

Association of Radiation Oncologists of India

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NEWS LETTER

GREETINGS FROM PRESIDENT'S DESK!

Dear Members,

It is a pleasure once again in meeting you all through this issue of Newsletter. Like you, I am very happy to note that Association's Newsletter is now regularly being published and is getting improved with every issue. It is a lively forum for interaction between all members and its regular publication is a healthy sign for the activeness of the Association.

A meeting of the Executive Body took place in Mumbai recently during the EBM Meeting in TMH. It was followed by an Extraordinary General Body Meeting in which several members attended. Honorable members will be delighted to know that our association will have close interaction with the ASTRO from now onwards. Participation in ASTRO Meetings will be more affordable for AROI members and we would get the ASTRO Proceedings in electronic format. Similarly we can look forward to increased participation of ASTRO members in our annual meetings. I am sure, these decisions will help in raising the levels of academic interaction and knowledge sharing between the members of two associations and increase the strength of bond between AROI & ASTRO.

Dr. Nagaraj Huilgol and his team has done an excellent job in improving the standards of the Association's journal and no doubt today it has got the true quality of an international journal in every respect. Our journal is the single most powerful medium through which we can tell the world about the good work that we are carrying out. I request the members to contribute more articles to the journal and help in making it a big success.

Wishing all the best to all the members,

Dr. G.K. Rath
President

FROM THE EDITORIAL BOARD

Dear members,

We take this opportunity to thank all the AROI members for their continuous support and encouragement for making this publication a regular feature. This venture is well appreciated by all which has been possible because of the dedicated and joint effort of all colleagues.

To make this publication more interesting and meaning full, we would appreciate contribution from your side in the form of case reports, interesting articles, papers, cartoon illustrations and material of interest to everyone. Looking forward for your active participation and suggestions.

MEMBERS OF THE EDITORIAL BOARD

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Forthcoming Conferences

The National Brachytherapy
update - 2006 on 20th-21st May 2006
Hosted by Bangalore institute of oncology
with Chandra Shekar Hospet as the organizing secretary.

ATTENTION

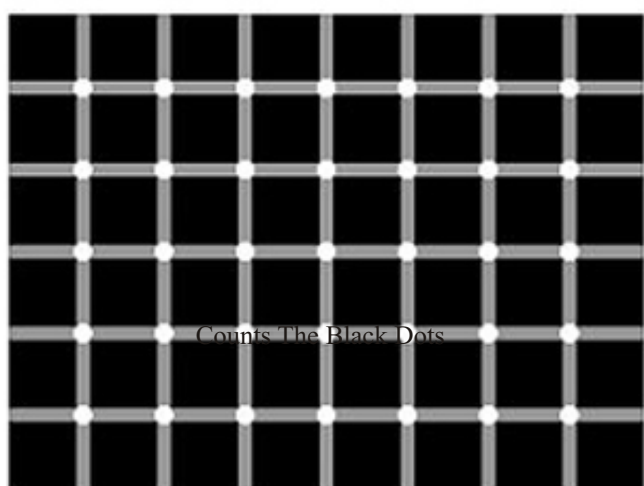
For the 28th AROI at Varanasi from 30th Nov to 3rd Dec. 2006.

All the members and students are requested to be ready with new abstracts & full paper for best paper session for the forth coming national conference AROI at varanasi(30th Nov-3rd Dec. 2006.) other articles and valuable suggestions can be sent to organizing secretary AROI 2006, Varanasi.

For the convience of the AROI members i am in a process of getting a new directory printed.It is a humble request to all the members to send the bio data and recent passport size photographs as soon as possible kindly take it as urgent because without your cooperation and support this project cannot be accomplished.

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Courtesy : Dr. M.L. Bhatt



Treatment guidelines in carcinoma prostate

Management of early Prostate Cancer(Organ Confined Disease)

Natural History of patients with localized prostate cancer who did not receive definitive local therapy has now been well documented in several large series, within ten to fifteen years most patients have cancer that grow locally, fewer patients develop metastasis and over all relatively few die from the disease. According to Peschel R.E.2003 patients diagnosed with early prostate cancer after 2000 can expect better outcomes from treatment than the patients who were diagnosed in 1980s and early 1990s. The improved outcomes are the result of stage migration, new technologies such as 3 dimensional conformal radiotherapy (3D CRT) and intensity modulated external beam radiotherapy(IMRT), better implant techniques and optimum use of hormone therapy.

