VOLUME 1 | ISSUE 6

ONCOLOGY FORUM'S

ONKOMAG

JULY 2022

Dr SVS Deo welcomes new board & executive members for a new journey @ Oncology Forum

ॐ सर्वे भवन्तु सुखिनः सर्वे सन्तु निरामयाः।
सर्वे भद्राणि पश्यन्तु मा कश्चिद्दुःखभाग्भवेत। ॐ शान्तिः शान्तिः शान्तिः॥

May all sentient beings be at peace, may no one suffer from illness,
May all see what is auspicious, may no one suffer. Om peace, peace, peace.

सभी सुखी होवें, सभी रोगमुक्त रहें,
सभी मंगलमय घटनाओं के साक्षी बनें और किसी को भी दुःख का भागी न बनना पड़े। ॐ शांति शांति शांति॥

INSIDE THIS ISSUE:

President's Message

Dr SVS DEO
Head, Department of Surgical Oncology
BRA-IRCH & National Cancer Institute (NCI)
All India Institute of Medical Sciences

It is my privilege and honor to take over as the president of this Oncology Forum 10 years after the establishment of the society. At the outset, I would like to thank all the members of the forum for giving an opportunity to new office bearers to carry forward the agenda and great efforts as envisaged by our founding members. Oncology Forum was established in 2012 with the main objective to bring all oncologists practicing in the Delhi region together on a singular platform to share their knowledge, wisdom, best practices to promote education, research, and high quality patient care. One of the objectives was to facilitate networking and collaboration with reputed national and international oncology societies. The past leadership has successfully organized a number of high quality collaborative academic events.

I would like to salute and thank the entire oncology community of NCR Delhi region for taking the leadership role during the COVID pandemic, and treating cancer patients with utmost dedication despite various hardships and personal risks. I am happy to share that the Oncology Forum has continued its academic activities during the pandemic on virtual platforms, and successfully hosted two major events, "NATCON-IASO 21" and "Annual Conference of Oncology Forum".

The field of global oncology is witnessing phenomenal growth and the landscape of oncology changing fast due to rapid advances in various fields. There is tremendous opportunity and scope for the Oncology Forum to expand its foot print and endeavours. There is a need to engage with all stake holders, including policy makers, research organizations, patient advocacy and support groups to facilitate a transformative change. I urge all members of the Oncology Forum, especially the seniors, to share their experience and wisdom, and the younger members to take leadership roles to steadfastly pursue the goals of our society.

Warm Regards & Best Wishes

Prof. SVS Deo

President, Oncology Forum

ONCOLOGY FORUM EXECUTIVE BODY

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BRA-IRCH & National Cancer Institute (NCI)
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ANNUAL CONFERENCE 2021 IN PICS

GROWING TERATOMA SYNDROME

– HOW TO TAKE ON A CHALLENGE

J R Jeena Josephin, Senior Resident, Dept. of Surgical Oncology, All India Institute of Medical sciences, New Delhi.
Amit Kumar, Senior Resident, Dept. of Surgical Oncology, All India Institute of Medical sciences, New Delhi.
M D Ray, Additional Professor, Dept. of Surgical Oncology, All India Institute of Medical sciences, New Delhi.

Background

Growing teratoma syndrome (GTS) is a rare condition seen in patients with germ cell tumors (GCT). Criteria for GTS are: 1) a persistently growing tumor during or after chemotherapy, 2) normal tumor markers, 3) presence of only mature teratoma component on the final histopathology after resection of the tumor. Growing teratomas lack the metastatic potential however local infiltration and encasement of surrounding structures seen. Surgical resection is the only treatment option as growing teratomas are resistant to chemotherapy and radiotherapy. Here we report a case of GTS in an18-year-old male who was deemed unresectable in tertiary care center due to encasement of external iliac vessels for a long segment.In this paper we like todescribe howwe tackled the tough situation successfully.

Case Presentation

An 18-year-old male presented with abdominal lump for 2 years, progressively increasing in size. He had the following past history before presenting to us. Patient had left testicular tumor for which left high inguinal orchidectomy was done 2 years back. Post-operative histopathology report was cystic trophoblastic tumor. Patient received adjuvant 4 cycles of BEP regimen (Bleomycin, Etoposide and Cisplatin). After tumor free interval of 4 months, patient developed abdominal lump. Patient received 3 cycles of EP regimen (Etoposide and Cisplatin). There was no tumor response. Patient was started on EMACO regimen (Etoposide, Methotrexate, Actinomycin-D and Vincristine). There is no regression in tumor size. So, patient underwent exploratory laparotomy, deemed inoperable due to extensive adjacent structure involvement. Biopsy was taken which showed mature cystic teratoma. Patient has been referred to us with above history. On examination, huge abdominopelvic bosselated mass involving all quadrants of abdomen with restricted mobility, not moving with respiration.

