

# Fall 1

## Bronchialkarzinom, Lungenmetastasen -TED-

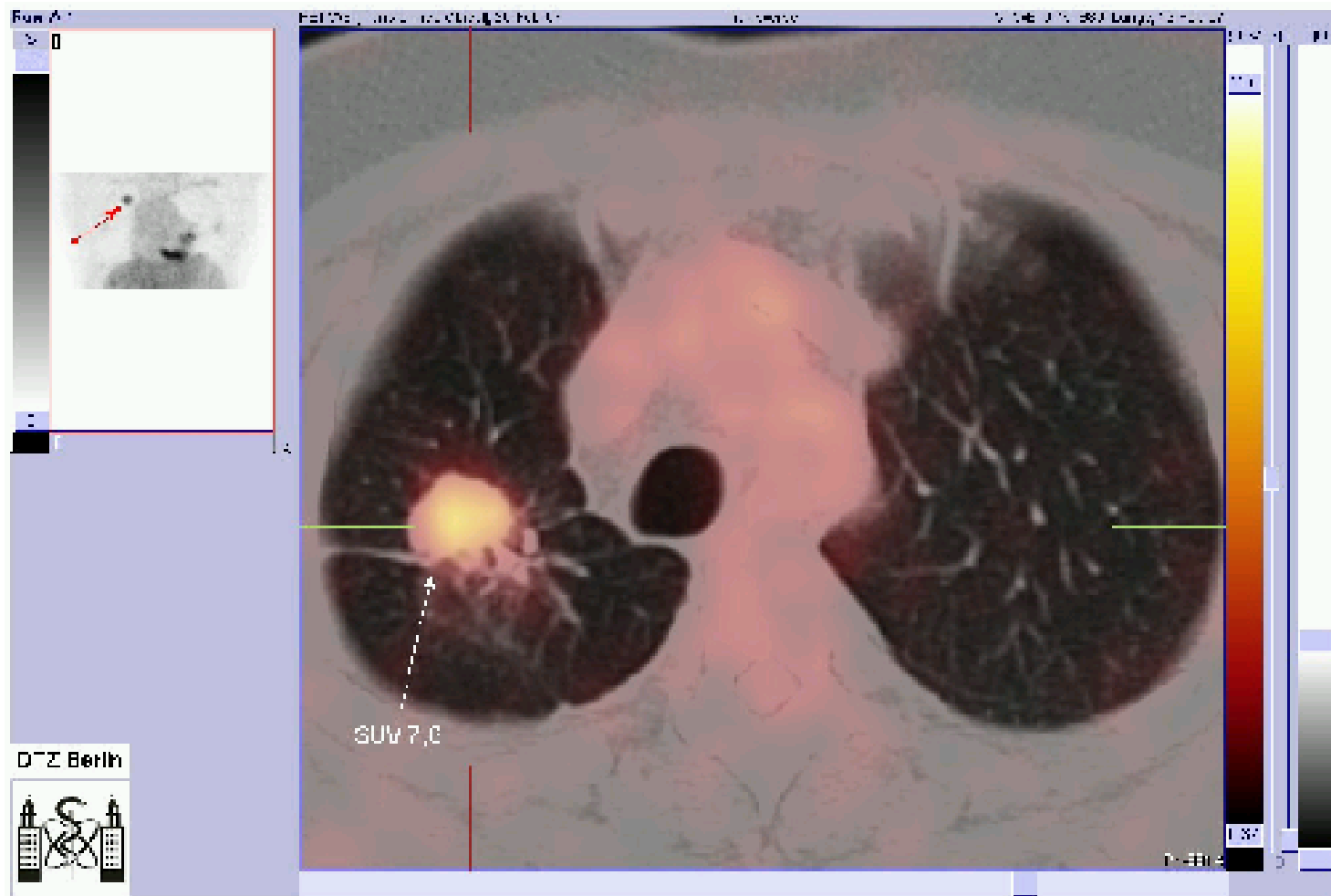
Jens Ricke

SAINT 2016

# Fall 1

- 68-jähriger Patient, ECOG 2
- NSCLC (Plattenepithel)
- EGFR mut. (L858R)
- Lungenfunktion:
  - FEV1 35%
  - Diffusionskapazität 40%
  - Max. O2 uptake 20ml/min/kg
- EF 40%