The optimal management of prostate cancer that is clinically confined to the prostate remains controversial standard treatment options for organ confined prostate cancer include :-

- 1.Surveillance/watchful waiting
- 2.Radical prostatectomy
- 3.Radical Radiotherapy - EBRT/ 3 D conformal RT / IMRT
- Brachytherapy

Surveillance :

Ideal candidates for surveillance are patients with

- low volume prostate
- low grade prostate carcinoma
- elderly patients

The absence of complications as compared to conventional Radiotherapy or Radical surgery and minimal costs involved are the potential benefits of surveillance. Surveillance alone has been shown to achieve comparable results with other treatment modalities like conventional external beam radiotherapy and Radical surgery. Follow up assessment includes 6 monthly consultation with routine and bone scans may be done as indicated.

The long natural history of low grade disease (Gleason 5 or less) in men with short life expectancy (less than 10 years) suggest that this is the group which is well suited to be watched closely rather than treated. Although the randomized trials from Scandinavia suggest that local therapy may decrease mortality from Prostate cancer, there was no difference in overall survival in the study. Thus further research need to be done to define the population for which the expectant management is optimal and determine the method by which patients should be observed.

RADICAL PROSTATECTOMY

It has been used to treat prostate cancer over hundred years .The appropriate selection of candidate for Radical prostatectomy requires an assessment of both the extent of cancer as well as the age and overall health of the patient.

Since radical prostatectomy is curative only if the entire tumor is removed and accurate, preoperative staging is essential. Extension of cancer beyond the immediate periprostatic tissue in to seminal vesicles or pelvic lymph nodes is associated with a high probability of cancer reoccurrence.

Radical retro pubic prostatectomy is indicated for cancers that are clinically confined to the prostate (Stage T 1 to T2B without evidence of regional lymph nodes or distant metastasis). Besides being curative due to complete removal of cancer, radical prostatectomy gives more accurate pathological staging. The result of non randomized retrospective reviews showed that 10 to 15 years' survivals are 10-15 % better after surgery than radiation or surveillance, particularly for the high risk group.

————— Edited by : —————

Dr. Parveen Kaur, Dr. Sandhya Sood, Dr. Ishu Sharma

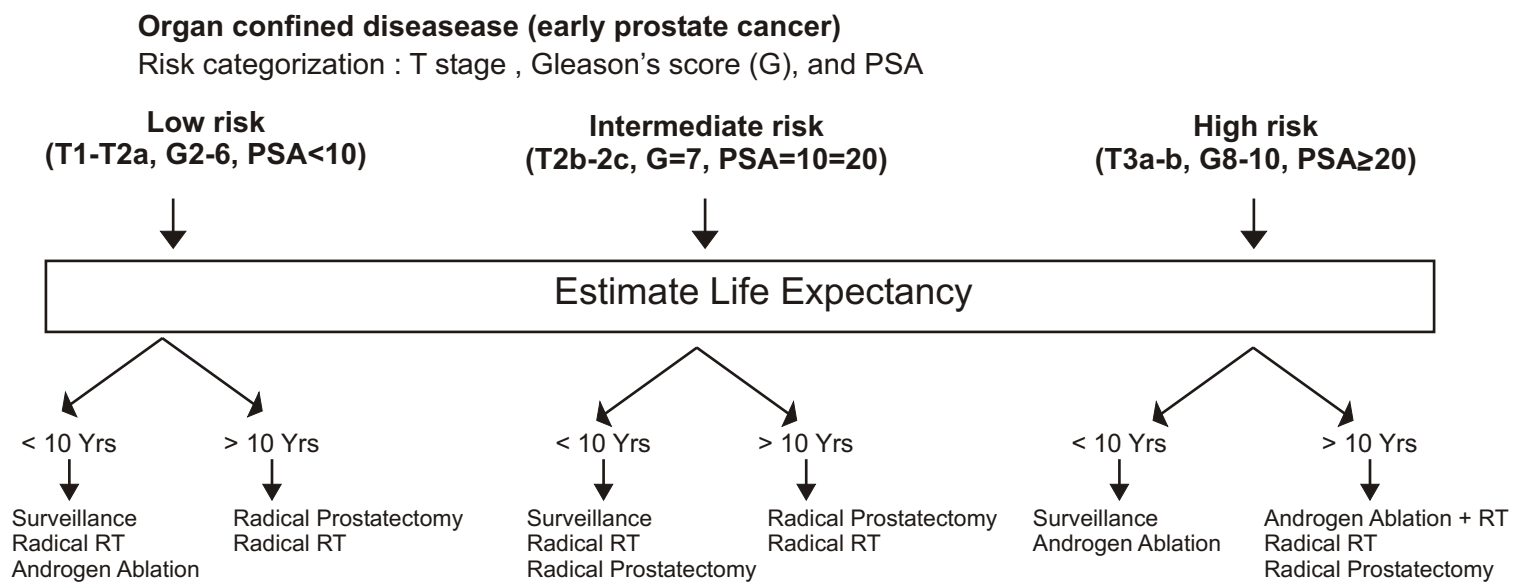
The risk of incontinence should be less than 5% in specialized centers and importance may be prevented by the technique of nerve sparing radical prostatectomy in suitable patients. Post radical prostatectomy follows up:-