A contrast-enhanced computed tomography scan ofabdomen showed a large multiloculated abdominopelvic cystic mass measuring 21x12 cm with foci of calcifications and few thick enhancing septations, infiltrating anterior abdominal muscles and encasement of left external iliac vessels. Few predominantly cystic paraaortic lymph nodes also seen. Beta human Chorio gonadotrophic hormone (Beta HCG) and alpha-fetoprotein (AFP) are normal but lactate dehydrogenase (LDH)was mildly elevated (351 U/L, normal range (120-246 U/L). Planned for exploratory laparotomy after obtaining consent for multivisceralresection.

Intraoperative findings showed approximately 25x25cm multiloculated solid cystic mass infiltrating anterior abdominal wall muscles, adherent to small bowel, urinary bladder and greater omentum and encasement of left external iliac artery (EIA) and external iliac vein (EIV).3x3cm nodal mass in para-aortic region and multiple centimeters sized retroperitoneal lymph nodes. En-bloc excision was done along with bilateral pelvic and retroperitoneal lymph nodal dissection. External iliac artery and vein on the left side were encased by the tumor. External iliac artery and vein, both are looped out separately, vessel loops applied proximally near the bifurcation followed by meticulous dissection of both vessels from the tumor and freed from the mass. Bleeding sites during dissection in external iliac vein sutured with 4-0 prolene. External iliac artery was totally deviated from its usual course and the iliac veins are not visualized separately. Vascular set was ready to tackle the vessels injury especially near the pelvic wall and we made plan to take the control from the groin. This part was very challenging as the vessels were fragile because of repeated chemotherapy and its course through the tumour and not well defined. Apart from this, in retroperitoneal area we were careful to dissect the posterior

GROWING TERATOMA SYNDROME –HOW TO TAKE ON A CHALLENGE

aspect of the tumour as we were apprehend with respect to infiltration to great vessels as the tumor was infiltrating type. At one point, we have sutured the IVC with 4-0 prolene. This is more challenging part of the dissection as the infiltrating teratoma could involve the IVC and aorta and the fellow new vessels because of the high tumour and nodal burden.

By careful dissection, tumor was separated from the whole length of small bowel, sacrificing the serosal layer in many parts of the bowel. The same way urinary bladder was separated from the tumour removing some part of bladder peritoneum, fat and muscles taking care both the ureters. Complete hemostasis obtained followed by wound closed in layers with two abdominal drains insitu. Patient was kept in NPO with parenteral nutrition for 4 days considering the multiple sites thinning out of bowel walls.Post-operative period was uneventful.

