Labelled meeting accredited with 20 ESMO MORA points

Indian cancer congress 2011

Bhubaneshwar

13th February 2011

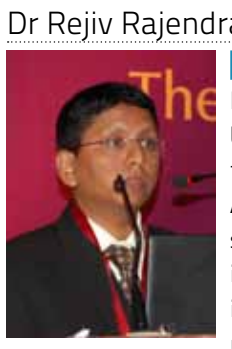
Biennial joint conference of ISMPO (Indian Society of Medical & Paediatric Oncology) and ISO (Indian Society of Oncology)

Theme: Targeting Cancer with Humility

The Cancer Institute (WIA), Adyar

Bone Sarcomas Overview and Impact of Chemotherapy

Dr Rejiv Rajendranath



CHENNAI

From 1970s to 2011s the management of bone sarcomas has changed from amputation to limb salvage. For the first time in India, Adyar Institute of cancer initiated limb salvage in this sarcoma. The age adjusted incidence rates of osteosarcoma in male is 0.5/100000 and in females 0.2/100000 patients. The priority is early and accurate diagnosis, staging and multi modality treatment approach. The usual work up is biopsy, MRI, CT and CT Angiogram, bone scan and PET-CT.

The Impact of chemotherapy has beem quiet significant from meagre OS of 15-20% to 55-80% in adjuvant setting. The recurrence after surgery within 6 months was 50% (pulmonary metastases). High Dose Methotrexate, Adriamycin, Cisplatin and Ifosfamide are the 4 important chemotherapeutic agents in osteosarcoma. The neoadjuvant chemotherapy benefits in tumors due to bulk which are borderline for LSS can be bought into the ambit of conservative surgery. All LSS protocols utilise primary chemotherapy. The predictors of survival are histologic subtype – fibroblastic v/s chondroblastic.

The chemotherapy for recurrent metastatic osteosarcoma has no accepted Standard approach. An aggressive multi agent chemotherapy and a complete surgical resection if feasible can be considered. The timing of treatment modalities tailored.

At Adyar institute about 224 patients were diagnosed with osteosarcoma of which 154 were analysed for survival. The 5 year survival data was about 52.6%. The large volume disease, unplanned biopsy, compliance and impact of completion of protocol including chemotherapy on survival factors influenced the otucome.

Bone and soft tissue tumors – Cancer Institute experience

Dr. N.Kathiresan

CHENNAI

Bone Tumours management aims at adequate staging, appropriate chemotherapy, surgical removal of tumor, restoration of skeletal integrity, achieving adequate soft tissue cover, and providing better quality of life. About 56% of patients undergo LSS, < 1% have internal hemipelvectomy and > 35% underwent amptuation. In our clinical experience the 5 year over survival was 45% and 60% with amputation and LSS respectively, which is statistically significant. Grading emerged as an important influencing factor in the outcome. Thirty three patients achieved > 90% necrosis and 5 year overall survival for good responders was 96.6% and poor responders was 59% .

During 1996 – 2005, 308 Patients with adult non metastatic STS were treated. A total of 101 patients had recurrence, which included local, metatastatic and combination. The size and grade of the tumour had significantly influenced the outcome in these patients especially on survival. The extremity soft tissue sarcomas patients size and grade had signficant difference on the survival.

The soft tissue and bone tumours need multidisciplinary approach. Surgery is the main stay of treatment. The initial surgery should be done with wide margins. The reexcision of scar should be considered if initial excision was marginal / intralesional. Physiotherapy and Rehabilitation is an important aspect.

Risk stratified current therapeutic algorithim in paediatric oncology: Paradigm shift from cure to quality of care.

Hodgkin's Lymphoma

Dr. Siddhartha Laskar

MUMBAI

Over the last 5 decades, the management of hodgkin's lymphoma has evolved with a clear cut recognition of the need to optimise therapy, prognostic groups and developemt of risk and response adapted therapy. A clear improvement in the survival over the last 4 decades.

