ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE
European Society for Medical Oncology

Labelled meeting accredited with 20 ESMO MORA points

Indian cancer congress 2011

Bhubaneshwar

13th February 2011

Biennial joint conference of ISMPO (Indian Society of Medical & Paediatric Oncology) and ISO (Indian Society of Oncology)

Theme: Targeting Cancer with Humility

Oral presentation

1.Dr. Mandip C. Shah
2.Dr. Mukul Goyal
3.Dr. V.L. Balaji
4.Dr. Arun Philip
5. Dr. Sanju Cyriac Pandarakalam
6. Dr. Rejiv Rajendranath
7. Dr. Bhavesh Bang
8. Dr. David Praveen Kumar
9. Dr. P Suresh Nair
10. Dr. Brijesh Arora

Poster presentation

1. Dr. Jayant sriramashatta
2. Dr. Mandeep Shah
3. Dr. Praveen Yadav
4. Dr. Sheikh Zahoor
5. Dr. Jita parija
6. Dr. P. Suresh Nair
7. Dr. Salim VP
8. Dr. Ananda Raja
9. Dr. Ayush Makkad
10. Dr. Rohan bhise
11. Dr. Rajaram
12. Dr. Rexeena V Bhargavan
13. Dr. Prabhath Kumar
14. Dr. P.N Shathia Murthy
15. Dr. Krishna Kumar
16. Dr. Virendra Rajpurohit
17. Dr. Prashanth Sharma
18. Dr. Rahul Patil
19. Dr. Vijay Patil
20. Dr. Manisha Mohapatra

All India Institute of Medical Sciences, New Delhi

Low grade glioma

Dr. G. K. Rath

NEW DELHI

Low grade gliomas (LGG) and High Grade Glioms (HGG) are distinctly separate entities. Grade I and grade II are called LGG Gliomas are limited access to clinical examination. Surgery is the primary treatment for Gliomas. Radio therapy along with CT is better option. Brain-as the vital organ every mm needs to be preserved during metastasis. LGG accounts for 11% of all CNS tumors. Incidences are more in males aged 55-65%. Increasing with age worsen the program. Recent advances in radiation treatment include: IMRT, IGRT: An approach to conformal therapy that not only conforms high dose to tumor tissue but also conforms low dose to surrounding sensitive and normal structures. Stereotactic irradiation: The most accurate form of radiation Advanced technologies available in AIIMS are Brain suite, cyber Knife, tomotherapy –includes serial tomotherapy - delivery of multiple fan beam discrete table increment between each axial gantry and helical tomotherapy: continuous synchronized gantry and table motions Surgery is the main stay of treatment for LGG. Radio therapy is indicated mainly as adjuvant treatment. Current radio therapy recommendations for LGG are localized field conformal radio therapy, preferred dose 50-55 Gy/1.8-2 Gy/fr and Chemotherapy is having a limited role in treating LGG.

High grade glioma

Dr. D. N. Sharma

NEW DELHI

All India Institute of Medical Sciences, New Delhi. Grade III and IV are called as malignant glioma. Glioblastoma is the Deadliest cancer in the human body. No improvement is seen in last 80 years. Management of Glioblastoma can be done better using surgical resection and adjuvant therapy including RT + Temozolamide. Extent of surgery has significant prognostic value. Maximal safe surgical resection- Is the aim of surgery.

MG is an aggressive entity and prognosis continues to be dismal. Surgical resection is the main treatment. RT is the standard adjuvant Rx. Current RT recommendations for MG include localized field RT Dose preferred is 60 Gy/30-33F/6-7 wks. Concurrent TMZ followed by adjuvant TMZ for 6 months.

Gujarat Cancer Research Institute , Ahmedabad

Ovarian Cancer

Second And Third Line Chemotherapy In Recurrent Epithelial Ovarian Cancer

Dr. Shilin N. Shukla,

AHMEDABAD

More than 80% of patients relapse at some point of time and having Poor Prognosis. Salvage CT is not curative. The treating physician must also consider the risk benefit ratio of such therapy and the impact of the chemotherapy on quality of life.

