IASO NEWSLETTER

August 2003
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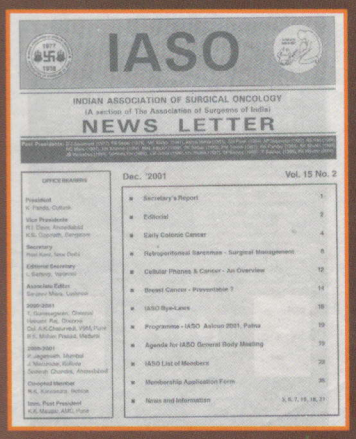

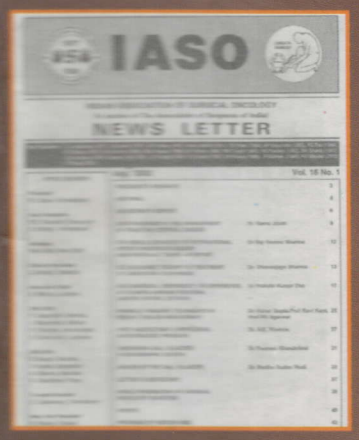

Silver Jubilee Celebration Year

Indian Association of Surgical Oncology

(A Section of The Association of Surgeons of India)

Indian Association of Surgical Oncology (IASO)

PRESIDENT	SECRETARY	YEAR
Dr. D. J. Jussawala	Dr. Ashok Mehta	1977-
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Dr. Ashok Mehta	Dr. N. C. Misra	1983-
Dr. D. D. Patel	Dr. N. C. Misra	1984-
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Dr. S. K. Sarkar	Dr. S. G. Deshpande	1990-
Dr. P. M. Trivedi	Dr. H. S. Shukla	1991-
Dr. K. K. Pandey	Dr. H. S. Shukla	1992-
Dr. S. K. Shukla	Dr. H. S. Shukla	1993-
Dr. J. B. Venkatrau	Dr. H. S. Shukla	1994-
Dr. Sambhu Pal	Dr. S. Kumar	1995-
Dr. C. K. Gupta	Dr. S. Kumar	1996-
Dr. H. S. Shukla	Dr. S. Kumar	1997-
Dr. S. P. Kharey	Dr. S. Kumar	1998-
Dr. P. Subhas	Dr. K. Kothari	1999-
Dr. K. K. Maudar	Dr. K. Kothari	2000-
Dr. K. Panda	Dr. Ravi Kant	2001-
Dr. R. I. Dave	Dr. Ravi Kant	2002-
Dr. K. S. Gopinath	Dr. L. Sarangi	2003-

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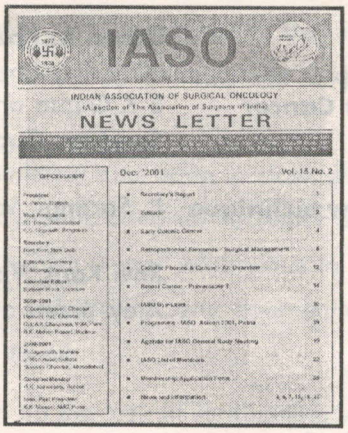

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President's Message

Dear Colleague,

I am greatly honoured and privileged to be the President of the IASO for the year 2003, the year of Silver Anniversary of the Association. Last 25 years we have witnessed the growth of specialty of Surgical Oncology in this country due to saga of service of all the Past Presidents of this association. The aim and objective of the association is to disseminate knowledge and skill to its members through workshops, CME programs, conferences etc,.

The purpose of newsletter or bulletins is to bring in close proximity between its members and the executive committee. The dynamic Editorial Secretary and Associate Editor have worked hard to bring in the newsletter, which is very informative to all its members. My appeal to all members is be proud of your association and contribute the scientific materials to this newsletter, which will be useful to all.

During this year we have taken up the task of formulating various committees to go in depth into the smooth running of the association with the idea of bringing out the manual of current practice of Oncology, I hope by the end of the year we will be able to full-fill and bring out the volume which contains management of common cancers in India.

We have to strengthen the specialty of Surgical Oncology by formulating structured training programme so that young general surgeon will develop keen interest in taking up the specialty.

I congratulate and thank editorial committee for bringing out IASO newsletter.

Dr. K.S. Gopinath
President, IASO 2003
Bangalore

Editorial

Changing Face of the Newsletter .....

The Indian Association of Surgical Oncology has complet glorious years. The association which started with few membe has over 500 members. Twenty five years may not be much organizations life time but it is definitely a milestone. An occas rejoice and a land mark to pause and ponder. The first Newsl the association which started as a four page publication by the Dr. N.C. Misra in 1979; what is the new discipline of Su Oncology was defined and elaborated in that Newsletter by the Editorial since then the Newletter has grown over the years and Surgical Oncolog established super speciality now. The newsletter has undergone changes from time t adding newer dimension to it. The quality of articles and published reports has improve time. With this hope of further improving the newsletter we have changed the cover a format of the newsletter. We have tried to make it more attractive and appealing. The q of articles is of very high standards. But this change is not the last one for the newslet still need to incorporate more changes in it like we do not have a standard form submitting articles for the newsletter. I would request you to send articles following the sta instructions for authors which can be obtained from the website : www.icmje.org. We also request the members to send their achievements, awards, conference/meeting repo organized by them so that they may be published in the newsletter. We also invite to symposium / panel discussion for the NATCON at Jaipur in 2004 and for the Se programme of IASO at ASICON 2004.

We hope you would like the changes in the Newsletter format and we invit suggestions and comment so that we can improve it further.

Dr. Sanjeev Misra
Lucknow

Secretary's Report

Dear Members,

I welcome you all to the National "Silver Jubilee" conference of the Indian Association of Surgical Oncology. I must express my deep sense of gratitude to all our past Presidents and senior members whose continuous and relentless efforts guided the association to this stage. We shall need their guidance and suggestions in future also.

At the beginning of this year an ambitious agenda for 2003 had been proposed and circulated to all the members in March. We have put in our sincere efforts to achieve the target.

1. NATCON 2002 – The NATCON at Ooty was highly successful. There was an active participation by nearly 500 delegates from India and abroad. The symposia on Conservation in Surgery, Cancer Surgery in Elderly, Predictive Oncology were well appreciated. All the guest lectures by overseas and national faculties captivated the audience and enriched their knowledge. The poster presentations and free papers were of very high standard. The Detroit fellowship for 2003-04 was awarded to Dr. K.A. Pathak of Mumbai. President and members of the Association enthusiastically lauded Dr. S. Sadashivam and his team for an excellent conference.

2. ASICON 2002 – In the new format of the scientific program adopted by the ASI the sectional programs were amalgamated to have a larger audience participation. The guest lecture by Dr. Ravi Kumar of USA on Radio Frequency Ablation was a real eye opener for most of the clinicians. The symposium on Carcinoma Breast convened by Dr. B.Fanthom and the IASO oration by Dr. K.Panda were of high standards. The panel discussion on Colorectal Cancer by D. K.S. Gopinath needs a special mention because of the overwhelming attention and participation of the audience. The symposium on Carcinoma Stomach convened by Dr. A. Sengupta jointly with Gastroenterology section was appreciated by all.

3. CME Programs – We have all decided to have 8 CME programs, 2 in each zone of the country on common malignancies to disseminate the knowledge of standard care of cancer in surgical fraternity. Till September 2002, four such programs have already been organized at Patna (Dr. Amitabh Singh, IGIMS), Pune (Dr. Sanjay Kapoor , AFMC), Ranchi, (Dr. Ajay Vidyarthi, CCL Hospital), Cuttack, (Dr. K. Panda, Panda Medical Centre).These programs were well attended. The speakers who shared their knowledge were senior members of our association. At Ranchi a one day Workshop was conducted with demonstration of a commando operation and a double flap reconstruction. We have invitations from Jamshedpur and Bokaro for similar programs.

4. NATCON 2003 – This Silver Jubilee NATCON will remain a memorable one. Organizing Committee has done a wonderful job and I am grateful to all the Past Presi overseas speakers and the national faculty who are attending the conference.

5. Detroit fellowship – Dr. S.V.S.Deo of AIIMS has availed the Detroit fellowship in A 2003. Dr. Donald Weaver has been intimated about the selection of Dr. K.A.Patha 2003-2004. The association shall remain ever grateful to Dr. Weaver and Dr.Maudar.

6. Baroda travelling fellowship – I am forced to say that there is not enough enthu in our younger colleagues for "The Baroda Travelling Fellowship". It may be due inade publicity. However a couple of applications have been received this year.

7. ASICON 2003 AT PUNE – There will be 2 symposia – one on "Bone Tumor" b M.Ganguly and the other one on "Carcinoma Esophagus" convened jointly wit Cardiothoracic section by Dr. S. Sharma. The IASO oration has been renamed as "The Jubilee IASO oration" and will be delivered by Dr. P.B. Desai. Two overseas speake Raashid Shabhazi of Ireland and Dr. Ramshaw Bruce of USA have consented to deliver lectures. The association is again thankful to Dr. Maudar for arranging them at s notice.

8. NEWS LETTER – Dr. Sanjeev Misra , Editorial Secretary has done a commendable producing such an excellent newsletter in spite of being the organizing secretary. It spe his worth, commitment, and stamina. With the progressively improving version newsletter, I am confident that this will ultimately emerge as the surgical oncology jou India. Members are requested to contribute evidence based, quality articles to fu dream.

9. FINANCE – At present the IASO has a fixed deposit of one FD of Rs.90000.00 mat February 2003 and has already been reinvested. I request the organizing secretaries past, present and future to contribute to the IASO fund. An organization financially via comfortably think of promoting more fellowships.

10. WFSOS – Dr. R.I. Dave has been nominated as the official representative of IA WFSOS. The membership subscription arrear has been cleared by him and he has participated in the international conference in Los Angles. We are thankful to him.

11. IASO – guideline for common malignancies – This has been in the agenda for 20 some preliminary work has already been done. We have identified the areas and the g to formulate the guidelines. With everybody's cooperation this may see the light the da end of 2003.

12. Fellowship in Surgical Ongology – It has been a long cherished dream association to introduce a fellowship in "Surgical Oncology" similar to the existing

"Colorectal section". Careful planning is needed in the formulation of the curriculum, training schedule and examination module. We are grateful to Dr. R.B. Singh and Dr. Ashok Ladha for their valuable suggestions.

13. Membership Drive – At present our membership is around 500. We have already inducted 30 full members and 11 associate members in the last 6 months. The membership drive must continue to bring in active surgical oncologists into the folds of IASO.

14. Future Directions - The future of the association lies in its acceptance by governmental and non-governmental agencies as the nodal body of cancer care in this country. It is a long, arduous path to be travelled with caution and great care. Our president has already written to MCI to start a DNB in surgical oncology. IASO practice manual and fellowship in surgical oncology will add extra feathers. The various sub committees formed at Ooty must be made functional. All these collective efforts can enhance the status of the association and help in achieving our goal.

At the end I once again thank all the members for their cooperation and help. I wish the conference a great success.

Yours sincerely

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Oncologic Rationale for Bilateral Tonsillectomy in Head and Neck Squamous Cell Carcinoma of Unknown Primary Source

Rehan A. Kazi

ABSTRACT

Objective : To demonstrate an oncologic basis for the recommendation to perform bilateral tonsillectomy as a routine measure in the search for a primary mucosal lesion in patients presenting with cervical nodal metastasis of squamous cell carcinoma (SCC).

Study Design : A case series of individuals selected from a 3-year period is reported.

Setting : Masina Hospital, Bombay -Academic medical center.

Results : Each individual presented with metastatic squamous cell carcinoma in a cervical lymph node from an unknown primary source. In each case, the primary, either located contralateral to the node, or in both tonsils.

Conclusions : The rate of contralateral spread of metastatic cancer from occult tonsil lesions appears to approach 10%. For this reason, bilateral tonsillectomy is recommended as a routine step in the search for the occult primary in patients presenting with cervical metastasis of SCC and palatine tonsils intact.

INTRODUCTION

The presentation of cervical metastatic head and neck squamous cell carcinoma (HNSCC) from a clinically occult primary is an unusual event, classically estimated as accounting for less than 5% of all HNSCC.[1] The actual rate of "unknown primary" cancer in any series of HNSCC depends on the definition applied when a case is assigned that designation. The recommended work-up for individuals presenting with metastatic SCC without an obvious mucosal primary site currently includes computerized radiographic evaluation and examination under anesthesia with biopsies taken from specified sites that may commonly harbor occult mucosal lesions.

There is growing support for the practice of tonsillectomy as a part of the screening directed biopsies used in the work-up of these patients. Several clinical series including our own have been published in the last decade indicating that an occult primary mucosal lesion can be identified in a tonsillectomy specimen in upwards of 30% of cases.[2-6] Our rationale for bilateral tonsillectomy was to create a symmetric faucial arch to avoid confusion during the clinical post treatment surveillance for recurrence and second primary cancer and to capture the rare case of bilateral disease. Subsequently, we have identified 3 individuals who present with unilateral metastatic SCC in a cervical node and were found to have a primary lesion only in the contralateral tonsil. Finally, there were 2 individuals with bilateral nodal metastases and found to have an invasive carcinoma in one tonsil and an in situ lesion in the other. These cases prompted a renewed evaluation and repeated emphasis of the oncologic value of bilateral tonsillectomy.

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Methods

The tumor data bases of the Department of Otolaryngology – Head and Neck Surgery, Masina Hospital was searched for all cases of metastatic cervical SCC requiring directed biopsy including tonsillectomy from 1998 through 2002. Those cases in which a primary lesion was identified in the contralateral tonsil were selected for detailed review.

Result

A total of 25 cases meeting the search criteria were identified. Twenty of these individuals had no primary source identified or had a tongue base primary lesion discovered. Five had a small cancer in the palatine tonsil. Of these 5, 3 were identified with cancer contralateral to the metastatic lymph node, and 2 had bilateral tonsillar primary lesions.

