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RTOG Institution # _____

RTOG 0813 **ELIGIBILITY CHECKLIST**

R I n s t i Tt u t i o n O G #

R T O G 0 8 1 3

used. Thus the argument for the use of heterogeneity corrections is much stronger for the

inflammatory response, synthesized by a variet

3.1.2.1 History/physical examination within

Patients can be registered prior to any protoc

is no hot spot within that organ,

Table 2

Serial Tissue	Volume	Volume Max (Gy)	Max Point Dose (Gy)	Avoidance Endpoint

6.5.2.4 Heart

The heart will be contoured along with the pericardi

6.5.2.11 Non-adjacent Wall of a Structure

For the esophagus, trachea and proximal bronchial tree, and great vessels, the non-

decline from baseline to a level 0.90 times the

6.10 Radiation Therapy Adverse Event Reporting

6.10.1 Adverse Events (AEs) and Serious Adverse Events (SAEs) Reporting Requirements

Adverse events (AEs) as defined in the tables below and all serious adverse events (SAEs) will be reported to the Cancer Therapy Evaluation Program (CTEP) via the Adverse Event Expedited Reporting System (AdEERS) application as directed in this section.

- **<u>Phase II & III Studies</u>: All unexpected potentially related SAEs;**
- **<u>Phase I Studies</u>: All unexpected hospitalizations and all grade 4 and 5 SAEs regardless of relationship.**

Any event that meets the above outlined criteria for an SAE but is assessed by the AdEERS System as "expedited reporting NOT required" must still be reported for safety

The site will provide details of the SAE to RTOG Headquarters and will be instructed to fax the completed lung adverse event form (AE), FAX:

All appropriate treatment areas should have access to a copy of the CTCAE version 4. A copy of the CTCAE version 4 can be downloaded from the CTEP web site, http://ctep.cancer.gov.

Adverse Events (AEs) and Serious Adverse Events (SAEs) that meet the criteria defined above experienced by patients accrued to this protocol **must be reported via AdEERS. SAEs must be reported within 24 hours of discovery of the event. Contact the CTEP Help Desk if assistance is required.**

All supporting source documentation being faxed to NCI, must be properly labeled with the RTOG study/case numbers and the date of the adverse event and must be faxed to the RTOG dedicated AE/SAE FAX, 215-717-0990, before the 5- or 10-calendar-day deadline. **All forms submitted to RTOG Headquarters also must include the RTOG study/ case numbers**; non-RTOG intergroup study and case numbers must be included, when

As discussed in Section 1.5, recent studies have shown correlations of genomic mutations (such

11.3.3 *Response Criteria* **(8/20/10)**

Evaluation of Target and Involved Lobe Lesions	
Complete Response **(CR)**	Disappearance of the target lesion; ideally, this determination will be made based on CT image evaluation.

evaluations for making this determination include physical examination and imaging studies. PET scan OR biopsy

NOTE: If for any reason the assigned course of treatment cannot be completed, RTOG

13.1.3 *Secondary Endpoints*

DLT+ simulations, 8-14 patients on average are treated on either of the 2 dose levels (8 and 9) with P(DLT) > 0.3, which result, on average in 3-5 DLTs. In the DLT++ simulations, 8-15 patients on average are treated on 1 of 3 dose levels (7, 8, and 9) with P(DLT) > 0.3 which result on average in 4-8 DLTs.

Primary tumor control was modeled as a function of dose by logistic regression model. A one-sided test with a significance level of 0.05 was employed, which is appropriate for a Phase II proof-of-concept trial. The right column of Figure 13.2 (below) assesses the power of the test of the null hypothesis that P (primary tumor control) < 0.7 at the chosen target dose. For all the simulations, it was assumed that pl=P (primary tumor control | dose level) increased linearly in the regression model between 60% of p9 at the lowest level, and p9, where p9 is graphed on the lower axis (for instance, trials labeled 0.9 indicated P (primary tumor control) increased linearly from 0.54 at Level 1 to 0.9 at Level 9, and equaled p6=0.83 at the true target dose). It is seen that, for the (DLT-td) trials, where the most efficacious dose has acceptable toxicity, the power exceeds 80% when p9 is 0.89 or greater, but that estimated power is more modest for the DLT+ or DLT++ simulations, where the selected target dose, and hence the efficacy at that dose, is lower. For example, with the DLT+ simulations, level 6 was the most frequently selected target dose (~ 40%), while dose levels 8 and 9 were uncommon (~4.5% and ~1.0%) This is an appropriate outcome, because these would be trials where adequate efficacy can only be achieved at unacceptably toxic doses.

