AROI NEWSLETTER



Dec 2021 Vol.17, Issue 4

From the office of AROI

Dear All, Greetings from AROI !!!

AROI continues to serve the academic needs of oncologists in the country. We had already conducted AROI-ICRO teaching courses through online Webinars and the same will continue in future. The Covid-19 pandemic has continued and so the webinars and virtual conferences. As per EC decision the AROI annual meeting is postponed till 2022. We deeply echo the feeling of meeting with you which has been delayed due to current scenario. We are equally involved in the grief of the families and friends of our colleagues who has lost the battle of life this year. We wish you all a safe and healthy life and a wish to see you soon.

Wishing all of you a happy., healthy and prosperous new year.



Dr. Vijay Anand Reddy Chair AROI



Dr. Rajesh Vashistha President AROI



Dr. G.V. Giri Secretary General AROI

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Dr. Manoj Gupta President Elect AROI

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From the office of AROI



Congratulations



Dr. Rajesh Vashistha



Congratulation to Dr. Rajesh Vashistha for being elected as Vice President of FARO (Federation of Asian Organizations for Radiation Oncology) committee



Minutes of EC meetings



Minutes of the Executive Body Meeting held on Wed 17, 2021

The meeting started by Dr Giri, Secretary with permission of the President AROI

- 1. Secretary Dr Giri updated the EC regarding the urgent nature of the meeting about the FINAL DRAFT of post graduate medical education published in the NMC website which is showing only General Medicine as a feeder branch for DM Medical oncology and Radiation Oncology is not included.
- 2. Dr Giri brought to the notice of the EC that the above has been done even after raising objections through various petitions & letters, and also most importantly after getting assurance from NMC members in the meeting that this issue will be referred to a committee that will include all stake holders including representatives from AROI.
- 3. The EC was also informed that a letter of objection to the above has been drafted and sent to the president PG committee and chairperson of NMC by registered post by Dr Manoj Gupta, Dr Giri and Dr Shamsundar in the capacity as office bearers of AROI.
- 4. Dr Madhu C S suggested that in addition to the objection filed we have to look for political solutions as well, trying to influence the NMC through pressure from politicians and bureaucracy. He also suggested that Chairman NMC is unduly influenced by the HOD Medical Oncology, AIIMS, New Delhi who is against radiation Oncologists taking DM Medical Oncology
- 5. Dr Manish Pandey informed the EC that he had met 3 lawyers, including one who has experience in cases like these and was recently involved in a case against NMC for legal opinion. The lawyers suggested that there is no case at present as the proposal is just a draft and is not yet notified and have suggested to wait until a final decision is reached and then to proceed with the legal option.
- 6. Dr Manish Pandey also informed that he is in contact with NMC and he was informed that the change in the latest version of the draft was a clerical error and they had no intention of changing. They also

informed him they will be forming the committee as discussed previously soon (within about 1-2 weeks' time).

- 7. Dr Manoj Gupta agreed to the above and said we will wait for the final decision from NMC before we will proceed with legal option, however he also suggested we have to be prepared if things don't go our way, and should continue consultations with the lawyers. He also asked Dr Giri to to nominate a person after consultation to represent AROI in the NMC Meeting.
- Dr Giri suggested the deletion of Radiation Oncology may not be clerical error and could have been done intentionally, mainly due to the lobbing by the medical oncologists. He suggested we have to get legal opinion to apply for a caveat to the FINAL DRAFT published.
- 9. Dr Ramesh Billimagga joined the meeting and suggested the Objection letter sent to NMC was the correct thing to do and also suggested we have to meet other lawyers also for opinion regarding the caveat and other legal recourse.
- 10. Dr Vasishta expressed his disappointment regarding the attendance of the EC meeting only 11 members attended the meeting. He also suggested we have to write letters to PMO office, secretary to PM, and Health ministry highlighting the issue.
- 11. The EC asked Dr Manoj Pandey to communicate with NMC and to schedule the meeting with NMC as soon as possible, and in the mean time to get legal opinion regarding the possibility of filling for a stay/caveat based on the FINAL DRAFT published on the website.
- 12. EC decided to Nominate a member to attend the meeting on behalf of AROI after consultations, try to get contacts in the government through politicians or bureaucrats to influence the NMC and also to write letters to high levels of the government including PMO office highlighting the issue.
- 13. To schedule next EC meeting next Friday (26/11/2021) to discuss on the updates.

AROI Directory

All AROI members are requested to send the updated CV to <u>drvashistha@gmail.com</u> for updating AROI Directory Or link- <u>https://drrajeshvashistha.com/aroi/aroi-member-form.php</u> FARO Council Meeting

MINUTES OF MEETING

FARO Council Meeting 18 Decemeber, 2021

List of Participants

Council Members:

- 1. Golam Mohiuddin FARUQUE (BSRO)
- 2. Qazi Mushtaq HUSSAIN (BSRO)
- 3. Yexiong LI (CSTRO)
- 4. Runye WU (CSTRO)
- 5. Rajesh VASHISTHA (AROI)
- 6. G.V. GIRI (AROI)
- 7. Angela GISELVANIA (IROS)
- 8. Endang NURYADI (IROS)
- 9. Yasushi NAGATA (JASTRO)
- 10. Naoyuki SHIGEMATSU (JASTRO)
- 11. Hong-Gyun WU (KOSRO)
- 12. Ikjae LEE (KOSRO)
- 13. Anita BUSTAM (MOS)
- 14. Muthukkumaran THIAGARAJAN (MOS)
- 15. Uranchimeg TSEGMED (MOSTRO)
- 16. Odontuya GONCHIG (MOSTRO)
- 17. Khin Cho WIN (MSTRO)
- 18. Moe HLAING (MSTRO-altenate)
- 19. Mohammad FAHEEM (PSCO)
- 20. Rab Nawaz MAKEN (PSCO)
- 21. Enrico TANGCO (PROS)
- 22. Manuel LOPEZ (PROS)
- 23. Balamurugan VELLAYAPPAN (SRS)
- 24. David TAN Boon HARN (SRS)
- 25. Mahendra PERERA (SLCO)
- 26. Prasad ABEYSINGHE (SLCO)
- 27. Imjai CHITAPANARUX (THASTRO)
- 28. Chonlakiet KHORPRASERT (THASTRO)

Council Offcers:

- 1. Shyam SHRIVASTAVA (President)
- 2. Miriam Joy CALAGUAS (Vice President)
- 3. Takashi NAKANO (Secretary General)
- 4. Junlin YI (Treasurer)
- 5. Xianshu GAO (President-Elect)
- 6. Tomoaki TAMAKI (Deputy Secretary General)
- Advisory Board:
- 1. Ramesh BILIMAGGA (Vice President [2015-2016])
- Soehartati GONDHOWIARDJO (President [2017-2018])
- 3. Ivan THAM (Vice President [2017-2018])
- Secretariat:
- 1. Nobuteru KUBO (FARO Office)

Observer: 1. Manoj GUPTA (AROI)

MEETING SUMMARY

Due to the COVID-19 pandemic, the FARO Council Meeting 2021 was decided to be held virtually in on-line format as held previously in 2020. The FARO Council Meeting 2021 was successfully held by the Council Officers with the participation of the Council Members and their alternates of 14 Member Organizations. The participants are listed as on page 2/13.

The agenda and the background papers of the Meeting and its appendices (Appendix 1) were provided to the Member Organizations prior to the Meeting, and the Meeting started from 1PM (Japan time) on December 19, 2021 using the Zoom platform.

Decisions made by the Council Meeting 2021:

- The Council Meeting decided that Korean Society for Radiation Oncology (KOSRO) will be the host of the 6th FARO Meeting in 2023. The Meeting is expected to be a face-to-face meeting at present. The format of the Meeting can be a matter of discussion depending on the situation of the COVID-19 pandemic and other issues.
- 2) The Council Meeting decided to add the following clause to the Constitution: "12.9.3 Terms of references for Committees will be devised by the Council Officers and should be endorsed by the Council Meeting. The endorsed terms of reference should be made available to the Member Societies on the FARO website."
- The Council Meeting decided to form 2 new Committees: Scientific Committee and Leadership Development Program Committee.
- 4) The Council Meeting approved the terms of references suggested for the 4 Committees (Education & Training Committee (ETC), Research Committee (RC), Scientific Committee (SC), and Leadership Development Program Committee (LDPC)), with a suggested addition of the clause "to evaluate and audit effectiveness of" committee in all terms of references (ToR) of all the Committees. The ToR will be circulated to the Member Societies and made available on FARO website.