Combined chemotherapy and radiation therapy shows an excellent outcome. The risk stratified treatment of low vs. intermediate vs. high, and a need to have an optimal combination of chemotherapy and radiotherapy needs to be answered. The question of avoiding chemotherapy for early stage favourable disease is answered by the article of JCO, which shows that CMT consisting of 2 cycles of ABVD plus EF-RT is more effective that EF-RT alone. The query of avoiding radiation therapy after the multiagent chemotherapy was resolved with the JCO study which shows a 93% of 3-year EFS in RT added group compared to chemotherapy alone. The current guidelines for hodgkin's lymphoma is Multiagent CTh x 2 - 4 cycles + IFRT for early Stage Favourable (Low Risk), Multiagent CTh x 4 cycles + IFRT for Early Stage Unfavourable (Intermediate Risk) and Multiagent CTh x 6-8 cycles ± IFRT For Advanced Stage (High Risk).

Pediatric B-NHL

Dr Brijesh Arora

MUMBAI

Burkitt's lymphoma, Diffuse large Cell B-lymphoblastic-are common types and Follicular and B-lymphoblastic lymphoma is rare with different biology. Ann Arbor staging is not useful in children and Standard St. Jude's staging is out of vogue. The prognostic factors in b-NHL are Stage, CNS involvement, BM involvement, LDH levels and and early response to therapy.

The management principles in b-NHL is to control the high growth fraction (especially Burkitt's) with pulse-Intensive, short, multi-agent CT given in courses of 3-5 days with a schedule characterized by fractionation or continued infusion of drugs. Due to the short doubling time: rapid regrowth, the courses administrated at shortest intervals. Aggressive CNS prophylaxis Rx adapted to tumor volume & response with Resection status, stage, LDH level and to tumor response during Rx.

In an Indian study, MCP-843 showed an excellent tolerability, treatment given on outpatient basis, minimal supportive care requirements, no need for total parental nutrition, minimal transfusion, growth factor & IV antibiotic requirements and no radiotherapy in the protocol. Thus, B-NHL in children is a highly malignant but highly curable lymphoma. The Short duration pulse intensive treatment adapted to risk status, Pre-Phase therapy, TLS management is critical. The Best Rx by centres that have a consistent protocol and facilities for intensive supportive care.

Wilms Tumor

Dr. Sajid S Qureshi

MUMBAI

The National Wilms Tumor Study Group (NWTSG) and Sociètè Internationale . Oncologie Pèdiatrique (SIOP) are the 2 pediatric cooperative group shows a contrasting approach where the former generally favour initial resection followed by chemotherapy and Radiotherapy and later initial chemotherapy followed by resection. The advantages of preoperative chemotherapy are reduction of frequency of tumour rupture, high frequency of stage I disease and prognostic indicator of response to treatment. The disadvantages are loss of staging information, modification of tumour histology and chemotherapy to benign or wilms tumour. The upfront surgery gives a accurate assessment of histologic diagnosis and tumour extent and The collection of untreated tumour for biology studies.

The relative advantages and disadvantages of one approach to another is questioned. However, with improved survival, emphasis is on reduction of complications and morbidity without affecting survival. In the Indian setting, a customised approach of upfront surgery for resectable disease and chemotherapy for borderline or unresectable disease.

Neuroblastoma

Dr. Purna Kurkure

MUMBAI

Neuroblastoma is the most common extra cranial solid tumor of childhood. It originates from neural crest cells. It is widely separated as on anatomical sites. Median age 2 yrs, males and females affected equally 85% of patients presents before 6 yrs of age and 50% of patients have disseminated disease at diagnosis. The age and stage at presentation are important prognostic factors

The current problems are classification to be done only on pre treatment material, biopsy sometimes difficult to accurately classify into GNB intermixed, nodular, NB. The diagnosis of NB – not otherwise specified and artefacts are many like crushing, necrosis, calcification

Children diagnosed with Neuroblastoma in any country should be stratified into Pretreatment groups using INRG classification system. Treatment outcome of each group should be reported individually. Adequate tumour material should be available for comprehensive genetic investigations on every patient. Identifying and standardising technologies that are not cost prohibitive would yield rapid and a reproducible result is the need. Risk group stratifications will be further refined as treatment for high risk disease improves and genome wide DNA expression analysis of tumour becomes routine.

Kidwai Memorial Institute of Oncology, Bangalore

Colorectal carcinoma: Where are we now?