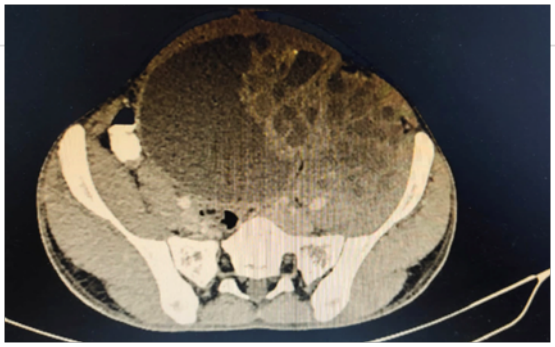

Figure 1 CECT image of GTS

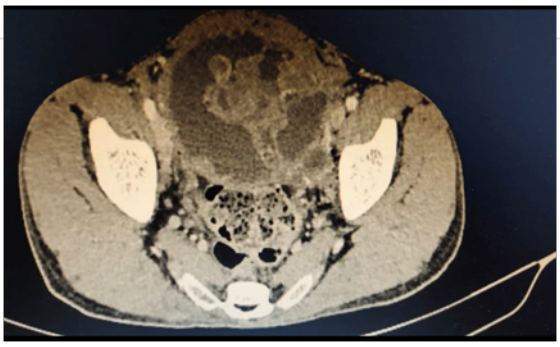

Figure 2 CECT showing EI vessel involvement

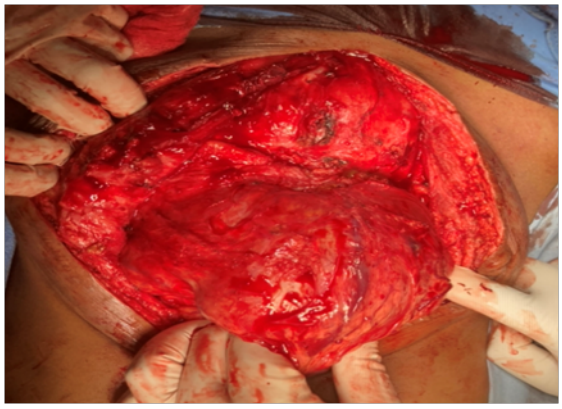

Figure 3 Intraoperative picture of tumor

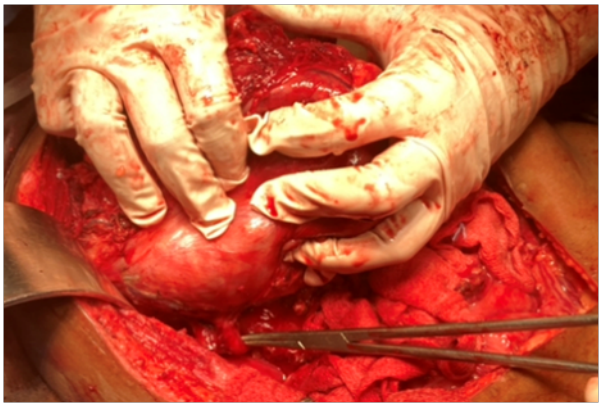

Figure 4 External iliac vessels involvement

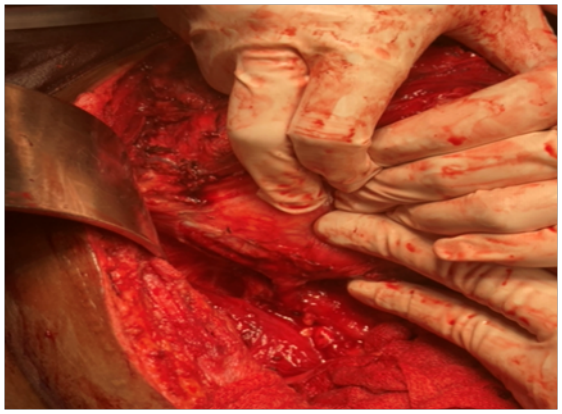

Figure 5 EI Vessels encased by tumor

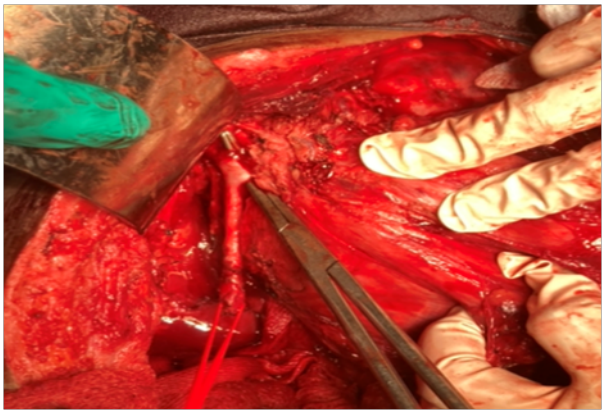

Figure 6 EIA held by vessel loop

GROWING TERATOMA SYNDROME –HOW TO TAKE ON A CHALLENGE

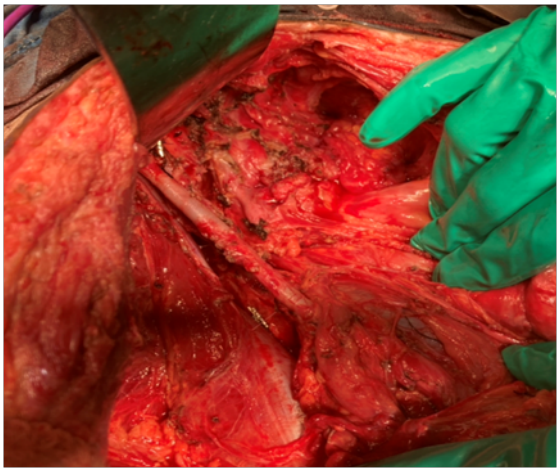

Figure 7 External iliac vessels dissected

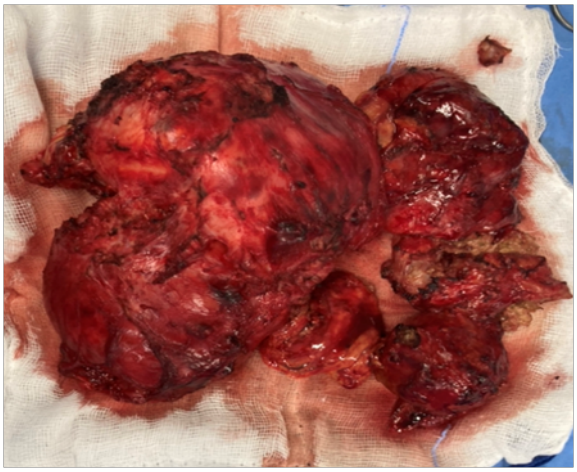

Figure 8 Post-operative picture of specimen from tumor

Discussion

Growing teratoma syndrome is a rare condition among patients with non seminomatous germ cell tumor with enlarging metastatic masses during or after appropriate chemotherapy with normalized serum tumor markers. The term growing teratoma syndrome was coined by Logothetis et al in 1982 (1) characterized by enlarging masses despite appropriate chemotherapy, normalized serum markers and histology reveals benign mature teratoma with no viable germ cell tumor. The prevalence of GTS is 1.9-7.6%. Logethetis et al described this condition in six patients fulfilling all the above criteria. Although GTS was first named in 1982, the concept of "benign maturation" of testicular carcinoma after chemotherapy was earlier published in 1969 by DW Smithers (2). He described five patients with seminoma and immature teratoma whose metastatic masses consisted of well differentiated teratomatous element. Hong et al in 1977 (3) described the GTS in 12 patients from Memorial Sloan Kettering cancer center. These reports highlighted the favourable prognosis after resection of these tumors. MD Ray in 2016 (4) published a case report of one of the largest growing teratoma syndrome with multivisceral resection. A similar transformation is seen in the setting of ovarian germ cell neoplasia named "chemotherapeutic retroconversion" by Disaia et al (5). Arguably, in GTS, the mature teratoma nodules must have undergone chemotherapeutic retroconversion but also have the ability to grow but in pure definition of chemotherapeutic retroconversion, the nodules do not increase in size.

Surgical resection is the standard treatment option. Local recurrence is 0%-4% after complete resection of tumor. It almost cures the patient. So, growing teratoma syndrome should not be considered unresectable disease unless surgical exploration done at a high-volume centre with experienced team failed to achieve a R0 resection. In our patient, dissection of external iliac artery and vein was a challenge. Tumor was encasing the vessels. Meticulous dissection freed the vessels from the tumor.

