IASO NEWSLETTER

August 2004
Vol 18 No. 1

Indian Association of Surgical Oncology

(A Section of The Association of Surgeons of India)

Indian Association of Surgical Oncology (IASO)

President	Secretary	Year
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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
Dr. K. Kothari	Dr. L. Sarangi	2004

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NEWSLETTER

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Indian Association of Surgical Oncology

(A Section of The Association of Surgeons of India)

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August 2004 Vol - 18 No. 1

President's Message

Dear Colleagues,

I am elated to write a few words to all the members regarding our Organization and the spectrum of its activities. outset, I thank you for giving me this prestigious responsibilities for the year 2004.

I also take this opportunity to thank Dr. Raj Govind Sharma Dr. Mehta for their efforts, towards organizing NATCON at Jaipur which I am sure is going to be a very successful and event.

This is 28th year of our association and it is not only sections of ASI but it is one of the most active sections. It has great work in disseminating knowledge and skill to its through workshop, CME, conferences fellowship programs for all these years. Dr. is doing commendable job for the past two years. This year we are all coming Cancer Treatment guidelines for various sites, during ASICON 2004.

The purpose of newsletter is to disseminate information of our association its members, along with scientific articles. I sincerely hope that this is going to take Surgical Oncology Journal in coming years. Dr. Sanjeev Misra is doing great job as of IASO News Letter.

Every year one of our young colleagues is selected for fellowship of Wayne State of Detroit, USA. We are thankful to Dr. Donald Weaver for this. This helps them international exposure.

Surgical Oncology is an established super specialty with its own post graduate and fellowship programs at few cancer centers like GCRI at Ahmedabad, Kidwai Institute at Bangalore and Adayar Cancer Institute at Chennai and King George's University, Lucknow. Our combined efforts in the war against deadly disease 'cancer' of early detection of various cancers with various screening programs and treatment diagnosed cancers by multimodality treatment of which Cancer surgery forms a major There is need for development of many such dedicated cancer centers in the country.

Also we should practice latest developments in Cancer Surgery like Minimally Surgery (MIS). Even though it is only getting accepted world wide now in cancer treatment strongly believe that in not so far future, MIS in thoracic and GI cancer treatment will conquer the world of Cancer Surgery. Better patient acceptance, better and magnified vision, early recovery and early return to day-to-day activities at the same time compromising the basic surgical oncologic principles are real advantages of MIS. Many international studies which are coming up are proofs of safety and advantages in Cancer Surgery. Keeping this in mind, we organized Indo Japanese Thoraco Laparoscopic Workshop 2004 at GCRI, Ahmedabad, very recently on July 30, 31 and August 1, 2004. delegates attended from all over India and we demonstrated 10 major Thoraco Laparoscopic surgeries of various sites successfully.

I take this opportunity to wish good wishes to all the members.

With kind regards

Prof. Kiran C. Kothari MS, DNB
Prof. of Surgical Oncology, GCRI, Ahmedabad
President, IASO

Editorial

There has been a major change in the attitudes towards malignant diseases in the last three decades. Surgical treatment of cancer is now, clearly, a major modality of treatment. In the past, cancer surgery was carried out mainly by general surgeons with no specific interest in cancer. Surgeons trained and dedicated to cancer surgery now carry out majority of surgical treatment of cancer in developed countries. In India the awareness about cancer is slowly increasing and patients are seeking treatment by cancer surgeons. However, in our country, where limited facilities for surgical oncology training are available, the number of trained surgical oncologists is not enough to meet the demands of the society, and, therefore, lot of patients get treated by general surgeons. The surgical oncology training programmes in India are at only a few centres – Chennai, Bangalore, Mumbai, Ahemdabad and Lucknow. There are also very few academic departments of Surgical Oncology in the country. There is thus, a strong need to have more trained surgical oncologists and surgeons with a special interest in cancer surgery who are trained and are familiar with new knowledge and skills. The Indian Association of Surgical Oncology has taken the task of providing surgical oncology education to the surgeons through its Newsletter, Annual Conferences and CME programmes. With this in mind the present newsletter reviews some important issues in the treatment of cancer. Dr. Gurpreet Singh reviews the status of sentinel lymph node dissection (SLND) for breast cancer. SLND has a definite learning curve and is not for the occasional breast surgeon. Estrogen and progesterone receptors have been the traditional prognostic factors in the management of breast cancer. There are a lot of new prognostic markers, which are slowly finding their way in predicting survival and treatment outcomes. Prof. Ravi Kant and his group from Delhi have very actively been studying these and give an overview of these prognostic markers. He also presents his debate for practice of oopherectomy in premenopausal breast cancer patients in India, as it is a simple, cost effective, one-time procedure especially appropriate for the rural patient. We also need to carry out proper designed clinical trials in India looking into the role of oopherectomy as an adjuvant treatment for breast cancer.

It is always not easy for the clinician to understand published data due to the statistics involved. Prof. Arun Chaturvedi presents an overview of how to interpret scientific data and the importance of p- value in the article "to p or not to p".

I would request you all to send in articles for the newsletter following the standard instructions for authors, which can be obtained from, the website: **www.icmje.org.** We would also request the members to send their achievements, awards, and conference/ meeting reports etc. organized by them so that they may be published in the newsletter. We invite your suggestions and comments so that we can improve further, till then - happy reading.

Dr Sanjeev Misra
Lucknow

Secretary's Report

Dear members,

I welcome you all to the pink city Jaipur and to NATCON
IASO is rapidly growing in strength both in academic activ
well as in membership. It has attracted the attention of interna
faculties that can be judged by the progressively increasing nu
of foreign guests participating in our conferences. It is time we
consolidate our position and make this association the nodal
in formulating cancer treatment in this country.

Like the last year, the agenda of 2004 has been circulated
our members sometime in April and all out efforts have been
to achieve the target.

1. **NATCON 2003-** The Silver Jubilee conference at Lucknow has been a watersh
conference in the history of IASO. For the first time a formal exchange program
with the British Association of Surgical Oncology. This could be possible due
enthusiasm of our past president Dr. Gopinath, Org. secretaries Dr. Arun Chatur
Dr. Sanjeev Misra and under the able guidance of Dr. D.D.Patel and Dr. N. C. Mis
association can never forget their contribution. This year also we have tried to con
the same exchange program. The conference was attended by over 500 delegates
the deliberations, symposia, video sessions, free papers were of international stand
There were three symposia on thyroid, soft tissue sarcoma, stomach(video) convene
Dr. K. Kothari, Maj.Gen(Dr) P. Subhas, Dr. Sanjay Sharma respectively. A record nu
of more than 50 free papers & posters were presented in the conference. I shall be
duty if I do not mention the contribution of Dr. Ravi Kant. He took care of the
hospitality of all our overseas guest faculties on their arrival at Delhi till their departu
Lucknow.

   The Detroit fellowship 2004-5 was awarded to Dr. Manoj Pandey of Thiruvunathapu
   & Baroda travelling fellowship 2003 to Dr. Prafull Kumar Das of Cuttack.

2. **ASICON 2003-** In the new format of sectional program in ASICON, each section
been allowed to have one oration, one guest lecture, one symposium. We follow
guidelines and had an additional symposium on carcinaoma esophagus jointly
cardiothoracic section besides our own on bone tumors. The symposium on bone tu
convened by Col.(Dr.) M. Ganguly was well attended. Dr. Sanjay Sharma convened
symposium on carcinoma esophagus in his own style in a packed auditorium on the
day of the conference. This year we propose to have one oration, three symposia
jointly with other sections), three guest lectures besides the free papers.

3. **Workshops & CME programs-** A couple of international workshops have already
organized with great success by our members in 2004. An international workshop
esophageal cancer was organized by Dr. Thomas Varghese and his team at Lisie
hospital & Research Centre at Kochi. Live demonstrations of three field lymphadenec
with total esophagectomy, D2 resection in gastroesophageal cancers were given by
surgeons from Japan & India. Similarly an Indo- Japanese thoraco- laparoscopic
surgery workshop was organized by our president Dr. Kiran Kothari at GCRI, Ahmed

recently. Both the workshops were very well attended & the faculty enthralled the audience by their masterly skill. Both the conferences have given a benchmark for any such endeavor. Dr. Sunil Kumar of Tata Main hospital, Jamshedpur organized a National oncology conference in his hospital with one day devoted to surgical demonstration both head & neck and GI cancers. He is planning a repeat conference this year also. Such conferences encourage our younger colleagues to take up oncology as a career.

4. **Detroit fellowship**—Dr. K. A. Pathak , Mumbai has already availed the fellowship. Dr. Weaver has been intimated of the selection of Dr. Manoj Pandey. We are looking forward to more number of such fellowships in future. I take this opportunity to remind the promise made by Dr. P. B. Desai to donate a decent amount to IASO to promote cancer education in this country.

5. **Baroda Traveling fellowship-** Dr. Prafulla kumar Das of Cuttack has already availed the fellowship in 2003. I am unable to understand why this fellowship is not able to attract young surgeons. Possibly the amount of Rs. 5000 needs enhancement to at least Rs. 10000.

6. **ASICON 2004 at Hyderabad-** The sectional program of IASO will be published in Dec. 2004 issue of the newsletter. We shall have an impressive performance better than last year. There will be three symposia, two of them jointly with GI & Rural surgery sections besides our own.

7. **Finance-** At present we have a fixed deposit of Rs 873000. The audited account of 2003 is being published in the newsletter. Rs. 25000 has been paid to Dr. Raj Govind Sharma as the seed money for NATCON 2004. I have requested him to transfer the amount to Dr. B.K.C. Mohan Prasad, organizing secretary of NATCON 2005.

8. **News Letter-** Publication of the newsletter has been regular and is improving with every issue. We must make serious efforts to index it.

9. IASO guidelines for common malignancies- We are lagging behind the schedule. Dr. Ravi Kant is requested to expedite the process.

10. **WFSOS news-** The membership subscription for 2004 has been cleared by our representative Dr. K. S. Gopinath. WFSOS had two executive council meetings at Budapest & Oporto(Portugal) this year.

11. **Membership drive-** Our membership is steadily rising. This year we have already enrolled 31 new members. Our aim is to have more number of active members than the sleeping ones.

I see a bright future for the association. Development of any association lies with the active involvement of its members. There has been an offer from European association of surgical oncology to have various collaborative studies. We have to workout an offer of fellowship exchange program with BASO also.

Collaborative studies involving international bodies will further enhance our status. This requires serious thinking, hard & honest efforts, blessings & guidance of senior members.

