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IASO



NEWSLETTER



Indian Association of Surgical Oncology

(A section of The Association of Surgeons of India)

[Www.iasoindia.in](http://www.iasoindia.in)

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY (IASO)

List of past presidents and Secretaries of the association

President	Secretary	Year
Dr. D J Jussawala	Dr. Ashok Mehta	1977
Dr. P B Desai	Dr. Ashok Mehta	1979
Dr. M P Vaidya	Dr. N C Misra	1981
Dr. Ashok Mehta	Dr. N C Misra	1983
Dr. D D Patel	Dr. N C Misra	1984
Dr. A P Majumdar	Dr. N C Misra	1985
Dr. R S Rao	Dr. N N Khanna	1986
Dr. N C Misra	Dr. N N Khanna	1987
Dr. N N Khanna	Dr. S G Deshpande	1988
Dr. B M L Kapoor	Dr. S G Deshpande	1989
Dr. S K Sarkar	Dr. S G Deshpande	1990
DR. P M Trivedi	Dr. H S Shukla	1991
Dr. K K Pandey	Dr. H S Shukla	1992
Dr. S K Shukla	Dr. H S Shukla	1993
Dr. J B Venkatrao	Dr. H S Shukla	1994
Dr. Shambhu Pal	Dr. Sandeep Kumar	1995
Dr. C K Gupta	Dr. Sandeep Kumar	1996
Dr. H S Shukla	Dr. Sandeep Kumar	1997
Dr. S P Kharey	Dr. Sandeep Kumar	1998
Dr. P Subhas	Dr. Kiran Kothari	1999
Dr. K K Maudar	Dr. Kiran 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
Dr. Sandeep Kumar	Dr. R Karwasara	2005
Dr. Ravi Kant	Dr. R Karwasara	2006
Dr. S. Sadasivan	Dr. Sanjeev Misra	2007

President	:	Dr. Sanjay Sharma, Mumbai
President Elect	:	Dr. L. Sarangi, Varanasi
Vice – President	:	Dr. Arun Chaturvedi, Lucknow
Secretary	:	Dr. Sanjiv Misra, Lucknow
Editorial Secretary	:	Dr. Manoj Pandey, Varanasi
Assoc. Editor	:	Dr. Jahar Majumdar, Kolkatta
E.C. Members (2007-08)	:	Dr. Vimal Bhandari, Delhi (North Zone) Dr. Deepender Sarkar, Kolkatta (East Zone) Dr. Mukul Trivedi, Ahmedabad (West Zone) Dr. Jacob Kurian, Manipal (South Zone)
E.C. Memebhrs (2008-09)		Dr. Chintamani, (North Zone) Dr. Ajay Kumar (East Zone) Dr. Raj Govind Sharma (West Zone) Dr. Raja Raman (South Zone)
Co-opted Organising Secretaries	:	Dr. Satish Jain, Ludhiana Dr. Raghuram Pillarisetti, Hyderabad
Past President	:	Dr. S. Sadasivam, Coimbatore

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PRESIDENT'S MESSAGE



Dear Colleagues,

It's a great privilege and honor to be writing to you today as one of you. It's been thirty years since IASO was established and has grown in strength over the years due to the interest taken by its esteem members their active participation, hard work and toil by the previous past presidents, secretaries and other office bearers.

As you all are aware that the specialty of surgical oncology has evolved over the years due to technological advances, ever increasing knowledge of biology and need for specialization due to result of specialist in the field showing better result then the non specialist. This is not to demean any other specialty of the other colleagues in the surgical fraternity but current data available shows large volume centers, large volume specialist have better results in terms of survival and less complications and good quality of life for surgical cases compared to that of less volume surgeons. This recognition is now been forth coming and is also reflected by more and more people joining the specialty. This also adds to increased responsibility and more challenges for us. These challenges are from within the medical fraternity, allopath i.e. radiation and medical oncologist, and other non allopathic medical sciences. The challenges are that we practice our science as per the guidelines based on the evidence base medicine. We have to be more ethical and also considerate with our patients, who are majority of time with moderate means.

Considering that India is developing fast, we should use our developing technology, judiciously and not to fall in trap by market driven forces. In this regard, I would request you to be more balanced and to take holistic approach for our Indian patients. As we are far and few in number to treat the large number of patients in our country, we should get above our narrow minded approach and spread the knowledge of surgical oncology to general surgeons and youngsters, so as to treat patients more effectively, till such times that we have our post graduation courses (Mch, DNB) spread all over the country and we produce enough number of qualified specialist, IASO should continue to impart training to general surgeons, general physician, nursing staff and NGO's to spread awareness for early detection and prevention of cancer. We also should try joining hands with government sources and NGO's for cancer prevention and educate people about ills of changing lifestyle.

We have our own website which gives you the details of the members and details of broad principle activities of the organization. I would also urge all of you to use this website for more active coordination between the national and international group for generating newer cancer research protocols and sharing our professional progress with one and all.

It is also very heartening and with great efforts with our overseas coordinators and the organizing secretary Dr. Pillarisetti Raghu Ram to invite BASO members to join along with us during this annual meeting. If you read the scientific contents and the lecture and oration by British surgeons, foreigners and national faculty will make it very interesting scientific sojourn there will also be very interesting video session, that will help our young surgeons to learn finer surgical steps for common, yet difficult surgical procedure from the experts. I expect you in large number to attend the Hyderabad conference which will probably be a new beginning of newer things to come up in our meeting. In this meeting to encourage youngsters we invite them to present their posters and oral presentations. IASO will reward them on the day of the valedictory functions on the 21st September 2008.

With Best Wishes and Warm Regards

Prof. Sanjay Sharma
Surgical Oncologist
Bombay Hospital & Research Centre,
Asian Institute of Oncology &
Lilavati Hospital
President IASO

SECRETARY'S REPORT



Dear Friends,

I welcome you all to the National Conference of the Indian Association of Surgical Oncology at Hyderabad. It is for the first time that the National conference is being organized in the state of Andhra Pradesh. It will be a meeting of IASO in association with the British Association of Surgical Oncology. The growth of our association has been due to the continuous and relentless efforts of the Past Presidents and senior members of the association. We look forward to their guidance and suggestions in future also. The year 2007 was rewarding to the association in several ways with many new ideas being suggested and implemented. Prof Sanjay Sharma, Mumbai took over as the President for the year 2008 from Prof S Sadasivam, Coimbatore. Dr L Sarangi as President elect, Prof. Arun Chaturvedi, Lucknow as Vice President. Four new executive members representing different zones were elected at Ludhiana - Dr Chintamani , New Delhi (North), Dr R Rajaraman, Chennai (South), Dr Raj Govind Sharma, Jaipur (West), and Dr. Ajay Kumar, Jamsedpur (East). I welcome them to the executive committee and look forward to their help and cooperation.

As in the last year I will need your cooperation and guidance to move the association forward. At the beginning of the year we had proposed an agenda for the year 2008. We have moved ahead and have been able to achieve few things.

1. **NATCON IASO – 2007:** The annual conference of Indian Association of Surgical Oncology (NATCON-IASO-2007) was a successful meeting and was held at Ludhiana, Punjab from 21-23 September 2007. There was a pre-conference workshop on 20th September 2007. The conference was attended by over 300 delegates from all over the country. Besides a distinguished National faculty several International delegates from Japan, USA and UK attended the conference. The pre-conference workshop had demonstration of operative Videos on common oncological procedures (open as well as laparoscopic) by the faculty. During the conference several symposia were held - Bone Tumours - Convenor - Dr. M Ganguly, Carcinoma Cervix – Convenor - Dr. Mrs. Veena Jain, Renal Cell Carcinoma, Convenor - Dr Kim Mammen and Dr. Satish Jain. There were panel discussions on Surgical Management of Metastatic Cancer, Convenor - Dr. Sanjay Kapoor, and Management of Periampullary Carcinoma, Convenor - Dr. L. Sarangi. The symposia and panel discussions were appreciated by the delegates.

This year the Dr. N.C. Misra Oration was delivered by Prof. Munemasa Ryu, Japan on Hepatic Resection. The Smt. Radha Devi Oration was delivered by our Past President Prof. Ravi Kant from New Delhi on Lasers in Surgery. The Moti Bhai Oration was delivered by Dr

John Sheperd, UK on Fertility sparing surgery for carcinoma cervix and Trachelectomy. The Detroit fellowship was awarded to Dr. T B Yuvaraja from Mumbai. The conference was organized by Dr. Satish Jain, Medical Director and Chief of Surgical Oncology, Mohan Dai Oswal Cancer Treatment & Research Foundation, Ludhiana. The members of the association and delegates thanked him for an academically fruitful meeting. Dr Jain has contributed Rs. 100,000/- to IASO from the saving of NATCON IASO 2007. We thank him for the same. The association has requested him to raise this amount to Rs. 200, 000 and he has promised that he will look into it.

2. **ASICON 2007** – The ASICON 2007 was held at Bhubaneswar. The Dr PB Desai – UICC IASO Silver Jubilee Oration was delivered by Prof. London Lucien Ooi, Singapore. The symposia on Carcinoma ovary convened by Dr Manoj Pandey and What not to do – Common errors in Cancer Surgery convened by Dr Sanjeev Misra and Dr Arun Chaturvedi were well attended and appreciated. The Master Video lectures were very popular with the delegates and we plan to have them this year also during the ASICON 2008 at Ludhiana.
3. **CME Programme** – In this fast pace of change of treatment of different cancer it is important to have continuing medical education programmes to keep the surgical oncologist and the surgeons updated. I had suggested that at least one CME per zone should be held as we have members in the executive from east, west, north and south (2 EC members per zone) - it is proposed / suggested that these executive members should work as coordinators or should organize CME in their region. This proposal has been accepted by the Executive Committee and the General Body of the IASO. This little effort may help in bringing major changes in cancer treatment in the country. IASO and its members should consider it as a part of their commitment to society. We have had two CME's organized this year one by Col M Ganguly and Col S Kapoor at R & R hospital , New Delhi and the other at Kolkatta by Dr Diptendra Sarkar. It is a good beginning and it will be better, if the future CME's are organized in non metropolitan cities. I request more members to come forward with their proposals to hold CME.
4. **NATCON 2008** - The conference at Hyderabad is expected to be an academically gratifying meeting. The scientific committee of the IASO and the organizing committee have done a wonderful job and I am sure everyone attending the meeting will benefit out of it. Cash awards for best free papers and posters have been instituted. It carries a handsome amount. On behalf of the IASO I am grateful to all the international and national speakers and delegates attending the conference.
5. **Detroit Fellowship** – Dr. T B Yuvaraj of Mumbai has been awarded the Detroit Fellowship at NATCON Ludhiana. He will avail the Fellowship in 2009. There is not enough enthusiasm among the young surgical oncologist about different fellowships. I request all young surgical oncologists to apply for this and other awards and request the seniors to encourage the youngsters to send papers for these awards and avail the opportunity to visit Detroit or Coimbatore.
6. **Baroda Travelling Fellowship** – Dr. Harish Sharma from Hissar was selected for Baroda Travelling Fellowship.

7. **Baroda - GCRI- IASO Travelling Minimal Invasive Surgery Fellowship (MIS) Fellowship** - The Association in its last General body meeting has agreed to start another fellowship which will be called the Baroda - GCRI- IASO Travelling Minimal Invasive Surgery Fellowship (MIS) at GEM Hospital, Coimbatore from 2008. The money for the fellowship has been provided by Dr R I Dave and Dr Kiran Kothari from GCRI, Ahmedabad. The funds from the Baroda travelling fellowship will be combined with the funds from GCRI and the fellowship will be thus named so. The selection for the fellowship will be done during the NATCON IASO 2008 at Hyderabad.
8. **IASO – NATCON LUDHIANA TRAVELLING FELLOWSHIP** - The Association received a sum of Rs 500,000.00 from Sri Prakash Singh Badal Honourable Chief Minister of Punjab during the Inauguration of the NATCON IASO at Ludhiana. This traveling fellowship will be called as IASO – NATCON LUDHIANA TRAVELLING FELLOWSHIP. The selection and eligibility criteria will be as per the guidelines suggested.
9. **ASICON 2008 at Ludhiana** – There will be 2 symposia
 - a) Case Capsules in GIT Malignancies – Dr. Sanjay Sharma, Mumbai
 - b) Carcinoma Lung– Jointly with ACVTSThose interested in participating in the symposium/ Panel discussion may kindly write to the convenors.
Dr PB Desai – UICC IASO Silver Jubilee Oration will be delivered by Prof Manjit S Bains, USA.
10. **NATCON IASO 2009** – The 2009 NATCON IASO will be held at Kolkatta on 18, 19, 20 September 2009. There will be a pre conference workshop on 17 Sept 2009. Dr Arnab Gupta is the Organising Secretary and Dr Samir Bhattacharya, Chairman Organising committee and the host institution is Cancer Centre Welfare Home and Research Institute, Thakurpukur. The Pre Conference workshop will be held at Cancer Centre and Welfare Home, Thakurpukur and the conference will be held at Science City, Salt Lake City.
11. **NATCON IASO 2010** - The venue for 2010 IASO will be decided during the 2008 meeting at Hyderabad. Proposals for the 2010 meeting are invited from the interested members. The interested member should be present to bid for the conference and should send the proposal to the **Secretary, IASO by 10 Sept 2008**. He should be prepared to make a presentation about the proposal – venue, accessibility of place by surface and air transport, local infrastructure available, logistics of organizing the meeting etc.
12. **Topics for symposium and Panel discussion for the NATCON IASO 2009 and ASICON 2009 and NATCON2010 and ASICON 2010.**
For the NATCON IASO 2009 and ASICON 2009 the last date will be 30 August 2008 and for NATCON 2010 and ASICON 2010 will be 30 August 2009.
13. **Newsletter** - The IASO newsletter has been fairly standardized. It can improved further with everyone’s cooperation. The convenors of symposiums should ensure that each speaker contributes to the newsletter his/her presentation as an article. This will improve the quality of article and theme based issues can be brought out.

14. **IASO Website** - The website is functional and the members can access the website by typing **www.iasoindia.org** or **www. iasoindia.in**. It has details about the Association and from it the ASI website can also be accessed from the links.
15. **Finance** - Dr. Satish Jain has contributed Rupees 100,000 from the NATCON IASO 2007 savings to the IASO. We are trying to generate more funds for the IASO. An organization financially viable can comfortably think of achieving greater heights.
16. **WFSOS** - Prof. Sanjay Sharma, President IASO will be the official representative of IASO in WFSOS. He will be participating in the next meeting of WFSOS as IASO's official representative.
17. **IASO and National Board of Examination** – The IASO has signed a memorandum of understanding with the NBE for conducting CME programmes.
18. **Membership Cards** –It is proposed that membership cards will be issued to all members - the process of doing so has started and during the NATCON IASO 2008 at Hyderabad this year it should be done. The membership number and card will be needed for all official functioning of IASO.
19. **Membership drive** - Our membership numbers have increased from before and are increasing. It should be our effort to enroll new members. All trainees in Surgical Oncology should be enrolled as Associate Members and on completion of training they should be made full members of IASO. Practicing Surgical oncologists should be encouraged to join the association.
20. **Future Directions** – The future of the association has in its acceptance by governmental and non governmental agencies as the nodal body for cancer care The functioning of the association should not only be confined to its role in organising NATCON and Sectional programme for ASICON. The association has to take initiative in organizing national trials for cancer treatment collaborating with international societies and agencies in carrying out trials and research. With bilateral cooperation both associations (International and IASO) will benefit. All these collective efforts can enhance the status of the associations.

I once again thank all members for their help, cooperation and wish the association a bright future.

Yours Sincerely,

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Secretary, IASO

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EDITORIAL



Time flies, and it flies real fast, before we realize the 2007 is well past behind us and 2008 is almost nearing an end. The first issue of 2008 is now in your hand, and it was possible this time to stick to the schedule because of the help that came from all quarters, the contributors, the office bearers and the sponsors, and most importantly, it came in time. Into the third issue and I have already realized that it is definitely a tough job to compile the newsletter, the only solace is that there is just one more issue to go for me. I have voiced my thoughts of converting this newsletter to a journal as I strongly feel that the contributors of news letter are at disadvantage. The contributions to newsletter can not be compared to that in journals, even in

non index local journals, and the authors do not get the due credit for their work. On the other hand, the satisfaction is to see it being used as a resource material, and I am sure with each issue being digitized and uploaded to IASO website, visibility will increase. Apart from sending it to members of IASO, I have taken steps to circulate it electronically to a 4000 strong mailing list of oncologists' world wide. The response from them had been encouraging.

Apart from the usual columns (the features), this issue has a very interesting article on cancer calendar contributed by Dr. Manoj Sharma, advisor on cancer control, government of capital territory of Delhi, which is thought provoking. Dr. Alfie's article on laparoscopic colonic surgery presents the evidence and current scenario in minimal access surgery for large bowel cancer and is complimented by an article from Dr. Amita maheshwari on laproscopy for ovarian cancer. Dr. Amitabh Gautam, my teacher and a transplant surgeon in Boston has contributed a state of art article on liver transplant surgery in hepatocellular carcinoma, an under represented area. Dr. Manoj Sharma has also contributed another short article on preparing the next generation for media blitz and has emphasized as to how important it is for us to be media savvy. Baroda-GCRI-IASO traveling fellowship is finally on, and there is an important announcement on eligibility criteria and procedure in this issue. The disheartening is lack of response to Detroit fellowship and award session this year with only one submission in this category. It is an opportunity for the young surgical oncologists which they should avail in larger numbers every year. This also reflects lack of surgical research in our country, and need more emphasis to be placed on it.

The program for joint meeting of IASO-BASO NATCON 2008 is enclosed, it's a Scientific feast that awaits us. All the sessions are must attend, though we will have to miss out on some due to unavoidable parallel sessions. The symposium on how to write a paper and get it published will be a **must attend** as the editors of three international surgical oncology journals i.e. "European Journal of Surgical Oncology" "Surgical Oncology" and "World Journal of Surgical Oncology" will deliberate in it. Beside there are a number of good lectures and orations in store. IASO

NATCON 2009 will be in Kolkata and the contact information can be found in this issue of newsletter. Members are requested to get in touch with the organizers and take advantage of early bird registrations.