We wish to highlight that growing teratoma syndrome is a potentially curable condition. So complete surgical resection should be the aim. Patients should be referred to high volume centres with good facilities and experienced team. Multivisceral resection can be done whenever appropriate and reconstruction to be done if needed. Major vessels involvement should be tackled by appropriate technique, meticulous dissection and also to be handled by experienced team who can deal with these conditions.

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INTRA OPERATIVE RT AND SURGERY FOR PREVIOUSLY RADIATED RECURRENT RECTAL CANCER - CASE REPORT

Dr Vineeta Goel, Head Department of Radiation Oncology, Fortis H, Shalimar Bagh, Delhi
Dr Archit Pandit, Senior Consultant Surgical Oncology, Max Hospital, Shalimar Bagh, Delhi

Case

53 years old gentleman presented to us with a history of recurrent lower third rectal adenocarcinoma in May 2019.

He had significant co morbidities including diabetes, ischemic heart disease (post PTCA) and chronic kidney disease (CKD). He had undergone renal transplant twice (in 1994 and 2010)for CKD and transplanted kidney was in left side of the pelvic cavity.

Prior to coming to us, in October 2017, he had adenocarcinoma of lower third rectum T3N0M0 for which he was treated with pre operative chemo radiation therapy (CTRT) to a dose of 45Gy/25 fractions along with concurrent Capecitabine till November 2017. Patient defaulted for surgery and remained well till May 2019.

In May 2019, he was reinvestigated for bleeding per rectum. On digital rectal examination and sigmoidoscopy, he had a growth starting 2 cm above anal verge for a total of 6 cm along anterior rectal wall. Biopsy from this lesion was moderately differentiated adenocarcinoma. MRI pelvis showed that there was a lesion in anterior rectal wall with loss of fat planes with prostate (Figure 1). FDG PET CT scan showed there was no extra rectal evidence of disease, so his final stage was rT4N0M0.

After discussion in multi-disciplinary tumour board (MDTB), patient was started on neo adjuvant chemotherapy with Capecitabine and Oxaliplatin. MRI and PET Scan after 8 cycles of chemotherapy showed partial response and there still was residual disease in anterior wall of rectum with invasion of prostate capsule. Since it was still inoperable we gave him IM- IGRT based reirradiation to a dose of 36Gy/20 fractions along with Capecitabine. We restricted ourselves to 36Gy as it was reirradiation after a gap of almost 2 years.

