Thank you for the opportunity. As discussed by Dr. Basusar, we are not satisfied with
our chemo radiation approaches and we are trying to either dose escalate or do something
to increase the efficacy of our chemo radiation. This is one attempt as he mentioned LU008
where they try to treat with two modern modalities of radiation. One is SBRT and another is chemo
radiation to different volumes. This was presented in Astro this year. So, principal investigator
is Dr. Charles Simone. So, the hypothesis is for locally advanced non-small cell carcinoma
concurrent chemo radiation followed by dole mop, dole mop, local control remains poor
despite of all efforts. So, there is a possibility of combining SBRT with chemo radiation to
the node SBRT to the primary tumor. So, this chemo radiation approach is being replaced
with conventionally fractionated radial therapy with SBRT to primary tumor. It is hypothesized
that it will be well tolerated and will it will improve the local control.
So, this is a representative case example. This study was done as a phase 2 study. This
is a phase 2 study. So, how the volumes would be? So, we know that there is a primary tumor
and there are medicinal or high learn nodes. Usually what we do is we treat both with chemo
radiations combined, but here they have tried treating primary tumor with SBRT and nodes with
the chemo radiation. But how it has changed the scenario? It has reduced the lung volumes
receiving certain doses like 40 grade, 20 grade, 10 grade. As you can see it is 44 percent
reduction, 29 percent reduction and 8 percent reduction. So, this phase 2 study was done
and the study results were published in 23. So, here 55 patients of locally advanced lung
cancer non-small cell were subjected to single arm study where SBRT followed by concurrent
chemo radiation to the nodes were done and subsequent treatment was common.
So, the one year PFS was 62 percent which was better than the results of historical results
of concurrent chemo radiation trials and one year PFS receiving lower volume was better
than the specific trial. Median OS was encouraging 40.8 months and most of the failures were
distant failures not the local failures. Toxicity were under control and were not very grave
they were better. So, this phase 2 study was designed in such a way that only single arm
study was done and, but the phase 3 study was planned on the basis of results of phase
2 and it was a randomized study where there were 2 arms one is control arm and one is
experimental arm. Control arm is the usual what we do in our usual practice chemo radiation
60 grade into grave perfection followed by the our protocol as immunotherapy. In the
experimental arm they combined SBRT with concurrent chemo radiation as we all know

SBRT we have
to give a BED of more than 100 grain then only it will be effective. So, the doses for
SBRT were either 54 grain 3 fractions or 50 grain 4 fraction depending on the location
and in both peripheral lesions tumors and if the disease was central or it was close
to the nodal disease then 50 grain 5 fractions. Then radiation to the higher or mediational
source was same as our previous practice like 60 grain 30 fractions and chemo concurrent
chemo was planned as per our usual practice like metallic or oetoposis or in adenolics
splat in parmatrixet and maintenance door volume up as indicated or if not indicated
then 2 cycles of polysoli rated chemotherape. So, the inclusion criteria was it should be
documented histological proof of non small cell and stage 2 and stage 3 which are medically
inoperable or refuse surgery who are candidate for chemo radiation identified primary tumor
and at least 1 nodal metastase. So, no positive disease they allowed the neodymium chemotherapy
up to 4 cycles. Primary tumor should be less than 7 centimeter because we are giving SBRT
is more than 18 year performance status of 0 to 2. Tumors which were close to the nodal
disease less than 2 centimeter were excluded and priority in the this region was subjected
to the physician choice. So, the primary objective was to compare overall survival and progression
free survival. There were many secondary objectives like response rate, local control, pattern
of failure, changes in pulmonary function, quality of life, toxicities and prognostic
value of baseline physical activity on theother parameters and there were some exploratory
objectives like collecting the biopsy specimens for future analysis and regional lung ventilation
and those thresholds on the toxicities. So,statistics this is a hybrid superiority
infinity design in whichthis study arm will be consideredrnotbetter only if it is proved
to be inferior andit is expected to increase the 5 year overall survival from 38 percent
to 48 percent andit is expected to increase the 2 year PFS from 41 percent to 53 percent
and 4 year PFS from 31 to 44 percent. So, alreadythe trial has started approval and
it is the sample size is around 450 patients andthere will be interim analysis based on
the PFS and OS whether it is going right or wrong it might be stopped in between andit
will bedoing a approval in 4.7 years and there will be pretreatment analysis for every 3
years in both arms at every center. So, currently what is published isthat it has
already started and as of now30 patients have been accrued and 266 sites have beenare open
for acryl andthis the good part of this is there is nolab or PFT cut off no city chest
MRI brain labtime windows no exclusion for any actionable mutations and it allows

PS
2 patients also andwe hope that this may change the standard of caring inoperablelocally advanced
nose molesale carcinoma. It might improve local control PFS and OS and as we aremoving towards
igh precision radiotherapy this might be helpful because we have the tool of SBRT it was
tried as a boost to CTRT but it failed because of toxicity's but now with this method we
can apply boththogether. Thank you.
Thank you.
Thank you.