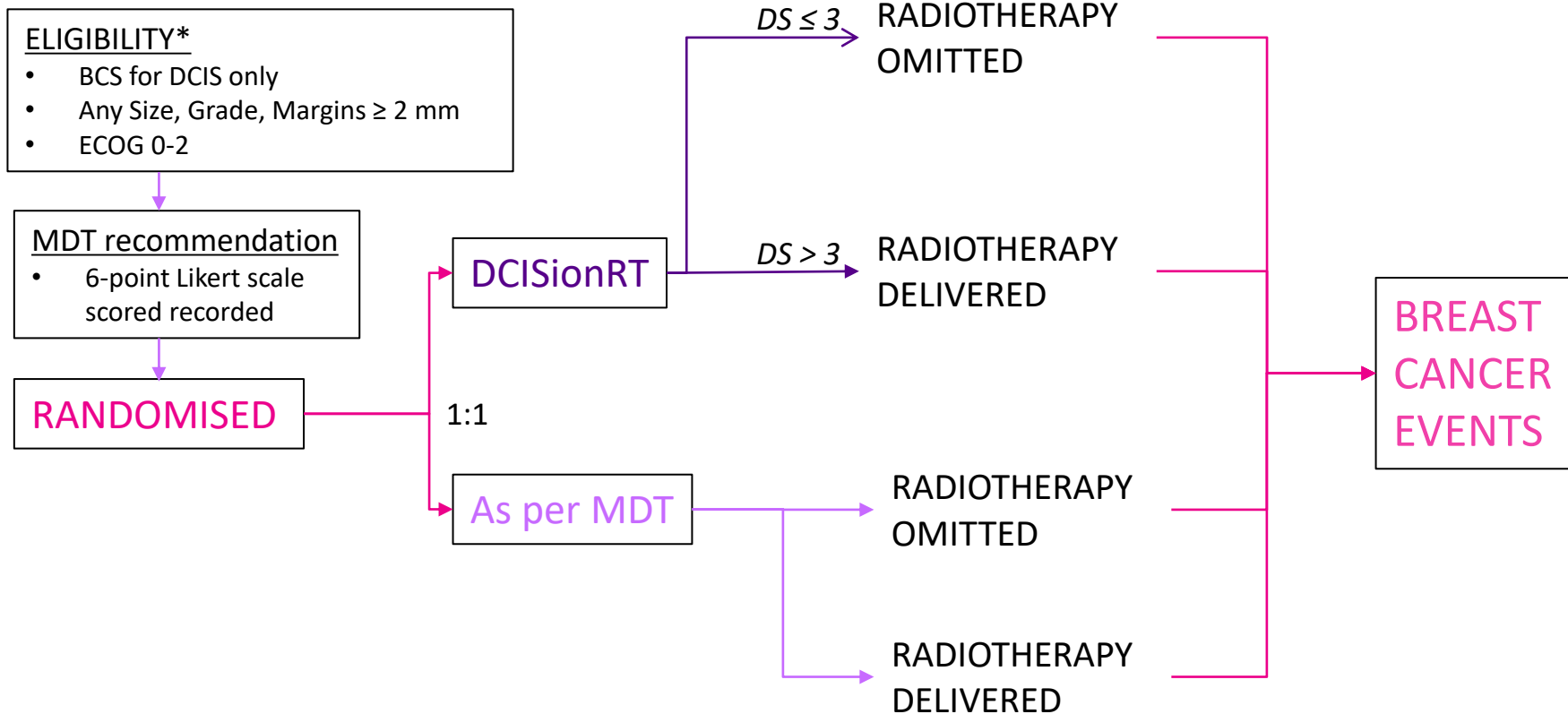
- ✓ Molecular profiling complemented by clinical-pathologic markers have potential to improve precision of LR risk prediction
- ✓ Cost-effectiveness to guide RT omission has not been shown from population perspective
- ✓ Prospective studies of molecular profiling on tumour control and decision impact in progress

DECIDER Study

DCISionRT Efficacy in Counselling Intervention for
Ductal Carcinoma in-situ adjuvant External-beam
Radiotherapy

