Now, we move forward and would like to invite Dr. Manoj Mahajan, senior consultant medical
oncologist from Udaypur.
And as a panelist, I would like to invite Dr. Pratamesh Paisa, Dr. Shivaiz there, Kumar sir can join Nitha Madhina and Dr. Bhayesh Polariyya, consultant medical oncologist
from Namanthana.
We are also learning.
So good evening everyone.
So we will be as we are running short of time, we will quickly go through the case.
So the said panic cancer session of 40 year male, case of recurrent relapse, carcinoma
tongue with metastasis, two bones, bilate latinels, bilate lungs, spleen, bilate kidneys
and bone marrow.
So quite extensive disease.
And to start with the at the onset, patient was locally advanced disease, post three cycles
of DCF underwent surgery, then CTRT in 2022, had recurrence after a year which was non-salvisable,
then patient received temporalism app plus pachlic arboh followed by a CTXMAP, JEMSIT
have been triple metronomic therapy, we know there have been.
So the question, obvious question is what next?
Either in the form of testing will we do something which will guide us for any, what
else?
So patient has received DCF earlier, then Pembro pachlic arboh, CTXMAP JEMSIT have been
triple metronomic, we know there have been.
We do many more things beyond that.
In fact, we have published some of those data on bed number stain, we have got some data
on mycydoxy, we have used the nvatinne, we have, so ideas what I'm saying, these are
not, you know, we will have an guideline.
But whatever I mention, if you go back and check, you will get data of phase two where
there are 15% patient where the tumor regresses.
So patient step and why do I use it?
These are off label use and off label, there is a way to use it.
Off label is one of the, you know, one of the way you practice and if you go, there is
a asco guideline for it, you know, that how do you use off label, you know, treatment.
So you see that, safety there or not, what I was suggesting.
And when you're using it, when you've exhausted the routine treatment, yes and I told you,
some of them, we have used it and some of them we have published it and that is in a public domain.
If not, kept citabin.
If you have gone through this, only DCF has been used, not sure how many cycles were
there.
Three cycles.
So that becomes a bit troublesome, but you have a, if you have a two, three years gap,
go back, if you see kept citabin, again you have a data for on 20% patient responding

to, you know, a head and neck cancer with these treatment.
So you'll realize that in clinic, you will have patients, not everybody, good number
of them in your career who will keep coming to you, they are fairly stable, disease increases
and then you look for, is there some treatment where the data is there to use it?
So we always search for the fallback options.
So we had tested this patient for, with the ingest testing.
So patient had H-RAS mutation and tipperaffin was denied and patient was not willing for
TCR due to time requirement and then patient was recommended for gamma delta T cell therapy.
Baseline markers were more or less normal, these were the markers and as we have the
NCC recommendations, most of them again in the similar pattern, we had exhausted with
most of the standard current options and if we look at the overall PFS about with
the Bembrulism app plus the tips, it's hardly around three months, four months, 15 weeks,
25 weeks and then other options which like OMCT or IWI, chemotherapy, median PFS is around
two to three months, median OS is around four to six months and even with the KAPAZ XL there was the published data by the PMH and so on.
So it has in non-inferality with the, to be inferior with the dose of the XL both in
terms of PFS and OS.
So we have the published data but again the median PFS and OS of two to three to four
to six months respectively.
So again this is a level therapy workshop.
So do we have any data in this domain?
So we had certain markers like B7H3 for Skullbase-Kottoma as ERB plus McVan-Targeted Carty
Cell in SCC, then results of ERB Carty especially patients who had received eight lines of
chemotherapy.
So this patient who has been reported after eight lines of chemotherapy with standard
all the options including surgery, radiotherapy, chemotherapy, this patient such, this patient
such group of patients around median PFS was around, overall was around 250 days.
So more than a year and few of the patient had data going beyond 400 days.
So again the TCR-engineered T cells targeting E7, again this group of patients, all the
patients had responded and cerebral was around 6 to 10 months, 6 to 9 months after multiple
lines of chemotherapy.
So that is the one area where we can think about adding the cellular therapy.
Again the overexpiration of HER2 in HEDERNIC cancer represents the patients as nowadays
we are using NR2.
And after NR2 also we have option of using the Carty Cell in such subset.
So for this patient gamma delta T cells, infusion was done on 14th of August, dose infuse
were around 174 million.
Patient had first fear spike on data of the infusion, then the patient was managed conservatively,
then medications were done the date of infusion, second infusion for the gamma delta T cells,