Thanking you
Yours sincerely
Dr. L. Sarangi
SECRETARY, IASO

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Sentinel Node Biopsy in Breast Cancer

Gurpreet Singh

Introduction

Axillary lymph node dissection has been an essential element in the treatment of cancer from the time of Halsted. In 1994, a National Cancer Data Base survey of patients with early-stage breast cancer treated throughout the United States found percent of the patients underwent axillary dissection [1]. The rationale behind the use of involves accurate staging, regional control of the disease and improved survival. this is the prognostic information obtained and the influence of the information gain the adjuvant therapy of the individual patient. All this is achieved at the cost of the of axillary dissection, which though not critical in terms of surgical complications, is sign in terms of quality of life in long-term survivors.

The widespread use of mammography and public education has resulted in presenting with smaller tumors and infrequent involvement of the axillary nodes. The of axillary dissection is thus restricted to fewer patients (those with involved nodes). chemotherapy is now being administered on the basis of characteristics of the primary The ideal approach would thus be to identify patients with axillary node involvement offer axillary dissection to them, thus optimizing the risk-benefit ratio of the procedure. lymph node biopsy (SLNB) is a minimally invasive technique for detecting axillary node metastases in patients with breast cancer. Potential surgical advantages of this invasive approach include decreased operative and anesthetic morbidity, decreased size, improved postoperative function, improved cost effectiveness, and improved accuracy.

The word 'sentinel' is defined in the Oxford dictionary as a guard or one who watch. When translated to an oncological concept, it represents the first lymph receive lymphatic drainage (and consequently, metastases) from the tumor. The SLNB presumes that that there is an orderly and predictable pattern of spread to the lymphatic basin and that the sentinel node will act as an effective filter for the draining cells. To be effective in clinical practice the status of the sentinel lymph node (metastatic non-metastatic) has to accurately reflect the status of the remaining nodes in the

Starting The Procedure

Like any new surgical procedure, SLNB too has to be learnt properly. Each desirous of starting the procedure should involve all the departments concerned and out an Institutional protocol. The selection of patients and the technique should be standardized and a back up axillary dissection done to validate the early experience of the periodic audit, both short term and long term is required before one can give up axillary dissection on the basis of SLNB.

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There is no doubt that there is a significant learning curve associated with learning the procedure and that different surgeons master the technique at different speeds. There is no consensus on the number of procedures required to overcome the learning curve. The American Society of Breast Surgeons initially recommended that 30 procedures were required to 'train' a surgeon in SLNB [2]. There is no other procedure in surgery that has such stringent credentialing criteria. Recognizing this fact, the society has decided to lower the number of cases but has laid stress on the outcome of the SLNB. The goal for the individual surgeon should be to achieve a < 5% false negative and / or failure to detect rate before proceeding to SLNB alone without axillary dissection back up.

Patient Selection

The patient most suited for a SLNB is one with a T1-2, N0 tumor. The incidence of axillary node metastasis in such patients is sufficiently low to warrant a selective approach to the axilla. Nonpalpable tumors can also be subjected to SLNB. In the West, DCIS represents about 20% of all tumors and the risk of axillary nodal involvement is about 1%. However, patients with high risk DCIS or DCIS with microinvasion may be suitable candidates for SLNB. Patients with larger tumors, but a favorable histology, i.e., medullary, mucinous, tubular, may also be candidates for SLNB considering the low frequency of involvement of the axillary nodes.

Patients with involved nodes are the biggest contraindication for SLNB. Mechanical obstruction of the lymphatics by tumor cells can lead to changes in the lymphatic flow and direct the tracer to the non sentinel lymph node. Patients who have had an excision biopsy and patients with multicentric disease were earlier considered relatively unsuitable for SLNB. With modifications in the technique, these patients can be taken up for SLNB.

Technical Aspects

The identification of the sentinel node is done by injecting a tracer around the tumor. This tracer can be visual (blue dye), a radionuclide, or both. The commonest blue dye used all over the world is 1% isosulfan blue. Limited availability and high cost prevent its free use in India. Methylene blue can be used as an alternative [3], but has certain drawbacks. One of the known complications of injecting this drug is fat necrosis. The particle size of Methylene blue is smaller and it may transit through the sentinel lymph node.

There are variations at every step of the technique but comparable results are obtained, no matter what the technique used. It is not possible to go into all the variations of the technique and their merits in this article. The reader can refer to excellent reviews on the subject [4,5].

When judging the success of SLNB, two statistics are vital.

- Sentinel lymph node identification rate: This is the proportion of patients in whom the sentinel lymph node is identified and removed. This figure judges the technical success of the procedure and may be improved upon by modifications in technique and increasing surgical experience.
- False negative rate: This is the proportion of patients with axillary metastases who have a negative SLNB. This figure judges the clinical usefulness of the procedure. This may be due to skip metastasis or an intraoperative assessment error. This figure may vary with the prevalence of axillary node involvement in the patient population being studied.

For a SLNB to be judged successful the identification rate should be 90% or more and the false negative rate around 5%.

Handling of The Sentinel Lymph Node

The average number of lymph nodes recovered in a specimen of axillary dissection varies from 15 to 20. The standard pathologic examination involves a single section of each node subjected to routine hematoxylin and eosin. In contrast, the number of nodes recovered during SLNB varies from1 to 3. Pathologists can thus focus their attention and resources to examining these nodes. Techniques, which would not be possible because of time and financial constraints, now become possible. There is at present no consensus on optimal handling of sentinel nodes in the laboratory. Most centers have developed their own 'in-house' protocols, which are invariably tied in with the institution's research and financial constraints. It is agreed upon that a single section is not enough to assess the presence of metastases in the lymph nodes. The minimum that should be done is to perform serial / step sectioning of the node. Additional immunohistocytochemistry with cytokeratin and other antibodies is being frequently utilized. The technique of reverse transcription polymerase chain reaction (RT-PCR) is an additional tool to assess the node for metastases [11].

The ideal situation would be where an intraoperative assessment of the sentinel node can be done using frozen section for serial / step sectioning and immunohistocytochemistry. A significant false negative rate, the loss of diagnostic tissue, and the time spent on performing the tests are hindrances to the universal acceptance of intraoperative assessment.

The use of these sophisticated techniques has resulted in the detection of 'micrometastases' that would not be detected on routine staining. A micrometastases is defined as a tumor deposit < 2 mm in size. The clinical significance of these micrometastases is hotly debated. However, there are numerous studies now that show a survival disadvantage in the presence of micrometastases [12,13].

Radiation Hazard During SLNB

When a radionuclide is used in the identification of the sentinel node, the problem of radiation exposure to the exposed personnel arises. The person injecting the isotope, the surgeon conducting the biopsy, the pathologist handling the frozen section and the employee handling the waste generated all are potentially exposed to this hazard. If the injection is performed in the department of Nuclear Medicine, then no special monitoring is required in the operating room. The radiation exposure in the operating room is maximal for the surgeon. The estimation of this exposure has shown that the effective dose delivered to the surgeon is so low that he can perform over 5000 SLNBs without approaching the statutory limits of radiation exposure [14]. This low limit of radiation does not merit monitoring in the operating room.

Results of SLNB

The initial experience with SLNB was reported using blue dye alone in 174 patients. An identification rate of 66% was achieved using blue dye alone and predicted the status of the axilla with 96% accuracy [6]. The first experience with radionuclide tracers was reported in 22 patients with an identification rate of 82% and an accuracy of 100% [7]. The first study using both the blue dye and radionuclide tracers was reported on 62 patients with 92% identification

rate and 100% accuracy [8]. Since then, numerous peer-reviewed studies have been published using a variety of techniques. The SLNB was validated in all series by a back up axillary dissection. A recent meta-analysis that included 69 studies evaluating SLNB in over 10,000 patients with operable breast cancer, demonstrated a 90% or greater success rate of identifying and removing a sentinel node in about half of the studies and an overall false negative rate of 8.4% (range 0–29) [9]. There was a complete lack of randomized controlled trials on the subject till August 2003 when one such trial was published from Italy [10]. They randomly assigned 516 patients with primary breast cancer in whom the tumor was less than or equal to 2 cm in diameter either to sentinel-node biopsy and total axillary dissection or to sentinel-node biopsy followed by axillary dissection only if the sentinel node contained metastases. Sentinel node was identified in all patients and the false negative rate was 8.8%. The local recurrence rate and survival was similar in both groups. This study shows that SLNB correctly predicts the status of the rest of the axilla and axillary dissection can be safely omitted if the sentinel node is negative for metastases. Other prospective studies on SLNB are going on at present (NSABP B-32; ACS Z10 and Z11) and will clarify the situation further.

Non Sentinel Node Involvement

In about half of the patients undergoing SLNB, on completing the procedure as an axillary dissection the sentinel node is found to be the only site of involvement. These patients probably have no further need for axillary dissection. We have no way of predicting the involvement of non sentinel nodes in the axilla. Some the factors associated with the presence of non sentinel node involvement are size of the primary tumor, the presence of extracapsular extension, size of the metastases in the sentinel node and peritumoral lymphovascular invasion. None of these factors, either alone or in combination, are strong enough predictors to exclusively identify all patients with non sentinel node involvement. Thus, patients with involved sentinel node are still be subjected to axillary dissection.

Internal Mammary Node Involvement

After the axillary nodes, the internal mammary nodes are the most frequent sites of metastases from breast cancer. The involvement depends on the size and site of the primary tumor and the presence of axillary node involvement. The detection of sentinel nodes in the internal mammary chain has restarted the debate on how best they are to be treated. There is yet no consensus on this subject and we have to go by what we have been doing in the past in the absence of SLNB.

SLNB After Neoadjuvant Chemotherapy

Locally advanced breast cancer constitutes a significant proportion of the patients treated by us. Neoadjuvant chemotherapy is now the standard of care for these patients. Neoadjuvant chemotherapy has the potential to completely eradicate the tumor from the breast and the axilla. In such patients, SLNB may be able to predict the status of the axilla and restrict the use of axillary dissection. Neoadjuvant chemotherapy induces fibrosis and scarring and this may alter the lymphatic pathway, thus making sentinel node identification more difficult. We also assume that the response of chemotherapy in both the sentinel nodes and the non sentinel nodes is the same. In a compilation of 204 patients undergoing SLNB after neoadjuvant chemotherapy, the sentinel node was identified in 87% and the false negative rate was 14% [15]. An alternative approach to incorporating SLNB in patients undergoing neoadjuvant chemotherapy is to perform SLNB before the start of chemotherapy.