1. Serum PSA estimation: 4-6 weeks post operative, 6 monthly for 10 years and then every year.
2. DRE :every visit
3. Bone Scans, CT scan and prostate bed biopsy-optional

Patients who are diagnosed as having metastatic lymph nodes at radical prostatectomy may benefit from radical prostatectomy in with addition to hormone therapy (either orchiectomy or medical castration) Survival benefit has been demonstrated by proceeding with radical prostatectomy with micro metastasis in pelvic node in non randomized trails. Patients with gross nodal metastasis are treated as per the guidelines for metastatic disease.

Radiation Therapy:-

Radiation therapy can be used as curative modality of treatment in patients with early stage prostate cancer. A number of retrospective and prospective studies support the long term efficacy of radiation therapy in the management of clinically localized prostate cancer. Although the long term result of radiation therapy are similar to radical prostatectomy the true incidence of local control may be lower in patients undergoing radiation therapy.



For low risk patients the 5 years relapse free survivals (RFS) rates for those treated with radiation therapy versus surgery were 81% versus 80% respectively. For high risk patients the 5 years relapse free survival rates for those treated with radiation therapy versus prostatectomy were 26% versus 37% respectively. In this subgroup there was no advantage to surgery if negative margins were achieved.

Routine inclusion of pelvic nodes in the radiation field has not shown any significant benefit in term of local control or survivals Data from published literature shows that dose escalation can be safely carried out, with 3D-CRT and IMRT.

Interstitial Brachytherapy:

Tumours , which can be completely encompassed by the implant high dose volume may be treated with brachytherapy alone. There are no randomized trails or large prospective studies comparing the clinical effectiveness of brachytherapy with radical, prostatectomy or radiation therapy. It may be reasonable alternative in patients with:-

1. low Risk
2. low volume T2 disease, especially in elderly patients
3. In conjunction with external beam radiation therapy in patients with intermediate & high risk with localized prostate cancer.

It is not recommended for patients with:-

1. Locally advanced disease.
2. PSA>10
3. High Gleason score.

MINUTES OF THE EXTRAORDINARY GBM HELD AT TMH, Mumbai On 27th Feb. 2006

The meeting was chaired by the President. The meeting was called to order. As the quorum was not complete, the meeting was adjourned and reconvened after half an hour. The minutes of the Annual General Body Meeting held at Ahmedabad were passed. Proposed by Dr. Shantanu Chaudhari and seconded by Dr. Shyam Srivastava. The Secretary presented the minutes of the Executive Committee Meeting held on 27/02/2006 at 3.00 PM at TMH. The minutes of the meeting are as under.