Active Drugs: Platinum resistant disease are: Topotecan, oral Etoposide, Emcitabine, liposomal Doxorubicin Vinorelbin.

Role of surgery in recurrent epithelial ovarian tumors

Dr. Kalpna S. Dave

AHMEDABAD

Although most recurrent ovarian cancer patients receive second-line chemotherapy, the response rate and benefits do not reach those of first-line chemotherapy. Secondary cyto-reduction should be offered in selected patients & large prospective studies are needed to define selection criteria for secondary cyto-reduction.

Role of cytoreductive surgery in ovarian cancer

Dr. Meeta Mankand

AHMEDABAD

Medically fit patient should be subjected to primary cyto-reduction. Current definition of optimum cyto-reduction is no evidence of macroscopic disease. Systemic lymphadenectomy should be performed in optimally cytoreduced peritoneal disease cases only. Advanced ovarian cancer should be referred to subspeciality unit, where a surgeon or a team of surgeons are well trained to attain complete cytoreduction.

PET CT In Recurrent Ovarian Cancer

Dr. Manas Mayank

AHMEDABAD

Recurrence of ovarian cancer is relatively high and requires precise and early diagnosis for better outcome. PET-CT is very sensitive to depict recurrent ovarian carcinomas with high positive predictive value, even for small and subtle lesions. This exhibit will help in understanding of functional method of tumor viability which eventually helps for therapeutic management of recurrent ovarian cancers.

Personalised medicine for early colon cancer: prognostic biomarkers

Dr. David J Kerr

UK

The Individualized therapy is very essential in the treating of stage II colon cancer. The challenge is which stage II colon cancer patients should be treated with adjuvant chemotherapy? Because, 75-80% are cured with surgery alone but there are no standard methods to identify them. And also benefit of chemotherapy is small and no consensus in guidelines on who to treat. To treat

with chemotherapy there will be significant toxicity. Today, decision to give chemotherapy subjectively based on: following aspects:, clinical/ pathologic markers of risk, MSI status and no other proven molecular markers are available to identify the stage II colon cancer. Overall Goal is to develop and validate a multi-gene expression assay which improves treatment decisions for patients with stage II colon cancer providing individualized assessment of recurrence risk following surgery, identification of patients with differential 5-FU/LV benefit, independent clinical value in the context of other measures such as T-stage and MMR/MSI and optimized for fixed, Paraffin-embedded colon tumor tissue. Assessment of 761 candidate genes in 1,851 patients in the development studies to yield final pre-specified assay for validation in QUASAR. In the parent QUASAR study 3,239 patients are enrolled. Among them) 68% (n=2,197) of patients are with collected blocks. And confirmed stage II colon cancer are 69 %(n=1,490). In the final evaluation of 1,436 patients. a significant relationship between the risk of recurrence and the pre-specified continuous. Although the recurrence score will likely yield its highest value when used as a continuous measure, to obtain individualized estimates of recurrence risk, an analysis of the QUASAR data permit the identification of "guideposts" which may be useful for clinical decision-making. These guideposts have been identified on the basis of internal consistency within the data and are not in any manner, meant to be prescriptive. Ultimately, decision making with an individual patient should be based on clinical judgment after review of the relevant clinical data, including recurrence score. In conclusion recurrence score has been validated as a predictor of recurrence in stage II colon cancer And a separate score, based on a distinct set of 6 genes, was not validated for prediction of differential 5FU/LV benefit. The implications for clinical practice, RS provides has the greatest clinical utility when used in conjunction with T stage and mismatch Repair (MMR/MSI), particularly for the majority of patients for whom those markers are uninformative (~70% of pts). The recurrence score is likely to be applicable to diverse ethnic groups but requires further validation.