Impact of SLNB on Current Practice

Whether SLNB has become the standard of care at present for patients with early cancer may be a matter of debate. It has however affected our current practice of management of these patients. In the latest revision of the TNM staging of breast cancer new categories for the pathological staging of nodal status have been introduced which include the presence of micrometastases and the method by which they have been detected (immunohistocytochemistry or RT-PCR) [16]. New categories of patients have been defined for the use of adjuvant therapy. Patients with micrometastases detected only on immunohistocytochemistry or patients with isolated sentinel nodes in the internal mammary chain are two such examples.

Key Points

- SLNB is a minimally invasive method of determining the involvement of axillary lymph nodes in patients with breast cancer with clinically uninvolved axillae.
- Many different techniques for SLNB have been developed, all of which appear to yield comparable results.
- Optimal pathological examination of the sentinel node is yet to be standardized, but will usually be more extensive than current examination.
- Though there is a lack of evidence from randomized controlled trials, a huge body of evidence exists verifying the clinical utility of SLNB.
- SLNB has the potential to alter the management of patients with early breast cancer and may soon become the standard of care for such patients.

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Prizes in IASO & NATCON IASO

Detroit Fellowship

☞ **Dr. Somesh Chandra** - 2000 - 1
Room14, Sterling Hospital,
Memnagar, Ahmedabad - 380052

☞ **Dr. S. V. S. Deo** - 2002 - 3
Asstt. Prof. of Surgery,
Surgical Oncology, IRCH, AIIMS
New Delhi 110029

☞ **Dr. K. A. Pathak** - 2003-4
E-703, Runwal Center
govandi Station Road, Deonar
Mumbai 400088
Maharastra

Baroda Travelling Fellowship

☞ **Dr. Prafulla Kumar Das** - 2003
C-17, 150-1 Compound
Kanika Square Tulsipur,
Cuttack 753008

Free Paper Presentation

☞ **Dr. V. S. Chauhan-** First prize—2003
Room No.9, Old Doctors' Hostel,
BHU, Varanasi – 221005

☞ **Dr. Atia Zaka-ur Rab** - Second prize— 2003
C/o Dr.M.Z.Rab
2 Wazir Manzil, Luxmibai Marg,
Aligarh, UP- 202001

Postor presentation

☞ **Dr. V. Seenu** First prize - 2003
C-6/21/1 SDA, Delhi-110 016

☞ **Dr. V. Kabra**-Second Prize-2003
K-302, King's Crown
ShalimarTownship,
AB Road, Indore-452010

Oncoquiz

☞ **Dr. Somesh Chandra-** First - 2003
Room14, SterlingHospital,
Memnagar, Ahmedabad-380052.

☞ **Dr. Pawan Gupta-**Second—2003
Cancer Surgeon
Dharamshila Cancer Hospital &
Research Centre, Dharamshila Marg,
Vasundhara Enclave, Delhi- 110 096

☞ **Dr. Saran Chaudhary-** Third— 2003
Prof. of Surgery
Q1/C Malignant Diseases Treatment
Centre Command Hospital (AF)
Airport Road, Bangalore-560076

IASO - Baroda Travelling Fellowship

Application are invited for IASO-Baroda Travelling fellowship for the year 200

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

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

This newsletter of IASO is going to be a regular feature and will be published two a year. It will contain relevant professional news, events and recent topics of comm interest. Members are requested to make use of the newsletter for dissemination 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 (on 31-12-2005) and he is required to present a research paper during **NATCON'2005** at Kodai Kanal, as a part of selection process.

Application must reach Secretary, IASO by 30th June' 2005

Prognostic Markers in Breast Cancer

Ravi Kant, Vishal Gupta, Ajay Yadav, Vivek Gupta, Manu Gupta, BC Das, BK Sharma, Bina Ravi, PN Agarwal[1],

Summary : Prognosis even in node negative breast cancer can be predicted. The useful prognostic factors are HSP - 27, C-myc, nm23, P-53, PS-2, Angiogenesis, Micro-vessel count, Integrin, UPA, PAI (Plasminogen Activator Inhibitor), Cathepsin-D, EGFR, erbb2 (Neu), Agnors, S-phase fraction.

Some of the currently well known prognostic factors for the breast cancer are host factors like *age, menopausal status, inflammatory response and adjacent in-situ disease* and tumor factors like *size, grade vascular invasion, nodal involvement, hormonal status, DNA-content, ploidy and S-phase.* Out of above, **nodal involvement is most important.** Lymph nodes in relation to pectoralis minor muscle are also a useful marker for predicting prognosis. Level I inferio-lateral to pectoralis minor (proximal), Level-II behind pectoralis Minor (middle), Level-III medial to pectoralis minor (distal). Involvement of upper nodes denotes a worse prognosis than involvement of proximal level lymph nodes. However, prognosis is related more directly to the total number of nodes involved, than to the level of involvement. The post surgical treatment pathologic classification is a better guide than the Clinical TNM Classification.

However, it is of interest to know the markers that can predict (a) **future of node negative disease** (b) **chemotherapy resistance** and (C) **resistance to hormone therapy in ER+ PR+ case.** Thus the key question is what is New?

Entirely new groups of prognostic factors are evolving. The breast cancer cell, restless and relentless, can be expected to have four qualities. Genetic, Adhesion, Invasion, & Proliferation. I prefer to call them four traits of a *naughty* malignant cell.

(1) The **genetic** factors of importance are lack of tumor *suppressor* oncogene like P53 and ras-gene, or, increased level of tumor *promoter* oncogenes like C-myc, nm 23, m RNA at g, HSP, Rb (retinoblastoma gene). BRCA 1 and BRCA 2 are important in familial cancer.

(2) **Adhesion,** *the* second quality of a naughty malignant cell is predicted by neo-angiogenesis and micro-vessel count, thus inviting role of agents like protamine and fumagillin, which inhibit neo-angiogenesis.

(3) The third quality of **invasion** can be predicted by Cathepsin D, Integrin, Laminin receptor, Matrix metalloproteases and enzyme collagenase Type IV (MMPz). *They also indicate high probability of loco-regional recurrence.* Invasion can also be predicted by markers such as Plasminogen Activator like Urokinase Plasminogen Activator (UPA), Laminin Receptor and Integrin.

Cathepsin-D denotes 7 times more chances of recurrence in node negative patient.

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(4) Now, the fourth quality that is **proliferation** can be predicted by either growth like neu (or erbb-2), EGF Receptor (ERBB-1), Insulin growth factor-1, Transforming factor (TGF), Fibroblast Growth Factor (bFGF), Platelet Growth Factor (PDGF), Proliferating Cell Nuclear Antigen (PCNA), Agnors, P 120 and last but not the least PS2.

The high level of erbb2 denotes 5 times more mortality in the Node negative. And in good nuclear grade, high level of erbb2 denotes relapse 3 times more and 5 times more often frequently as compared to low level of erbb2 in the same set of.

PS2 is better that ER or PR in predicting response of hormone therapy *and can predict ER+ PR+ will not respond to hormone therapy and which ER-ve will respond.* High EGFR denotes resistance to Tamoxifen. *The high level of HSP27 denotes strong possibility of resistance to Adriamycin and Toremifene can overcome the resistance.* **High level of denotes strong possibility of resistance to CMF.**

However, out of above markers, ER, PR, PS2, P53, Cathepsin D, and neu are easily available. Lot of work is being done in Delhi on BRCA1, BRCA 2 and many newer markers.

Role of tissue biomarkers?

Prognostic markers predict patient outcome irrespective of the treatment given. factors reflect biologic characteristic of the tumor including proliferation, invasion, and Predictive factors indicate responsiveness to a particular therapy. Some factors may prognostic as well as predictive e.g. ER status. So biomarkers relate to prognosis and response to treatment.

Table 1 : Classification of prognostic factors

Markers of proliferation	*Markers regulating cell cycle and cell*
Proliferating cell nuclear antigen(PCNA)	p53, bcl-2
Markers of angiogenesis	c-erbB2, EGFr, TGFß, TGFa
VEGF	*Markers of invasion and metastases*
ßFGF	PA-1
Panendothelial marker	TPA
Micro vessel count	Metallproteases

Markers of proliferation

Markers of proliferation have been investigated extensively as a means to characterize an individual's chance of recurrence. There are different methods to rate of proliferation. New techniques have been developed for evaluating potential of proliferation that are expressed in the various phase of cell cycle.

Table 2 : Markers Expressed in Variaous Phases of Cell Cycle

Marker	G0	G1	S	G2
Mitosin	-	-	-	±
Histones	-	-	+	±
Topoisimerase	-	-	±	+
DNA polymerase	-	±	+	+
Cyclins (PCNA	-	±	+	±

Mitosin : A new proliferation marker that is expressed in G2 and M phase. It is found to be good predictor of disease free survival.

Proliferating cell nuclear antigen (PCNA) : It is a nuclear protein associated with DNA polymerase a, that is present through out cell cycle in proliferating cells. The monoclonal antibody PC10 recognizes an epitope of human PCNA in fixed breast cancer tissue. Most studies have found only weak correlation with other prognostic factors and association with clinical outcome has been poor.

Detection of micro metastasis : Axillary lymph node status of one of the most important prognostic indicator in breast cancer. Usually it is determined by H&E staining under light microscope. The detection of micro metastasis in lymph nodes or other tissue would identify 25-30% of lymph node negative patients who are destined to relapse with out adjuvant systemic therapy. Studies have been focused on the prognostic significance of micro metastasis. But to date it has not been conclusively demonstrated that occult metastasis is a significant prognostic factor.

Lymph node Micrometastasis : By conventional light microscopy methods, two third of patients with a newly diagnosed breast cancer have negative axillary nodes. About 30 % of these patients will go on to develop disease recurrence. So, detection of occult lymph node involvement might identify a subset of node-negative patients with higher chances of relapse. Micrometstasis has been defined as areas of metastasis extending $\leq$2 mm. The presence of micrometstasis disease can be identified by number of methods. Light microscopy of H&E stained serial sections of node is a labor intense procedures it is estimated that in order to detect a single tumor cell with in a mean diameter of 20μm, 250 slides would be needed to be generated from single 5-mm node[1]. Other methods are IHC or PCR for epithelial or tumor associated antigens. The presence of micrometstasis is associated with worse prognosis. In international breast cancer study group trial V[2], axillary nodes of 736 patients were examined by serial sectioning and by IHC. Micrometstasis was found in 27% cases. The presence of micrometstasis independently predicted for a modestly higher risk of recurrence. Overall, these studies suggest that the presence of micrometstases predicts for a slightly worse prognosis than for patients who are truly node negative. Presently further studies are required before incorporating information derived from IHC staining of axillary nodes into routine practice.