Case Report

1. MA, a 55-year-old male presented with a right-sided level-II cervical node containing metastatic SCC. Clinical examination and CT revealed no obvious primary mucosal lesion. At excisional biopsy and biopsies of the pyriform sinus and base of tongue: all results were negative for tumor. On referral to our clinic, bilateral tonsillectomies were performed in conjunction with panendoscopy. Both tonsil specimens contained small foci of SCC. The patient went on to have a right modified radical neck dissection and postoperative radiation therapy encompassing all Waldeyer's ring and the right neck.
2. HM, a 70-year-old male presented with a left sided level II-III cervical lymph node containing metastatic SCC. Bilateral tonsillectomy was performed in conjunction with a panendoscopy and directed biopsies. The right tonsil was found to contain a small focus of squamous cell carcinoma. The patient went on to receive radiation therapy to the left neck.
3. HA, a 61-year-old male presented with a large right-sided level II lymph node with extranodal extension of SCC. At the time of panendoscopy, he was found to have a slightly firm left tonsil on palpation. Excision of both tonsils was performed and the initial frozen section confirmed SCC in the left tonsil. The patient went on to receive radiation therapy to the oropharynx and both necks after a right radical neck dissection.
4. MH, a 71-year-old female with bilateral neck masses were found to contain SCC by fine needle aspiration biopsy. Clinical examination revealed no obvious primary source, and so the patient underwent examination under anesthesia including bilateral tonsillectomy. The left tonsil was found to harbor a T1 primary lesion, whereas the right tonsil contained carcinoma in situ. She went on to have bilateral modified radical neck dissections, followed by postoperative radiation therapy to both necks and Waldeyer's ring.

Discussion

The 4 cases presenting with cervical nodal metastasis contralateral to a minute tonsil primary lesion represent approximately 10% of the 41 individuals with HSNCC without clinically obvious primary lesion at our institution over the 3-year period. In case 1, the metastasis most likely spread from the ipsilatral tonsil, however, a unilateral tonsillectomy would have missed the second primary lesion in the opposite tonsil. Cases 2 and 3 both harbored primary lesions in the tonsil opposite the presenting neck node. The metastases in cases 4 most likely both emanated from the small invasive cancer. If that is true, this tonsil cancer spread bilaterally. Once again, a unilateral tonsillectomy would have left behind a lesion with high malignant potential in the contralateral tonsil.

Lindberg's[7] classic article tabulating the incidence of nodal metastasis at various levels of the neck in patients with tonsil cancer indicates an approximate rate of contralateral nodal spread from a tonsil primary of 10%. That figure, however, is derived from cases of clinically obvious primary cancer. The phenomenon of contralateral cervical nodal metastasis as the only presenting sign of head and neck SCC would seem to be a much more unlikely event. Tonsil tumors typically spread to the subdigastric node (level II), but may also involve mid and low jugular nodes.[8] Cystic neck masses are also characteristic of metastases from tonsillar HNSCC.

The identification of a primary mucosal lesion in the patient who present with a cervical nodal metastasis has several clinical benefits. First, it permits the complete surgical excision of the primary cancer. Wide local excision with neck dissection may alone be curative in some cases without the need for radiation therapy. In the setting of more aggressive disease for which radiation is indicated, the identification of a primary site can influence treatment delivery and may preclude the need for wide filed coverage of Waldeyer's ring, or the larynx.[5] If the contralateral parotid gland and nasopharnx can be spared, severe xerostomia and related delayed complications may be reduced. However, this would clearly not be desirable for a patient who has metastatic spread from a contralateral primary site in the tonsil. Thus, the certain identification of primary lesion helps to accurately direct the focus of radiations therapy. Finally, the identification a primary lesion assists the oncologist in postreatment surveillance for recurrent disease by focusing attention to the known primary site. For all of these reasons it is quite desirable that the primary site be identified.

Bilateral tonsillectomy adds little by way of morbidity to a unilateral excision. If it reveals the primary site in even 10% of cases, bilateral tonsillectomy would be a highly useful measure. Based on our experience, it is advised that every patient who presents with cervical metastasis of head and neck SCC without obvious primary mucosal disease and in whom the palatine tonsils are present undergo a bilateral tonsillectomy.

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Treatment of Axilla in Breast Cancer

S K Gupta and Sandeep Gupta

Introduction

Breast cancer remains the most common cause of cancer in women and is the second leading cause of cancer death. The surgical management of breast cancer has evolved over the last 40 years from radical ablative procedures to breast conservative surgery as the preferred method of treatment for early stage disease. The presence of axillary lymph node metastasis remains the best prognostic indicator for patients with breast cancer and the main stay of surgical management of breast cancer has included the removal of level I, II and at times level III axillary lymph nodes. The presence of axillary nodal metastases is often used to identify patients who would benefit from adjuvant treatment or a more aggressive adjuvant therapy regimen. However, over the last 10 years, the need for adjuvant therapy has often been based on the primary tumor characteristics (lymphatic / vascular invasion, tumor size, nuclear grade, tumor palpability, perineural invasion, S-phase using flowcytometry, over expression of oncogenes, absence of estrogen, receptors, high proliferative indices, tumor aneuploidy, presence of C-erb B2 or Cathepsin D) and an increasing number of node negative women are offered adjuvant therapy. This has led some to question the need for axillary surgery.

In the Halstedian era, surgeons believed that resection of a node negative breast cancer was curative believing that such tumors were excised before distant spread occurred through the axillary lymphatics. Eventually the long term follow up studies of axillary node negative patients revealed that 30% die of metastatic breast cancer. Today the Halsted paradigm is no longer considered valid. Regional lymph node metastases are not considered a prerequisite for distant metastasis. Nonetheless, axillary treatment remains an integral part of management of primary breast cancer, indicated for invasive breast cancer but not for in situ lesions.

Axillary Lymph Node Dissection (ALND)

This refers to extirpation of lymph nodes in the axilla. It is of 3 types:

1. Complete ALND dissection of axillary nodes from level I to level III
2. Partial ALND dissection of level I and II
3. Axillary SAMPLING removal of nodes from level I

In most cases metastases to axilla occur sequentially. Skip metastases are seen in only 4% of patients. Thus most authorities recommend a level I and II dissection (partial ALND) which generally results in the removal of 10 or more lymph nodes. It correctly stages 96% of the patients with primary breast cancer and rarely gives rise to significant lymphedema of the upper extremity. Removal of level III nodes provides little additional prognostic information and increases the risk of arm lymphedema.

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Prognostic Importance of ALND

Axillary lymph node status is the most important prognostic indicator in breast cancer and the prevalence of axillary metastasis is associated with reduced overall and disease free survival. The number of axillary nodes also has prognostic significance. The results at a national survey by American College of Surgeons indicate 72% survival rate and 19% recurrence rate in the absence of any axillary nodal disease. These figures change to 63% and 33% in presence of one positive lymph node and to 52% and 44% in the presence of four positive lymph nodes.

Therapeutic value of ALND

These is substantial evidence that ALND provides excellent local disease control in the axilla with a local recurrence rate of 2% or less. Control of local disease within the axilla is essential as uncontrolled axillary clearance can be exceedingly unpleasant to the patient with a significant reduction in the quality of life. Moreover it is a difficult condition to treat. The NSABP trial protocol B-04 however concluded that failure to treat involved axillary nodes is not associated with a worse survival outcome.

Arguments in favour of ALND

Complete axillary clearance is a simple surgical procedure which provides excellent local tumor control and in expert hands carries minimal morbidity. It provides complete staging and the best widely available prognostic information. Although the proportional reduction of odd of death with adjuvant systemic therapy is similar (30%) in both node negative and node positive patients, the absolute benefit is more in node positive patients.

Arguments Against ALND

If lymph nodes are not involved, there is no survival advantage for the patient. This part of the operation, however, is responsible for most of the inpatient costs, operating time and subsequent morbidity. Moreover axillary irradiation provides comparable local control and the decisions about adjuvant systemic therapy can be made without axillary nodal status based on the histology and biological parameters of the primary tumor. The prognostic information that is not gained by not dissecting the axilla could be guessed fairly accurately by the characteristics of the primary tumor. It would be sound advice to only dissect an axilla with involved nodes as detected by clinical examination, imaging and USG guided cytology. Papaioannou speculates that the regional lymph nodes are important components of resistance against breast caner and that extirpation of these nodes may even adversely affect survival.

Morbidity of Axillary Treatment

Axillary treatment is often associated with a significant morbidity that adversely affects the quality of life. Potential complications of axillary treatment include wound infection and morbidity of upper extremity, stiffness, loss of sensation, pain, swelling, brachial plexopathy, lymphedema with increased incidence of lymphangiosarcoma in the affected arm.

Today more than half the patients with primary breast cancer are node negative. If the status of the axillary nodes could be determined preoperatively those who are node negative could be spared any interference to the axilla and thus the potential morbidity be reduced. Unfortunately, clinical examination and the present imaging techniques are not reliable. Pathologic staging of the axilla is therefore necessary. Various methods short of a full axillary dissection to obtain lymph nodes for histologic staging have been tried. These are:

Methods to obtain lymph nodes for staging the axilla:

1. Pectoral node biopsy: Cant et al reported that there was a consistent lymph node in the parenchymatous axillary tail but later the same group showed that no lymph node could be identified at this site in 1/3rd of cases. Among patients in whom a pectoral node was found and was negative with no further treatment given to axilla, the axillary recurrence rate was higher than among those who had further treatment to axilla. This technique was therefore abandoned.

2. Tripple Node Biopsy: It requires sampling from lower axilla, apex of axilla and internal mammary chain. The Nottingham group showed this to be a valuable predictor of outcome. They have confirmed that lower axillary nodes were invaraibly involved when the higher lymph nodes were positive. This technique gives valuable prognostic information but it is more difficult elaborate to perform particularly when treating patients by breast conservation.

3. Four Node Sample Technique: The Edinburgh group developed a four node sample procedure in which surgeon had to pick out by inspection and palpation at least four lymph nodes from axillary tail and lower axillary fat. On comparison with axillary clearance it was seen that node positivity was same in two groups.

Sentinel Node Biopsy

The recent introduction of sentinel node biopsy provides a less invasive, but highly accurate alternative of axillary assessment to axillary node dissection and permits avoidance of axillary dissection in patients with negative nodes. The concept of sentinel node is based on the principle that this is the first lymph node to receive lymphatic drainage from a tumor. One might assume that if sentinel node is free of metastatic tumor, then all other lymph nodes in the basin should be free of tumor. Alternatively involvement of the sentinel node may indicate that other nodes in the basin are involved.

The surgeon identifies the first draining lymph node by injecting blue dye or radioactive colloid intradermally around the primary tumor. The sentinel node is removed and sent for histopathology and/or immunohistochemistry and the results dictate the further treatment.

Controversies Regarding SNB

Definition

Different investigators have defined a sentinel node in different ways.

(a) According to some (and the most widely accepted one) a sentinel node is either a blue or radioactive node and every blue and/or hot node is a sentinel node. They disregard the fact that some of the tracer tends to pass through the first tier lymph nodes and lodges in the secondary nodes that are not directly at risk of harboring metastasis. Hence this definition is too broad and leads to the situation where too many nodes are removed. Removal of secondary nodes is of no additional value if the sentinel node itself is positive.

(b) Another definition is that the first lymph node that becomes visible on lymphoscintigraphy images. But there may be more than one sentinel node as in case of two lymphatic ducts originating from the primary tumor running in two different lymph nodes. Because of a preferential flow, one node may be appearing on images earlier. On the other hand, the decreased flow to other node may be caused by tumor

deposit at enterance of lymphatic duct. Thus this definition is too narrow and too few nodes are labeled sentinel and metastases may be missed.

Techniques

(a) Ideal size of colloid particles is not known. Large size particles fail to migrate and tend to remain in the interstitium at the site of injection. Small sized travel so quickly that secondary nodes light up as well and they tend to penetrate capillaries and enter the blood stream.

(b) Dose of injection is also controversial with a range of 0.2 to 4.0 ml, a 20 times difference. Small dose does not disturb the physiology of lymph flow and avoid the risk of visualizing non-sentinel nodes. Advocates of large dose say that they do want to change the physiology and thereby increase the chance of visualizing a lymph node.

(c) Place of injection Injecting in the overlying skin increases the false likelihood of depicting a lymphatic duct and a lymph node because drainage from skin is far richer than drainage from breast parenchyma. Injecting farther away from lesion carries the risk that a watershed is crossed and a node is visualized that drains another area of breast and not the area with the tumor.

Finding the Sentinel Node

There has been a percentage of patients in whom a sentinel node could not be identified and a percentage in which sentinel node was falsely negative. Failure to identify a sentinel node in a node positive patient is a failure of the technique.

Prognostic Information

SNB does not by itself given sufficient prognostic information. Patient who have a positive SNB would require a second procedure (axillary clearance) to obtain sufficient prognostic information thus increasing the cost and psychological implication.

Pathological Examination

Various techniques like frozen section biopsy, imprint cytology, hematoxylin and eosin staining of tissue sections and cytokeratin immunohistochemistry have been used. While frozen section and imprint cytology provide on the spot (i.e. during the surgery) results, they are not very accurate and have high false negative rates. On the other hand, it is not realistic for a pathologist to make a large number of slides from a lymph node and examine them. Finally the cytokeratin immunohistochemistry is not widely available. Thus micrometastases may remain undetected.

False Negative Rates and Clinical Relevance

The false negative rates of SNB have been calculated in most studies where complete axillary dissection was also performed after SNB. The clinical relevance of such low false negative rates is unknown since very few studies are available where axillary clearance was not done after negative SNB. Thus the clinical recurrence rate is unknown.

Arguments in Favour of SNB

1. It can be argued that sentinel nodes sometimes are removed from locations that would not be touched in a routine axillary node dissection.

2. The pathologist is inclined to spend extra time and energy examining the sentinel node. After all the surgeon removes one or at the most few lymph nodes and not 20 or so in axillary dissection. The pathologist thus receives the nodes with the greatest possibility of harboring metastasis and can submit such nodes to more detailed examination and using immunohistochemistry.

3. The prognostic information that is not gained by not dissecting the axilla can be gained from the primary tumor characteristics itself. Thus the decision to give adjuvant systemic therapy can be guided by tumor characteristics.

4. The literature is studded with studies that indicate that false negative rates of the SNB is with in acceptably low limits. These studies are based on the principle that formal axillary dissection follows every SNB and a negative report of axillary disasection specimen testifies the negative sentinel node.

5. In the recent times, studies are emerging where axillary dissection is not done after negative SNB and patients are clinically followed up, to detect recurrence. Veronesi et al followed 285 patients of early breast cancer with negative sentinel nodes and no axillary dissection. They have accumulated 343 person years at risk and no patient has developed axillary metastasis.