Breast Cancer

Personalization of CT in Breast Cancer

Dr. Raju Chacko

The gene expression arrays identify five molecular subtypes that overlap with clinical-pathologic characteristics, which would drive current medical treatments. The major oncogenic events can be either shared across subtypes (i.e. PI3KCA mutations) or are subtype-specific (FGFR1). Molecular classes could be re-divided according to molecular events. Drugs used targeting HER2 are Trastuzumab, T-DM1, Pertuzumab, Lapatinib, Neratinib. Neratinib (HKI-272) is small-molecule irreversible pan-ErbB kinase inhibitor (ErbB-1, ErbB-2 and ErbB-4) which covalently binds to ErbB receptors at ATP binding site and inhibits tyrosine kinase activity resulting in G0/ G1 cell cycle arrest given orally. Targeting HER2/neu by overcoming resistance to TrastuzumabBevacizumab (BV), a monoclonal antibody, inhibits vascular endothelial growth factor (VEGF), a key bmediator of angiogenesis. Three randomized trials (E2100, AVADO, RIBBON-1) have demonstrated significantly improved PFS for BV combined with different chemotherapies as first-line MBC treatment. PFS improved when BV combined with chemotherapy regardless of hormone receptor status, sites of metastases, disease-free interval (DFI), or prior adjuvant taxane use.

Bevacizumab and oral chemotherapy for patients with lymphangitic breast cancer: A phase II randomized study of Bevacizumab with sequential versus concurrent oral Vinorelbine plus Capecitabine in patients with locally advanced breast cancer . The aim of the study was to assess activity of Bevacizumab in combination with Capecitabine and oral Vinorelbine (sequential and concurrent administration).

To conclude, oncogenic events can be shared across molecular classes, no first-in-class agent for triple negative, but clear sensitivity to DNA damaging agents in the neoadjuvant, adjuvant and/or metastatic settings. Second-in-class drugs to reverse resistance to be developed according to molecular profiling. Integrated biology approach could help to improve results in patients who develop resistance.

Non palpable Breast Cancer-Recent advances

Dr. Arun Kurkure

MUMBAI

Breast Surgeon should be familiar with all Imaging modalities, localization approach, Oncoplasty principles, adj. Systemic Treatment, and conservation of Radiotherapy.

Management of Non-Palpable Lesion

In Identification of Abnormality, Localization, Single Wire Vs Multiple Wires, Surgical technique, Complication of Localization, Specimen Mammography, Multiple lesions. Non palpable lesions may not be speculated, Failure to appreciate USG as adjuvant tool, Cranio caudal route may not be shortest route to lesion, Use of more than one guide wire is beneficial, Failure to document lesion in specimen.

Image Detected Breast Cancer: Localization and Biopsy.

Hooks should be placed beyond the lesion. Wires are stable in fibro glandular tissue as compared to fat, position of needle to be documented in two views, Use scalpel as wire; may be transacted by scissor, Electrocautery can cause thermal injury or fracture the wire. In the techniques of needle localization speculated lesion at level of nipple is done in the lateral view of breast. In cranicaudal view of breast, speculated lesion at a shorter distance from lateral skin surface. The direction of guide wire lesion is in anterior half and superior quadrant-cranicaudal. Most of the other lesions are mediolateral/ lateromedial.

The Surgical use of Breast Ultrasound has improved the quality of screening, has made capable of imaging nearly 50% of non-palpable lesions. Concordance of breast US by surgeons and radiologists is 96%. The lesions can be characterized on US margin definition, echogenecity, internal echo pattern, retrotumoral acoustic imaging phenomenon, compressibility, and, lateral versus anterior dimension ratio.

