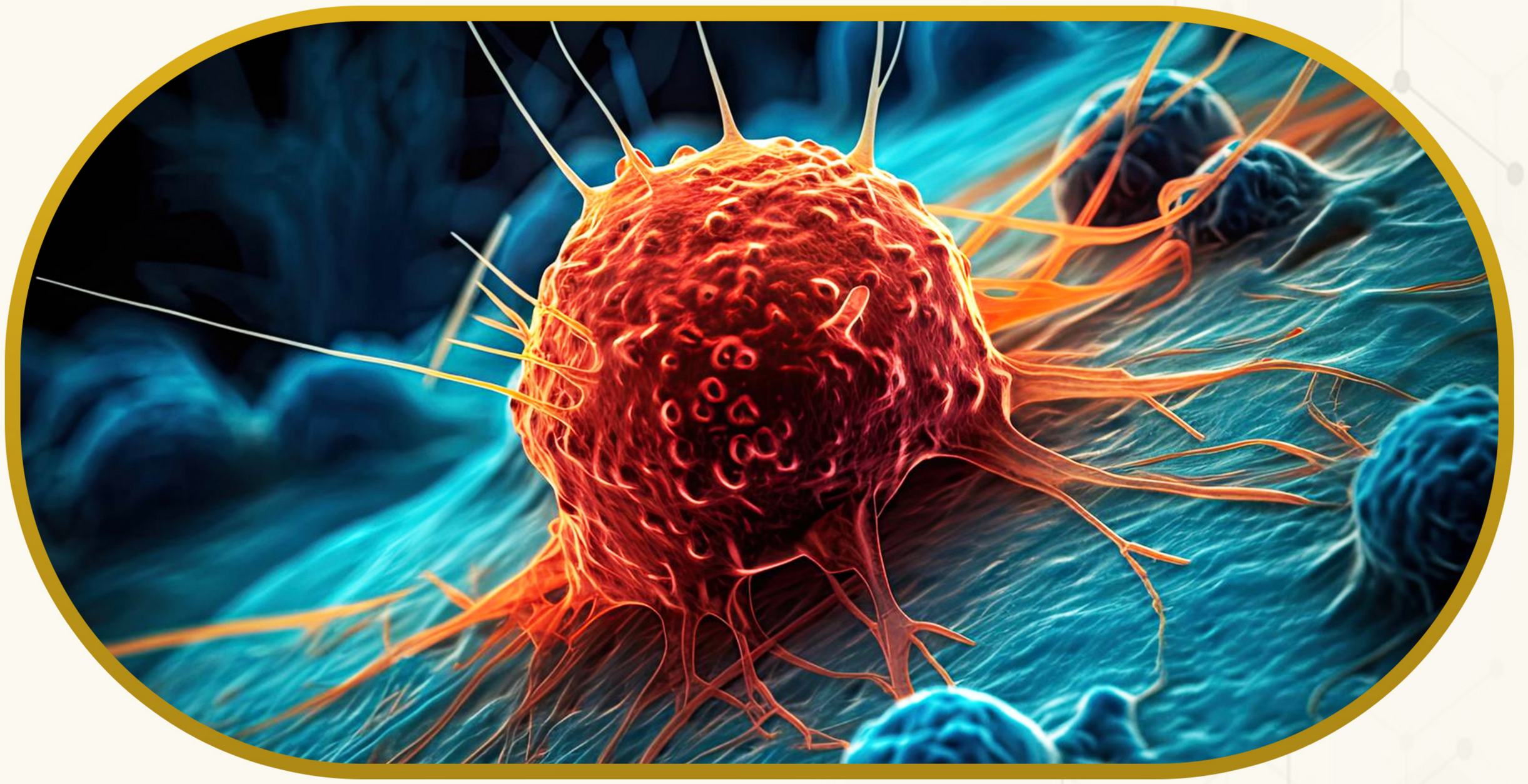
OnkoMag

May 2025 Issue



ONCOLOGY FORUM

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ABOUT ONCOLOGY FORUM

Established in 2013, Oncology Forum is a registered organization that unites leading oncology professionals from government, private, and public hospitals across Delhi, the NCR region, and beyond. Our mission is clear and collective: Collaborate to Combat Cancer.

Bringing together experts across all facets of oncology, we serve as a platform for regular academic meetings and discussions covering the entire cancer care continuum—prevention, diagnosis, treatment, rehabilitation, survivorship, palliation, and research. Through these collaborative efforts, we strive to create a uniform and high-quality framework for cancer care delivery.

The organization is managed by a team of 15 elected office bearers, with elections held every three years. Our dedication and progress are reviewed annually through our Annual Conference and General Body Meeting (GBM), where members reflect on achievements and set goals for the future.

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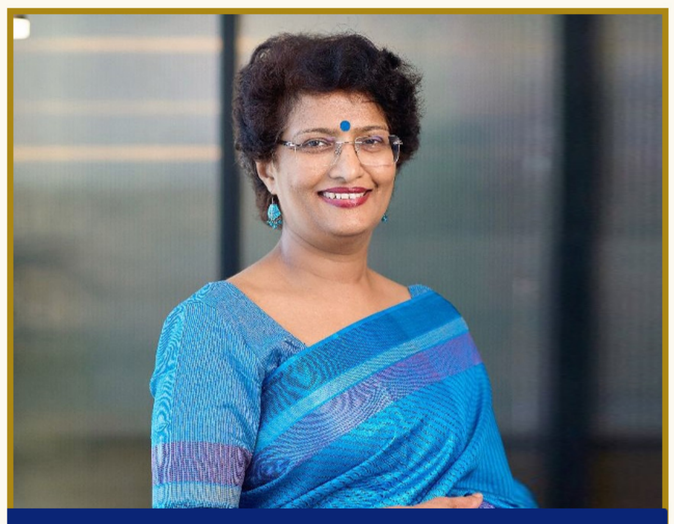

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OVERVIEW OF THE GENERAL BODY MEETING

OFCON 2024-2025 was held on january 18th and 19th 2025.
A key highlight of the conference was the significant leadership transition. During the General Body Meeting, the outgoing president, Dr. S.V.S. Deo, presided over the proceedings and formally handed over the baton to the incoming president, Dr. Geeta Kadayaprath. Dr. Kadayaprath, along with her newly elected team, will lead the forum for the next three years, continuing its mission to advance excellence in oncology practice and collaboration.

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PRESIDENT'S MESSAGE

President
Dr. Geeta Kadayaprath

Dear friends,

Thank you for placing your trust in me as I embark on an exciting journey as President of the Oncology Forum. I must thank my immediate predecessor Dr SVS Deo and the entire of Executive body and the conveners of the of sub groups for lifting OF to the next level during their tenure. I look forward to keeping the momentum going and stepping up the efforts to make Oncology Forum an example of nclusivity, a forum where each member (Oncologists, pathologists). Radiologists, Nuc med specialists, geneticists, palliative care specialists etc) has a voice and is willing to stand solidly to promote the science behind oncology, ethically and passionately.

Without doubt, we stand on the shoulders of the visionaries who laid robust ground rules for Oncology Forum, and stitched together a delightful Oncology canvas where the young oncologists got an opportunity to rub shoulders with the experienced. I have been a fortunate witness to how a small seed sown in the minds of a group of top oncologists of the city 14 years ago, led by Dr Ranga Rao has bloomed to its present state.

It is for us, especially the young oncologists, to seize the opportunity and make a statement to the rest of the world. With the UICC membership, thanks to the efforts of Dr Deo and Dr Ashutosh Mishra, OF, now has a global presence. The platform has surely become bigger and I would urge each one of you to step up the game and contribute in any which way possible. You have amazing mentors in this group who will surely support a good idea and help you find your place under the sun.

I foresee the opening of uninhibited conversations between the mentors and the mentees through this classroom and shaping of the multidisciplinary thought process in the young minds. We will seek each one of you to support us in this endeavour.

If there is something that we take pride in, about Oncology Forum, is its multidisciplinary structure, the democracy and the bonhomie.

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SECRETARY'S MESSAGE

Secretary
Dr. Kanika Sharma Sood

Dear Esteemed Colleagues,

I am honored to take on the role of Secretary of the Oncology Forum Delhi NCR. This forum has been a cornerstone for knowledge exchange, collaboration, and advancements in oncology, and I look forward to building upon its strong foundation. Together, let's continue fostering meaningful discussions, innovative research, and impactful initiatives that shape the future of cancer care. I invite all members to actively engage, share insights, and contribute towards our shared mission of excellence in oncology.

Looking forward to an exciting and productive journey ahead! Warm regards,

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HIGHLIGHTS FROM OFCON 2024

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The Annual Conference of Oncology Forum, OFCON 2024-25, was a landmark gathering of oncology professionals, held to discuss the latest advancements, innovative practices, and multidisciplinary approaches to cancer care. The event was skilfully organized by Dr. S.V.S. Deo, Dr. K. Geeta, and Dr. Raghu Ram from Indraprastha Apollo Hospital, whose efforts ensured a dynamic and impactful experience for all attendees.

The program featured a diverse array of sessions covering critical aspects of oncology:

- Sessions provided a deep dive into precision oncology, highlighting advancements in personalized treatment and integration of biomarkers.
- Panel discussions engaged experts in debating the challenges of immunotherapy, emerging trends in radiation oncology, and developments in diagnostic and medical oncology.
- Sessions explored site-specific cancers, with updates on head and neck, breast, and gynaecologic oncology, emphasizing multidisciplinary strategies.

A special highlight was the felicitation ceremony, honouring three stalwarts for their monumental contributions to oncology:

- **Dr. Shyam Agarwal (Medical Oncology)**: For his leadership in advancing systemic therapies.
- **Dr. Shelly Hukku (Radiation Oncology):** For his impactful and enterprising work in radiotherapy techniques.

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- **Dr. Anurag Mehta (Oncopathology):** For his excellence in oncologic pathology and diagnostics.

The conference was well attended by 250 doctors and witnessed great enthusiasm from budding oncologists through poster and oral presentations. In all 18 posters and 14 abstracts were presented by our young oncologists.

Winners of Abstracts are

1. **Bhavya Mishra**: L1 Mandible Reconstruction Guide: Enhancing precision in surgical restoration

2. **Gurasis Singh:** contrast-enhanced mammography in dense breasts- A prospective study

3. **Meenu Rani**: Role of crs hipec in carcinoma ovary where we stand today with our experience from a tertiary referral oncology centre, India

4. **Pooja Agarwal:** A comparative study between racist 1.1 using MRI and persist 1.0 using pet/CT to evaluate the response in patients of carcinoma breast re-ceiving neoadjuvant chemotherapy.

5. **Prachi Agarwal:** Molecular characterisation of non- small cell lung carcinoma and its correlation with histological type and grading - a single tertiary centre study

6. **Yatee Gupta:** High-Performance antimicrobial hospital supplies to prevent surgical site infections in cancer patients.

Winners of Posters are

1. Ankur Jain: Limb preservation in a case of giant cell tumour of distal radius

2. Dhiraj Kumar Singh: Role of pih1d1 a component of r2tp complex in stabilization of p53 and cell cycle regulation.

3. Rashmi Gupta: Epigenetic modulation in dendritic cell-based post vaccination: promising strategy for advancing ovarian cancer immunotherapy

4. Rohan Kapoor: Relapse pattern and its management of gall bladder cancer patients following curative resection – ananalysis of long term follow up data from single centre.

5. Shreya Sardana: Analytical review of surgical outcomes of breast oncoplastic techniques at a tertiary centre in India

6. Venugopal Ravi: Perioperative morbidity and long-term outcomes of pelvic exenteration for locally advanced pelvicmalignancies - a report from a tertiary oncology centre in India

Several young achievers were recognized for their innovative research and contributions during various sessions.

The event also marked a significant transition in leadership. During the General Body Meeting (GBM), the outgoing president, Dr. S.V.S. Deo, presided over proceedings and passed the baton to the incoming president, Dr. K. Geeta, along with her newly elected team, who will guide the forum for the next two years.

LIFETIME ACHIEVEMENT AWARDS

Dr. Shelly Hukku

(Radiation Oncologist)

Dr. Hukku is MBBS from Dr. SN Medical College, Jodhpur, and MD in **Radiotherapy** from PGI, Chandigarh.

He is well known for his skills in the treatment of cancer by radiotherapy. He has more than 39 years of experience in cancer treatment using radiation therapy. Dr. Hukku has a very high standard of precision in using Radiation Therapy, IMRT (Intensity Modulated Radiation Therapy), Proton Therapy, and Linear Acceleration Therapy.

Dr. Hukku has a special interest in radiotherapy using advanced techniques like Radio Surgery (Gamma Knife) and IGRT (Image Guided Radiotherapy). He is one of the best cancer treatment doctors for Head and **Neck Cancer and Brain Tumors**.

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LIFETIME ACHIEVEMENT AWARDS

Dr. Shyam Aggarwal
(Medical Oncologist)

Dr. Shyam Aggarwal is a distinguished figure in the medical field, currently serving as the Head of the Department of **Medical Oncology** at Sir Ganga Ram Hospital in Delhi, India. Holding degrees in M.B.B.S. from Maharshi Dayanand University and M.D. in Medicine from PGIMER, Chandigarh, his impressive academic journey sets the foundation for his contributions to oncology and haematology.

Dr. Aggarwal's expertise is grounded in comprehensive training. This includes Internal Medicine training and Blood Banking basics at PGIMER, Chandigarh, and Clinical Bone Marrow Transplantation at renowned institutions such as the University of Ulm, Germany, St. Vincent's Hospital, Australia, and Los Angeles, USA. Dr. Aggarwal is also a National Talent Search Scheme scholar of ICMR, awarded in 1980

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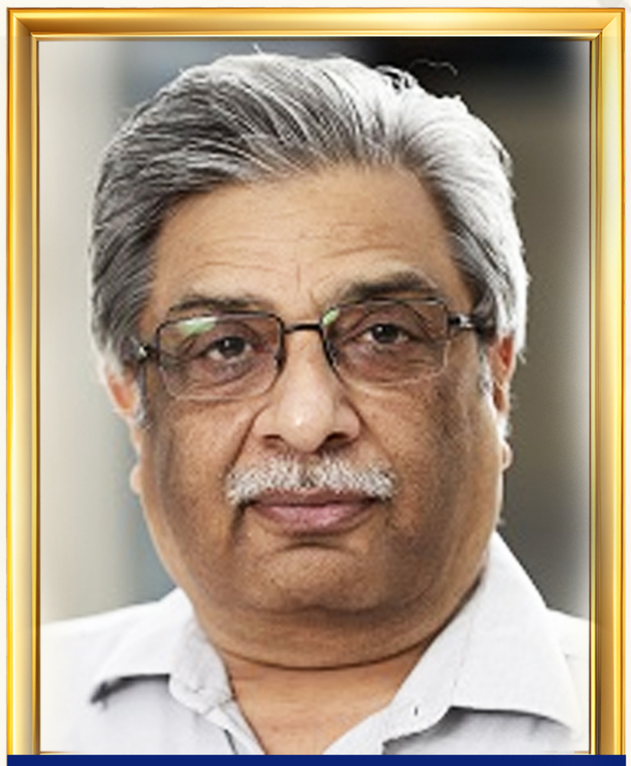
LIFETIME ACHIEVEMENT AWARDS



Dr. (Col) Anurag Mehta

MD (PATHOLOGY)

Dr. Mehta has been awarded

1. Dr YG Bende Gold Medal for outstanding performance and standing first at MD pathology at Pune University

2. Gen KS Master silver medal for best student in Advance service course in pathology

An encyclopaedia in different facets of the practice of pathology, Dr. Mehta has created a state-of-the-art molecular diagnostic laboratory, rated as one of the most advanced in the country. His contribution is key for the success of Mesta stop, as he bridges the clinicians with the researchers by providing critical insights into patient sample isolation and analysis.