Conclusion

Treatment of axilla with either radiotherapy or surgery remains an integral part of management of patient with invasive breast cancer. Once lymphatic dissemination to the axilla is established, it is generally accepted that treatment of axilla is indicated. In clinically overt disease, complete axillary lymph node (ALND) dissection provides the best axillary tumor control. There is as yet no evidence that axillary treatment improves survival, but the issue remains controversial. If the lymph node metastasis are found in the ALND specimen, in general axilla is sufficiently treated except in extensive dissemination: arbitrarily more than 4 positive lymph nodes, a positive apical node, extra nodal growth which are indicators for adjuvant radiotherapy. With increased emphasis on mammographic screening and early detection, the incidence of node positive breast cancers is decreasing. Today only about 30% to 40% of all invasive breast caners are node positive. Thus in most cases, the potential morbidity of ALND could be avoided if the status of the axillary nodes were ascertained with a less invasive procedure.

The current prototype for this selective axillary management is the sentinel lymph node biopsy with lymphatic mapping. This technique has shown a high accuracy rate, an acceptabily low false negative rate and low morbidity. It can eliminate the need for general anaesthesia, surgical drains, in patient hospital stays and lymphedema in a significant number of patients. It is vastly superior to ignoring the axillary node. It is also unlikely that imaging modalities will surpass lymphatic mapping and sentinel lymph node biopsy in the near future, as most metastatic disease is microscopic and below the resolution of present technologies.

If after SNB, lymph node metastasis are found, there is a substantial risk that there are more tumor positive nodes left behind in the axilla. These findings justify elective treatment of axilla in the form of either complete ALND or radiation therapy. What treatment leads to the best regional control with the least toxicity and long term morbidity remains to be established.

The main controversy lies in treatment after negative SNB. The current concept is to leave axilla as such (i.e. no completion ALND) and to follow the patient.

But it must first be demonstrated beyond any doubt that SNB (without completion ALND) does not adversely affect outcome. Randomized controlled trials must address these concerns and

surgeons must await completion of these studies before accepting SNB as the standard of case.

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NEWS

The first Four articles published in World Journal of Surgical Oncology (WJSO) (www.wjso.com/start.asp) have now been listed in Pubmed (MEDLINE). The data base has been linked and now the articles published in WJSO will be availble in Pubmed within 48 hours of becoming live on WJSO website. We have also made arrangements for automatically updating the home page of the journal, it was being done mannually and hence there was a disparity between home page (start.asp) and browse article page (browse.asp). You would have also noticed that the access to WJSO is now faster as it has been transferred to new system. Thank You all for your help and cooperation, Let's work together to establish WJSO as one of the best journals in Surgical Oncology. The next step will be to get more articles and improve citations, so as to achieve a good impact factor.

Dr. Manoj Pandey
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References

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Breast Duct Endoscopy—A new technique

L. Sarangi

Breast cancer either starts in the lining of lactiferous duct or in the lobule, an area to which there is no direct access other than the tissue that is removed surgically or by fine-needle aspiration. Various intermediate markers like atypical epithelial hyperplasia, ploidy, p53, epidermal growth factor receptor have been identified to assess the relative risk of development of cancer breast. To obtain cells for identification of these markers researchers have to depend on nipple discharge fluid or cells collected by fine needle aspiration (FNA). But in cases where the changes are limited to one ductal system, the chance of finding these markers by FNA or pooled fluid from all ducts is small. So attempts were made to visualize or retrieve ductal cells by a technique called breast duct endoscopy to study the of biology of the premalignant & malignant lesions. This technique was first published in 1991 by Makita et al[1] to evaluate the nipple discharge. He used a 1.2 mm rigid ductoscope to identify duct papilloma. Subsequently thinner, flexible scopes have been devised which allow cannulation of the ducts with less trauma. This technique is still in its infancy and various pilot studies have been published.

Procedure

The breast is prepared and draped. A pair of magnifying loupes helps in identifying the duct orifice. One or more ducts cannulated with a rigid metal duct-probe (6 fr) and dilated up to 0.45-0.5 mm. A right angled cannula inserted (0.4mm diameter) into the duct orifice and 0.20-0.50 ml physiological saline instilled to wash the duct lumen. The washing collected and analysed cytologically. Some workers instead of washing the duct aspirate the duct fluid and stated to be more representative. In their opinion only premalignant duct yields fluid and the normal ducts are less likely to shed cells and/or yield fluid on stimulation of the nipple; non yielders have a low subsequent risk of breast cancer[2]. The duct lumen is then dried by injecting 0.20-0.50 ml of air. At the end of final insufflation, the orifice is held shut by pinching the end of the nipple. A fibreoptic endoscope (0.4mm) is threaded into the duct orifice while maintaining the dilatation of the duct with air. The endoscope inserted 5 to 10 mm and position confirmed on the monitor screen. The cannulation continued as far distally as possible. Some times saline is instilled instead of air to maintain the dilatation[3].

Indications

At present the indications are less defined. They revolve mostly around nipple discharge, bloody or serous. Some workers employed it routinely before lumpectomy in Ca. Breast. Love et al[3]. in their pilot study, 9 cases (DCIS or invasive breast cancer diagnosed by previous excision or core biopsy) were subjected to duct cannulation and endoscopy by 0.4 mm ductoscope under anaesthesia just before mastectomy. Ductal lavage fluid was collected after cannulation and before endoscopy. 7 patients could be successfully cannulated and fluid cytology done. They concluded that breast duct cannulation and endoscopy can give access to the milk ducts, yield cells that can be analyzed for intermediate markers and give information about the anatomy of the ductal system and the pattern of DCIS.

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Dooley[4] employed the technique routinely as a part of the operative procedure for bloody nipple discharge. He could scope successfully 26 out of 27 patients and in all of them at least one lesion accounting for the bleeding were seen. In 19 patients multiple intraluminal defects identified, two early caners detected and in both the cases there was a more proximal papilloma in the same duct system. He concluded that as there is high incidence of multiple lesions, a classic blind resection of a limited distance of the duct in the retroareolar space may significantly underestimate the true extent of proliferative disease accounting for pathologic nipple discharge.

In a more recent study Dooley[5] also did breast endoscopy routinely during lumpectomy. Out of 201 patients 150 could be successfully scoped. Additional lesions outside the anticipated lumpectomy were identified in 41% of cases, there by reducing the chance of a positive margin from 23.5% to only 5%. So it can reduce the need for re-excision lumpectomy and can also find substantially more cancerous and precancerous disease than anticipated by routine pre-operative mammography and ultrasound.

The intraductal approach to early breast cancer diagnosis is gaining momentum and a series of research papers have been published in past couple of years[6]. This is opening a new insight into the breast duct system in identifying the premalignant changes that herald or accompany cancer breast. It's potential as an aid to surgeons to decide on the margins and depth of resection needs a closer look and duplication of results.

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OBITUARY

We mourn the passing away of

DR. RAJESH BHADWAR

Surgeon, Tata Memorial Hospital, Mumbai.

IASO - Baroda Travelling Fellowship

Rs. 5000/- only will be provided to a young surgeon who is aspirant to and has arranged attachment / observership with a Surgical Oncologist / Centre in India for 4 to 5 weeks.

An application on a plain paper enclosed with the Curriculum Vitae, place of attachment, acceptance from the centre, short objectives of the reasons for attachment and forwarding letter from the 2 members of the Indian Association of Surgical Oncology (IASO) should be sent to the office of the Secretary, IASO. The applicant must be MS in Surgery and citizen of India.

This newsletter of IASO is going to be a regular feature and will be published twice a year. It will contain relevant professional news, events and recent topics of common interest. Members are requested to make use of the newsletter for dissemination of any valuable information.

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ANNOUNCEMENT

Detroit Medical Centre, Wayne State University, USA has instituted a visiting fellowship for four weeks at their centre for a young member of IASO, The fellow has to arrange his own passage. He will be provided free accomodation and sustenance allowance.

Those members desirous to apply for 2005-2006 may do so by sending their bio-data, research papers and publications to Secretary IASO. The candidate must be below 40 years and he is required to present a research paper during **NATCON'2004** at Jaipur, as a part of selection process.

Application must reach Secretary, IASO by 30th June' 2004

Controversies in Melanoma

Ravi Kant, Vishal Gupta, Ajay Yadav and Bina Ravi

Biology of melanoma development and progression

Clinical and histologic studies have resulted in defining distinct steps of melanoma development and progression. Progression includes melanocytes to nevus to dysplastic nevus to radial growth phase to vertical growth phase to metastases. The transition from mature melanocytes to the formation of nevus is characterized by loss of cell to cell cross talk between melanocytes and keratinocytes, leading to escape of the melanocytes from the regulatory control of keratinocytes.

Melanoma cells express all major groups of adhesions receptors including Integrins, adherine, and cellular adhesions molecules. Melanocytes express E-adhering while melanoma cells express N-adhering. E-adherine allows melanocytes to adhere to keratinocytes, while melanoma cells can not adhere to keratinocytes. With progression, melanoma cells show an increase in production of growth factors and cytokines. bFGF is the most significant autocrine growth factor in melanoma. Blocking of bFGF production by antisense oligonucleotides stops melanoma cell proliferation. The biologically most significant stimulating growth factor for tumor infiltration of fibroblasts is PDGα. Melanoma cells produce both A and B isoforms. PDGF is mutagenic for melanoma cells, induces the production of fibronectin and collagen, which provide melanoma cells scaffolding to which to adhere. In early melanoma, infiltrating Europhiles and monocots mat have a stimulatory role for tumor by producing angiogenic cytokines such as TNFa . High production of these chemokines can lead to a strong infiltration of the inflammatory cells, which can kill the malignant cells.

Melanoma : Screening

Who should examine patients dermatologist or non-dermatologists ? Although dermatologists have superior accuracy compared with nondermatologists in the diagnosis of melanoma. There are few dermatologists for all routine screening[1]. Dermatologists are generally more qualified in identifying these lesions. Screening for melanoma by a dermatologist has a sensitivity of 89% -97% and positive predictive value of 17-75%[2].

To determine the sensitivity and specificity of dermatologists in screening for melanoma, Raman and colleagues[3] followed up on 1551 patient with negative screening skin examination results. They found 15 new skin cancers. Three were nonmelanoma skin cancers that were present at the original examination. They calculated a screening sensitivity of 93% and specificity of 97%. The positive predictive value was 99.8%. Their data supports the better professional education and periodic skin examination by skilled healthcare providers.

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Is routine full-body skin examination necessary ?

The controversy over screening skin examination is highlighted by a study reported by De. Rooiji et al[4]. No histologically confirmed cutaneous melanoma was found on skin examination performed on 1221 subjects seen during screening for melanoma.

Conversely, Berwick et al[5] reported a reduction of melanoma incidence and advanced disease in those who practiced skin self-examination. Skin self-examination can prove to be a useful and inexpensive method of screening.

Large, well-designed, prospective studies need to be conducted to identify the most effective approach to screening.

Prognostic factors

Tumor thickness vs Level of invasion – Prognostic value.

Prognostic values to tumor thickness (Breslow's) and level of invasion (Clark's level) have been compared in studies using single factor and multifactorial statistical analysis. Vollmer evaluated 54-multivariate analysis of prognostic factors using data from 48 papers[6]. Tumor thickness was significant in 42 of 54 studies; where as level of invasion was an important prognostic factor in only 8 of 48 studies. Buttner et al[7] examined the prognostic value of the combination of tumor thickness and level of invasion of 5093 patients. By multivariate analysis, the combination of tumor thickness and level of invasion were found to be prognosticating less significantly than tumor thickness alone. When tumor thickness was correlated with survival, it was found that relative risk of death from melanoma as a function of tumor thickness was nearly linear to 6mm, and that stratification of tumor thickness with cut off of 1mm, 2mm and 4 mm resulted in the best fit for these data. They therefore suggested that the current tumor thickness cutoffs of 0.75 mm, 1.5mm and 4mm be changed to 1mm, 2mm, and 4mm because these strata were slightly superior in establishing prognotically distinct groups and simpler to use.

This observation is further supported by study by Buzaid et al[8] after analyses of 4568 patients of primary MM; they found that tumor thickness and ulceration were the most important prognostic indicators. In contrast level of invasion was significant in only the subgroup of patients with tumor thickness ≤1mm. Furthermore, the best statistical fits for tumor thickness cutoffs were at 1, 2 and 4 mm.

Although the controversy regarding tumor thickness and level of invasion continues, above studies suggest that the Clark level of invasion is a minor prognostic factor. Simpler cutoffs of tumor thickness such as 1mm, 2mm and 4mm provide better prognostic information. This has been accepted in 2002 AJCC staging of melanoma.

Ulceration : prognostic significance

Vollmer[6] found ulceration to be a significant prognostic factor by multivariate analysis in 7 of 11 studies reviewed. Batch[9] conducted a metaanlysis that included 793 patients with localized melanoma. Among pathologic factors, tumor thickness and ulceration were two most dominant features, and these factors are the strongest predictors of outcome. Buzaid et al[8] analyzed the influence of ulceration according to the tumor thickness and demonstrated that ulceration has the most significant impact on survival.

Ulceration was not included in AJCC staging until current 2002. Presence of ulceration upstage these patients comparable with those having melanoma of equivalent thickens but without ulceration.

Satellites vs in-transit metastasis

In 1997 AJCC staging, stage II included both patients with high risk melanoma (>4mm) and patients with satellite nodules (pT4b). This suggests that the presence of satellite nodules affects prognosis to the same extent as do high risk primaries. Several studies, suggest that the prognosis of patient with satellites is usually worse than that of patient with in transit or nodal metastasis (stage III). [8, 10-16]

Because, in transit and satellite metastases can be considered common manifestations of intralymphatic metastasis and metastases associated with poor prognosis. The AJCC has now included patients with satellite nodules in Stage III.

Prognostic value of Lymph node size vs number

Since 1983, the AJCC staging systems have used nodal size as prognostic indicator. Size of nodes as a prognostic indicator has been evaluated in different studies including one prospective study by Dropper et al [17]. In this study, univariate analysis revealed that size was not significant even after stratification according to cutoff size. Several potential prognostic factors have been studied in patients with nodal metastases. The most consistent prognostic factor identified by multivariate analyses is the number of positive nodes [8]. In view of strong evidence of important prognostic role of number of metastatic lymph nodes; size of lymph node mass has been replaced by number of positive nodes in current 2002 AJCC staging system.