Bone marrow micrometstases (BMM) : BMM has been identified by using immunocytochemical staining directed at variety of epithelial antigens, including cytokeratin, membrane bound mucking, or tumor associated antigens. Current techniques allow the detection of about one tumor cell in $2X10^6$ mononuclear cells. In one study [3], 727 patients were evaluated by immunocytochemical staining against tumor associated antigen. BMM was found in 55% patients with positive Nodes and in 31% patients with negative nodes. Presence of micrometstases was an independent prognostic factor for both DFS and OS.

Markers of Angiogenesis

Tumor growth and metastases are critically dependent on tumor induced angiogenesis. This process is a highly regulated multistep system involving a delicate balance between angiogenic and antiangiogenic factors, eventually leading to an increase in number of intratumoral micro vessels. The dependence of tumor growth on angiogenesis has led to numerous studies investigating the relationship between tumor angiogenesis and breast cancer prognosis. the most commonly used measure of angiogenesis is light microscopy counting of

intratumoral vessels stained with either anti-factorVIII- blood related antigen/von W factor or antiCD31. Micro vessel count is a statistically significant independent pr DFS and OS in both node positive and node negative patients[1]. In addition to MCD, between angiogenic factors and patient outcome has been investigated. Many angiogenic peptides have been discovered, but few have been evaluated in human cancer. Vascular endothelial growth factor (VEGF), a selective mitogen for endothelium, has been investigated. In one study[4], VEGF level was evaluated in negative patients. After 5 years of follow up, low VEGF (≤54pg/mg) was associ recurrence and death in 7% and 3% respectively. In contrast, high CEGF level (> mg) was associated with risk of recurrence and death in 23% and 11% patients VEGF and fibroblasts growth factor (bFGF) expression has been evaluated in 305 After 40 months of follow up, the recurrence rate was 42% in VEGF positive as com 17% in VEGF negative patients. There was no correlation between bFGF and outc

An attractive feature of angiogenesis is that it offers a target for novel the interventions. Several antiangiogenic agents have been developed and evaluated in of systems. These include:

1. Polysulfated glycosamines. prptidoglycans, polyglcosylated lipids
2. Enzymes that control the vascularization process
3. Steroid and steroid related substance
4. Antibiotics and synthetic antibiotics
5. Nonspecific biological response modifiers

Clinical trials are being designed to test these agents singly and in combination regimens may have their maximum efficacy early in the course of the disease.

To summarize, there are data supporting that evaluation of angiogenic individual specimen might distinguish between more indolent or aggressive tumors the data are mostly from small retrospective studies. Large studies are needed to delineate the prognostic role of the tumor induced angiogenesis.

Markers of invasion and metastases

The process of cancer invasion and metastases is complex. Tumor cells adhe extra-cellular matrix and recruit stromal cells. Subsequently, matrix degrading mediates tumor cell passage through basement membrane and extracellular matrix to tumor progression. Identification of markers that are related to the process of invasion and metastases might therefore be very useful. Researchers have tried correlate markers of invasion with prognosis. However at present, none of the markers in this category can be applied for the routine use.

Matrix metalloproteinases : Matrix metalloproteinases (MMPs) and their (tissue inhibitor of metalloproteinases [TIMP] play important role in tissue modeling normal physiological conditions, the actions of these proteins are balanced and regulated. In cancer, inceased ability to degrade the extracellular matrix by disrupt the MMP-TIMP system is correlated with invasion and metastases. The MMP are related zinc-dependent proteinases capable of degrading various extracellular components.MMP-2 and MMP-9 has the ability to degrade collagen type IV, the major protein of the basement membrane. MMP-11, also known as stromelysin 3 (STC

identified member that is found to be overexpresed in the stroma of various cancers. Work in breast cancer has suggested that MMP-2, TIMP-2, and ST3 may be important in human breast cancer invasion and metastases and thus may represent new areas for diagnosis, prognosis, and treatment.

Markers regulating cell cycle and cell death

With the increased understanding of cell biology over the last decade, it was identified that both proliferation and apoptosis are important in the tumorogenesis. Many proto-oncogenes and tumor suppressor genes regulates the process of cell cycle and cell death. Interruption of the normal balance between inhibitors and promoters of apoptosis could lead to tumor growth and invasion.

P53 : It is a tumor suppressor gene located on chromosome 17. The p53- encoded nuclear protein has an important role in regulating transcription of many other genes. In the response to cell damage, wild type p53 can induce cell cycle arrest in G1 phase. If repair mechanisms are not sufficient, p53 also serves as a critical regulator of cellular entry in to apoptotic pathway. The p53 gene is mutated in up to 50% patients with invasive female breast caner, 41% of male breast cancer, and 16% of in situ breast cancer. The normal protein has a short half life; however, most mutations in the p53 lead to a conformationally altered, more stable protein that accumulates in the nucleus and is unable to perform its normal function. Prognostic role of p53 has been studied but, results are conflicting. It is because of different methods of p53 expression assessment. Immunohistochemistry, FISH (fluorescent in situ hybridization), PCR-SSCP (Polymerase chain reaction –single strand conformation polymorphism), and other methods have been used to assess p53. Elledge and Allred[6] reviewed 57 studies involving > 13000 patients and concluded that inactivation of this gene appears to be associated with a poor out come as measured by OS and DFS, but its prognostic significance is not powerful enough to allow its use in clinical decision making. Based on the results of previous studies, American college of clinical oncology panel concluded that there is insufficient data to support the clinical use of p53.

Bcl-2 family: Several members of bcl-2 family have a critical role in the regulation of apoptosis. In general, over expression of bcl-2 is associated with resistance of cells to apoptosis. On the other hand, bcl2 is regulated in breast cancer by the ER and high levels of the protein are associated with good prognosis and improved out come. Other members of the bcl family include bax, a promoter of apoptosis, and bclx, an inhibitor of apoptosis. Prognosis reflected by balance between two. Only limited data is available to correlate these markers with prognosis in breast cancer.

Growth factors and receptors:

The epithelial cells of the breast are under the influence of a variety of hormones and growth factors. The tyrosine kinase growth factor receptors are best studied and classified in to 9 different families. The type 1 growth factor receptor includes the epidermal growth factor receptor (EGFR) family. Members of this family are: EGFR (also known as c-erb-b1), HER-2/neu (also known as c-erb-b2), HER-3 (also known as c-erb-b3), and HER4 (also known asc-erb-b4).

EGFR: It is present in low concentration in normal breast epithelial cells. Thirty five to 60% of primary breast cancer over expresses EGFR. It can be detected by methods like immunocytochemical analysis, imunoenzymatic assays. Over expression of this factor is found

to be associated with higher grade and increased proliferation rates. It is an prognostic factor for primary breast caner, but the lack of standardization of the assay small numbers of patients and short follow up in most of the studies, it is impossible firm conclusion about the optimal role of EGFR status in determining prognosis. The EGFR status as a predictive factor for hormone therapy is well defined. Tumors EGFR are more likely to be resistant to hormonal therapy. It is because a negative has been found between EFGR and steroid receptor status. Monoclonal antibodies been developed that are directed to EGFR.

HER-2/neu: It is located on chromosome 17. It is expressed in low concentration epithelial and myoepithelial cells of normal breast tissue. In human, oncogenic protein are manifested when the protein is overexpresed rather than mutated. expressed in comedo, large cell, DCIS, but relatively low levels are found in papillary cribriform in situ tumors. Predictive role of HER2/neu has been studied. Potential neu status has been evaluated for predicting response to chemotherapy. It is patients with no or little detectable levels of HER2/neu derive considerable benefit based chemotherapy while those with high level (i.e. overexpression of this gene benefit from chemotherapy. This observation is not supported by prospective studies. al[7] showed in his study that patients with high expression of HER2/neu gene do better to CAF. The results of NSABP study[8] showed that patients with tumors with HER2/neu have the same clinical outcome with and without the use of doxorubicin addition of Doxorubicin improved clinical outcome in patient with HER2/neu positive This result has also been supported by the South West Oncology Group Study[9]. HER2 tumors are also found to be resistant to paclitaxel[10]. Predictive role of HER2/neu status to hormonal therapy has also been evaluated. High serum level HER2/neu levels associated with decreased response to droloxifene in advanced tumors. Similar has been observed with tamoxifen.

Results of these studies may suggest that patients whose tumors overexpress should not receive endocrine therapy even if tumor is ER positive. It may be that benefit from endocrine therapy for ER positive patients with over expression of may be reduced, the benefit may be better than might be expected alternatively. Secondly, these results are derived from small nonrandomized series. Additional well and well designed studies must be conducted before HER2/neu status can be used whether to administer or with hold endocrine therapy.

Biomarker use in clinical practice:

The American society of clinical oncology (ASCO) has prepared clinical practice for the use of tumor markers in breast tumors[11]. The ASCO recommendations are

1. ER/PR are relatively weak predictor of long term relapse and breast caner related rates, and are not recommended to be used alone to assign a patient to groupings.
2. Present data are insufficient to recommend routinely obtaining DNA flow derived estimation of DNA content or S phase.
3. DNA flow cytometry –derived ploidy is not recommended to be used to assign to prognostic groupings. There is insufficient evidence to recommend the use determination for assigning patients to prognostic groupings.

4. Present data are insufficient to recommend the use of DNA flow cytometry derived ploidy (DNA index) or flow cytometric measures of proliferation (% S phase and related analysis) for selection of the type of adjuvant therapy to be given.
5. Present data are insufficient to recommend the use of DNA flow cytometry derived information to select among different treatment options for metastasis disease.
6. Present data are insufficient to recommend the use of c-erbB2 gene amplification or overexpression for management of patients.
7. Present data are insufficient to recommend the use of p53 measurement for the management of patients.
8. Present data are insufficient to recommend the use of cathepsin D measurement for the management of patients.

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National Conference of Indian Association of Surgical Oncology NATCON-IASO-2004

The **NATCON IASO 2004** will be held in Jaipur on **24, 25 & 26th of Sept. 2004.** It is being organized by the Dept. of Surgery, SMS Medical College Jaipur, Rajasthan. **Organizing Secretary** is **Dr Raj Govind Sharma Asst. Prof in Surgery** and the Organizing Chairman is Dr J M Mehta Prof & Head, Dept. of Surgery. The **venue is Hotel Clark's Amer, Jaipur** a five star hotel situated on the outskirts of Jaipur near the Airport. **The Theme of the conference is Operative Surgery including Minimal Access Surgery**. The scientific session would consist of Continuing Medical Education Program, Interactive sessions, Free Papers, Symposia, Posters, Orations, Panel discussions and Guest lectures. International & National leaders in the field of Oncology have been invited for the conference. The topics for the symposiums include Cancer Rectum, Cancer Cervix, Head & Neck Cancer and Quality of life issues. These and other topics have been chosen keeping in mind the wider spectrum of participation by Gynecologists, ENT surgeons and Psycho-oncologists, Pain management groups and other caregivers. There would be competition & awards, which includes the Detroit Traveling Fellowship and Best Poster award. Scientific exhibition would display the latest in technology and pharmaceuticals.