28 of August, 160 million of cells, patient complained of, patient had a ICANNs, complaints
of confusion while typing and writing the message or email, then patients at the responses
were recorded day 0, day 30 and day 60.
So we are like days 70 plus but at day 60 these were the results and so tumor is responding, we do not know we are not very sure how long the response will last but this
is how the tumor is responding.
So that option and with some clinical data we have to support cellular therapy in this
setting as well.
In one more case like HER2 new positive salivary gland, 72 year male comorbidities, hypertension
diabetes, now allergic to none, treatment options were surgery followed by radiation
done, then local regional recurrence, patient was given HER2 directed therapies especially
thrusters map, progressed in 3 months, TDM1 again progressed in 3.5 months, EPSIT have
been left in it, progressed in 4 months, TDXD, progressive disease in 2 months.
So again planned for HER2 new CARTI, hervesting was done 2nd of November and her patient was
lymphodipleated, rested for 2 days and infusion was done on 3rd of December and these are
the pictures within few weeks.
This was at onset and tumor is resolving, there is certain kind of granulation tissue.
So that is it for the case presentation, any comment from the expert panels especially
in this critical situation where we are not considering the financial toxicity.
If patient is fit, finances are no issue or we have clinical trials, will you go?
In a recurrence setting, we have to look at the standard way of choosing a patient.
So you are going to choose a patient who has had a better disease fee survival, you want
to choose a patient who you can actually resect it R0, you want to choose a patient whom
you may be possible to give RERT.
So if those patients are there, you would consider standard therapy.
If you have a patient now where the recurrence is in a difficult location, you may want to
consider second-line chemotherapy to downsize it and to consider surgery and re-radiation.
In those patients you might consider this but you need to have guidelines because I know that these are very exciting, you would want to do good for your patients and you
know that these are markers for future treatments, guidelines which will come in and we will
have to establish them.
So select out a group of patients that actually will benefit.
So maybe the same, you know, good way in 2000 and 2000, had meta-analysis which showed
that these are the group of patients that you should focus on.
Now you will have to select out a group of patients that nobody wants to treat, like
the first case he showed.
Nobody has an answer for that.
So those group of patients you need to select out and have guidelines, okay, if it is

in these locations, you might use these therapies and have an outcome.
So we have submitted the project for ICM and funding and that actually deals with such
kind of difficult solvents surgery patients who are not a candidate for re-radiation
but come back within one and a half year and the surgeon feels that it would be difficult
to dissect and that is the reason why I wanted to.
See in the days of the past we were not radiating again.
Today we are re-radiating.
Now I have a couple of patients who have received two radiations and have had a deceitful survival
of few months and now I have come back.
I cannot re-radiate again.
No one will.
Those are the group of patients that you need to select out.
Bavashani comments from your side?
So we do come across because had an egg patient, if your nutrition is maintained, they are
going to live longer and the recurrence will keep happening within six months or one year.
So this is a very common scenario where we have exhausted three to four lines of therapy
and then we are in a fix that patient is still walking and coming to you but the disease
is progressing and you don't have a good answer.
So I think there we can either put it on a clinical trial or a cardiotherapy.
Some therapy which is going to have some responses and safety, both the things we have to take
it in.
I think more needs to be done as far as understanding what is the biology now.
We have many times we have the locally controlled disease.
Now this patient may have the tongue was controlled but now he has got a burden all over the
body.
And that is something which is different.
It may not be actually a tongue cancer now that I am treating.
And that's why you might see benefit with the other therapies which are off label.
See in the head and a cancer and we have worked together.
So till recently we didn't have chemotherapy drugs where especially in oral cavity cancer
where responses had been higher.
We have published our paper of DCF, we have published our paper of bottle and the sectable and the response rate used to be around 30 percent odd.
It's not larynx.
Remember we are not talking larynx.
And that's the reason the patient once labeled palliative used to be palliative.
We know that once we started using triple metronomic chemotherapy adding IV to it and we
had a jump in our, you know, response rate.
Now we have dozens of patients from joint clinic coming as palliative systemic therapy.
They have gone back because the responses has been excellent.
They have gone back for surgery.
So issue was what kind of systemic therapy we had.
You know, it happens in other tumors more commonly than here.
And here we started seeing when you have this jump and then we have, you know, more heterosexual.
Same way if take palliative, you know, immunotherapy has come.

