1° SYMPOSIUM ON SBRT* FOR ORGAN CONFINED AND OLIGOMETASTATIC PROSTATE CANCER

MONZA (I)- FEBRUARY 5th/6th, 2026

RAZIONALE SCIENTIFICO

La diagnosi e il trattamento del carcinoma prostatico hanno subito notevoli cambiamenti negli ultimi anni, con l'emergere di nuove opzioni terapeutiche.

L'evento "1st Symposium on SBRT* for Organ-Confined and Oligometastatic Prostate Cancer" nasce con l'obiettivo di promuovere un confronto multidisciplinare vivace tra radioterapisti oncologi e fisici medici, con particolare attenzione alle potenzialità e alle sfide nell'impiego della radioterapia stereotassica (SBRT).

Negli ultimi anni, l'adozione della SBRT (Stereotactic Body Radiation Therapy) per il trattamento del carcinoma prostatico, sia in fase localizzata che (oligo)metastatica, ha conosciuto una rapida espansione, supportata da crescenti evidenze scientifiche che ne attestano l'efficacia, la tollerabilità e la qualità di vita. In questo contesto, il simposio rappresenta un'opportunità unica per approfondire le innovazioni tecnologiche che hanno reso possibile l'erogazione di dosi ablative in modo sicuro e preciso, grazie anche ai progressi nella pianificazione dosimetrica, nell'imaging, nei sistemi di tracking e nelle tecniche di adattamento al movimento d'organo.

Sarà approfondito inoltre il ruolo emergente delle strategie adattative e personalizzate, l'integrazione della SBRT (SBRT Stereotactic Body Radiation Therapy) con le terapie sistemiche, e le implicazioni biologiche e cliniche di tali combinazioni, alla luce delle più recenti evidenze.

Attraverso sessioni interattive, discussioni di casi clinici e tavole rotonde, il simposio intende stimolare il confronto tra esperti, con l'obiettivo di favorire una pratica clinica sempre più orientata all'evidenza scientifica, alla centralità del paziente e alla riduzione della tossicità a lungo termine.

Infine, l'evento si propone di rafforzare la collaborazione tra centri, promuovendo sinergie nell'ambito della ricerca, nella prospettiva di un'evoluzione continua e condivisa della radioterapia oncologica nel carcinoma prostatico.

***SBRT** Stereotactic Body Radiation Therapy

Thursday February 5th, 2026

02.00 pm	participants' registration
02.30 pm	INTRODUCTION *S. Arcangeli*
	session 1 "THE EVOLVING LANDSCAPE OF PROSTATE SBRT"* *S. Arcangeli, D. Panizza*
03.00 pm	PROSTATE SBRT*: STATE OF THE ART AND FUTURE CHALLENGES *P. Ost*
03.30 pm	HOW FAR CAN WE GO? THE ROAD TO THE SINGLE FRACTION *C. Greco*
04.00 pm	PROSTATE SBRT* WITH PROTONS: WHEN, WHY, AND FOR WHOM? *B.A. Jereczek*
04.30 pm	DISCUSSION
04.45 pm	*coffee break*
	session 2 "SBRT FOR HIGH RISK DISEASE"* *R. Mazzola, A. Fodor*
05.15 pm	DOSE ESCALATION IN PROSTATE SBRT* *C. Draulans*

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05.45 pm	PELVIC RADIOTHERAPY IN THE PSMA/PET ERA: WHEN AND HOW TO INTEGRATE NODAL TREATMENT IN PROSTATE SBRT*? *C. Zamboglou*
06.15 pm	STRATEGIES TO REDUCE TX-RELATED TOXICITY AND MANAGEMENT OF SIDE EFFECTS *G. Sanguineti*
06.45 pm	DISCUSSION

Friday February 6th, 2026

Session 3 "PROSTATE MOTION, TRACKING & COMPENSATION: IMPACT OF TECHNOLOGICAL INNOVATIONS ON SBRT DELIVERY"*
F. Alongi, C. Franzese

08.30 am	THE ADAPTIVE PERSPECTIVE: MRI-BASED SBRT* *R. Ruggeri*
0G.00 am	THE ADAPTIVE PERSPECTIVE: AI LINAC-BASED SBRT* *M. Fusella*
0G.30 am	THE NON-ADAPTIVE PERSPECTIVE: ROBOTIC SBRT *C. Fiorino*
10.00 am	THE NON-ADAPTIVE PERSPECTIVE: VMAT SBRT* *V. Faccenda*
10.30 am	DISCUSSION
10.50 am	*coffee break*