For **details** please contact ; **Dr Raj Govind Sharma**, MS FACS FICS FUICC, 17 Uniara Garden, Jaipur 302004. Tel –0141 2622783, 2620343.

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

Vice President	**- 1**
Secretary	**- 1**
Editorial Secretary	**- 1**
Joint Editorial Secretary	**- 1**
EC Members	**- 4**

Nominations must reach the Secretary, IASO by 12.00 noon 24th Sept. 2004

Topics for Symposia, Panel Discussions, Gust Lectures are invited from the members for the NATCON IASO-2005 and for the IASO Sectional meeting during ASICON-2005. Please send your suggestions and Topic to the Secretary, IASO

Ovarian Ablation as Adjuvant Therapy in Early Breast Cancer

Ravi Kant, Bina Ravi, Vishal Gupta, Vivek Manchanda,

Adjuvant systemic therapy is defined as the administration of cytotoxic chemotherapy the use of ablative or additive therapy after primary surgery of the breast. Role of ovarian ablation either by surgical oopherectomy or by irradiation has been studied [1,2]. Significant Disease free survival (DFS) and Overall survival (OS) have been observed in some reports.

In women less than 50 years of age, adjuvant chemotherapy alone reduces the annual odds of recurrences by 37 % and the annual odds of mortality by 27% [5]. Ovarian ablation alone shows similar results with 30% reduction in the annual odds of recurrences and 24% reduction in the annual odds of mortality [5]. These results are better than Tamoxifen alone. Interest in ovarian ablation developed after the observation that chemotherapy induced amenorrhea is associated with superior disease free survival [6, 7, 8,9,10].

Scottish trial conducted by the Scottish Cancer Trial Breast Group and the ICRF unit of Guy's Hospital, was the first trial to compare ovarian ablation directly with chemotherapy [11]. Three hundred and thirty three pre-menopausal, node positive patients were randomized to either ovarian ablation or chemotherapy (CMF) for 6-8 cycles. After median follow-up of 5.9 years, no statistically difference was found in the DFS or OS between two groups. It suggests gently that adjuvant surgical oopherectomy may be equal to adjuvant chemotherapy in its effect.

Meta-analysis conducted by EBCTCG (Early Breast Cancer Trialist Collaborative Group) in 1996, included data from 12 properly randomized trials of ovarian ablation involving 2101 patients younger than 50 years of age[2]. Seven of these trials compared ovarian ablation with chemotherapy and 5 trials compared ovarian ablation + chemotherapy with chemotherapy alone. Younger women had a significant DFS and OS advantage with ovarian ablation as compared to no treatment (25 ±7% and 24 ± 7% reduction in the annual odds recurrences and mortality respectively.) Improvement in survival was seen in both node positive and lymph node negative patients. These results are compared to those which are achieved on younger patients < 50 years of age. Although ovarian ablation is comparable to chemotherapy alone, it adds little to chemotherapy as shown in this meta-analysis and other studies as well[12]. It is because of chemotherapy induced chemical ovarian ablation. Patients with high ER (>20 fmol/ mg of protein) are benefited more than patients with low (< 20 fmol / mg of protein) [11].

In women > 50 years, ovarian ablation produces insignificant improvement in DFS and OS, as ovarian functions in general are substantially less in this age group as most of the women are postmenopausal[2].

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Database from which to draw definitive conclusions in the value of ovarian ablation is much substantiated than that for adjuvant Tamoxifen or chemotherapy. Further randomized trials are required to assess additional of ovarian ablation in the presence of chemotherapy, to assess these effects in the presence / absence of prolonged anti-estrogen therapy and to assess relevance of hormonal receptor measurement. Similarly, more information on long-term consequences of ovarian ablation in young women is required. Premature coronary artery disease can occur in such patients. Bone loss is seen patient with endometriosis with even on short-term goserelin therapy[13].

Ovarian ablation may be considered as an adjuvant therapy in those who refuses other treatment or patient with hereditary breast cancer syndrome. Additional relevance of ovarian ablation in population when adjuvant therapy being used, requires further study but it's value is known to be substantial and persistent in reducing both recurrence and mortality in population where adjuvant therapy is not used routinely or patient is not able to come for regular follow up or patient's compliance can't be relied upon or patient can not afford Tamoxifen. In addition, ovarian ablation in pre-menopausal women will help in family planning in such countries. More important is its role in poor and rural population which may be lost to follow-up, as they are unable to visit hospital again after one visit due to either social or financial or cultural reasons. Poor and rural patients are to be offered the best of treatment, but in one visit. Surgical oophorectomy in such a patient is scientific, proven beyond doubt to be useful, evidence based, economic, and widely available.

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The National Conference of Indian Association of Surgical Oncology NATCON - IASO 2005

The **NATCON IASO 2005** will be held in **Kodaikanal, Tamilnadu** on **24th 25th Sept 2005.** The conference is being organized by Dept. of Surgical Onco Madurai Medical College and Govt. Rajaji Hospital , Madurai and the Madurai Insti of Oncology, 32, West Avani Moola Street, Madurai – 625001, Tamilnadu. **Organi Secretary is Prof. B.K.C. Mohan Prasad, Madurai.** The **venue** will be **either Carlton or Hotel Tamilnadu, Kodaikanal.** Interactive sessions, Operative Sessions, Free Papers, Symposia, Posters, Orations, Panel discussions and Guest lect will constitute the Scientific Programme. International and National leaders in the of Oncology will be present.

Kodaikanal, the "Princess of Hills" of India is a picturesque hill station in Tamilna Come with your family, as there is a lot to see and enjoy in Kodaikanal. Beautiful La Mountains, Valleys, Gardens, Temples Traditional art and culture of Tamilnadu and gre of all, the local cuisine awaits your arrival.

We expect the conference to continue the tradition of excellence, amity and c fellowship. It will be great occasion to meet pioneers and masters from abroad and own country.

For details please contact :-

Prof. Dr. B. K. C. MOHAN PRASAD, M.S.,M.Ch.,
32, West Avani Moola Street, Madurai – 625 001.
Tel.: 0452 – 2345911, 2345822
Fax : 91 - 452 - 2346626. E-mail: madinonc@eth.net

Statistical Significance: 'to p or not to p'

Arun Chaturvedi

The development of modern medicine in the 20th century from an empirical science to a scientifically rigorous, evidence based discipline has largely resulted from high quality medical research. Medical statistics is now an integral part of medical research and statistical analysis is essential for presentation of meaningful results. However, this requires the clinician to have a degree of statistical literacy to critically and accurately interpret statistical data.

Statistics is used as an analytical tool to prove or disprove scientific hypothesis. To the uninitiated the p-value of less than 0.05 represents a 'holy figure', which cannot be questioned. This value churned out by complex mathematical methodology from equally complex computers and statistical software remains unchallenged. The purpose of this article is to help understand this 'magic number' and what it stands for, its pitfalls and its alternatives.

Statistics is used to make inference from a sample (the study subjects) to the overall population. The statistical significance (p-value) of a result is an estimated measure of the degree to which it is 'true' (in the sense of representative of the population). In a two arm clinical trial the p-value is the probability that the difference between arm 1 and 2 is at least as large as that observed in the sample if there is actually no difference in the overall population (assuming the null hypothesis).

The null hypothesis of the study is often that there is no difference between the two arms. If the p-value is low (an arbitrary level could be 5% or 0.05), we reject the null hypothesis. It is important to remember that we are not proving the alternative hypothesis but rejecting the null hypothesis of 'no difference'.

A trial for, example, evaluating the response to two different combinations of chemotherapy shows 45% response in one arm and 55% in the other arm. How do we know that these results actually show a real difference and this difference is not a chance finding, a fluke? Statistical analysis of this data shows the difference to be statistically significant with a p-value of 0.03. The interpretation of this result is that if the null hypothesis of there being no difference in the response to the two combinations is true, there is a 3% chance of observing a response difference as large or larger than the one observed. If there was truly no difference in the treatments in the overall population and the trial was repeated infinite number of times this response difference of 10% would be expected to occur by chance in 3 out of 100 such trials.

A small p-value shows that the probability of obtaining the observed differences by chance alone is low and it is assumed that the null hypothesis does not hold; conversely if the p-value is large, it is possible that the data are consistent with the null hypothesis, which cannot be rejected.

Prof. Arun Chaturvedi is Professor of Surgical Oncology at Deptt. of Surgical Oncology, King George's Medical University, Lucknow
Correspondence to : Prof. Arun Chaturvedi, Deptt. of Surgical Oncology, King Geroge's Medical University, Lucknow

Despite the fact that a p-value of 0.05 is frequently used as a default benchmark for significant results this is a fallacious standard. Interpreting a p-value is sensitive to a host of factors all of which should be taken in to account by a conscientious researcher. Also, issues relating to study design and its execution are perhaps much more important than this single 'magic p-value'.

Important points to be considered when interpreting a p-value:

1. A p-value without a null hypothesis is meaningless. One should never interpret a p-value without knowing the null hypothesis with which it is associated.
2. The p-value does not prove that the alternative hypothesis is true; p-values are based on the assumption that the null hypothesis is true and only provide evidence against the null hypothesis, not evidence to support the alternative hypothesis.
3. The p-value depends on existing differences between the study groups, the scatter of data (the standard deviation) and the sample size. The larger the difference between the study groups, the smaller the standard deviation or the larger the sample size, the more significant the p-value.

   An important difference between study groups may not be statistically significant in a small trial. Conversely, an unimportant difference may appear very significant in a large trial.
4. The arbitrary p-value of 0.05 should not be used as a cut-off for significant results. It may be more relevant and meaningful to give the absolute p-values. Reporting that the p-value is less than 0.05 is less informative as it could mean a p-value of 0.049 or 0.0001. It is much more informative and helpful to give the exact p-value.
5. A non-significant p-value does not demonstrate that the null hypothesis is true. Large p-values may be simply due to small sample size or highly scattered data. A non-significant p-value only means that the evidence is not strong enough to reject the null hypothesis.
6. A p-value set at 0.05 may not be appropriate and may have to be set lower in certain situations such as multiple comparisons.