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A BREATH OF SAFETY: INTEGRATING DIBH IN LEFT BREAST IRRADIATION PROTOCOLS

Dr. Tripti Saxena
Senior Consultant
Radiation Oncology

INTRODUCTION: Radiation therapy is an integral component of breast cancer treatment, particularly after breast-conserving surgery. However, irradiation of the left breast carries a significant risk of cardiac morbidity due to the proximity of the heart to the treatment field.

Historically, the increased mean radiation dose to the heart has been directly associated with elevated risks of cardiac morbidity and mortality (1,2).

Studies have shown a 4–7% increase in the risk of heart disease and coronary events for every 1 Gy increase in the mean heart dose, withno clear threshold (3) below which the risk is eliminated (Fig. 1).

These risks have prompted the development of advanced radiation techniques, among which the Deep Inspiratory Breath Hold (DIBH) method stands out as a major advancement in minimising cardiac exposure.

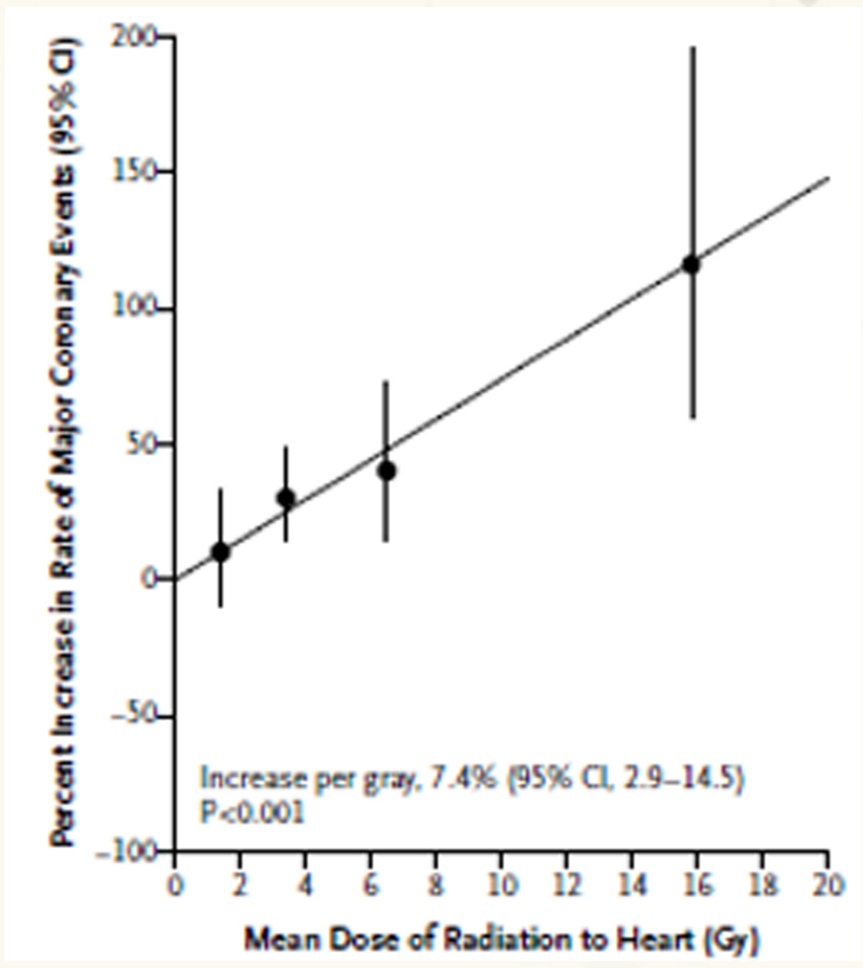

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Fig. 1: Rate of major coronary events according to mean radiation dose to heart, as compared with the estimated rate with no radiation exposure to heart (Darby et al)

WHAT IS DIBH: DIBH is a technique that leverages physiological changes during deep inspiration to displace the heart away from the chest wall. When a patient inhales deeply, the diaphragm flattens, and the lungs expand, pulling the heart inferiorly and posteriorly (Fig. 2). This displacement increases the distance between the heart and the left breast, thereby reducing cardiac dose during irradiation. During both simulation and treatment, the patient takes a deep breath and holds it, allowing radiation to be delivered in this optimised anatomical position. This technique significantly decreases radiation dose to critical organs, especially the heart and the left lung (5).

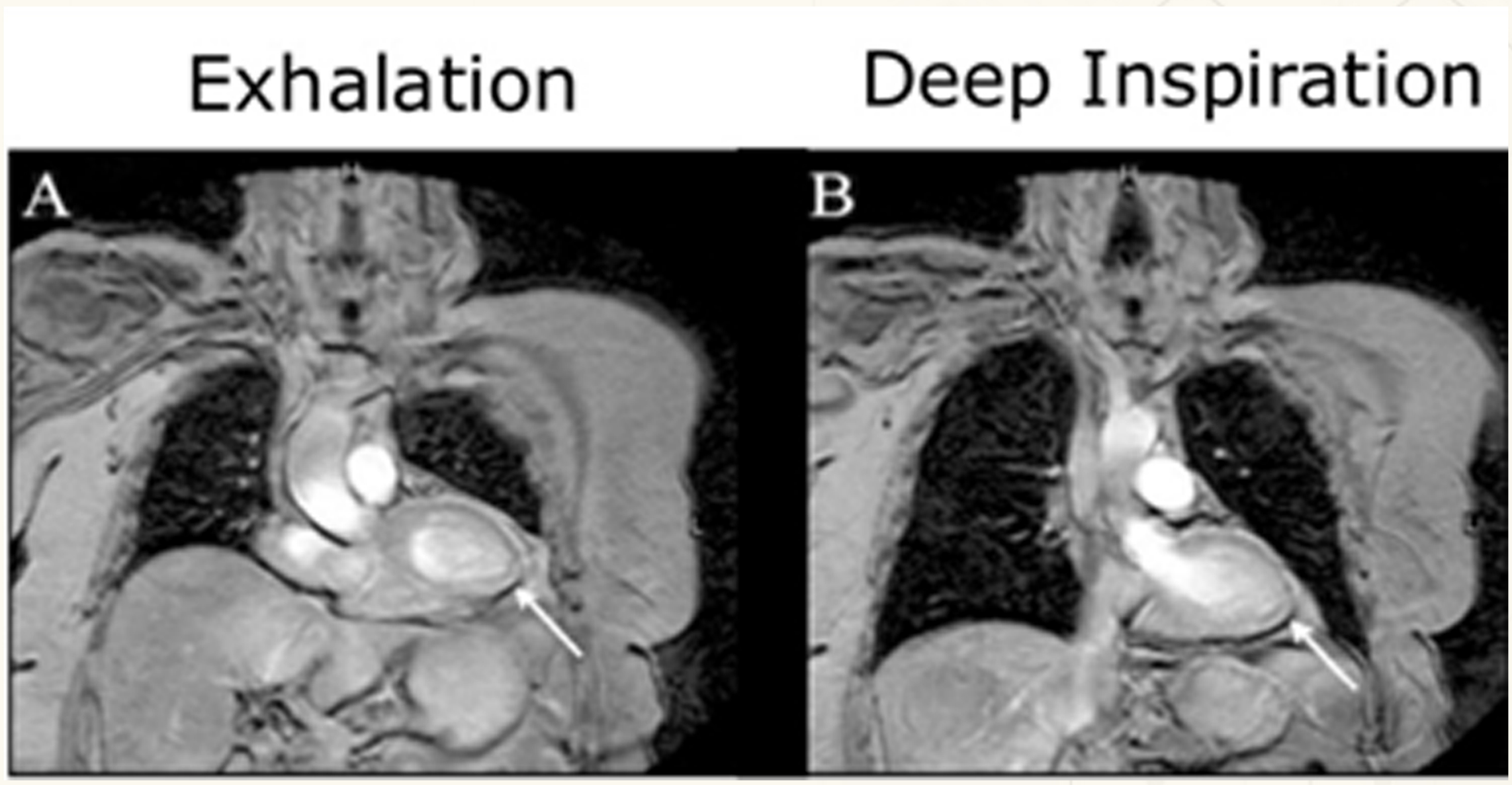

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Fig. 2: Position of heart, diaphragm, and volume of the lung in different phases of the respiratory cycle

IMPLEMENTATION PROCESS:

1. **RESPIRATORY COACHING SESSIONS**: Successful execution of DIBH relies heavily on patient compliance and reproducibility, which is ensured through pre-treatment respiratory coaching. These sessions typically begin five days prior to the start of radiation therapy and are conducted on the CT simulation couch with the patient positioned for treatment (supine, both arms raised above the head). Patients are trained to achieve maximal upper chest expansion and gradually increase their breath-hold time in 10-second increments. These exercises foster consistency in breath-hold patterns, enhancing setup accuracy and treatment reproducibility.

2. **PLANNING CT SIMULATION**: After successful coaching, CT scans are obtained in both Free Breathing (FB) and DIBH phases—from the mandible to 7 cm below the inframammary fold. Breathing is monitored using the Varian Real-Time Position Management (RPM) system, which synchronizes imaging and treatment delivery with respiratory cycles (Fig. 3).

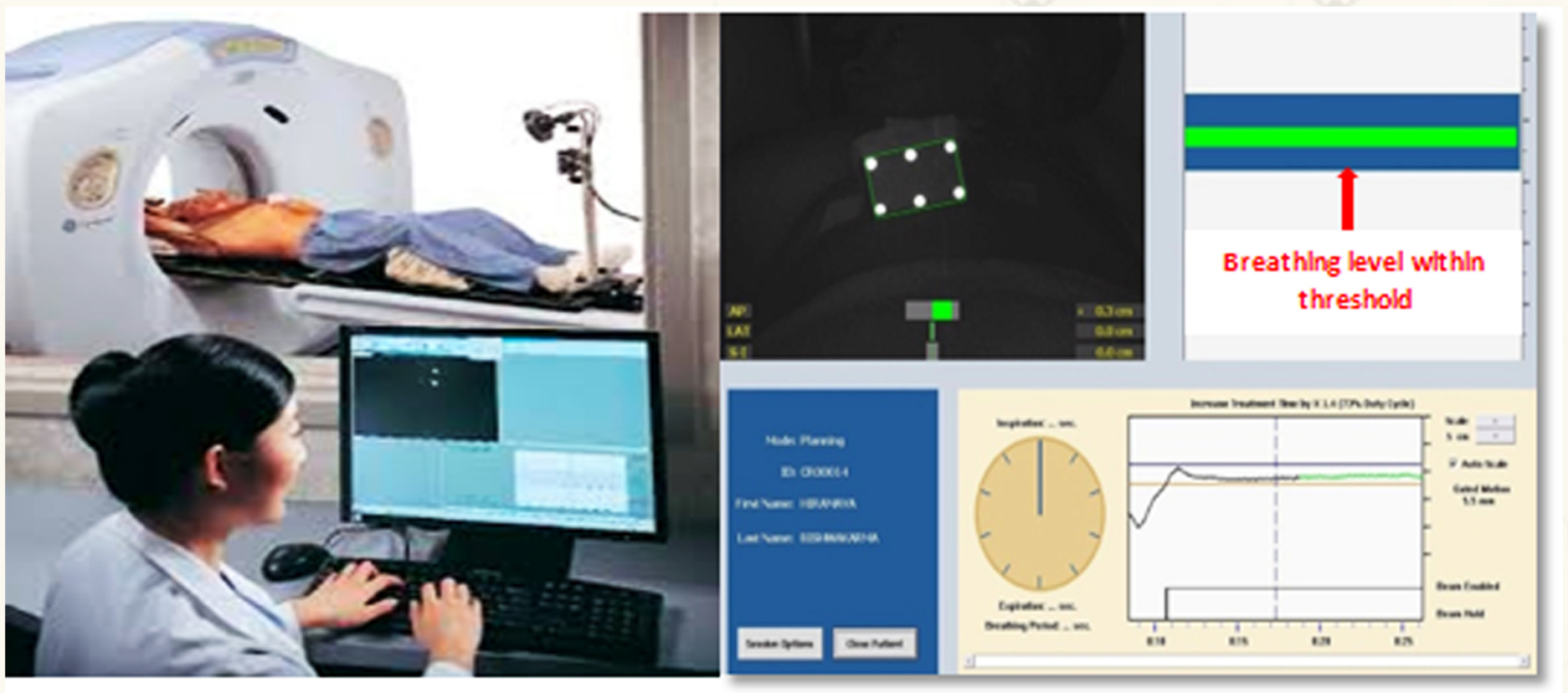

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Fig. 3: Varian Real Time Position Management (RPM) respiration synchronized imaging and treatment system

3. CONTOURING AND TARGET DELINEATION: Target delineation includes the primary tumor bed, left and right lungs, heart, contralateral breast, left anterior descending artery (LAD), esophagus, and brachial plexus. In DIBH scans, heart and left lung volumes are contoured and compared with FB scans for dosimetric evaluation (Fig. 4).