Session 4 "SBRT IN THE MANAGEMENT OF BIOCHEMICAL AND CLINICAL RECURRENCES"*
A. Lancia, F. Matrone

11.20 am	SALVAGE SBRT* AFTER RADICAL PROSTATECTOMY *F. Ferrario*
11.40 am	SALVAGE SBRT* FOR (RADIO)RECURRENT PROSTATE CANCER *G. Francolini*
12.10 pm	DISCUSSION

Session 5 "INTERPLAY BETWEEN SYSTEMIC TREATMENT AND PROSTATE SBRT: BALANCING ONCOLOGIC OUTCOMES AND SIDE EFFECTS"
A. Bruni, M. Sepulcri

12.20 pm	OPTIMAL TREATMENT FOR PELVIC OLIGORECURRENT PROSTATE CANCER *G. Marvaso*
12.50 pm	ADT AND ARSI IN THE ERA OF PROSTATE SBRT* *L. Triggiani*
01.20 pm	DISCUSSION
01.30 pm	EVALUATION QUESTIONNAIRE *S. Arcangeli*
01.45 pm	CLOSING REMARKS *S. Arcangeli, D. Panizza*

SBRT: Stereotactic Body Radiation Therapy
PSMA: Prostate- Specific Membrane Antigen
PET: tomografia a emissione di positroni
TX -related: Treatment related
MRI- based: Magnetic Resonance Imaging Based
AI Linac-based: Artificial Intelligence linear acceleretor based
Vmat : Volumetric Modulated Arc Therapy
ADT: Androgen Deprivation Therapy
Arsi: Inibitori del Segnale del Recettore Androgenico

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CON IL PATROCINIO DI:
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AIRO - Associazione Italiana di Radioterapia ed Oncologia Clinica
AITRO - Associazione Italiana Tecnici di Radioterapia Oncologica e Fisica Sanitaria
ESTRO - European Society for Radiotherapy and Oncology
ISRS - International Stereotactic Radiosurgery Society
SIURO - Società Italiana di Urologia Oncologica

FACULTY

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SEGRETERIA SCIENTIFICA

Prof. Stefano Arcangeli: Fondazione IRCCS San Gerardo dei Tintori, Monza (MB) - Università degli Studi di Milano-Bicocca
Dott. Denis Panizza: Fondazione IRCCS San Gerardo dei Tintori, Monza (MB)

DATA e SEDE

05/06 Febbraio 2026 - Hotel de la Ville (Viale Regina Margherita, 15 - 20G00 Monza, MB)

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ABSTRACT

DRAULANS

Dose escalation in prostate SBRT

Stereotactic body radiotherapy (SBRT) has emerged as a highly effective and convenient treatment modality for localized prostate cancer, offering excellent oncologic outcomes with a short treatment course. As evidence accumulates, interest in dose escalation within SBRT protocols continues to grow, driven by the potential for improved tumor control. However, this must be carefully weighed against the risk of increased toxicity, particularly to organs-at-risk such as the rectum, bladder, and urethra. The current rationale, evidence, and ongoing trials evaluating dose escalation strategies in prostate SBRT will be reviewed. Key topics will include biological considerations, clinical outcomes, toxicity data, patient selection, and target delineation. Special attention will be given to emerging data on ultra-hypofractionation and the use of focal boosting, as well as the role of imaging and biomarkers in guiding personalized dose escalation.

FACCENDA

THE NON-ADAPTIVE PERSPECTIVE: VMAT SBRT

Stereotactic Body Radiotherapy (SBRT) for prostate cancer can be successfully delivered with Volumetric Modulated Arc Therapy (VMAT) even in a non-adaptive setting. VMAT-based SBRT without adaptive replanning can achieve excellent disease control and low toxicity, provided that systematic strategies such as daily IGRT, motion tracking, and rectal/bladder preparation are consistently implemented. This lecture will address the key techniques and clinical strategies aimed at improving the accuracy and safety of prostate SBRT delivered with this widely available technology.