The retroareolar tumors has high rate of multicentricity

Partial Breast irradiation

Current Status and Future Potential

Dr. Subodh Pande

NEW DELHI

Up to 43% patients are eligible to receive BCS elect to have a MRM and some 15 - 30% with lumpectomies do not undergo further RT. This attitude leaves them at ignificant risk for local recurrence. The reasons for reluctance

- Travel and lodging problems
- Work and care-giving responsibilities
- Remoteness from RT Center
- Finance
- Counseling and awareness

APBI –has an attractive proposition because of the following reasons

- Socio-economic salvage
- Higher treatment compliance
- Reduced morbidity
- Improved QOL
- Clinical influences

APBI Techniques includes, Interstitial brachytherapy, intra-cavitary, brachytherapy, intra-operative radiotherapy (IORT), 3-Dimensional Conformal Radiotherapy (3-DCRT)

The pros in the IORT-issues are maximal normal tissue sparing and patient A, pathologic benefit obscured. The major two devices are IntraBeam (Carl Zeiss, Germany) it has 50kvp X-rays, 3.2 mm diameter probe, multi-sized applicators for conformal cavity coverage, the dose methodologies are 20 Gy at surface and 5 Gy at 1 cm in 30 minutes. The other IORT device is mobetron (intraop Med Corporation, CA) it has 4, 6, 9 and 12 MeV electrons, therapeutic ranges up to 4 cm, uniform dose delivery of 10-25 Gy/ SF at 10 Gy/minute. The Pilot ELIOT Trial was conducted by Dr. Veronisi et.al, in 1999, this test was conducted in 921 patients', who were thus treated with 21 Gy to the tumor bed. The results were recorded as follows at medical follow up of 42 months, local rec. of 1.6%, hematoma-1.3%, liponecrosis-4.2%, mild fibrosis-2.6% Ongoing Prospective Trial: BCT + WBRT vs. BCT + ELIOT (21 Gy). In the TARGIT-A trial (2001) Vaidya et.al, there were researchers from 31 international centers/ 9 countries. Random selection of 2232 patients of early breast cancer was made in 1,113-Intraop APBI with 20 Gy/ SF (IntraBeam), vs., 1,119-WBRT to 40-56 Gy/15-25 free margins (+/- boost)

PBI is based on the premise of:

- Ocal recurrences predominantly occur in tumor bed
- Reduction of irradiated volume would thus limit
- Treatment time and toxicity
- Despite variability of radiation techniques, there should be

No compromise in local control or survival cf. WBRT No PBI modality could be considered most efficacious and the relative role of the different techniques is yet to be clearly identified PBI currently lacks long-term clinical outcome results. No randomized trial is currently available to unequivocally establish reduction of in-breast local rec. as effectively as WBRT. Till availability of the analysis of NSABP B-39/RTOG 0413, the use of PBI should be done judiciously and within a protocol setting. It is evident that APBI will play a crucial role in the management of a select group of early breast cancer cases in the near future, which would reflect favorably on their long term survival and QOL

"Ixabepilone is indicated as monotherapy for the treatment of metastatic or locally advanced breast cancer in patients whose tumors are resistant or refractory to anthracyclines, taxanes, and capecitabine"