FARO Council Meeting

FARO Council Meeting 18 Decemeber, 2021

- 5) The Chairs for the 4 Committees for the term of 2022-2023 was appointed by the Officers and approved by the Council Meeting. The appointed Chairs were Dr. Supriya SASTRI CHOPRA (India) for Research Committee, Dr. Mayang PERMATA (Indonesia) for Education & Training Committee, Dr. Manuel LOPEZ (Philippines) for Scientific Committee, and Dr. Tomoaki TAMAKI (Japan) for Leadership Development Program Committee. The Member Societies were requested to nominate members of the Committees for the term of 2022-2023 according to the ToR decided as 4).
- The Council Meeting elected the FARO Council Officers for the term of 2022-2023 by the vote of confidence as the following:
- Vice-President: Dr. Rajesh VASHISTHA (AROI)
- Secretary General: Dr. Yasushi NAGATA (JASTRO)
- Treasurer: Dr. Junlin YI (CSTRO)
- President-elect: Dr. Imjai CHITAPANARUX (THASTRO)

Items approved by the Council Meeting 2021

- The Council Meeting approved that the Letter of Intent in regard to Joint FARO-ESTRO Congress @ ESTRO meets Asia as presented by the President (Dr. Shrivastava) should be further pursued for conclusion.
- 2) The Council Meeting approved the current effort of FARO to participate in the formation of International Radiation Oncology Society, the effort led by the IAEA with participation of regional and national radiation oncology societies worldwide.

Action required by the President (Old: Dr. Shrivastava, New: Dr. Gao):

- To communicate with ESTRO and take follow-up actions required to conclude the letter of intent based on the conditions presented to the Council Meeting.
- To continue communication with the IAEA in order for FARO to participate in the activity of International Radiation Oncology Society.

Actions required by the Secretary General (2021: Dr. Nakano, 2022: Dr. Nagata):

- 1) To assist the President in communication with ESTRO.
- 2) To assist the President in communication with the IAEA.

 To circulate the revised Constitution according to the decision made by the Council Meeting and make it available in the FARO website.

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- To circulate the modified ToR for the 4 Committees according to the decision made by the Council Meeting and make them available in the FARO website.
- 3) To collect the nominations of members for the 4 Committees for the term of 2022-2023 from all the Member Societies, convey the information to the Committee Chairs, and issue certificates to the Chairs and the members of the Committees.
- 4) To assist the Chairs of the 4 Committees to implement their activities according to the new ToR.

Actions required by the Committee Chairs (Dr. Dr. Sastri Chopra (Research), Dr. Permata (Education & Training), Dr. Lopez (Scientific), and Dr. Tamaki (Leadership Development Program):

 To implement the activities of the Committees according to the newly approved ToR, which include meeting regularly (preferably monthly) and reporting to the FARO Officers and the Council Meeting.

Actions required by the FARO Council Officers (2022-2023):

1) To support the organization of FARO Meeting to be held by KOSRO in 2023.

Actions required by the FARO Council Members:

- To nominate members (one senior and one young radiation oncologist) for the 4 Committees for the terms of 2022-2023 and ensure the commitment to activities of the Committees by supporting their own nominated members.
- 2) To collaborate with KOSRO for the preparation of the 6th FARO Meeting in 2023.

Actions required by the FARO Council Members of AROI, JASTRO and THASTRO:

 To nominate a Council Member to fill the vacancy of the newly elected Officers (Dr. Vashistha, Dr. Nagata, and Dr. Chitapanarux).

Action required by KOSRO (Dr. Wu and Dr. Lee):

 To prepare for the implementation of the 6th FARO Meeting in 2023 according to the list of responsibilities for FARO Meeting hosts.



Meeting Minutes

The Council Meeting was attended by the Council Members or their alternates from the 14 Member Organizations. The participants are listed as on page 2/12. The attendance was verified by roll call of the participants.

The Meeting was started by the greeting from the President, Dr. Shyam Shrivastava and chaired by the Secretary General, Dr. Takashi Nakano. The agenda, the background papers, and appendices for the Meeting (Appendix 1-3) was circulated to the Council Members prior to the Council Meeting.

1. Discussion of FARO Meeting (2023)

Prior to the FARO Council Meeting, the Secretariat has informed the Member Societies that, if a Member Society wishes to host FARO Meeting in 2023, the Member Society can make a presentation of 5 minutes detailing their plan. The Secretariat has received the request from KOSRO (and no other Societies) to make the presentation. Dr. Wu made the presentation on behalf of KOSRO detailing their plan to host FARO Meeting in Korea (Appendix 4), and the Council Meeting took note of the presentation. At the time of the Council Meeting, FARO expected the host to hold a physical meeting in 2023. Dr. Wu presented that KOSRO intends to hold a face-to-face meeting, but, depending on the situation with the pandemic and other possible reasons, KOSRO can also change the mode of the meeting to be online.

After discussion, the Council Meeting decided that KOSRO will be the host of the 6th FARO Meeting to be held in 2023. (14 Yes vs. 0 No)

Dr. Wu mentioned that, although the date is not fixed yet, KOSRO Meeting is usually held in the second Thursday to Saturday in October.

2. Discussion of collaboration between ESTRO and FARO

The FARO Council Meeting in 2020 (online with Zoom) has decided on the terms for the FARO Officers to proceed with the discussion of MoU with ESTRO. The discussion has been pending for a while due to the COVID-19. Facing the disruption due to the COVID-19 pandemic, ESTRO has resumed the discussion in 2021 with FARO.

The current discussion has followed the general line of previous FARO Meeting decisions, and the followings are

the general points:

1. The MoU should specify that the meeting/conference be implemented in 2024 and 2026.

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The terms on the "name of the conference" (Joint FARO-ESTRO Congress @ ESTRO meets Asia) and the "finances" (in case of benefit, fixed royalty of € 25k for 2024 and € 30k for 2026 paid to FARO) should be maintained.

The President reported on the progress and presented a draft Letter of Intent between ESTRO and FARO specifying the above points. (Appendix 5)

After discussion, the FARO Council Meeting approved the plan for FARO to proceed with the communication with ESTRO and conclude the Letter of Intent for the future collaboration with ESTRO regarding Joint FARO-ESTRO Congress @ ESTRO Meets Asia.

The President-elect (Dr. Gao) requested the assistance of the President (Dr. Shrivastava), the Secretary General (Dr. Nakano), and the Deputy Secretary General (Dr. Tamaki) in FARO's future communication with ESTRO regarding this Letter of Intent and further collaboration in order to maintain the continuity of the relationship between FARO and ESTRO.

3. Discussion of suggested changes in Constitution

The current FARO Constitution defines about Committees in a very simple clause as "12.9.2 Other Committees will be constituted by Council." The Officers suggested the following addition to "the 12.9 Committee" section of FARO Constitution in order to at least provide the basis of rules/functions of Committees. This proposal was circulated to the Council Members prior to the Council Meeting in a form of a background document. The proposed clauses were as follows:

"12.9.3 Terms of references for Committees will be devised by the Council Officers and should be endorsed by the Council Meeting. The endorsed terms of reference should be made available to the Member Societies on the FARO website."

After discussion, the FARO Council Meeting approved the proposal to add the clause above (12.9.3) to the Constitution by a unanimous vote (14 Yes vs. 0 No). The revised Constitution will be circulated to the Member Societies by the Secretariat and made available on FARO website Member-only page.

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4. Discussion of formation of new Committees

The President proposes the formation of the following Committees: 1) Scientific Committee and 2) Leadership Development Program Committee. The purpose of Scientific Committee is to promote the scientific activity of FARO, mainly by taking an active role in preparation and administration of "FARO Meeting" in cooperation with the local organizer. In the past FARO Meeting, the Council Officers were the direct counterpart with the local organizing Society in the preparation and implantation of FARO Meeting, and there were many challenges because of a large amount of involved work in the task of implementing FARO Meeting. The formation of Scientific Committee is expected to improve the current situation by designation of committee who would be specifically responsible for preparation FARO Meeting in the interest of FARO as a whole. The Scientific Committee is also expected to develop a protocol of sustainable mechanisms and procedures for the implementation of future FARO Meetings. The purpose of Leadership Development Program (LDP) Committee is to implement LDP in the future. The past LDP (3 classes of LDP) were initiated by the effort of Indonesian Radiation Oncology Society under the leadership of Prof. Gondhowiardjo. In the face of the success of the past LDP, the program is proposed to be continued by FARO itself under this LDP Committee.

After discussion, the FARO Council Meeting approved the proposal to form Scientific Committee and Leadership Development Program Committee.

Along the proposal of the suggested change to the Constitution (Discussion item 3.), the terms of reference (ToR) for the existing 2 Committees and the newly proposed 2 Committees were prepared by the Officers and circulated to the Member Societies as additional annex prior to the Council Meeting (Appendix 3). The terms of reference were discussed by the Council Meeting. There was a suggestion to add a clause similar to "To evaluate and audit effectiveness of Leadership Development Program from time to time" (ToR of LDP Committee) to the ToR of the other three Committees.

The FARO Council Meeting approved the proposed terms of reference for Research Committee, Education & Training Committee, Scientific Committee, and Leadership Development Program Committee with incorporation of the suggestion mentioned in the above discussion. According to the ToR, the Chairs and the members of the Committees will be serving with the term coinciding with the terms of the Council Officers, which indicates that the next term will be 2022-2023. As defined by the ToR, the Chairs of the 4 Committees were appointed by the Officers and introduced to the Council Meeting by the President as follows:

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- Dr. Supriya SASTRI CHOPRA (India) for Research Committee
- Dr. Mayang PERMATA (Indonesia) for Education & Training Committee
- Dr. Manuel LOPEZ (Philippines) for Scientific Committee, and
- Dr. Tomoaki TAMAKI (Japan) for Leadership Development Program Committee.