Dr Adam Ofri
BMed MS FRACS

DECIDER Trial



Study Duration: 10 years (+ accrual time)

DECIDER Trial



Study Duration: 10 years (+ accrual time)

Radiation therapy for DCIS

- Introduction
- Evidence from the past
- Recent additions
- Discussion
- Conclusions



SGBCC 2023

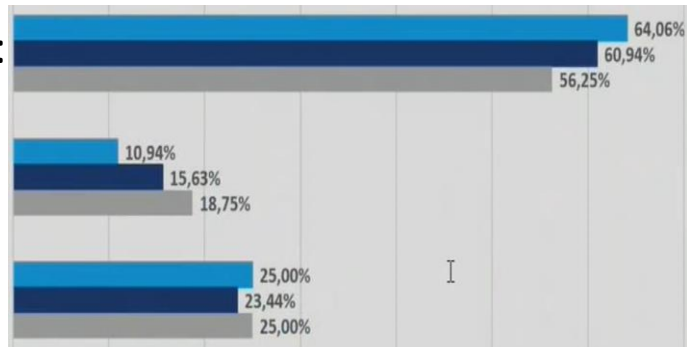
18TH ST.GALLEN INTERNATIONAL BREAST CANCER CONFERENCE 2023

15 – 18 March 2023, Vienna/Austria

st.gallenoncology
conferences

The preferred radiation schedule for (see below) is:

- ✓ Moderate hypofractionation (15-16 fractions/3 weeks):
- ✓ Ultra-hypofractionation (5 fractions/1 week):
- ✓ Abstain:



Chest wall RT, irrespective of RNI, after mastectomy



WBI, irrespective of RNI, after BCS



WBI after BCS for DCIS



SGBCC 2023

18TH ST.GALLEN INTERNATIONAL BREAST CANCER CONFERENCE 2023

15 – 18 March 2023, Vienna/Austria

st.galleroncology
conferences

The preferred RT plan and schedule for lower-risk DCIS after breast conserving surgery:

✓ WBI in 25 fractions:

0,00%
0,00%

✓ WBI in 15-16 fractions:

33,85%

50,00%

✓ PBI in 5 fractions:

20,00%

4,69%

✓ Any of those

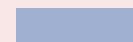
23,08%

20,31%

✓ Abstain

23,08%

25,00%



Post-MP



Pre-MP



SGBCC 2023

18TH ST.GALLEN INTERNATIONAL BREAST CANCER CONFERENCE 2023

15 – 18 March 2023, Vienna/Austria

st.galleroncology
conferences

A healthy woman has undergone BCS for DCIS. The DCIS is grade 1 to 2, without comedonecrosis, and spans less than 2 cm. Should she receive radiation therapy?:

✓ Yes:

✓ No:

✓ Abstain:

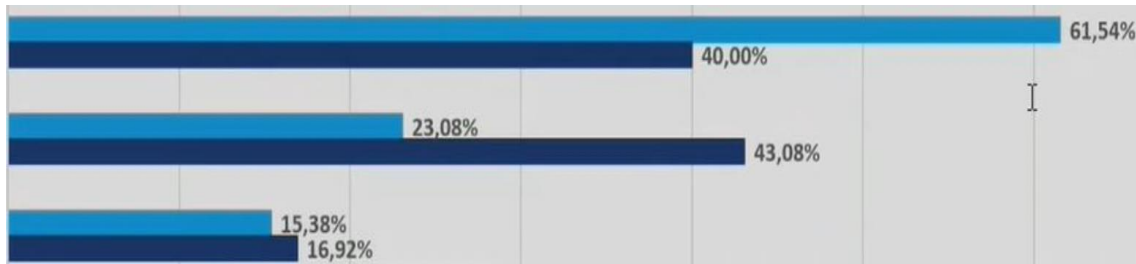


If the same patient will take endocrine therapy for ER+ DCIS, would you recommend RT:

✓ Yes:

✓ No:

✓ Abstain:



Pre-MP



Post-MP



SGBCC 2023

18TH ST.GALLEN INTERNATIONAL BREAST CANCER CONFERENCE 2023

15 – 18 March 2023, Vienna/Austria

st.gallenoncology
conferences

Consider patients after BCS for DCIS, with margins > 2 mm. Which require RT:

Indicators:

✓ Age (years):	<50	51-70	>70
✓ Tumour size (cm):	>2cm		≤2cm
✓ Comedonecrosis:	yes		no

Range of “yes varies between 18% and 98%

Age = strongest driver with cut-off of 50 years



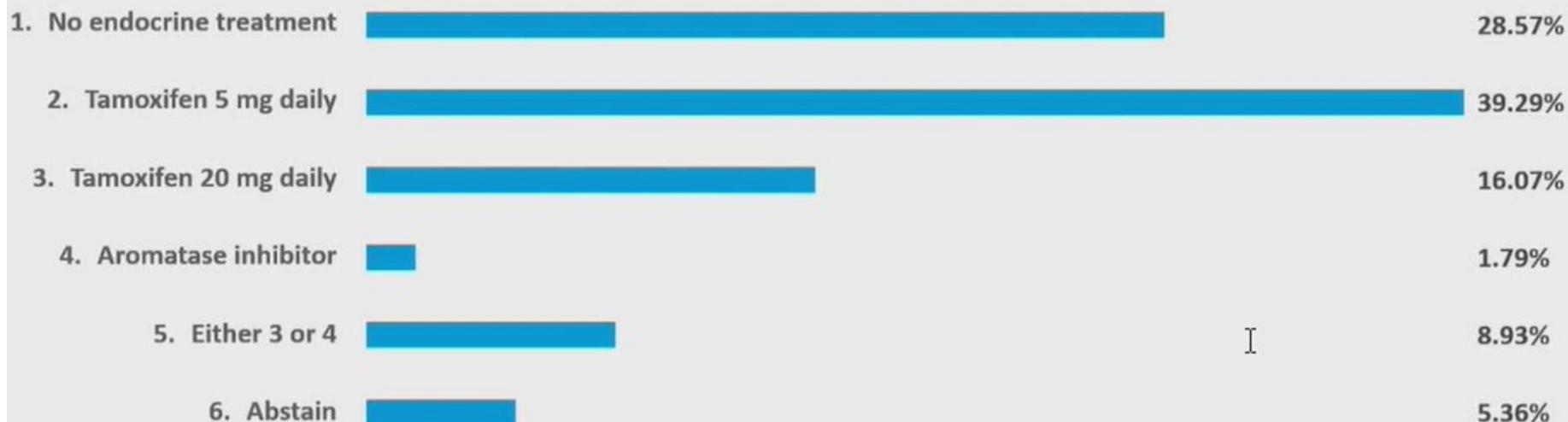
SGBCC 2023