# NSCLC stage IB (3.2cm)



# **Is radiofrequency ablation more effective than stereotactic ablative radiotherapy in patients with early stage medically inoperable non-small cell lung cancer?**

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- 16 von 219 Publikationen
- Local progression SBRT 3.5–14.5% vs. RFA 23.7–43%
- Komplikationen:
  - RFA: Pneumothorax (19.1–63%) (Rippenfx 15%)
  - SBRT: Fatigue (31–32.6%), pneumonitis (2.1–12.5%), chest wall pain (3.1–12%)

# Cancer

Original Article

## Radiofrequency ablation of stage IA non-small cell lung cancer in medically inoperable patients: Results from the American College of Surgeons Oncology Group Z4033 (Alliance) trial

Damian E. Dupuy MD [✉](#), Hiran C. Fernando MBBS, Shauna Hillman MS, Thomas Ng MD, Angelina D. Tan BS, Amita Sharma MD, William S. Rilling MD, Kelvin Hong MBBS, Joe B. Putnam MD

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Volume 121, Issue 19, 2015; 3491–3498

# RFA in NSCLC IA (n=54)

- OS 86.3% at 1 year and 69.8% at 2 years
- Local tumor recurrence-free rate 68.9% at 1 year and 59.8% at 2 years
  - worse for tumors > 2 cm
  - 19 patients with local recurrence, 11 re-treated with RFA, 9 radiation, 3 chemotherapy
- There 21 grade 3 adverse events, 2 grade 4 adverse events, and 1 grade 5 adverse event in 12 patients
  - None of the 4 or 5 events were attributable to RFA
- No change in the FEV 1 or the diffusing capacity

## Comparison of Survival Rate in Primary Non-Small-Cell Lung Cancer Among Elderly Patients Treated With Radiofrequency Ablation, Surgery, or Chemotherapy

Heon Lee · Gong Yong Jin · Young Min Han ·  
Gyung Ho Chung · Yong Chul Lee ·  
Keun Sang Kwon · David Lynch