Dr. Sastri Chopra and Dr. Permata are current and active members of Research Committee and Education & Training Committee, respectively. Dr. Lopez was the local organizer (Meeting President) of the 5th FARO Meeting in 2021 and is expected to bring the experience and insight of organizing FARO Meeting to Scientific Committee, and Dr. Tamaki is the current Deputy Secretary General.

The FARO Council Meeting approved the appointment of the 4 Committee Chairs for 2022-2023 by the Council Officers.

The Deputy Secretary General informed the Member Organizations that they are requested to nominate 2 members (1 senior and 1 junior radiation oncologists) for the 4 Committees preferably by the end of 2021 and that the request will be sent to the Member Organizations.

5. Discussion of formation of International Radiation Oncology Society (IROS)

There has been a discussion regarding formation of International Radiation Oncology Society (IROS) under the leadership of the IAEA. FARO has been invited to the discussion, and the President, the Secretary General, and the Deputy Secretary General have been participating in the preparatory meetings organized by the IAEA. The President presented about this effort, and the general concept of IROS (Appendix 5). In the current model, IROS is an entity composed of regional and national societies, and the representation of the society member is through its CEO or President or named deputies carrying the same decision-making authority.

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The Presidency is expected to rotate among societies yearly, and meetings will be held bi-annually at the major society meetings with agenda that includes topics such as education, research, coordination challenges, communication related to IROS' mission and goals. The secretariat function will be hosted by the year's Presidency society.

Other efforts by the IAEA to improve global information sharing (ORION database), co-develop educational material (CeLP – comprehensive e-learning platform), collaborate in research (IRIS – International Research Integration System), along with the development of Lancet Oncology Commission on Radiotherapy & Theranostics were also presented to the Council Meeting by the President.

The FARO Council Meeting took note of the report and approved the plan for FARO to further participate in the framework of IROS.

The President-elect (Dr. Gao) requested the assistance of the President (Dr. Shrivastava) in the future participation of FARO in IROS and requested for his participation in the monthly teleconference of FARO Officers. The Presidentelect also requested the assistance of the Secretary General (Dr. Nakano), and the Deputy Secretary General (Dr. Tamaki) in FARO's future communication with the IAEA and other societies based on their past experiences of working with the IAEA. Dr. Shyam, Dr. Nakano, and Dr. Tamaki agreed that they will provide support to the President(-elect) and FARO as requested.

6. Report of the financial status (fiscal year of 2019)

The FARO Secretary General, Dr. Nakano, and the Treasurer, Dr. Yi, reported on the financial status of FARO of the fiscal year of 2020. Dr. Kubo, a member of FARO Office, reported the details of the financial status of the year of 2020 (Appendix 6). The income was interest income and membership fee incomes from the Member Organizations including 2 corporate members, and the expenditure was operating expenses (FARO Travel Grants 2019 for 3 Japanese winners and FARO website renewal/maintenance) and administrative expenses (foreign exchange fee, local tax, tax accountant fee, personnel fee, account maintenance fee, transfer fee, and others). As of December 31, 2020, 225,751.12 US dollars and 32,441 Japanese yen (approximately 290 US dollars) remained in total. The balance of the Fund from ICRR2015 (donation from ICRR2015 at the time of President Hiraoka) became 0 at the end of 2020.

The accounting report was presented to the attending Council Members. The treasurer, Dr. Yi, has verified the details of the budget against the bankbook of FARO Office. The Council Meeting endorsed the report. A preliminary report of the fiscal year 2021 up to November 30, 2021 was also reported to be noted by the Council Members.

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7. Final report of the 5th FARO Meeting, Philippines (Lopez)

Dr. Lopez presented the final report of the 5th FARO Meeting held on 1-3 October 2020 virtually in online platform (Appendix 7). The FARO Meeting was hosted by Philippines Radiation Oncology Society (PROS). There was a total of 780 attendees (945 registrants in total) from all of the 14 Members Societies and 93 abstract submissions from 9 Member Societies. During the 3 days, there were 22 lectures by the regional/international experts, and there were 10 proffered paper presentations and 40 poster presentations. Four best proffered paper awards (1st to 3rd places) and 6 best poster awards (2 posters for 1st place and 4 posters for 2nd place) were selected and awarded on the last day of the Meeting. The financial summary of the Meeting was also presented. The Council Meeting thanked the great effort by PROS and the local president to make this meeting a successful event for FARO.

8. Report of Education and Training Committee (ETC) (Bustam)

Dr. Bustam, who became the chair of ETC in June 2021 after Dr. Calaguas, presented the activities of ETC in 2021. According to the decision by the Council Meeting of 2020, new members were nominated by each Member Society early in 2021. The list of current ETC members, the overview of FARO webinars, other collaborative education activities including the collaboration with the IAEA/RCA projects, and updating of FARO list of experts were presented (Appendix 8). A total of 10 FARO webinars were successfully held in 2021, generally attended by average of 200-300 participants. There were significant contribution of Indonesian Radiation а Oncology Society and Indonesian Radiation Oncology Resident Association (IRORA) in conducting the webinar such as designing webinar flyers and setting up virtual platform. The recordings of past webinars are available from the FARO website. The plans for webinars in 2022 were also presented.

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Dr. Bustam pointed out that the commitment of the ETC members varied among the Member Societies, some taking very active roles while others not attending the ETC teleconference for 6 consecutive months without responding to e-mail notice from the Chair. Dr. Bustam sincerely requested the FARO Council Members to be responsible about the activities of ETC and the nomination of the ETC members.

9. Report of Research Committee (Wu)

Dr. Wu reported the activity of the Research Committee (Appendix 9). The Chair presented the list of Research Committee. The Committee took the task of abstract review for FARO Meeting: 93 submitted abstracts were reviewed by all of the 14 FARO Member Societies. Dr. Wu also explained about an ongoing research project undertaken by the research committee, radiation oncology survey in FARO member countries. While the attendance to the online meeting was satisfactory, the Chair experienced a difficulty in receiving cooperation of the Committee members regarding agreement on survey items and in proceeding the research project forward due to the discussion of the sponsorship from Varian.

10. Report of RAS6086: Collaborative project of FARO and IAEA/RCA (Nakano)

Dr. Nakano reported on the activities of the IAEA/RCA project "Strengthening Cancer Management Programmes in RCA States Parties through Collaboration with National Regional Radiation Oncology Societies (RCA)" and (Appendix 10). Due to the COVID-19 pandemic, the 3rd RTC "Multidisciplinary Approach to Palliative Radiotherapy in Cancer Management" was postponed from 2020 and held virtually online on March 22-25, 2021 by Malaysia. The 4th RTC "Risk Management, Radiation Safety, and Quality Assurance in Radiotherapy" was held virtually online on August 16-18, 2021 by Philippines. The Final Review Meeting was held virtually online on December 13-15, 2021 by Japan (Dr. Nakano). Due to the COVID-19 pandemic, the allocated budget for RTC and meetings, which include a significant amount for travel, remained unspent. The IAEA has decided that the unused budget was to be allocated to the purchase of items necessary for implementing activities in line with the scope and goal of the project. A purchase of remotely accessible Eclipse RTP system (10 sets) was approved by the IAEA and currently are ordered to be installed in the National Institutes for Quantum Science and Technology (QST, Japan). The RTS system will be available for use for implementing Regional/National Training Courses and other training activities. A purchase of 7 phantoms for practicing interstitial need implantation for IGBT was also approved, and the phantoms will be provided to several Member States.

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Dr. Nakano mentioned that this RCA project, RAS6086, is considered by many RCA Members States and the IAEA to be one of the most successful projects, and one of the reasons for the success is its cooperation with FARO. Dr. Nakano thanked the contribution of the participating countries and also requested for the sustainability of the project activity even after the project completion at the end of 2021.

11. Report of Leadership Development Program (Gondhowiardjo)

Dr. Gondhowiardjo presented about the overall review of LDP. The first 3 programs were conducted by a few lecturers with 10-13 participants from FARO Member Countries to foster the future leaders in the FARO Member countries. The budget of the LDP has been about 10,000-13,000 US dollars; the finance of the first 2 LDP was covered with the management of Indonesian Radiation Oncology Society. The travel grant of the 3rd LDP participants was covered by the general fund of FARO. Dr. Gondhowiardjo presented the results of a survey conducted on the graduates of the LPD, and the results showed that the overall feedbacks on the program are positive and that young leaders are being developed in the FARO member countries by the LDP. Dr. Gondhowiardjo reported that a similar effort is now taken up by ESTRO and ASTRO and that she hopes this effort will be continued through the activity of the newly formed LDP Committee.

12. Any other business

There were no items discussed under "any other business"

13. Election of FARO Officers 2022-2023

Upon the call of nominations for FARO Council Officers 2022-2023, nominations have been made with the deadline of October 18, 2021. Nominations have been received by the Secretariat and reviewed/considered appropriate by the Election Committee (Dr. Shrivastava, Dr. Gondhowiardjo, Dr. Bustam, Dr. Faheem, and Dr. Tsegmed.)

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For Vice President, Rajesh Vashistha was nominated by AROI. By the vote of confidence from the Council Meeting (14 Yes vs. 0 No), Dr. Vashistha was elected to be the Vice President for the term of 2022-2023.