Dr. Usha Amirtham

BANGALORE

Colorectal Cancer represents a major disease burden. In 2006-07, the relative proportion of colon cancer is 2.6% and 3.9% in females and males respectively. The relative proportion of rectal cancer in males is 3.7% in 200-07 which is one of among the 10 leading cause of cancer. Thus, the data indicates a lower incidence compared to westren countries. About 80% of cases of colorectal cancer is spoadic and 20% is familial. Hereditary non polyposis CRC (HNPCC) is autosomal dominant disorder with a germ-line mutation and somatic mutation. MSI is the genetic instability observed in micorstatellite DNA. Three phenotypes have been identified. MSI-H tumours show better prognosis, have a more likely to have node negative, mucinous type, high grade, diploid and associated with TIL. More than 90% of cases show MSI in HNPCC.

- At present, anatomic staging is the mainstay of clinical decision making
- The molecular markers may be a part of staging system and therefore a part of standard care.

Surgery for colorectal cancer

Dr. C. Ramachandra

BANGALORE

The short term outcomes of laparoscopy colectomy are faster return of bowel function, shorter hospital stay, less pain and analgesia use, less impairment of pulmonary function, lower stree response, lower blood loss, longer duration of surgery. The laproscopic colectomy cancer outcomes aoe incidence of port site metastatis < 1%, number of removed lymph nodes are equal in numbers, and the marginal status are also equal, higher operative costs are observed. Metastatic tumor is operable primarily with resectable liver mets that meet with surgical resection, whereas multiple livers meet chemotherapy. Meso-rectal margin is circumferential. TME has advantages like better radial clearance, decrease in tumor spillage, improved over all survival etc. TME has disadvantages like high incidence of urgency and faecal leakage.

Evolving therapeutic options in mCRC

Dr. K.Govind Babu

BANGALORE

CA Paradigm shift in CRC Treatment has been observed. In the ASCO GI 2010 by Dr. Pant comments are:

- The absolute benefits of anti EGFR antibodies appear to increase in later line treatment.
- There is a preference of Bevacizumab in first-line, and role of Cetuximab in salvage treatment.
- KRAS predicts resistance to anti-EGFRs, not Bevacizumab
- Other molecular markers will soon restrict the use of anti-EGFRs to only patients who will benefit

Dr. Dillip Agarwala

Renal cell carcinoma

In this session, the discussion was restricted to adult urocancers. In the adults, renal cell carcinoma, Invasive papillary carcinoma, medullay carcinoma, carcinomas of the collecting duct were the common cancers arising from kidney. Among these, carcinoma of the collecting duct is highly aggressive.

An overwhelming change in understanding of the pathology and staging of renal cell carcinoma has been observed. Bilateral renal cell carcinoma was Familial and posed a challenge in the mangement for the clinician.

In a bigger way, nephrectomy was the standard of care for decades. However, radical nephrectomy had more risk and was associated with CRF deficiency syndromes. Of late, the possibility of nephronsparing surgery has emerged. Extensive research has revealed a comparable efficacy on nephrosaving tumor and radical nephrectomy.This surgery can be perfomed, open and laprascopically. The laprascopic procedure is gaining extenive acceptance among the surgeons. The positive margins are a concern, for which we require to investigate on. The recurrence rate with positive margins was low due to the diathesis, ischemia. But close vigilance needs to be done.

The target therapy has evolved and many clinicans have moved towards the sunitinib and anti-angiogenic agents. But, not much good results are observed in all the patients. Only very few patients for few months show benefit. They are not good enough data for support of these agents in renal cell carcinoma. However, the medical oncologist can take their call.

Case Discussed

Dr. Deepak Parikh

A 56 year old male patient was admitted with massive hematuria. However, from last 4-5 years, he had on and off hematuria. He was investigated across the tertiary hospitals where the sonography, IV pyelogram was completely normal. The cause for hematuria was not identified. Emperically, he was on antiTB and anti filarial treatment.

A massive blood transfusion (16 bottles) was done for fluid resuscitation. Repeat radiological investigation, revealed no abnormality. The patient continued to have severe colic pain and massive hematuria. On cystoscopy, fresh blood clots from left kidney were observed. Lapratomy was perfomed and the left kidney was resected to control the bleeding.

On gross examination, the left kidney was healthy and but on section, a peanut size of tumour was noted in the pelvis of the kidney. Pathological examination revealed carcinoma of the left kidney. On follow up, the patient survived for 20 years post nephrectomy.