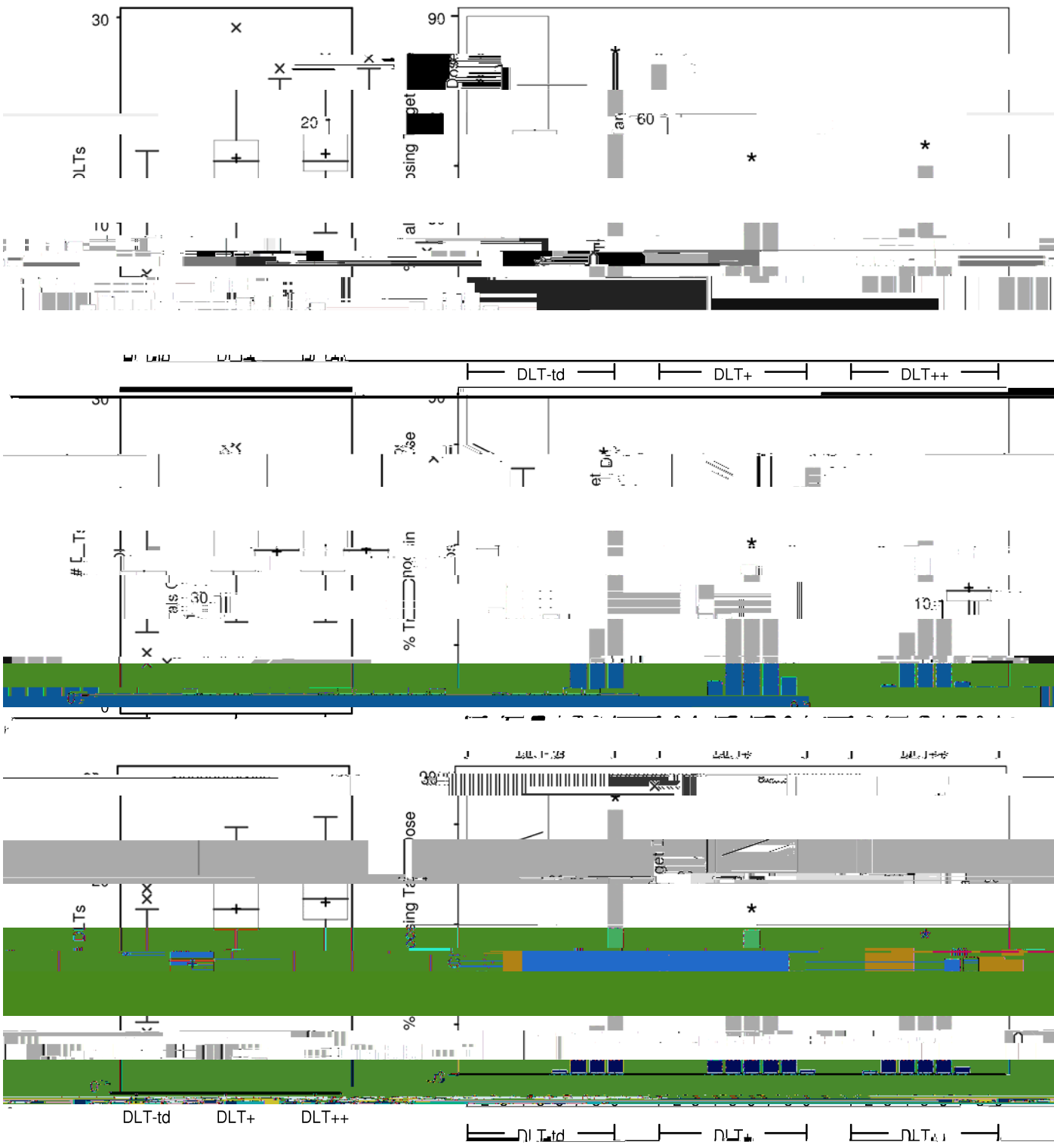


Figure 13.1: Operating characteristics for observed toxicity and selection of target dose d28