In the end, it is always a pleasure to see once work in print and get encouraging feedback, I wish to thank all members who took time out of their precious schedules and sent back their feedback. These are important to improve the look and content of the newsletter. I look forward to more of these this year, and sincerely hope that the newsletter will continue to improve with each subsequent issue and editorial secretary. I look forward to meet you all in Hyderabad.

Dr. Manoj Pandey

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**MINUTES OF THE IASO EXECUTIVE COMMITTEE MEETING
Bhubaneswar, December 28, 2007**

1. Meeting called to order by President Dr. Sadasivam
2. President briefed the committee about the IASO activities for the year 2007
3. The President and the Secretary informed the committee about the BASO meeting. Prof. I Taylor of BASO has promised that he will inform the IASO executives about the 2008 ESSO meeting.
4. The Secretary briefed about the IASO activities for the last one year that will be published in the December issue of 2007 including call for election and fellowships etc. including the new amalgamated IASO-Baroda-GCRI minimal access fellowship and procedure involved for selection. The procedure which will be followed will be similar to Detroit fellowship. The presentation and selection process will be clubbed with the Detroit presentations in a special session. The details are in the bye laws approved at GBM at Ludhiana.
5. As the newsletter is delayed the executive committee decided to discuss the audited accounts of IASO for the year 2005, 2006 and 2007 (upto March) in its next meeting in Hyderabad after the newsletter is circulated and members have a chance to see it.
6. NATCON 2008: It was decided that the Hyderabad meeting need to be popularized and announced well in advance to increase the attendance at the conference
7. NATCON 2009: The EC suggested that Dr. D Sarkar be used as a coordinator between the IASO and the local organizing committee. It was also suggested that all surgical oncologists of Kolkatta, North East be active members of the organsing committees. It was also suggested to explore the possibility of involving SAARC countries in that conference. The members also felt that the conference venue should be the Science city or the hotel like Taj Bengal and not the hospital auditorium, the organizers agreed to look at it and to finalize the venue before next EC meeting.
8. NATCON 2007: Dr. Satish Jain informed the committee that he will be contributing Rupees one lakh towards the contribution to IASO. The members appreciated his gesture and Dr. Gopinath and Dr. Sanjay Sharma requested him to make it 2 lakhs, to which he promised to seriously look at the possibility of doing so.
9. Scientific program for NATCON 2008: Dr. Sanjay Sharma suggested inclusion of head neck cancers as a topic of local symposium at Hyderabad, Dr. Raghu said he will consider the proposition, this will be further discussed in the scientific committee meeting.
10. The EC members suggested that a session on "Problem oriented cases" be started from next meeting. The Sanjay Sharma gave a brief outline of how this can be done, the members thought that this matter be discussed in scientific committee and it may take a decision in this regard.

11. CME accreditation and instructional course lectures: Dr. Sharma briefed the members about his attempts at getting the CME accredited by MCI and accreditation points issued to members attending the CME, this will attract more people to the meetings.
12. Aberdeen fellowship: The committee unanimously agreed to revive the Aberdeen fellowship, it was decided to call Dr. Shailesh Chaturvedi to ASICON 2008 at Ludhiana to deliver the IASO oration. The members felt that attempts should be made to start the fellowship from 2008 itself and guidelines can be framed and approved in next EC and GC at Hyderabad. The house was informed that Dr. Karwasara has availed this fellowship in 2006-2007. Dr. Sanjeev Misra will contact Dr. Chaturvedi and finalize the issue. The committee also felt that Aberdeen lecture may be restarted and this may be kept in ASICON each year as the NATCON program is too crowded and it is difficult to find a slot in NATCON. If the Aberdeen lecture is revived in 2008 ASICON at Ludhiana, the Dr Shailesh may be asked to nominate a speaker for the same, and how this will be done in subsequent years can be discussed with him, as to whether he will find speaker each year or the IASO will do it as it does for other orations.
13. IASO Newsletter: Dr. Manoj Pandey informed that the Newsletter is in press and will be posted in the first week of January. The electronic copy will be emailed by 2nd January and will be followed by the hard copy
14. Website: The issue of updation of web site was discussed and members felt that it need to be updated regularly. Things like newsletter, accounts etc along with election notice and fellowship announcements may be posted on the web. Dr. Sanjeev Misra informed the house that a google search of IASO leads to a older website hosted by IDN. Dr. Sanjay Sharma said he will talk to IDN and will try to get it off the web. The attempts will be made to popularize the web page.
15. Letters of members: Dr. Sanjeev Misra read the letter of Dr. D. D. Patel who has suggested modifications in the NATCON program, the EC forwarded the letter to scientific committee and asked it to be discussed there and his suggestions may be considered while making a final program.
16. Any other matter with permission of Chair:
 - a. Dr. Diptender Sarkar informed the EC about his plan to hold an eastern zone CME at Kolkatta on 8th March, it was suggested to him to hold it on 15th as there were other meetings at that time and this also happens to be international women's day.
 - b. Dr. Gopinath raised the issue of uniform curriculum and informed the house that National Board has formed a committee under the chairmanship of Dr. Chintamani an executive of IASO. He suggested that IASO office bearers may get in touch with him and contribute to formulation of uniform curriculum. Dr. Manoj Pandey suggested to form a curriculum committee which can meet and decide the curriculum, the members agreed to this suggestion, Dr. Manoj further expressed the desire to host the first meeting of this committee at Varanasi to which the members agreed. The date of this meeting can be decided at later date.

- c. Dr. Sanjeev Misra suggested that a tie for IASO to be designed, the members suggested to have it designed and circulate to members for selection of final design.
 - d. The EC members suggested to invite Prof. Manjit Bains and Dr. Iko as orators for NATCON 2008, the EC referred the matter to scientific committee.
17. The meeting ended with thanks to the chair.

Prof Sanjeev Misra
Secretary IASO

**IASO DETROIT FELLOWSHIP AND
BARODA - GCRI- IASO TRAVELING
MINIMAL INVASIVE SURGERY
FELLOWSHIP (MIS)**

FELLOWSHIP SESSION

POSTPONED TO

IASO SECTION IN ASICON 2008

LUDHIANA DECEMBER 26-30, 2008

DUE TO INSUFFICIENT NUMBER

OF PAPERS

MEMBERS ARE REQUESTED TO SEND THEIR
PAPERS FOR CONSIDERATION OF THE ABOVE
FELLOWSHIPS TO THE SECRETARY

BY

OCTOBER 30, 2008

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY
MINUTES OF THE GENERAL BODY MEETING
September 22, 2007 Ludhiana

Minutes:

1. **Meeting** was called to order by the President
2. **Quorum** was complete and all the members signed the attendance
3. **Condolence** was held for untimely demise of Dr. G. N. Shukla, Baroda, Dr. Amitabh Singh, Patna and Dr. Shubha Sharma, Ahmedabad. One minute silence was observed
4. **Annual report** was read by the secretary Dr. Sanjeev Misra. Dr. Manomoy Ganguly proposed its acceptance and Dr. K. Gopinath Seconded.
5. **Minutes of the last General body** held at Varanasi on September 23, 2006 were approved by the general body. No objection was received from any member. The minutes were circulated in the August 2007 issue of IASO Newsletter. Dr. K.S Gopinath proposed its acceptance and Dr. Ravikant seconded.
6. **Audited accounts of IASO** for the year 2005 and 2006 were presented, the house decided to circulate these by publishing in the December 2007 issue of newsletter and approve these subsequently in next general body meeting. The house debated the issue of releasing Rs. 40,000/- to Col. Ganguly for publication of IASO Newsletter for the year 2006. Dr. Ganguly pointed out that the cost of printing of one issue in 2006 was Rs. 55,000/- with another 5-7 thousand spent on postage. He stated that this was pointed out to Executive committee in September 2005 and a subsidy was approved. He pointed out that the cost of printing was Rs. 1,00,000 of which only 40,000/- were received from the association and rest he has borne by himself. Dr. Sandeep Kumar pointed out that the Rs.10,000/- per issue subsidy that was approved by the EC in September 2005 was not back dated and was for the subsequent issues. Dr. Karwasara stated that though this amounts to Rs. 20,000/- for one year and two issues and decision was taken in September 2005 and hence an actual amount of Rs. 30,000/- should have been paid but more was paid as an oversight. He also brought to the notice of house that Dr. Ganguly has not brought out one issue of Newsletter. At this juncture, the President elect Dr. Sanjay Sharma intervened and suggested that on production of bills and if General body approves the expenditure of Rs. 40,000/- towards the Newsletter be approved as one time expenditure with request from succeeding news letter editors to kindly arrange for this corpus themselves and not to burden the association any further with this expenditure. Prof. Shukla proposed that this be approved and Dr. Gurpreet Singh and Gen. Subhas seconded the proposal, the house approved the suggestion of Dr. Sanjay Sharma.
7. **Audited accounts of IASO NATCON 2006** were presented, the house decided to circulate these by publishing in December 2007 issue of Newsletter and approve these subsequently in the next general body meeting at Hyderabad.

8. **Proposed budget and program for 2008 directory update** was approved. The house agreed to the proposal of issuing membership cards.
9. **Venue for NATCON 2008 as Hyderabad was reconfirmed** The dates for the proposed meeting from September 19-21, 2008 were approved. Dr. Raghu invited the members to Hyderabad and proposed to hold Breakfast how I do it sessions, introduction of Ronald Regan fellowship, and no pre-conference workshop. It was decided to increase the number of penal discussions. It was decided to keep the Registration amount to Rs. 2000/- for delegate and Rs. 1250/- for spouse till March 31, 2008. There after the registration amount will be raised to 2500 and 1500 till 31 July 2008, 3000 and 1750 and to Rs. 3500 and 2000 for spot.
10. **Venue for NATCON 2009 was selected to be Kolkata:** The conference will be held at Thakurpukur cancer centre. The house was informed that plenty of accommodation is available around the hospital and the hospital is located at 40 minutes driving distance from station and 60 minutes from airport. Other proposals were from Col. Kapoor to hold it in Delhi, Dr. D. Savant to hold it in Mumbai, Dr. Ajay Kumar for Jamshedpur.
11. **The house discussed the minimal access surgery fellowship** which is being established with a corpus of Rs. 75,000/- it was proposed to limit the age of fellowship to 40 years and amount of fellowship to Rs. 6000/- it was proposed that two members from Gujarat cancer Research institute Ahmedabad, president and Secretary of IASO should decide who should get this fellowship. Dr. Sandeep Kumar proposed to have a competition like that of Detroit fellowship for selection of candidate. Dr. Gopinath suggested to talk to Dr. Palanivelu to waive off the registration amount and suggested that the corpus be increased to one lakh. The president assured that he will talk to Dr. Palanivelu. Dr. Ravikant proposed to add another 25000 to this corpus to make it one lakh and combine it with Baroda traveling fellowship and rename it as Baroda-GCRI-IASO minimal access surgery fellowship, this will raise the corpus to 2 lakh. It was approved by the GC to rename the fellowship as Baroda– GCRI-IASO Minimal Access Surgery Fellowship and the selections will be held in Hyderabad during NATCON IASO 2008.
12. **Bye-law amendment** on election of executives from four zones as NEWS (north, east, west and south each) was proposed by Dr. Ravikant and was seconded by Dr. K. Gopinath. The house approved the amendment.

The secretary read out the proposed amendments to the Bye Laws and the proposed election process for the election during NATCON IASO approved by the EC and the house accepted them without any change.
13. The proposal to have Honorary Fellowship to IASO proposed by the Secretary was accepted by the house.
14. **The IASO News letter** was appreciated by the house, Dr. Pandey stated that he will be able to manage all four issues without any subsidy from the association. The cost of each issue including postage will be around 50,000/- that can be managed by securing advertisements.

15. **Web site** issue was discussed and it was decided to add the web address on the first page of newsletter. The web address is <http://www.iasoindia.org> it was decided that the Secretary will be Coordinator of the website and President of IASO as Chairman and Editorial secretary and Associate editor as executives to supervise the development and updating of web site. Dr. Sandeep Kumar will be Adviser to the website.
16. **Prof. S. Sadasivam, President IASO** was nominated to WFSOS as representative of IASO for the year 2007-2008.
17. **The house congratulated Prof. DD Patel** for being elected as Honorary member of BASO.
18. **Detroit fellowship was awarded to Dr. T.B. Yuvaraja** of TMH, Mumbai for the year 2009.
19. **Baroda Traveling fellowship was awarded to Dr. Harish Sharma, Hissar.**
20. **Onco Quiz and Results:** Dr. Ravi Kant proposed to increase the corpus of Onco Quiz, Dr. Gopinath agreed. Dr. Gopal Gurjar, Dr. Vinayak Rohan and Dr. Naresh Ledwani of Cancer Research Institute, Ahmedabad
21. **Results of Election:** Dr. N Chintamani from North, Dr. Ajay Kumar from East, Dr. Raj Govind Sharma from West and Dr. Raja Raman from South zone were elected as executive members. Dr. Arun Chaturvedi was elected as Vice President.
22. **Any other matter** Dr. Ravi Kant proposed that a minimum of 100 rupees or 10% of registration money to be given to the IASO. The house agreed to a 10% of the minimum contribution including the registration in foreign currency taken in Indian equivalence
23. Dr. Sandeep Kumar wanted to discuss the scientific program of IASO NATCON 2008. Dr. Gopinath informed the house as to why the scientific committee was formed and stated as this has been earlier approved in GBM that scientific committee will form the program it need not be discussed in GBM any more. Prof. Shukla stated that the scientific program is heart and soul of the society and may not reflect the sentiments of GBM and may not be accommodative there should be mechanism to discuss the program. Dr. Ravi Kant stated that the wisdom lies in scientific committee getting feedback from members. Dr. Sanjay Sharma informed the house that this is already taken care of, the house approved again that there is no need to discuss the program in GBM and showed its full confidence in the scientific committee.
24. **Vote of thanks** the GBM thanked the organizing committee of NATCON 2007. Dr. Sadasivam proposed a special vote of thanks to the honorable chief Minister of Punjab Sardar Prakash Singh Badal ji for his special contribution to IASO. Dr. Gopinath and Dr. Ravi Kant Seconded and house passed the vote of thanks.
25. **The meeting ended with thanks to chair.**

Prof. Sanjeev Misra
Secretary, IASO

NATCON IASO 2008

19 – 21 Sept 2008, Hyderabad

TENTATIVE SCIENTIFIC PROGRAMME

FRIDAY, 19 SEPTEMBER 2008

- 08 00** : **REGISTRATION**
08 00 – 17 00 : **POSTER SESSION**
09 00 – 10 00 : **‘HOW I DO IT’ SESSION** (*Three parallel Halls*)

Hall A – Head and Neck (60 min)

1. Near Total Laryngectomy- *Anil D’cruz, India*
2. Laser Hemi laryngectomy- *D. Parikh, India*
3. Mandibular reconstruction with sliding mandibulotomy- *Alok Pathak, Canada*

Hall B – Genitourinary (60 min)

1. Laparoscopic Radical Prostatectomy- *A. Ramani, India*
2. Laparoscopic Radical Nephrectomy- *V. Mahendra, India*
3. Robotic Radical Prostatectomy- *J E Pontes, USA*

Hall C – GIT (60 min)

1. Radical Gastrectomy- *S. Sharma, India*
2. Anterior resection- *S. Shrikhande, India*
3. Total mesorectal excision- *V. Parisi, Italy*

- 10 00 – 10 30** : **COFFEE**

- 10 30 – 11 30** : **RONALD RAVEN AWARD SESSION**

1. Angiogenic switch during human breast carcinogenesis is driven by hypoxia inducible factor 1-alpha, *S. Menakuru, UK*
2. Insulin like binding protein 7 - evidence for a possible paracrine protective effect in human breast cancer, *A. Subramanian, UK*
3. Laparoscopic Radical Gastrectomy for gastric cancer: A Single-centre Experience from United Kingdom, *V. Upasani, UK*
4. Detection of breast cancer metastasis in sentinel lymph nodes using intraoperative realtime Genesearch TM BLN Assay in the Operating room – Results of Cardiff validation study, *A. Goyal, UK*
5. The role of VEGF-A genetic variation on protein levels and breast cancer susceptibility, *S. Balasubramaniam, UK*
6. Recurrences after ROLL lumpectomy for invasive breast cancer, *H. Ramesh, UK*

11 30 – 12 00 : **SMT. RADHA DEVI ORATION**
Soft tissue sarcoma – Revisited - *Dr S Sadasivam, Coimbatore, India*

12 00 – 13 00 : **Dr KS Gopinath – DR KS PANDA ONCO QUIZ**

13 00 – 14 00 : **LUNCH**

14 00 – 14 30 : **FREE PAPER SESSION – HALL A & B**

HALL A

14 00 – 14 10 : Sonographic & cytologic evaluation of thyroid in breast cancer, *A. Kumar, Varanasi*

14 10 – 14 20 : Breast Conserving Surgery after neo adjuvant chemotherapy in locally advanced breast cancer – a realty check, *A. Chauhan, New Delhi*

14 20 – 14 30 : Immediate fixed form implant based breast reconstruction – reducing costs but not at the expense of cosmesis, *A Deshpande, UK*

HALL B

14 00 – 14 10 : Partial Breast reconstruction – expanding the indications for breast conservation, *H. Lekawale, UK*

14 10 – 14 20 : Hyperthermia & isolated limb perfusion in malignant tumours of the extremity, *GSN Raju, Hyderabad*

14 20 – 14 30 : Osteosarcoma – malignant bone tumour, *G Senthil Kumar, Chennai*

14 30 – 16 00 : **HALL A**

Symposium: Cancer screening in women

Convenors: *Prof. Subrahmanyeswar Rao, India & Mr H. Singhal, UK*

HALL B

Symposium – Cutaneous malignancies

Convenor: *Dr BKC Mohan Prasad, Madurai*

16 00 – 16 30 : **TEA**

16 30 – 17 30 : **INAUGURATION**

Chief Guest: *Mr Mike Connor,*

British High Commissioner for Southern India

18 00 : **Coaches departs from Mariott to Chowmahallah Palace**

19 00 – 19 45 : **Satellite Session (Sponsored by Dr Reddys Laboratories)**

20 00 hrs : **Hyderabadi Nite**

23 30 : **Coaches depart from Chowmahallah Palace to Mariott**

SATURDAY, 20 SEPTEMBER 2008

08 00 – 17 00 : Poster Session
08 00 – 09 30 : ‘How I do it’ Session (Three parallel Halls)