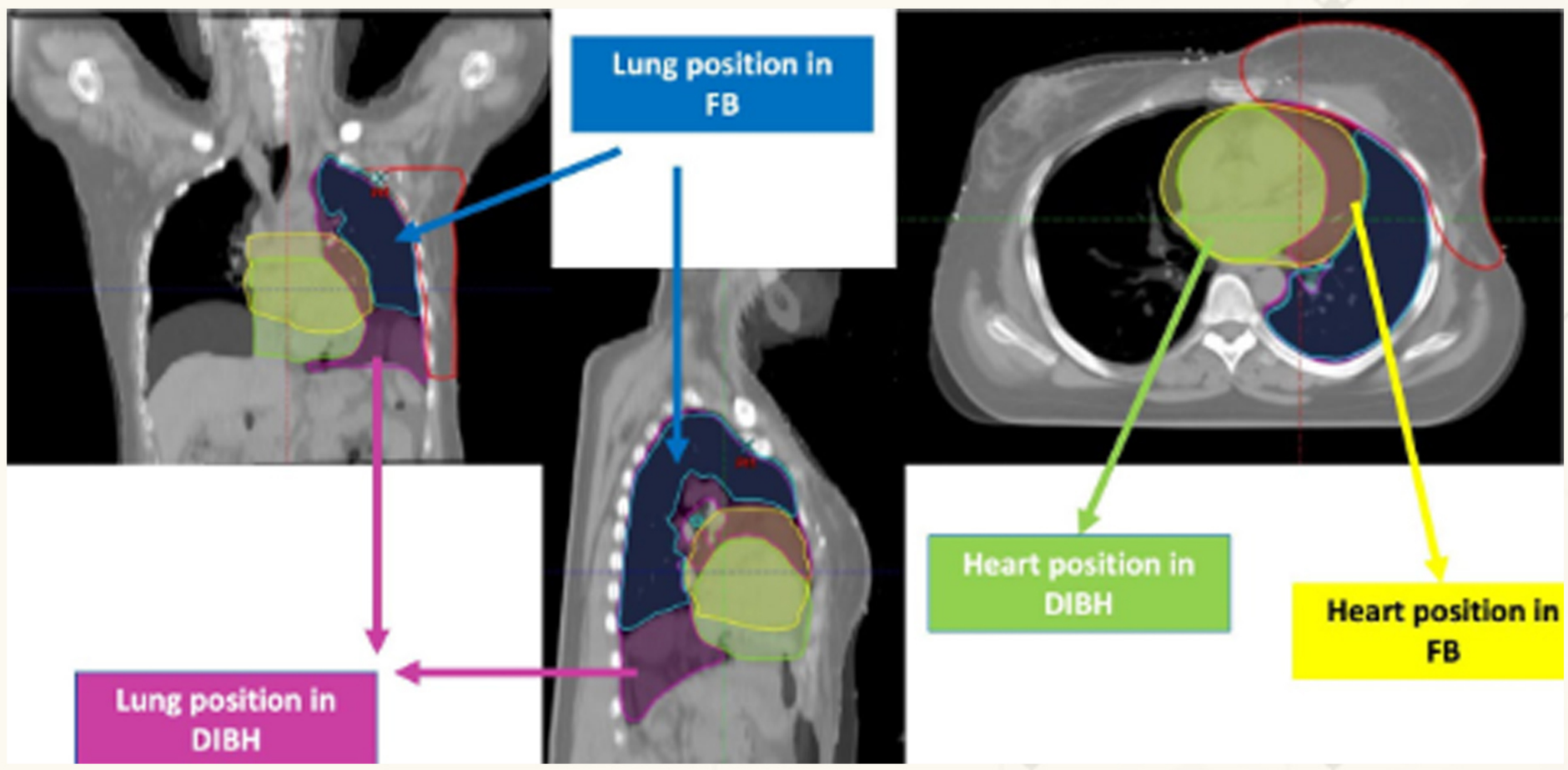

Fig. 4: Target delineation and co-registration with FB scan

4. TREATMENT PLANNING AND EVALUATION: Treatment plans are developed using the Eclipse Planning System. The goal is to ensure that 95% of the target volume receives at least 95% of the prescribed dose, while keeping the dose to organs at risk (OARs) within acceptable limits as per national and international guidelines. Plan evaluation involves dose-volume histogram (DVH) analysis. Notably, DIBH plans consistently demonstrate lower mean doses to the heart and left lung compared to FB plans (Fig. 5).

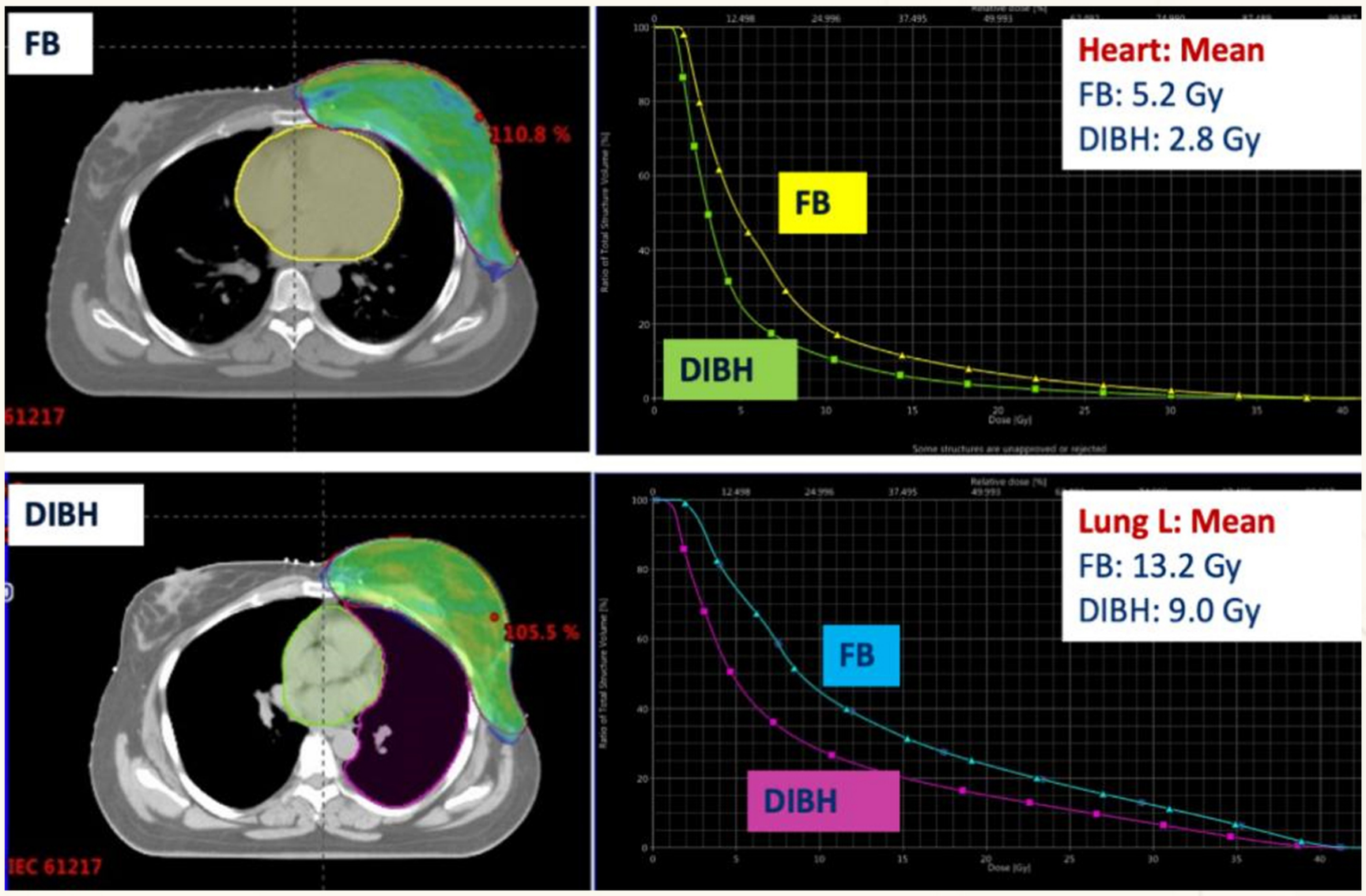

Fig. 5: Plan evaluation in both DIBH & FB scans, the doses to OARs (heart & left lung) are comparatively less in DIBH plans

5. RADIATION DELIVERY: On treatment days, patients are positioned supine with arms above their heads. The respiratory pattern is monitored in real time via the RPM system. Setup verification is performed through image guidance before each session (Fig. 6). Radiation is then delivered during consistent breath-hold phases.

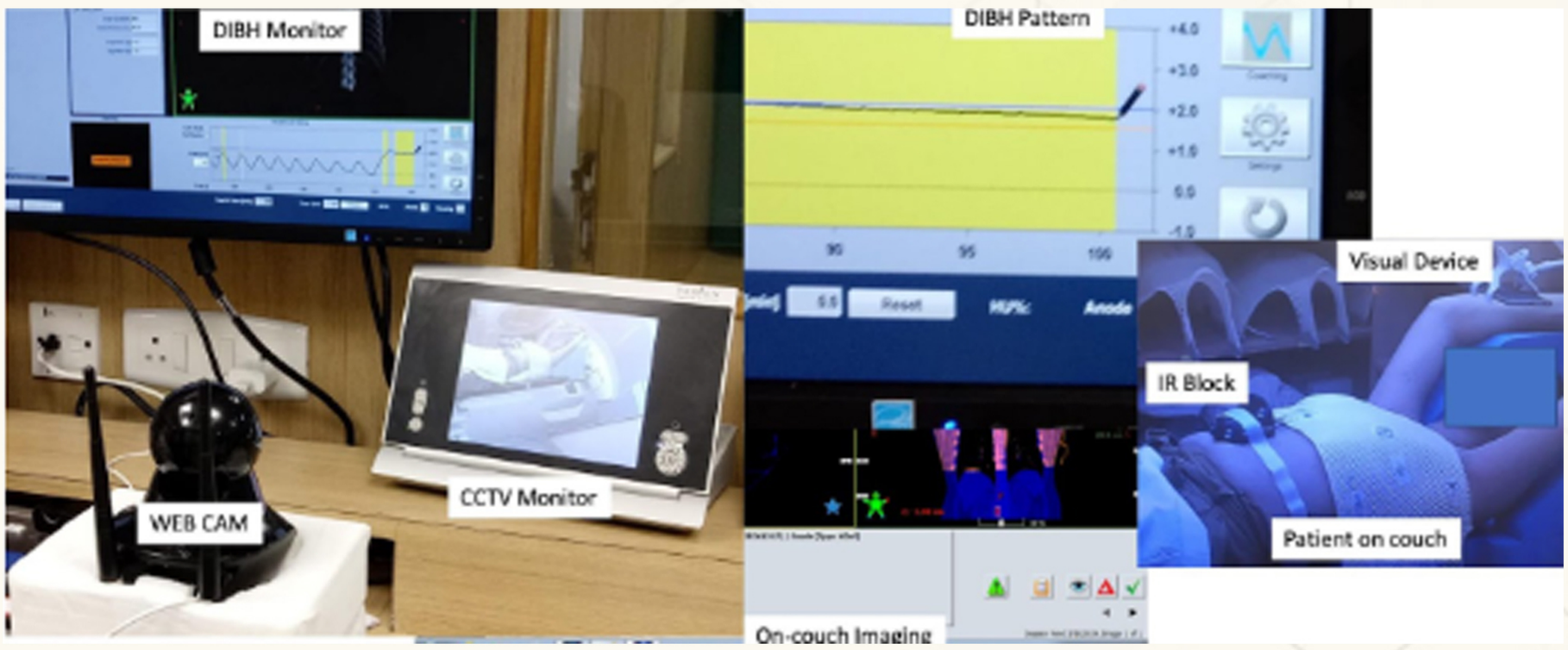

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Fig. 6: Radiation treatment delivery by DIBH technique

CONCLUSION: The DIBH technique represents a major advancement in the safe delivery of radiation therapy for patients with left-sided breast cancer. By significantly reducing cardiac and pulmonary doses without compromising target coverage, DIBH enhances both oncologic outcomes and long-term quality of life. Incorporating structured respiratory coaching, robust imaging protocols, and advanced planning tools ensures high reproducibility and optimal outcomes. As more centres adopt this technique, DIBH is poised to become the standard of care in left-sided breast irradiation.

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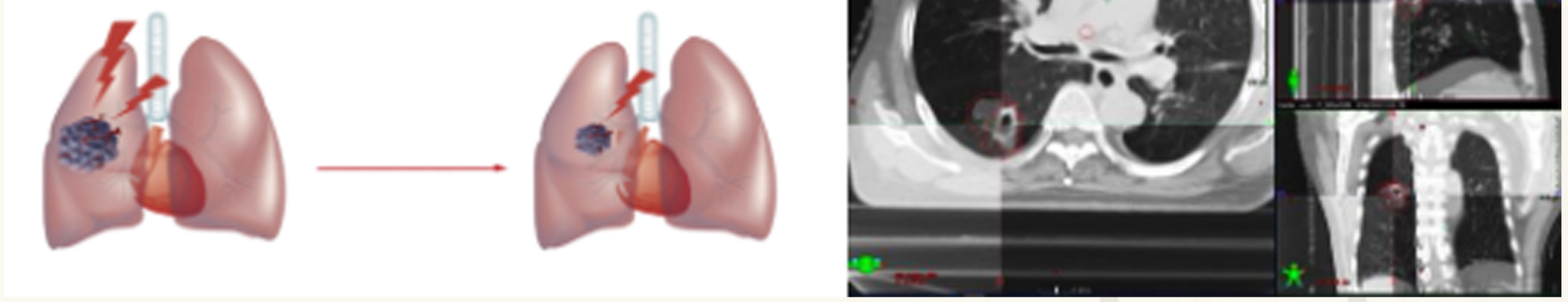
TARGETING LUNG CANCER

Dr Kanika Sood Sharma
Director and Clinical Lead
Radiation Oncology
Dharamshila Narayana Superspeciality Hospital

Introduction: Locally advanced Lung carcinoma remains one of the most challenging cancers to treat . Cytotoxic chemotherapeutic regimens, once the cornerstone of management of advanced disease, have been largely augmented by targeted therapy and immune checkpoint inhibitors. Radiation therapy stands out as a modality of choice in the management of locally advanced lung carcinoma. Lung cancer treatment is constantly evolving due to technological advances in the delivery of radiation therapy. However, the dynamic nature of lung tumours(volumetric changes during course of treatment), coupled with the delicate surrounding anatomy, demands precision and adaptability in radiation in delivery.

What is adaptive radiation therapy ?

Adaptive radiotherapy (ART) is a type of radiation therapy that involves continually adjusting treatment to account for changes taking place within the patient's body, with the goal of administering the most accurate radiation dosage possible. ART allows for modification of treatment plan with the goal of improving the dose distribution to the tumour due to anatomic or physiologic deviation from initial simulation. Two categories of ART – offline adaptive replanning based on scheduled images and online ART with daily replanning – have been applied in various antitumor radiotherapies, such as liver tumors, bladder cancers and cervical cancers However for implementation of ART in lung cancer one needs to critically assess who to adapt, when to adapt and what are the actual benefits of adaptation.



Volumetric Regression of lung tumours during course of treatment

Who Benefits from Adaptive Radiation Therapy?

An analysis of 158 megavoltage computed tomography (MVCT) images obtained from seven lung cancer patients revealed significant reductions in Gross Tumor Volume (GTV) ranging from 60% to 80% following adaptive radiation therapy (ART). This decrease in GTV was accompanied by a notable decline in the volume of the ipsilateral lung receiving 20 Gy (lung V20), averaging a reduction of 21% (with a range of 17% to 23%) among patients subjected to adaptive planning. Particularly noteworthy was the substantial benefit observed in patients with initial tumor volumes exceeding 25 cm3, with the degree of GTV reduction directly correlating with the magnitude of this benefit during treatment.