One-tail versus two-tail p-value

A two-tailed (or two-sided) p-value represents the probability of the difference, assuming the null hypothesis to be true, being as large or larger than observed with either treatment being superior to the other. One-sided p-value considers one treatment being superior to the other as specified in the alternative hypothesis.

Unless there is absolute certainty that the difference between two interventions can go only in one way two-tailed p-values should be used. If a one-tailed p-value is used the alternative hypothesis must be stated in advance (a priori) specifying the intervention believed to be superior. Changing from two-tailed to one-tailed p-values to obtain statistically significant results at the end of a trail is misleading. There are suggestions that for one-tailed p-values significance levels should be set at 0.025.

Clinical versus Statistical significance

Since the p-value depends on the sample size, large samples (trials) may prove small clinically insignificant differences to be significant. On the other hand large clinically significant differences may not be shown statistically significant if the sample size is small.

It is important in these situations to judge how the results should be interpreted. Confidence intervals in this situation can provide additional useful information.

Confidence intervals

Confidence intervals (CI) provide a useful tool to determine a range of values in which the parameters of the target population are likely to reside.

A 95% CI represents a range of values that will include the true population parameter in 95% of all cases. If an infinite number of samples of the same size are taken from the same overall population and the CI calculated in the same manner, the true parameter in the overall population would be included 95% of time.

Confidence intervals and p-values are complementary. However, confidence intervals provide more information than p-value alone. Several journals now request these to be reported in the statistical analysis.

If the 95% CI includes the value of the null hypothesis (eg. 0 for difference between means or 1 for risk or odds ratio) the p-value will be greater then 0.05. If the CI does not include the value of no difference p-value will be less than 0.05.

If the 95% CI includes values that look clinically important but the p-value is not significant then this could be because of a small sample. Results of such trials, though not statistically significant, are still important. The width of the CI is also a measure of the precision of the estimate. A narrow (tight) confidence interval generates more 'confidence' in the results.

Multiple comparisons and subset analysis:

The more analysis you perform on a data set, the more results will meet 'by chance' the conventional significance level. Multiple comparisons carry the risk of providing false positive results. If multiple independent null hypotheses – all of which are true – are tested in the same investigation, the probability that one p value may become statistically significantly by chance alone increases.

If 10 different null hypotheses are tested the probability of obtaining a statistically significant result at an alpha of 0.05% is 40%, for 50 null hypotheses it is 92%, for 100 null hypotheses it is over 99%. The p-values must be considered cautiously if many independent null hypotheses are tested. Corrective measures, like the Bonferroni method needs to be applied to have a p-value adjusted for multiple comparison.

Subset analysis is another potential source of obtaining spurious results similar to that with multiple comparisons. Subgroup findings should be viewed as exploratory, subject to confirmation in another trial.

Investigations for which hypothesis are formulated after the study has been conducted (a posterior hypothesis), rather than before performing the study (a prior hypothesis), should be viewed more as hypothesis generating rather than hypothesis testing and even more so if they look at patient subsets and perform multiple comparisons. Often investigators resort to 'data dredging' or 'fishing expedition' by testing multiple hypotheses and only the statistically significant findings are reported. This is misleading and potentially dangerous if the study has clinical implications. It is important to clearly state and report all tested hypothesis and associated p-values.

Minutes of Annual General Body Meeting of IASO held at Lucknow during NATCON-IASO 2003 on 20th September 2003

1. Meeting called to order by President
2. Adjourned due to lack of quorum
3. Meeting again called to order
4. Minutes AGM at Kolkata read and passed
5. Audited account of 2002 presented and passed
6. Annual report of IASO read by secretary and passed.
7. Bylaws amendments-

a) Post of Associate Editor for two years – passed

b) Immediate Past Organizing secretary incorporated as co-opted executive member for one year.

c) Guidelines for invitation of NATCON-

i) Organising secretary or his representative must be present in the 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) Organizing secretary shall make efforts to donate a decent amount from the profit of NATCON besides Rs. 100 per delegate to IASO

v) It has been decided that on request, a loan of Rs. 25000 may be given to the Organizing secretary of NATCON as seed money to start preparation, repayable within 6 months of the conference.

d) Silver jubilee IASO oration in ASICON- passed

i) National or International speaker

ii) Rs. 2000 oration award, a medallion and a citation to be presented

8. a) Detroit Fellowship- For 2004-5 Dr. Manoj Pandey of Trivandrum selected.

b) Baroda Traveling Fellowship- Dr. Prafulla Kumar Das of Cuttack selected for 2003-4. Dr. G.N. Shukla reminded that he had been instrumental in instituting the fellowship. On information the money will be released to the fellow directly. But as per stipulation one of them may be included in the selection process. So it was decided to include DR. G. N. Shukla as a permanent member in selection.

9. a) Jaipur has been confirmed as the venue of NATCON 2004. Dr. Raj Govind Sharma, Organizing secretary presented the logistics of the conference. The proposed dates are 24th , 25th &26th of September 2004; to be confirmed in consultation with the secretary of IGES. Since the NATCON's of both IASO & IGES are scheduled for 3rd week of September every year, the matter is in the agenda of GC meeting of ASI to be discussed on 26th December at Pune.

b) Orations—Names yet to be finalized.

c) Symposia— 1. Quality of life issues in cancer- Dr. Manoj Pandey- Trvandrum
2. Cancer Rectum—Dr. T. Gunasagaran-Chennai
3. Cancer of Uterine cervix—Local organizing committee
4. Operative video sessions on Head & Neck cancers- Dr. Anil D'Cruz-Mumbai
5. Minimal invasive surgery— Local organizing committee

10) a) Symposia in ASICON Hyderabad- Dr. R. Pillarisetty, U.K (topic to be announced)
b) Workshop on Oesophageal cancer— 2nd week of March 2004 at Cochin
Org. secy—Dr. Thomas Vergese, Cochin

11) News Letter— General body congratulated Dr. Sanjeev Misra for an excellent news letter. Members urged to send quality articles & news items. Two issues per year to be published; in July & December.

12) a) Chairpersons of all the subcommittees urged to formulate programs & activate them.
b) Dr. Ravikant informed that the IASO guidelines on common cancers will be ready by December.
c) Modalities of fellowship program in Surgical Oncology are being worked out

13) WFSOS— Dr. R. I. Dave attended the WFSOS meeting at Los Angeles presented his report. The next meeting is in Hungary, in March 2004. The editor advised to announce the schedule of various meetings in the newsletter.

14) Venue of NATCON 2005—three proposals— Kodaikanal, Mount Abu, Ludhiana Kodaikanal selected by show of hands. Organising secretary will be Dr. B.K.C. Mohan Prasad.

15) Election of office bearers—

a) Vice president— Four nominations
Dr. RaviKant, Dr. B.K.C. Mohan Prasad, Dr. S. Sadasivam, Dr. Sanjay Sharma.

DrB.K.C. Mohan Prasad, Dr. S. Sadasivam, Dr. Sanjay Sharma Withdrew, Dr. Ravi Kant declared elected unanimously.

b) Executive members—Six nominations

Dr. Sanjay Sharma, Dr. Amitabh Singh, Dr. Rajan. Tankshali, Dr. K.A. Pathak, Dr.S Sadasivam, Dr.Satish Jain. Dr. Sanjay Sharma & DR. Satish Jain withdrew. Rest four members declared elected unanimously for 2004-5.

16) Any other matter—

a) DR. S.K. Shukla emphasized the need of CME programs in smaller places & reminded the obligatory role of IASO to the society in this regard. He was supported by almost all the members. President announced that our association had already taken initiative with four such CME programs in 2003 & similar activities should in future also.

b) The question of using IASO banner in CME programs, Workshops & Conferences generated considerable interest and debate. Finally it was decided the CME where delegation fee was charged, a token amount of Rs. 5000 or Rs. 50 per delegate for one day event or Rs. 75 for two days event which ever was more must be deposited to use IASO banner.

c) AGM thanked DR. R. Karwasra, Dr. S. Sadasivam for contribution of Rs. 51,000 & 70,000 respectively from NATCONS organized by them.

d) AGM thanked Dr. Astha Misra for donation of Rs. 50000 to Dr. N. C. Misra oration.

17) President & members profusely thanked organizing committee for an excellent Silver Jubilee NATCON.

18) President thanked the members for co-operation.

19) DR. D. D. Patel and members thanked President & executive committee for their performance.

The meeting closed by president.

Dr. K.S Gopinath	Dr. K. C. Kothari	Dr. S. Kumar	Dr. L. Sarangi
President	Vice-President	Vice-President	Secretary

Secretariat
162 A, N.E. Railway Officer's Colony,
Lahartara, Varanasi-221002
Phone-0542-2370361
Email- lsarangi@satyam.net.in

Conference Diary

28 September –1 October 2004
16th EORTC/AACR/NCI Symposium on Molecular Targets and CancerTherapeutics
Geneva, Switzerland Contact : Email : info@fecs.be

3– 7 October 2004
46th Annual Meeting of the American Society for Therapeutic Radiology and Oncology Atlanta, GA, USA Contact : Email : georgettes@astro.org

3–8 October 2004
10th Biennial Meeting of the International Gynecologic Cancer Society Edinburgh, United Kingdom Contact : Email : igcs-10@kenes.com

10–14 October 2004
6th Congress of the European Association of Neuro-Oncology Jerusalem, Israel Contact : Email : info@ortra.com

15–16 October 2004
9th International Conference on Geriatric Oncology : Cancer in the Elderly San Francisco, CA, USA Contact : Email : imedex@ageoftravel.com

24–28 October 2004
23rd Annual Meeting of the European Society for Therapeutic Radiology and Oncology
Amsterdam, Netherlands Contact : Email : info@estro.be

25–30 October 2004
7th International Conference of Anticancer Research Corfu, Greece Contact :
Website : www.iiar-anticancer.org

29 October–2 November 2004
29th Congress of the European Society for Medical Oncology Vienna, Austria Contact :
Email : alessia@esmo.org

28 November–3 December 2004
9uth Meeting of the Radiological Society on North America Chicago, IL, USA Contact :
Email : rsna@itsmeetings.com

8–11 December 2004
27th Annual San Antonio Breast Cancer Symposium San Antonio, TX, USA Contact :
Email : rmarkow@ctrc.net