Dr. Divyesh Mehta

USA

Upper Gastro-Intestinal Cancer

Changing trends in Management of SSC of Oesophagus

Dr. Hemanth Raj

CHENNAI

Among the commenest cancers in males stomach cancer has the highest CIR(6.3), in females cervix cancer has the highest CIR(26%). The recent advances have been in epidemology and biology of ca esophagus, recognition of preinvasive lesion, early diagnosis of invasive carcinoma, endoscopic interventions, multimodality Management burgeoning role of defective CRT, status of surgery. The recent advances in the diagnostic modules are Trimodal endoscopy- white light endoscopy autofluorescence, NBI, Chromoendoscopy, Confocal flourescence microscope, Elastic scattering sprctroscopy, Optical coherence tomography, cytological screening, Gene signatures for scc esn, FISH/PCR, and Serum biomarker. High grade Intraepithelial is malignant potential and 30% of lesions are invansive carcinoma. PET plays an important role in initial staging of disease with no evidence of M1 (NCCN 2010), assesment of response restaging, T staging – limited (43% -accurate, 29%-over diagnosis, 29%-underdiagnosed), N status. Recent advances in early esophagal ca are EMR, an endoscopic technique developed for removal of sessille or flat removal of sessile or flat neoplasms confined to the superficail layers of GI tract and ECD is an endoscopic technique for en bloc removal of larger flat tumors involving dissection into the sub mucosa with electrosurgical knives. The endoscopic resection plus prophylactic CRT reduce Morbidity of an eso phagectomy and high level failure rates with CRT alone thus it is concluded that EMR+CRT is safe, effective and superior to surgery in superficial eso ca. The locally advanced ca esophagus that is Neoadjuvant CT plus surgery showed two survival benefits out of four randomised trials. The survey conducted predicted that Palliative procedure stent or dilatation had a P value of 0.005, 3 month mortality with 0.005 p value and the length of hosp stay had 0.5 P value. The results of planned esophagectomy after CRT proved in improving only the local area, doubtful effect on OS especially in SSC, respiratory complications, cardiac surgery. Thus, detection of pre invasive and early invasive cancers and their endoscopic management will increase, Surgery or CRT can be regarded as definative treatment for locally advanced Squamous carccinoma of oesophagas and Surgery is must for resectable nonresponders residue and recurrence.

Proximal Gastric Cancer & CO junction

Dr. Sanjay Sharma

MUMBAI

In GE junction cancer pre treatment evaluation CT scan chest and upper abdomen gives out the overall accuracy of about 66-77% and also nodal assessment is poor Major limitations is failure to detect early gastric tumors and small (<5mm) liver or peritoneal mets where as Laparoscopy and laparoscopic USG is now recommended by many as essential as it delivers accurate diagnosis of peritoneal and small liver mets. LUS is not easily available, expensive, insufficient data available. In GE junction cancer surgery is the best modality of therapy for. resectable lesions. Two important aaspects has to be covered in surgery the extent of resection and extent of lymphadenectomy. RO resection apart from TNM remains important independent prognostic factor. The advantages of perioperative treatment are increases rate of curative resection by tumor downstaging, eradication of micro metastatic disease, demonstrates in vivo chemo sensitivity and better tolerated than post-operative therapy.

Adjuvant treatment the post op Radiotherapy is recommended for patients with positive regional nodes and in patients with positive resection margins and no significant improvement in overall survival had been demonstrated.

Case Discussed:

What is the life expectancy?

Case 1

A 76 year old male patients with hypertension, coronary artery disease with CABG, hyperlipidemia. He was on standard medication of aspirin, atenolol, and lovastatin. The recent investigation revealed mild microcytic anemia. Colonoscopy reveals mass in the descending colon with adenocarcinoma. Patient underwent hemicolectomy and pathologic staging of T3, N2 (4 nodes positive) M0 – Stage III colon cancer.

In 75 year old patient with stage III colon cancer, Comprehensive Geriatric Assessment requires assistance with Instrument assisted daily activities, frequent falls, a memory disorder. The life expectancy is lowest 25% for age (4-5 years). An high likelihood toxicity from adjuvant chemotherapy

In case of 85 year old with stage III colon cancer, for a fit patient in excellent health, life expectancy is 9 years, for an average health patient, life expectancy is 4-5 years.

Case 2

A 75 year old woman with diabetes on diet controlled, with baby aspirin presented with left breast mass. On physical exam a 4 cm primary mass, and lymphnode of 2cm in size. Biopsy revealed ER/PR positive and HER2/neu negative. The metastatic work up was negative. Patient underwent lumpectomy and axillary node dissection. The final staging was T2, N1, M0 (Stage IIB). Echocardiogram was normal, with LVEF of 60%.

The geriatric assessment reveals no deficits except for diabetes that is well-controlled. The life expectancy is 10-15 years. From adjuvant on-line (Good health) 31% die because of cancer, 22% die from other causes, 7 of 100 alive because of hormonal therapy, 9 of 100 alive because of chemotherapy and 14 of 100 alive because of combined therapy.