18TH ST.GALLEN INTERNATIONAL BREAST CANCER CONFERENCE 2023

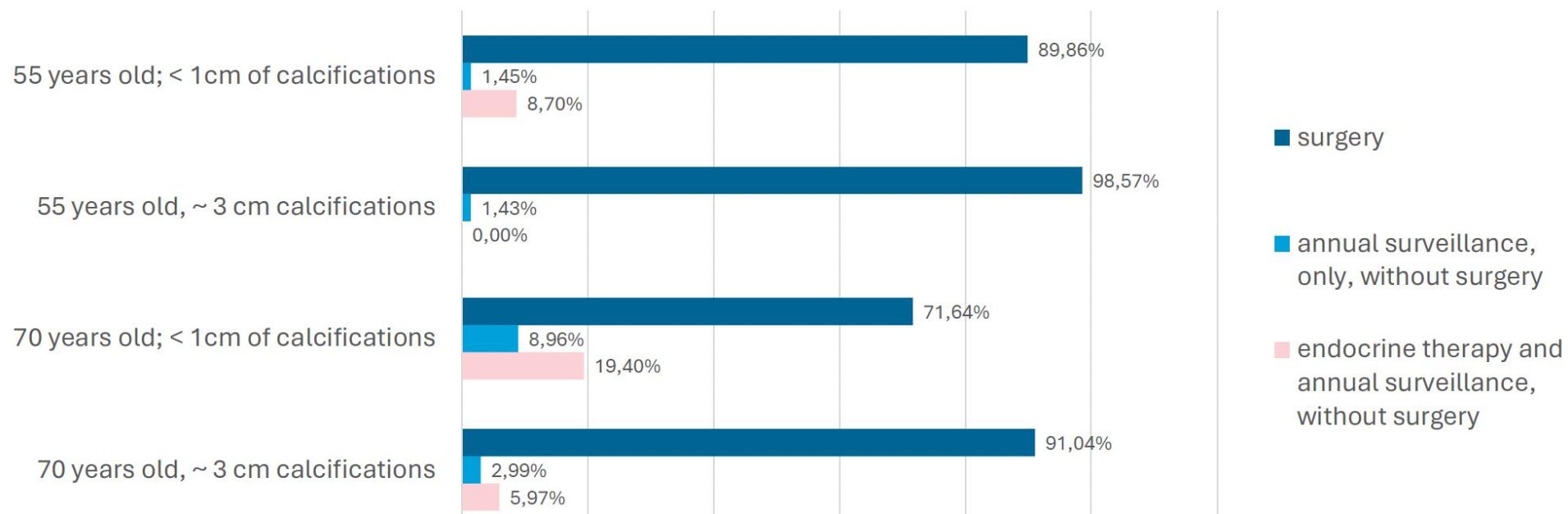
15 – 18 March 2023, Vienna/Austria

st.gallenoncology
conferences

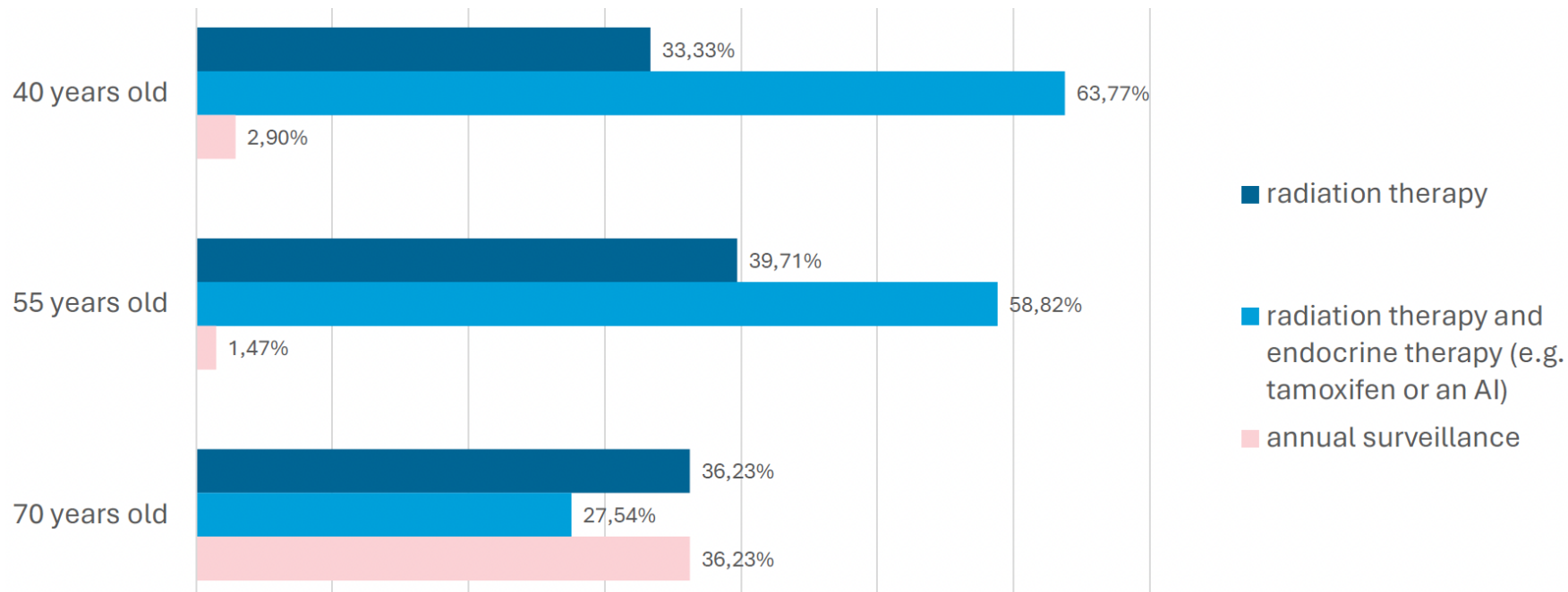
Consider post-MP DCIS patients after BCS+RT, with concerns about IBTR & QoL: which ET?