DEV ANANG GUPTA & CO.
CHARTERED ACCOUNTS

Vidya Complex, Kabir Road
Varanasi-221 001
Phone No. (0542) 2214450

Indian Association of Surgical Oncology

Receipts & Payments Accounts for The Period From 1.1.2003 TO 31.12.2003

Receipts	Amount	Amount	Payments	Amount	Amount
Opening Balance :			Salary		11,000.00
Bank of Maharastra	2,172.00		Purchase of Medals		9,384.00
FDR with CBI -981962	90,000.00		Citation		8,860.00
FDR with CBI -981997	75,000.00		IASO Agenda Expenses		2,350.00
FDR with Bank of Maharastra :			Stationary Expenses & Postages		5,301.00
No. 256619	230,000.00		Audit Expenses		2,000.00
No. 677486	150,000.00		Oration Award		9,000.00
No. 677828	50,000.00		Bank Charges		893.00
No. 154776	50,000.00		**Closing Balance :**		
Cash in Hand	1,266.00	648,438.00	**FDR with Bank of India :**		
Membership Contribution		62,350.00	FDR No.1460820 Dt. 15.12.03 to 15.12.06	50,000.00	
Receipt from NATCON, Ooty		70,000.00	FDR No.1460821 Dt. 15.12.03 to 15.12.06	50,000.00	
Receipt from Dr. N.C. Mishra Oration Fund		50,000.00	FDR No.1460822 Dt. 15.12.03 to 15.12.06	50,000.00	
Contribution from NATCON/PANCHKULA		51,000.00	FDR No.2159541 Dt. 30.4.03 to 30.4.06	125,000.00	
Saving Bank Interest		308.00	**FDR with Bank of Maharastra :**		
FDR Interest On Matured FDR		82,919.00	FDR No. 677486 Dt. 7.9.02 to 07.12.05	150,000.00	
			FDR No. 677828 Dt. 01.11.02 to 01.11.09	50,000.00	
			FDR No. 154776 Dt. 11.2.03 to 11.2.2001	50,000.00	
			FDR No. 764044 Dt. 16.12.03 to 1.9.08	273,293.00	
			FDR with Central Bank :		
			FDR No. 981997		
			Dt. 23.12.99 to 23.12.04		
			TDS		
			Cash Balance		
		965,015.00			

Note : The above Receipts & Payment Account has been compiled on the basis of papers & datas as produced before us and information as given to us.

For : Dev Anand Gupta & Co.
Chartered Accountants

Dated : 15.1.2004

Place : VARANASI

(Dr. L.Sarangi)
Secretary

For : Indian Association of Surgical Oncology

(Dev Anand Gupta)
Proprietor

RAJIV PRIYANKA & ASSOCIATES
Chartered Accountants

2/22, Vivek Khand – 2, Gomti Nagar,
Lucknow - 226 010
Phone : (0522) 391049
E-mail : rajivfca@satyam.net.in

Audit Report

We have examined the Receipt and Payment Account on NATCON IASO 2003 CONFERENCE at Lucknow held from 19th September to 21st September 2003, which are in agreement with the books of account.

We have obtained all the information and explanations which, to the best of our knowledge and belief, were necessary for the purpose of the audit.

In our opinion and to the best of our information and according to the explanations given to us, the said Accounts give a true and fair view :-

i) In the case of the receipt and payment account of "NATCON IASO 2003 CONFERENCE."

For Rajiv Priyanka & Associates
Chartered Accountants

(Rajiv Agarwal)
Proprietor
Membership No. – 73268

Date : 16.08.2004
Place : Lucknow

NATCON IASO – 2003

Held at Lucknow from 19th September to 21st September-2003

Receipt And Payment Account

Receipts	Amount	Amount	Payments	Amount	Amount
By Opening Balances –					
Cash in Hand	0.00		To Salary/Honrarium		24750
Allahabad Bank	0.00	0.00	To Printing & Stationery		15787
			To Postage, Courier & Fax Charges		24860
			To Telephone & Internet Expenses		6400
By Delegate Fee and Donations		762225.00	To Accommodation & Conference Expenses		1637416
By Advertisement, Sponsorship & Stall Charges		1527663.00	To Audio Visual Expenses		55100
By Interest Income		14613.00	To Bank Charges		1355
By Others		9600.00	To Miscellaneous Expenses		16544
			To Momento & Compliment Expenses		61500
			To Donation to Parent Body		100000
			To Prof. N.C. Misra Oration		50000
			To Audit Fee		1620
			To Travelling Expenses		138045
			To Closing Balances –		
			Cash in Hand	0.00	
			Allahabad Bank	**38632.50**	38632.50
			(Reserved for printing of IASO News Letter and proposed CME Oncology)		
	Total Rs.		**2314101.00**	**Total Rs.**	2314101.00

As per our report of even date on separate sheet.
For Rajiv Priyanka & Associates
Chartered Accountant

Date : 16 Aug 2004
Place – Lucknow

(Rajiv Agarwal)
Proprieter

Organising Secretaries

Chairman

Agenda of AGM 2004 at Jaipur

Date : 25th September 2004; Time : Afternoon after the scientific sessions
Venue : Hotel Clarks Amer

1. Presidential address
2. Minutes of last AGM on 20th September at Lucknow to be presented
3. Audited accounts of 2003
4. Annual report of IASO
5. Bylaws amendment proposals
   a) Shifting of NATCON from 3rd weekend of September to 4th weekend of September. This is being proposed to avoid clashing of annual conference of gastroenterology section. They have promised to prepone their conference to second weekend of September.
   b) Proposal from Dr. Ravi Kant—Before any one is elected vice-president, he must have served one term in the Executive and either he must have served as Secretary of IASO or must have published a minimum of six articles in any indexed journal related to Cancer. He must have attended last three IASO meetings.
   c) Immediate past president of IASO will be the official representative in WFSOS.
   d) Proposal from Dr Sanjeev Misra— The applicants for Detroit Fellowship should present work done in India only. Work done outside India will not be considered for the award. The applicant should be not more than 40 years of age on 31 December of the year of application.
6. Fellowships
   a) Detroit 2005-2006
   b) Baroda traveling fellowship 2004-2005
7. NATCON 2005
   a) Confirmation of the venue- Logistics to be presented by the org. secretary
   b) Orations
   c) Symposia
8. ASICON 2005- Trivandrum
   a) Silver Jubilee Oration
   b) Symposia
   c) Guest lectures
9. Program & budget of 2005
10. News letter
11. IASO practice guidelines on common cancers
12. Venue of NATCON 2006
13. Any other matter with permission of the chair
14. Election of office bearers
    Vacancies—
    Vice- president—1
    Secretary —1
    Editorial secretary- 1,
    Joint editorial secretary—1
    EC members—4
15. Vote of thanks

IASO BYE LAWS

The bye-laws of the IASO as adopted at one of the general body meetings held in December 1997, Mumbai and 2002 and amended time to time.
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 organisations 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 surgery but belong to other specialties, such as Radiology, Pathology, Biochemistry and who may not be in 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 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 - Ist. January to 31st December.
8. **Management:**
   (a) IASO will be manged 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. Associate Editor
      vi. 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 the 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 resikgned, 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 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 outline 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 ASI. Rs. 5000/- have been donated for the oration by the family of Dr. S.P. Jain. The orator will get a plaque, a cheque for Rs. 2000, certificate and a medcal.

   (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. D.D. 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 the 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. N.C. 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 Student of Dr. N.C. Mishra", who have donated Rs. two lakhs and fifty thousand 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) Silver Jubilee oration in ASICON - Will be delivered by national or international faculty. The orator shall receive a medallion, citation and Rs. 2000.

(e) Detroit Visiting Fellowship - A fellowship to visit Detroit will have local hospitality included by the host institution excluding the travel cost to and from 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.

(f) 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, Secretary IASO & Dr. G.N. Shukla, Eligibility of applicant - young surgeon, selection based on CV.

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

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

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

(ii) Dr. K. S. Panda - Dr. Gopinath Quiz Award : During NATCON meeting winner will be awarded Rs. 700 and runners up to 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.

24. **Guidelines of invitation for NATCON -**

(a) Organising secretary or his representative must be present in AGM to present his proposal.

(b) Rs. 100 per delegate must be deposited in IASO account. Besides this a opart of the savings may be donated to IASO.

(c) Audited accounts to be presented by next NATCON or circulated in the Newsletter.

(d) It has been decided that on request, a loan of Rs. 25000 may be given to the organizing secretary of NATCON as seed money to start preparation, repayable within 6 months of the conference.

25. Use of IASO banner in CME programs, Workshops & Conferences - It was decided that in CME where delegation fee was charged, a token amount of Rs. 5000 or Rs. 50 per delegate for one day event of Rs. 75 for two days event which ever was more must be deposited to use IASO banner.

Scientific Programme
NATCON-IASO - 2004

Day 1 (24th September, 2004)

HALL A

08 : 00 – 09 : 00 a.m. **Registration**

09 : 00 a.m. onwards

Lectures,

The Evolution of Breast Cancer Care in The United Kingdom, **Dr. Raghu Pillarisetty, UK**

Lymph Node Management in Early Stage Breast Cancer: the Learning Curve and Questions of Relevance, **Dr. James Rucinski, USA**

Breast Cancer, **Dr. Andrew Baildam, UK**

Moti Bhai Oration, Health economics on the role of Aromatase inhibitors in the adjuvant management of Breast cancer", **Dr. Robert Mansel,**

Radha Devi Oration, The Mandible AS Viewed by the Surgical, **Dr. K. S. Gopinath**

Pathak memorial oration, "Redefining the Role of the surgeon in Oncology",

Dr. P. B. Desai

Symposium Quality of life issues in cancer

Moderator: Dr. Manoj Pandey,

Participants : Dr. Sandeep Kumar, Col. L Vohra, Dr. Pankaj Chaturvedi, Dr. Gurpreet Singh, Col. Manomoy Ganguly, Dr. Rajeev , Dr. SVS Deo, Dr. Harit Chaturvedi

01:00 – 02:00 p.m. **Lunch & EBM,**

2.00 p.m. onwards

Symposium, Carcinoma uterine cervix,

Moderator: Dr. Hemant Tongaonkar & Dr. Mridul Gehlot

Participants: Dr. Urveshi Jha, Dr. Mridul Gehlot Dr. M.R. Kamat, Dr. Shrivastva , - Dr. Hemant Tongaonkar , Dr. Rama Joshi

Lectures,

The Essentials of Reach To Recovery International,

Ranjit Kaur, Malaysia

Post mastectomy breast reconstruction,

Dr. Gurpreet Singh

Oncoplastic Surgery in Breast Cancer,

Dr. Shailesh Chaturvedi, UK

Lymphadema in Malignancies,

Dr. Ajay Kumar Khanna

Papers

Inauguration followed by Dinner

HALL B

03:00 p.m. onwards **Lectures**

Molecular Targets in Breast Cancer & Genetic Strategies, **Dr. Raashid I. Shahbazi, Ireland**