For Secretary General, Yasushi Nagata was nominated by JASTRO. By the vote of confidence from the Council Meeting (14 Yes vs. 0 No), Dr. Nagata was elected to be the Secretary General for the term of 2022-2023.

For Treasurer, Junlin Yi was nominated by CSTRO. By the vote of confidence from the Council Meeting (14 Yes vs. 0 No), Dr. Yi was elected to be the Treasurer for the term of 2022-2023.

For President-elect, Dr. Imjai Chitapanarux was nominated by THASTRO. By the vote of confidence from the Council Meeting (13 Yes vs. 0 No vs. 1 Abstain), Dr. Chitapanarux was elected to be the President-elect for the term of 2022-2023.

The terms of Vice-President, Secretary General, and Treasurer will be from January 1, 2022 to December 31, 2023.

At the end of the Council Meeting, the out-going Officers expressed congratulations to the newly elected FARO Officers and wished for their success and the success of FARO. List of Appendices

Appendix 1: FARO Council Meeting 2021 Background papers Appendix 2: FARO Council Meeting 2021 Annex1 Appendix 3: FARO Council Meeting 2021 Annex2 draft ToR for Committees Appendix 4: Presentation of KOSRO for hosting the 6th FARO Meeting (2023) Appendix 5: Presentation by Dr. Shrivastava Appendix 6: Financial Report 2020 Appendix 7: Report of the 5th FARO Meeting Appendix 8: Report of Education & Training Committee Appendix 9: Report of Research Committee Appendix 10: Report of RAS6086

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Federation of Asian Organizations for Radiation Oncology (FARO)



Wait and Watch policy in rectal cancers: Is the wait over or is it time to watch more?



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The current treatment paradigm for patients with stage II or III rectal cancer is neo-adjuvant therapy in form of either short course radiotherapy (SCRT) or long course chemo-radiotherapy (LCCRT) followed by total mesorectal excision (TME) and adjuvant chemotherapy. Essentially, this becomes a tri-modality therapy (TMT). The standard preoperative CRT approach yields approximately a 15% to 27% pathologic complete response (pCR) rate [1] Patients who achieve a pCR after preoperative CRT have a significantly lower local recurrence (0.7% v 2.6%) and better 5-year OS rate (92.9% v 73.4%) compared with no response or partial pathologic response [2]. However, radical resection is associated with significant toxicity viz surgical complications in ~30%, per-op mortality up to 3%, permanent or temporary stoma, impaired bowel function and late complications like bowel obstruction, incisional hernia, urinary incontinence, sexual dysfunction etc.

Primarily driven by the patient preference, an effort has been made by certain dedicated cancer centres to explore the feasibility of non-operative management (NOM) in patients responding well to the neo-adjuvant therapy. Since, this approach does not totally exclude



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surgery from the management but in principle is an active surveillance protocol in patients achieving clinical complete response (cCR) to neo-adjuvant therapy with salvage surgery in case of local regrowth/ recurrences, this is also popularly known as "Wait and Watch policy" (WW policy)

Clinical results of WW policy

The pioneering initial work were published by Prof. Angelita Habr-Gama and their team from University of São Paulo, Brazil in 2004. The authors reported 5 year OS and DFS rate of 100% and 92% respectively for a cohort of 71 patients followed after cCR. The cCR rate was 26.8%. In a subsequent update on 99 patients with cCR, the authors reported local recurrence rate of only 5% at median follow up of 5 years. Notably, the patients included in these studies were distal rectal adenocarcinoma located 0-7 cm from the anal verge. The local recurrence reported in the Habr-Gama series was 31% but most of them were salvaged with surgery (93%) and they also noted regrowth mostly within 12 months of follow up [4].



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The long term outcomes of cCR patients after neoadjuvant treatment has been reported by the International Watch & Wait database registry [5]. This included 880 patients with median follow up of 3.3 years. 2-year local regrowth rate was reported to be 25.2% with 88% of regrowth diagnosed in first 2 years and 97% being confined to the bowel wall. The 5-year OS and DFS were reported as 85% and 94% respectively. While the results appear promising, the results form Memorial Sloan Kettering Cancer Center, New York suggested a higher rate of distant metastasis in WW group patients with local regrowth vs those who did not have local regrowth (36% vs 1%, p<0.01). Although, higher T stage (80% T3) and more number of N1/2 patients (60-70%) in their series may have been the reason behind this [6]

The extent of surgery after a local regrowth may be either a local excision or TME. The GRECCAR-2 study in their 5 year results of a randomized phase 3 trial found that patients with ypT0-1 after local excision may safely omit TME with no difference in long term oncological outcome [7].

Regarding the sequencing of neo-adjuvant treatment viz. chemoradiotherapy followed by consolidation chemotherapy (upfront CRT) versus induction chemotherapy followed by chemoradiotherapy (delayed CRT), the results from the OPRA trial [8] suggests that the former approach may have better organ preservation rate (58% vs. 43%) and this has been supported by the long term results of the CAO/ARO/AIO-12 randomized clinical trial which suggested a higher pathological complete response rate with upfront CRT approach [9].

WW Policy Summary of Current Evidence

- WW policy is still not recommended outside a protocolized setting and is investigational
- Rectal adenocarcinoma treated with neo-adjuvant therapy have cCR in 15-25% of patients and these are candidates for WW
- Approximately one fourth of these patients (20-25%)

will have local re-growths predominantly in first 2 years of follow up

• 90-100% of these local re-growths can be salvaged with surgery

Initial T2-T3 patients with local regrowth may safely omit TME if the local excision reveals T0-1 disease, rest will undergo TME

Distant metastasis risk may be slightly higher in these cohort of patients

CRT followed by consolidation sequence may be better than Induction followed by CRT

Current challenges and limitations with the WW policy

One of the current challenges is selection of ideal patient best suited for the WW policy. Expanding the horizon of patients suitable for WW policy, an effort has been made to make patient eligible even if there is no cCR after neo-adjuvant therapy and this has been reported to be possible with the use of contact X-ray brachytherapy boost. The authors reported in a series of 83 patients with residual tumour <3 cm after neo-adjuvant therapy to achieve cCR in 64% after brachytherapy boost [10].

Some patients may be at a higher risk for recurrence and may not be suitable for WW policy and these include cT3/4 disease (higher risk of local regrowth: 31-37%); circular cancers, tumour length >7cm and volume >120 cm3 (poor cCR rates); T3 tumours with more than 10-15 mm mesorectal invasion (35% decrease in pCR rates for every millimetre of invasion) and patients with lateral pelvic lymph node disease (recurrence beyond salvageable surgery).

There has also been keen research towards intensifying the neo-adjuvant treatment with a zest to improve the cCR/pCR rates. While, escalating the radiotherapy dose to 54 Gray from 45-50.4 Gray has not helped, addition of oxaliplatin to the concurrent chemoradiotherapy regimen has yielded mixed results. However, a recent phase III UNICANCER-PRODIGE 23 trial have reported higher pCR rates, better DFS rates and 90% compliance rate with induction FOLFIRINOX and long course CTRT compared to the current standard of care [11]



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The role of short course radiotherapy in the NOM remains elusive with limited data to this effect. The recent results of the RAPIDO trial published in Lancet Oncology 2020 which reported pCR rates of 28% and included high risk group of patients may be an indicator of feasibility of SCRT in the WW policy. Ongoing trial results would clarify this more in the time to come.

One of the challenges in the NOM is also the variability in the proposed cCR criteria by various groups. However, certain factors as follows are common and may be used as a guide: normal digital rectal examination, normal proctoscopy finding (flat scar, mucosal whitening, telangiectasia may be present), normal imaging (MRI), biopsy negative in suspicious cases. ESMO guidelines also suggests to have a normalized CEA level (<5 ng/ml) after CTRT if initially elevated as one of the criteria for establishing cCR.

Molecular biomarkers have been emerging to predict response to CTRT in rectal cancers. Lower pCR rates have been reported for patients with KRAS mutation only, KRAS/TP53 mutation combination and those with EGFR positivity. Elevated carcinoembryonic antigen (CEA) level before CRT and persistent CEA is associated with a decreased pCR rate. Post-CRT cell-free DNA levels have been shown to be significantly lower in patients with response to CRT than in nonresponders. High serum mIR-345 expression has been noted in CRTresistant patients.

Since, most of the recurrences with WW policy appear in the initial 2-3 years, intensity of active surveillance may be reduced in patients maintaining cCR within first 3 years of this approach. The surveillance protocol consists of digital rectal examination with proctoscopy with or without biopsy and serum CEA every 1-3 monthly in first year, every 2-6 monthly in second year and 6-12 monthly in years 3-5. Imaging (MRI/CT Abdomen plus pelvis) is frequented every 6 monthly in first 3 years and then annually afterwards.

Challenges and future directions for WW policy

• Some patients are not suitable for WW policy:

- Higher stage disease (T3 with DOI>10-15 mm, T4 disease)
- Circular cancers, tumor length >7 cm, Tumor volume >120cm3
- Proximal tumors (>6-7 cm away from anal verge)
- Patients with no cCR and with minimal residual disease may be boosted with contact brachytherapy and those achieving cCCR after this may be kept on W&W policy [Experimental]
- Intensified pre-operative regimen like FOLFIRINOX and SCRT with chemotherapy [TNT approach] are worth exploring strategies to further optimize outcomes
- Surveillance protocol needs to be more intensive in first 2 years
- WW policy has a promising future, but patient selection and personalization is key for an optimal outcome [Double edged sword!!]