Prognostic value of Biochemical and serologic markers

The association of elevated levels of serum LDH with the presence of liver metastases was recognized in the early 1970's. It has been assessed as a significant prognostic factor in melanoma. LDH, S-100-B and melanoma inhibitory activity serum markers have been evaluated in patients in metastatic melanoma [18].

After logistic regression analysis, LDH is found to be the only statistically significant marker for progressive disease and the most relevant overall parameter. AJCC staging committee recommended that patients with distant metastases at any site be assigned to the M1c category if the serum LDH is elevated above the upper limit of normal. The use of an elevated LDH to stage patient is indicated only when there are two or more determinations obtained more than 24 hrs apart.

Workup of patients with melanoma

Chest X-Ray.

A baseline chest radiograph to the most common screening test obtained in patient with melanoma. Although studies evaluating the role of routine CXR fail to demonstrate its utility, it is an inexpensive screening tool for patients at risk for systemic metastasis[19]. Most important fact is that the lungs are the most common site of solitary visceral metastases, and resection of isolated pulmonary metastases has been associated with prolonged survival [20].

PET scan

Improvements in PET have made it a valuable staging study in melanoma. FDG-PET scan has been prospectively evaluated for staging and surveillance of patients with melanoma [21, 22]. When compared with conventional imaging including CT and MRI, it was found that FDG-PET was 94-100% sensitive and 83% -94% specific. In comparison, CT was 55-84% sensitive, and 68-84% specific. These studies suggest that FDG PET is significantly better than CT at detecting

regional and mediastinum lymph nodes, abdominal visceral and soft tissue metastasis. But CT scan was found better for small lung metastases (87% vs. 70%) with the exception of brain imaging, where MRI is superior. it has been suggested that a single whole body PET scan could replace all other imaging modalities in melanoma.

Presently, in view of it is cost, limited availability and lack of sufficient data, it cannot be recommended for routine use.

Surgical Margins

The *depth of melanoma resection does not require inclusion of the underlying muscular fascia*, although this was initially suggested by Handley. Biopsy should go down on, but not include fascia. Elson et al [23] and Kennedy et al [24] have shown that the depth of excision need not include the muscle fascia to control disease. No difference in disease survival or local recurrence rates was seen between the fascial excision group vs groups in whom the fascia was preserved.

Wide excisions for melanoma were first popularized by Handley in 1967. Untill more recent trials, 3-5 cm margin of excision was standard treatment. Although the rate of recurrence was known to depend on tumor depth, there was no correlation between the extent of operation and tumor thickness.

Is Wide margin really necessary for improving survival ?

Breslow and Mach first questioned the need for wide (3.5 cm) resection margin for thin melanoma in 1990. The first prospective randomized clinical trial evaluating the margins required to produce adequate local control was conducted by WHO[25]. Overall survival was equivalent when group with 1cm margin of excision was compared with group with 3 cm margin for tumor between 1-2 mm thicknesses. Although recurrences were more in 1cm margin of excision as compared with group with 3 cm margin for tumor between 1-2 mm thicknesses. Similarly Belched et al [26] found no significant difference in survival for excision margin 2cm or 4cm for tumor between 1mm and 4mm, while the need for skin grafting was significantly reduced when margin was 2 cm. This suggests that margin of 2 cm is sufficient for tumor ≥1mm thickness. Similar results have been shown by Swedish melanoma group[27]. No significant difference in survival was seen for margins 2 or 5 cm for tumors between 0.6 mm to 2mm. Based on these data, it is safe conclude that the narrower margins have no adverse effect on survival. Based on above observations, the margins that have been recommended are given in Table – 1.

Table – 1 : Recommended margin of Resection

In situ	0.3-0.5 cm
< 1.0 mm	1cm
1.0-2.0 mm	2 cm
2.01-4.0 mm	2 cm
>4.0 mm	2-3 cm

However, controversy still exits, as the guidelines followed at the European Institute of Oncology in Milan and at the National Cancer Institute of Naples, are to perform a resection at 1 cm from margin in any primary melanoma. This approach also taken into consideration the

guidelines proposed by WHO melanoma Programme meeting in 1997[28], where a margin of 1cm was accepted up to Breslow's thickness of 2mm, while a 2cm margin was reserved for thicker lesions. Current recommendations for surgical margins for primary cutaneous melanoma: [29]

In situ	5 mm
<2mm	1cm
>2mm	2cm

Mohs Micrographic Surgery (MMS)

MMS employs repeated shallow (3mm) resections, each examined histologically by frozen section. Margins are generally taken some what less than the WHO and intergroup trails found appropriate. This has generated much criticism

Proponents of MMS claim that repeated frozen sectioning is accurate and saves normal tissue. Critics claim that frozen section is inaccurate for identification of melanoma [30]. Zitelli et al compared frozen tissue technique to the fixed tissue technique for melanoma [31], and found both the techniques comparing favorably in terms of overall survival. Further studies [33] confirmed the efficacy of this technique for the treatment of melanoma compared to the use of wide local excision. It has also been shown that the local recurrence rate following MMS was lower than after conventional surgery [34].

Although a great deal of data have been gathered to support the use of this surgery for melanoma, a disadvantage to the use of this technique is that it is labor and time intensive, requiring surgeons and pathologists trained in this technique. Although immunoperoxidase techniques have improved the accuracy and ease of identifying melanoma cells, it requires additional expertise. As yet, there have been no prospective long-term studies comparing MMS to conventional surgery. On the other hand, retrospective studies show that MMS offers equivalent or better 5 year survival rates compared to conventional wide excision. The biggest advantage of MMS is the preservation of tissue in anatomic sites where cosmetic and functional concerns are high as in head, neck, hand, and feet. This is particularly true for lentigo maligna melanoma of head and neck, which often are large, ill defined and may extend beyond apparent clinical margins.

Elective Lymph Node dissection (ELND)

It has been clearly shown that the survival of patients with clinically positive lymph nodes is worse than that of patients with clinically negative nodes at the time of primary tumor resection. A clear benefit has been demonstrated following therapeutic lymph node dissection. One persistent area of controversy has been elective lymph node dissection.

Selecting patients who may be candidate for ELND has been based on the depth of the primary tumor. Patients with tumor less than 1 mm depth of the primary tumor have a 98% cure rate and would not benefit from this procedure.

Incidence of micro metastases in clinically negative nodes is 14% -80% [35-38]. Benefit of ELND has been shown in retrospective as well as in prospective studies. In respective study by Goldsmith et al[36], overall 5 year survival rates in the patients with clinical stage I was 78% for those who underwent ELND and 68% for those who did not, supporting the need of ELND.

Belch et al[39] showed that there was a 15% incidence of distant metastases and 83% survival rate in the patients with intermediate thickness melanoma who underwent ELND.

Incidence of distant metastases and survival rates were 78% and 37% respectively for those who did not undergo lymphadenectomy. In patients with melanoma >4 mm thickness the benefit of ELND were less apparent because of the high risk (> 70%) of distant metastasis. Benefit of ELND is further supported by prospective randomized trial conducted by intergroup melanoma surgical program[40]. In this study, ELND significantly improved survival rates in the patients with tumors. 1 mm to 2 mm thickness, those without ulceration and those who were younger than 60 years.

ELND has been advocated as a prognostic indicator since, in patients with regional, the actual number of nodes involved in the most important predictor of overall survival[41]. Regional node disease may determine candidates for adjuvant treatment such as IFN-α. Opponents point out the morbidity of the operation, the lack of clear therapeutic benefit of ELND and a controversial advantage of IFN-a treatment. One of the most important criticism is that upto 40% of patients may have negative nodes on pathology. At Breslow's depths of less than 0.76 mm, 0.76-1.5mm, 1.5-2.5 mm, 2.5-4.0 mm and more than 4 mm, the regional nodal seen was positive in 0%, 5%, 16%, 24% and 36% of cases respectively[42].

No difference in survival at 10 years was demonstrated at 10 years by Sim et al[43]. The patients were divided into groups undergoing immediate excision, delayed excision, or no excision.

In a series of 252 patients, published by WHO showed no effect of routine ELND on survival[44].

After years of controversy surrounding the potential benefit of elective nodal dissection and numerous trials, it is ironic that, regardless of the conclusions reached, the new technique of Sentinel LN biopsy, has cast a shadow on all the answers recently obtained.

Sentinel Lymph Node Biopsy

While ELND remove all clinically negative lymph nodes, even though occult metastasis affects only 12-15% patient, SLN biopsy allows upto 85% of patients with melanoma to be spared a formal lymph node dissection, thus avoiding complication associated with that procedure.

After nodal mapping, regional recurrence rates are acceptably low and the sensitivity and specificity are quite high. SLN biopsy was 100% sensitive and 97% specific in one series[45]. Essner et al[46] were the first to show sentinel node biopsy followed by completion lymphadenectomy did not decrease survival compared with patients undergoing ELND. The overall incidence of nodal metastases and survival were no different between the sentinel node and ELND group, but the incidence of occult nodal disease was significantly higher among patients with occult nodal disease was significantly higher among patients with intermediate thickness primary tumors who underwent sentinel node mapping. Sentinel node mapping is therapeutically equivalent but prognotically more accurate than ELND.

Clinical significance of sentinel lymph node micrometastases. Numerous trials have been conducted to evaluate the prognostic and clinical efficacy of SLN mapping. While SLN status has been shown to be an important prognostic indicator, there is no proof that SLN biopsy has any impact on disease free survival and overall survival[47]. SLN dissection not only accurately selects the lymph node most widely to harbor micrometastases but also may be used as tools to predict clinical outcome. The significance of the identification and elimination of micrometastsesm melanoma remains unknown. It remains unclear whether selective sentinel lymph node dissection will lead to an overall survival benefit. A trial by Morton et al[44], (the multicenter selective lymphadenectomy trial) (MSCT) may help answer this important question. The MSCT randomizes patients with clinical stage I melanoma to wide excision and

nodal observation or to wide excision and SLN dissection, followed by therapeutic lymph node dissection of the SLN is positive[48].

Who should be offered SLN biopsy?

The most important aspect of the SLN dissection procedure is in selection of appropriate patients. Careful staging for the presence or absence of metastatic melanoma in lymph node can improve survival by identification of patients who should requir adjuvant therapy. SLN mapping should be offered to patients who have a sufficient risk (5-10%) of metastatic disease. Potential candidates for high dose IFN-a2b adjuvant therapy should also be offered SLN mapping. Patient with melanoma <1 mm thickness have less than 2% chance of regional lymph node or distant metastasis and SLN mapping in such patients is not justified. There is subset of patients in this group who are candidate for SLN biopsy. These include those with melanoma of head, neck or trunk, those with incision and those with Clark level III or greater. These patients have 10% risk of recurrence[49].

Patients with primary tumors between 1mm and 4mm thickness should be offered SLN biopsy with completion therapeutic lymphadenectomy, if there is metastatic disease in SLN. This group of patients have up to 45% incidence of occult nodal metastases [50].

Patients with thick (> 4mm), clinically node negative melanoma carry a high risk of both regional nodal micrometastases (60-70%) and occult systemic (70%) disease at the time of initial presentation. As the risk of distant metastases is so high in these patients that it may negate any potentially curative benefit of a regional operation. Therefore, regional lymph node dissection in patients with thick melanoma has generally been deferred until nodal metastases become evident.

Who should not be offered SLN mapping?

SLN mapping has no role in several clinical situations. If histopathological examination confirms that clinically palpable lymphadenopathy is regional node metastases, therapeutic node dissection is not required. If a patient has undergone wide local excision of primary site or prior surgery involving the regional lymphatic basin, ELND or nodal observation is recommended as pattern of lymphatic drainage has been altered by such procedure.

Isolated Limb Perfusion (ILP)

Role of Prophylactic (adjuvant) Isolated Limb Perfusion

Prophylactic ILP provides neither a survival benefit nor a much greater reduction in local recurrence when compared with excision alone[51]. In a multiinstitution prospective trial conducted by the consortium of the EORTC, the WHO, and the North American Perfusion Group, no difference in survival was found after median follow up of 6.4 yrs when patients were randomized to have wide local excision or wide local excision plus ILP with melphalan and hyperthermia. Prophylactic ILP with melphalan can not be recommended as an adjuvant to standard surgical therapy in high risk patients.

Therapeutic Isolated Limb Perfusion

Multiple randomized studies, including two prospective randomized trials suggest improved survival and low recurrence rates in a subgroup of patients undergoing ILP. Halfstrom et al reported a prospective randomized trial in 69 patients [52]. Median disease free survival was 17 months in the perfusion group and 10 months in the control group. There were 15 locoregional recurrences in the perfusion group and 24 in the control group. The disease free survival was better for the perfusion group, but no significant difference in the overall survival was noted.

Drugs in Isolated Limb Perfusion

Melphalan perfusion is the standard single agent for ILP, as all other agents like dacarbazine, nitrogen mustard have offered no therapeutic advantage in terms of rate and duration of clinical response.

TNFα in ILP gained wide acceptance after the impressive tumor response rates observed in the early 1990s by Lienard et al [53]. Role of TNF in ILP is still under clinical evaluation; since no prospective randomized study has shown that TNF plus melphalan regimen have any advantage over melphalan alone. It may be advantageous for bulky dieses [54]

Who are candidates for Isolated Limb Perfusion ?

Candidates for ILP should be patients in good condition, with in transit disease confined to a limb, with no signs of distant metastases at presentation. If at first presentation the number of lesions is limited (<10), and tumor size is<3cm, first option is surgical excision followed by a watch and see policy. Should the patient recur without distant metastases, patient becomes candidate for ILP with melphalan. TNF plus melphalan may be used for patients with further recurrences.

Adjuvant therapy

The role of adjuvant therapy in high risk melanoma patients remains an area of intense investigation. Patients with high risk for metastatic disease should be offered this therapy. High risk patients may be identified by prognostic factors identified by Clark et al [55] and Song and Weiss[56], and by sentinel lymph node biopsy. Treatment options include high dose interferon, tamoxifen.