Moreover, the implementation of ART resulted in a noteworthy decrease in the Mean Lung Dose (MLD) for lung cancer patients, reducing it from an average of 14.6 Gy to 12.6 Gy. This reduction in MLD signifies a favorable shift towards decreased radiation exposure to the lung tissue, potentially mitigating treatment-related toxicities. Additionally, ART facilitated a significant enhancement in the coverage of the prescribed dose to the tumor, Underscoring its efficacy in optimizing treatment outcomes for lung cancer patients.

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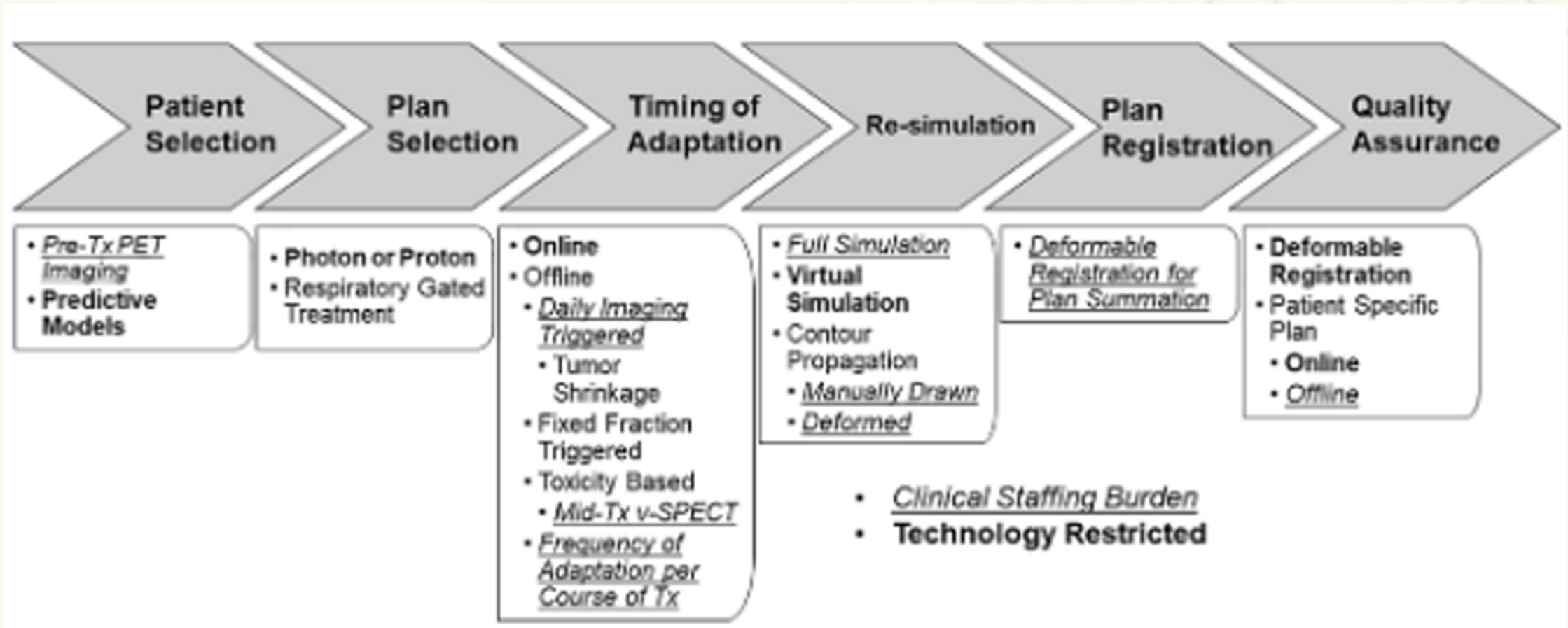
1. Patient-Specific Tumor Characteristics:--

The diverse nature of lung carcinomas underscores the need for tailored treatment strategies. Adaptive radiation therapy (ART) proves particularly advantageous for tumors exhibiting irregular shapes, varying sizes, and unpredictable responses to treatment. Through continual assessment of tumor response and adaptation of radiation plans, ART ensures optimal dose delivery while minimizing damage to surrounding healthy tissues. Research suggests that non-small cell lung cancer (NSCLC) patients with larger initial tumor volumes (>25 cc), early response to radiotherapy, and significant tumor volume reduction stand to benefit most from ART. Identifying individuals with high radiosensitivity through the development of personalized gene phenotypes or biomarkers, or the creation of prediction models based on such markers, holds promise for optimizing ART outcomes. For instance, a prospective trial involving 92 consecutive stage III NSCLC patients treated with radical radiotherapy established a survival model incorporating radiosensitivity associated single-nucleotide polymorphisms. Such models could enhance predictions of radiation-dose response, facilitating individualized ART guidance.

2.Concurrent Comorbidities: Patients with lung carcinoma often present with concurrent comorbidities, such as chronic obstructive pulmonary disease (COPD) with lung atelectasis and collapse. ART offers the advantage of adapting radiation plans based on changes in patient anatomy and volumetric changes due to opening up of collapsed lung, thereby reducing the risk of treatment-related toxicities and improving overall treatment compliance.

When to Implement Adaptive Radiation Therapy?

Tumor regression, tumor displacement, pleural effusion and/or atelectasis could cause anatomical changes, which would lead to significant differences between the planned prescription dose coverage and the actual dose cover- age .However all forms of ART place a substantial personnel burden on the department: the physician may need to create new contours, review/approve contours, and review/approve the adapted plan; the dosimetrist/-physicist may need to create a new plan; and the physicist may need to perform quality assurance (QA) on the adapted plan or add additional QA procedures to the existing QA program due to implementation of new technologies to facilitate ART. However, the staffing burden may be outweighed by the potential benefits of better dosimetric coverage of the tumour and sparing of dose to the organs at risk (OARs).



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ART Workflow

The main emphasis of ART research should focus on tracing tumor regression and changes in the surrounding anatomical structures over time to schedule ART at the appropriate time point. At present, CBCT is the most common strategy to monitor changes in anatomical location and dose distribution. If the changes exceed the standard judged acceptable by the clinical oncologist, the adaptive plan will be recalculated according to the newly delineated GTV and PTV. However, this trigger standard is often subjective, and there is no uniformly applicable standard. Irrespective ,the triggers for adaptive radiation therapy primarily includes treatment Response Assessment. Regular assessment of treatment response is crucial in determining the need for adaptive strategies. Imaging modalities such as positron emission tomography (PET) and cone-beam computed tomography (CBCT) provide valuable insights into tumor regression, progression, or anatomical changes during the course of treatment.
Incorporating these imaging findings into treatment protocols enables timely adjustments to radiation plans, enhancing therapeutic effectiveness. Lim et al. examined respiration related cone-beam computed tomography (CBCT) scans of locally advanced NSCLC patients, taken weekly during radiotherapy.

They observed an average tumor volume reduction of 50.1% after radical radiotherapy and 40.2% after 15 fractions. Notably, 60% of patients exhibited a volume reduction exceeding 30% after 15 fractions, indicating this time point as suitable for implementing adaptive radiation therapy (ART). Similarly, Lee et al. analyzed weekly CBCT images from 32 NSCLC patients undergoing radiotherapy, revealing an average gross tumor volume (GTV) reduction of approximately 50%.

The most significant GTV change occurred between sessions 15–20, suggesting the need for updated CT scans and adaptive plans during this phase to account for actual dose coverage deviations on tumors and surrounding organs at risk (OAR). Berkovic et al. conducted quantitative analysis of daily CBCT scans in NSCLC patients treated with concurrent chemoradiotherapy (CCRT) and sequential chemoradiotherapy, noting tumor volume reductions of 50.1% and 33.7%, respectively. They recommended implementing ART at the 15th fraction of radiotherapy for CCRT patients with large initial tumor volumes.

The period between 30–50 Gy/15–25 fractions during conventionally fractionated radiotherapy for NSCLC patients undergoing concurrent chemoradiotherapy (CCRT) marks the most notable change in tumor volume. Hence, this phase may represent the optimal timing for arranging adaptive radiation therapy (ART).
However, the challenge lies in selecting an individualized ART time point for each patient. To address this, there's a pressing need to devise a monitoring model characterized by simplicity and trackability, based on the tumor response–radiotherapy dose relationship.

How to Optimize Adaptive Radiation Therapy for Lung Carcinoma?

At present, ART research in NSCLC patients mainly focuses on the application of differe nt forms of imaging guidance, such as CBCT, MRT and PET-CT, in the investigation of GTV reduction, dosimetric parameters of OAR and radiotoxicity risk

1.Robust Imaging Protocols: High-quality imaging is the cornerstone of effective ART implementation. Employing imaging protocols tailored to capture both tumor morphology and motion characteristics is essential for accurate target delineation and treatment planning. Integration of advanced imaging modalities, such as 4D CT and MRI, enhances the precision of target delineation and facilitates adaptive re-planning based on real-time anatomical changes.

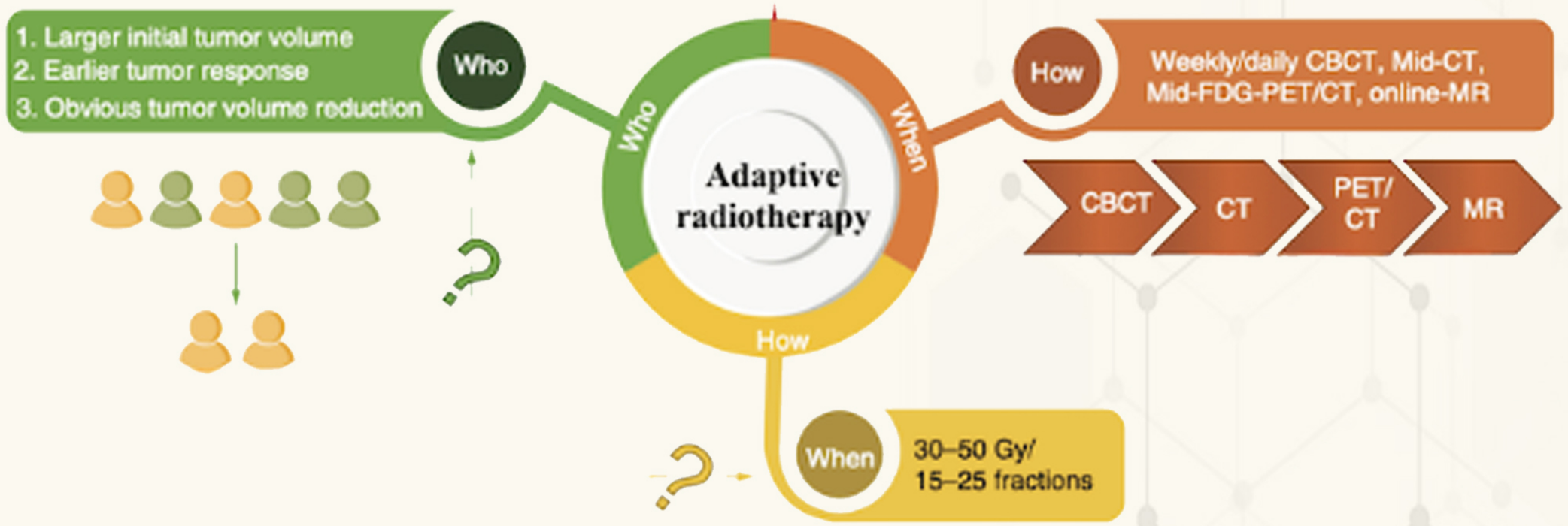
	Advantage	Disadvantage
CBCT	Early detection of anatomical changes by daily/weekly CBCT	Image quality is poor for the quantitative analysis of tumor and anatomical changes Increased burden on radiation oncologists and technicians Extends the time of maintaining passive position in patients treated with radiotherapy CBCT images are inadequate for the adaptive plan, and new CT simulations need to be arranged after changes observed by CBCT
Mid CT	A scheduled plan greatly assists in implementing resource preallocation and ART effectively CT images can be directly applied to the design of new adaptive plans	Impossible to track the changes of tumor and anatomical structures in time The scheduled time point is not suitable for every patient because of differences in tumor response to the same radiation dose
Mid-PET/CT	PET/CT-guided GTV delineation is conducive to boosting GTV dose	Extra medical treatment consumed (except for CT simulations) New GTV delineation is dependent on the results of PET/CT and CT simulation image fusion, which is normally a subjective decision by different doctors
Online MRI	Good for reviewing changes of tumor and anatomical structures and motility changes in a timely manner	This technology has not yet been popularized High cost Safety and reliability remain unclear

ART: Adaptive radiotherapy; CBCT: Cone-beam computed tomography; CT: Computed tomography; GTV: Gross tumor volume

Comparison of different forms of image guidance

2. Adaptive Planning Algorithms: Advanced treatment planning algorithms capable of rapid plan adaptation play a pivotal role in ART for lung carcinoma. Utilizing deformable image registration algorithms and dose accumulation techniques enables seamless integration of new imaging information into existing treatment plans, ensuring optimal dose distribution while adhering to dose constraints for critical structures. Furthermore, automated planning tools streamline the adaptive
process, minimizing manual intervention and reducing planning time.

3.Multidisciplinary Collaboration: Successful implementation of ART requires close collaboration among radiation oncologists, medical physicists, dosimetrists, and radiation therapists. Regular communication and feedback loops among team members ensure timely adaptation of treatment plans based on evolving clinical scenarios, ultimately improving patient outcomes.



The three key questions -Who ,How and When?

Conclusion: Adaptive radiation therapy represents a paradigm shift in the management of lung carcinoma, offering personalized and dynamically optimized treatment strategies. By addressing the challenges posed by tumor heterogeneity, anatomical variability, and treatment-related toxicities, ART holds the promise of improving therapeutic outcomes while minimizing treatment-related morbidities. Embracing the principles of patient-centered care, timely adaptation, and interdisciplinary collaboration is essential in harnessing the full potential of ART for lung carcinoma management.