1. As informed by Dr P.K. Julka (by telephone), the committee formed for change of name of radiation oncology to a suitable name which will meet the aspirations of the Radiation Oncology community is doing its best and is in constant touch with MCI. The conclusive decision is expected within 3 months. The issue was discussed by the members and Dr. K.A. Dinshaw pointed out that AROI Members (Medical) are first physicians and then Radiation Oncologists. It was pointed out by her that when a surgeon or MD degree holding physicians are practicing chemotherapy, the radiation oncologists for sure can practice chemotherapy. The syllabus of DNB and various universities have a paper in chemotherapy and it is included as part of the curriculum, which is as per the directions of the MCI clarification in the Director, RCC, Thiruvanthapuram's query. All members of the GBM endorsed this view.
2. If anybody has problem with AERB, he has to discuss the matter with committee formed under Dr Shyam Srivastava (who is the chairman of the committee to interact with AERB) and in turn he will discuss the matter with authorities at AERB.
3. Dr Subir Ganguly informed that committee is collecting the data for amendment of constitution of the AROI and will submit to the central office within 3 months.
4. Dr Vashistha informed the committees that he had discussed with Dr R.K Vyas about distribution of CD of AROICON05 to all the delegates who attended the conference. The CD is ready and will be distributed to delegates within 20 days.
5. New logo of AROI of good quality to be designed and to be part of cover page of AROI journal.
6. It was decided that name of the previous editor-in-chief be included in the editorial board for subsequent issues of the journals.
7. Audited account of the journal to be prepared and to be presented by 31st March, 2006 to the central office.
8. Dr Vashistha informed on behalf of Dr Arvind Verma that Dr Verma had given application to bank for closure of bank account of AROICON-04. Once it is closed, amount will be transferred to AROI.
9. As discussed earlier, the central office has discussed with Dr. Firuza Patel to be the election commissioner for the elections to be held and she has agreed for the same. Money for elections will be transferred in March, 2006 and the election process will start in April / May, 2006.
10. The central office has received the bio-data of Dr. Solomon Padam Singh and Dr. Rangji Prasad. It was decided to collect the bio-data of Mrs. Parvati Devi, Dr. Neal and Dr. C.D. Joseph through the valuable help of senior members.
11. It was decided that the AROI chapters will be grouped into 5 zones. Each zone can bid for the conference after a minimum gap of 2 years.
12. Regarding the income tax return of the AROI, the papers have been submitted to Chartered Accountant and he is going to submit the audited report within 2 weeks.
13. For deciding the scientific program for AROICON, it was decided that a 10 member committee consisting of President, Secretary General, Editor-in-chief, Chairman, ICRO and 2 senior members from different zones by the President and 4 members from the local Organising Committee will be formed.
14. It was decided to write a letter to Dr. R.K. Grover for return of money of journal along with the audited account.
15. Dr. Vashistha informed the committee members about his discussion with Dr. Prabakar Tripuraneni, President,

ASTRO.

A. Collaboration with ASTRO: ASTRO members will be allowed to attend the AROI meeting and deliver guest lectures in AROI meetings. They will bear the travel expense. AROI will provide the local hospitality and waive off the registration charges. Same will be applicable for AROI members attending ASTRO meetings.

The General Body decided that 5 members of AROI, to be nominated by the President, AROI, to attend the ASTRO meetings. These members must have presentation (oral/poster) in the ASTRO meeting.

B. For training of members in different institutions in India, the desirous institutes will collaborate and some members from ASTRO will come to India to provide practical training. They will bear the travel expenses. The host Institute will provide the local hospitality.

C. ASTRO to give some fellowships to few senior and junior Radiation Oncologists of India in form of training by ASTRO in designated centers in US.

D. Teaching material of ASTRO will be provided to AROI members.

12. It was informed that some centers in India (like SN Medical College, Agra and MLN Medical College, Allahabad) are giving degrees without any radiation treatment faculties. Due to this the quality of training cannot be assured. The executive committee took a serious view of this and decided that the central office will write letter to MCI Health Secretary and the concerned Universities.

The Editor-in-chief requested that the association should write to various companies for sponsorship of journals. He also appealed to the members for submission of articles.

The above points were proposed by Dr. J.P. Aggarwal and seconded by Dr. Nagaraj.

The meeting came to an end with thanks to the chair person.

Advanced Diseses (Metastatic and Loweregional) :-Hormonal therapy has served as the mainstay of treatment for advanced Prostate cancer for over five decades. Current clinical practices have been guided by the results of large scale randomized trails that showed that, used alone agents that block androgen production are comparable with respect to their antitumor effects, regardless of whether these effects are assessed by measurable tumor regression, normaltition or percentage decline of a tumor marker such as PSA or ACP or Clinical response.

Transurethral Resection of the prostate for lrally advanced Disease Some belive that TURP is the Prostate cancer patient with local progression and bladder outlet obstruction will cause dissemination of loially advanced disease. other have questioned this and suggested that tumor grade may be a factor in the statistically significant lower 5 and 10 year survival rates of patients diagnosed with prostate cancer via TURP as opposed to needle Biopsy. Still other have refuted TURP or needle Biopsy as a independent cause of adverse effect on increased rate of metastatic disease. There authors suggest that the stage grade and amount of obstructive symptomatology are true factors determining progress and outcome.

Prognostic Factors:-The recognition that hormonal therapies, are not curative and there exists within a tumor mass a proportion of cells that can proliferate independent of androgens framer the controversy of when to imitate treatment A number of scheme have been proposed on which to assess prognosis.

1. a) Minimal Disease:- Patients good performance status no visceral metastasis and disease limited to axial skeleton.

b) Extensive Disease:- Lower performance status, appendicular as well as axial metastasis.

c) visceral Metastasis .