While some investigators feel that the use of high dose interferon (HD-IFN) is the standard of care, this issue remains to be further clarified. The encouraging results observed in the other trials involving GM-CSF, tamoxifen/cisplatin, vindesine; suggest that approaches other than HD-IFN may hold promise.

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Awards & Achievements

Dr. H. S. Shukla, Prof. of Surgical Oncology, BHU, Varanasi and Past President IASO was appointed Associate Editor of Journal of Surgical Oncology from 2003

Dr. N C Misra, Past President IASO was awarded the Col. Sangham Lal Oration of National Academy of Medical Sciences, New Delh and he was also Elected as a Member Executive Council – Asian Clinical Oncology Society Japan

Dr Sanjeev Misra was Visiting Professor King's College London for the year 2002

Members are requested to send their achivements to the Editorial Secretary IASO so that they may be printed in the newsletter.

Report on Zonal IASO-CME at IGIMS, Patna on 22nd & 23rd Feb. 2003.

Continuing Medical Education on Surgical Oncology was held in **Patna at RCC, IGIMS by Surgical Oncology Department** on 22nd & 23rd February 2003. The CME was inaugurated by **Hon'ble Minister Medical education Dr. Shakeel Ahmad**, Govt. of Bihar. The CME was organized by **Dr. Amitabh Singh** I/C & Assist.Prof. Surg. Oncology; and those who attended as **Resource persons were Dr. L Sarangi (Hon.Secretary, IASO), Prof. Ravikant, Prof. A. Chaturvedi, Dr. Sanjeev Misra, Dr. KA Pathak, Dr. A.K Khanna, Dr. Gaurav Agarwal, Dr. Subodh K. Singh and Dr. Ratan Sharma.**

Prof. Gopinath (President, IASO), Prof. H.S.Shukla, Dr. N Deo could not attend it because of their pre-commitment and engagements which was unavoidable. Altogether about 55 delegates were registered as Delegates/Participants besides Resource persons and chairpersons for CME, which was quite encouraging. The topics discussed were on Oral cancers, Breast Cancer, Malignant melanoma, Gallbladder Cancer, Thyroid Cancer, Soft tissue Sarcoma, Postoperative pain, Radiotherapy in multimodality treatment, Dilemma in Onco-path/Onco-radiology, Wilms'tumour, Reconstruction after Surgical excision in cases of breast and Oral cancers. The deliberations were of high academic standards for the learning of young oncologists and postgraduates. The CME provided a very good opportunity for exchange of scientific ideas amongst the participants and resource persons. It was a good idea adopted by our IASO office to hold 2 CME in each zone of the country for every year to come, which will be very helpful for all young oncologists and general surgeons to keep them abreast with latest developments in the field of Surgical Oncology.

Report on Zonal IASO-CME at Command Hospital Armed Forces Medical College, Pune, 19th & 20th July, 2003

The Zonal CME of IASO, for Western zone was organized by Lt Col P G Chitalkar, Medical Oncologist and Lt Col Sanjay Kapoor, VSM, Surgical Oncologist of Command Hospital Pune, at Armed Forces Medical College on 19th and 20th July 03.

The Zonal CME of IASO was part of the CME in Oncology-2003 organized by the Malignant Diseases Treatment Centre of Command Hospital Pune, to celebrate the 30th Anniversary of the centre.

The CME was attended by Dr K S Gopinath and Dr L Sarangi, President and Secretary of IASO, besides other members of the association. The guest faculty consisted of over fifty eminant oncologists of the country including Dr S H Advani, Dr P Subhas, Prof G P Christian Brig G Rajagopal, Maj Gen MP Jaiparakash, Dr P Jaganath Dr R Deshpande, Dr A Kurkure, Dr Ravi Kant, Dr (Mrs) P Kurkure, Dr (Ms) A Borges, Dr R Badwe, Dr P Parikh, Dr A D Cruz, Dr R Mistry.

With a theme of 'Oncology in General Practice' the CME was aimed at imparting awareness of early cancer detection and the recent trends of multimodality cancer care amongst general practitioners, specialists, Oncologists and post graduates. There were Panel discussion on Carcinoma Thyroid, Oesophagus and scientific sessions on Brain Tumours, Head and Neck and Genito urinary malignancies.

The CME was attended by about 250 delegates from all over India. A scientific Exhibition was also organized and Handbook of Oncology was released at the occasion.

Report on Zonal IASO-CME at Central Hospital, Ranchi, 3rd August, 2003

A CME program on common cancers was organized by IASO at Gandhinagar Hospital, Central Hospital of Central Coalfields Ltd, Ranchi on 3rd August 2003.This program was organized with the help of ASI, Jharkhand chapter, Ranchi, Obs & Gynec Society, and Ranchi ENT Club. This was the first such CME in Oncology being held in the states of Bihar & Jharkhand.. Shri.S.C.Chaturvedi, Director (Personnel), Central Coalfields Ltd was the Chief Guest on the occasion. 110 delegates attended it from both the states including prominent surgeons, gynecologists and ENT surgeons of Ranchi, Jamshedpur and Bokaro.The topics discussed were as follows:

1.	Cancers of Buccal – alveolar complex —	**Dr.L.Sarangi** Varanasi
2.	Reconstruction procedures in head & neck —	**Dr.Subodh K.Singh**, Varanasi
3.	Recent concepts in Adjuvant therapy in Breast Cancers —	**Dr.R.C.Joshi**, Varanasi
4.	Cancers of the Uterine- Cervix —	**Dr.Rama Joshi**, Varanasi
5.	Stomach Cancers —	**Dr.R.R.Sinha**, Ranchi
6.	Recent concepts in Cancer Pancreas —	**Dr.Sunil Kumar**, Jamshedpur
7.	Cancers of the Gall Bladder —	**Dr.L.Sarangi**, Varanasi
8.	Early changes in the Cervix —	**Dr.Tesu Shrivastava**, Ranchi
9.	Palliative treatment in terminal patients —	**Dr.S.Pradhan**, Varanasi
10.	Nutritional support in malignant diseases —	**Dr.A.K.Dam**, Bokaro
11.	Early breast cancers —	**Dr.A.Vidyarthi**, Ranchi

Dr.Sarangi and Dr.Subodh K.Singh also demonstrated a Commando Resection to the doctors of CCL on 2nd August 2003.

Nominations are invited from the members-IASO for the following Vacant Post on a plain paper, proposed and seconded by member IASO

Vice President - 1

EC Members - 4

Nomination must reach the secretary IASO by 12.00 Noon 19th Sept., 2003.

Topics for Symposia, Panel Discussions, Gust Lectures are invited from the members for the NATCON IASO-2004 at Jaipur and for the IASO Sectional meeting during ASICON-2004, Hyderabad. Please send your suggestions and Topic to the Secretary, IASO

Minutes of Annual General Body Meeting of IASO held at Kolkata during ASICON'2003 on 29/12/2002 at 4 PM

1. a. Meeting called to order by President
   b. Meeting adjourned for 10 minutes due to lack of quorum
   c. Meeting called to order after 10 minutes by President
2. Welcome address by President
3. a. Minutes of last GBM held at Patna on 29/12/2001 read.
   b. Anything arising out of it - Nothing
   c. Minutes passed
4. a. Audited accounts for 2001 presented
   b. Anything arising out of it - Nil
   c. Accounts passed
   d. Un-audited account of 2002 presented

   The interest generated from fixed deposits invested in cumulative mode. Rs. 2, 00,000/- fixed deposits in the name of Dr. N.C. Mishra Oration

   Suggestion received from Dr. Sanjay Sharma to invest the money in RBI bonds to generate more interest.
5. WFSOS: Amendment No. 23(h) - modified.

   It will be the responsibility of President to generate $ 500 for yearly membership of WFSOS. The official representative of IASO in WFSOS will be President or his nominee. For 2003 the official nominee is Dr. R.I. Dave WFSOS will be communicated about this decision.
6. NATCON 2003:

   Venue : Lucknow

   Org. Secretaries: : Dr. A. Chaturvedi
   Dr. S. Misra

   a. Symposia : 1. Ca Thyroid — Dr. Kiran Kothari
   2. Video Symposium on Ca Stomach — Dr. Sanjay Sharma
   3. Soft tissue sarcoma — Gen. P. Subhash

   Two more symposia to be convened by local organizers.

   b. Orations: Matibhai Oration – To be declared among foreign speakers

	Dr. N.C. Misra oration	To be declared among foreign speakers
	Radha Devi Oration –	Dr. R. I. Dave, Imm. Past President

Dr. Sanjeev Misra informed that 3 to 4 eminent oncologists from abroad have confirmed their participation.

7. Program: ASICON'2003

Venue : Pune

a. Symposia :	Ca Esophagus Jointly with Cardiothoracic section	Dr. Sanjay Sharma
	Bone tumor	Col. M. Ganguly
b. Guest Lecture :	Dr. Sanjay Sharma has been entrusted with the task of arranging a speaker from USA	
c. IASO Oration :	to be decided in consultation with President	

d. Members are required to submit of abstract of free papers by 30th June. So that ASI headquarter may be communicated in time.

8. Venue for NATCON' 2004

Invitations	1. Jaipur	Dr. I.M.S. Narula Dr. R. G. Sharma
	2. Mahabaleshwar Panjim Miraj	Dr. S. Desai
	3. Mount Abu	Dr. Kiran Kothari
	4. Patna	Dr. C. Khandelwal

Votes taken by show of hands and the offer of Dr. Narula/Dr. R.G. Sharma accepted. Dr. Narula to present logistics in NATCON' 2003 at Lucknow

9. Guidelines for bidding for future NATCON'S to be formulated

10. Amendments of bye-laws circulated: Passed except minor change in WFSOS representation. Election to various offices to be held at NATCON and elected members to assume office from 1st Jan of next calendar year.

11. **Committees of IASO formed at Ooty :**

The various sub-committees proposed in EC meeting at Ooty presented for discussion. It was decided that as the committees were headed by past presidents, one member of EC may be associated with each one of them to run these cells. They shall come out with concrete proposals for discussion in EC/GBM meetings at Lucknow. President and secretary are ex-officio members of each committee.

a. Research trial	:	Dr. R.I. Dave Dr. Manoj Pandey
b. Training	:	Dr. N.C. Mishra Dr. S.V.S. Dev
c. Gender	:	Dr. H.S. Shukla Dr. C. Khandelwal

d. Certification : Dr. K. Panda
Dr. D.K. Acharya

e. Quality assurance : Dr. K.K. Pandey
Dr. Saran Chaudhary

12. Election to various vacant offices:

Vice President	:	One
Secretary	:	One
Editorial Secretary	:	One
Ass. Editor	:	One
EC members	:	Four

a. Vice President : Two nominations Dr. Sandeep Kumar and Dr. Ravi Kant, Dr. Ravi Kant withdrew, Dr. Sandeep Kumar declared elected unanimously

b. Secretary : Three nominations of Dr. Ravi Kant, Dr. L. Sarangi,Col. M. Ganguly. Dr. Ravi Kant and Dr. M. Ganguly withdrew, Dr. L. Sarangi declared elected unanimously

c. Editorial Secretary : Three nominations Dr. L. Sarangi, Dr. S. Misra, Lt. Col. M. Ganguly. Dr. L. Sarangi and Lt. Col. M. Ganguly withdrew. Dr. S. Mishra declared elected unanimously

d. Ass. Editorial Secretary : Two nominations : Dr. S. Mishra and Lt. Col. M. Ganguly, Dr. S. Misra withdrew, Lt. Col. M. Ganguly declared elected unanimously

e. Executive Committee Members : The following members declared elected unanimously
Dr. C. Khandelwal
Dr. D.K. Acharya
Dr. Manoj Pandey
Dr. S.V.S. Dev

Dr. A. Chaturvedi and Dr. S. Sadasivam became co-opted members as org, secretaries of future and past NATCONS

13. Members of General Body profusely thanked the out going President and Secretary for there excellent performance.

14. Dr. R.I. Dave handed over the president ship to Dr. K.S. Gopinath. He thanked the members of General Body for there co-operation.

15. The meeting ended with vote of thanks.

Agenda of AGM 2003 at Lucknow

Date : 20.08.2003 **Time : 06.30PM** **Venue : Taj Residency, Lucknow**

1. Meeting to be called to order by President.
2. Minutes of last AGM held on 29.12.2003 at Kolkata to be presented.
3. Audited accounts of 2002
4. Annual report of IASO
5. Bylaws amendment proposals
   a. Associate Editor : Post does not exist Proposed new- tenure 2yrs
   b. Incorporation of immediate past organizing secretary of NATCON as co-opted EC member for one year.
   c. Guidelines of invitation for NATCON
      i) Organizing secretary or his representative must be present in AGM in NATCON to present his proposal.
      ii) Rs. 100/- per delegate to be deposited to IASO after the conference
      iii) Audited accounts of NATCON to be presented in the next AGM or may be circulated in the newsletter.
      iv) 1/3rd of the profit of NATCON besides Rs. 100/- per delegate may be deposited in IASO account.
   d. Silver jubilee IASO oration in ASICON- Proposed new.
      i) National or international speaker
      ii) Rs.2000 oration amount, a medallion and a citation
6. a. Detroit fellowship 2004-2005
   b. Borada traveling fellowship 2003-2004
7. a. Confirmation of Venue of NATCON 2004
   b. Orations NATCON 2004
   c. Symposia NATCON 2004
8. Program & Budget for 2004.
9. News letter
10. a. Sub. Committee's activities
    b. IASO practices guideline on common cancers
    c. Fellowship program in surgical oncology
11. WFSOS: representative of IASO for 2004
12. Venue of NATCON'2005
13. Any other matter with the permission of the chair.
14. Election of office bearers
    Vacancy: Vice- president-1 E C member-4
15. Vote of thanks to organizing committee
16. Vote of thanks to members
17. Meeting to be closed by President.

IASO BYE LAWS

The bye-laws of the IASO as adopted at one of the general body meetings held in December 1997, Mumbai and amended in the general body meeting at kolkata in December 2002.

These bye-laws supercede all previous bye-laws of the IASO.