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WINNERS OF POSTERS

DR. DHEERAJ

The R2TP complex is a co-chaperone conserved from Yeast to mammals. The R2TP complex comprises of RUVBL1, RUVBL2, PIH1D1 and RPAP3 in Human is known to be a specialized Co-chaperone of Hsp-90 protein. This multimeric-protein complex is involved in the assembly and maturation of several multi-subunit complexes including RNA polymerase II, small nucleolar ribonucleoproteins, and complexes containing phosphatidylinositol-3-kinase-like kinases. PIH1D1 contains a conserved phospho-peptide binding (Lys57 and Lys64) domain that binds to DpSD-D/E motif of bridging proteins, phosphorylated by CKII. Recent study shows that CKII mediated phosphorylation in p53 protein at its specific site DpSD. We proposed that p53 is also recognized by PIH1D1 and is being stabilized by R2TP protein complex and this interaction could be a novel mechanism of cell cycle regulation. To better understand we have investigated here the mechanism by which the mutant p53 and wild type p53 protein is being stabilized and so control cell cycle. So first to check the interaction between p53, (wild type and mutant) with PIH1D1 were investigated with cell lysates collected from cell lines (either wild type/mutated p53) in presence of MG132. 2-3 µg of antibodies against PIH1D1 and p53 were added to the lysates for co-immunoprecipitation assays. For the binding assay PIH1D1 and p53 were cloned in GST tagged prokaryotic expression vector pGEX2T and GST-tagged protein were immobilized on GST beads. Interaction with p53 were analyzed by western blotting. Upon successful this study we have established that wild type and mutant p53 protein are directly interacting with PIH1D1, a component of R2TP/PAQosome. We demonstrate that immunoprecipitation (IP) of PIH1D1 results in the co-IP of p53 from human breast cancer cells. In addition, we provide evidence that PIH1D1 is able to pull down wild type and mutant p53 protein. So by this study we conclude that the interaction between wild type and mutant p53 protein with PIH1D1 may have an important role in p53 stabilization and regulation in cancers.

WINNERS OF POSTERS

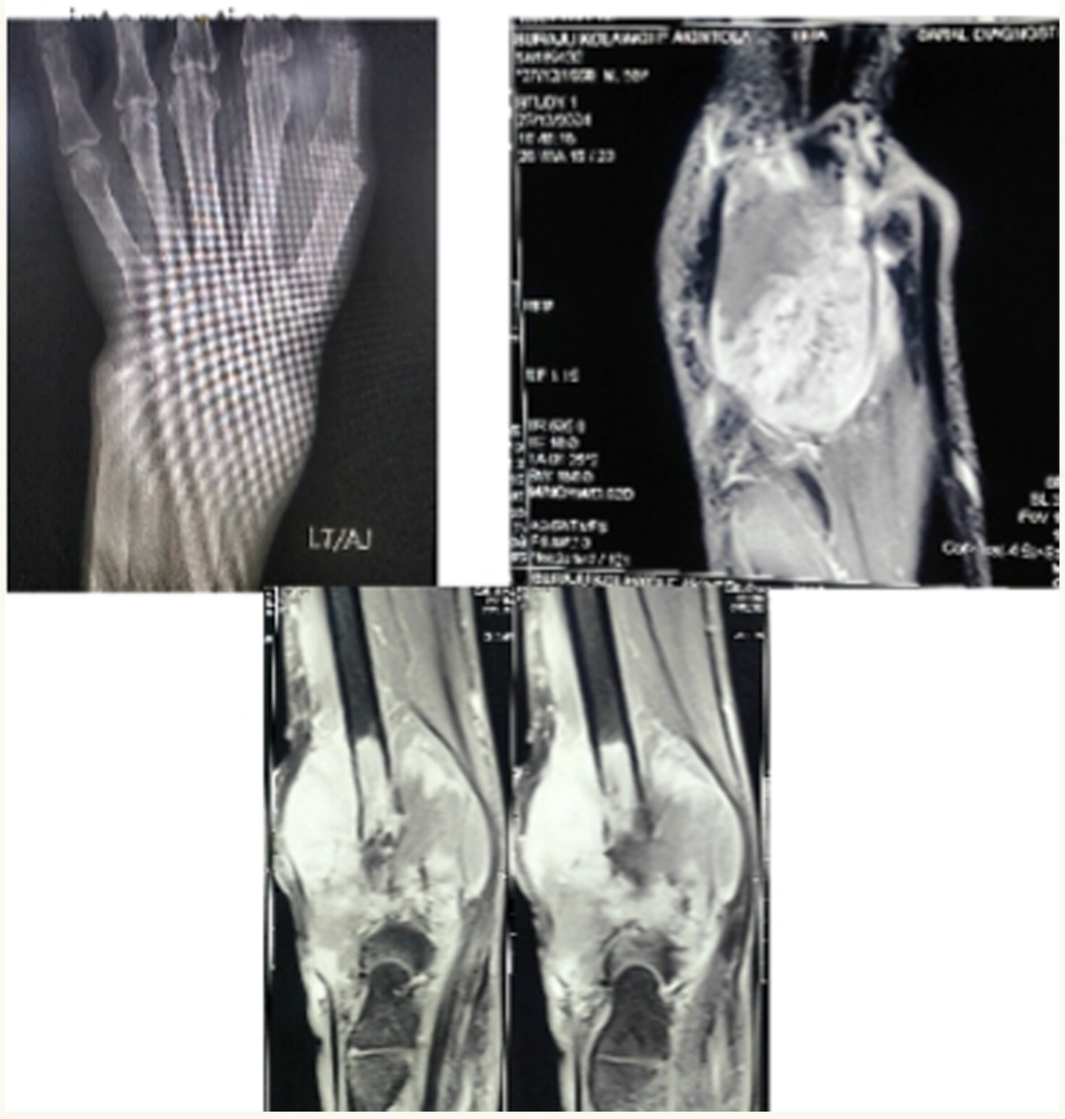
DR ANKUR JAIN

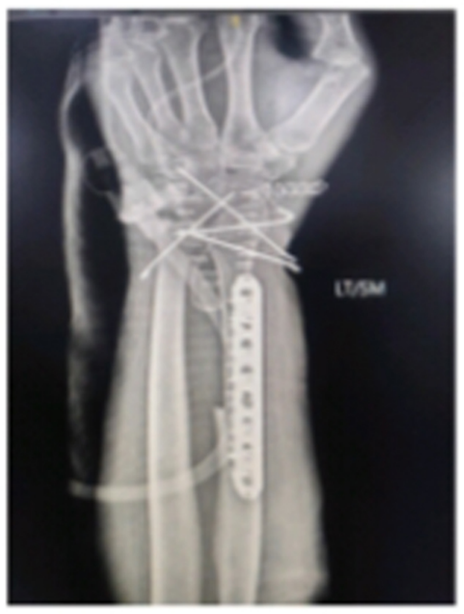
ABSTRACT

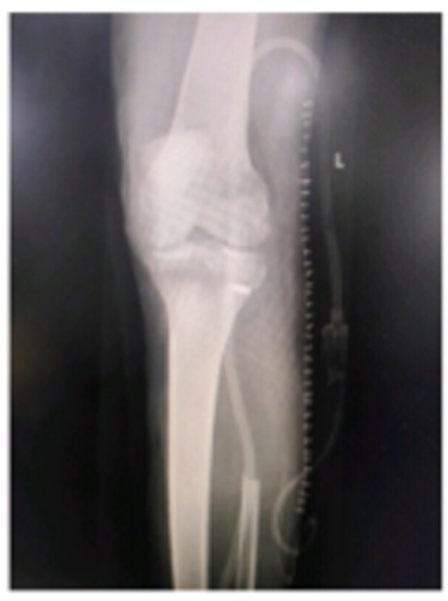
- GCT are the benign aggressive tumour of epiphyseal end of long bones with distal radius as most common site in upper limb.
- Here we report a case of 37 year patient who presented to Indraprastha Apollo Hospital with complain of pathological fracture and swelling over left distal forearm which was diagnosed as Giant cell tumour Campanacci grade 3.

BACKGROUND

- A 37-year male patient normotensive, non-diabetic with complaints of pathological fracture and swelling over left distal foream for 3 months
- no past history of trauma or previous







DISCUSSION

- Limb preservation should always be tried with arthroplasty reconstruction to be done in order to maintain the function of the limb.
- Different modalities for arthroplasty – are use of vascularized or non vascularized fibular graft , ipsilateral ulnar mobilization followed by radiation treatment
- Lung metastasis generally are benign and if possible should be resected
- 5 year DFS is 76 % and 17% is the mortality rate if metastasis occurs.

CONCLUSIONS

- GCT should be operated with multidisciplinary team so that limb preservation is possible. CT chest should always be done to rule out lung metastasis , commonly in Campanacci grade 3 GCT.

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AWARD WINNING ABSTRACTS

DR PRACHI AGGARWAL

Molecular characterization of Non- Small Cell Lung Carcinoma and its Correlation with Histological types and grading- A Tertiary Centre study

INTRODUCTION

The effectiveness of targeted therapies with tyrosine kinase inhibitors in non-small-cell lung cancer (NSCLC) depends on the accurate determination of the genomic status of the tumour.

Immunohistochemistry is easier to implement and interpret and is most useful screening tool for molecular characterization of NSCLC, which in-cludes EGFR mutation, ALK rearrangement, ROS-1 translocation and PD-L1 expression analysis.

Nevertheless, fluorescence in situ hybridisation (FISH) is used to confirm the rearrangement and decide on ambiguous immunostainings.

AIM OF THE STUDY

To perform a comprehensive evaluation on incidence of histopathological types and immunohistochemistry based molecular subtype of Non Small Cell Lung Carcinoma and their correlation with grading and gender prevalence.

MATERIAL AND METHODS

An ambispective observational study from February 2019 to February 2024 (5 years)

Inclusion Criteria- All needle core lung biopsies.
Exclusion Criteria- Patients having thoracic metastasis from non- pulmonary primary cancer and resected lobectomies were excluded.

Total Cases- 200 Non- small cell lung carcinoma needle biopsies. (137-Males, 63-Females, Median age-55 years)

Molecular characterization was done by using Ventana ALK D5F3 CDx Assay, SP-384 Antibody for ROS-1 IHC and SP-263 for PD-L1 expression (Tumour Proportion score-TPS) and further correlation with type, grading and gender prevalence was analyzed.

TABLE 1- INCIDENCE OF HISTOLOGICAL TYPES STUDIED AND REPORTED-

HISTOLOGICAL TYPES STUDIED	NUMBER OF CASES
Adenocarcinoma	**134**
Squamous cell carcinoma	47
Adeno-squamous carcinoma	05
Large Cell Neuroendocrine Carcinoma	04
Sarcomatoid carcinoma	01
Non Small Cell Lung Carcinoma, NOS	09

Adenocarcinoma (67%) was the most common histological subtype, followed by squamous cell carcinoma and other histological types.

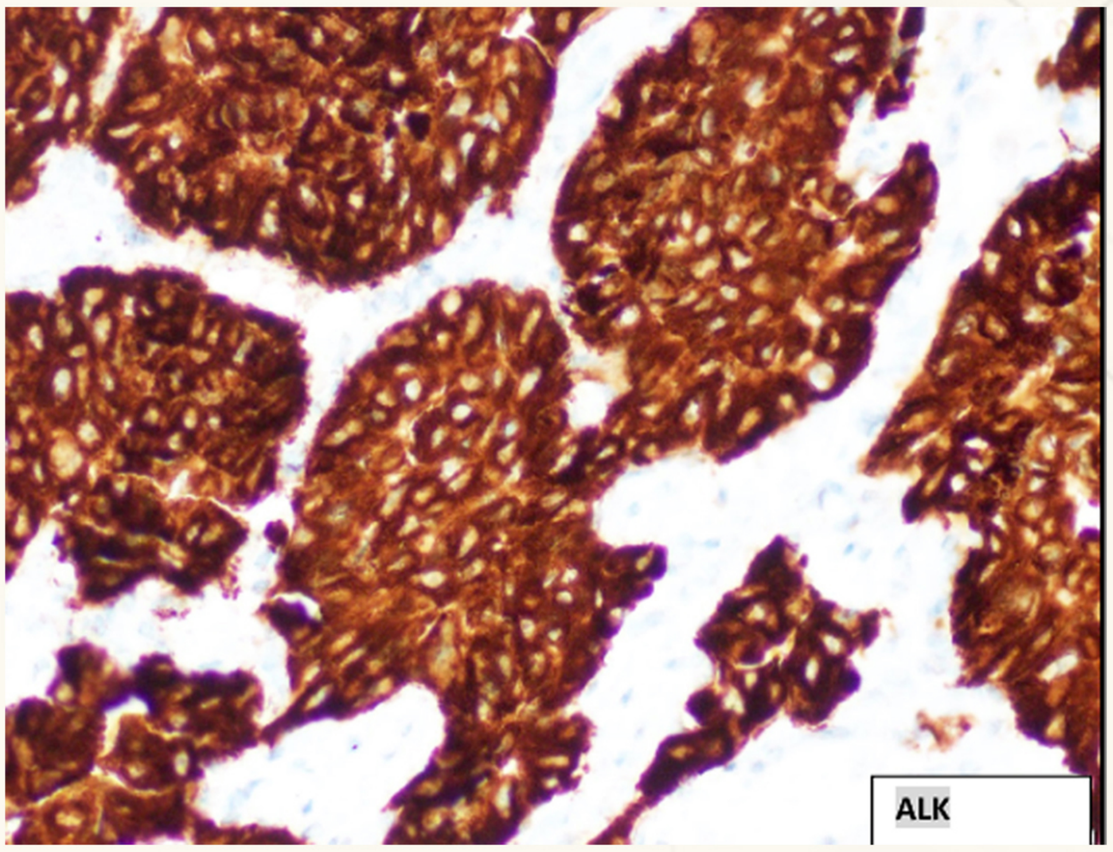
TABLE 2- INCIDENCE OF ALK, ROS-1 AND PD-L1 AND THEIR CORRELATION WITH HISTOLOGICAL TYPE AND GRADING-

Total Non- Small Cell Lung Carcinoma -200 (Males-137,Females-63)- (M:F-2.1:1)			
Adenocarcinoma (134)		Squamous Cell Carcinoma(47)	
ALK Positive-17 cases	ROS-1 Positive -12 cases	ALK Positive -01 case	ROS-1 Positive -0

-Correlation of ALK with grading and gender in Adenocarcinoma cases- Chi-square, Df, P-value- 0.919, 2, 0.63- Insignificant Correlation of ALK with grading and gender in Squamous Cell Carcinoma cases- Chi-square, Df, P-value-1.375, 2, 0.50- Insignificant-Whilst, for ROS-1, the incidence in females was 10/12.

Grade 1 -01- Female Grade2 -06(4-males,2-females) Grade3-10(3 males, 7-females)	Grade1-02 (Females) Grade2-05(3-females,2males) Grade3-05(Females)	Grade1-00 Grade2-01(male) Grade3-00	Grade1-00 Grade2-01(male) Grade3-00
PD-L1 Expression (200 cases)			
>50% (36cases)-POSITIVE		<50%(164 cases)- NE	
Adenocarcinoma(27) Males-23 Females-04	Squamous Cell Carcinoma(09) Males-05 Females-04	Adenocarcinoma(114) Males-68 Females-46	Squamous cell Males-33 Females-05

Positive for ALK Presence of strong granular cytoplasmic staining in tumor cells (any percentage of positive tumor cells).