HALL A

1. Superficial Parotidectomy- *RP Deo, India*
2. Marginal Mandibulectomy- *L Sarangi, India*
3. Buccal fat pad for reconstruction of intraoral defects- *S. Ghosh, India*
4. Open Radical Prostatectomy- *J N Kulkarni, India*
5. Laparoscopic Radical Hysterectomy- *B. Narasaiah, India*

HALL B : GI SURGERY

1. Right Hepatectomy using hanging liver technique *G. Poston, UK*
2. Laparoscopic hepatectomy - *Clark Gamblin, USA*
3. Right extended hemihepatectomy for locally advanced carcinoma gallbladder using tissue link for parenchymal dissection- *S. Gupta, India*
4. Radiofrequency ablation of liver tumour – open method- *M.Prasad, USA*
5. Thoracoscopic Oesophagectomy with radical lymphadenectomy- *Suraj Pawar, India*

HALL C : BREAST

1. Breast conserving surgery and axillary dissection- *R Badwe, India*
2. Oncoplastic Breast conserving surgery- *H Singhal, UK*
3. Oncoplastic Breast surgery with mini Latissimus dorsi flap- *G Singh, India*
4. Latissimus dorsi after MRM with implant- *D. Sawant, India*
5. Sentinel node biopsy - *D. Clark, UK*

09 30 – 10 00 : COFFEE

10 00 – 11 00 : Detroit & MIS Fellowship Award Session
Postponed to ASICON

11 00 – 11 30 : Motibhai Oration
Rectal Cancer Surgery after Chemo-Radiation- *Prof Valerio Parisi, Italy*

11 30 – 12 00 : Prof. N.C. Misra Oration
Quality and outcomes in Hepatobiliary cancer surgery- *Dr. Graeme Poston, UK*

12 00 – 13 00 : INVITED LECTURES (HALL A & B)

HALL A

- 12 00 – 12 20 : Management of Gastrointestinal stromal tumours- **Ravi Kant, India**
12 20 – 12 40 : Tissue ablation in Surgical oncology- **M. Prasad, USA**
12 40 – 13 00 : Palliative care & Hospice- **S. Kapoor, India**

HALL B

- 12 00 – 12 20 : Genomic variation in breast cancer- **M. Reed, UK**
12 20 – 12 40 : Targeted therapy in Breast cancer- **S.H. Advani, India**
12 40 – 13 00 : Taxane resistance in Breast Cancer- **A. Delgado, Phillipines**

13 00 – 14 00 : LUNCH

14 00 – 15 00 : FREE PAPER SESSION (Hall A & B)

HALL A

- 14 00 – 14 10 : Surgery for carcinoma gall bladder – 7 yrs experience with CCWHRI, **A. Gupta, Kolkatta**
14 10 – 14 20 : Analysis of bacterial infection in patients with carcinoma gall bladder, **M. Tiwari, Varanasi**
14 20 – 14 30 : Prognostic factors for recurrence following resection of GI stromal tumours, **R. Seshadri, Chennai**
14 30 – 14 40 : Results of 6 yrs experience of liver resection treated by radiofrequency ablation, **V. Singh, Bhopal**
14 40 – 14 50 : Gastric cancer: pancreas and spleen preserving D 2 Gastrectomy – CCWH & RI, **S. Bhattacharya, Kolkatta**
14 50 – 15 00 : Cystic neoplasms of the pancreas – experiences and lessons learnt **D. Sarkar, Kolkatta**

HALL B

- 14 00 – 14 10 : Minimally invasive esophagectomy – our experience & results, **P. Mullrepatan, Kolhapur**
14 10 – 14 20 : Emergency management of malignant large bowel obstruction – 15 yrs experience, **K.K. Maudar, Bhopal**
14 20 – 14 30 : Pelvic exenteration for locally advanced Gynaecological malignancy – 5 yr review, **A. Mathew, Trivandrum**
14 30 – 14 40 : Parathyroid neoplasms – a diagnostic dilemma, **P. Ramakant, Lucknow**
14 40 – 14 50 : Scoring system based on cytological and USS features – Thyroid nodules, **S. Gupta, Kolkatta**
14 50 – 15 00 : Comparative study of USS neck with FNAC & SNB with imprint cytology – oral cancer, **A. Samaiya, Bhopal**

15 00 – 16 30 : **HALL A**
Joint IASO – BASO Symposium
How to write a scientific paper and get it published
Convenors: *Prof. A. Chaturvedi, India & Mr D. Rew, UK*

HALL B
Joint IASO – BASO Symposium
**Have we moved on from the days of Haagensen? - Controversies
around management of locally advanced primary breast cancer**
Convenors: *Prof. K.S. Gopinath, India & M. K.L. Cheung, UK*

16 30 – 17 00 : **Tea**
17 00 – 19 00 : **Elections & Annual General Body Meeting**
19 00 – 19 30 : **Dances of India (Cultural programme)**
19 30 onwards : **Bollywood nite & Banquet Reception (Hotel Mariott)**

SUNDAY, 21 SEPTEMBER 2008

09 00 – 10 30 : **Symposium – Post mastectomy breast reconstruction**
Convenor: Dr P. Raghu Ram, Hyderabad

10 – 30 – 11 00 : **COFFEE**

11 00 – 13 00 **INVITED LECTURES (HALL A & B)**

HALL A

11 00 – 11 20 : Sentinel node biopsy after Neo Adjuvant chemotherapy- **R. Jackesz, Austria**
11 20 – 11 40 : Evolution of Breast surgery as a Subspecialty in the UK- **D. Hansel, UK**
11 40 – 12 00 : Laparoscopic liver resection- **Clark Gamblin, USA**
12 00 – 12 25 : Minimally investigative Parathyroid Surgery- **D. Rew, UK**
12 25 – 12 45 : Chemotherapy for Head and neck Cancers - TBA
12 45 – 13 00 : Breast surgery without drains - **Thomas Verghese, India**

HALL B

11 00 – 11 20 : Rectus Abdominis flap for perineal wounds- **H. S. Shukla, India**
11 20 – 11 40 : Radical prostatectomy – recent advances in management- **JE Pontes, USA**
11 40 – 12 00 : From Bench to Bedside, New Paradigms for Implementing Change in an
Era of Technology- **D. Weaver, USA**

- 12 00 – 13 00 : HALL B**
POSTER AWARD SESSION
Oral Presentation of 10 selected Posters from 20 and 21 September.
(3 mts oral presentation + 3 mts Discussion for each Poster Presentation)
- 13 00 – 13 30 VALEDICTORY FUNCTION & CLOSE OF MEETING**
- 13 30 - LUNCH**

BARODA - GCRI- IASO TRAVELING MINIMAL INVASIVE SURGERY FELLOWSHIP (MIS) FELLOWSHIP

The Association in its last General body meeting has agreed to start another fellowship which will be called the Baroda - GCRI- IASO Traveling Minimal Invasive Surgery Fellowship (MIS) at GEM Hospital, Coimbatore from 2008. The Money for the fellowship has been provided by Dr R I Dave and Dr Kiran Kothari from GCRI, Ahemadabad. The funds from the Baroda traveling fellowship will be combined with the funds from GCRI and the fellowship will be thus named so. The selection for the fellowship will be done during the NATCON IASO 2009 at Kolkatta.

For selection the eligibility is - the candidate should be less than 45 years of age (on 31 - 12-2009), and permanently employed. He should be permanently employed a full member of IASO for a minimum of two years and attended two conferences of NATCON IASO. Selection will be based on CV and paper presentation during NATCON meeting. The paper must be on the work done in India only. The selected candidate will get Rs 6000/- for the fellowship and his registration charges at Coimbatore will be waived off by Dr Palanivelu. The Application must reach Secretary IASO by 15 August 2009.

The Significance of Observation of Cancer Calendar of the Year

*Manoj Sharma **

Introduction:

Scene: Taj Connemara, Madras, Circa 1980, Place: Venue III AROI Conference Session. Last Session of the last day of conference.

Paper presenter: Dr. Manoj Sharma, Topic: Cancer Education Methodology,

Number of audience: 15, 10 foreigners including Dr. Frank Neil (Sheffield Fame) and 5 Indians.

One colleague from Kanpur joked at the end of presentation during question and comments – “Dr. Sharma why don’t you put these posters pinned to your shirt or at the best get them printed on your shirt”. Prof. Frank Neil arises from the audience and shuts down the Kanpur radiation Oncologists and comes to dais to congratulate Dr. Manoj Sharma.. For 30 minutes Dr. Frank Neil enlightens the remaining crowd that was slowly joined by some more from the tea stalls outside. For next 15 years there were no preventive oncology presentation in any of the oncology related conferences barring once in a while presentations by the author. Abstracts often rejected !

One wonders if the Oncology Community had taken a lesson then, the scenario would have been slightly different in the stage presentation of cancer patients in our country.

The Cancer Date Calendar:

What is cancer date calendar and what are the dates? Can be seen below in the table:

S.N.	Date	The Day
1	March 11 th	Cancer Awareness day for Gynecological Cancers
2	May 30 th	WHO Anti-Tobacco day Brown Ribbon Day
3	September 12th	Cancer Awareness Day for Head and Neck Cancers
4	September 14 th	International Lymphoma Day
5	October 22 nd	Pink Ribbon Day for Breast Cancer Patients
6	November 7 th	International Cancer Awareness day
7	June 19 th	Cancer Survivors Day Yellow Ribbon Day
8		International AIDS awareness Day for Reminder of HIV related cancers
Proposed Activities on other dated		
9	November 14th	Awareness of Pediatric Cancers on BAL DIWAS related activities and programmes
10	International Mothers Day	Awareness of Mothers Protection from various cancers that include Gynec and Non gynec cancers such as Gall Bladder Post Cricoids, Esophagus etc.
11	International Elders Day	Awareness of increasingly prevalent Geriatric Oncology Problem in India society due to betterment of average age.

*Associate Professor, Maulana Azad Medical College. New Delhi and Advisor, Cancer Control Programme Govt. of CT of Delhi

The sole purpose of observing the calendar dates related to various cancers is to remind ourselves in first place as to how significant it is to make a media publicity about such and such cancers. One day of the year or for that matter week long celebrations on International Cancer awareness day on 7th November are not sufficient to create the awareness of blooming varieties of cancers in this country.

These Awareness days need to be seen form three different perspectives:

1. The Methods to intensify the campaign for a particular cancer on the calendar date with special reference to its higher incidence or prevalence in that region of the country.
2. Necessity to intercept and contribute the truth of cancer in other Social Days viz. Children's day Mother's Day , Elders Day , Women's Day etc etc.
3. Methods to collect realistic data on these cancers from various "Cancer Patients Record Sections" of various oncology departments viz. radiotherapy, surgical, medical and pediatric oncology departments, and regional centers. The data compilation and presentation to public and in the press and finally to a central compiling authority such as ICMR National Cancer Registry Project .Because that shall be the realistic statistic and not the so called representative ICMR statistics that is based mainly on four Metropolitan Tumor Registries and very few regional centers .**The large gray areas of cancer dense populations still left out for census.**
4. Introspection for the treatment facilities available for these cancer—bare minimal for basic cancer treatment centers and MCI recommendations for the teaching radiotherapy departments. Some Collective approach to correct the faulty Departments running illegal M.D. Radiotherapy courses for decade now.

Added to it should be

1. A renewed attempt or reminder campaign for declaring cancer as a notifiable disease for better handling of the detection, statistical compilation and treatment facility provision.
2. **WHO Anti-Tobacco day Brown Ribbon Day** Local and National Debate to deal with the causative factors such as Tobacco and hence stress on budgetary allocation for crop conversion programme to generate other alternative golden crops in place of tobacco - finally banning of tobacco farming, like many other countries have done .
3. Campaign to raise taxes on tobacco and tobacco products or to put "Cess for Cancer Treatment Center constuction" on tobacco products to generate funds for more cancer treatment facilities.
4. **On the National Head and Neck Cancer Day** implementation of antismoking laws, promulgation of "World Anti-tobacco Law" . Statewide implementation of Tobacco ban.
5. **National Gynecological Cancer day:** Stress on family planning, sterilization, barrier contraception, hygiene, Literacy, Nutrition, Hemoglobin levels in relation to cervical and other cancers in females. Citing Chinese Example of automatic cancer cervix control with one child norm.

6. **Pink Ribbon Day** :Stress on life style modifications in case of breast cancers. Promotion of Self Examination culture and concept of Yearly Comprehensive Female Check Up .
7. **National Lymphoma Day:** stress on Child care and self examination of Nodal areas and methods of de-stressing the child during his student days. School Cancer Education Programme
8. **National Cancer Awareness Day :** Stress on promotion of motivated reading of cancer awareness material and encouragement and promotion of more awareness related writing by professional in oncology ,sociologist and psychologists. Screening of films on cancers and cancer treatment centers thorough cable operators, satellite channels and DD.

The Recommended Activities on National Calendar days for Cancer Prevention:

1. Local Newspaper and magazine articles -one week in advance, and even one week later (the articles can be written in vernacular as well as English by the oncologists and in case of inability to do so can be obtained from the author at payment of postal charges.
2. School Lectures and programmes and screening of short films that can be made by the concerned oncologist on a **betadigi format** from available camera and can be transformed to CD or can be obtained from the author by payment of postal charges and copying charges. Pharma or Equipment companies if have any audiovisual CD prepared by them.
3. Notices to School to organize competition and activities related to cancer awareness on BAL DIWAS or on International Lymphoma Day .The programme can be chalked out by the oncologists or can take directives from the Book **Cancer Ki kahani Jo Bacchon Ko Hai Sunani** or “Story of Cancer, Children ought to have been told”, written by the author.
4. Issuance of Notices to various Governmental organizations to Observe the whole week as the awareness week in form of various TV programmes by various oncologists, radio talks, “**phone in**” programmes and health quiz programmes.
5. Always participate in HIV related activities so as to get the opportunity to highlight HIV related cancers.
6. Always participate in women and child welfare programmes so as to highlight commonest Indian female cancers and pediatric cancers.
7. Try to have a word in Kamgar Majdoor programmes on industrial carcinogenesis or profession related cancers.

The Ideology behind going into full swing for these kinds of media blitz is multi-pronged

1. Biting the media time for more important issues such as health issues as media persons with their not so sophisticated/ higher education background have not realized the outcome of neglect of health and education issues. They have also no method of analysing and calculating the impact of what they are serving to the public with sole commercial objective and namesake entertainment. There is no qualified and intelligible feedback system. Instead TRP is worked out at the convenience out of the already addicted viewer to these hopeless programmes.

2. Exposure and knowledge to the public about the brighter side of Indians and breaking of the myth that life is not Bollywood, Big Bs, Khans, cricket, Scamology or stock market or politics. In other words changing the taste of public toward more constructive and useful TV watching.
3. Reaching the most vulnerable population that is the population of illiterates.
4. Developing a rapport with media and self-training in media presentation.

The tips on media presentation

1. Language: Should always use vernacular and if possible local dialect unless and until insistence for English is there in some special programmes.
2. Simplicity of presentation that can be understood by common man
3. Creating curiosity, sensationalism and also “Fear is the Key” as they say. This is specially so for an adamant Indian population who tends to jump into well even though pointed out that there is a well.
4. **Visual media tools:** lots of explanatory graphics, **betadigi** video clips and Calligraphic messages in case the studio does not have the facility to type it. Or when the programme is live and not pre recorded. Conversion from VHS to betadigi is now possible but is costly.
5. Insistence for bottom runners messages when the programme is on or all time bottom runner messages when the week is under celebration.
6. The message can be drafted depending upon the local ethos, traditions idioms and ideas or can be obtained from the author on payment of postal charges/ or through e-mail(drmanojsharma@gmail.com / drshamanoj@yahoo.co.in)
7. Always prepare an outline for the programme and be firm as to what you want to say in front of camera or mike. Please don't let the anchor or compeer drive you away from the main issue don't get overwhelmed by the studio milieu, although a decent compromise between your thought process and anchors philosophy or thinking or at times his primitiveness can save the programme from becoming a disaster presentation.
8. Use a smiling face and informal attire and attitude, cut short callers questions if they are not related to the topic of the day.

Fund and Resource developments

1. The relatives and friends of the patients who are connected with or employed in media, press, radio or television channel need to be requested/ pressurized to do a programme. Generally in time of their need they become our friends indeed. Exploitation for good cause.
2. Own relatives and friends who can help do such programmes and published articles in newspapers on a particular day or even year round.
3. The Hospital / Govt authorities to be convinced for fund allocation for OPD distribution of the material and Hospital based Celebration or early detection camp of the Cancer Dates.

4. Pharma companies to contribute for printed readable material or audiovisual preparation. The expenditure they do on various methods of publicity is miniscule in front of printing information booklets in thousands or 27 minute documentary on cancer related problems
5. Shun and discourage drink parties at the expense of pharma and equipment companies that too in disguise of academic meeting of CME (Delhi pathetic example of one oncology related specialist community that holds such drink parties regularly in guise of CME or academic meet Especially when the infrastructure and treatment opportunities are pathetic, as evidenced by 4 month plus waiting lists and unavailability of basic treatment modes).
6. If at all sponsored events by pharma are to be done then do them in the department of the medical college instead of 3 or 5 star hotels. This sends a wrong message- when the patients are suffering due to waiting lists the oncologists are celebrating in five starers. Call other specialist or the department related to oncological management such as gynec, surgery, medicine and pediatrics pathology to share your view point with them.
7. Discourage pharma companies for gifts , brochures pamphlets .Instead ask them to provide preventive education and patient information materials in vernacular languages. – in bulk so that it can be distributed from the OPDs.
8. Rich business houses and individual can be motivated to contribute for the Societal Cause to the Cancer welfare NGOs or society from where the awareness material under their auspices can be printed – providing income tax relief to the donor.
9. The Business establishments themselves can sponsor awareness material book, pamphlettes or brochure. The required stress on the message must be edited and added by the oncologist
10. If unable to assemble or write, the whole book can be provided on CD with payment of processing charges and book composers/ setter charges The copyright remains reserved with the author.
11. Divert NGOs attention toward the cancer problem. **Helpage** for Geriatric Cancers, **CRY** for Pediatric Cancers etc. Indian Cancer Society for dearth of vernacular educative material.
12. Rotary LION, Round Table, JCs Gymkhanas etc can be involved for such activities one by one for each cancer event calendar day.
13. Highlight the National Cancer Calendar Day events on your website if you have one.
14. Inter specialist bulk e-mailing for the reminder of the calendar cancer days.