1. In these Bye-laws, unless there is anything repugnant in the subject or context,
   a) IASO means "Indian Association of Surgical Oncology". - This will remain a section of the ASI.
   b) ASI means "Association of Surgeons of India".
   c) Memorandum and Rules and Regulations mean "Memorandum of the Association and Rules and Regulations of the ASI" which came into force in 1985.
2. **Name :** The name of the Association is "Indian Association of Surgical Oncology : - A section of ASI.
3. **Address :** The office of IASO is the place from where the Secretary functions.
4. **Objects :** IASO is formed as per guidelines set in schedule II of memorandum of ASI and was approved as a section in 1977. The objectives of IASO are same as stated in schedule III of memorandum of ASI. Further to that, IASO will encourage and advance the study and practice of the science and art of surgical oncology and allied organizations concerned with cancer problems.
5. **Membership :**

   (a) **Life Membership :** A life member should be a full member (Annual/Life) of the parent body "The Association of Surgeons of India". All persons, being surgeons with sufficient interest in cancer surgery/practicing cancer surgeons/completed an acceptable training in cancer surgery/pursuing research in cancer surgery or related subject, are eligible for becoming life member.

   (b) **Associate Membership :** Those who are under training in cancer surgery or those who are interested in cancer surgery but belong to other specialties, such as, Radiology, Pathology, Biochemistry and who may not be the member of the ASI. Subscription of membership will be as decided from time to time by the general body of the IASO. Generally all members will be inducted as life members.
6. **Termination of Membership :**

   a) If a member of IASO ceases to be a member of ASI, he/she will cease to be a member of IASO.

   (b) If a member fails to pay subscription by due date or resigns, he/she will cease to be a member of IASO.
7. **Year :** The year of the IASO will be same as of ASI - 1st January to 31st December.
8. **Management :**

   (a) IASO will be managed by an Executive Committee consisting of following office bearers, members and ex-officio members:

   i. President

   ii. Vice President: 2

iii. Secretary

iv. Editor

v. Members: usually 8 members will constitute the executive committee.

(b) All past Presidents will be invitees to Executive Committee meetings.

(c) Organizing Secretaries of both immediate past and future NATCON will be co-opted members of Executive Committee of IASO for that year.

(d) Only those members and life members who have put in minimum 5 years of membership are eligible to election to Executive Committee.

(e) Save and except President, the tenure of all office bearers and members will be for two years.

(f) The President shall hold office for one year. Senior Vice President will be the President after expiry of his term unless he/she has resigned, indisposed or disqualified otherwise.

9. **Election :**

(a) Election of the vacant posts as notified by the Secretary of IASO will be conducted in the Annual General Body Meeting of IASO to be held during the annual conference of IASO in NATCON every year.

(b) Every eligible member shall be proposed and seconded by two full members of IASO in the meeting after the proposed member has consented for the election.

(c) If there is no contest, the President shall declare the member elected for the post. Otherwise the election shall be by show of hands or secret ballot as decided by the President.

(d) If a poll is demanded by at least 25% of the members of IASO present in the meeting and President is satisfied that such demand has been carried out by majority of members present in the meeting, the vote shall be taken by ballot.

10. **Power of Executive Committee :** Shall be same as that of the Governing Council of ASI.

11. **The function and responsibility of different office bearers of IASO** will be same as that of ASI. The secretary will maintain and present the audited accounts each year at the annual conference.

12. **Meeting and Conference :**

(a) IASO shall hold Annual General Body Meeting every year during the annual conference of NATCON and transact the business stated in bye-law 15(b). Other meetings, be it of Scientific, Social / executive Committee/General Body in nature, may be held as per the requirements of IASO.

(b) IASO shall endeavor to organize Mid-term Conference at least once every year and appoint an organizing secretary for the conference in its Annual General Body Meeting.

13. **Annual Report :** An annual report stating the activities of the year shall be prepared by the Secretary for Annual General Body Meeting, a copy of which is to be sent to Headquarters of ASI.

14. **Accounts of the year :** Accounts of the year of IASO shall be prepared by Secretary and audited by an auditor appointed by General Body within six months of the closing

of the year. This should be placed in the General Body Meeting and after adoption, a copy sent to Headquarters of ASI.

15. **Annual General Body Meeting :**

a) Annual General Body Meeting (AGM) shall be held once every year as stated in Bye-laws.

b) The following business will be transacted in the AGM.

i. Annual report.
ii. Audited accounts of the previous year.
iii. Programme and budget of the next year.
iv. Recipients of various orations for the next year.
v. The venue of Mid-term Conference and appointment of Organising Secretary.
vi. Election of the office bearers and members of the executive Committee.
vii. Any other business with the permission of the President. Topics of the symposia and Their conveners, theme of CME, workshops and programme outluine should be discussed in the General Body Meeting.

16. **Journal :** IASO shall publish its own Newsletter and shall elect Editor for the same. He will be the sectional editor of the Indian Journal Surgery.

17. **Income :** Income of the IASO shall be derived from:

a) Admission fees and subscription from members, life members and associate members.

b) Excess of income over expenditure in Mid-term Conference.

c) Donations.

18. **Investment :** IASO shall have account with nationalized or reputed bank to be operated by persons authorized by General Body Meeting. The surplus fund after meeting statutory annual expenditure shall be invested in fixed deposits of such banks and approved securities or in any other manner to be decided in the General Body Meeting.

19. **Utilization of Funds :** IASO shall have account with nationalized or reputed bank and shall invest funds not required for its regular day to day activities in fixed deposits of such banks or approved securities as had been decided by the General Body Meeting. The accounts will be operated as per provisions of memorandum of ASI. The proceeds of income from various deposits and investments shall be strictly spent for specific purpose for which such fund / funds are created.

20. **Representation :** IASO shall be represented as per Memorandum of ASI.

21. **Amendment of Bye-laws :** Any of the Bye-laws of IASO may be altered or rescinded to or new Bye-laws may be made at General Body Meeting by majority vote. The amendment shall come into force after it is circulated to all members and provided objection to such amendment of IASO is not received from ASI and 50% of valid members of IASO within three months from the date of circulation. A copy of such amendment is to be sent to Headquarters of ASI.

22. **Schedule :** IASO secretariat shall maintain a schedule comprising the various orations, fellowship research grant or any other grant for scientific works with rules and regulations for these awards and management.

23. (a) **Radha Devi Oration** Will be delivered by the outgoing President at the Annual meeting of A S I. Rs 5000 have been donated for the oration by the family of Dr. SP Jain. The orator will get a plaque, a cheque for Rs 2000, certificate, and a medal.

(b) **Motibhai Oration** will be delivered by an orator selected by the executive committee, and endorsed by the GBM. The oration will be delivered at the Annual meeting of IASO -Natcon. Rs 50,000 have been donated for the cause by Dr. DD Patel and family. Only interest is to be used. 50% of interest is to be reinvested to generate same amount of money even in the era of falling interest rates. Thus, only 50% of interest should be available in a year to award the orator a plaque, a cheque for Rs 2000, a certificate and a medal. Local hospitality by the organising secretary Natcon.

(c) **Dr. NC Misra Oration :** Will be delivered preferably by an eminent foreign speaker selected by a panel consisting of the President IASO, Secretary IASO and the Organizing Secretary of the NATCON. In case of selection of eminent speaker from India, consultation will be held with the nominee of "The Students of Dr. NC Misra", who have donated Rs two lakhs as endowment. Only interest is to be used. 50% of interest is to be reinvested to generate same amount of money even in the era of falling interest rates. Thus, only 50% or less of interest should be available in a year to award the orator a plaque, a cheque for Rs 5000 or more / less (subject to calculation of interest), a certificate and a medal. Local hospitality by the Organizing Secretary NATCON.

(d) **Detroit Visiting Fellowship**-A fellowship to visit Detroit will have local hospitality included by the host institution excluding the travel cost to and fro USA. The candidate should be less than 40 years of age, and permanently employed. Selection based on CV and paper presentation during NATCON meeting. Selection panel includes Dr. KK Maudar, President and Secretary of IASO. In case Dr. KK Maudar is not available than a person nominated by him or in case nominee is not available, than senior vice president will be member of the panel.

(e) **Baroda fellowship :** Rs 5000 will be awarded to a young surgeon for visiting travel support to a research or therapy oriented cancer center. No person can be awarded the prize again. Frequency of award-Once a year. Selection panel: President, Senior Vice President and Secretary IASO. Eligibility of applicant- young surgeon, selection based on CV.

(f) Best paper presentation will be awarded Rs 1000 towards complimentary Associate Membership of the IASO. Eligibility: Post-graduate student

(g) Best poster presentation will be awarded Rs 1000 towards complimentary Associate Membership of the IASO. Eligibility: Post-graduate student.

(h) **WFSOS :** The official representative of IASO in WFSOS will be President or his nominee. It will be the responsibility of President to generate $ 500 for yearly membership of WFSOS.

(i) **Dr. K Panda-Dr. Gopinath Quiz award :** During NATCON meeting, winner will be awarded Rs 700 and runners up Rs 300. Dr. K Panda & Dr. Gopinath donated Rs 10,000 each towards the seed money for the Quiz award. Eligibility- all the delegates of NATCON. In case of prize being won by a person who is not a member, the winner will get an additional Rs 300 from the IASO towards his life membership dues, and cash award will be adjusted towards the life membership of IASO.

IASO Audited Account

Receipt & Payments for the period 01-01-2002 to 31-12-2002

(In Rs.)

Receipts	Amount	Amount	Payments	Amount	Amount
Opening Balance			**Opening Balance**		
Bank of Maharastra	12,162		Expenses Payable (LY)	7,110	
FDR with CBI	1,65,000		Audit Fees Payable (LY)	3,150	
FDR with Bank of Maharastra	2,30,000		Radha Devi Oration (LY)	2,000	12,260
Cash in hand	Nil				
		4,07,162	Awards & Gifts		4,826
			Radha Devi Oration		2,000
Membership Fees		84,970	Audit Fees		3,250
Interest Received		2,984	Office Expenses		2,647
IASO-Udaipur		11,000	Printing & Stationery		5,896
IASO-Puri		10,000	Postage & Courier		10,131
Received From			Salary Exp.		14,400
Dr. K Panda			Bank charges		1,419
Receipt from students		5,000	TDS		1,249
Of. Dr. N.C. Misra			Mem. Fees sent to HQ		14,600
		2,00,000			
			Closing Balance		
			Bank of Maharastra	2,172	
			FDR with CBI-981962	90,000	
			FDR with CBI-981997	65,000	
			FDR with Bank of Mahs.		
			No. 256619 2,30,000		
			N0. 677486 1,50,000		
			No. 677826 50,000		
			No. 154776 50,000	4,80,000	6,48,438
			Cash in hand	1,266	
		7,21,166			**7,21,116**

We have compiled the above Receipts & Payments account for the period 01-01-2002 to 31-12-2002 form the ledger & cashbook produced before us and informations given to us. Membership Fees received & payments made after 31-12-2002 have also been included in the above receipts since they belong to above-mentioned period.

For **RAJ JAIPAL & ASSOCIATES**
CHARTERED ACCOUNTANTS

RAJ KUMAR)
PROPREITOR
Place : Delhi
Dated: 21-05-2003

For **INDIAN ASSOCIATION OF SURGICAL ONCOLOGY**

(DR. RAVI KANT)
SECRETARY

Scientific Programme*
NATCON-IASO 2003

19 September 2003

8.00 AM onwards — Registration

Session – I
9.00 AM – 10.30 AM

Chairpersons

9.00 AM – 9.30 AM	Local flaps in Breast Conservation Surgery, Cosmesis and patient satisfaction	Dr. Shailesh Chaturvedi, UK
9.30 AM – 10.00 AM	Newer Hormonal agent in Breast cancer	Dr. H.S. Shukla Varanasi
10.00 AM – 10.30 AM	Metastatic Liver Tumours: Towards Chemo-Surgery	Dr. I.S. Benjamin UK
10.30 AM – 10.50	**COFFEE**	

Session – II
10.50 AM – 1.00 PM

Chairpersons

10.50 AM – 11.30 AM	**Motibhai Oration** Management of Carcinoma Rectum-What is new ?	Dr. A.P. Majumdar, Kolkatta
11.30 AM – 1.00 PM	**Video Symposium -** Gastric Cancer Convenor	Dr. Sanjay Sharma, Mumbai

1. Carcinoma GE-junction & proximal stomach - *Dr. Manjit Bains*, USA
2. Distal Gastrectomy D1, D2 dissection - *Dr. Hemant Raj*, Chennai
3. Total Gastrectomy -D3 resection for stomach cancer - *Dr. T Takahashi*, Japan
4. Reconstructive procedure for stomach resection - *Dr. Sanjay Sharma*, Mumbai

1.00 PM – 2.00 PM — **LUNCH**

Session – III
2.00 PM – 3.40 PM

Chairpersons

2.00 PM – 2.40 PM	**Radha Devi Oration** Progress and Experience of Surgery for Esophagel Carcinoma	Dr. R.I. Dave, Ahemdabad
2.40 AM – 3.10 PM	Management of Chest Wall Tumours	Dr. M.S. Bains USA

* Tentative programme : Subject to change

3.10 PM – 3.40 PM	Genetic basis for head and Neck Cancer development and treatment	Dr. Bhuvanesh Singh, USA
3.40 PM – 4.00 PM	**COFFEE**	

Session – IV
4.00 PM – 5.30 PM

Chairpersons

4.00 PM – 4.30 PM	The role of laparoscopic Surgery in the diagnosis & treatment of Maligancy & The Place of Minimal Access Surgery in Surgical Oncology	Dr. David Rosin UK
4.30 PM – 5.00 PM	Getting More Patients with Colorectal Liver Metastases to Surgical Resection	Dr. G J Poston UK
5.00 PM – 5.30 PM	What is New in Chemotherapy for Lung Cancer	Dr. Rizvi Naiyer USA
6.00 PM	**INAUGURATION**	

20 September 2003
Session – I
8.30 AM – 10.40 AM

Chairpersons

8.30 AM – 10.00 AM **Symposium Soft Tissue Sarcomas**
Convener- Gen. P. Subhas, Palakkad

1. Introduction and a brief approach - *Dr P Subhas*, Palakkad
2. Anatomical basis and Imaging - *Col L S Vohra*, Bangalore
3. Role of Pathologist - *Lt Col Ritu Lakhtakia*, Pune,
4. Staging of tumours - *Dr Gunasagaran*, Chennai
5. Radical surgery - *Lt Col Sanjay Kapoor*, Pune
6. Limb salvage surgery - *Lt Col Manomoy Ganguly*, Chandigarh
7. Role of Radiotherapy - *Dr Manoj Pandey*, Thiruvananthapuram
8. Role of Chemotherapy - *Col R Ranga Rao*, New Delhi
9. Concluding Remarks - *Dr P Subhas*, Palakkad