PS 0-2, >60y; n=40 RFA, n= 17 surgery, n = 18 CTx

– RFA: comorbidities

OS (1) surgery vs (2) RFA

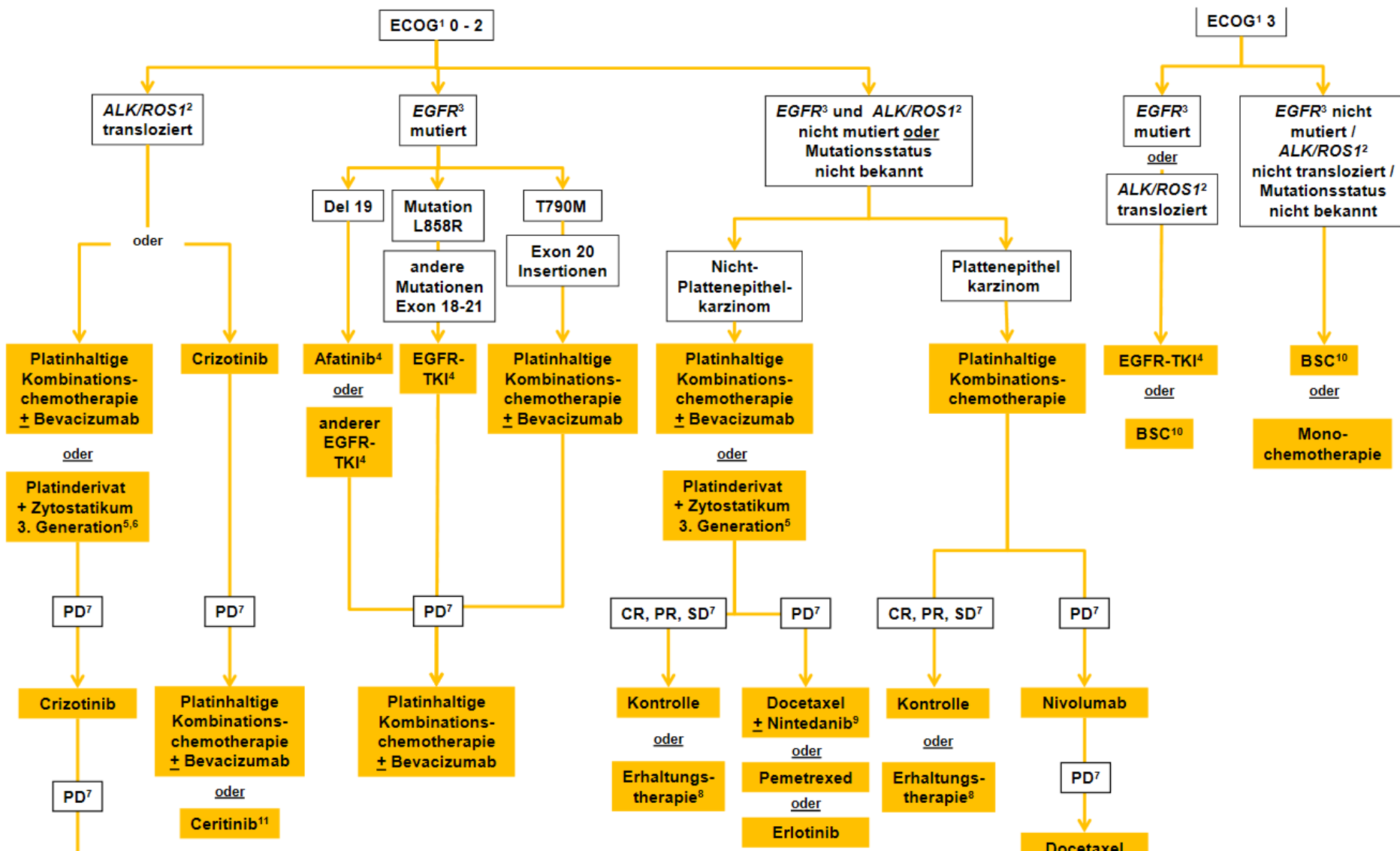
– stage I to II lung 33.8 and 28.2 months (p = 0.426)

OS (1) chemotherapy vs. (2) RFA with chemotherapy

– stage III to IV 29 and 42 months (p = 0.03)

Lee H, CVIR 2012

# Palliative Chemotherapie bei NSCLC





# Therapie?

1. Resektion
2. SBRT
3. Thermische Ablation
4. EGFR TKI
5. Best supportive care



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(am Phantom oder Großtiermodell)**

**Individuelle Kurskonzepte auf Anfrage**



Organisation

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## **TUMORKONFERENZSIMULATION FÜR MINIMAL-INVASIVE ONKOLOGIE**

Referenten:

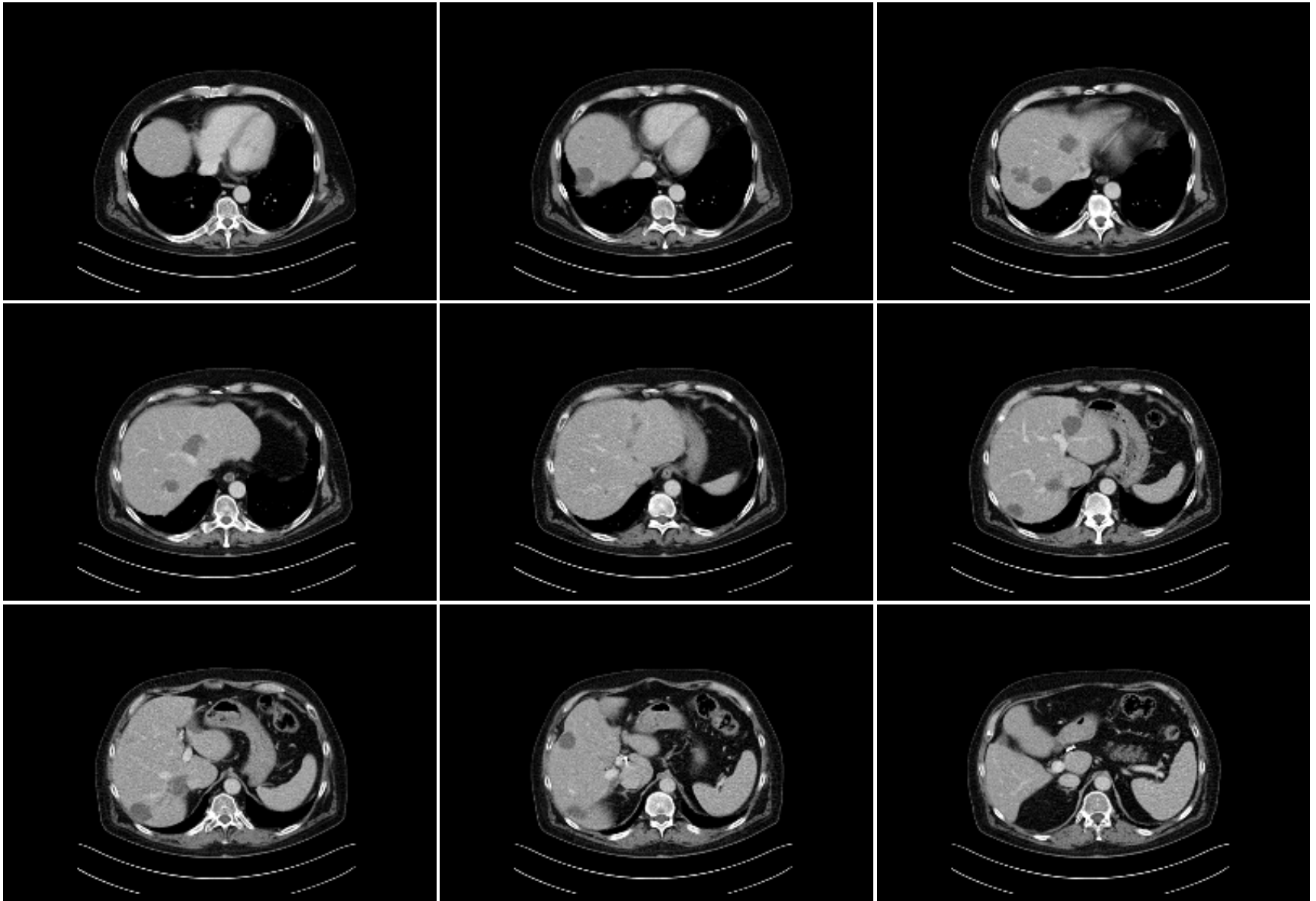
Prof. Dr. med. C. Bruns (Magdeburg, Chirurgie)  
PD Dr. med. K. Schütte (Osnabrück, Gastroenterologie)  
Prof. Dr. med. J. Ricke (Magdeburg, Radiologie)