Radiguided Occult Lesion Localisation technique for impalpable breast lesions, **Dr. Rana Nadeem UK**

Tumor Markers in Breast Cancer, **Dr. G. L. Telang**

For HER 2 Positive breast cancer, **Dr. Hemant Malhotra,**

Papers

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* Tentative Programme : Subject to change

HALL C
:00 p.m. onwards — **Videos, Papers**

Day 2 (25th September, 2004)

HALL A
: 00 a.m. onwards

Detroit Papers
Lectures
Transmandibular approach to total maxillectomy,
Dr. Ram Mohan Tiwari
Head & Neck Reconstructions, **Dr. Kalra**
Dr. N. C. Misra Oration,
Recent advances in head & neck cancer management,
Dr. Jatin Shah, USA
Symposium on Head & Neck cancers (Video)
Moderator: Dr. A. D'Cruz
Lasers - Vocal Cords, Supraglottis - **Dr. Deepak Parikh,** Recent Advances in Voice Conservation - Supracricoid Laryngectomy,NTL - **Dr. S A Pradhan,** Supraglottic Laryngectomy - **Dr. Sameer Mehta,** Total Thyroidectomy - **Dr. Devendra A Chaukar**, Extended Thyroid Resection (Trachea) - **Dr. J P Shah,** MND - **Dr. Kannan,** Tracheal Resection for Tracheal Tumor - **Dr. Somesh Chandra,** Marginal Mandible - **Dr. Sudhir Bhahadur,** SOHD- **Dr. Kiran Kothari,** Fibullar bone graft implant - **Dr. Sanjay Kapoor,** Parotid surgery - **Dr. Ravi Deo,** Deeplobe parotid - **Dr. J P Shah,** Vertical Partial Laryngectomy - **Dr. Mandar Desphande**
Rathi memorial oration,
"Advances in multimodal approach to GI Malignancies",
Dr. P. Jagannath

:00 – 02:00 p.m. — **Lunch**

:00 p.m. onwards — **Panel Discussion,** Carcinoma Rectum,
Dr. T.Gunasgaran & Dr. Sanjeev Misra
Lectures
Hepato Bilary Surgery, **Dr. Koji Tsurata,Tokyo**
Hepato Bilary Surgery, **Dr. Hiroyuki Baba,Tokyo**
Port Site Metastasis - myth or Reality, **Dr. Ravi Kant**
Expandable Stents in Gastro Intestinal Tract,
Dr. S. S. Sharma
Papers
Oncoquiz, Dr. Sanjeev Gupta & Dr. Arun Giri
AGM
Banquet at Raj Palace

HALL B
:50 p.m. onwards

Lectures
Microsurgical Vascularized double barrel bone transfer as limb salvage procedures in Osteoclastoma / Osteogenic Sarcoma & Soft tissue tumors of long bones,
Dr. Ashok Gupta
Database development in Surgical Oncology,
Dr. S. V. S. Deo
Transrectal Ultrasono for ProstateBrachytherapy,
Dr. Sayan Pathak USA
Papers

HALL C

03:50 p.m. onwards — **Videos, Papers**

Day 3 (26th September, 2004)

HALL A

08:00 a.m onward — **Papers Lectures,**

Chemotherapy and Surgeons, **Dr.Purveesh Pareekh**

Minimal access surgery in thoracic malignancies, **Dr. Rajesh Mistry**

Symposium on Minimal Invasive Surgery

Laparoscopic Videos

Moderator: Dr. C Pallanivellu

Participants: Dr. H. Ramesh,Dr. Ramesh Arthanari, Dr. Gopinath,Dr. Gaston,Dr. Parthasarathi R., Dr. Sendhil Kumar K. Moderator:, Dr. Kiran Kothari,Dr. Gopinath, Dr. L. Sarangi

Laparoscopic Anterior resection :

Current Trend in Minimal Access Cancer Surgery,Esophagectomy, Distal Gastrectomy, Jejunal Pouch formation, TME, Right and Left colectomy technique, Distal Pancreatectomy, Nephro Uretrectomy, Lap. Hepatic Resection

Lectures

Hepatic Resection, **Dr. H. Ramesh**

What is new in management of Barrett's esophagus and esophageal cancer ,

Dr. Pramod Bhonde, Canada

Peritoneal carcinomatosis of colorectal origin, a potentialy curable disease,

Dr. Frans A. N. Zoetmulder, Netherlands

Imaging guided interventions in the hepatobiliary malignancies, **Dr. Brijendra Rawat, Canada**

01:00 – 02:00 p.m. — **Lunch**

2.00 p.m. onwards — **Videos**

Valedictory function

HALL B

08:00 a.m. onwards — **Papers**

11:00 a.m. onwards — **Lectures**

Pegylated Liposomal Doxorubicin in Recurrent Carcinoma Ovary, **Dr. Sanjeev Misra**

Pegylated Liposomal Doxorubicin in Metastatic Breast Cancer, **Dr. I.D. Sharma**

HALL C

08:00 a.m. onwards — **Papers**

Videos

IASO New Members and Associate Members

New Members (01.01.04 to 31.07.04)

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h-Surgical Oncology

ognition granted by the Medical Council of India to start the prestigious course
Ch-Surgical Oncology in the Department of Surgical Oncology, King George's
lical University, Lucknow

istration of IASO

Indian Association of Surgical Oncology has been registered under the
eties Registration Act 1860

Laughter the Best Medicine

Marriage Programme

This is what a guy wrote to a Systems Analyst (Marriage Programme);

Dear Systems Department,

I am desperate for some help! I recently upgraded my program from Girlfriend 7.0 to Wife 1.0 and found that the new program began unexpected child processing and also took up a lot of space and valuable resources. This wasn't mentioned in the product brochure. In addition Wife 1.0 installs itself into all other programs and launches during systems initialization and then it monitors all other system activities.

Applications such as "Boys' Night out 2.5" and "Golf 5.3" no longer run, and crashes the system whenever selected. Attempting to operate selected "Saturday Rugby 6.3" always fails and "Saturday Shopping 7.1" runs instead.

I cannot seem to keep Wife 1.0 in the background whilst attempting to run any of my favourite applications. Be it online or offline. I am thinking of going back to "Girlfriend7.0", but uninstall doesn't work on this program. Can you please help?

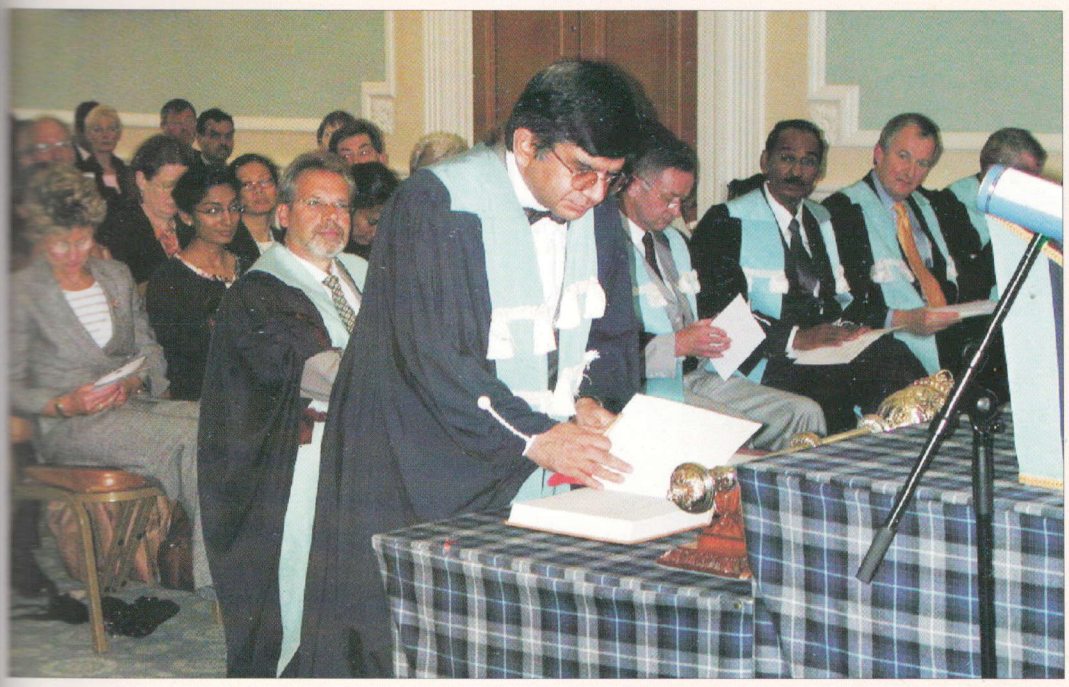
AND THIS WHAT THE ANALYST SAID:

Dear Customer,

This is a very common problem resulting from a basic misunderstanding of the functions of the wife 1.0 program.

Many customers upgrade from Girlfriend 7.0 to Wife 1.0 thinking that Wife 1.0 is merely a UTILITY AND ENTERTAINMENT PROGRAM.

Actually, Wife 1.0 is an OPERATING SYSTEM designed by it's creator to run everything. You are unlikely to be able to purge Wife 1.0 and still convert back to Girlfriend 7.0, as Wife 1.0 was not designed to do this and it is impossible to uninstall, delete or purge the program files from the system once it is installed. Some people have tried to install Girlfriend 8.0 or Wife 2.0 but have ended up with even more problems. (See manual under Alimony/Child Support and Solicitors' Fees). Having Wife 1.0 installed, I recommend you keep it installed and deal with the difficulties as best as you can. When any faults or problems occur, whatever you think has caused them, you must run the C:\APOLOGIZE\FORGIVE_ME program and avoid attempting to use the Esc-key for it will freeze the entire system. It may be necessary to run C:\APOLOGIZE\FORGIVE_ME a number of times, and eventually hope that the operating system will return to normal. Wife 1.0, although a very high maintenance programme, can be very rewarding. To get the most out of it, consider buying additional software such as "Flowers 2.0" and "Chocolates 5.0" or "HUGS\KISSES 600.0" or TENDERNESS\UNDERSTANDING 1000.0", or even "Eating Out Without the Kids 7.2.1" (if child processing has already started). DO NOT under any circumstances install "Secretary 2.1" (Short Skirt Version) or "One Nightstand 3.2" (Any Mood Version), as this is not a supported application for Wife 1.0 and the system will almost certainly CRASH.



Prof. Ravi Kant, Vice President, IASO at 'Taking the Seat' Ceremony at Royal College of Surgeons Edinburgh in July 2004

Prof. K. S. Gopinath, Past President IASO receiving FRCS at Royal College of Surgeons Edinburgh in July 2004