Six weeks after completion of CTRT, his disease was reevaluated clinically and radiologically with MRI pelvis and FDG PET CT scan. There was further regression in disease, but small residual disease was still present along anterior rectal wall and prostatic capsule. Ideally, he now merited pelvic exenteration, but it was not feasible due to history of renal transplant. After much discussion in MDTB, he underwent Abdomino perineal resection (APR) with excision of prostatic capsule and intra operative Radiation Therapy (IORT). We did IORTusing HDR brachytherapy to prostate bed after. As a part of IORT procedure, after APR, we placed IORT Frieberg flap along prostate bed through both abdominal and perineal route and secured it in position using stitches to parities We packed pelvic cavity with Gauze rolls to hold applicator in position as well as displace bowel and bladder away from potential radiation zone. We also placed a small lead shield on ureter to protect it from radiation. HDR catheters were then threaded in the IORT flap. Patient was then shifted to brachytherapy room. He was then given 10 Gy in single fraction (at 1cm from source axis) after connecting tubes with HDR brachytherapy machine. Generally, 10 Gy in single fraction would be radiobiologically equivalent to 20-24Gy of conventional dose. It took us about 20 minutes to deliver this radiation therapy. Patient was then shifted back to main operation theatre and Brachytherapy applicator was removed and final closure done by surgical oncology team.

Patient had an uneventful post operative recovery. Final histopathology showed microscopic residual disease and he was started on adjuvant Capecitabine tablets for 12 months

After a follow up of 2 years patient remains disease free.

INTRA OPERATIVE RT AND SURGERY FOR PREVIOUSLY RADIATED RECURRENT RECTAL CANCER - CASE REPORT

Discussion

IORT is an important tool especially in setting of locally recurrent and previously radiated rectal cancers. In a series of 147 locally recurrent rectal cancers by Rutten et all from Netherlands, it was shown that reirradiation was safe and feasible. This series also showed that patients who had reirradiation had longer local recurrence free and overall survival as compared to patients who were not given pre operative reirradiation.

It takes strong cohesive multidisciplinary team and democratic tumour board to do surgery and IORT. IORT has the advantage of delivering high focused doses of radiation to operative bed with least side effects and radiation doses to surrounding normal organs. This patient had several challenges in his treatment including local recurrence, reirradiation, adjacent organ infiltration as well as his immunocompromised state due to renal transplant. IORT does not have a long learning curve and can be easily practiced in centres with facility of HDR brachytherapy.

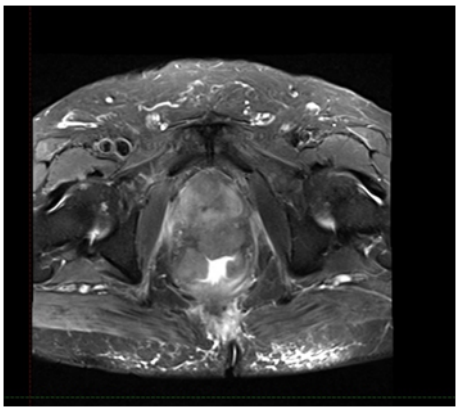


Figure 1- Axial MRI at the time of recurrence showing rectal mass with infiltration in prostate

TOTAL BODY IRRADIATION

OUR INSTITUTIONAL EXPERIENCE FOR FIRST EVER TBI DONE ON HALCYON MACHINE

Dr Manisha Himthani
Dharamshila Narayana Hospital , Noida

Background

Total body irradiation (TBI) is a form of radiation therapy in which a patient's whole body is treated with radiation. It is indicated as conditioning regimen for allogeneic hematopoietic stem cell transplantation and is employed for treating malignant conditions, like multiple myeloma, leukemia, lymphoma, and some solid tumors and certain benign diseases such as aplastic and Fanconi anemia[1]. Important considerations are sparing critical organs while delivering adequate dose to all tissues including sanctuary sites.
Various conventional methods like extended SSD technique have been employed but they come along with drawbacks of increased treatment time and higher doses to crucial areas like gonads, kidneys or lung , which may cause infertility[2], renal dysfunction[3] or radiation pneumonitis[4] respectively.

Hence, Employing newer techniques helps improving dose conformity with better homogeneity to the target area along with decreasing treatment time and highly conformal sparing of organs at risk(OARs)[5,6].

TOTAL BODY IRRADIATION

OUR INSTITUTIONAL EXPERIENCE FOR FIRST EVER TBI DONE ON HALCYON MACHINE

The methodology for TBI on Halcyon, is however limited. Studies have tried feasibility of VMAT based TBI on Halcyon[7]. Our institute was first to implement fluence based RT for TBI on a Halcyon LINAC.