Now it has given another hope for people that in case you have patients with, you know,
in head and a cancer median survival used to be 8 months odd.
Now if you have those 20, 30 percent patient who lives four years or five years and if
there is a residual disease in the past we used to not resect or give local therapy but
in almost most solid tumor we have started looking for.
If you have a good therapy, if you are getting something residual, plan for it.
For example, lung, we routinely send it.
You have a metastatic disease.
If you have a oligo residual and there is oligo progression, you send for a radiotherapy
because someone is started, one of the, you know, part of your therapy is started working
very well and then you require help from other places.
In head and a cancer since cisplatna, the factor means there has been no therapy.
I repeat, there was no therapy till immunotherapy came which has ever improved survival.
No radiotherapy, no technology, no research.
And no rene chemotherapy also.
First time you had immunotherapy and the data for locally advanced came now.
So head and neck isn't desperate need to have improvement.
For me I am not looking only for this.
In case this result gets sustained and reproduced and good thing is it is like the gamma delta
what I understand, my summary is my limited.
This is, this can be, you know, not a person to person, it can be used.
Then can be combined.
So you are not looking only there.
If it works out, looks like this is not so toxic.
If it works, reproduce, can it be combined.
So for example, T1 T2 you don't want to give it, you know, Pratimish does it and you
have those 80, 90 percent patient doing very well.
But those T4 entries, those patient recurrent tumor, what you suggested, think about T4
patient recurrence, T3, T4 tumor coming back within six months.
So Barbara Bhattis, she was there, you know, in FHNO recently.
You know what is the trial design?
The trial design is you do for surgery and whatever you do.
And one, I am only immunotherapy, resectable patient, I am saying this is not transsectable
patient, that's the trial design, you know, going on in the United States.
What it means, they also feel those bigger tumors when they come back, especially they
come back within nine months or six months.
If you do surgery, what you are trying to convey was their outcome survival is around 20
percent with the best case scenario.
So people are looking, can you add some new therapy?
So yes, I do agree that these are some of the things, once it becomes easier to use,
once we have some reproducible data, you will see various combinations, what you are
seeing in hematolumphoid.
Hematolumphoid, you are not doing cartilage leaving it.
You are trying to combine with other therapy, you are trying to combine with immunotherapy,

you are trying to combine with bone marrow transplant to see that can you improve outcome.
And head and a cancer, I totally agree.
We don't have a real good development for last 30-35 years.
Pratmai, I just one question.
So have you found any difference, you know, the previously anesthetized chemotherapy versus
now anesthetized immunotherapy, operating challenges or anything new, you know, because
I always speak about thoracic surgeon, they will see, they see a lot of fibrosis and
while operating.
So do you feel any challenges when you know pre-immunotherapy, anesthetized?
I have not seen so many patients where I have had to operate, you know, if they are responding, they go on to have a response.
So I am not really required to salvage it.
My another point that struck me was in hedonic cancers, especially oral cancers, we are
dealing with not recurrences, but second and third and fourth and fifth primaries.
These are what you need to look at, because now I do a functional surgery first thing.
And then I remove some more tissue.
By the time it is the third primary, I don't have any functional human left.
I am removing tongue, I am removing bone, I am removing maxilla skin, I can do one reconstruction,
second reconstruction.
Third time on flat depletion.
So these are the multiple primaries that come back and you will have patients coming
with multiple primaries.
Same side, but up, down, anterior, posterior.
These are the ones that you require to target, because now surgery also may not be really
functional and patient may not offer it.
So this is where you might look at new modalities.
Just for, you know, maybe next year, you will require a whole lot of locally advanced
hedonic cancer, a keynote 689, press releases there, you know, that's a new adjuvant immunotherapy,
trial, event-free survival is positive.
Data is not out, most likely to be in an ASCO.
And if it comes out, you will have whole lot of locally advanced hedonic cancer, which
are surgically resectable, receiving new adjuvant immunotherapy in near future, most likely
hopefully June July.
You have the data in the loop, too.
Thank you, sir.
Thank you for your time.
Thank you.