Always remember that the influence on the Pharma , Equipment and Reagent industry has to be total , combined and comprehensive from the oncology community .When all the oncologists start demanding their societal contribution for awareness material and not for entertainment by Mans Machchali , Meetha and Madira (money and Mahila , remains unmentioned) the industry is bound to accept our proposal for this noble cause.

Let us **not** make fabulous encashment on cancer, instead prevent encashment of cancer patients wealth by treating an early stage organ conservable disease.

Laparoscopic Colonic Resection in Cancer – Where Do We Stand Now?

*Alfie J. Kavalakat **

Introduction:

Minimal access surgery has revolutionized the way we approach abdominal surgery. Laparoscopy has become the standard of care for many procedures. Reports on laparoscopic colon surgery were first published in 1991 [1, 2]. But it did not enjoy much popularity like many other laparoscopic procedures have during the 1990's. This has been mainly due to the concerns about the oncological safety of the procedure in cancer and the steep learning curve for the surgeon [3]. In 1992 the American Society of colon and rectal surgeons in its position statement recommended that laparoscopic colon resection for cancer be limited to clinical trials [4]. In 2000 the National Institute for Health and Clinical Excellence published a Technology Appraisal Guidance on the use of laparoscopic surgery for colorectal cancer. The guidance stated that for colorectal cancer, open rather than laparoscopic resection should be the preferred surgical procedure [5].

Short term benefits:

Several trials have demonstrated short term benefits for laparoscopic colon resection for cancer. These studies have shown a shorter postoperative ileus [6, 7, 8], less use of postoperative analgesics, lower postoperative pain scores [7], enhanced postoperative mobilization [7] and a shorter hospital stay [6, 8, 9, 10] when compared to traditional open surgery. The Cochrane systematic review on the short term benefits for laparoscopic colorectal resection which analyzed 25 randomized clinical trials was published in 2005. It showed that the intensity of postoperative pain and duration of post operative ileus was shorter after laparoscopic approach and that the pulmonary function was improved after laparoscopic colorectal resection [11]. The operative blood loss was less and the operative time longer with laparoscopic surgery. Wound infections were less and there was improved quality of life in the first thirty days.

Adequacy of oncological resection:

Two factors extensively studied to assess the adequacy of oncological resection in case of laparoscopic colectomy for cancer are the number of lymph nodes recovered from the surgical specimens and the adequacy of proximal and distal resection margins. The studies have shown no significant difference between laparoscopic and open groups [12]. Data from the large scale randomized clinical trials (European COLOR -Colon cancer Laparoscopic or Open Resection trial [13], COST- Clinical Outcomes of Surgical Therapy Study Group of the Laparoscopic Colectomy Trial [9] and UK MRC CLASICC- Medical Research Council trial of Conventional versus

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Laparoscopic-Assisted Surgery in Colorectal Cancer [14]) have also shown no significant difference in the median number of lymph nodes recovered and the longitudinal resection margins. These data confirm that from a surgical standpoint, the laparoscopic approach provides as good a resection as the open approach for colon cancer.

These trials have also provided definitive evidence against a higher incidence of port site metastases in laparoscopic colon surgery compared with traditional resection. Earlier in 1995 Wexner and Cohen in a review of all published cases till then had reported an incidence of 6.3% (range 1.5% - 21%) for port site recurrence following laparoscopic colon cancer resections [15]. Port-site recurrence in the Barcelona trial was 0.94% [6] and 0.5% in the COST trial. Laparoscopic wound/port-site recurrence was 2.5% in the CLASICC trial of which only one (0.2%) was reported as a true port-site recurrence, with the remainder being retrieval site recurrences. The majority of retrieval site recurrences occurred in patients with larger tumors or more advanced disease, which emphasizes the need for adequate wound protection during specimen extraction [16]. The early reports of high incidence rates appear to be related to surgeon inexperience and inappropriate handling of tumour laparoscopically [17].

Long-term results:

One of the first randomized controlled trials comparing laparoscopic-assisted and open resection for colon cancer was published by Lacy et al in 2002 [6]. In this single centre (University of Barcelona) study there was a non significant decrease in the tumour recurrence rate in the laparoscopic group. Over all mortality was not significantly different between the groups but the cancer related mortality was less in the laparoscopic group. Subgroup analysis suggested that laparoscopic resections may provide a potential survival advantage for Stage III colon cancer. But these results have not yet been replicated in the large scale randomized trials.

The multi-center COST study (2004) showed that there was no significant difference in the rates of tumour recurrence and overall survival at three years of follow-up between laparoscopically assisted colectomy and open colectomy. There was also no significant difference between groups in the time to recurrence or overall survival for patients with any stage of cancer. The data suggested that the laparoscopic approach is an acceptable alternative to open surgery for colon cancer [9]. The American Society of Colon and Rectal Surgeons jointly with the Society of American Gastrointestinal Endoscopic Surgeons made a position statement that - Laparoscopic colectomy for curable cancer results in equivalent cancer related survival to open colectomy when performed by experienced surgeons. Based on results from the COST trial, they cited that performing 20 procedures is necessary to attain the level of expertise that is required to undertake laparoscopic resection of colon cancers on a curative basis [18].

In August 2006 National Institute for Health and Clinical Excellence issued a new guidance on laparoscopic surgery for colorectal cancer replacing the earlier one [19]. It states that laparoscopic resection is recommended as an alternative to open resection for individuals with colorectal cancer in whom both laparoscopic and open surgery are considered suitable. It also states that laparoscopic colorectal surgery should be performed only by surgeons who have

completed appropriate training in the technique and who perform this procedure often enough to maintain competence. It further states that the decision about which of the procedures (open or laparoscopic) is undertaken should be made after informed discussion with the patient with particular reference to the suitability of the lesion for laparoscopic resection, the risks and benefits of the two procedures and the experience of the surgeon in both procedures.

Long-term results of the CLASICC trial also shows that there is no difference in the 3-year overall survival, disease-free survival, local recurrence and long term quality of life between conventional and laparoscopic-Assisted surgery for colon cancer [16]. This confirms that successful laparoscopic-assisted surgery for colon cancer is as effective as open surgery in terms of oncological outcomes. The Cochrane systematic review on long-term results of laparoscopic colorectal cancer resection was published recently [20]. Twelve randomized clinical trials were included in the analysis. No significant difference in tumour recurrence and occurrence of port-site/wound recurrences were observed between laparoscopic and open surgery for colon cancer. Similar cancer-related mortality was found after laparoscopic surgery compared to open surgery. From the data authors conclude that laparoscopic resection of carcinoma of the colon is associated with a long term outcome no different from that of open colectomy.

Conclusion:

The large randomized trials have shown that laparoscopic surgery for colon cancer is a safe procedure that is associated with a survival rate equal to survival after open surgery. The procedure can therefore be offered now routinely to patients in hospitals where surgeons with sufficient experience in laparoscopic colon surgery are available. It is important that the Surgeon should be well trained both in advanced laparoscopic techniques and in oncological surgical principles.

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Hepatocellular Carcinoma (HCC) and Liver Transplantation

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When liver transplantation (LTx) became a clinically feasible treatment modality in the early 1960's one of the undisputed indication for the procedure was primary hepatic malignancy, which could not be treated by sub total hepatic resection (Iwatsuki S et al, 1985). The recurrence rate of tumors in the early series was prohibitively high dampening the early enthusiasm and lead to retrospective reviews and a quest to re-define the role of LTx in hepatic malignancy and especially Hepatocellular Carcinoma (HCC). The presence of unfavorable histology especially vascular invasion and non-fibrolamellar hepatomas had a higher and earlier rate of recurrence.

The vast majority of HCC occur in the setting of a cirrhotic liver, itself a consequence of chronic viral hepatitis (Hepatitis B in developing countries and hepatitis C in the developed countries) (Mazzaferro V, 2007). Theoretically total hepatectomy followed by orthotopic LTx offers the opportunity for total removal of the tumor burden as well as removal of the residual cirrhotic liver left behind by a partial resection with the possibility of development of de-novo or the growth of previously sub clinical foci of HCC. The expansion of indications for LTx for non malignant conditions and the resulting shortage of deceased donor organs and a waiting list for recipients places an added dimension to the current debate regarding the indications for LTx and HCC. In this short presentation I will try to review the current consensus and the debate regarding future development and refinements of the indications.

Prior to widespread adoption of the so called Milan criteria for early HCC the 5 year survival rate after LTx for HCC ranged from 18-40% which improved to >70% after careful patient selection based on these criteria (Mazzaferro, 2007). Multivariate analysis showed that size and number of tumors were the only independent variables predicting patient survival and tumor recurrence. The criteria for LTx was radiological evidence of a single tumor ≤ 5 cm in diameter or 2-3 tumors each with a maximum diameter ≤ 3 cm (Mazzaferro et al, 1996). These results were validated in numerous liver transplant centers around the world and the United Network for Organ Sharing (UNOS) adopted it in the allocation criteria for deceased donor liver in the United States. The intent of the original Milan criteria was to define a subgroup of patients with HCC who had an excellent prognosis after LTx and not to predict a poor prognosis in patients who did not fulfill these criteria (Mazzaferro, 2007). The University of California, San Francisco (UCSF) proposed an extension of the Milan criteria based on a study of the explanted liver (Yao et al, 2001). They found that a single lesion ≤ 6.5 cm or 3 lesions, the largest lesion ≤ 4.5 cm and total tumor diameter ≤ 8 cm, resulted in a 5 year survival of 75.2%. However these criteria were based on the pathology of the explanted liver, and at least one study where these criteria were applied to the findings at the time of listing (intention to treat) failed to show these good results

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(Decaens T et al, 2006). Our current state of art pre operative radiological techniques underestimate the disease seen on the explanted liver in 20-30 % of cases (Burrel M et al, 2003) and therefore it is not surprising that these criteria developed on study of explanted livers may not be applicable to listing. Similarly the Pittsburgh group retrospectively analyzing their data suggested a subgroup of patients exceeding the Milan criteria who were cured by LTx (Marsh and Dvorchik, 2003). However the Pittsburgh model is based on assessment of vascular invasion and lymph node status which is not applicable to pre transplant listing. There is an urgent need for development of molecular markers (Llovet, 2007) for predicting tumor behavior which can be tested prospectively, and help define the two contentious subgroups, 1. Those fulfilling the Milan criteria but with early recurrence after LTx , and 2. Those exceeding the Milan criteria but with a less aggressive phenotype who do well after LTx (Llovet, 2006). Markers such as mRNA in plasma may predict presence of circulating tumor cells and therefore recurrence after LTx (Cheung et al, 2008).

The place and indication of surgical resection of HCC and LTx has also been evolving. It appears that small and uninodular and binodular tumors which were considered to be candidates for resection have a better outcome with transplantation (Bismuth et al, 1993). The underlying liver status after resection has to be considered, and it has been shown that patients with compensated liver cirrhosis but with tumors outside the Milan criteria can undergo resection (Belghiti et al, 2002).

With the development of techniques and accumulating experience with living donor liver transplantation initially in the pediatric population and now increasingly in the adult population, results are now available for the use of this in HCC. Due to the legal and social barriers to deceased donor transplantation, the Japanese have a longer experience with the use of living donors. Todo (2004, 2007) has reported on the Japanese experience. Three year disease free survival was 79.1% in patient meeting the Milan criteria and 52.6% in those who did not. The experience in the subgroup of patients exceeding the Milan criteria is vital as it is this subgroup which needs to be studied in detail to see if pre operative markers like AFP and PIVKA II can predict aggressive tumor behavior. Judicious use of both living and deceased donors and pre operative selection has resulted in some remarkable long term (27% at 15 years) survival (Island et al, 2008).

An additional complicating factor is the rise in HCC in cirrhotics with hepatitis C. The outcome after LTx for hepatitis C remains poor (Lake et al, 2005). A recent retrospective review showed poorer outcome in patients with HCC and hepatitis C (Bozozgadeh, et al, 2007). However in a large cohort (168) from University of California, San Francisco and Columbia University of patients with HCC undergoing LTx, hepatitis C (61% of subjects) was not shown to be a significant predictor of tumor recurrence when compared to hepatitis B or alcoholic liver disease (Yao et al, 2005).

It is now accepted that LTx in HCC which meets the Milan criteria results in excellent 5 year survival, the challenge remains to define the subgroup of patients with HCC which exceed the Milan criteria but could be treated with LTx with good results. The role of loco-regional therapy as a bridge to LTx continues to be defined and the improvement in molecular based prognostic factors to predict tumor biology may help us to further refine our approach to this difficult clinical problem.

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Role of Laparoscopic Surgery in the Management of Ovarian Cancer

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Introduction:

Laparoscopic surgery is considered the gold standard in the management of benign ovarian tumors. It has been shown to be superior to open surgery in terms of intra-operative complications, organ preservation, postoperative morbidity, recovery time, cosmetic results and overall cost of the treatment ¹. However, its role in the management of ovarian cancer remains highly controversial. Conventionally, laparoscopic surgery is contraindicated in patients with pre-operative diagnosis of ovarian malignancy and a formal laparotomy is recommended in these cases. Major concerns related to laparoscopic surgery in the management of ovarian cancer are the risk of port site metastasis, accuracy and adequacy of surgical staging and the risk of tumor rupture leading to intraperitoneal dissemination of malignant cells.

However, advances in the technique and instrumentation of laparoscopic surgery and increasing experience in this field have led to the use of laparoscopic surgery in the management of ovarian cancer. Depending on the stage of disease and surgical goals, laparoscopic procedures can be used in various circumstances in the management of ovarian cancer:

1. Management of adnexal mass
2. Laparoscopic restaging and staging of early stage disease
3. Evaluation of advanced ovarian cancer
4. Second look laparoscopic surgery.

1. Laparoscopy in the management of adnexal mass:

Preoperative distinction between benign and malignant ovarian tumors is not always possible based on routine measurements e.g. tumor markers and imaging modalities including transvaginal ultrasonography, color Doppler and Magnetic Resonance Imaging. The incidence of malignancy in adnexal masses managed laparoscopically varies from less than 1% to 14%. ²

Most complex adnexal masses diagnosed on ultrasonography are benign and therefore can be managed laparoscopically. Childers et al ³ showed that only 14% of ovarian masses suspicious on ultrasonography were actually malignant. Therefore, initial laparoscopic evaluation with an immediate laparotomy if malignant tumor is found can be recommended for an adnexal mass. Using this approach the number of laparotomies for non-neoplastic masses can be reduced substantially. The decision to perform laparotomy in a patient with adnexal mass may be made in the following situations:

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1. Before surgery for an adnexal mass suspicious on pre-operative evaluation.
2. During surgery because ovarian mass is grossly diagnosed as malignant.
3. During surgery because the diagnosis of malignancy is confirmed on frozen section examination

Every complex adnexal mass should be considered potentially malignant and should be managed by an expert laparoscopic surgeon in a specialized center with facilities for intra-operative frozen section examination. The patient should be counseled for the need of laparotomy in case malignant disease is found and consent for the same should be taken. Peritoneal fluid/washings should be collected and the entire pelvic and abdominal cavity should be thoroughly inspected before proceeding for removal of the mass. Any extra-ovarian suspicious lesion should be biopsied. The decision to puncture the adnexal mass should be made with great caution since it may have potential adverse consequences in cases of malignancy. Masses suspicious of malignancy on pre and intra-operative evaluation should not be punctured and adnexectomy instead of cystectomy should be done. Endobags should be used routinely to retrieve the tissue. If malignancy is found during laparoscopy a gynecologic oncologist should be available to perform an immediate staging procedure. Despite above measures, the pre and intra-operative diagnosis of ovarian malignancy is missed in a number of cases leading to initial inadequate treatment of early stage disease which may adversely affect the outcome. If the diagnosis of cancer is made on permanent histopathology, the delay between the laparoscopy and staging procedure should be as short as possible.

2. Laparoscopic staging and restaging the early stage disease

Nearly 20% of all ovarian cancer cases present with early disease. These patients have good prognosis with 5 year survival rates up to 90%. Management of early EOC consists of comprehensive surgical staging which includes peritoneal washings/cytology, total abdominal hysterectomy, bilateral salpingo-oophorectomy, random peritoneal biopsies, omentectomy and pelvic and para-aortic lymphadenectomy, performed through a midline vertical incision. However, in a substantial number of cases, the diagnosis of malignancy is made on the final histological examination of the adnexal mass and therefore upfront surgical staging is not performed. It has been demonstrated that as high as 30% of patients with apparently early ovarian cancer actually have microscopic metastatic disease.⁴ Common sites of occult metastasis are peritoneal cytology specimens, omentum, diaphragmatic peritoneum and retro-peritoneal lymph nodes. Besides having prognostic implications upstaging of the disease has therapeutic value and may affect patient's survival by deciding the need for adjuvant chemotherapy. Therefore, the optimal surgical staging of patients with apparently early stage EOC is crucial especially in patients who are considered for observation without adjuvant chemotherapy after surgery.

In 1994 Querleu and Leblanc⁵ for the first time reported the adequacy and feasibility of laparoscopic approach for surgical re-staging in 8 patients of EOC. In 2004, same group reported their further experience with laparoscopic restaging in 53 patients of ovarian cancer.⁶ Laparoscopic restaging was possible in all but one case (due to dense adhesions) and included peritoneal fluid cytology, through abdominal inspection, multiple random peritoneal biopsies, infracolic omentectomy and pelvic and para-aortic lymphadenectomy up to the level of renal vein.