Haemato-Oncology

New drugs in MM

Dr. B. K. Smruti

MUMBAI

Multiple myeloma treatment in 1960's were the alkylating agents ± Prednisolone, in 1980's it was combination CT non alkylating alkylating interferon, in 1990's it was high dose therapy bisphosphates and finally in 2000's novel targeted therapies. The novel drugs include Immunomodulators-Thalidomide and Lenalidomide, Proteasome inhibitors-Bortezomib, Arsenic Trioxide, Farnesyltransferase inhibitor, 2-methoxytri-oxide, VEGF inhibitors, HIstone deacetylase inhibitors. Two drug combination: Dexamethasone +Thalidomide/Lenalidomide/ Bortezomib.Three drug combination: VTD, RVD, Pegylated doxorubicin+ Bortezomib+ Dexamethasone, Cyclophosphamide

Four drug combination: Cyclophosphamide+ Bortezomib + Lenalidomide + Pegylated doxorubicin. Non transplant options for elderly include combinations like MPT, VMP, MPR, VMPT, Rx option continued till stable disease

So, its concluded that noval therapies have significantly improved survival in MM, relapses are substantial dose limiting toxicities reduce compliance, new agents are targeting different targets and differs in toxicities, combination with existing drugs is feasible.

Autologous BMT in MM

Dr. Atul Sharma

INDIA

ASCT Procedure has the following objectives: Case selection, Central line insertion, Stem cell mobilization, Stem cell harvest, infusion Conditioning: high dose melphalan 200 mg/m^2. (Elderly or renal failure: 120-160 mg/m^2). Post Tx prophylaxis, Engraftment, Maintenance therapy, Follow up. Remove stem cells from deep freezer, thaw to 37 degree Cels. The infusion is done intravenously. Cryopreservation is done at -80 degree Celcius in liquid nitrogen. Autologous SCT, AIIMS diagnosis was conducted in 255 patients. The case of multiple myeloma was observed in a total of 168 (65.9%) patients, lymphoma (hodgkin's and NHL) was observed in 46 (18%) patients, leukemia was observed in 33 (9%) patients, solid tumors was observed in 18 (7.1%) patients. The median age in these patients was 52 (26-68 years). Multiple Myeloma is majorly constituting of three step models namely, Induction therapy, Consolidation (ASCT), Maintenance therapy. ASCT associated with higher RR. Early transplant, Maintenance therapy. Options of treatments for renal failure is Bortezomib + dexa, MP + bortezomib is used for Thrombo-embolism. CR is a surrogate marker for overall survival, newer agents have dramatically improved CR rates and survival, Auto SCT remains the standard of care in transplant eligible patients. Maintenance is indicated.

Advances in Treatment of Low Grade Lymphomas

Dr. Reena Nair

MUMBAI

Follicular NHL has common indolent NHL that is rising in incidence.

Variable clinical course are Incurable with standard therapy; multiple remissions and relapses, histological transformation and has median survival improvement. With such a long natural history to the disease and competing morbidity in older patients, it is reasonable to ask if delaying Rx as long as possible is a reasonable strategy. 316 patients with low grade histologies (65% follicular) have Stage III/ IV disease, Absence of B- symptoms, No organ dysfunction. It is randomized to initial chronic oral chlorambucil or observation. Trials exists utilizing interferon- alpha after chemotherapy.No consistent statistically significant improvement in OS or TTP was observed. However, some trials still use it as maintenance Rx. Galiximab induces ADCC in lymphoma cell lines. It delays progression of human NHL xenografts in SCID mice.Transplantation needs to be considered when NHL becomes refractory to rituximab. Radioimmunotherapy is a highly active, low morbidity treatment option.

