MRO.ART
MODERN RADIATION ONCOLOGY
36° RESIDENTIAL COURSE

Gemelli
Fondazione Policlinico Universitario Agostino Gemelli IRCCS
Università Cattolica del Sacro Cuore

G-ART
Advanced Radiation Therapy

Interactive discussion audience-faculty



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How much incremental benefit does pembrolizumab provide when the radiotherapy backbone is consistently delivered to EMBRACE-level standards?
Do we have evidence on whether radiotherapy quality modifies the benefit of pembrolizumab—or are we still dealing with two separate questions?
(**If KEYNOTE-A18** had been conducted with fully standardized **EMBRACE-II-**quality radiotherapy in every patient, do you think we would have observed the same absolute benefit from pembrolizumab?

KEYNOTE
A18: Is the observed benefit mainly driven by the interaction between immunotherapy and radiotherapy, by the ma intenance phase, or do the available data allow us to distinguish between these contributions?

CALLA-KEYNOTE-A18: Is baseline PD-L1 expression insufficient to predict the benefit of immunotherapy, or is a more dynamic assessment of the tumor–immune response might needed?

Could serial ctHPV-DNA monitoring help guide the duration of pembrolizumab maintenance therapy? Specifically, could ctHPV-DNA clearance support treatment de-escalation, while persistent positivity identify patients who might benefit from treatment intensification? What evidence would be needed before implementing such an approach in clinical practice?”

EMBRACE-II has moved us toward more individualized, risk-adapted radiotherapy. With the benefit of pembrolizumab now established, is there a rationale for testing selective radiotherapy de-escalation—or should we regard the definitive chemoradiation backbone as non-negotiable, since that is the setting in which the benefit was demonstrated?”fda+1

EMBRACE-II shows that we can substantially reduce irradiated volumes without compromising disease control. Now that immunotherapy improves outcomes, could systemic intensification give us an opportunity to further de-escalate some components of radiotherapy?”

When we talk about radiotherapy quality, which component matters most for disease control? If you had to prioritize just one—overall treatment time, brachytherapy target coverage and dose, MRI guidance, appropriate use of interstitial techniques, or nodal coverage—which would you choose, and why?”
“And in future trials of systemic intensification, would you use that parameter as a stratification factor—or should it be a mandatory quality requirement before a center can participate?”

3We often see positive lymph nodes as a reason to intensify systemic treatment. But radiotherapy can also improve nodal control. How do we decide whether these patients need **better radiotherapy**, more systemic treatment, or both?