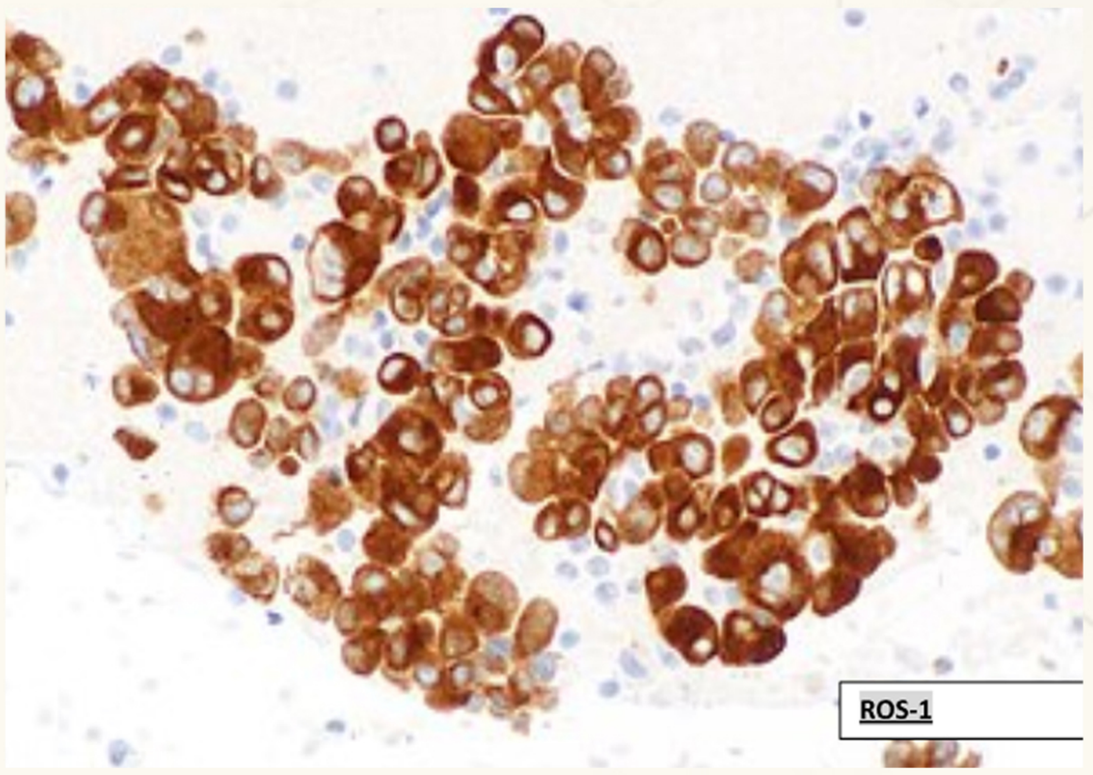


ROS1 by Immunohistochemistry Interpretation

Negative - Score of 0 (no staining), 1+ (weak intensity)

Positive - Score of 2+ (moderate intensity), 3+ (strong intensity)

Note - Scoring method of cytoplasmic staining of 2+ or above in more than 30% tumor cells have the highest correlation with a FISH -positive status



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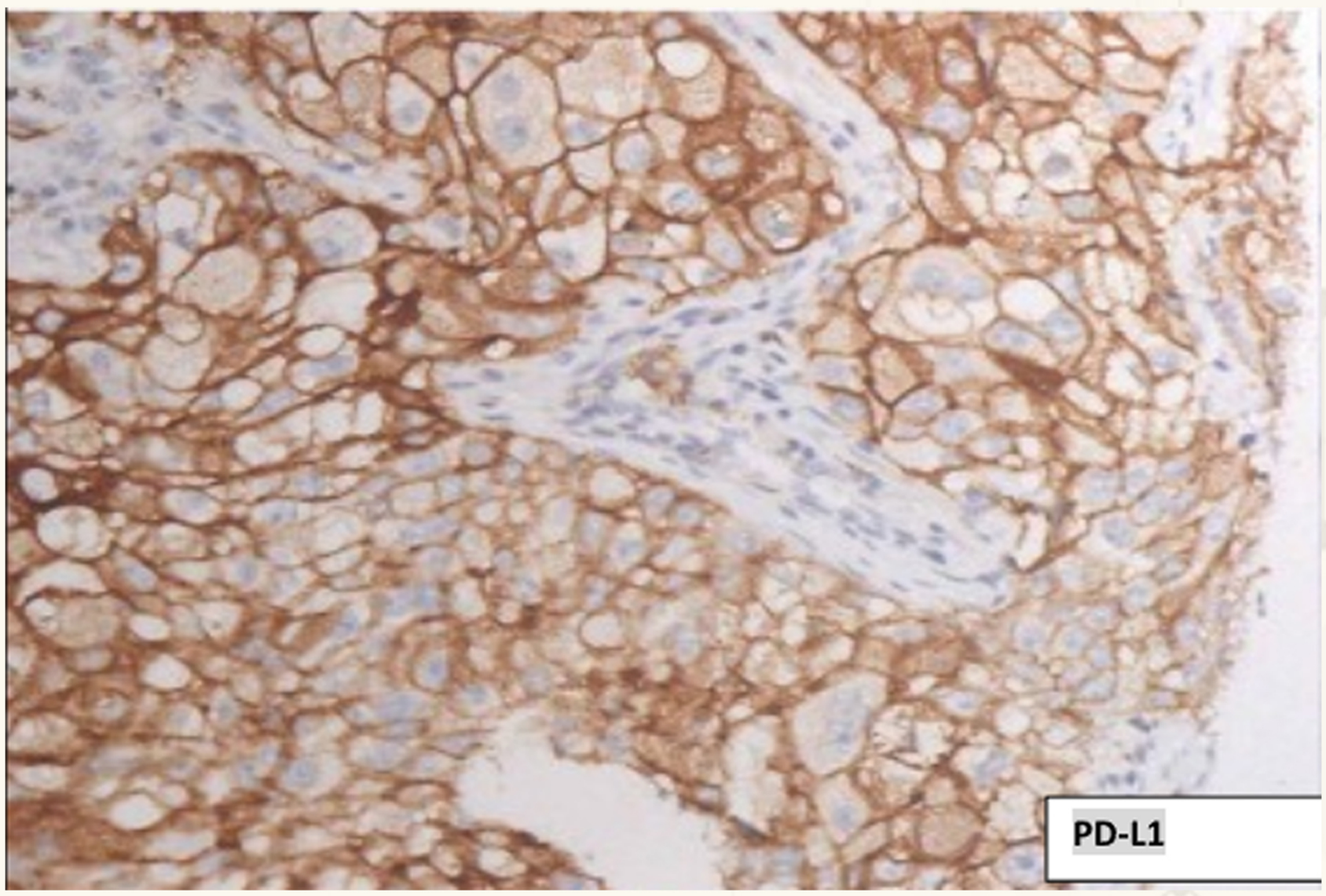

TPS is calculated- Number of PD-L1 positive tumour cells divided by the the total number of all tumour cells multiplied by 100.

DISCUSSION

According to extended NCCN guidelines version 3.2025, the ALK and ROS-1 IHC is now also advisable in cases of squamous cell carcinoma, <40years of age, females, non- smokers and in peripherally located tumour.

ALK- D5F3 is indicated as an aid in identifying patients eligible for treatment with XALKORI® (crizotinib), ZYKADIA® (ceritinib), or ALECENSA® (alectinib).

Technical benefits of anti-ALK (D5F3) IHC testing over ALK FISH. ALK FISH can present technical challenges in evaluating patient results and offers the potential for false negatives.

Recent studies indicate that the VENTANA ALK (D5F3) Assay stained with OptiView DAB Detection and Amplification is sensitive and specific for determination of ALK status, and a better alternative to ALK FISH. There are reports of ALK IHC-positive, FISH-negative patients benefitting from treatment with XALKORI, ZYKADIA or ALECENSA.

CONCLUSION

ALK positive cases were more in poorly differentiated adenocarnoma(10) and in females(10). The difference in incidence of ALK positivity between gender & different grading of adenocarcinoma and Squamous Cell carcinoma was statistically non-significant.

Higher ALK and ROS-1 positivity was detected in females and in Poorly differentiated adenocarcinoma categories, whilst the expression was low in Squamous cell carcinoma and in males.
The correlation between PD-L1 expression and with histological type, grading and gender wise was found to be statistically non- significant. ($p>0.05$).

IHC is less expensive and more readily available detection method and should be employed in all Non small cell lung carcinoma patient, which aids in treatment and prognosis of the patient.

THANKS AND BEST REGARDS
DR.PRACHI

AWARD WINNING ABSTRACTS

MEENU RANI ,M D RAY

Role of CRS HIPEC in Carcinoma Ovary where we stand today- With our experience from a tertiary referral oncology centre, India

Background: The recurrence rates in advanced epithelial ovarian cancer (EOC) after standard treatment are very high. The addition of HIPEC increases the survival by reducing peritoneal recurrence with acceptable morbidity. In this study we assessed disease free survival (DFS) in CRS and HIPEC in upfront, interval and secondary settings and compared the DFS in CRS and HIPEC in upfront and interval setting.

Methods: This is a single-centre retrospective study from prospectively maintained database from 2014-2022. Our study cohort includes 400 EOC patients who underwent upfront, interval and secondary CRS or CRS and HIPEC. The drug used was Cisplatin 75mg/m2 for 60 -90 minutes in upfront, interval setting and Cisplatin 75mg/m2 + Doxorubicin 15mg/m2 for 90 minutes in secondary setting.

Results: For a median follow-up of 80 months, the DFS in CRS with HIPEC and CRS alone were 34.3 months vs 22.7 months in the upfront group (p <0.001), 18.9 months vs 13.3 months in the interval group, (p 0.04) and 14.7months vs 11.9 months in secondary group, (p 0.13). On comparing DFS in CRS+HIPEC in upfront versus interval settings there was a significant difference in the primary setting (34.3 months vs 18.9 months, p 0.01).

The median OS in the CRS with HIPEC vs CRS without HIPEC group was 72.1 months vs 43.3 months in the upfront setting, (p-value 0.034) and 54.2 months vs 44.7 months in the interval setting (p-value 0.44). At 5 years, 49% in the upfront setting and 28% in the interval setting were alive in the CRS with HIPEC arm.

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Conclusion: The addition of HIPEC to a complete cytoreductive surgery has improved DFS in all settings of Advanced EOC. Comparing the DFS of CRS+ HIPEC in upfront vs interval setting, it showed significant difference in HIPEC Arm but overall CRS plays the pivotal role in Adv EOC.

Table 1:

Table showing the demographic characteristics of our study cohort and distribution of surgical procedures across all time frames

Study Cohort	Total patients (N=400)
Median age (yrs)	52 (19-80)
Ovarian carcinoma stage • Stage III • Stage IV	 327 (81.7%) 73 (18.3%)
Time frames of CRS • Upfront CRS • Interval CRS • Secondary CRS	 125 (31.3%) 177 (44.2%) 98 (24.5%)
Surgical procedure in the study cohort • CRS and HIPEC • Only CRS	 226 (56.5%) 174 (43.5%)
Cytoreduction scores • Optimal cytoreduction (CC0+CC1) • CCO • CC1 • CC2 & CC3	 376 (94%) 316 (79%) 60 (15%) 24 (6%)
Primary CRS • CRS+HIPEC • Only CRS • HITAC • Staged HIPEC • Palliative HIPEC	**125 (31.3%)** 51(40.3%) 67(54%) 1(1.1%) 4 (3.5%) 2 (1.1.%)
Interval CRS • CRS+HIPEC • Only CRS • HITAC • Staged HIPEC • Palliative HIPEC	**177 (44.2%)** 85(48.2%) 79 (44%) 4 (2.3%) 7 (3.7%) 2(1.3%)
Secondary CRS • CRS+HIPEC • Only CRS • HITAC • Staged HIPEC	**98 (24.5%)** 66 (67.3%) 28 (28.5%) 1 (1%) 3 (3%)

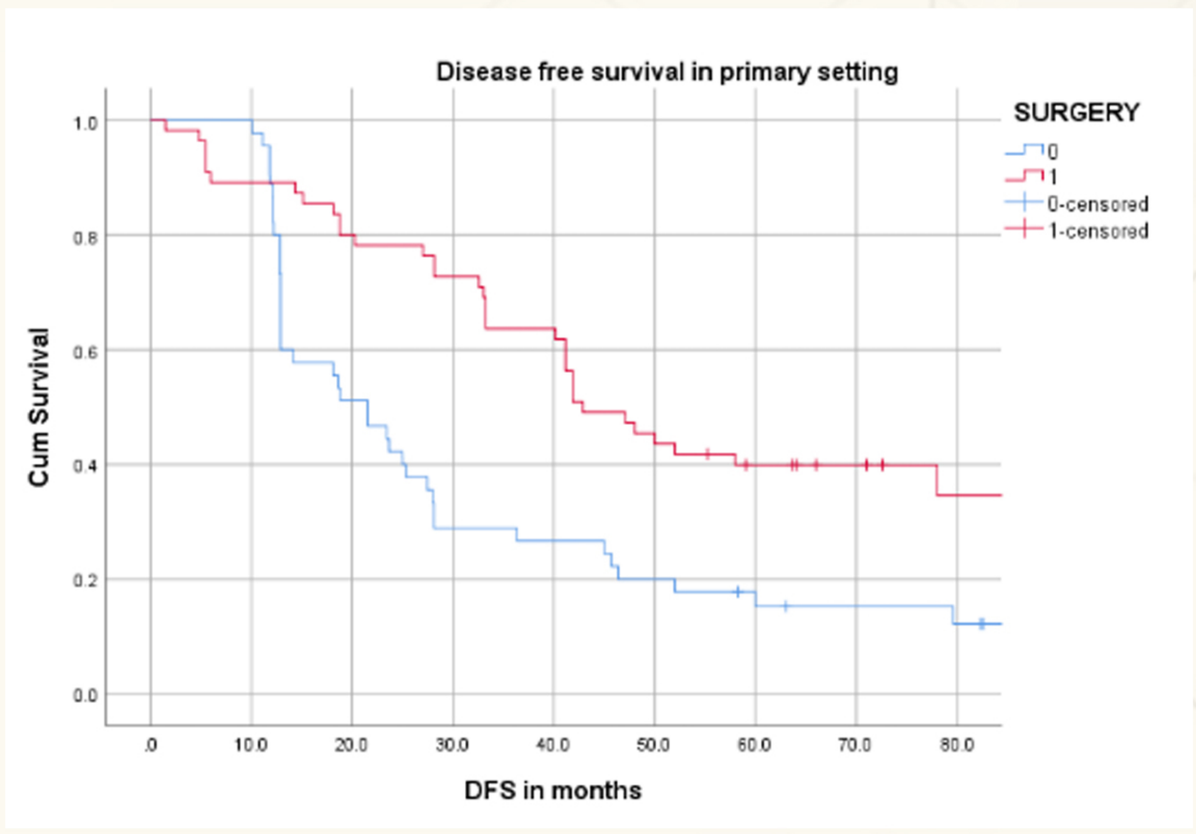
Table 2:

Table showing postoperative complications (Clavein Dindo III &IV) in each group

Complications	CRS with HIPEC (226)	Only CRS (174)	P Value
Intestinal anastomotic leak	5 (2.21%)	3 (1.72%)	0.99
Urologic complications (Bladder + Ureteric anastomotic leaks)	3 (1.33%)	2 (1.15 %)	0.91
Sepsis	5 (2.21%)	1 (0.57%)	0.51
Surgical site infection	13 (5.75%)	6 (3.45%)	0.64
Median ICU stay (days)	6	5	**0.016**
Renal dysfunction/ Dyselectrolytemia	7 (3.10%)	1 (0.57%)	0.19
Relaparotomy	6 (2.65%)	4 (2.30%)	0.90

Figure 1:

Kaplan Meier Survival graphs for DFS and OS in Upfront (Primary) CRS and CRS with HIPEC DFS:



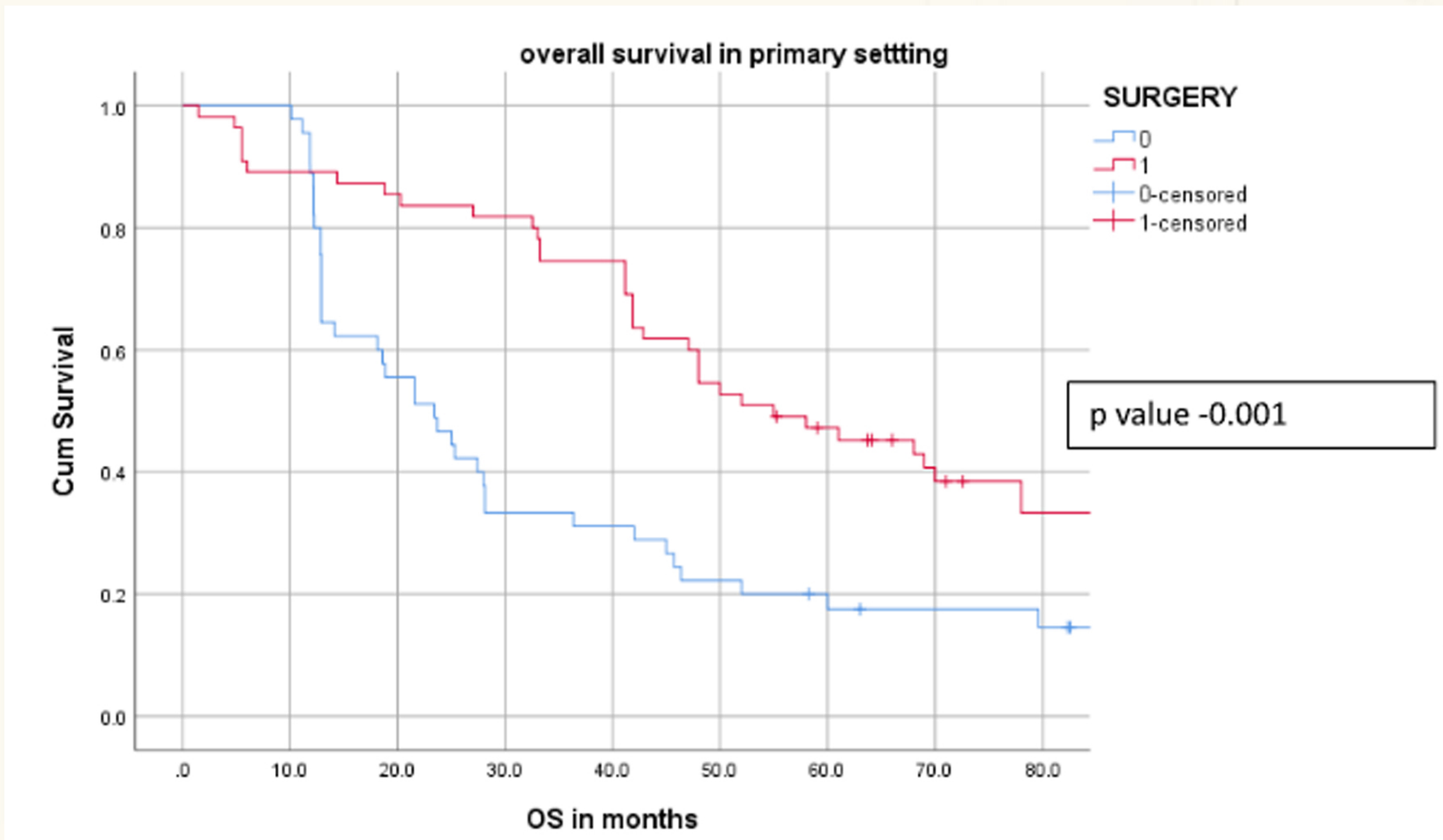
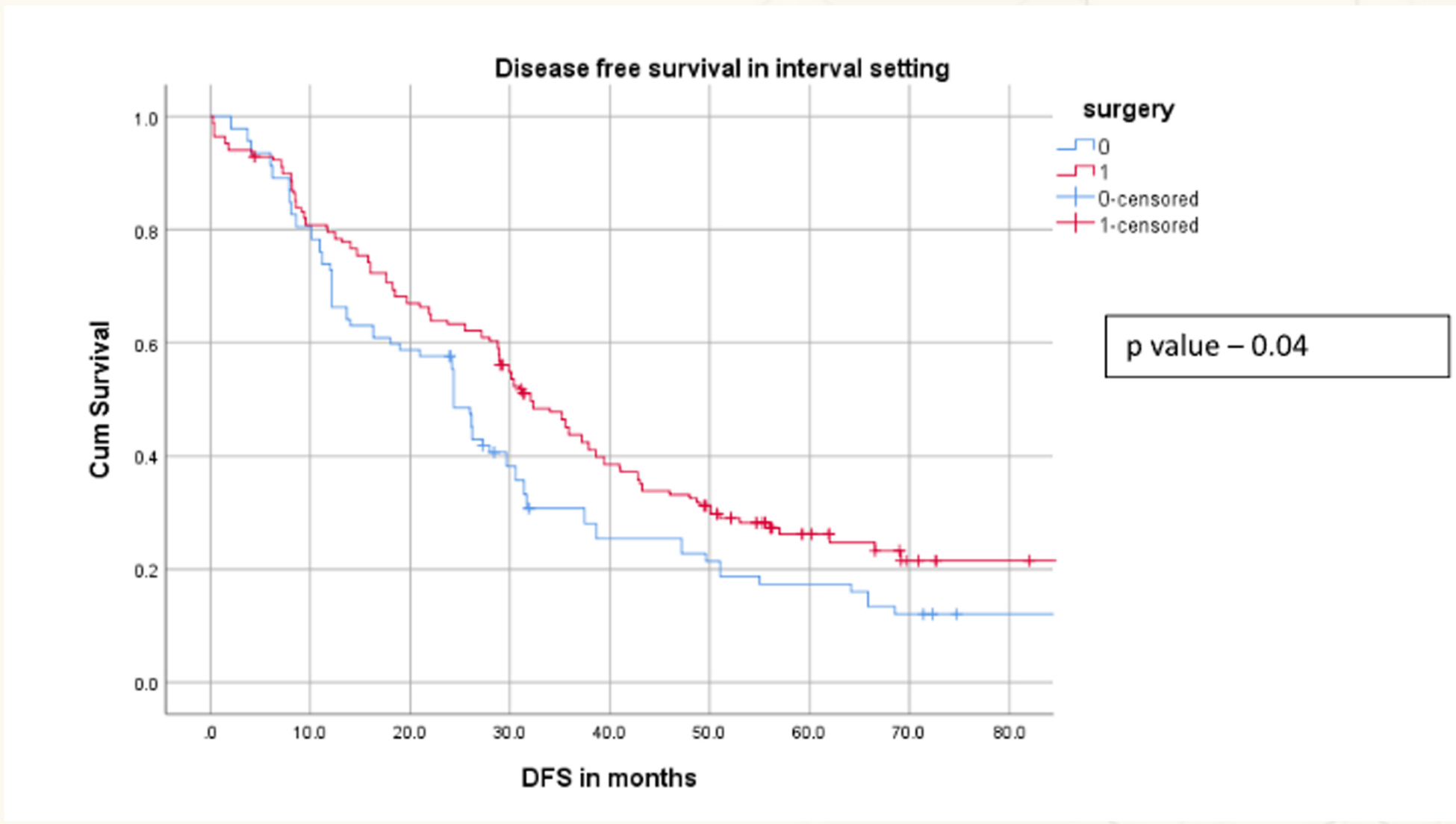


Figure 2

Kaplan Meier Survival graphs for DFS and OS in Interval CRS and CRS with HIPEC



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OS

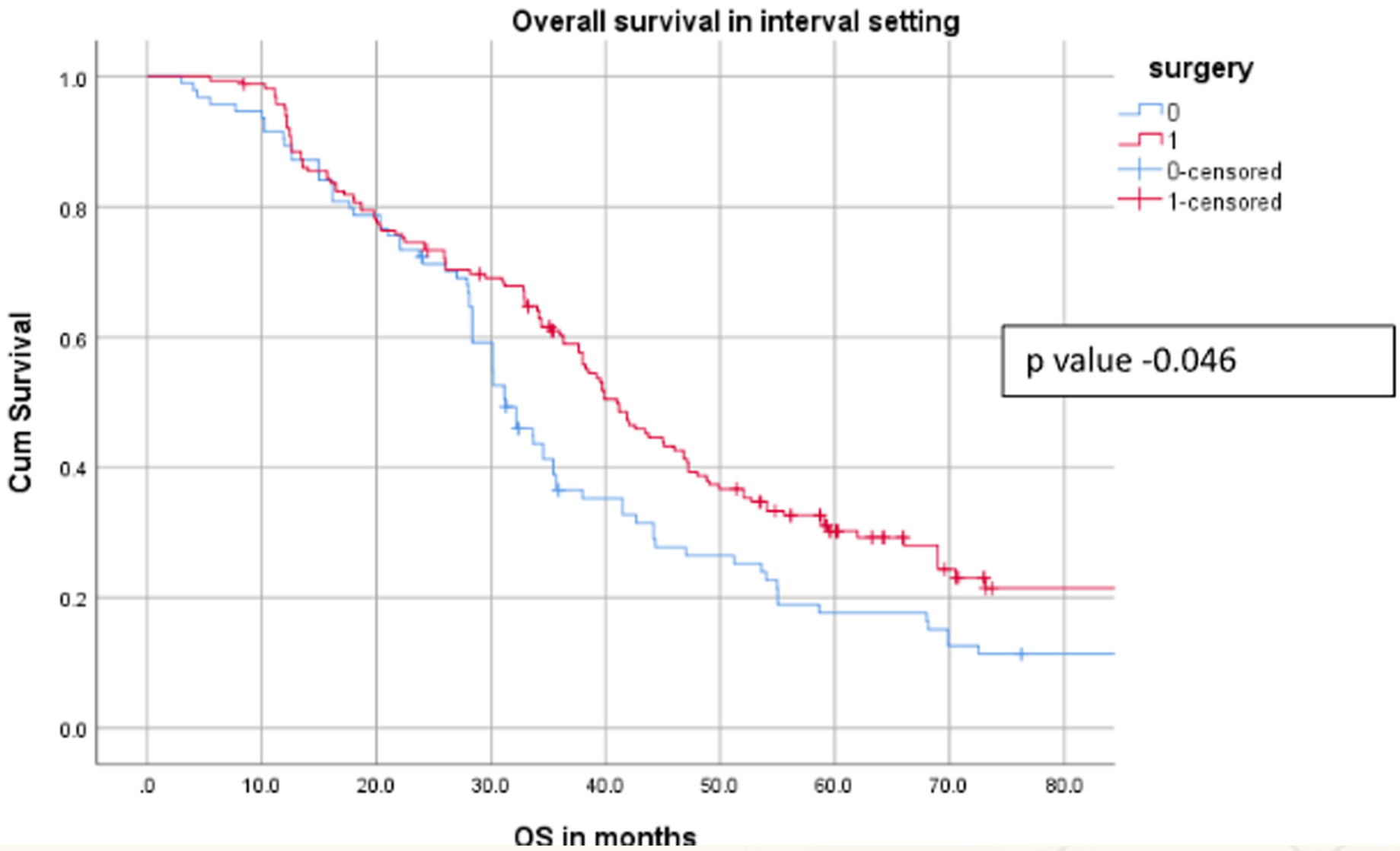

Figure 3:

Kaplan Meier Survival graphs for DFS in Secondary CRS and CRS with HIPEC

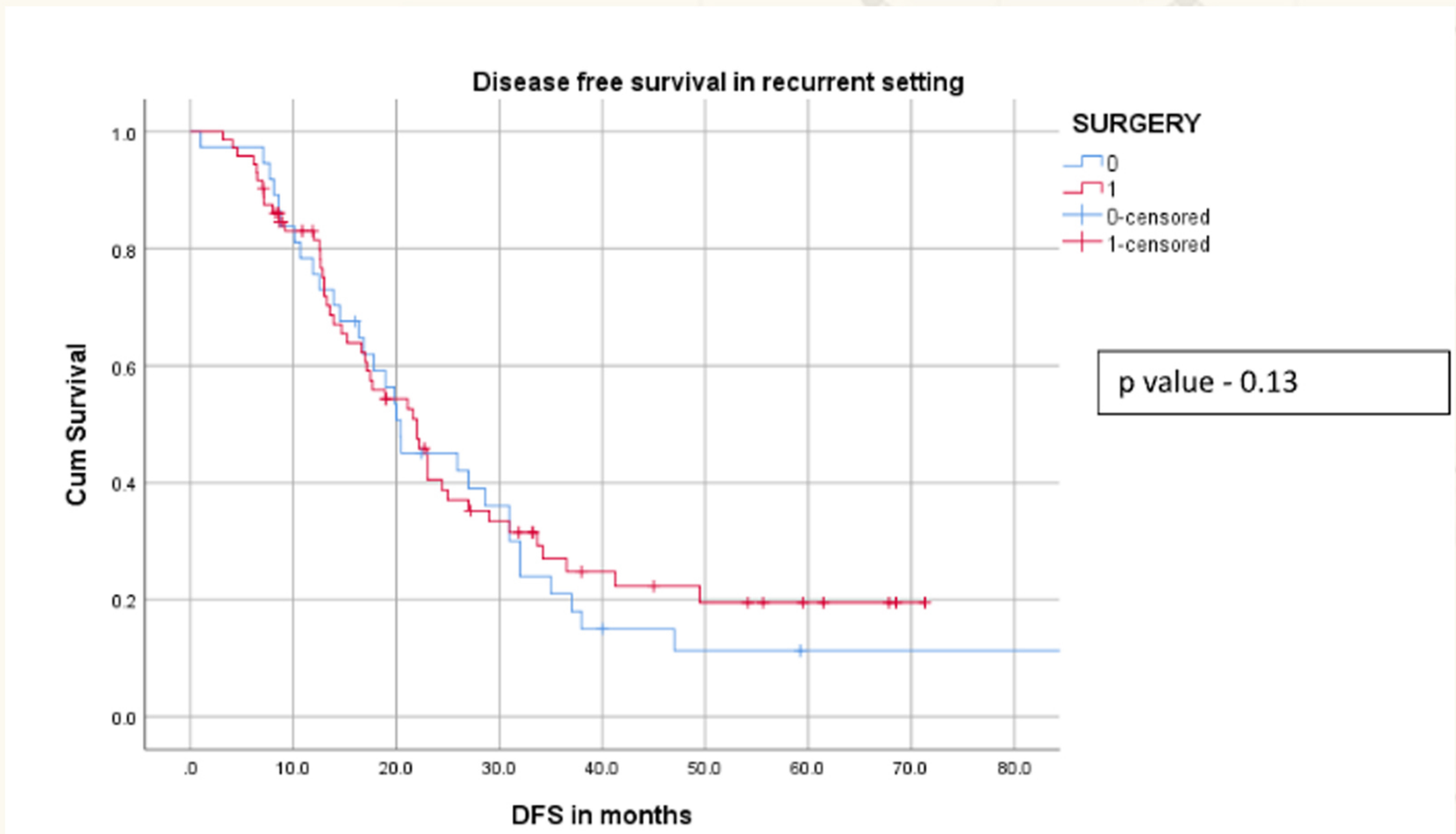

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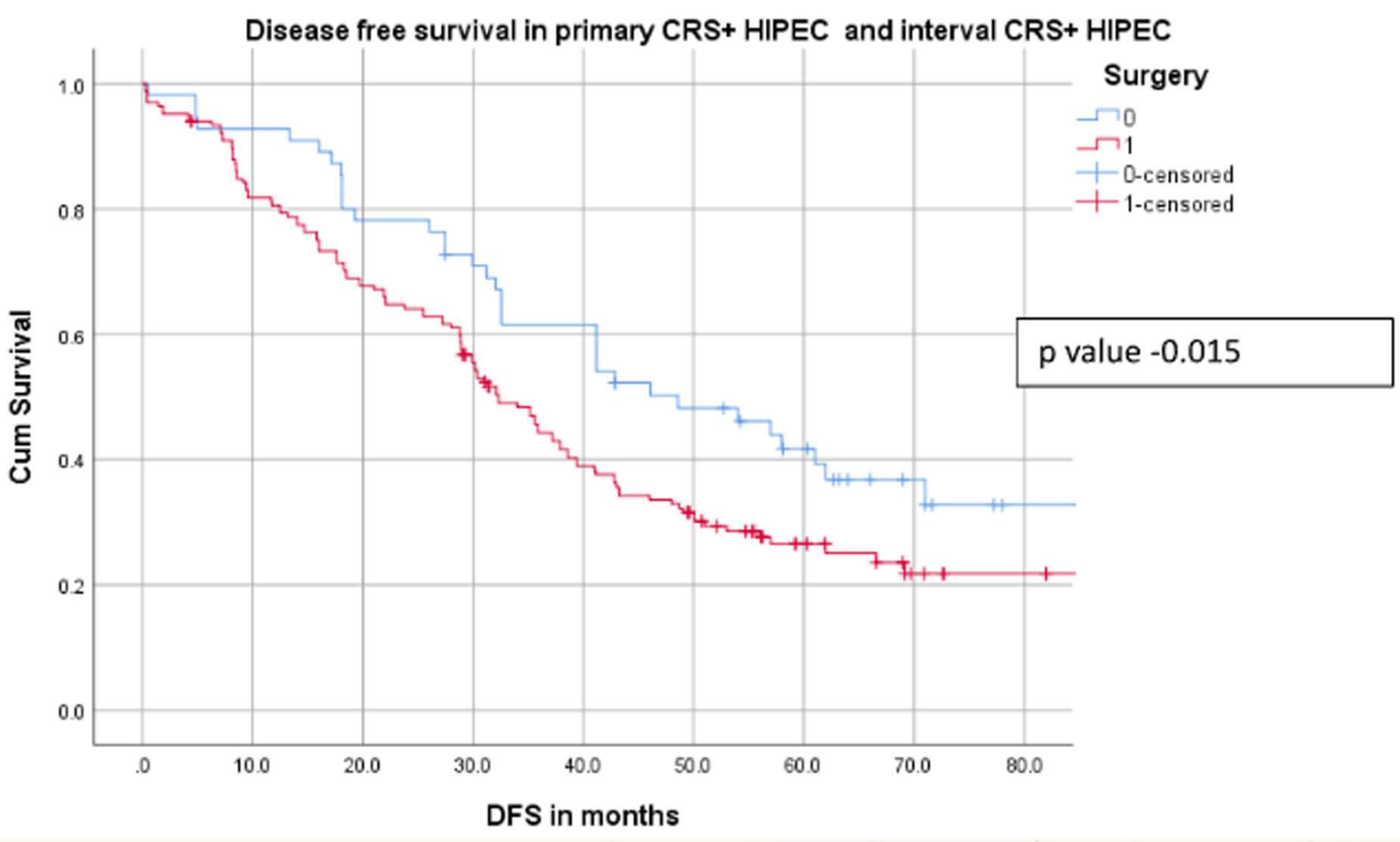
Figure 4.

Disease free survival in CRS and HIPEC arm upfront (primary) vs interval setting



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POETRY

आज सुनाते हैं हम यारों अपनी कहानी अपनी जुबानी
चलते चलते इस जीवन में हिम्मत से ही बात बनी

इक दिन तो ऐसा आया था जब सांसें हमारी थम थी गईं
आँखों में थोंड़ा पानी था और दिल की धड़कन बढ़ थी गई
पर मन में हमने ठान लिया हमें जीत के आगे बढ़ना है
आज सुनाते हैं हम यारों अपनी कहानी अपनी ज़ुबानी ..

वो दिन तो थोड़ा मुश्किल था पर हिम्मत हमने छोड़ी नहीं
बस थाम लिया आशा का दामन विश्वास की डोरी तोड़ी नहीं
बस चलते रहे और बढ़ते रहे खुशियों की ज्योति जलती गई

आज सुनाते हैं हम यारों अपनी कहानी अपनी ज़ुबानी ..
वह ईश्वर थे या अल्लाह थे,यह बात हमें मालूम नहीं
वह ईसा थे या गुरू नानक, अरदास थी किसकी मालूम नहीं
आशीष की वर्षा होती रही खुशियों की ज्योति जलती गई

कुछ दिल की बातें कहने की
इन डॉक्टर्स को और नर्सेज को स्टॉफ को थैंक्यू कहने की
जिन्होंने जीवनदान दिया और
बेड़ा हमारा पार किया

आज सुनाते हैं हम यारों अपनी कहानी अपनी ज़ुबानी. ...

“डॉ शन्नो श्रीवास्तव ”

Senior Consultant
Radiation Oncology

POETRY

In a quiet room where machines hum low,
A doctor stands, a beacon in the glow.
With steady hands and plans both clear and keen,
We wage a silent war, where hope is seen.

We map and measure every vital part,
Each beam a whispered prayer from heart to heart.
IMRT, SRS, SBRT: the artful, gentle light,
Carving paths of healing through the night.

The patient rests, with hope and trembling fear,
We hold their hand and whisper, “I am here.”
A scan, a shift, a careful final check,
Then radiant beams embrace the tumor’s neck.

“Will it hurt?” they ask, voice soft and slight;
“Just a little,” we assure, “we’ll keep you tight.”
Though some days are heavy and the hours long,
Our care and courage make the weak grow strong.

Behind the warmth and healing we impart,
Paperwork and meetings test the heart.
Yet even in the bureaucratic thrall,
Our passion for each life outshines it all.

So here’s to every member of our team:
The techs, the physicists, the dreamers who redeem.
While cancer fights its battle in the fray,
With beams of light, we bring a brighter day.

“Dr. Tripti Saxena”
Senior Consultant
Radiation Oncology

POETRY

जब तक जीवन है बिंदास जियो !
इसके हर पल को बनाकर का खास जियो !

किसी भी बीमारी को लेकर क न उदास जियो !
दुखो से कह दो ना उलझे हमसे आकर !
हमने तो जीना सिख लिया है इनको पाकर !

रब ने हमको बनाने से पहले कुछ तो सोचा ही होगा !
रब ने हमको बनाने से पहले कुछ तो सोचा ही होगा !
कोई न कोई हुनर देकर भेजा ही होगा !
न सोचो की ये न हो पायेगा !

जीवन में कुछ भी तो ऐसा नहीं, जो इंसान ना कर पायेगा !
जब तक जीवन है बिंदास जियो !
इसके हर पल को बनके के खास जियो !

" डॉ रीना मित्तल "

Senior Consultant
Radiation Oncology

ACTIVITIES AND EVENTS
(JANUARY-MARCH 2025)

DATE TIME	PLACE			ORGANIZING SECRETARY	Topic
		EXECUTIVE COMMITTEE MEETING	ACADEMIC MEETING		
01.02.2025	Conference Hall, Service Floor, Tower-1 Max Hospital, Vaishali		Delhi Stereotaxy Group (DSG)	Dr. Rashi Agarwal Dr. Harshit Garg Convenors (DSG)	SBRT in prostate cancer: where do we stand
06.02.20245 6.30pm-7.30pm	Google Meet	EC Meeting		Ms. Nidhi Mittal	
08.02.2025 8.00am-6.00pm	Fortis Hospital Shalimar Bagh		Oncology Forum Academy Lecture 1	Dr. Vineeta Goel Dr. Kanika Sood Sharma & Team	Oral and Oropharyngeal Cancers
22.02.2025	Dharamshila Narayana Superspecialty Hospital		Oncology Forum Academy Lecture 2	Dr. Shubham Garg Dr. Atul Shrivastava Dr. Ambesh Singh Dr. Ranjit Pandhari	Neck Dissection
05.03.2025	Zoom		DSCOG	Dr. Megha Pruthi Convenors DSCOG	Parental Nutrition vs comfort oral intake: What, When and Why?
08.03.2025. 8.00am onwards	Dharamshila Narayana Superspecialty Hospital		Oncology Forum Academy Lecture 3	Dr. Kanika Sood Sharma Dr. Pooja Khullar Dr. Aditi Tanwar Dr. Manisha Himthani Dr. Jhanja Mohapatra	Laryngeal cancers carcinoma of unknown primary
16.03.2025	Sunder Nursery		Oncology Forum Picnic		
20.03.2025. 8.00pm-9.00pm	Zoom	EC Meeting		Ms. Nidhi Mittal	

ONCOLOGY FORUM

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Email : oncologyforum1@gmail.com I Phone no. : 011-42334196, 935043142

29.03.2025	Max Superspecialty Hospital Vaishali		Oncology Forum Academy Class 4 (Surgical)	Dr. Sowrabh Arora Dr. Khyati Bhatia	Management of Thyroid Carcinoma
17.04.2025	Zoom 6.30pm – 7.30pm	EC Meeting		Mrs. Nidhi Mittal	
26.04.2025	Auditorium Paras Hospital Gurugram		Oncology Forum Academy Class 5 (Radiation)	Dr. Indu Bansal and Team	Nasopharynx and Sino nasal malignancies
10.05.2025	Training Room Basement 1 Max Superspecialty Hospital Dwarka-		Oncology Forum Academy Class 6 (Surgical)	Dr. Shilpi Sharma Dr. Sowrabh Arora Dr. Akshat Malik	Oral Cancers
15.05.2025 6.30pm – 7.30pm	Zoom	EC Meeting		Mrs. Nidhi Mittal	
17.05.2025	Auditorium 3rd Floor, Metro Cancer Institute, Sector 16A Faridabad		Oncology Forum MIDCON 1	Dr. Vikas Kumar Dr. Swarupa Mitra Convenors DSG and DGOG	Gynecological Cancers- What you need to know in 2025 Lung SBRT: Contemporary insights and recent Advances
07.06.2025	Auditorium Max Superspecialty Hospital Vaishali, Delhi		Oncology Forum Academy Lecture 6	Dr. Rashi Agarwal and Team	Early Breast Cancer
21.06.2025	Auditorium Max Superspecialty Hospital Saket		Oncology Forum Academy Class 8 (Surgical)	Dr. Charu Garg	Locally advanced and metastatic breast cancer

DELHI ONCOLOGY FORUM

REGISTRATION FORM AND PAYMENT DETAILS

Please Paste a recent colored photograph and attach a spare copy of the photograph with your signature on its back.

ONCOLOGY FORUM
(Reg No.0676/2012 Act XXI 1860)
MEMBERSHIP APPLICATION FORM

For Office Use Only

Membership No._____ Date:____/____/_____

Membership approved /not approved: _____

The Secretary

ONCOLOGY FORUM, New Delhi

Kindly enroll me as a Life member of the ONCOLOGY FORUM. I am submitting the membership form and subscription fee of Rs. 3000/- (Three Thousand only) towards membership registration; vide crossed demand draft/cheque no._____ drawn on _____ dated _____ in favor of 'ONCOLOGY FORUM'.

I undertake to abide by the rules and regulations as laid in the constitution of ONCOLOGY FORUM.

1. Name in Full: FIRST_____MIDDLE_____LAST_____
2. Date of Birth: _____Sex _____.Nationality _____
3. Email address: _____Mobile no.:_____
4. Academic Qualifications: _____

	Examination Passed (Last three)	College / University	Year
1			
2			
3			

5. Medical Regn. No_____Date_____Regn. Council_____. MCI No:_____
6. Membership of IASO/ISO/AROI/ISMPO & Membership No. _____
7. Membership of any other National/ International Oncology body: _____
8. Residence Address: _____
_____PIN_____Telephone_____Fax No_____
9. Hospital/Office: _____
_____PIN_____Telephone_____Fax No_____
10. Permanent Address: _____
_____ PIN _____Telephone_____Fax No_____
11. Preferred mailing address: Residential/ Hospital/ Permanent.
12. Area of work: Surgical/ medical/ radiation/ pathology/ radiology/ epidemiology/ preventive or_____
13. Area of interest (any two regions)_____
14. Oncology constitutes what % of your work_<25%/ 25-50%/ >50%/ 100%._____
15 Signature:_____Date_____

Send to: Dr. Harit Chaturvedi B – 38 3rd Floor Greater Kailash 1,Delhi 110048 , Phone number - 42334196

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