Changing Face of Leukaemia Diagnosis

Dr. Deepak Mishra

KOLKATA

Classification is a language of medicine: Diseases must be described, defined and named before they can be diagnosed, treated and studied. A consensus on definitions and terminology is essential for both clinical practice and investigation. A classification should contain diseases that are clearly defined, clinically distinctive, and non-overlapping and that together comprise all known entities. Classification is of two types, biologically rational classification and clinically useful classification. Acute Leukaemia of ambiguous lineage is classified by WHO as follows:

- Undifferentiated acute leukaemia.
- Bilineal acute leukaemia.
- Biphenotypic acute leukaemia.

Most heterogeneous Gp in AML has normal looking karyotype by conventional methods.

Gastro esophageal cancer is the 2nd most common cancer. The incidince of GE junction are increasing while that of gastric cancer is decreasing. The incidence of gastric cancer is changing in western population.

Dr. T. Raja

Shifting Paradigms in use of Taxane in Breast Cancer

Dr. Bhawna Sirohi

The primary therapeutic goal in metastatic breast cancer (MBC) is palliation, where the selected systemic therapy aims in balancing efficacy with toxicity with or without local palliaion. Disease-specific and patient-specific factors determine the choice of systemic therapy in MBC. Over 3 decades, there has been a significant trend in improvement of survival in MBC patients. Clinical evidences have established an improvement in objective response with symptom palliation. Various factors influence the choice of combination chemotherapy vs single agent as initial therapy. However, single agents are preferred over cytotoxic chemotherapy combinations in patients who have symptomatic disease and/or high tumour burden and resistance to endocrine therapy. Currently, Taxanes are the cornerstone in the management of MBC.

Nab-Paclitaxel, albumin bound paclitaxel has a distinctive advantage of being cremephor free, shorter infusion time with no requirement of premedications when compared to conventional paclitaxel. Nab-Paclitaxel binds to the gp60-albumin receptor on the endothelial cells and undergoes endocytosis. The endocytosed Nab-Paclitaxel binds to the SPARC which is highly expressed by the tumour cells and present in the interstitial fluid. This leads to achieve high concentration inside the tumour cells leading to tumor lysis. Pharmacokinetically, Nab-Paclitaxel shows a linear curve which makes it predictable unlike the conventional paclitaxel (3 hour infusion), which is non-linear and less predictable. Phase III study has revealed a signficant greater response rate and median TTP with Nab-Paclitaxel compared to conventional paclitaxel. Nab-paclitaxel at 100mg/m2 qw, 150 mg/m2 q3w, 300 mg/m2 q3w dose showed statistically significant higher RR, PFS compared to docetaxel with lower incidence of neutropenia, fatigue, mucositis and no difference in peripheral neuropathy. Nab-Paclitaxel patients with peripheral neuropathy showed a faster time of improvement compared to docetaxel. Nab-Paclitaxel has been studied in combination with biological agents like Bevacizumab revealing promising results.

To conclude, Nab-Paclitaxel, a targeted albumin bound paclitaxel, with high specificty towards SPARC. Estimation of SPARC level would act as a predictive marker for response to Nab-paclitaxel in MBC patients. Thus, the advent of Nab-Paclitaxel marks a step near to the destination in the better management of metastatic breast cancer.

Panel Discussion

Dr. G.S. Bhattacharyya: How do you choose the MBC patient for Nab-Paclitaxel?

Dr. Ghanshyam Biswas: Performance status, prior exposure to chemotherapy and associated comorbid conditions would be the major factors considered for choosing the Nab-Paclitaxel. Looking at the evolution of Nab-Paclitaxel from conventional Paclitaxel has provided a better option as weekly Nab-Paclitaxel is equivalent to Docetaxel 3 weekly.

Dr. G.S. Bhattacharyya: Does the panel consider Nab-Paclitaxel as new drug?

Dr. Govind Babu: Yes, FDA recommends need of clincal trial, which implies the new drug status.

Dr. G.S. Bhattacharyya: What are the major hindrances for use of Nab-Paclitaxel?

Dr. Bhawna Sirohi: There is no hindrance from my side. We require more data on the usage of Nab-Paclitaxel in prior taxane usage. I use the combination of Nab-Paclitaxel with Carboplatin to my patients.