10.00 AM – 10.40 AM	**Dr. NC Misra Oration** Rectal Cancer Surgery; Autonomic Nerve Preservation and Colonic Pouch Anus Anastomosis	Dr. T. Takahashi, Japan
10.40 AM – 11.00 AM	**COFFEE**	

Session – II
11.00 AM – 1.00 PM

Chairpersons

Hall – A

11.00 AM – 11.30 AM	Practical management of Lymphnode metastasis in Head and Neck Cancer	Dr. Bhuvanesh Singh, USA

11.30 AM – 12.00	The Role of the Busy Surgeon in Cancer Research	Dr. T.C.Holme, UK
12.00 Noon-12.30 PM	Carcinoma Rectum – Of course every effort should be made to save the Anal Sphincter	Dr. A. Ladha, Indore
12.30 PM-1.00 PM	Clinicopathological study on gastric carcinoma in high and low mortality countries; Comparison between Japan and US	Dr. M Maruyama Japan

Hall – B

11.00 AM-11.30 AM	Breast conservation surgery following a complete clinical response to neo-adjuvant chemotherapy- a ten-year prospective study	Dr. Shailesh Chaturvedi, UK
11.30 AM-12.00Noon	Newer treatment option for Metastatic Breast Cancer	Dr. A. Kurkure, Mumbai
12.00 Noon-12.30 PM	Oncoplastic Surgery for women with breast cancer	Dr. A.D. Baildam UK
12.30 PM-1.00 PM		Dr. Raghu Ram Pillarisetti UK
1.00 PM – 2.00 PM	**LUNCH**	

Session – III
2.00 PM – 3.40 PM

Chairpersons

Hall – A

2.00 PM – 3.00 PM **Award Paper**

1. Study of Retroperitoneal Sarcoma - *Pawan Gupta*,Somesh Chandra, Rajen A Tankshali, Rajendra I Dave, Dharamshila Cancer Hospital and Research Centre, Delhi
2. Role of Non-R_0 Resection and adjuvant therapy in Stage IV Ca Gallbladder - *Ajay Vidyarthi*, Gandhi Nagar Hospital, Ranchi
3. Mandibular Invasion in Oral Squamous Cell Carcinoma - *Majoj Pandey*, Latha P. Rao, Sheima R. Das, Anita Mathews, B.R. Naik, Elizabeth Chacko, Department of Surgical Oncology and Pathology, Thriuvananthapuram
4. Palliation of Malignant Dysphagia by Metal Stents without C-arm – Experience of a Cancer Hospital - *A Gupta*, Mandal A., Basak S. N.. Guha A., Guha Majumdar D. N., Depts. Of GI Endoscopy and ENT, Cancer Centre Welfare Home Research Institute, Thakurpukur, Kolkata, W. Bengal. Keywords- Palliation, Dysphagia, Metal StentsThakurpukur, Kolkata
5. Neoadjuvant chemotherapy in locally advanced breast cancer- A retrospective analysis of 51 patients - *Daljeet Singh*, Ludhiana
6. Establishing Sentinel Node Programme for breast cancer: Results from a tertiary care hospital - *V Seenu*, Rakesh Kumar, S. Datta Gupta, Kusum Verma, SN Mehta, Department of Surgical Disciplines, Nuclear Medicine & Pathology, All India Institute of Medical Sciences, New Delhi.

3.00 AM – 3.4 0 PM **Free Paper II**

1. Atomic Genetics and Basic Etiology of Cancer - *Vijay Mohan Das*, Fatehgarh
2. Conservative management of $pT_1 G_3$ TCC of Urinary Bladder – our result & Rationale - *N.K. Mohanty*, Arora, RP, Nayak RL, Malhotra V, Dept. of Urology, V.M. Medical College, & S.J. Hospital, New Delhi
3. Biliary Nitrate and Risk of Carcinoma of the Gallbladder - *V.S. Chauhan*, A Prakash and V.K. Shukla, Department of General Surgery and Radiology, Institute of Medical Sciences, Banaras Hindu University, Varanasi
4. A Prospective Audit of Laryngeal Cancer Surgeries in a Teaching Hospital - *P Chaturvedi*, R Kantharia, AK Decruz, KA Pathak, PS Pai, DA Chaukar, MS Deshpande, Head and Neck Service, Tata Memorial Hospital, Mumbai

Hall – B

2.00 PM – 3.40 PM **Free Paper I**

1. Is it necessary to remove Nipple and areola in all mastectomy cases – Need not be – An analysis - *BKC Mohan Prasad*, Madurai
2. Post Mastectomy Breast reconstruction – A seven years experience – *Abraham S.J.*, Thomas H, Ahammed I, Pushpangathan V.S., Vidyadharan R, Lourdes Hospital, Ernakulam, Kerala
3. Management of LABC-Experience at PGIMS, Rohtak - *Harish Sharma*, R.K. Karwasara, Vinod Malik, Sanjeev Parshad, Department of Surgical Oncology, PGIMS, Rohtak
4. Correlation of the clinical response of breast cancer to neoadjuvant chemotherapy with expression of C-erbB2 oncogene and host immune response - *Raj Kumar Chejara*, Kundu A, Bhandari V, Chaudhary R, V.M. Medical College and Safdarjung Hospital, New Delhi
5. Role of apoptotic markers in assessing the response to neoadjuvant chemotherapy and its association with clinical parameters in Carcinoma Breast - *Vinay Singhal*, Chintamani, Anju B, Saxena S, Sinha AN, Department of Surgery and ICMR Vardhman Mahavir Medical College, Safdarjang, New Delhi
6. Genetic Abnormalities of E-Cadherin - Expression in Human Breast Cancer - Amit Goyal, We G Jiang, Robert E Mansel, Department of Surgery, University of Wales College of Medicine, Cardiff, UK
7. Magnetic Resonance Imaging - An important tool in altering the management of breast disease - A Prabhudesai, E Dinakara Babu, N Tariq, F A Aref, R Vashisht, West Middlesex University Hospital, Middlesex, UK
8. Correlation between the levels of UROC28 with prognosis and nodal involvement in breast cancer patients: A quantitative study - K F Gomez, W G Jiang, G H Cunnick and R E Mansel, Metastasis Research Group, University Department of Surgery, University of Wales College of Medicine, Cardiff.UK
9. Radioguided Occult Lesion Localisation (Roll): a innovation in the surgical management of clinically occult breast lesions - R Nadeem, L S Chagla, R A Audisio, Department of Surgery, Whiston Hospital, Prescot. UK
10. Primary Sarcoma of the Breast - *Thampi K. Ampadi*, Manoj Pandey, Aleyamma Mathew, Elizabeth K. Abraham B. Rajan, Department of Surgical Oncology, Epidemiology, Pathology and Radiation Oncology, Regional Cancer Centre, Thriuvananthapuram, Kerala.

3.40 PM – 4.00 PM **COFFEE**

Session – IV
4.00 PM – 6.30 PM

Chairpersons

4.00 PM – 4.30 PM Cystic Neoplasms of pancreas — Dr. Donald Weaver, USA

4.30 PM – 6.00 PM *Panel Discussion, Gallbladder Cancer* — Prof. N.C. Misra, Lucknow; Dr. L. Sarangi, Varanasi

Panelists- Dr. L. Sarangi, Dr. H.S. Shukla, Dr. Arun Chaturvedi, Dr. Sanjeev Misra, Dr. Deepak Agarwal

6.00 PM – 6.30 PM Onco Quiz — Dr. Ravikant, New Delhi

6.30 PM GBM

21 September 2003
Session – I
8.30 AM – 10.30 AM

Chairpersons

8.30 AM – 10.00 AM **Symposium Thyroid Cancer** — Dr. Kiran Kothari, Ahemadabad

Convener-

1. Introduction - *Dr.Kiran Kothari*, Ahmedabad
2. Clinical Examination and Investigations - *Dr Rajen Tankshali*, Ahmedabad
3. Role of Biopsy including FNAC - *Dr.Samir Mehta*, Mumbai
4. Treatment strategy including surgery for well differentiated thyroid cancers - *Dr Anil D'cruz*, Mumbai
5. Radical Surgery for Advanced Thyroid Ca - *Dr Santosh Abraham*, Cochin
6. Total V/s Hemithyroidectomy - *Dr. Bhuvanesh Singh*, USA
7. Medullary Thyroid Cancer & MEN-2 - *Dr. Gaurav Agarwal*, Lucknow
8. Adjuvant Radioiodine Therapy - *Dr. Krishna*, Mumbai

Concluding Remarks - *Dr. Kiran Kothari*, Ahmedabad

10.00 AM-10.30 AM Cryo or RF Ablation for liver metastases from colon cancer — David Morris Australia

10.30 AM – 11.00 AM **COFFEE**

Session – II
11.00 AM – 1.00 PM

Chairpersons

Hall A

11.00 AM – 11.20 AM Care of the Stoma — Dr. R.B. Singh, Mumbai

11.20 AM – 1.00 PM **Free Papers III**

1. Colorectal Cancer in Children and adolescents – a 7 years Retrospective Surgery – *Gupta* A, Mandal A, Mishra P, Bhowmick A, Banerjee S, Bhattacharya S, Das S, Department of GI Surgery, Cancer Centre Welfare Home & Research Institute, M G

Road, Thakurpukur, Kolkatta

2. Major Liver Resections for Liver Tumours - *S. Sadasivam*, GKNM Hospital, Coimbatore

3. Laparoscopic abdominoperineal resection (APR) for Carcinoma of Rectum: Early Results of a prospective study involving 12 patients – *Jain Akhilesh*, Chander J, lal Pawanindra, Philips P, Ramteke VK, Department of Surgery, Lok Nayak Hospital and Maulana Azad Medical College, New Delhi

4. Pediatric Rhabdomyosarcoma – Initial Results of Pulse VAC Therapy - *Balamourougane P*, S. Agarwal, M Srinivas, M Bajpai, V Bhatnagar, DK Gupta, D K Mitra, A K Gupta, B K Mohanty, Department of Pediatric Surgery, Radiodiagnosis and Radiotherapy, All India Institute of Medical Sciences, New Delhi

5. Survival After Placement of Colorectal Stents - A J M Watson, V Shanmugam, I McKay, S Chaturvedi, V Duddalwar, J K Hussey, Department of Surgery and Radiology, Aberdeen Royal Infirmary, Aberdeen, Scotland, UK.

6. Does repeat FNA increase the yield of cancer in benign thyroid noduled? - Rajeev P, Mr Palazzo FF, Mr Sadler G, Dr Buley I, Dr Roskell, D, Dr Shah K, Department of Endocrine Surgery & Department of Cellular Pathology, John Radcliffe Hospital, Oxford. UK

7. Reconstruction of the Symphyseal Segment of Mandible – *Bhattacharya S*, Misra NC, Chaturvedi A, Khanna A, Bhatnagar SK, King George's Medical College, Awadh Hospital, Lucknow

8. Spinal Accessory Nerve Repair – *Singh S.K.*, Sarangi L, Mishra PK, Indian Railway Cancer Institute and Research Centre & G.S. Memorial Plastic Surgery Hospital, Varanasi

9. Proposed New Classification for Operations on the Thyroid Gland - *S Choudhri*, G Rajagopal, Armed Forces Medical College & Army Hospital (R&R) Delhi Cant, Pune

10. Alterations in surgical Technique for favourable prosthetic prognosis in Maxillary and Mandibular defects – *Tripathi Arvind*, Kumar Narendra and Chandra Suresh, Lucknow

Hall B

11.00 AM-11.20 AM Virtual biopsy

Dr. Bina Ravi,
New Delhi

11.20 AM – 1.00 PM **Free Papers IV**

Sacral Tumors-Clinical features and management – Series of five cases - *Gurpreet Singh Brar*, Srivastava Atul, Bhomik KT, VMC & Safdarjung Hospital, New Delhi

Second Echelon Sentinel node biopsy in Oral and Breast Carcinoma - *Anurag Srivastava*, Kuldeep Bassi, Sunil Chumber, V Seenu, Department of Surgery, All India Institute of Medical Sciences, New Delhi

Half suction versus full suction drainage after mastectomy-A prospective study in patients with locally advanced carcinoma breast – *Chintamani*, Vinay Singhal, Bhatnagar D, Sinha AN, Department of Srugery, Vardhman Mahavir Medical College, Safdarjang Hospital, New Delhi

Early Axillary Drain Removal After Mastectomy - *Nitin Gupta*, Varanasi

Intra operative celiac plexus bloc-A palliation in inoperable advanced Carcinoma Head of Pancreas - *Prafulla K Das*, B.K. Patnaik, S. Nayak, P Devi, Acharya harihar Regional Cancer Cenre, Cuttack

6. Oropharyngeal Cancer: A Clinical - pathological profile from Uttaranchal State - *Saini Sunil*, Ghildiyal JP, Gaur Dushyant, Singh Manish, Virendra, Oncology – Dept. of Surgery, Dept. of Pathology, , HIMS, Swamin Ram Nagar, Dehradun

7. Psychological Sequelae of Mastectomy for Carcinoma Breast - *Ratnagiri Rangnath*, Sarath Chandra S, Chandrasekaran R, Robinson Smile S, Jimper, Pondicherry

8. In the shadows of Halsted - *M. Tewari*, Shukla HS, Kumar V, Singh TB, Department of Surgical Oncology, AIIMS, New Delhi (at present) and IMS, BHU, Varanasi UP; Dept. of Pediatrics, IMS, BHU, Varanasi

9. Functional Outcomes After Neck Dissection: A Prospective Clinical study - *Dr. Somesh Chandra*, Manali Shah, Chief Physiotherapist GCRI, Chief Surgical Oncologist Sterling Hospital; Ahmedabad.