The average operative time was 238 minutes and hospital stay 3.1 days. Nineteen percent patients were upstaged after laparoscopic restaging and were given chemotherapy. Overall complication rate was 7.5% (4/53) which compares favorably to nearly 10% complication rate at open surgical restaging. One laparotomy was needed to manage a ureteric transection. The recurrence rate in patients who were not given adjuvant treatment after restaging was 6.5% (3/34) which is comparable to 3-18% recurrence rate observed after open re-staging.

Several other investigators have also shown encouraging surgical outcomes, low-complication rates and no differences in proportion of patients upstaged between conventional and laparoscopic restaging. The optical magnification during laparoscopic surgery offers better visualization of peritoneal surfaces than direct visualization during laparotomy and help in identifying small volume disease which may be missed otherwise.

Very limited data, mainly in the form of retrospective review or case reports is available on the role of laparoscopy in the primary management of early EOC. Various issues related to the technical feasibility, safety and adequacy of laparoscopic approach need to be answered before laparoscopy can be recommended in this setting.

Operative laparoscopy can also be used in the definitive management of borderline ovarian tumors. In a recent publication, Odegaard et al ⁷ retrospectively compared the outcome after surgery by laparoscopy or laparotomy in 107 patients of stage I borderline tumors. Thirty-eight patients were operated primarily by laparoscopy and 69 by laparotomy. Intra-operative rupture was more frequent during laparoscopy than laparotomy in tumors >10 cm in diameter. Postoperative complications were less frequent after laparoscopy but laparoscopic surgeries were less extensive as compared to laparotomy. There was no significant difference between fertility rates between the two groups. Laparoscopic management seems to be safe and feasible in early stage, moderate size borderline tumors.

3. Laparoscopy in the management of advanced ovarian cancer:

Surgical cytoreduction followed by platinum based combination chemotherapy is considered to be the standard of care in patients with advanced EOC. The amount of residual tumor at the end of primary surgery is the most important prognostic factor in patients with advanced stage disease and the survival benefit of aggressive cytoreduction is seen only in patients in whom primary and metastatic tumor can be cytoreduced optimally. The definition of optimal cytoreduction varies in the literature from 0 to 2 cm of the maximum diameter of residual tumor. Patients with no gross macroscopic disease have the best survival outcome.

Despite aggressive surgery, upfront optimal cytoreduction is not possible in a substantial number of cases with advanced EOC. One of the therapeutic approaches in these cases is neo-adjuvant chemotherapy followed by interval debulking surgery. The goal of neo-adjuvant chemotherapy is to downstage the tumor and to increase the optimal debulking rates, decrease intra and post operative complications and improve the quality of life without compromising the survival. An ongoing randomized trial by EORTC is comparing neoadjuvant chemotherapy followed by interval debulking with primary debulking and adjuvant chemotherapy (Protocol #55971).

Laparotomy is the most accurate way to evaluate the tumor burden and establish optimal cytoreducibility of the disease. However, it is an invasive approach associated with significant operative morbidity and delay in the start of chemotherapy. Various non-invasive methods like CT scan based scoring system; pre-operative serum CA-125 levels and ascitic fluid volume have been used to predict the probability of optimal debulking rates. However, the data on the use of these methods is non-consistent.

Recently, laparoscopic approach has been used to assess the disease resectability in patients with advanced EOC. In 1998, Vergote et al ⁸ reported their experience with diagnostic open laparoscopy in 77 patients of advanced ovarian cancer judged to be in-operable based on clinical and radiological criteria. Based on laparoscopic assessment 28 patients were subjected to a primary debulking surgery. Optimal cytoreduction to less than 0.5cm residual tumor was possible 79% of cases. Fagotti et al ⁹ evaluated the role of diagnostic laparoscopy in 64 patients of advanced ovarian cancer. They reported the overall accuracy of laparoscopy in assessing optimal cytoreduction was 90%. All cases found to be unresectable by laparoscopy remained so on laparotomy also (100% negative predictive value). However, optimal cytoreduction was achieved in 34 of 39 (87%) cases judged to be resectable on laparoscopy. Angioli et al ¹⁰ reported 96% optimal cytoreduction rate in 53 patients judged to be operable on diagnostic open laparoscopy. No major peri-operative complication occurred due to laparoscopy.

Advantages of diagnostic laparoscopy include visualization of the pelvic and abdominal organs under magnification and bright illumination, ability to get tissue for histological diagnosis, short operative time, avoidance of opening the abdomen, quick post-operative recovery, reduced operative morbidity and early institution of chemotherapy. Some of the drawbacks of this technique are the risk of port site metastasis, visceral and vascular injury and difficulty in assessing disease at certain sites e.g. posterior surface of the liver or the left hemidiaphragm.

4. Second look laparoscopic surgery:

The role of second look surgery in the management of ovarian cancer is controversial. The second look surgery is defined as the surgical evaluation of patients who are in complete remission after adequate first line treatment consisting of cytoreductive surgery and adjuvant chemotherapy. The aim of second look surgery is to evaluate the efficacy of adjuvant chemotherapy and guide subsequent treatment. However, several studies have shown that despite an extensive exploration with multiple biopsies, recurrence rate after pathological negative second look is as high as 50%, further more there is no survival benefit conferred by second look surgery. Therefore, currently second look procedures are recommended as part of a clinical trial or to evaluate the efficacy of investigational regimens including novel targeted molecules, intraperitoneal or intravenous maintenance therapies. Traditionally, the second look surgery is performed by laparotomy through a long vertical incision and includes thorough exploration of the abdomen, pelvis and retroperitoneum and multiple peritoneal washings, multiple random biopsies and nodal sampling.

With the advent of advanced minimal access surgery, laparoscopic approach has been used by several groups for second look evaluations. Initial studies of second look laparoscopy reported inadequate visualization with false negative rate up to 50%, high complication rate and a high recurrence rate following negative second look laparoscopy. Clough et al ¹¹ prospectively evaluated the feasibility, reliability and complications of a laparoscopic second look surgery and compared it with an immediate second look laparotomy. The study was performed upon twenty patients of ovarian cancer who were in complete remission after primary surgery and adjuvant chemotherapy. The positive predictive value of laparoscopy for the diagnosis of residual disease was 100% (6 of 6 cases), while the negative predictive value was 86% (2 false negative out of 14). The visualization of the entire peritoneal cavity was poor on laparoscopy due to post-operative adhesions; 41% for laparoscopy while 95% for laparotomy. The complication rate of laparoscopy requiring laparotomy was 5.3%. Based on these results, the authors concluded that a laparoscopic second look was less reliable than laparotomy.

With technical advances and more experience in operative laparoscopy, recent studies have shown that laparoscopic second look evaluations are equivalent to laparotomy with significantly less blood loss, decreased operating time, shorter hospitalization and decreased overall cost. In 2001, Husain et al ¹² reported their experience with second look laparoscopy in 150 patients of ovarian cancer. The rate of negative evaluation and the rate of recurrence in patients with negative second look were equivalent to those with laparotomy. The complication rate was 2.7% (4 out of 150) and included injury to bowel in 3 patients and bladder in one patient.

Laparoscopy may be less accurate in assessing certain regions such as porta hepatic and root of mesentery and small volume disease in these regions can be missed leading to false negative second look laparoscopy. Therefore a combined approach has been recommended to improve the yield of second look laparoscopy. According to this approach, an initial evaluation is done by laparoscopy; patients with peritoneal carcinomatosis or metastatic disease are put on second line treatment while those with negative laparoscopy are subjected to a formal laparotomy for a more detailed evaluation. This combined approach can lead to reduction of laparotomy in a substantial number of patients.

The presence of post-operative adhesions is the main obstacle to a reliable and safe evaluation at laparoscopy. The reported incidence of adhesions varies from 20-70% in various series. Complete adhesiolysis is difficult and carries the risk of intestinal or vascular injuries. Besides, the presence of adhesions may lead to difficulty in accessing the peritoneal cavity or visceral injury during the introduction of trocars. To avoid trocar related injuries an open method (i.e. direct trocar access with cut down to fascia) of peritoneal access is recommended by some investigators; however others did not find statistically significant difference in complication rates between open and closed techniques of peritoneal access. ¹³

Advantages of Laparoscopy:

Therapeutic efficacy of operative laparoscopy has not been found to be superior to conventional open surgery in the management of cancers. Therefore to be useful, laparoscopic

surgery has to score over open surgery in terms of other parameters. Potential advantages of minimal invasive approach are:

1. Better assessment of intraperitoneal disease
Due to optical magnification and bright light illumination, visualization of intraperitoneal disease is excellent at laparoscopy.
2. Early postoperative recovery and shorter hospitalization
3. Better cosmetic outcome
4. Low overall cost

Concerns about the Laparoscopic surgery for ovarian cancer:

There are many concerns regarding safety and applicability of laparoscopy in the management of ovarian cancer.

1. Accuracy and adequacy of surgical staging:

Accurate assessment of the extent of disease is crucial in the management of early EOC because the decision to give adjuvant chemotherapy is based on the stage. Certain areas especially root of the bowel mesentery and porta hepatic are less accessible to laparoscopic evaluation. There is a possibility of missing small volume disease at these sites which in turn may result in under staging and inadequate adjuvant treatment. Also, laparoscopy lacks the advantage of palpation at open surgery. However, most studies have not shown any difference in the proportion of patients upstaged between laparoscopy and open group and laparoscopy seems to be safe and accurate in the hands of experts.

2. Port site metastasis:

One of the major concerns about the use of laparoscopy in the management of malignancies is the risk of port site metastasis. Port site metastasis can be defined as “early tumor recurrences that develop locally in the abdominal wall, within the scar tissue of one or more trocar sites or an incision wound after laparoscopy and these should not be associated with peritoneal carcinomatosis.” Reymond et al.¹⁴ The first case of port site metastasis was published in 1978 by Dobronte et al.¹⁵ in a patient with malignant ovarian tumor. Since then many cases and case series have reported the occurrence of port site metastasis in various intra-abdominal malignancies. The incidence of port site metastasis in patients with ovarian cancer varies from less than 1% to 16% in the literature.² The exact mechanism of the development of port site metastasis is not known. However, several disease and surgery related factors and pneumoperitoneum have been implicated in the tumor cell implantation at surgical incision sites.

Among disease related factors; advanced disease stage, high tumor grade, presence of carcinomatosis and ascites play critical role in malignant cell implantation at the site of surgical scars.

Surgical technique:

Tumor cell spillage during surgery increases the risk of metastasis both in open and laparoscopic procedures. Spillage can occur due to inadvertent trauma during instrumentation, during morcellation or during unprotected extraction of the tumor. Laparoscopic port sites, due to active healing and cellular proliferation, provide fertile ground for tumor cell nidation. The port site may become contaminated with tumor cells through various surgical instruments used during the procedure. Allardyce et al¹⁶ reported that port utilized by the lead surgeon had more tumor contaminant than either those used by the assistant or the port that was used for placement of the laparoscope. There is more movement and exchange of the instruments at the ports used by the lead surgeon. An increased number of tumor cells have been seen in ports with excessive manipulation. Other crucial factors in facilitating port site metastasis are morcellation and tumor extraction. The risk of tumor seeding is more with morcellation and unprotected specimen extraction.

Pneumoperitoneum:

Carbon dioxide is the most widely used gas during laparoscopic surgeries. Both animal and human studies have suggested that CO₂ pneumoperitoneum may be one of the factors responsible for intraperitoneal cancer cell spread and port site metastasis. The exact role of pneumoperitoneum in the development of port site metastasis is not known. However, several hypotheses have been put forward: The turbulent gas flow during operative laparoscopy may favor the emolization of exfoliated malignant cells to the port sites.¹⁷ The malignant cells are preferentially transported to port sites because of micro-leakages along the trocars; the phenomenon is known as “chimney effect.” Use of high intra-abdominal pressure has also been shown to increase the risk of port site metastasis.

In addition, CO₂ pneumoperitoneum has shown to compromise local immune response. Ost et al¹⁸ in their syngenic murine model, showed peritoneal immune depression during CO₂ pneumoperitoneum based laparoscopy compared to open surgery. Tumor necrosis factor alpha (TNF- α) secreted from the peritoneal macrophages may play a critical role in maintaining local host resistance to the development of malignancy. CO₂ pneumoperitoneum substantially reduces TNF- α secretion, thereby may attenuate local immune surveillance and promote development of peritoneal carcinomatosis and port site metastasis. Another factor implicated in the development of port site metastasis is increased release of hyaluronic acid from mesothelial cells during pneumoperitoneum. Hyaluronic acid facilitates adhesion of cancer cells to mesothelial cells.

Prevention of port site metastasis:

The risk of port site metastasis can be reduced substantially if oncologic surgical principles are followed strictly. Various strategies have been recommended to prevent the development of the port site metastasis. Excessive manipulation of the tumor bearing organ is associated with a higher incidence of scar metastasis. Therefore unnecessary handling of the tumor should be avoided. Other preventive measures include: use of endobags for extraction of the tumor, judicious use of morcellation, abundant peritoneal washings at the end of the surgery, povidine-

iodine irrigation of laparoscopic instruments, trocar and port site wounds, full thickness resection of the trocar sites of primary surgery, closing the port site peritoneum if it is 10mm or more. Although controversial, use of low pressure pneumoperitoneum or gasless laparoscopy might lower the risk of port site metastasis.

3. Intra-operative tumor rupture:

The risk of inadvertent intra-operative tumor rupture resulting in tumor spillage and upstaging of the disease is another concern with the use of laparoscopy in EOC. The significance of intraoperative ovarian tumor rupture is controversial and unequivocal evidence of the poor prognostic value of intra-operative cyst rupture is lacking. Vergote et al.¹⁹ in a retrospective review of 1545 patients with FIGO stage-I epithelial ovarian cancer found intra-operative rupture of the tumor to be an independent predictor of survival.

The risk of ovarian cyst rupture and spillage of its content is more with laparoscopy compared to open surgery. Havrilesky et al.²⁰ reported an overall rupture rate of 25% during laparoscopy for adnexal mass. The risk of rupture is higher with ovarian cystectomy than with adnexectomy. In a study of 1600 adnexal masses managed laparoscopically, Canis et al.²¹ reported that 9 of 32 (18.1%) invasive cancers and 23 of 34 (67.6%) borderline tumors were punctured for diagnostic purposes.

The prognostic value of tumor rupture during laparoscopic surgery is unknown. Cases of disseminated intraperitoneal disease have been reported following tumor rupture during operative laparoscopy. The high intra-abdominal pressure and CO₂ pneumoperitoneum may further facilitate malignant cell dissemination and implantation. A judicious case selection for operative laparoscopy can reduce the incidence of rupture. Childers et al.³ recommended performing laparotomy instead of laparoscopy in following cases:

1. Masses ≥ 10 cm
2. Masses < 10 cm, but adherent to the pelvic side walls
3. When cystectomy is planned in a complex adnexal mass

Utmost care should be taken to avoid rupture and spillage in every case. Endobags should be used to remove all tissues. In case of rupture, generous abdominal lavage should be given.

Conclusions:

The role of laparoscopy in the management of ovarian cancer continues to evolve. The long term data on the survival rate in patients managed by operative laparoscopy is still lacking. Laparoscopy can be used in the management of adnexal masses, in restaging apparently early stage disease, in assessing operability in advanced disease and in the settings of second look surgery. However, concerns remain about the radicality of surgery compared to the conventional laparotomy, the ability to explore the entire abdominal cavity satisfactorily and potential laparoscopy related complications i.e. the risk of port site metastases and tumor spillage. Strict guidelines should be followed to minimize the complications and avoid compromising the survival outcomes. These procedures should be undertaken only by a surgeon with adequate

training both in advanced laparoscopy and gynecologic oncology. The general applicability of laparoscopy is not yet established and in absence of unequivocal data on the superiority of laparoscopic surgery over laparotomy, the latter remains the standard of care in the management of ovarian cancer.

Key points:

1. Oncological surgical principles as applied to open surgery should be followed strictly in operative laparoscopy.
2. Laparoscopy is a valuable tool in the management of adnexal masses, in surgical restaging of early disease, in assessing the operability in advanced cases and in second look surgery in the hands of experts.
3. However, until more data is available, laparoscopy can not be considered as an alternative to laparotomy in the overall management of ovarian cancer.

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The Talent Development and Art of Writing and Preparing Programme for Preventive Oncological “Media Blitz”

*Manoj Sharma **

Viewing the totality of oncological management in India if one major calamity that has happened other than inadequate treatment facilities, unavailability of expertise and waiting list for management of cancer is the neglect of preventive oncology and its practice.

Fortunately the preventive steps if taken timely for cancer in India would have given the best results than in the developed countries where they are being done at the exorbitant costs. The initiative by the Directorate of Health Services Govt. of NCT of Delhi has yielded such results that created acute shortage of treatment facilities for a common man. The rise in numbers of early and late cases was obvious in the hospital statistics.

Somehow the representation or space allocation for preventive oncology in the text books of preventive medicine has been miniscule and that too was in form of a pittance in the chapter on communicable disease. Arduous attempts made over last five years with the publishers to include one chapter on preventive oncology has failed miserably. Those who have interacted with the faculty of preventive medicine department do very well understand and can see their prioritization and interest in preventive oncological work. There is no doubt that the oncology has been neglected in form of “no or very little time allocation” during undergraduate teaching. Stress on preventive oncology at the undergraduate level is indeed a far cry. The effect and impact is obvious on the new generations of medical professional.

The scenario with post-graduate teaching within oncological sciences alone has been disappointing. It is about time that the initiatives to develop talent and aptitude towards preventive oncology move forward side by side with post graduate training viz., M.D., DNB and Post doctoral D.M. and M.Ch courses. To begin with small hints in question papers and later on related preventive oncological questions during viva voce exams shall certainly steer the students to explore preventive oncology literature in websites as well as in journals. Such type of carefully structured questions or their moderation have yielded very good results in a popular national examination system as could be understood during the assessments of answer sheets and later in practical exams. This indeed does not take much of time out of a busy examination schedule.

So if that is the truth one would have to devise methods to overcome that lacuna in the undergraduate teaching and in post graduate teaching at its best. Carving out a radiation oncologist with preventive oncology / potentials / talents should be able to answer the problem of oncological management in India in totality.