Dr. Raju Titus Chacko: Choosing the right taxane is fairly settled now. Nab-Paclitaxel seems to be scientifically developed formulation showing better tolerability, which is well documented based on clinical data and TMH experience. We need to go for Nab-Paclitaxel.

Dr. G.S. Bhattacharyya: Is there an issue of neurological toxicity with Nab-Paclitaxel?

Dr. Bhawna Sirohi: Reviewing the data, Nab-Paclitaxel has a lower incidence of neuropathy compared to other taxanes. Further, grade 1 or 2 neuropathy shows fast and reversible recovery compared to other taxanes. However, development of peripheral motor and mixed neuropathy is of concern compared to sensory neuropathy.

Dr. Govind Babu: Nab-Paclitaxel is cremophor free, avoids premedication, and has less toxicity and reversible grade 1 or 2 neuropathy, which reverses by 3 weeks vis a vis conventional which would take 5- 6 weeks which would lead to skipping of the next cycle in patients. Hence, Nab-Paclitaxel scores over conventional taxanes.

Dr. Biswas and Dr. Ganshyam agreed on the same that Nab-Paclitaxel scores over other taxanes.

Dr. G.S. Bhattacharyya: In diabetic patients, would you consider Nab-Paclitaxel?

Dr. T. Raja: In diabetic patients, I would not consider taxanes, especially if there is prior history of taxane use.

Dr. Bhawna Sirohi: I would prefer to use Nab-Paclitaxel, as taxanes are the best drugs for MBC. I would closely monitor for neuropathy.

Dr. G. S. Bhattacharyya: In patients with high serum liver enzymes level and bilirubin level, would you prefer to use Nab-Paclitaxel?

Dr. Raja: I would consider using Nab-Paclitaxel but with close monitoring.

Dr. G.S. Bhattacharyya: Can Nab-Paclitaxel be considered for usage in adjuvant and neoadjuvant setting?

Dr. Raja, Dr. Govind Babu and Dr. Chacko commented that they would wait for the data in adjuvant setting. However, Dr. Govind babu stated that there is a definitive role in neoadjuvant setting.

Dr. Bhawna Sirohi: I would choose to use in both adjuvant and neoadjuvant setting.

Dr. S.H. Advani: NCCN 2011 guideline has stated clearly that Nab-Paclitaxel can be used interchangeably with Paclitaxel. Thus there is a definitive use of Nab-Paclitaxel in adjuvant and neoadjuvant setting. It is absolutely safe and there is no reason for not considering in this setting.

Dr. G.S. Bhattacharyya: Which schedule of Nab-Paclitaxel is preferred?

Dr. Bhawna Sirohi: I would start with 100 mg/m^2 and reach up to 130 mg/m^2 weekly.

Dr. Biswas: I would use 100 mg/m^2, weekly.

Dr. T. Raja: I would prefer 125-130 mg/m^2, weekly.

Dr Govind Babu: In my patients, I use 100 mg/m^2, weekly.

Dr. Chacko: The dose used in our setting is 100-150 mg/m^2, weekly.

In triple negative patients, Nab-Paclitaxel is well tolerated with 100mg/m^2, weekly in combination with Carboplatin.

Dr. G.S. Bhattacharyya: What are the future indications?

Dr. Bhawna Sirohi: My friend, Dr. Ranga has used in the off-label indication of head and neck cancer.

Dr. Biswas: I have used Nab-Paclitaxel in 5 patients with metastatic and locally advanced pancreatic cancer. In these 5 patients, 4 had prior treatment with Gemcitabine and Platinum and 1 was chemonaive patient. A significant response with good tolerability was observed. We are following up the patients.

Dr. Govind Babu: We have used Nab-Paclitaxel in lung cancer and prostate cancer. Patients are showing good response.

C & D : www.magnahealthsolutions.com I MHS I JC I 11 I 1350