Methods

Positioning and simulation

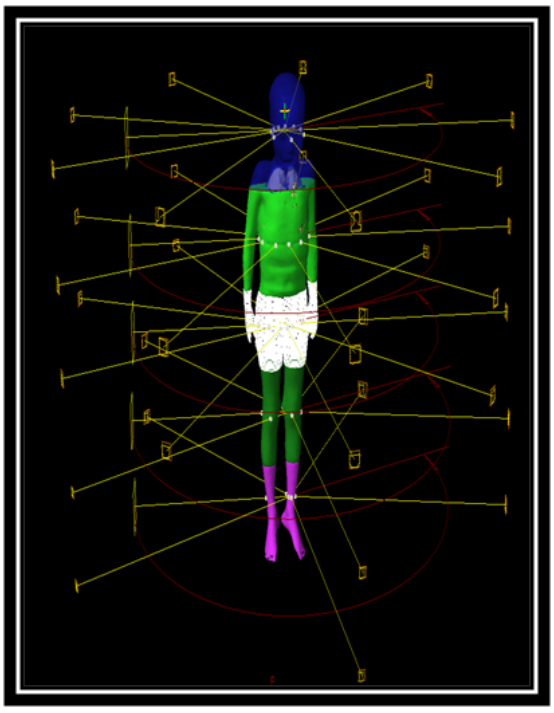
Patient was immobilised in supine position using customised thermoplastic 3-point masks for head using head rest and 4- point mask chest, abdomen and pelvis in a paediatric patient. Planning CT images were acquired with 5 mm slice thickness, head-first supine from the patients' vertex to the toes.

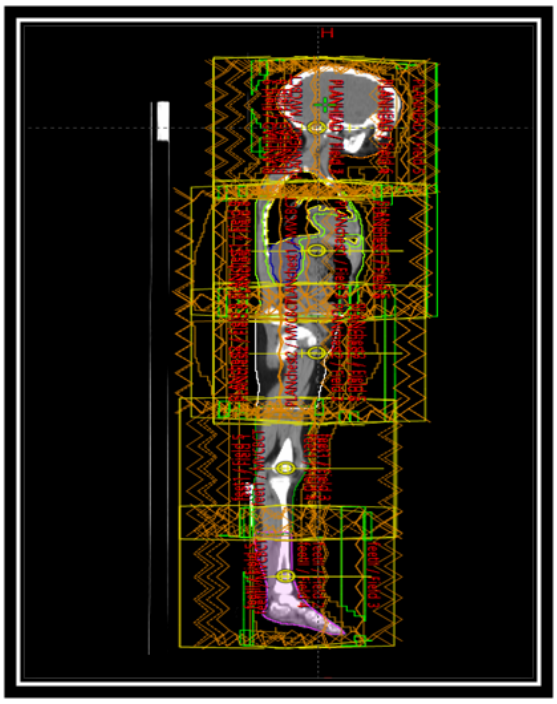
Data Sets and Contouring

CT images were transferred to treatment planning system. Planning was done on Eclipse Software version 16.1. Important OARs like Lungs, Liver ,Lens, Gonads and crucial neural structures like Brain, Brainstem, Spinal cord were delineated. Other thyroid, pituitary, parotids, bowel bag were also contoured for data reporting purposes.

Dose prescription and treatment planning

Dose prescription to the PTV was 4 Gy in 2 fraction, delivered twice a day (BID) @ 2GY per fraction with an inter-fraction interval of at least six hours. Fluence based RT planning was done.





Plan evaluation

Dose coverage to target was 95% to 95% of PTV volume and with ALARA dose constraints to lungs, kidneys, lens and gonads. Dose hot spots(107% of prescribed dose) were allowed on bone marrow or musculature.

Positioning and Image Guidance

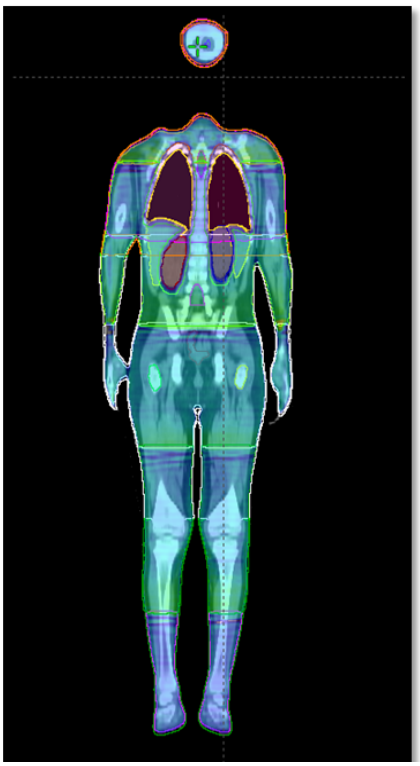
MV-CT was used to verify correct positioning errors.