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Total Neoadjuvant Therapy in Carcinoma Rectum: An evolving approach towards organ preservation



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Total Neoadjuvant Therapy in Carcinoma Rectum: An evolving approach towards organ preservation Incidence of carcinoma of the rectum has been steadily increasing worldwide, especially in developing countries. In India, the annual incidence rate for rectal cancer is 4.1 per 100000. Colorectal cancer is the second cause of cancer-related deaths worldwide and accounts for 10% of all cancer types Majority of rectal cancers are adenocarcinomas (>90%). **Standard treatment options:**

Mainstay of curative treatment in carcinoma rectum is surgery. However, despite improvement in surgical techniques, patients with locally advanced rectal cancer (LARC) have a high risk of local and distant failure after surgery alone. To improve local control and survival rates, adjuvant treatment in the form of postoperative chemoradiation and preoperative chemoradiation have been evaluated and various strategies have been employed.

Management of carcinoma rectum has evolved over the past three decades, with an aim to improve outcomes and reduce treatment related morbidity. Neoadjuvant chemotherapy and radiotherapy are now standard preoperative practice for locally advanced rectal cancer. These can be given as concurrent chemo-radiotherapy (CRT) followed by surgery and adjuvant chemotherapy. Other acceptable options include short-course radiotherapy (SCRT) followed by chemotherapy and surgery.

Challenges in Treatment delivery:

Clinicians and patients encounter many challenges during this multimodality treatment, some of which include inability of many patients to complete the entire course of adjuvant chemotherapy, frequent delays in chemotherapy due to hematological toxicity and high toxicity of chemoradiation.



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It has been noted that delay in initiation of adjuvant chemotherapy is associated with decreased overall and disease free survival(1). Each four week delay in adjuvant systemic treatment has been correlated with a 14% decrease in overall survival(2). As distant metastases represent the most significant cause of mortality for rectal cancer patients, greater emphasis has been placed on incorporating systemic therapy earlier in the treatment course.

For many patients permanent colostomy is not an acceptable option.

Total Neoadjuvant therapy, a novel approach:

An evolving strategy known as total neoadjuvant therapy (TNT) involves the administration of CRT plus neoadjuvant chemotherapy before surgery with the goal of delivering uninterrupted systemic therapy to eradicate micrometastases.

Some of the advantages offered by TNT include better compliance, an earlier exposure to multiagent chemotherapy to take advantage of chemosesitivity and better control of occult metastases.

Different protocols for TNT:

Total neoadjuvant therapy can be administered exclusively as induction chemotherapy before CRT or as consolidation chemotherapy after CRT.

Preliminary results from the OPRA (Organ Preservation of Rectal Adenocarcinoma) trial(3) showed a significantly higher rate of organ preservation in the consolidative TNT arm as compared to induction TNT arm but no significant difference when it came to 3-year disease-free or distant metastasis—free survival.

PRODIGE, a phase III multicenter randomized clinical trial, concluded that Neoadjuvant mFOLFIRINOX plus CRT is safe, and significantly increased ypCR rate, DFS and MFS.

RAPIDO (Rectal Cancer And Pre-operative Induction Therapy Followed by Dedicated Operation) trial(4) SCRT followed by neoadjuvant CAPOX (capecitabine and oxaliplatin) or FOLFOX with subsequent total mesorectal excision (TME) after approximately 6 months with the preoperative long-course CRT followed by TME and optional adjuvant CAPOX or FOLFOX. The SCRT group showed a statistically significant improvement in pCR rate and a higher distant metastasis-free survival at 3 years. Further it was observed that no increase in the surgical and postoperative complications and no added toxicity in SCRT arm. Overall survival (OS) was similar in both the arms.

Apart from being better tolerated by the patients SCRT saves much time and resources of the patient and the hospital, which is more pertinent during of COVID-19 pandemic.

One of the two recently published meta analyses on TNT observed that it leads to better pCR and disease free survival(DFS), whereas the other concluded that TNT strategy might also improve OS and reduce the risk of distant metastasis.

Toxicity of TNT:

TNT trials have shown increased grade 3 and grade 4 hematological toxicities, GI toxicity like diarrhoea and peripheral neuropathy but these are manageable and did not lead to any dose reduction of chemotherapy and disruption of treatment.

Factors influencing the outcomes, pathological complete response:

As the neoadjuvant therapies evolved, it was observed that pathological complete response (pCR) is a pivotal prognostic criterion for long-term outcomes in LARC.(5) A survey of the National Cancer Database(6) revealed a 13%overall rate of pCR after conventional neoadjuvant CRT in all patients with rectal cancer, whereas our study demonstrated a cumulative rate of 29.9%for pCR after TNT.

Patients pCR after neoadjuvant treatment are less likely to have a local tumor recurrence and more likely to have a better survival outcome than patients with an incomplete response.(7) In a pooled analysis of survival outcomes for those attaining a pCR after preoperative chemoradiotherapy, 88.8% remained free of distant metastasis compared with 74.9% of patients without pCR at 5 years.



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Similarly, overall survival was 87.6%vs 76.4%for those with and without pCR, respectively, at 5 years.(8) These results were replicated in the preoperative chemoradiotherapy arm of the German Rectal Trial (CAO/ARO/AIO-94 trial),(9) pCR rates also increase as the time between surgery and chemoradiation increases. In the TIMING trial,(10) a higher number of cycles of mFOLFOX6 as well as a longer gap between CRT and surgery were both independently associated with a pCR.

Wait and Watch:

Higher pCR with TNT has raised the question mark on the need of surgery in patients who have achieved a pCR and are apprehensive about an amputative procedure. The Wait and watch policy was introduced by Habr-Gama et al,(11) who reported a highly promising overall survival of 97.7% and disease-free survival of 84% after a decade of follow-up in those who forgo surgery after attaining complete clinical response (CCR). Another international multicenter registry-based study(12) has also reported favorable outcomes for those with CCR who opt for the watch-and-wait approach, with a disease-specific survival rate of 94% with only 8% patients developing distant metastasis at 5 years. In a recent meta-analysis,(13) patients opting for a watch-and-wait strategy after CCR to neoadjuvant chemoradiotherapy and patients with PCR identified at resection had no differences in terms of local recurrence or cancer-related mortality. The watch-and-wait approach may be deemed preferable because surgery can lead to bowel or bladder incontinence and sexual impairment as well as a short-term or permanent ostomy.

Those patients who have a CCR or poor response to aggressive neoadjuvant approach can be enrolled for Wait and Watch or taken up for surgery respectively Management of patients with consolidative neoadjuvant protocols who do not have a complete clinical response is the biggest clinical challenge.

Future Directions:

More studies are required to compare induction vs

consolidation or combined approach of chemotherapy. Higher toxicity of chemotherapy needs to be controlled. Exploration of newer options by incorporating immunotherapy and targeted therapies into the treatment armamentarium, optimal diagnostic test for monitoring of these patients in terms of imaging or gene expression profiling, and the appropriate followup duration, remains to be answered.

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Prostate cancer screening in India: reasonable or ridiculous ?



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Prostate cancer is the second most common cancer and the fifth leading cause of cancer-associated mortality among men worldwide[1]. Prostate cancer is the second leading site of cancer among males in large Indian cities like Delhi, Kolkatta, Pune and Thiruvananthapuram, third leading site of cancer in cities like Bangalore and Mumbai and it is among the top ten leading sites of cancers in the rest of the population based cancer registries (PBCR) of India[2]. The incidence rates of this cancer are constantly and rapidly increasing in all the PBCRs. Therefore, one would argue that prostate cancer is a reasonably large public health problem to deserve screening. Screening for prostate cancer with serum prostate-specific antigen (PSA) aims to detect prostate cancer at an early stage at which relatively safe interventions (such as active surveillance, radical prostatectomy or radical radiation therapy) are available, that can considerably reduce the incidence of prostate cancer specific mortality. However, the evidence has so far has not demonstrated that the PSA screening for prostate cancer saves lives. Instead, it has certainly demonstrated that the screening may be associated with increased risk of overdiagnosis and complications of treatment for indolent disease. Nevertheless, PSA screening for prostate cancer remains a highly controversial subject. The five large randomised trials [3-7] addressing this question have several limitations. Due to the above factors there is a significant variation in practice and often there is a dilemma whether to advice PSA screening. The US Preventive Services Task Force (USPSTF) updated their recommendation statement, changing it from a grade D (recommendation against PSA based screening for

prostate cancer) to a grade C recommendation (advocating for an individualised approach to screening). All the evidence for or against the PSA screening comes from either north America or western Europe. With very limited literature from India or Indian subcontinent, can we extrapolate the benefits or harms of prostate cancer screening in studies from the western hemisphere to Indian context, especially in the background of significantly lower prevalence of prostate cancer in this region?