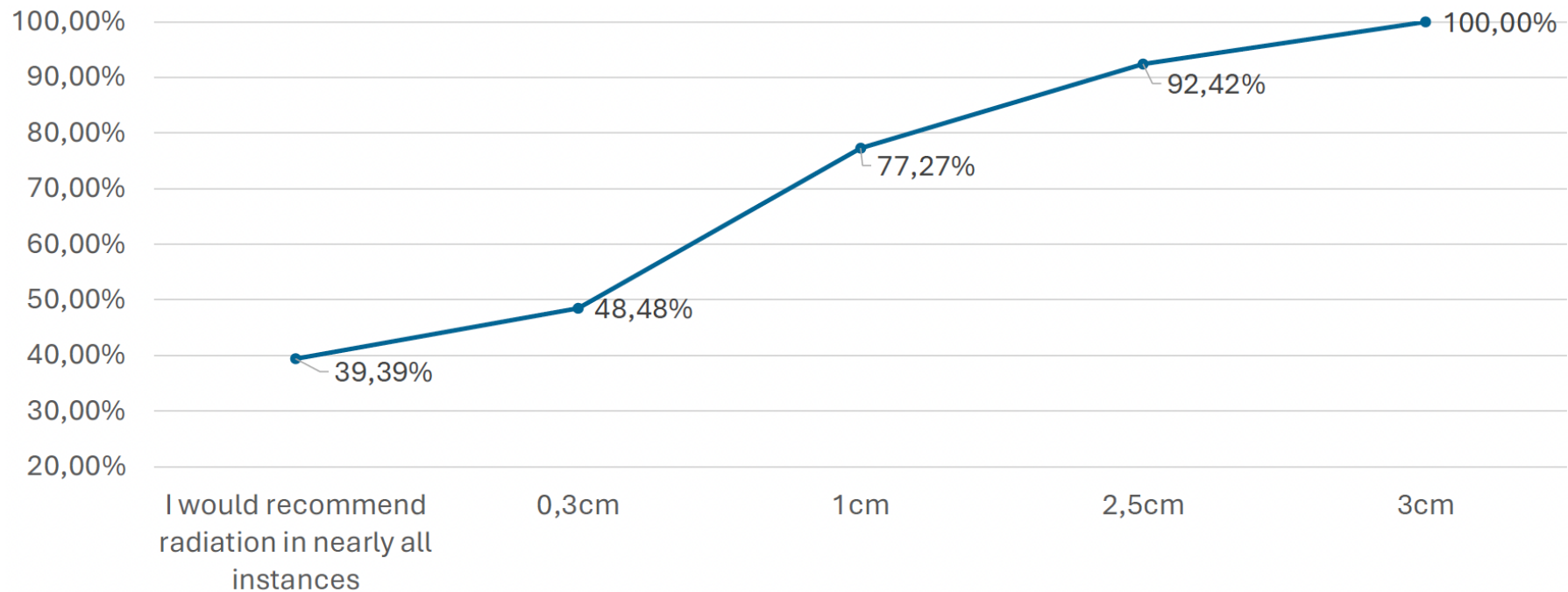
Woman with calcifications on screening mammography. Core biopsy: DCIS, grade 2, ER+, MRI negative. As next treatment steps, you would recommend:



Woman after BCS for DCIS, grade 2, measuring 1-2 cm, ER+. As next treatment you would recommend:



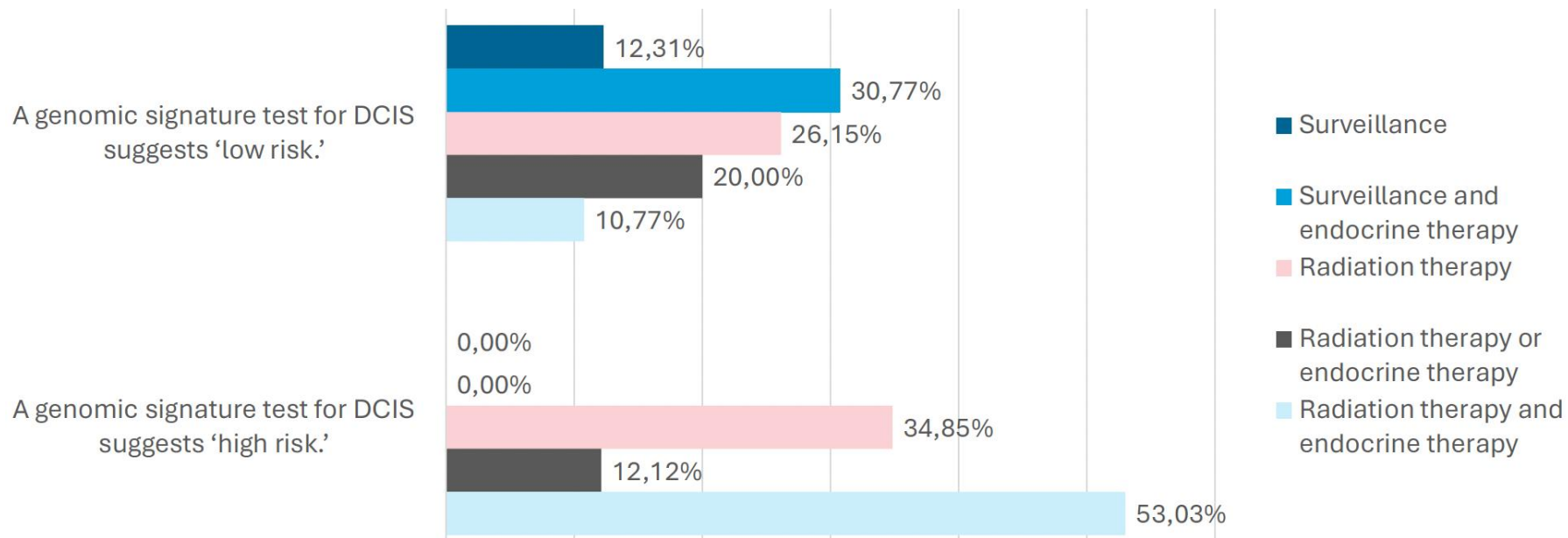
Healthy, non-elderly DCIS patient, grade 2, ER+, DCIS size threshold for radiation therapy:



Should we endorse genomic signatures for DCIS Management?



55 year woman after BCS for DCIS, grade 2, measuring 1-2 cm. As additional treatment, you would recommend:



Radiation therapy for DCIS: *Acknowledgements*

Too many to list...

... risking forgetting people...

Orit Kaidar-Person · Icro Meattini · Philip Poortmans *Editors*

Breast Cancer Radiation Therapy

A Practical Guide for Technical Applications

The book provides, in a comprehensive yet concise way, essential information to improve the knowledge and skills of all healthcare providers involved in the treatment of patients with breast cancer. The content does not focus on general information that is widely available via different sources, but on technical aspects – “hands-on” daily practices and principles of radiation oncology that are not included in other books. Drawing on information taught in courses at e.g. the ESTRO School, as well as the authors' broad clinical experience, the respective contributions reflect and share the expertise of leading experts in breast cancer radiation therapy, supported by sound data and evidence. Each chapter includes a short introduction summarizing the evidence in the literature and “pearls” (a short bullet-point summary), and is enriched by tables, figures and illustrations to provide a concise, easy-to-follow and appealing overview.

The book, containing also useful electronic supplementary material, will be of interest to a wide range of readers, including radiation oncologists, radiation technicians, medical physicists, and others involved in breast cancer care.



► [springer.com](https://www.springer.com)

Kaidar-Person · Meattini · Poortmans *Eds.*



Breast Cancer Radiation Therapy

Breast Cancer Radiation Therapy

A Practical Guide for Technical
Applications

Orit Kaidar-Person
Icro Meattini
Philip Poortmans
Editors

 Springer