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It is needless to reiterate that the health awareness is the key to most of the health related problems in developing and underdeveloped counties. It acquires a special significance in India where the upward growing graph on treatment expenses and downward going graph of the common man's affordability has no meeting point. In such a scenario disease prevention through education and awareness is the only economical path of providing best out of the whatever health services budgetary allocations are done every year. "Self administered health care", "Self administered clinical examination" and "self administered first aid" for the patients receiving treatment, "self administered cancer detection" can all be made reality with the help of audio visual media blitz and initiative of a dedicated oncologist. .

It is this training or art of media presentation, or art of convincing the general masses or enactment of impressive showbiz on health education that does not become the part of medical education or medical sciences teaching curriculum. However this can very well be introduced through the yearly or regular college extra curricula activities. The Annual College Day is one event that is attended enthusiastically by most of "the doctors in making" the budding health providers. Such occasions that are largely attended by other institutions also have been characterized by debates, dance, essay writing, singing, sports and other types of competitions. Now it is high time that we introduce a new competition of "Media Presentation of Health Related Topics" for awareness purposes. Instead of very few from the crowd knowing the art of anchoring, larger populations of medical students need to be trained in this "Extra Curricular Specialization" No doubt, developing expertise in media utilization is like adding a new generation of specialization and gadgetry that every specialist or hospital would like to have in their hospital to claim availability of the latest treatment technique and expertise with them.

It is time for talent development for writing skills for the magazines and news papers read by common people in vernacular languages as well as live Radio and TV presentations , in form of talks, quiz, skit, docudrama, street play ,script writing for a play even structuring a street play "the Nukkad Natak", so on and so forth .

The Quality Control of Such Activities

To facilitate and legitimize this process it will be of great use to appoint a board of guides and advisors from the media channels, and it will be lot more easy to amalgamate their media expertise with messaging of modern medical sciences. Through one yearly seminar or CME or refresher one can utilizing the services of All India Radio and Prasar Bharti to guide and educate the students through seminars with regards to the technicalities of the programme making and as to how to go about creating such media presentation. Similar people from the related walks of life then can be called as judges on the Annual Day of such presentations.

Creating such activities and back ground shall certainly create a pressure on media time to accept these programmers. For example best three presentations on media presentation in Annual College Day functions shall have to be broadcast of telecast.

This kind of activity shall start a new tradition/ wave or era whatever you may call, of slowly encroaching upon that media time that is being wasted in covering non stop coverage on baby fall

in well or multiple marrying groom or atrocities of mother in law/ daughter in law disgusting cricket matches and the accidents , injuries and sprains that occur every day to common prosperity giving citizen of India but only those happen to a cricketer come to lime light – The list of such contra productive or non productive programmes is endless and need to be replaced by health programmes

The Source of Information for Preparing Items for Media Competition Presentation:

Practically at the level of undergraduate level there isn't much of information that the student has on social, psychological and preventive aspect of cancer. This is purely because not enough has been written in the preventive medicine books about the second most prevalent killer in India. There is not even a chapter of preventive oncology in the Preventive Medicine textbook that is being used by the postgraduate and under graduate students. What ever is available is in the book written by the Canadian writer. And undergraduates neither read that nor does it apply much to Indian scenario.

In most of the existing oncology departments that are generally radiotherapy departments of a medical college, there is not enough of cancer prevention programmes that are organized by the respective heads of the departments or medical superintendents of the hospital. Availability of related material for public distribution is a far cry. It is here when, most of our radiotherapy departments draw a blank.. The Social Worker and onco-psychologist is a far cry in these departments. Therefore the Students must have reference material on public cancer awareness and preventive oncology to understand the aspect that need to be understood and emphasis that has to be given according to the loco regional milieu and then prepare the programme.

In such a situation the students can be directed to pursue the following:

1. At the best the student /competitor or his teacher guide can collect information from some 15 books that are already published by the author on various aspects of cancer that can be explained to public. These books have been found useful even by the general practitioners and alternative system of medicine practitioners. School and college students to do their projects profusely use them
2. Through a "Google search" can refer to websites to collect information on preventive oncology topics and prepare a programme or write up. Recommended website for web address <http://www.Indiancancersociety.com>., Websites of National Cancer Institute, and National Institute of Health, American Cancer Society and European Cancer Society. These web sites shall give ideas, graphics and information that need to be transformed according to Indian scenario instead of making a "Cut and Paste" versions very common and popular with many book writers even.
3. Getting in touch with a personnel or website of the ICMR National Cancer Registry to collect the required information .The statistical data is an important component to make lay public understand more about the cancer problem and the subject.

4. They can come to the Oncology/ Radiotherapy Department of their respective institution and can see for themselves the reality related to cancer and can discuss their proposed programme with the consultants there or the residents who may guide them. As a matter of fact the oncology residents themselves should make such presentations, as this is one aspect of their training that gets neglected. It is felt by many like-minded radiation oncologists that the role of preventive oncology has to be increasingly taken by the radiation therapists who handle all the varieties of cancers when compared to a surgeon, gynecologist, ENT specialist and medical oncologist.
5. In Delhi and other metropolitan towns there are several NGOs connected with cancer related activities and inputs can be taken from them to prepare the programmes.

The List of readable material readily available through mail or E-mail

1. **School Cancer Education book** that covers most of the aspects related to cancer cause, prevention, treatment, social and psychological aspects, tumor markers, preventive oncology , industrial carcinogenesis ,diet and cancer, anticancer agro forestry , Sahajayoga and religion in rescue of cancer prevention dates and Melas related to cancer, address of “Nukkad natak” professionals. Brief coverage on pediatric cancers
2. **Cancers Found in India males and females:** covers most of the cancers found prevalently in Indian males and females ,the social plight of Indian women and the behavioral pattern of Indian male towards the female and himself.
3. **Smoke related cancers** (mainly tobacco related) and Industrial carcinogenesis
4. **HIV/AIDS related cancers** (The Hindustan Petroleum Truckers Book)
5. **Anti cancer Agro-forestry** and relation of agriculture in back yard kitchen garden/ terrace garden farming and growing of anti cancer, antioxidant food items.
6. **Self examination** of 7 body areas from the view point of cancer prevention .Specially significant due to advent of HIV related cancers. An Indian authors version of “Self administered Cancer Screening”.
7. **Answers to 100 Questions on Cancer;** dealing with socio-political aspects of cancer in addition to myths and fancies about cancer and other cause, effect of lifestyle food in causation of cancer types and sites of cancers, types of treatment for cancer self examination and answers to some side effects of cancer treatments
8. **The Patient Information Book:** Dealing with the self administered first aid for the squeals, complications and side effects related to radiotherapy, chemotherapy, chemo radiation, surgery and intensive care scenario to give assurance to the patients for what is happening inside Oncological ICU. The psychological and social aspect of the cancer patient that is devastated by the diagnosis and treatment. The Advise on acceptance on alternative methods of therapies and Babas.
9. **Docudrama on Commonest Indian Female Cancer**

10. Docudrama on Breast cancer

- 11. Three books of Breast cancer** dealing with various aspects of diagnosis staging treatment, and follow-up management of breast cancer patients
12. Detailed information for Oncological and general nurses on breast cancer .
13. Cancers of Aero digestive Tracts, Bone Skin and soft tissue cancers.
14. Cancers prevalent in and around Delhi Including brain tumors.
15. Totally dedicated to **Ovarian tumors**
16. Totally dedicated to **Colorectal tumor**
17. Totally dedicated to **Gastro intestinal tumors**
18. Totally dedicated to **geriatric tumors and Geriatric oncology**
19. **Totally dedicated to obesity related cancers.**

NATCON IASO 2009

Dates: 18, 19, 20 September 2009

Venue: Science City, Salt Lake City, Kolkatta, West Bengal

PRE CONFERENCE WORKSHOP

Dates: 17 Sept 2009

Venue: Cancer Centre Welfare Home and Research Institute, Thakurpukur

Organising Secretary

Dr Arnab Gupta

Chairman Organising Committee

Dr Samir Bhattacharya,

Host Institution

Cancer Centre and Welfare Home, Thakupukur

Does Diet Plays A Role in Gallbladder Carcinogenesis?

Manoj Pandey *

Although rare in west carcinoma of the gallbladder is a relatively common neoplasm in India. The gallbladder cancer is characterized by a wide geographical variation in its incidence and female preponderance. Not much work has been carried out on this neoplasm leading to it being labeled as an “orphan cancer”. The incidence of gallbladder cancer varies from 27/100,000 in Chile to 1/100,000 in US[1]. The incidence in India ranges from 10/100,000 in Delhi to 2-3/100,000 in south [1]. The incidence is reported to be higher from the Gangetic belt however, due to absence of cancer registries in these parts the exact incidence cannot be commented upon. In Varanasi, it is estimated to be around 4.4% of all cancers and about 16% of all gastrointestinal cancers [2-4].

What causes gallbladder cancer has always remained a matter of debate? A number of factors have been proposed though none of them are able to explain the gallbladder carcinogenesis *in toto*. Cholelithiasis with or without chronic cholecystitis has been the forerunner among these causes [5-7]. Other factors that have been proposed are chronic infections like typhoid carrier state[8,9] or Helicobacter infections [10,11], xanthogranulomatous cholecystitis [12], lipid peroxidation, genetic susceptibility etc. The list is never ending. The most attractive hypothesis that may explain the geographical variation is diet and life style factors [13]. In this issue the study from Delhi population control study shed some more light on the issue. It was Fraumani in 1975 [7], Who first tried to explain the epidemiology of biliary tract cancers and proposed that lithogenic factors like diet, pregnancies, hyperlipoproteinemia and familial tendencies may be responsible for carcinogenesis. One must remember that it was a time when gallbladder cancer was not separately registered as cancer by cancer registries around the world and was clubbed with other extrahepatic biliary tract cancers like cholangiocarcinoma. The first evidence however came in 1979 when Tominaga reported that consumption of noodle and pork was probably associated with increased biliary tract mortality [14].

Kato et al in 1983, reported on 109 cases of gallbladder cancer and 386 age and sex matched control, in what was probably the first case control study on this aspect [15]. They found an increased risk in patients with taste for oily food and intake of animal proteins and fats such as fish, eggs, meat, etc., ingestion of vegetables and fruits were low risk factors for gallbladder cancer [15]. A Polish case control study in 1992 showed increase risk with increase in total calorie intake, and a weaker association with carbohydrate, protein and cholesterol. An inverse relationship was observed with fiber intake, vitamin C and E [16]. In 1995, Moerman et al showed a low risk associated with vegetable consumption and a higher risk of added sugar in desserts and drink to be associated with biliary tract cancer [17] and later showed the effects of

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life style factor [18]. The same year in an multicentric study the body mass index, history of typhoid and family history of gallstones along with diet were found to be associated with gallbladder cancer [19]. Zatonski et al reporting on a multicentric case control study from SEARCH program of International Agency for Research on Cancer (IARC) reported elevated body mass index, high total energy intake, high carbohydrate intake (after adjustment for total energy intake), and chronic diarrhea to be associated with gallbladder cancer [20].

The 21st century saw an increased attention being paid to the diet and a number of studies were published including those from India. Our group was the first one to come up with an association of diet with gallbladder cancer [21]. We demonstrated a significant reduction in odds ratio with the consumption of radish (OR 0.4; 95% CI 0.17-0.94), green chili (OR 0.45; 95% CI 0.21-0.94) and sweet potato (OR 0.33; 95% CI 0.13-0.83) among vegetables, and mango (OR 0.4; 95% CI 0.16-0.99), orange (OR; 0.45; 95% CI 0.22-0.93), melon (OR 0.3; 95% CI 0.14-0.64) and papaya (OR 0.44; 95% 0.2-0.64) among fruits [21]. On the other hand, a statistically insignificant increase in the odds was observed with consumption of capsicum, beef, tea, red chili and mutton [21]. Serra et al in the same year (2002) showed that the consumption of red chili and low intake of fruits and sugar to be associated with gallbladder cancer substantiating some of our results [22]. Rizvi et al in a study from Pakistan too showed higher incidence with low consumption of fiber, vitamins and higher consumption of fat [23], they also found an increase in incidence in patients with prolong fasting which has not been demonstrated earlier [23].

This progress was first reviewed by us in 2003 [3] and later by others [24]. In 2004 another study by Tsunoda et al., showed higher energy intake as possible cause of gallbladder cancer [25]. The data of Rai et al., was published in 2005 and 2006 [26-28]. The results were almost similar to what has been earlier reported that higher fruit and vegetable consumptions were associated with low risk of gallbladder cancer. They also found a low BMI for patients with gallbladder cancer and attributed it to malnourishment and cancer cachexia associated with the disease [28]. Obesity and poor socioeconomic condition has also been proposed as a risk factor for gallbladder cancer but these could be surrogate for diet and nutrition [29,30]. Of the recent studies, tea drinking has been found to reduce risk [31], while body mass index, smoking and consumption of alcohol increase the risk [32,33]. A recent meta analysis evaluating the role of obesity and risk of gallbladder cancer reporting on 8 cohort and 3 case control studies has shown higher relative risk of gallbladder cancer in those who are over weight or obese, with this association to be stronger among women than men [34]. The study from Delhi population based cancer registry too reinforce the role of life style factors like tobacco and alcohol, past history of typhoid fever and cholelithiasis in gallbladder carcinogenesis. This is the first population based data from India.

Presently there is enough data to indicate that diet may play a role in gallbladder carcinogenesis, however inherent problems with the study designs, high heterogeneity among studies and complexity of confounding variables cast a shadow of doubt. What is clear from the studies published so far is that a higher consumption of fruits, vegetable and fiber and low consumption of meat, fat, and calories may prevent development of gallbladder cancer. The need for further well designed, large, multicentric cohort and case control studies can not be understated.

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AGENDA FOR ANNUAL GENERAL BODY MEETING AT HYDERABAD ON 20 SEPTEMBER 2008

1. Meeting called to order by President
2. Quorum
3. Annual report
4. Minutes of the last GBM at Ludhiana on 22 Sept 2007
5. Audited account IASO 2005, 2006, 2007
6. Audited account NATCON IASO 2007
7. IASO Sectional programme ASICON 2008
8. Confirmation of venue for NATCON 2009
9. Oration, symposia etc 2009
10. Venue for NATCON 2010
11. Baroda GCRI IASO Travelling Minimal Invasive Surgery Fellowship
12. IASO – NATCON Ludhiana Travelling Fellowship
13. Bye Law Amendments
14. IASO news letter
15. Website
16. Aberdeen Fellowship
17. WFSOS
18. Onco quiz results
19. Declaration of results of election of office bearers of IASO
20. Any other matter with permission of chair
21. Vote of thanks to Organisers of NATCON IASO-2008
22. Vote of thanks

A.K.BANSAL & ASSOCIATES
CHARTERED ACCOUNTANTS

1891 SONARIA STREET
BAHRA MOHALLA
ROHTAK
9896586215

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY
RECEIPTS & PAYMENTS ACCOUNT FOR THE PERIOD FROM 1-1-05 TO 31-12-05

RECEIPTS	AMOUNT RS	AMOUNT RS	PAYMENTS	AMOUNT RS	AMOUNT RS
OPENING BALANCE			EXPENDITURE		
OPENING CASH BALANCE		17636	Salary		12000
FDR with Bank of India			Purchases of Medals & Presidential collar		18000
FDR No. 1460820 Dt 15-12-03 to 15-12-06	50000		Stamp, postages & misc.		5355
FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000		IOH membership fees		5000
FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000		Oration award & quiz		12000
FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000		Bank charges		351
FDR with Bank of Maharashtra			Closing Balance :		
FDR No. 677488 Dt 7-9-02 to 7-12-05	150000		FDR with Bank of India		
FDR No. 677828 Dt 1-11-02 to 1-11-09	50000		FDR NO.1460820 Dt.15-12-03 To 15-12-06	50000	
FDR No. 154776 Dt. 11-02-2003 to 11-02-2010	50000		FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000	
FDR No. 764044 Dt. 16-02-2003 to 1-09-2008	273293		FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000	
FDR with Central Bank			FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000	
FDR No. 981997 Dt 23-12-99 to 23-12-04	75000		FDR with Bank of Maharashtra		
TDS	8064		FDR No. 677488 Dt 7-9-02 to 7-12-05	150000	
FDR with Allahabad Bank, Lucknow			FDR No. 677828 Dt 1-11-02 to 1-11-09	50000	
FDR No. TD-409651 Dt 20-9-04 to 20-9-06	50000		FDR No. 154776 Dt. 11-02-2003 to 11-02-2010	50000	
FDR with Union Bank of India, Varanasi			FDR No. 764044 Dt. 16-02-2003 to 1-09-2008	273293	
FDR No. 6473027 Dt. 31-12-2004 to 31-12-2007	60000		FDR with Allahabad Bank, Lucknow		
FDR No. 6473028 Dt. 31-12-2004 to 31-12-2007	60000		FDR No. TD-409651 Dt. 20-9-04 to 20-9-06	50000	
FDR No. 6473031 Dt. 31-12-2004 to 28-1-2008	40000		FDR with Union Bank of India, Varanasi		
FDR No. 6473071 Dt. 28-1-2005 to 28-1-2008	40000		FDR No. 6473027 Dt. 31-12-2004 to 31-12-2007	60000	
FDR No. 6473025 Dt. 31-12-2004 to 31-12-2009	60000		FDR No. 6473028 Dt. 31-12-2004 to 31-12-2007	60000	
FDR No. 6473026 Dt. 31-12-2004 to 31-12-2009	60000		FDR No. 6473031 Dt. 31-12-2004 to 28-1-2008	40000	
FDR No. 6473030 Dt. 31-12-2004 to 31-12-2007	30000		FDR No. 6473071 Dt. 28-1-2005 to 28-1-2008	40000	
BALANCE WITH BANK OF INDIA		1281337	FDR No. 6473025 Dt. 31-12-2004 to 31-12-2009	60000	
		10271		60000	

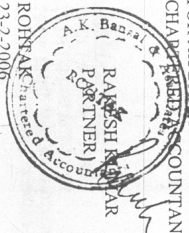


RECEIPTS
 Membership contribution
 Interest from FDR from central bank of India
 Saving Bank Interest
 Contribution from NC Mishra Oration
 Management Advance