Five large randomized trials with varying frequency of PSA testing (ranging from one time testing to annual testing) have been performed to address this question [3-7]. The results of the pooled analysis of all these studies [8] with a follow-up ranging from 10-20 years, have shown certain important findings which are as follows:

- 1. Effect on all-cause mortality: With a serious risk of bias, the incidence ratio (IR) for all-cause mortality was 0.99 (CI-0.98-1.01) suggesting there was little or no effect on all-cause mortality.
- 2. Effect on prostate cancer mortality: With a serious risk of bias, the IR was 0.96 (0.85 to 1.08), suggesting there was little or no effect on prostate cancer specific mortality.
- 3. Effect on prostate cancer detection: PSA screening detected 7 more early prostate cancers per 1000 screened, whereas it slightly decreased the incidence of advanced (stage 3 and 4) prostate cancers (2 fewer per 1000 screened).
- 4. Effect on Quality of life (QOL): Based on a single study[9] which measured the QOL, PSA screening did not have an effect on QOL.
- 5. Biopsy related complications: Based on a single study (intervention arm of CAP/ProtecT trial) [10-12] which measured the biopsy related early complications, (follow-up of 35 days) most common biopsy related complications were blood in the semen (93%), blood in urine (66%), pain (44%), shivers (19%), and fever (18%). 1.4% of men were admitted to hospital due to biopsy related complications (most due to sepsis).





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- 6. Treatment related complications: At 6 years, rates of any pad use (incontinence) was 8%, 17% and 4% with active surveillance, surgery and radiation therapy. At 6 years, rates of erectile dysfunction was 70%, 83% and 73% respectively.
- Complications of subsequent prostate cancer treatment: Among 1000 men, between those screened vs. not screened, subsequent treatment for prostate cancer resulted in about 3 more with urinary incontinence, and 25 more with an erection not firm enough for intercourse[10-12].
- False positives: Based on the data from 61,000 patients in one study[13], the false positive rates were 66.5%, 66% and 63% in first, second and third round of screening respectively. Among men with PSA level ≥4 ng/mL at screening, about 67% will have a negative subsequent biopsy
- 9. False negatives: Based on data from 2950 patients in 1 study[14] with a follow up duration of 7 years, among men with PSA ≤4 ng/ mL at screening, about 15% could be false negative and will subsequently be diagnosed with prostate cancer, about 2% with high grade cancer (GS>7).
- 10. Effect on anxiety about having a cancer: Based on data from 2 large observational studies with a follow-up ≤1 year, it is uncertain whether screening results in changes in anxiety about having cancer, but a diagnosis of prostate cancer might increase immediate risks of suicide and cardiovascular death.

The included studies each contained serious risk of bias. The European randomized trial of prostate cancer (ERSPC trial)[5] which probably has the lowest risk of bias, found a small absolute survival benefit with PSA screening; at 13 years, the prostate cancer mortality rate in the screening group was 0.43 compared with 0.54 per 1000 person-years in the control group. Survival benefit increased over longer-term follow-up (Relative Risk for prostate cancer mortality 0.85 at 9 years, 0.79 at 13 years). At 13 years, the absolute risk reduction of prostate cancer death was 1.28 per 1000 men, meaning that to avert one prostate cancer death, 781 men needed to be screened, of whom 27 were expected to be diagnosed with cancer, and at least 16 of those treated with definitive treatment either with surgery or radiation.

Studies of cost-effectiveness of prostate cancer screening, suggest that screening does not clearly improve quality-adjusted life years (QALYs), even if mortality is reduced[15-16]. In a simulation modelling study that used ERSPC data, annual screening between ages 55 and 69 years was projected to result in 9 fewer prostate cancer deaths per 1000 men followed for their lifetime, with a total of 73 life-years gained. However, the simulation model using the same data to calculate QALYs showed a gain of only 56 QALYs (CI- 21-97 QALYs).

Overdiagnosis in the context of prostate cancer screening is detection of clinically insignificant cancer which does not result in improvement of overall survival or prostate cancer mortality.

There is a considerable risk of overdiagnosis in prostate cancer screening given the high prevalence of undiagnosed prostate cancer detected on autopsy series. However, the increased adoption of active surveillance may mitigate the treatment-related harms of overdiagnosis of prostate cancer. Based on computer-simulation models built from SEER database or ERSPC estimated that 23-50% of prostate cancer diagnoses were likely over-diagnosed[17-19]. The risk of overdiagnosis of prostate cancer appears to increase with age. A systematic review estimated that the percentages of screening detected cancers that were over-diagnosed was 20.7% in the Prostate, lung, colorectal and ovarian cancer screening trial (PLCO) and 50.4% in the ERSPC, respectively[20]. There is some variation among recommendations regarding the age for prostate cancer screening. However, 50 is the lowest age at which most guidelines would consider discussing prostate cancer screening in general population. Men with known BRCA1/2 mutations or with a family history of fist degree relative diagnosed with young prostate cancer (<65 yr), may benefit with screening from the age of 40 years. Expert guidelines also vary as to screening interval recommendations. The American Urology Association states that screening interval of 2 years may be preferred to annual screening. Some guidelines suggest that screening intervals be individualized based on a baseline PSA level.



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The range of adjustments varies among guidelines (from yearly to every 2/3/4 years) based on the prior PSA level. PSA cut offs would also determine the sensitivity and specificity of PSA testing. A serum PSA of >4 ng/dl is recommended by many as the cut off for a biopsy/further evaluation, however the sensitivity improves and specificity (and overdiagnosis) worsens with a lower PSA cut offs. Even with a PSA cut off of 1.1ng/dl, 17% of prostate cancers would be missed including 5% of high grade cancers[21]. For men who are on finasteride or dutasteride (5-alpha reductase for benign prostatic hypertrophy, a inhibitors) correction factor (usually 2, meaning doubling of serum PSA value) must be applied for an accurate interpretation.

To conclude, many guidelines currently suggest that the physician must engage in shared decision making about prostate cancer screening. This is easier said than done in the Indian context. Practically, in the absence of reliable India specific data, routine and widespread PSA testing for screening of prostate cancer should not be recommended. There is also a need for prospective data of Indian patients who undergo screening to understand the full spectrum of benefits and harms. Meanwhile benefits, harms and futility of PSA testing routinely and as part of commercially sold general/master health check-up packages must be disseminated across all the stakeholders including patient groups, physicians/professional societies, hospitals and insurance companies.

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Obituary





Prof. M Krishnan Nair. MD, FRCR 1939-2021	

Prof Dr M Krishnan Nair was born in Konni, Kerala in 1939. Dr Nair completed his MBBS from the University of Kerala in 1963 and joined as a tutor in the Department of Radiotherapy & Oncology, Medical College, Trivandrum in 1965. Thereafter he went on to attain MD (Radiotherapy & Oncology) from the University of Punjab in 1968. He also obtained training in the UK leading to the award of FRCR (Clinical Oncology) from the University of London. Dr Nair returned to become Professor in the same department and went on to become the founding Director of the Regional Cancer Centre Trivandrum(RCC) in 1981. He retired in 2003 after 22 years of untiring service as Director of an institution he built up from scratch.

Prof MK Nair was a visionary with social commitment. Alleviating the suffering of patients was his primary focus. He was an excellent clinician with high optimism. During his tenure at RCC, Prof Nair started many new departments such as Paediatric oncology, Community Oncology and Pain and Palliative Medicine which were the first of their kind in India. Morphine availability was very poor in India in the eighties; he made it available to patients through the Pain Clinic at RCC. He started a facility for manufacture of oral morphine which has been a boon for suffering patients. He initiated an innovative hospital-based health insurance programme called 'Cancer Care for Life' whereby economically weaker individuals could obtain life-time cancer treatment on paying a nominal one-time premium. In addition, paediatric and adolescent curable cancers were treated free of cost from revenue generated by RCC.

Prof Nair implemented a 10-Year Action Plan in Kerala and led the anti-tobacco movement in Kerala. He highlighted the need early detection of cancer and addressed the issue of travel hurdles by setting up screening, early detection and follow up clinics through the length of Kerala-at Ernakulam, Karunagappaly, Kozhenchery and Palakkad. It was during his time that RCC was designated as a WHO collaborating centre for cancer control for developing countries.

Prof Nair had unparalleled international and national repute in his time and served on several committees for cancer control. To name a few, he was a prominent member of the planning group of the National Cancer Control Programme of India and a member of the Expert Advisory Panel on Cancer of the World Health Organisation (WHO) for a decade. He has served in the advisory committee of the Director-General, WHO and Cancer Technical group of WHO. He also served in the Scientific Advisory Board of ICMR and Board of Radiation and Isotope technology of the Department of Atomic Energy of India.

Prof Krishnan Nair was a founding member of the Association of Radiation Oncologists of India and served as National President from 1984-86.

He had over 300 publications. His areas of interest were health effects of background radiation in coastal areas, cancer epidemiology and empowerment of health care workers for cancer screening apart from clinical oncology research. Prof Nair has inspired and trained a large number of medical professionals, who practice around the world and hold leadership roles in their own right.

He has received numerous awards including the Bhishmacharya Award of outstanding contribution in the field of Medicine and Roll of Honour (1996) by International Union Against Cancer (UICC), Geneva.

He was awarded the National Civilian Award Padma Shri in 2001 for his contributions to the field of Cancer Care.

Following his retirement, MKN, as he is fondly known, practised at the Amrita Institute of Medical Sciences, Kochi and SUT hospital, Trivandrum.