13.3 Sample Size

The weight function reflects the amount of information available from a patient. If a (12 months w
observed, the full information from this patient is available and the weight will ight Ohe rwise,

3. Reason for dose modification

13.5.1.2 *2-year Primary Tumor Control Rate at MTD*

level and actual dose received. If the number of applicable toxicities is adequate for

REFERENCES

1. Shields TW. Surgical therapy for carcinoma of the lung. *Clinicc in Chest Medicine*. Vol. 14, No. 1, 1993.
2. Mountain CF. A new international staging system for lung cancer.

19. Cheung K, Chappell R. Sequential designs for phase I clinical trials with late-onset toxicities. *Biometrics*. 56:1177-1182, 2000.

20. Normolle D, Lawrence T. Designing dose eccalation trials with late onset toxicities using the time-to-event continual reassessment method.

REFERENCES

Chest radiotherapy can cause changes in normal lungs. These changes can be as unimportant as small amounts of "scarring" seen on x-rays that does not cause symptoms. Some

***You may also call the Operations Office of the NCI**

Benefits

The benefits of research using tissue, urine, or blood include learning more about what causes cancer and other diseases, how to prevent them, and how to treat them.

Risks

APPENDIX IV

AJCC Staging
Lung, 6th Edition, 2002

Primary Tumor

STAGE GROUPING

Occult Carcinoma	TX	N0	M0	
Stage 0	Tis	N0	M0	
Stage IA	T1	N0	M0	
Stage IB	T2	N0	M0	
Stage IIA	T1	N1	M0	
Stage IIB	T2	N1	M0	
	T3	N0	M0	
Stage IIIA	T1	N2	M0	
	T25.5(N0	)-392	M0	
	T3	N1	M0	
	T3	N2	M0	
Stage IIIB	Any T	N3	M0	
	T4	Any N	M0	
Stage IV	Any T			NAny N

Rules for Completing the Charlson Comorbidity Index (CCI)

(Charlson et al.

CHARLSON COMORBIDITY INDEX (CCI)

Scoring Sheet

RTOG 0813

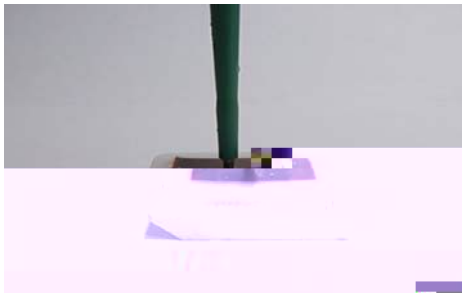
RTOG Institution Name/Number:_____

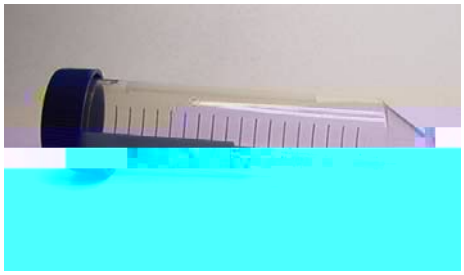
Patient Initials (First Middle Last):_____RTOG Patient Case Number:_____

Name of Person Completing Sheet:_____Phone Number:_____

APPENDIX V

APPENDIX VI





APPENDIX VI (
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C
ç L ry for the whole blood collected. Label them with the RTOG study and case number, collection date/time, and tim

Process:
1 m

APPENDIX VI

APPENDIX VII

Timing of Dose Limiting Toxicities (DLTs) During the First Year in Two Completed RTOG Lung Trials

RTOG 0236, "A Phase II Trial of Stereotactic Body Radiation Therapy (SBRT) in the Treatment of Patients with Medically Inoperable Stage I/II Non-Small Cell Lung Cancer"

Study population: Patients with T1, T2 (≤ 5 cm), T3 (≤ 5 cm), N0, M0 medically inoperable non-small cell lung cancer; patients with T3 tumors chest wall primary tumors only; no patients with tumors of any T-stage in the