FERRARIO

SALVAGE SBRT AFTER RADICAL PROSTATECTOMY

This presentation will explore salvage SBRT as a treatment for biochemical recurrence of prostate cancer after radical prostatectomy. Recurrence rates and prognostic factors will be reviewed, with a focus on timing and mechanisms of failure, and the role of advanced imaging techniques such as PSMA PET-CT and multiparametric MRI in detecting recurrence and guiding patient selection will be discussed. Clinical evidence from prospective and ongoing trials, including SCIMITAR, SHORTER, the SPANISH trial, and the multicenter POPART study, will be summarized to highlight feasibility, toxicity, and oncologic outcomes. A comparative analysis will evaluate SBRT against conventional and moderately hypofractionated postoperative radiotherapy regimens. The toxicity profile of salvage SBRT will be addressed in detail, with emphasis on genitourinary and gastrointestinal adverse events, patient-reported outcomes, and quality of life.

FIORINO

THE NON-ADAPTIVE PERSPECTIVE: ROBOTIC SBRT

Robotic SBRT using the Cyberknife system exploits well assessed, efficient and safe technology to provide tracking during the delivery of the treatment. This makes available to avoid the need for any adaptive correction, if assuming a limited impact of local deformation of prostate (and, in the case, seminal vesicles). According to ESTRO Acrop guidelines on prostate IGRT [1], margins as small as 2mm should be considered safe, once accurate tracking is provided. The run toward few (ideally one) fraction(s) can be facilitated using this kind of technology. At our institute, after several years of extensive experience using 4-5 fraction protocols (i.e.: the Fuller and the RTOG-like respectively), the PROFAST trial exploring the feasibility of a 24 Gy one-fraction approach, was clinically implemented [2]. Beyond the high ablative dose, a relevant characteristic of the protocol is that the whole workflow (imaging, fiducial implantation, contouring, planning, QA and delivery) is delivered in one day. The results on the first 22 patients (the ones treated at sept 2025) confirm its feasibility (with all patients completing the whole workflow in one day) and excellent short-term outcome both in terms of acute toxicity and early biochemical response. The current presentation will focus more on the physics aspects regarding planning, QA and delivery individually analyzed for the first 13 patients, owing to the first Phase I part of the trial. A highly efficient template for plan optimization was built and finetuned after the first few patients resulting in relatively fast optimization and respect of all the pre-defined constraints (including urethra sparing); QA results showed excellent agreement between delivered and measured doses in phantom. Tracking efficiency wasperformed through the analysis of the residual error as measured by fiducial detection during delivery, considering the corrections applied during treatment as a (redundant) estimate. Overall, mean population deviations for the three main axes were within 0.2mm: the worst axis (posterior-anterior) showed an overall SD of 0.54mm, confirming that the applied margin of 2mm is safe.

FUSELLA

THE ADAPTIVE PERSPECTIVE: AI LINAC-BASED SBRT

Prostate SBRT is an ideal application for AI-enabled CBCT-LINAC adaptation. This talk outlines our online/offline

workflow, focusing on high-quality CBCT imaging, AI-assisted contouring, rapid plan re-optimization, and a rigorous end-to-end quality chain. Dose accumulation is an important step in adaptive radiotherapy, and we address it as a component of our process—mapping and summing per-fraction dose on the anatomy-of-the-day to better quantify the delivered dose to targets and OARs, monitor safety thresholds, and inform clinical decisions. We also share practical metrics, selection criteria, and insights for scaling safe and robust CBCT-based ART across multiple centers.

JERECZEK-FOSSA

PROSTATE SBRT WITH PROTONS: WHEN, WHY, AND FOR WHOM?

Proton therapy is increasingly recognized as an effective and well-tolerated modality for localized prostate cancer, particularly within the stereotactic body radiotherapy (SBRT)framework. Its physical advantages, notably the Bragg peak, enable highly conformal dose delivery while sparing adjacent organs at risk. In the phase III randomized trial NCT01230866,stereotactic body proton therapy (SBPT, 38 Gy/5 fractions) was shown to be noninferior to conventionally fractionated proton therapy (CFPT, 79.2 Gy/44 fractions) in patients with lowrisk disease, with 2-year freedom from failure of 100% in both arms, comparable toxicity, and stable quality of life. In addition, the recent systematic review by Corrao et al. confirmed that hypofractionated PT is associated with significantly lower rates of acute gastrointestinal toxicity and improved 5-year biochemical relapse-free survival compared with photon therapy,especially in low- and intermediate-risk patients. Beyond primary treatment, proton therapy and SBRT are also being explored as promising options for re-irradiation in prostate cancer recurrences. Together, these data support proton therapy as a safe, effective, and patient convenient strategy that deserves further prospective evaluation.