Prof Nair passed away on on 28/10/2021 but will continue to inspire the medical fraternity with his untiring work ethic and optimism in the fight against cancer.

Obituary





Dr. Dhairyasheel Narayan Savant

30 March 1962 – 24 November 2021

Qualification: M.B.B.S. MS. FICS. **Designation** Consultant Surgical Oncologist, Reconstructive & Microvascular Surgeon

- Asian Cancer Institute Mumbai and Bhubhaneshwar
- Saifee hospital Charni road Mumbai
- Breach Candy Hospital Mumbai

Achievements:

- Secretary Indian Society of Oncology
- President Indian Association of Surgical Oncology
- Secretary General 3rd Indian Cancer Congress 2021
- Member Endocrine /Head and Neck Cancers Working Group: Society Of Surgical Oncology 2018-2021

New account details of AROI & AROI-ICRO

AROI

Account No.:39535464615 (Current) IFSC: SBIN0000731 STATE BANK OF INDIA MILLER GANJ, LUDHIANA POST BAG NO.30, P.O.INDUSTRIAL ESTATE LUDHIANA DIST: LUDHIANA, PUNJAB 141003 Branch Code: 731 Branch Phone: 2532768

AROI-ICRO

Account No.:39535445525 (Current) IFSC: SBIN0000731 STATE BANK OF INDIA MILLER GANJ, LUDHIANA POST BAG NO.30, P.O.INDUSTRIAL ESTATE LUDHIANA DIST: LUDHIANA, PUNJAB 141003 Branch Code: 731 Branch Phone: 2532768

JCRT contribution

Dear Executive members,

As all of us decided in executive committee meeting, that every chapter will contribute Rs 30,000 for continuation of Journal of Cancer Research & Therapeutics {JCRT - our AROI association journal}. Kindly contribute on time.

Current account of AROI A/c 39535464615 IFSC - SBIIN0000731 Branch Code: 731 STATE BANK OF INDIA MILLER GANJ, LUDHIANA POST BAG NO.30, P.O.INDUSTRIAL ESTATE, LUDHIANA DIST: LUDHIANA, PUNJAB 141003



15th SRMS Contouring Classes

13th -14th November & 4th -5th December, 2021, SRMS-IMS, Bareilly

Update from : Dr. Piyush Kumar

"If you can dream it, you can do it", with this motivation we completed 5 years of SRMS contouring classes. Fifteenth hands on workshop of SRMS Contouring Classes was divided in two sessions considering the pamdemic covid 19 and was conducted on 13th-14th November & 4th-5thDecember, 2021. The theme was "Contouring of Pelvic Malignancies". The workshop aims to teach faculty and residents about the latest radiotherapy techniques.

Dr. Piyush Kumar, Professor and Head of Department was CourseChairman, Dr. Pavan Kumar (Associate Professor) and Dr. Ayush Garg (Asst Prof) were Course Coordinators.

Senior Residents and Junior Residents from Safdarjung Hospital (New Delhi), SN Medical College (Agra)and Pandit Bhagwat Dayal Sharma Post Graduate Institute of Medical Sciences (Rohtak)attended this workshop.

At the end of this workshop the delegates were able to identify the normal structures and OARs of Pelvis. Moreover, the delegates were able to delineate various clinical target volumes of Pelvic region.

The Medical Physics team demonstrated the VMATplanning of Cancer Cervix which was followed by the live demonstration of delivery of Radiotherapy by

IGRT technique. The delegates appreciated the efforts taken by the Medical Physics and technical teamto come on a holiday and provide a visual impact of the VMAT and IGRT technique.

The instructorsfor the course wereSenior Residents Dr. Prachi Upadhyay, Dr. SK Azharuddin, Dr. Anand Sachan and Dr. Naina Guptaalong with three tutors Dr. Aparajeeta, Dr. Diksha Chaturvedi and Dr. Himanshi Khattar.

The workshop was well appreciated by delegates and the feedback was very motivating. The resident from Rohtak Dr. Prachi, who attended this contouring session for the 1st time, commented "Very informative, new experience for us. Hands on experience will definitely help us in the future" and "Amazing experience, quite informative training class as expected. Wonderful teachers as well as tutors. Came here for the second time and my experience was far beyond satisfactory" were the inspiring words of the resident from Agra.

A compact disk consisting of a collection of relevant books, articles and contouring guidelines is also being provided to the delegates along with a booklet for reference.





36th ANNUAL CONFERENCE TN&PY – 2021

Update from : Dr. K.S.Kirushna Kumar. Meenakshi Mission Hospital and Research Centre, Madurai

36th Annual state conference of Radiation oncologists of Tamilnadu and Puducherry chapter was organised by Harshamitra super speciality cancer center and research institute, Tiruchirapalli. It was conducted on December 4 & 5, 2021 at SRM Hotel, Tiruchirapalli, Tamilnadu.

Dr.P.Sasipriya was the organising secretary for the conference. It was Inaugurated by the Deputy collector of Tiruchirapalli, Ms.Pavithra in the presence of Guest of Honour Dr.M.S.Ashraf, (Past IMA President), Dr.M.Nagarajan State President AROI, Dr.K.S.Kirushna Kumar (State Secretary AROI), Organising Chairman Dr.G.Govindaraj and Organising Secretary Dr.P. Sasipriya Govindaraj.

There were 279 registration and active participation from the other states like Kerala, Karnataka, Andhra Pradesh, Telangana, Uttar pradesh and also from Uttarkhand.

Two orations were delivered. Dr Ida B Scudder oration was delivered by Dr G Amarnath, Senior consultant, HCG Cancer Center, Chennai on December 4th 2021. Dr. Rai

memorial oration was delivered by Dr.P.Mahadev , Senior Consultant & HOD Radiation oncology, Apollo Speciality Cancer Hospital,

Chennai on the 5th December 2021.

There were five panels, seven topics and two Debates.

We had three International speakers speaking to us virtually. There were 118 Abstracts submitted of which 27 were oral presentation and 90 were Poster presentation.

Election was conducted and new office bearers were elected on 4th December 2021 in the GBM.

2021 -2023, State AROI Office will be taken over by President : Dr. Alex.s.Prasad Secretary: Dr. Saritha Damodharan Treasurer : Dr. H.Y.Prahalad.

EC members list will be sent by Dr.Saritha (Secretary) It is decided in the GBM that the next state AROI of TN & PY, 2022 will be held in Chennai.





32nd UPAROICON S N Medical College Agra

Update from : Dr-Surabhi Gupta, Agra

32nd UPAROICON 2020 was organized successfully by department of radiation oncology, S.N.Medical College, Agra from 18th Dec. - 19th Dec. 2021 at Agra. Approximately 200 delegates all over from U.P and Uttarakhand actively participated in this conference. The theme of conference was "Precise and personalized cancer treatment-need and impact in current scenario." Speakers from various institution of U.P, Delhi and Uttarakhand delivered their talks on precision and personalization of radiation treatment on cervical cancer, breast cancer, GI cancer and head and neck cancer. Total 70 research posters and papers were presented by PG

residents in the conference. The other attractions of this conference were panel discussions on-cancer care in covid and post covid period and another on –MD thesis, why is it needed to train a doctor. The conference was inaugurated by chief guest prof S.P.Baghel, minister of state for law and justice-GOI and guest of honour, Dr.Rajesh Vashistha, President AROI. Dr.Shaleen Kumar ,prof, SGPGI. Lucknow was elected as president and Prof(dr.) Surabhi Gupta (organizing secretary of uparoicon 2020) was elected as general secretary of UP chapter of AROI for 2022-24





Maharashtra AROICON 18th Dec 2021

Update from : Dr. Umesh Mahantshetty

Tata Memorial Hospital and Apollo Hospital, Navi Mumbai jointly organized and hosted the Annual conference of Maharashtra State Chapter of AROI on 18th December 2021. The meeting was conducted as Hybrid meeting (due to ongoing Covid-19 pandemic) at Apollo Hospital, Navi Mumbai. It was conducted according to the guidelines of Government of Maharashtra and in full COVID appropriate behavior. The theme of the meeting was Recent Updates and Controversies in Radiation Oncology. The motto of this conference was to promote young radiation oncologists of Maharashtra state. Many of the post-graduate students and young oncologist from across the Maharashtra presented in this conference. We have also received abstracts which was displayed online during poster presentation. The conference was well attended by approximately 70-80 participants in person and another 70-80 participants attended online through Zoom meeting. The Organizing Secretaries for this conference were Dr. Sandeep De and Dr. Anil Tibdewal. The Maharashtra Medical council has also awarded 2 credit points for delegates. According to the feedback received post conference, many participants felt that scientific content of the conference was good and was conducted well.

Post conference, the annual general body meeting of MS AROI was also conducted.









WEBINARS



ICRO PRODVANCE 2021 WEBINAR

24th, 25th and 26th of November 2021 Update from : Dr.V.Srinivasan - Secretary-ICRO

During these Pandemic times, the AROI-ICRO Executive committee decided that we will continue to teach our members and students in the form of WEBINARS which is the new normal in teaching activities. The ICRO PRODVANCE 2021 Webinar on Trending Updates in Radiation Oncology was organised for Post MD up to 10 years and we also encouraged final year MD Radiation Oncology Students to participate.