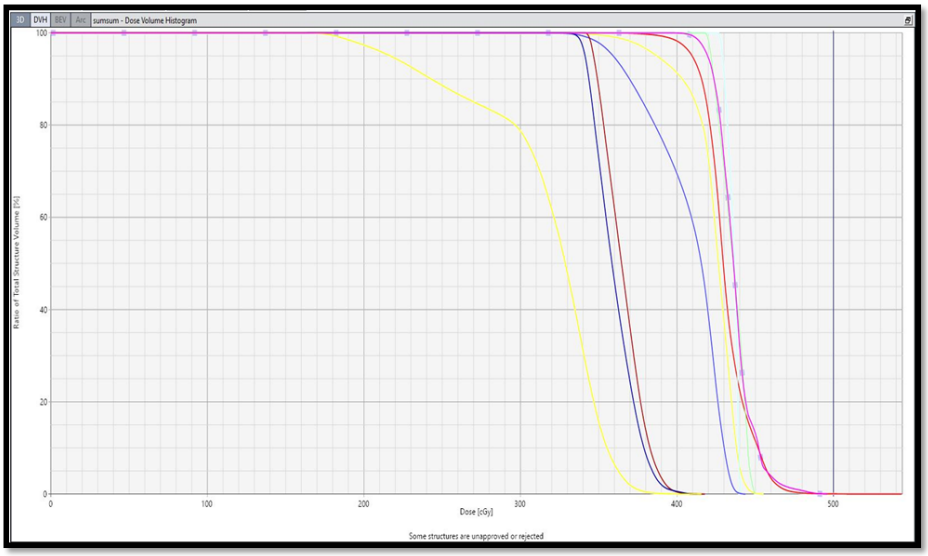
TOTAL BODY IRRADIATION

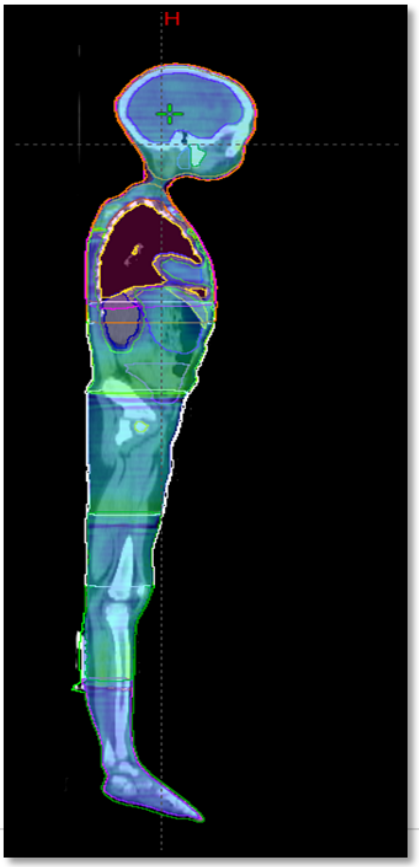
OUR INSTITUTIONAL EXPERIENCE FOR FIRST EVER TBI DONE ON HALCYON MACHINE

Results

The dose stats achieved and DVH are summarised below.







Structures	Parameters	Result
PTV	D95%	95% of PTV
Lungs	D_{mean}	3.16 Gy
Right Lens	D_{mean}	4.35 Gy
Left lens	D_{mean}	4.35 Gy
Right Kidney	D_{mean}	3.65 Gy
Left Kidney	D_{mean}	3.60 Gy
Gonads	D_{mean}	4.29 Gy
Liver	D_{mean}	4.23 Gy

The beam on time was approximately 40 minutes.

TOTAL BODY IRRADIATION

OUR INSTITUTIONAL EXPERIENCE FOR FIRST EVER TBI DONE ON HALCYON MACHINE

The concept of fluencebasedRT for TBI offers multiple advantages over conventional LINAC-based TBI with higher conformity due to the 360° of beam application versus the standard fixed beam approach. Nonetheless, it allows better sparing of organs at high risk of radiation induced toxicity.

The treatment can be done in even small bunkers that can accommodate Halcyon based LINAC and thus dodging the extended SSD approach to treat, that requires large bunkers.

The use of MVCT before treatment also helps reducing setup errors. Using invivo dosimetry can behelpful in further assessing accurate doses delivered and monitoring for future toxicities.

The disadvantage is higher MU's for treatment which in turn increases the overall integraldose. Another limitation of treating on HALCYON is the treatment length of the patient. Lateral and vertical movement of the couch is locked, treatment of lower part of the body becomes challenging using multiple isocenters and treatment planning and execution procedure becomes more tedious and exhausting.