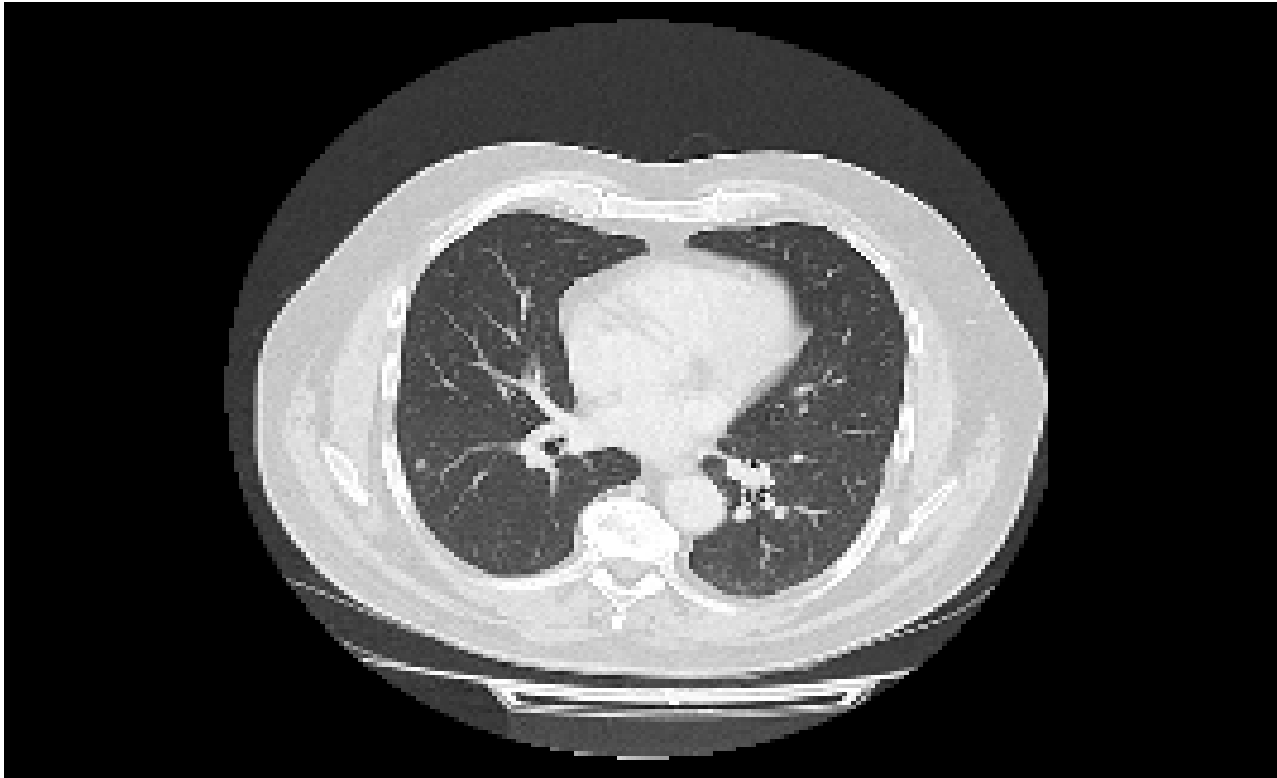
**10./11. MÄRZ 2016  
BERLIN**

[www.dafmt.de](http://www.dafmt.de)

# Fall 2

- 48 Jahre, Coecumkarzinom, ECOG 0
- Metachrone Leber- und Lungenmetastasierung
  - DFS 4 Jahre
- RAS-mut.
- Erfolgreiche Induktion mit FOLFOXIRI und Avastin, Ergebnis: Remission
  - Neuropathie Grad 2