The program was designed by ICRO Team and the entire focus was to given to choose the best topics with renowned faculties and to stand above all in teaching activity. We choose the 24th, 25th and 26th of November 2021 for the program, three consecutive days and five lectures everyday and planned from 5.30pm to 8.00pm. While there were many Webinars being done every other day in India, We had a astonishing 160 paid registrations and there were nearly 200 participants across ASIA watching the Webinar every day and the attendance tracker revealed 98% of participants sitting and listening to the entire two and half hours on all three days.

We covered the technological updates on Day 1 – FLASH RT, MR LINAC, SGRT, Artificial Intelligence and Radiogenomics in Medulloblastoma and the following day we had Practice Changing updates covering FAST FORWARD Trial in Breast, POP-ART, CHHIP & STAMPEDE in Prostate, De-escalation in HPV positive Oropharyngeal malignancies, Organ preservation in Rectal Cancer and ISRT in Lymphoma and the final day focussed on Clinical Research updates – CATNON and CODEL in Gliomas, PORTEC 3 in Endometrium, ICRU-89 and CT Adaptation of ICBT , Oligometastatic Lung SBRT and PARCER trial updates.

The Faculties were crystal clear in their presentations and explanations about the topic given to them with evidence. It was designed in such a way that the young professionals sit at home and learn about Trending Updates which would help them to improve their day to day practice.

All the speakers did an excellent job and the participants were very happy and interactive and were firing questions for every lecture. The final day we organised the PRODVANCE Quiz and selected the top three and they will be honoured in our next Annual National Conference - AROICON 2022.

Winners were:

First-Dr. Manavalan M, JIPMER, Puducherry Second-Dr. Prashasti Sharma, Dr.BBCI,Guwahati Third- Dr. Ajitesh Avinash, AHRCC, Cuttack.

The three day Webinar ended in a happy note with all the lectures completed on time and lots of appreciations from the delegates saying that they are looking forward to such Webinars. This was very motivating to the ICRO team to do more such Webinars in the near future.

Last but not the least our sincere thanks go to Mr.Arvind Suri, SUN oncology who was a strong pillar of support in doing this Webinar and to Webstream World Communications.



Secretary – ICRO Dr. V Srinivasan



Vice Chairman – ICRO Dr. D N Sharma



Chairman - ICRO Dr. Satyajit Pradhan

UPCOMING...



AROI-ICRO TEACHING PROGRAM -2022		
PROGRAM	PLACE	ORGANIZERS
AROI ICRO SUN PG TEACHING	N PG TEACHING AIIMS, Rishikesh Dr. Manoj Gupta	
COURSE -2022	Sri Shankara Hospital Bangalore	Dr. G V Giri
	MGM Med College, Indore	Dr. Preety Jain
PRODVANCE -2022	SZ - MIOT, Chennai	Dr. V.Srinivasan
	EZ -AHRCC, Cuttack	Dr. S N Senapati
	WZ-Kokilaben Dhirubhai Ambani	Dr. KaustavTalaptra
	Hospital and Medical Research	
	Institute/ Or Nanavati Hospital	
	Mumbai, MAHARASHTRA	
	NZ - Army hospital RR Delhi	Dr.(Col.) Ashok Kumar
	cantonment, New Delhi	
RADIOBIOLOGY -2022	EZ -Paras Hospital Patna	Dr. Shekar Khesri
	WZ-SMS, Jaipur	Dr. Shantanu Sharma
	NZ-AIIMS, Rishikesh	Dr. Manoj Gupta
	SZ-MVRCC, Calicut	Dr. Dinesh Makuny
AROI ESTRO GYNEC COURSE	R G Kar Medical College Tentative	Dr. Chandan Das Gupta
2022	date March/April	
AROI ESTRO ADVANCED	Apollo Hospital, Kolkata	Dr. Tanweer Shahid
TECHNOLOGY COURSE -2022	Tentative date NOV/DEC 2022	
Best of Astro -2022	Ruby Hall, Pune	Dr. Sumit Basu

Applications are invited for hosting YROC meeting 2023



For more information please visit www.aroi.org



We hope this communication finds you in good health.

It bears no reminding that being the cultural and scientific center of India, Delhi remains India's heart. Delhi is the hub of Radiation Oncology treatment and its gradually expanding to NCR as well. The growth of this field in the city is unparalleled as compared to any other city.

Which is why one peculiar point to note is that the Annual Conference of Association of Radiation Oncologists of India (AROICON) was last held in the capital city nearly 4 decades ago.

While preparations were underway immediately after AROI nominated North Zone Chapter to host the 42nd chapter of this prestigious conference in the city of Delhi for November 2020, the AROICON organizing committee and all the Radiation Oncologists of India were very excited. A grand program was finalized including a variety of academic and cultural activity. The venue chosen was The Manekshaw Centre which is one of the leading and most prestigious exhibition centers in the city of New Delhi. Everyone was looking forward to attending this event and experience the multicultural and unique life of Delhi.It was very unfortunate that we were not able to conduct the 42nd Annual Conference of Association of Radiation Oncologists of India (AROICON) in November 2020 due to the Covid-19 pandemic and the decision was taken by AROI executive to postpone the conference according to government guidelines.

After discussion with the Core Committee which included AROI office bearers, NZAROI office bearers and AROICON core members, it was decided to postpone AROICON for 2021. There were encouraging signs of the pandemic abating early this year, however, in a short span of a few weeks, the pandemic has taken a terrible turn towards the worse. We have reviewed the situation many times with AROI office bearers, NZAROI office bearers and AROICON core committee. An online meeting was held on 16th April 2021 with the office bearers and the members reached a consensus that conducting a physical conference will not be possible considering the present scenario due to the pandemic and rules and regulations of the government.

The Core Committee decided that physical meeting for AROICON may not possible as per scheduled timings of AROICON in November/ December 2021.

To review the situation again AROICON core committee hold an online meeting again on 23 Dec 2021 and it was decided unanimously to organise AROICON on 1Dec to 4 Dec 2022 (As ICC scheduled to be in 2023) in a hybrid mode

This pandemic's unpredictability also casts a shadow on any assumptions we may harbour on 'when' we may consider an in-person conference realistic. Considering this this was decided in meeting that furthers decisions about conference will taken after two months in a review meeting The organizing committee remains fully motivated and committed for this task.

Dr. Munish Gairola Organizing Chairperson

Dr. Manish Bhushan Pandey Organizing Secretary

UPCOMING...







39th SUN ICRO Teaching Course "HIGHLY CONFORMAL RT TECHNIQUES" February 16th,17th and 18th of 2022

Appreciation



AROI Congratulates The Newly Elected Zonal Members

Tamilnadu and Puducherry Chapter

President Dr. Alex Antony Prasad Chennai Cancer care hospital, Chennai **Secretary** Dr. Saritha Damodaran Billroth Hospitals, Chennai





Maharashtra Chapter

President Dr. Manish Chandra Juipter Hospital, Thane





Tatulal

West Bengal Chapter

President Dr. Litan Naha Biswas Apollo Gleneagles Medical Centre, Kolkata





Secretary

Dr. Abhishek Basu

Appreciation



Uttar Pradesh Chapter

President Dr. Shaleen Kumar SGPGI, Lucknow Secretary Dr. Surabhi Gupta SN medical College, Agra





WINNERS OF PRODVANCE 2021

atulation



First Dr. Manavalan M. Senior Resident JIPMER, Puducherry



Second Dr. Prashasti Sharma IIIrd year PG Dr.BBCI, Guwahati



Third Dr. Ajitesh Avinash Senior Resident AHRCC, Cuttack

This issue is brought to you by Dr. Vikas Jagtap Associate Professor & HOD drvikasj@yahoo.co.in,+91 - 88222-31236, NEIGRIHMS – Shillong On behalf of Association of Radiation Oncologists of India (AROI)

Doctor's Insurance



AROI – Cover You® Initiative

AROI has appointed Couverture Management Consultants Pvt. Ltd. (Known as trade name Cover You[®]) as Consultant and service provider for Professional Indemnity Insurance Policy through ICICI Lombard GIC LTD. The MoU signed on 23rd Sep 2021 between AROI and Cover You[®] covers both Individual and Medical Establishment Indemnity Insurance for AROI members. Cover You will provide dedicated team of Insurance Professionals for AROI doctors. The details of the premium and contact info is attached.

Beds	20 lakh	40 lacs	60 lakhs	80 lakhs	1 Cr
1-10 beds	3252	5483	7713	10655	12390
11-15 beds	7310	9045	10799	12514	14249
16-20 beds	9169	10903	12638	14372	16107
21-30 beds	11027	12762	14496	16231	17966
31-40 beds	12886	14620	16355	18089	19824

Premium Chart for Medical establishment Indemnity insurance (Including GST)

Premium Chart for Individual Indemnity insurance (Including GST)

Sum Assured	AROI Members
50 Lacs	Rs. 2,124
70 Lacs	Rs. 2,973
1 Cr.	Rs. 4,248
2 Cr.	Rs. 8,496



Mr. Manoj Rajput Insurance Consultant - Retention +91-98219 51333 manojrajput@coveryou.in

Contact Person

Doctor's Insurance



AROI – Cover You® Initiative