2. Proposed Classification scheme using the number of lesions on bone scan.

3. Based on parameters like testosterone level alkaline phosphate and symptoms of weight loss or pain. By using either of these schemes, patients with good progress can be considered for treatments designed to miminite toxicities, while those with poor prognosis can be evaluated early, for the treatment directed at the hormone independent population of cells.

Hormonal Therapies:-

-ESTROGEN

-PROGESTATIONAL AGENTS

-GONADOTROPIN RELEASING HORMONE ANALOGUES

-ADRENAL ENZYME SYNTHESIS INHIBITORS

-ANTIANDROGENS

-COMBINED ANDROGEN BLOCKADE

Neo adjoined Androgen Deprivation:-The result with radiation therapy or surgery for patients with clinical T3 and T4 lesions are discouraging which has led to reevaitaion of hormonal therapy prior to the definitive treatment a concept that was originally evaluated in 1940's more recently results of Randomized

Comparisons have confirmed that neoadjuvant hormone therapy reduce the rate of positive surgical margins from an average of 47% to an average of 22%. However benefits with clinical T2b disease lesions, since no significant improvements were apparent for patient with clinical T3 disease. More recent trials comparing 3 years of androgen deprivation prior to radiation therapy versus radiation therapy alone control rate (95% vs 75%), a higher metastasis free, survival (89% vs 56%) and overall survival rate (78% vs 56%) at 5 years. These results have important therapeutic implications and would provide support for the concept of early endocrine therapy.

Targeting cytoskeleton:-

- Estramustine phosphate is currently the only FDA approved drug for relapsed prostate cancer.
- The drug inhibits microtubule assembly and disassembly at sites that are distinct from vinca alkaloids and has synergistic.
- Effects Affects the nuclear matrix, which functions to control the chromatin structure and nuclear shape In contemporary trial of 14 mg/kg/dg it produced over a 50 % decline in PSA in 21% of case

Other Compounds - That target cytoskeleton :- Etoposide and paclitaxel

- Have minimal activities as single agents
- Synergy with estramustine.

CANCER CI-2006 FINAL REPORT

CANCER CI-2006 a conference dedicated to Cancer Care Education & Research was organized on 11th, 12th February 2006 at Hyderabad. Primary hosted by Apollo Cancer Hospital, Hyderabad in association with New York Medical College, Valhalla, New York and Cure Foundation, Hyderabad.

The conference was aimed to involve all the specialties of Oncology, Radiation, Medical & Surgical and hence it was hosted in association with all the four major Oncological societies of India Association of Radiation Oncologists of India (AROI), Indian Society of Oncology (ISO), Indian Society of Medical & Pediatric Oncology (ISMPO) & Indian Co-operative Oncology Network (ICON). As the conference was mainly focused on Ca. Breast, Gynaec, Head & Neck and Urological Malignancies. In this two days event, all the controversial areas were addressed by eminent speakers from abroad and within India.

Highlights of the Conference:

- Evidence Based Cancer Management Guidelines to practicing Oncologist, General Surgeons, Gynecologists, ENT Surgeons and Urologists.
- Revolution in Cancer Diagnosis and its effect on patient care.
- Molecular imaging, Functional Imaging, PET-CT Scan.
- Technology Explosion in Radiation Oncology IMRT, IGRT, PET-CT Guided Radiotherapy.
- Comprehensive Multimodality management of Cancer and Organ Preservation.
- Head & Neck Cancer Work Shop: CO₂ Laser Surgery in Head & Neck Cancer.

The conference was inaugurated by Shri K. Rosaiah, Hon'ble Minister of Health & Finance, A.P., and the Guest of Honour was Dr. Pratap C. Reddy, Chairman of Apollo Hospitals Group. The august gathering was also addressed by Ms. Sangita Reddy, Executive Director, Apollo Hospitals, Hyderabad. The conference was extensively covered by all the local and National News papers, T.V. Channels. Several interviews of the eminent speakers were also covered in News papers.

CANCER CI 2006 was highly appreciated by all and we sincerely thank all the participants for making this a Grand Success.

Dr. Vijay Anand P. Reddy
Organizing Secretary CANCER CI 2006
Director, Apollo Cancer Hospital

Tribute

In the Memory of Prof. N. Anantha

With profound grief and sorrow we inform the sudden demise of our senior member Prof. N. Anantha, former Director and Head of radiotherapy, Kidwai Memorial Institute of oncology, Bangalore. No words can express the grief of losing him.

God treasure him in your garden of rest and peace and give his family the strength to bear this irreparable loss

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