29300	FDR No. 6473026 Dt. 31-12-2004 to 31-12-2009	60000	1198293
39330	FDR No. 6473030 Dt. 31-12-2004 to 31-12-2007	30000	
3394	Cash in Hand		6136
50000	Deposit with Punjab national bank		170000
11000	Balance with Punjab National Bank		15153
1442288			1442288

AUDITOR'S REPORT : AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US

FOR AK BANSAL & ASSOCIATES
 CHARTERED ACCOUNTANTS



PLACE
 DATE

ROHRAK
 23-2-2006

FOR INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

(Signature)
 DR. K. KARWASRA
 SECRETARY

AK BANSAJI & ASSOCIATES
 CHARTERED ACCOUNTANTS

189/1 SONARIA STREET
 BABERA MOHALLA
 ROHTAK
 9896586215

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY
 RECEIPTS & PAYMENTS ACCOUNT FOR THE PERIOD FROM 1-1-06 TO 31-12-06

RECEIPTS	AMOUNT RS	AMOUNT RS	PAYMENTS	AMOUNT RS	AMOUNT RS
OPENING BALANCE			EXPENDITURE		
OPENING CASH BALANCE		6136	Salary		12000
FDR with Bank of India			Traveling expenses		12949
FDR No. 1460820 Dt 15-12-03 to 15-12-06	50000		Stamp, postages & misc.		6935
FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000		Bank Charges		1375
FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000		Oration award & quiz		12000
FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000		Newsletter printing charges		40000
FDR with Bank of Maharashtra					
FDR No. 677488 Dt 7-9-02 to 7-12-05	150000		Closing Balance :		
FDR No. 677828 Dt 1-11-02 to 1-11-09	50000		FDR with Bank of India		
FDR No. 154776 Dt. 11-02-2003 to 11-02-2010	50000		FDR NO.1460820 Dt.15-12-03 To 15-12-06	50000	
FDR No. 764044 Dt. 16-02-2003 to 1-09-2008	273293		FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000	
			FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000	
			FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000	
			FDR with Bank of Maharashtra		
			FDR No. 677488 Dt 7-9-02 to 7-12-05	150000	
			FDR No. 677828 Dt 1-11-02 to 1-11-09	50000	
			FDR No. 154776 Dt. 11-02-2003 to 11-02-2010	50000	
			FDR No. 764044 Dt. 16-02-2003 to 1-09-2008	273293	
			FDR with Allahabad Bank, Lucknow		
			FDR No. TD-409651 Dt 20-9-04 to 20-9-06	50000	
			FDR with Union Bank of India, Varanasi		
			FDR No. 6473027 Dt. 31-12-2004 to 31-12-2007	60000	
			FDR No. 6473028 Dt. 31-12-2004 to 31-12-2007	60000	
			FDR No. 6473031 Dt. 31-12-2004 to 28-1-2008	40000	
			FDR No. 6473071 Dt. 28-1-2005 to 28-1-2008	40000	
			FDR No. 6473025 Dt. 31-12-2004 to 31-12-2009	60000	
			FDR No. 6473026 Dt. 31-12-2004 to 31-12-2009	60000	
			FDR No. 6473030 Dt. 31-12-2004 to 31-12-2007	30000	
			BALANCE WITH PUNJAB NATIONAL BANK		
			Deposit with Punjab National Bank	15153	
				170000	



RECEIPTS			
Membership contribution	38700	FDR No. 6473026 Dt. 31-12-2004 to 31-12-2009	600000
Baroda Travelling Fellowship	12000	FDR No. 6473030 Dt. 31-12-2004 to 31-12-2007	300000
Saving Bank Interest	8695	Cash in Hand	1198293
Contribution from NATCON 2004	20000	Deposit with Punjab national bank	6571
Management Advance	22800	Balance with Punjab National Bank	190000
TDS received	759		12413
	<u>1492536</u>		<u>1492536</u>

AUDITOR'S REPORT : AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US

FOR AK BANSAL & ASSOCIATES
 CHARTERED ACCOUNTANTS



FOR INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

[Signature]
 DR. R.K. KAPWASRA
 SECRETARY

PLACE
 DATE

ROHTAK
 6-2-2007

AKBANSAL & ASSOCIATES
CHARTERED ACCOUNTANTS

189/1 SONNARIA STREET
BAHRA MOHALLA
ROHTAK
9806586215

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY
RECEIPTS & PAYMENTS ACCOUNT FOR THE PERIOD FROM 1-1-07 TO 31-3-07

RECEIPTS	AMOUNT RS	AMOUNT RS	PAYMENTS	AMOUNT RS	AMOUNT RS
OPENING BALANCE					
OPENING CASH BALANCE		6571			
FDR with Bank of India			Seed Money NATCON-2007		25000
FDR No. 1460820 Dt 15-12-03 to 15-12-06	50000		Management advance paid		33800
FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000		Misc. expense		200
FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000				
FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000				
FDR with Bank of Maharashtra					
FDR No. 677488 Dt 7-9-02 to 7-12-05	150000		Closing Balance :		
FDR No. 677828 Dt 1-11-02 to 1-11-09	50000		FDR with Bank of India		
FDR No. 154776 Dt 11-02-2003 to 11-02-2010	50000		FDR NO 1460820 Dt 15-12-03 to 15-12-06	50000	
FDR No. 764044 Dt 16-02-2003 to 1-09-2008	273293		FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000	
			FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000	
			FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000	
			FDR with Bank of Maharashtra		
			FDR No. 677488 Dt 7-9-02 to 7-12-05	150000	
			FDR No. 677828 Dt 1-11-02 to 1-11-09	50000	
			FDR No. 154776 Dt 11-02-2003 to 11-02-2010	50000	
			FDR No. 764044 Dt 16-02-2003 to 1-09-2008	273293	
			FDR with Allahabad Bank, Lucknow		
			FDR No. TD-409651 Dt 20-9-04 to 20-9-06	50000	
			FDR with Union Bank of India, Varanasi		
			FDR No. 6473027 Dt 31-12-2004 to 31-12-2007	60000	
			FDR No. 6473028 Dt 31-12-2004 to 28-1-2008	40000	
			FDR No. 6473031 Dt 31-12-2004 to 28-1-2008	40000	
			FDR No. 6473025 Dt 31-12-2004 to 31-12-2009	60000	
			FDR No. 6473026 Dt 31-12-2004 to 31-12-2009	60000	
			FDR No. 6473030 Dt 31-12-2004 to 31-12-2007	30000	
			BALANCE WITH PUNJAB NATIONAL BANK		
			Deposit with Punjab National Bank	1198293	
				12413	
				190000	



RECEIPTS

	FDR No. 6473026 DL. 31-12-2004 to 31-12-2009	600000	
	FDR No. 6473030 DL. 31-12-2004 to 31-12-2007	300000	
	FDR with Punjab National Bank		
	FDR No. 362146 DL. 30-3-2007 to 30-3-2010	1000000	
	FDR No. 362147 DL. 30-3-2007 to 30-3-2010	500000	
	Cash in Hand		1348293
	Balance with Punjab National Bank		405
			<u>26907</u>
Saving Bank Interest		2328	
Contribution from NATCON 2005		25000	
		1434605	<u>1434605</u>

AUDITOR'S REPORT : AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US

FOR AK BANSAL & ASSOCIATES
CHARTERED ACCOUNTANTS



FOR INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

[Signature]
DR. R. K. ARVASRA
SECRETARY

PLACE ROHTAK
DATE 16-9-2007

A.K.BANSAL & ASSOCIATES
CHARTERED ACCOUNTANTS

1891 SONARIA STREET
BARBA MOHALLA
ROHTAK
9896586215

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY
RECEIPTS & PAYMENTS ACCOUNT FOR THE PERIOD FROM 1-1-07 TO 31-3-07

RECEIPTS	AMOUNT Rs	AMOUNT Rs	PAYMENTS	AMOUNT Rs	AMOUNT Rs
OPENING BALANCE					
OPENING CASH BALANCE		6571			
FDR with Bank of India					
FDR No. 1460820 Dt 15-12-03 to 15-12-06	50000		Seed Money NATCON-2007		25000
FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000		Management advance paid		33800
FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000		Misc. expense		200
FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000				
FDR with Bank of Maharashtra					
FDR No. 677488 Dt 7-9-02 to 7-12-05	150000		Closing Balance :		
FDR No. 677828 Dt 1-11-02 to 1-11-09	50000		FDR with Bank of India		
FDR No. 154776 Dt 11-02-2003 to 11-02-2010	50000		FDR NO.1460820 Dt.15-12-03 To 15-12-06	50000	
FDR No. 764044 Dt 16-02-2003 to 1-09-2008	273293		FDR No. 1460821 Dt 15-12-03 to 15-12-06	50000	
			FDR No. 1460822 Dt 15-12-03 to 15-12-06	50000	
			FDR No. 2159541 Dt 30-4-03 to 30-4-06	125000	
FDR with Allahabad Bank, Lucknow			FDR with Bank of Maharashtra		
FDR No. TD-409651 Dt 20-9-04 to 20-9-06	50000		FDR No. 677488 Dt 7-9-02 to 7-12-05	150000	
FDR with Union Bank of India, Varanasi			FDR No. 677828 Dt 1-11-02 to 1-11-09	50000	
FDR No. 6473027 Dt. 31-12-2004 to 31-12-2007	60000		FDR No. 154776 Dt. 11-02-2003 to 11-02-2010	50000	
FDR No. 6473028 Dt. 31-12-2004 to 31-12-2007	60000		FDR No. 764044 Dt. 16-02-2003 to 1-09-2008	273293	
FDR No. 6473031 Dt. 31-12-2004 to 28-1-2008	40000		FDR with Allahabad Bank, Lucknow		
FDR No. 6473071 Dt. 28-1-2005 to 28-1-2008	40000		FDR No. TD-409651 Dt. 20-9-04 to 20-9-06	50000	
FDR No. 6473025 Dt. 31-12-2004 to 31-12-2009	60000		FDR with Union Bank of India, Varanasi		
FDR No. 6473026 Dt. 31-12-2004 to 31-12-2009	60000		FDR No. 6473027 Dt. 31-12-2004 to 31-12-2007	60000	
FDR No. 6473030 Dt. 31-12-2004 to 31-12-2007	60000		FDR No. 6473028 Dt. 31-12-2004 to 31-12-2007	60000	
FDR No. 6473071 Dt. 28-1-2005 to 28-1-2008	40000		FDR No. 6473031 Dt. 31-12-2004 to 28-1-2008	40000	
BALANCE WITH PUNJAB NATIONAL BANK	30000		FDR No. 6473025 Dt. 31-12-2004 to 31-12-2009	60000	
BALANCE WITH PUNJAB NATIONAL BANK	1198293				
Deposit with Punjab National Bank	12413				
	190000				



RECEIPTS

	FDR No. 6473036 Dt. 31-12-2004 to 31-12-2009	60000	
	FDR No. 6473030 Dt. 31-12-2004 to 31-12-2007	30000	
	FDR with Punjab National Bank		
	FDR No. 362146 Dt. 30-3-2007 to 30-3-2010	100000	
	FDR No. 362147 Dt. 30-3-2007 to 30-3-2010	50000	
	Cash in Hand		1348293
	Balance with Punjab National Bank		405
			<u>26907</u>
			1434605
Saving Bank Interest	2328		
Contribution from NATCON 2005	25000		
	1434605		

AUDITOR'S REPORT : AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US

FOR AK BANSAL & ASSOCIATES
 CHARTERED ACCOUNTANTS



FOR INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

DR. R. K. P. VASRA
 SECRETARY

PLACE ROHTAK
 DATE 16-9-2007

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

BALANCE SHEET AS AT 31st DECEMBER 2007

<u>Liabilities</u>	<u>Amount</u>	<u>Amount</u>	<u>Assets</u>	<u>Amount</u>	<u>Amount</u>
CORPUS FUND			CURRENT ASSETS		
Opening Balance	1438401.00		Cash in Hand	0.00	
Add: Excess of Income over Expenditure for the year	<u>187809.90</u>	1626210.90	Allahabad Bank in SB Account	1040258.90	
GCRI-Baroda-IASO MIS Fellowship Fund		75000.00	Allahabad Bank in SB Account - Unrealised Cheques	12600.00	
			Banks in FDRs - As per details attached	<u>648352.00</u>	1701210.90
Total Rs.		<u>1701210.90</u>	Total Rs.		<u>1701210.90</u>

AUDITOR'S REPORT: AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US
FOR RAJIV PRIYANKA & ASSOCIATES FOR INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

CHARTERED ACCOUNTANTS



RAJIV AGARWAL
PROPRIETOR

PLACE: LUCKNOW
DATE: 16.08.2008

DR. SANJEEV MISRA
SECRETARY
DR. SANJEEV MISRA
SECRETARY, IASO

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 45 years of age (on 31-12-2009), a full member of IASO for a minimum of two years, and permanently employed and attended two conferences of NATCON IASO. Selection is based on CV and paper presentation during NATCON meeting. The paper must be on the work done in India only. Application must reach Secretary IASO by 15 August 2009.

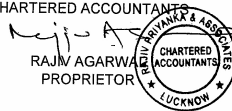
INDIAN ASSOCIATION OF SURGICAL ONOLOGY

INCOME & EXPENDITURE ACCOUNT FOR THE PERIOD FROM 1st APRIL 2007 TO 31st DECEMBER 2007

EXPENDITURE	AMOUNT	AMOUNT	INCOME	AMOUNT	AMOUNT
Bank charges		1222.10	Membership Fee/Contribution		52625.00
Dr. N. C. Misra Oration Expenses		5000.00	Interest on FDRs from Banks		134122.00
Miscellaneous Expenses		4216.00	Saving Bank Interest		144.00
Memento & Medals Expenses		800.00	Donations		35000.00
Ms. Radha Devi Oration Expenses		2000.00			
Postage Stamps		6500.00			
Printing & Stationery		4200.00			
Sri Moti Bhai Oration Expenses		2000.00			
Travelling Expenses		2143.00			
Website Expenses		6000.00			
Excess of Income over Expenditure		187809.90			
Total Rs.		221891.00	Total Rs.		221891.00

AUDITOR'S REPORT: AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US
FOR RAJIV PRIYANKA & ASSOCIATES
CHARTERED ACCOUNTANTS FOR INDIAN ASSOCIATION OF SURGICAL ONOLOGY

PLACE: LUCKNOW
DATE: 16.08.2008



Signature of Dr. Sanjeev Misra
DR. SANJEEV MISRA
SECRETARY
DR. SANJEEV MISRA
SECRETARY, IASO

DR KS PANDA DR GOPINATH QUIZ AWARD

Held each year 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 and Dr. Gopinath has kindly agreed to increase this corpus to one lakh. The quiz is being conducted by Col. L. S. Vohra, Pune.

Eligibility:

All the registered 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.

INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

RECEIPTS & PAYMENT ACCOUNT FOR THE PERIOD FROM 1st APRIL 2007 TO 31st DECEMBER 2007


RECEIPTS	AMOUNT	AMOUNT	PAYMENTS	AMOUNT	AMOUNT
OPENING BALANCES			PAYMENTS		
Cash in Hand	405.00		Bank charges		1222.10
With Punjab National Bank in SB Account	26907.00		Dr. N. C. Misra Oration Expenses		5000.00
With Banks in FDRs - As per details attached	1411089.00	1438401.00	Miscellaneous Expenses		4216.00
			Momento & Medals Expenses		800.00
			Ms. Radha Devi Oration Expenses		2000.00
RECEIPTS			Postage Stamps		6500.00
Membership Fee/Contribution		52625.00	Printing & Stationery		4200.00
Interest on FDRs from Banks		134122.00	Sri Moti Bhai Oration Expenses		2000.00
Saving Bank Interest		144.00	Travelling Expenses		2143.00
Donations		35000.00	Website Expenses		6000.00
GCRI-Baroda-IASO MIS Fellowship		75000.00			
			Closing Balances		
			Cash in Hand		0.00
			With Allahabad Bank in SB Account		1040258.90
			With Allahabad Bank in SB Account - Unrealised Cheques		12600.00
			With Banks in FDRs - As per details attached		648352.00
Total Rs.		1735292.00	Total Rs.		1735292.00

AUDITOR'S REPORT: AUDITED FROM THE BOOKS OF ACCOUNTS PRODUCED BEFORE US

FOR RAJIV PRIYANKA & ASSOCIATES

FOR INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

CHARTERED ACCOUNTANTS

PLACE: LUCKNOW
DATE: 16.08.2008RAJIV AGARWAL
PROPRIETOR

 DR. SANJEEV MISRA
 SECRETARY
 DR. SANJEEV MISRA
 SECRETARY, IASO

WEB SITE OF INDIAN ASSOCIATION OF SURGICAL ONCOLOGY

<http://www.iasoindia.in/> and <http://www.iasoindia.org>

These websites are now functioning and are maintained by the IASO secretariat. The web site is maintained with a generous educational grant from Pfizer India. The site is presently being updated. Contributions and suggestions are welcome for regular updating of the website. These can be sent to either the Secretary Dr. Sanjeev Misra, or editorial secretary, Dr. Manoj Pandey, Associate Editor Dr. Jahar Majumdar, or to any of the executive member of the society. Contributions could be in form of news, events, links to other useful website, snippets, interesting cases, articles or biographical contributions.