Beam modifier planning is difficult for which arbitrary bolus has to be put and with no field lightprojection 2D treatment becomes impossible. Another downside is less degree of freedom so it requires more arc placement-vis-a-vis a standard LINAC.

However, with careful planning and execution TBI is feasible on HALCYON, especially in pediatric cases, and thisdeems useful in centers which have HALCYON as the only available LINAC. Similar feasibility attempts for whole-axis treatment on helical machines have been made at other centers as well [8]

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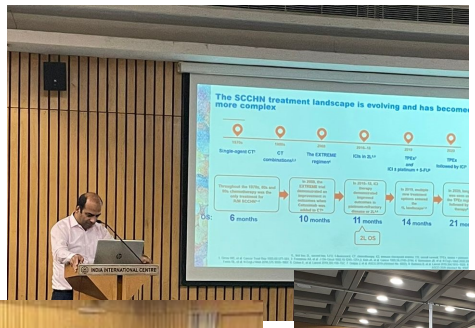
EVENTS IN HIGHLIGHTS

SOCIAL NIGHT (9th Apr 22)

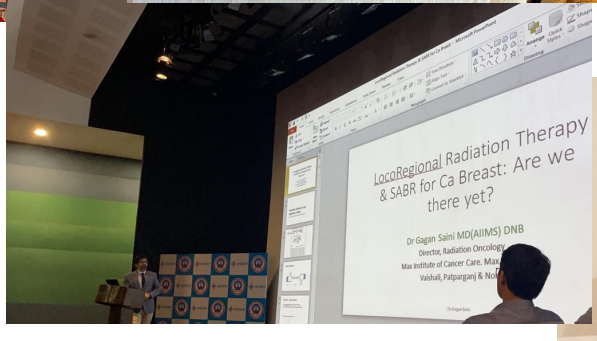
DNOG meeting IIC Delhi (29th Apr 22)

EVENTS IN HIGHLIGHTS

DHNOG (13th Apr 22)



DBOG (4 Jun 22)



ONCOLOGY FORUM CALENDAR JANUARY – JUNE 2022

DATE	PLACE	EXECUTIVE COMMITTEE-MEETING	ACADEMIC MEET-ING	ORGANIZING SECRE-TARY	DURATION
19.01.2022	Zoom	-	Geriatric Oncology Group (DGEOG)	Dr. Kanika Sood	6.00 pm on-wards
26.01.2022	Zoom	-	DNOG	Dr. Indu Bansal	6.00 pm onwards
02.02.2022	Zoom	-	DMOG	Dr. Amit Verma	6.00 pm onwards
09.02.2022	Zoom	-	DIOG	Dr. ArvindChaturvedi	6.00 pm onwards
16.02.2022	Zoom	-	DGIOG/DMOG	Dr. Swarupa Mitra	6.00 pm onwards
23.02.2022	Zoom	-	DBOG	Dr. Geeta K.	6.00 pm onwards
02.03.2022	Zoom	-	DUOG	Dr. Gagan Saini	6.00 pm onwards
09.03.2022	Zoom	-	DGOG	Dr. kanika Gupta	6.00 pm onwards
16.03.2022	Zoom	Executive Com-mittee	-	Ms. Nidhi Mittal	6.00 pm onwards
23.03.2022	IIC	-	DGIOG	Dr. Saphalta, Dr. Jaskaran Sethi, Dr. Sandeep Bhoriwal	6.00 pm onwards
30.03.2022	IIC	-	DHNOG	Dr. Sowrabh Arora	6.00 pm onwards
09.04.2022	Ambassador Hotel	Oncology Forum Social Night	-	Ms. Nidhi Mittal	7.00 pm onwards
13.04.2022	IIC	-	DHNOG	Dr. Gagan Saini	6.30 pm – 9.00pm followed by Dinner
29.04.2022	IIC	-	DNOG	Dr. Amal R Chaudhary Dr. Aditi Aggarwal. Dr. Suman Karanth	
15.05.2022	Zoom	EC	-	Ms. Nidhi Mittal	7.00 pm onwards
18.05.2022	IHC	-	DTOG	Dr. Jyotishman Saikia	7.00 pm onwards followed by din-ner
27.05.2022	IIC	-	DSCOG	Dr. Megha Pruthi Dr. Gaurav Chanana Dr. Raajit Chanana	6.30 pm onwards
04.06.2022	Asian Hospital	-	DBOG	Dr. Vikash Kumar	2.00 pm onwards

Do visit our website for membership details, field updates and upcoming events
https://www.oncologyforum.in/

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