10. Forehead for the reconstruction of intraoral defects - *Raj K Misra*, AK Singh, Vijay Kumar, Sumit Malhotra, Aninda Mandal, C.S.M. Medical University, Upgraded King George's Medical College, Lucknow

Standby

11. Lymph Node metastases and Lymphadenectomy: Scientific or Oversimplified view- *Dr. Somesh Chandra*, Sterling Hospital & Add Life Medical Institute, Ahmedabad

5. Histological Prognostic Markers in Early Stage Oral Tongue Cancer - *P Chaturvedi*, R Kantharia, AK Decruz, KA Pathak, PS Pai, DA Chaukar, MS Deshpande, Head and Neck Service, Tata Memorial Hospital, Mumbai

Hall C

11.20 AM – 1.00 PM **Video**

1. Laparoscopic Gastrectomy – *DR. Senthil Kumar*, Dr. C. Palanivelu, Dr. K. Sendhil Kumar, Dr. G.S. Mahesh Kumar, Department of Surgical Gastroenterology and Advanced Laparoscopic Surgery, GEM Hospital, Coimbatore, India Coimbatore, India.

2. Laparoscopic Distal Pancreatectomy – DR. *Senthil Kumar*, Dr. C. Palanivelu, Dr. R. Parthasarathi, Dr. S. Rajesh Kumar Department of Surgical Gastroenterology and Advanced Laparoscopic Surgery, GEM Hospital, Coimbatore, India.

3. Laparoscopic abdominoperineal resection - *Senthil Kumar*, Dr.C. Palanivelu, Dr.P.S. Rajan, Dr.S. Rajapandian, Department of Surgical Gastroenterology and Advanced Laparoscopic Surgery, GEM Hospital, Coimbatore, India.

4. Thorocolaparoscopic Esophagectomy - *Senthil Kumar*, Dr.C.Palanivelu, Dr.Roshan Shetty, Dr Senthilkumaran S, Department of Surgical Gastroenterology and Advanced Laparoscopic Surgery, GEM Hospital, Coimbatore, India.

5. Laparoscopic APR – *Dr. K.S. Gopinath*, Bangalore

6. Uncommon Head and Neck Surgeries – *Dr. Somesh Chandra*, Ahmedabad

1.00 PM – 2.00 PM **LUNCH**

Session – III
2.00 PM – 3.30 PM

Chairpersons

Hall A

2.00 PM – 2.20 PM	Role of Aromatase inhibitor in Neo-Adjuvant Therapy of Breat Cancer	Dr. Sanjay Sharma Mumbai

2.20 PM – 2.40 PM	Sentinel node biopsy in breast cancer	Dr. Gurpreet Singh Chandigarh
2.40 PM – 3.00 PM	Marginal Mandibulectomy	Dr. K.A. Pathak Mumbai

Hall B

2.00 PM – 2.20 PM	Reconstruction of Intraoral defects with local flaps	Dr. S.K. Singh Varanasi
2.20 PM – 2.40 PM	Laparoscopic surgery in colorectal cancer	Dr. G.R. Verma Chandigarh
3.00 PM – 3.30 PM	**COFFEE**	
3.30 PM	**Valedictory Function**	

Poster Session I
19th September 2003

1. Estrogen & Progestron Receptor Status in Breast Cancer: Effect of Oral Contraceptive Pills and Hormone Replacement Therapy –*Tewari M.*, Shukla HS, Kumar V, Singh TB, Department of Surgical Oncology, AIIMS, New Delhi (at present) and IMS, BHU, Varanasi, U.P. Dept. of Pediatrics, IMS, BHU, Varanasi, U.P. India.
2. Management of Hormone Resistant Cancer Prostate (HRCaP) with Docetaxel as Monotherapy – A Preliminary Report – *Mohanty N K*, Nayak RL, Arora RP, Malhotra V, Department of Urology, V.M. Medical College & S.J. Hospital New Delhi, India.
3. Lycopene as Chemopreventive in Treatment of High Grade Prostate Interaepithelial Neoplasia (HGPIN) – *Mohanty N K*, Nayak RL, Arora RP, Malhotra V, Department of Urology, V.M. Medical College & S.J. Hospital New Delhi, India.
4. A rare case of pancreatic Neoplasm – *Saggar V*, Chejara RK, Bhandari V, Chaudhury R, V.M. Medical College & Safdarjung, New Delhi.
5. Newer Diagnostic Imaging Modalities in Carcinoma of the Gallbladder – *V.S. Chauhan*, AK Agrawal, VK Shukla, Department of General Surgery & Radiology, Institute of Medical Sciences BHU Varanasi.
6. Reconstruction of chest wall following resection of extensive chondrosarcoma – *Singh S.K.*, Sarangi L, Kumar S, Indian Railway Cancer Institute & G.S. Memorial Plastic Surgery Hospital, Varanasi.
7. Clear Cell Sarcomas of the Kidney in Children - *Balamourougane P*, S. Agarwala, M Srinivas, M Bajpai, V Bhatnagar, DK Gupta, PK Mitra, AK Gupta, BK Mohanty, Department of Pediatric Surgery & Radiodiagnositc & Radiotherapy, AIIMS, New Delhi, India.
8. Malignant Germ Cell Tumors in Children - *Balamourougane P*, S Agarwala, V Bhatnagar, M Bajpai, DK Gupta, PK Mitra, AK Gupta, Department of Pediatric Surgery & Radiodiagnositc, AIIMS, New Delhi, India.
9. Colostomy site recurrence of adenocarcinoma of the rectum following abdomino-perineal resection in the absence of any local recurrence: A rare case report with review of literature– *Chintamani*, Vinay Singhal, Aashima Lyall, Ashok Arya, Sinha AN, Department of Surgery, Vardhman Mahavir Medical College, Safdarjang, New Delhi
10. Are chemotherapy induced side effects good predictors of response to neo adjuvant chemotherapy in patients with locally advanced breast cancers-A prospective -

Chintamani, Vinay Singhal, Bhatnagar D, Sinha AN, Department of Surgery, Vardhman Mahavir Medical College, Safdarjang, New Delhi

11. Sweat gland adenocarcinoma - A clinico pathological dilemma - *Chintamani*, Vinay Singhal, Rohini B, Saxena S, Bhatnagar D, Sinha AN, Department of Surgery, ICMR, Vardhman Mahavir Medical College, Safdarjang, New Delhi

12. A rare case of Breast Sarcoma- Case report with review of literature – *Chintamani*, Vinay Singhal, Gupta A, Saxena S, Bansal A, Sinha AN, Department of Surgery, ICMR, Vardhman Mahavir Medical College, Safdarjang, New Delhi

13. Invasive lobular carcinoma developing in Cystosarcoma Phylloides- A rare case report – *Vinay Singhal*, Chintamani, Gupta A, Saxena S Bansal A, Department of Surgery, ICMR, Vardhman Mahavir Medical College, Safdarjang, New Delhi

14. Carcinoid of the stomach - An unusual presentation - *Chintamani*, Vinay Singhal, Anju Bansal, Saxena S, Sinha AN, Department of Surgery & ICMR, Vardhman Mahavir Medical College, Safdarjang, New Delhi

15. Isolated splenic metastasis from colon Carcinoma – *Srivastava Atul*, Bhatnagar Amar, Brar GS, Sood Naresh, Thakre Madhukar G, Bhowmik K.T., VMMC and Safdarjung Hospital, New Delhi

16. Oropharyngeal Cancer: A Clinical - pathological profile from Uttaranchal State –*Saini Sunil*, Ghildiyal JP, Gaur Dushyant, Singh Manish, Virendra, Oncology – Department of Surgery, Dept. of Pathology, HIMS, Swami Ram Nagar, Dehradun, UA

17. Lymph Node metastases and Lymphadenectomy: Scientific or Oversimplified view- *Somesh Chandra*, Chief Surgical Oncologist, Sterling Hospital & Add Life Medical Institute, Ahmedabad

18. Magnetic resonance spectroscopic evaluation of axillary nodes in operable breast cacner to detect metastases – *V Seenu*, MN Pavan Kumar, Uma Sharma, NR Jagannathan, Siddarth D Gupta, SN Mehtra, New Delhi

19. Breast Cancer: Experience at Himalayan Institute of Medical Sciences, Dehradun - *Ghildiyal J.P.*, Saini Sunil, Gaur D.S, Singh Manish, Virendra, Oncology – Department of Surgery, Dept. of Pathology, HIMS, Swami Ram Nagar, Dehradun, UA

Poster Session II
20th September 2003

1. Chest wall reconstruction: A retrospective analysis of 31 patients.- Nirmal Lamichhane, Nepal

2. Reconstructing Perineal Defects after Ablative Cancer Surgery – S. Bhattacharya, Lucknow

3. Haemangioma – Surgery, Indications and Results. – S. Bhattacharya, Lucknow

4. Role of Perioperative hyperalimentation in patients undergoing major Oncosurgical Operations – Dalbir Sandhu, Rohtak

5. Primary Primitive neuro-ectodermal tumor of the kidney – Vinod Malik, Rohtak

6. Papillary Carcinoma in Ectopic thyroid tissue – Sanjeev Prashad, Rohtak

7. Chronic Cholecystitis and Carcinoma Gallbladder a Diagnostic dilemma – J.V. Hardikar, Mumbai

8. SPONTANEOUS ENTEROCUTANEOUS FISTULA 25 YEARS AFTER RADIOTHERAPY IN A PATIENT OF CARCINOMA PENIS- A CASE REPORT WITH REVIEW OF LITERATURE – J.P. Singh, New Delhi
9. SQUAMOUS CELL CARCINOMA OF THE SCROTUM DEVELOPING FOLLOWING FOURNIER'S GANGRENE- CASE REPORT WITH REVIEW OF LITERATURE – J.P. Singh, New Delhi
10. Unusual Presentations of Osteosarcoma – K. Chandramohan, Thiruvananthapuram
11. Role of Self-Expandable Metallic Stents in Tracheo-bronchial Tree: A team experience – Vedant Kabra, Mumbai
12. Mandibular Support by K-Wire; following segmental mandibulectomy – S. Ghosh, Kolkatta
13. Cytohistological evaluation of salivary Gland Tumours – N. Gupta, Varanasi
14. Clinico- Pathollogic Profile of Neoplasms in Children: A 5-year Experience - Atia Zaka-Ur Rab, Aligarh
15. Primary Squamous cell carcinoma of Thyroid, an unusual Presentation – Ashima Lyall, New Delhi
16. A Retrospective Analysis of Reconstructive procedures in Patients of Oral Cancers at a Tertiary Centre – Anuj Mishra, New Delhi
17. Effect of Ayurvedic therapy HUMA on inoperable tumors - Hina Fatima, Lucknow
18. Histological Prognostic Markers in Early Stage Oral Tongue Cancer - P Chaturvedi, Mumbai
19. Diagnostic accuracy of high resolution ultrasonography and helical CT scan in assessment of palpable and impalpable neck nodes – SK Singh, Lucknow

Indian Association of Surgical Oncology
New Member List

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30.	Dr. Nitin Babel IASO No. B0039	B-14, Kailash Nagar J.K. Cement Works, Nimbahera, Distt. Chittorgarh-312617 (Rajasthan) Tel. : 01477-221597 (R), 01477-220087 (O) E-mail : nittinbabel@hotmail.com

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04	Dr. Ashok Kumar Rai Associate Member IASO 19	Laxmi Medical & Surgical Care Centre S-17/329, Maladahiya (Cantt.), Varanasi Tel. : 0542-2208731, 0542-2200501 (W) Mobile : 9415227070
05	Dr. Sanjoy Panda Associate Member IASO 20	Panda Medical Centre Kesarpur, Cuttack-753001 Tel. : 0671-2615829 (R) Mobile: 98610-55677
06	Dr. Madhusudan Modi Associate Member IASO 21	C/o Dr. Manju Modi Press Chowk, Madhupatna, Behind TC Marbles, Cuttack (Orissa) - 753010 Tel. : 0671-2343435 (R), 0674-2300570 (W) Mobile : 94370-32211 E-mail : madhu modi@yahoo.com
07	Dr. Gajanaj D Wagholikar Associate Member IASO 22	12/12 Sakal-Nagar, Baner Road, Pune-411 007 Tel. : 020-25658085 (R) E-mail : drgajanan2002@yahoo.com
08	Dr. Akhilesh Kumar Upadhyay Associate Member IASO	Room No. 329, new P.G. Hostel Swaroop Rani, Hospital, Allahabad Tel. : 0542-2224527 (R), Mobile : 9415354126
09	Dr. Rishi Nayyar Associate Member IASO 24	C-61, New Multan Nagar, Rohtak Road, New Delhi-110056 Tel. : 011-25257811 (R), E-mail : nayyarrishi@yahoo.co.in
10	Dr. Sushanto Neogi Associate Member IASO 25	C3A/3A Janak Puri, New Delhi - 110058 Tel. : 01125529124 (R), Mobile : 9811594511 E-mail : sushan8@bat.net.in

Form for Membership/Change of Address of Indian Association of Surgical Oncology (IASO)

To,
Dr. L. Sarangi, Secretary
Indian Association of Surgical Oncology (IASO)
162 A, N. E. Railway Officers Colony
Lahartara, Varanasi-221 002

Tel. No. : 0542-2370361
E-mail : lsarangi@satyam.net.in

Sri

1. I wish to become a member of Indian Association of Surgical Oncology (IASO) (a section of ASI). I enclose Rs. 1000.00 (one thousand only) or Rs. 1100.00 (one thousand one hundred only for outstation cheque) by Cheque/Draft/Cash dated _____ drawn on _____ payaple at Varanasi. Enclosed Detailsas per para 1 to 6. Draft in favour of Secretary IASO payable at Varanasi.
2. Or I am an existing member of IASO. My address details have changed as per para 1 to 4.

Signature of Applicant : _____ Date of Application _____

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1.4 Date of birth _____ 2.1 ASI Number : _____
2.2 IASO Number (to be filled up by the office) : _____
3.1 Present Address, Including pin code : _____
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4.5 E-mail : _____ 4.6 Personal Website : _____
5.1 Percentage of Oncology work : _____
5.2 Research in Oncology : _____
5.3 Educational Qualifications : _____
5.4 MCI Number : _____
5.5 Experience-details attached : _____
5.6 Papers published : _____ and presented (List only the number of publications and presentations above and attach a separate sheet with details.)
6.1 Name of proposer : _____ ASI number : _____
Signature of Proposer : _____
6.2 Name of Seconder : _____ ASI number : _____
Signature of Seconder : _____
Comments by Secretary : Accepted/not accepted Signature of Secretary

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