ROMESH K. AGGARWAL & ASSOCIATES

CHARTERED ACCOUNTANTS

G. T. ROAD, MILLER GANJ, LUDHIANA-141 003.

PHONES : 2532920, 2534289

We have audited the accounts of "NATCON –IASO 2007" an International Integrated meeting organized with Annual National Conference of Indian Association of Surgical Oncology organized from 20th September 2007 to 23rd September 2007 at Punjab Agricultural University, Ludhiana. Sources and Application of funds are as under:

Sources of Funds:

1	Registration Fee		471000
2.	Amount received from:		
a)	Medical Council of India	100000	
b)	Indian Council of Medical Research	50000	
c)	Indian Association of Surgical Oncology	25000	
d)	Spencers	2406541	2581541
	TOTAL		3052541

Application of Funds:

1	Audio, Visual and Recording expenses	178900
2	Accommodation	219021
3	Catering	828129
4	P.A.U. Venue expenses	156950
5	Tours and Travels	212352
6	Kits, Momentous and Gifts	236434
7	Postage and Couriers	50000
8	Souvenir expenses	286000
9	Conference Material (Brochure, Abstract Books, CDs, DVDs, Certificates etc)	249511
10	Scientific Stalls, Back Drops, Posters etc	114370
11	Entertainment	50000
12	Miscellaneous (Office)	60000
13	Association of Surgical Oncologist of India	125000
14	Computers, Projects, Periodicals, Books of Journals	225800
15	Cash in hand transferred to A/c of AGOICON 2009)	
	Association of Gynaecologic Oncologist of India Conf. 2009	60074
	TOTAL	3052541

For Romesh K. Aggarwal & Associates
Chartered Accountants

(Romesh K. Aggarwal)

Partner

M.No. 80037

For NATCON – IASO 2007

Organising Sect. Co-ordinator

Dated : 16.06.2008

Place : Ludhiana

IASO BYE LAWS

IASO has been registered under society of registration at Varanasi (UP) in the year 2004-05 bearing registration number 627. The income tax PAN number is AAA14187N issued on 27th August 2004.

The bye-laws of the IASO have been adopted at one of the general body meetings held in December 1997, Mumbai and amended time to time.

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

1. In the byes-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 in to 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. **Objectives:** IASO is formed as per guidelines set in schedule II of memorandum of ASI and was approved as a section in 1997. The objectives of IASO are same as stated in schedule III of memorandum of ASI. Further to that, IASO will encourage and advance the study and practice of the science and art of surgical oncology and allied organizations concerned with cancer problems.
5. **Membership:**
 - a) *Life Membership:* A life member should be a full member (Annual/life) of the parent body The Association of Surgeons of India. All persons, being surgeons with sufficient interest in cancer surgery/practicing cancer surgeons /completed an acceptable training in cancer surgery/pursuing research in cancer surgery or related subjects, 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 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 IASO will be same as of ASI-1st January to 31st December.

8. **Management:**

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

- President
- President elect
- Vice President
- Secretary
- Editorial Secretary
- Associate Editor

Members: usually 8 members will constitute the executive committee. The executive committee will have a representative from each from North, East, West and South zones (NEWS). The distribution of zones will be as follows

North Zone: Delhi, Haryana, Punjab, Himachal Pradesh, Jammu and Kashmir, Chandigarh, Uttar Pradesh and Uttaranchal

East Zone: Bihar, Jharkhand, Chattisgarh, Orissa, West Bengal, Assam and North Eastern states

West Zone: Maharashtra, Gujarat, Rajasthan, Madhya Pradesh and Goa

South Zone: Kerala, Karnataka, Tamilnadu, Andhra Pradesh, Puddichery, Andaman & Nicobar and Lakshadweep

(Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)

- 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 for election to Executive Committee.
- e) Save and except President, President elect and Vice President the tenure of all office bearers and members will be for two years. (Resolution 7 GBM, 23/9/2006, Varanasi)
- f) The President shall hold office for one year. President elect will be the President and Vice President will be President Elect after expiry of his term unless he/ she has resigned, indisposed or disqualified otherwise. (Resolution 7 GBM, 23/9/2006, Varanasi)

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. Nomination for Vacant posts will be called by the Secretary in March / April of the year of election. They will also be advertised in the Newsletter- December issue of the preceding year (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
- c. The last date for nomination being 30 August of the year of elections. The nominations are to be sent to the Secretary, IASO. If 30 August is a holiday the next working day will be the last date. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
- d. No member will contest for more than one post at the same time. Every eligible member shall be proposed and seconded by two full members of IASO. One member can propose or second only one candidate. There should be a signed no objection certificate and consent from the candidate with the nomination. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
- e. At the time of sending the nomination the candidate should send the following information – He should send a brief summary of his/her achievements (a brief background about his achievements and contributions - publications, conference organized, scientific contribution etc.), contribution to IASO and Bio-data all this not exceeding 250 words signed by him/her . This should also have a mention of IASO conferences attended in last 5 years. This should be signed and dated by the candidate. This information will be put forward to the members before the voting. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
- f. Invalid Nomination - If the nomination is found invalid the candidate will be informed about the same and the reason for invalidity mentioned. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
- g. Withdrawal of Nomination - The candidates can withdraw their nominations till the executive meeting or 5.00PM on first day of NATCON IASO. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
- h. Voting - The voting will be by a secret ballot every year during the NATCON IASO in a special session 'Elections IASO' before the Annual General Body Meeting. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
 - i. Each member will have to sign the register before voting and receiving the ballot paper. If /when membership cards are available it should be presented for inspection before voting.

- ii. The President IASO, President Elect and Vice President, Secretary will guide the election process and the counting will be done under their supervision. Election officer to be the President or President elect.
 - i. A nominee of the candidate / candidate himself or herself will be present during the counting of ballots. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
 - j. Results will be declared during the GBM (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
 - k. If there is no contest, the President shall declare the member elected for the post. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
 - l. If no nomination is received it is on the President and President elect to nominate one person for that post. (Resolution 12, GBM 22/09/2007 NATCON 2007, Ludhiana)
 - m. A full member of IASO who has completed 10 years as full member and has served at least one term as executive member is eligible to contest for the post of Vice-President. (Resolution 11, GBM 23/09/06 Varanasi)
10. **Power of Executive committee** shall be same as power of 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 present and maintain the audited accounts each year at the annual conference.
- 12. Meeting and Conference:**
- a) IASO shall hold Annual General Body Meeting every year during the Annual Conference of NACTON 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 annual conference at least once every year and appoint an organizing secretary for the conference in its annual General Body Meeting. The dates of the conference will be fourth weekend of September.
- 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.

- Annual report
- Audited accounts of the previous year
- Program and budget of the next year
- Recipients of various orations for the next year
- The venue of annual conference and appointment of Organizing Secretary
- Election of the office bearers and members of the executive committee

Any other business with the permission of the President. Topics of the symposia and their conveners, theme of CME, workshops and program outline should be discussed in the General Body Meeting.

- 16. Journal:** IASO shall publish its own Newsletter and shall elect Editorial secretary for the same. He will be 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 annual conference and zonal CME's.
 - 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 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. Orations, Fellowship & Awards: Will be decided by a scientific committee consisting of President, President Elect, Immediate Past President, Vice President, Secretary, Immediate Past Secretary, Editorial Secretary and Organizing Secretary of NATCON. (Resolution no 9, GBM 23/9/06, Varanasi)

- 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. Jain. The orator will get a plaque, a cheque for Rs. 2000, certificate and a medal.
- b) *Motibhai Oration* will be delivered by an orator selected by the executive Scientific committee, and endorsed Presented to 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 to be used. 50% of interest 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 organizing secretary NATCON. (Amended as per Resolution no 9, GBM 23/9/06, Varanasi)

- 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 Scientific Committee. In case of selection of eminent speaker from India, consultation will be held with the nominee of “The Student of Dr. N.C Misra”, who have donated Rs. three lakhs as endowment. Only interest is to be used. 50% of interest is to be reinvested to generate same amount of money even in the era of falling interest rate 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. (Resolution no 9, GBM 23/9/06, Varanasi)
- 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 (the cut off date is 31st of December of the year of application), a full member of IASO, and permanently employed. Selection is based on CV and paper presentation during NATCON meeting .The paper must be on the work done in India only. Selection panel includes Dr.K K Moudar, President and Secretary of IASO. In case Dr. KK moudar is not available than a person nominated by him or in case nominee is not available, then President Elect will be member of the panel. (Resolution no 7, GBM 23/9/06, Varanasi)
- f) *Baroda Traveling fellowship:* Rs.5000/- will be awarded to a young surgeon for visiting 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, full member of IASO, selection based on CV.

- g) *Best paper presentation* will be awarded TRs.1000 towards complimentary Associate Membership of IASO. Eligibility: Post-graduate student.
- h) *Best poster presentation* will be awarded Rs.1000 towards complimentary Associate Membership of IASO. Eligibility: Post-graduate student.
- i) *WFSOS*: The official representative of IASO in WFSOS will be immediate past president of his nominee. It will be the responsibility of President to generate \$500 for yearly membership of WFSOS.
- j) *DR. K. S. Panda-Dr. Gopinath Quiz award*: During NATCON meeting winner will be awarded Rs.700 and runners up Rs: 300. Dr. K. Panda & Dr. Gopinath donated Rs. 10,000 each towards the seed money for the Quiz award. Eligibility- all the delegates of NATCON. In case of prize being won by a person who is not a member, the winner will get an additional Rs. 300 from the IASO towards his life membership dues, and cash awards will be adjusted towards the life membership of IASO.
- k) *Free papers and posters*: All the short papers / posters should be sent to Secretary who will send them after finalizing to Organizing secretary (Resolution no 9, GBM 23/9/06, Varanasi)

24. Guidelines of invitation for NATCON

- a) Organizing secretary or his representative must be present in AGM to present his proposal.
- b) Rs. 100 per delegate or 10% of registration money must be deposited in IASO account. 10% of the minimum contribution including the registration fee in foreign currency taken in Indian equivalence be given to IASO account. Besides this a part of the savings may be donated to IASO (Resolution 21 annual GBM IASO NATCON 2007, Ludhiana).
- 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, & Conference - 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.

LIST OF NEW MEMBER OF IASO IN THE YEAR – 2008

IASO Number B0049

Dr. Balasubramanian

18/3, Kamalam Nagar

Thirupodiripuliyur

Cuddalore – 607002

Tamilnadu

IASO Number B0051

Dr. Jaydip Biswas

EE 174 A, Apartmet 2,

Sector 2, Salt Lake

Kolkata-700 091

IASO Number B0053

Dr. Vipin Kumar Bhatia

Kothi No. 3, Opposite Manmohan Petrol Pump

Near Haryana Cold Store,

G.T. Road SHD (M)-136135

Distt. Kurukshetra, Haryana

IASO Number G0049

Dr. Govindasamy Gopu

Plot 'H' Isha Malhar

Tharakeswari Nagar, Ist St

Sembakkam, Chennai – 600073

IASO Number K0070

Dr. Surender Kumar

C/o Dr. Chandra Kanta

Department of Paediatrics

C.S.M. Medical University

Lucknow-226 003

IASO Number M0057

Dr. Vimalakannan M

221/102, Ground Floor

Kutchery Road

Mylapore, Chennai-600004

IASO Number B0050

Dr. S. Jagadesh Chandra Bose

1766A, 6th Avenue

Block 1ST Street

Anna Nagar W

Chennai - 600 040.

Tamil Nadu

IASO Number B0052

Dr. Gurpreet Singh Brar

86-G, BRS Nagar

Ludhiana – 141001

Punjab

IASO Number G0028

Dr. Govindaraj Ganesan

No. 8/76, Naidu Street

Kottur, Chennai-85

IASO Number J0015

Wg Cdr (Dr.) Pradeep Jaiswal

Malignant Disease Treatment Center

Command Hospital

Southern Command

Pune 411 040

IASO Number M0056

Dr. Vijayashree Vasudev Murthy

M-4, Satyam, Sion Circle,

Mumbai – 400022

IASO Number N0016

Dr. Sandeep P. Nayak

63/4, Charu Chanra Place (East),

Kolkata-700033

I

IASO Number P0046

Dr. Arulraj P.

13A1, 3rd Street,

Laksmi Nagar

Kavundampa Palayam

Coimbatore – 641030

IASO Number P0048

Dr. Saravanan Periasamy

12/7, Karunanidhi Colony

Round Road, Dindigul – 624005

IASO Number R0036

Dr. Sripriya Rajan

BG-1 'Akshaya',

No. 2 Brindavan Street

Mylapore, Chennai-600 004

IASO Number S0115

Dr. P. Ravi Shankar

Old No. 9, New No. 8

Flat IB, Sivagami Square,

Noble 3rd Street, Alandur

Chennai – 600016

IASO Number S0117

Dr. Marimuthu Saravamamuthu

1/20 A, Old Gandarrakoltai

Gandarrakoltai, Pudukoltai DT-613301

IASO Number S0119

Dr. Shailesh Vinayak Shrikhande

220, West View Heights, 4th Floor

Sir Bhalachandra Road,

Matunga, Mumbai 400 019

IASO Number P0047

Dr. Venkat Panneer

26, North Street, Sriram Nagar

Alwarpet, Chennai-600018

IASO Number R0035

Dr. S Rajasundaram

A/2, 'BSR Elysium'

865/221, P.H. Road,

Kilpauk, Chennai-600010

IASO Number R0037

Dr. M. Ramesh

7-2/9, Telephone Nagar

Krishnapuram Colony,

Madurai 625014

Tamilnadu

IASO Number S0116

Dr. Amarendra S.

No. 142, 1st floor, Classic Orchards,

Behind Meenakshi Temple,

Bannerghatta Road,

Bangalore – 560 076

IASO Number S0118

Dr. Subbiah Shanmugam

Department of Surgical Oncology

Cancer Block, Government Royapettah

Hospital, Chennai - 600 088

IASO Number S0120

Dr. Ramakrishnan Ayloor Seshadri

Dept. of Surgical Oncology

Cancer Institute (WIA)

Annexe Campus, No. 18,

Sardar Patel Road, Guindy

Chennai-600 036

IASO Number V0018

Dr. Jayaraman Vijayan

AA 24 (old No. 91), First Street
Third Main Road
Anna Nagar West
Chennai – 600040

IASO Number W0005

Dr. Ashish Wakhlu

1/147, Vivek Khand
Gomti Nagar
Lucknow 226 010, U.P

Associate Members IASO-55

Dr. Christudas Madhan

Christudas Hospital
011 Elangovan Street
East Tambatu
Chennai-600059

Associate Members IASO-56

Dr. Kalyan Das

C/o Mr. R.M. Das
D-8, Gluster III, Purbachal,
Sector II, Salt Lake,
Kolkata-91

Associate Members IASO-57

Dr. Moni Abraham K vriakose

Amrita Institute of Medical Sciences and
Research Centre
Amrita Lane, Ponekkara
Kochi, Kerala -26

Associate Members IASO-58

Dr. Subramania Ayer

Amrita Institute of Medical Sciences
Kochi, Kerala 682026

Associate Members IASO-59

Lt. Col. (Dr.) Mala Mathur Sharma

Malignant Disease Treatment Center
Command Hospital
Southern Command
Pune 411 040

Associate Members IASO-60

Dr. Duraikkannu Jayakumar

2-A, Sai Dev Flats W-109-I
Cross Street, II Avenue
Anna Nagar West Extension
Chennai – 600101

**FORM FOR MEMBERSHIP / CHANGE OF ADDRESS OF
INDIAN ASSOCIATION OF SURGICAL ONCOLOGY(IASO)**

To
Dr. Sanjeev Misra
Professor of Surgical Oncology
Department of Surgical Oncology
King George's Medical University
Lucknow-226 003
Email: misralko@satyam.net.in

Phone :
0522-2255346 (O)
0522-3240428 (O)
0522-2324656 (R)
0522-2386829 (R)



- Sir,
1. I wish to become a member of Indian Association of Surgical Oncology (IASO)(a section of ASI).I enclose Rs. 2000.00 (two thousand only) or Rs. 2100.00 (two thousand one hundred only for outstation cheque) by Cash/Cheque/Draft/ no.....dated.....drawn on.....payable at Allahabad bank KGMU branch Lucknow.
2. Cheques & Drafts should be made in favour of Secretary Indian Association Of Surgical Oncology(IASO)
Enclosed details as per para 1 to 6.
3. Or I am an existing member of IASO. My address details have changed as para 1 to 4.

Signature of Applicant : Date of Application

DETAILS :

- 1.1 First Name..... 1.2 Middle Name.....
1.3 Last Name..... 1.4 Date of Birth.....
2.1 ASI Number.....
2.2 IASO Number (to be filled by the office).....
3.1 Present address, including pin code:
.....
3.2 Present Institution /Place of Work :
.....
3.3 Institutional address, including pin code :
.....
3.4 Preferred mailing address :
.....
3.5 Permanent address, including pin code:
.....
4.1 Mobile :..... 4.2 Telephone (R) please write STD code.....
4.3 Telephone(W) :..... 4.4 Fax :.....
4.5 E-mail :..... 4.6 Personal Website :.....
5.1 Percentage of Oncology Work:
5.2 Research in Oncology :
5.3 Educational Qualifications :
5.4 MCI Number :
5.5 Experience-details attached :
5.6 Papers published : and presented (List only the number of publications and presentations above and attach a separate sheet with details.)
6.1 Name of Proposer : ASI Number.....
Signature of Proposer
6.2 Name of Seconder ASI Number.....
Signature of Seconder

Comments by Secretary : Accepted/Not Accepted..... Signature of Secretary

RECEIPT

Received Rs.2000.00(outstation cheque Rs.2100.00) cash/draft/cheque no.....
from Dr..... towards IASO membership on date

Form for Membership directory and Membership card - 2008

IASO Number Year of IASO Membership

ASI Number FL/FA

First Name

Middle Name

Surname

Designation

Corresponding Address

.....

.....

City State Pincode

Telephone Office (.....
Area Code).....


Residence (.....
Area Code).....

Mobile

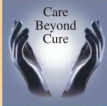
E-mail:

Please mail this information to the Secretary, IASO

Prof. Sanjeev Misra
MS, MCh, FICS, MAMS
Secretary, IASO
Professor of Surgical Oncology
Department of Surgical Oncology
King George's Medical University
Lucknow-226 003, UP, India
Phone: 0522-2255346 (O)
0522-3240428 (O)
0522-2324656 (R)
0522-2336629 (R)
Email: misralko@satyam.net.in
misralko@gmail.com



A concern for the cancer patient



Capegard Tablets
Capecitabine 500 mg

Docetax Injection
Docetaxel 20/80/120 mg

Oncogem Injection
Gemcitabine Hydrochloride 200/1000/1400 mg

Zoldria Lyophilised Injection
Zoledronic Acid 4 mg

Cipla
ONCOCARE




ADRIAMYCIN[®]
doxorubicin

AROMASIN[®]
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