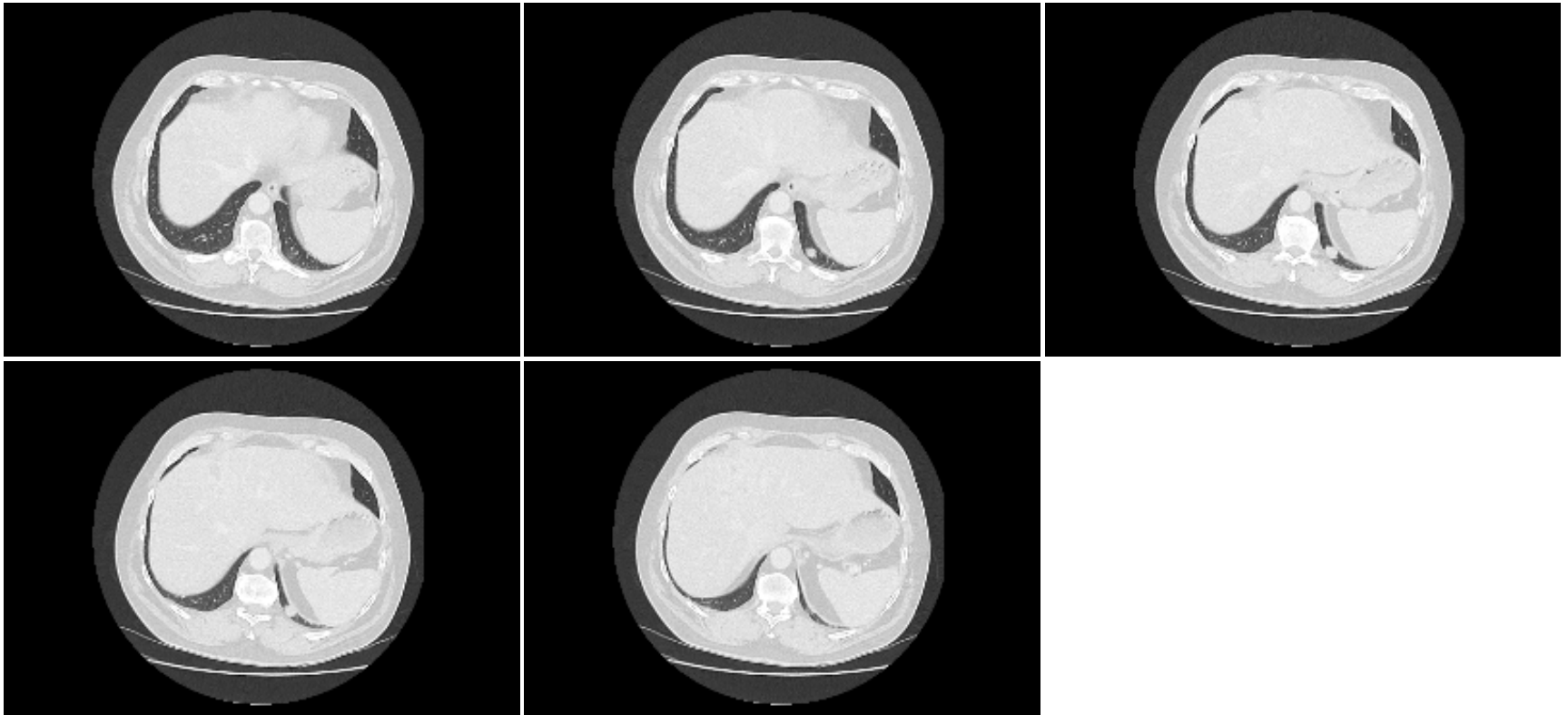


# Frage Konsolidierungstherapie?

1. Deeskalierte Erhaltungstherapie (5-FU)
2. Chirurgische Resektion Leber, RFA Lunge
3. Lokale Ablation Leber und Lunge
4. SIRT Leber, RFA Lunge
5. Pfortaderembolisation und Leberresektion, Lunge  
watchful waiting und ggf. Ablation/Resektion

# Fall 3

- 76-jähriger Patient, ECOG 1, sehr alert
- Typ 2 Diabetes, medikamentös eingestellte Hypertonie, sonst gesund
- R0 Resektion Cholangiozelluläres Karzinom vor 2 Jahren
- Jetzt neu aufgetretener Lungenherd





# Frage Therapie?

1. Biopsie ja
2. Biopsie nein

# Histo: CCC – Therapie?

1. Watchful waiting
2. Lokale Ablation
3. SBRT
4. VATS (Resektion)
5. Systemische Chemotherapie (GemCis)