OST

PROSTATE SBRT*: STATE OF THE ART AND FUTURE CHALLENGES

Stereotactic body radiation therapy (SBRT) has emerged as a highly effective treatment modality for localized prostate cancer, with 5-year biochemical relapse-free survival rates exceeding 90% in low- to intermediate-risk patients. Advanced delivery techniques now incorporate tracking, magnetic resonance-guided radiotherapy (MRgRT), adaptive radiotherapy, AI-based auto-segmentation for improved accuracy, and simultaneous integrated boost protocols targeting dominant intraprostatic lesions. These innovations enable smaller planning margins and enhanced normal tissue sparing while preserving excellent oncological outcomes. Future challenges include optimizing treatment for high-risk disease, and integrating novel systemic therapies and emerging technologies. Promising developments encompass AI-driven personalized treatment planning using genomic and imaging biomarkers, and advanced predictive modeling for toxicity reduction. As SBRT continues evolving, the focus remains on maximizing therapeutic efficacy while minimizing long-term toxicity through technological innovation and evidence-based protocol optimization.

RUGGIERI

THE ADAPTIVE PERSPECTIVE: MRI-BASED SBRT

Prostate-SBRT is typically performed by prescribing 35-40Gy in 5 fractions, with eventually a simultaneous integrated boost on the dominant intraprostatic lesion (DIL) at 42.5Gy or 45Gy. Such a schedule is already demanding for a high accuracy in dose delivering to the Target, while trying to spare the adjacent rectum and bladder, and the internal urethra, by assuring a maximum dose to their hotiest cubic centimeters below 35Gy. Which makes it useful an online adaptive approach, where a plan-of-the-day is generated while the patient is on the linac-couch waiting for treatment, based on the contours edited by the physician on a 3D-scan depicting the anatomy-of-the-day. MR-imaging is currently the best performing 3D-scan in terms of soft-tissue contrast, which is the image-quality metric mostly relevant for the pelvis. And this is relevant because you can contour what you see, and the appropriateness of the adaptive plan rests determined by the quality of such contours. This is the first reason why the usage of the MRi-linac is indicated for prostate-SBRT treatments. In a near future shorter treatment schedules, such as by 2 or even by 1 only fraction, seems likely: the importance of an online adaptive workflow, compensating not only for inter-fraction but also for intra-fraction anatomic variability, will be further increased by the correspondingly increased risk of rectal, or bladder, or urethral toxicities for the increased dose-per-fraction. Which further supports the usefulness of the high-quality MR-imaging. The main current limitation of an online adaptive MRgRT consists of the excessive duration of the re-contouring and re-planning phases of the workflow,

thus increasing the risk of intra-fraction motion. The current available solution to compensate for such intra-fraction target motion by the 1.5T MRlinac is limited to the target translations, while neglecting potential target rotations and/or deformations. Fast solutions for the online adaptive re-contouring and re-planning tasks are then needed.

ZAMBOGLUO
PELVIC RADIOTHERAPY IN THE PSMA PET ERA: WHEN AND HOW TO INTEGRATE NODAL TREATMENT IN PROSTATE SBRT?

Stereotactic body radiotherapy (SBRT) to the prostate—and increasingly to the pelvis—together with the implementation of PSMA PET/CT have been two major advances in recent years. Yet, how best to combine them remains unclear. This talk synthesizes the most current evidence and proposes risk-adapted pathways for daily practice. For PET-positive disease, we discuss simultaneous integrated boost (SIB) to involved nodes or oligometastases, andhow to balance SIB versus elective nodal irradiation versus lymph node-directed radiotherapy. For PET-negative scans, we address the limits of detection (micrometastatic risk), criteria for prostate-only SBRT versus ENI, and the role of short-course ADT. We review outcomes and toxicity from contemporary series and trials, highlighting GI/GU toxicity, tumor control, and quality of life —to answer the recurring questions: what to do when PET is positive, and what to do when it is negative.

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