panel discussion will be the board editor will be Dr. Roshab Kothari
Will you ask for your panelist please? Yeah, Dr. Sunil Dr. Sandip Dr. Nithi
Dr. Thunse
I think two of them are not there so
No, no, we have only three apps section four people
Okay, so we will be discussing on the three abstracts on supportive care
which were presented we start off with
CINV
So as we all know that acute and delayed amesis is something which we always are
worried of and
More so patients are worried of
While chemotherapy and once image is set in
The breakthrough image is and the psychological or anticipatory message is
something which is very difficult to break
So if we are very good at
management of acute and delayed image is that will help us and patients a lot so
Starting from Dr. Thunse, how do you decide so you are giving a chemotherapy
regimen? How do you decide which anti-matic rate?
drugs are doing
Well, it depends on the
Ematogenic potential of the regimen so high moderate or no, yeah, so I
Always find it difficult to remember in which category the regimen falls in
Basically any cisplatin containing regimen cyclophosphamide more than 1,500 mg per
meter square anything which contains an anthraciculin and
Enrycyclophosphamide
Caboplatin AUC4 I wouldn't I haven't seen that much of ematic potential with
Caboplatin per se as in the
cisplat or
AC or cyclophosphamide then
rarer drugs like streptosysine and other thing then comes the moderate ematogenic
any
Caboplatin and
Any other combination of cyclophosphamide I-phosphamide
with
anthraciculins per se so low ematic potential are
Other medications so there is either a chart which you need to
But what I wanted to convey with there are some applications available where you
just write the regimen and they will tell what
Ematogenic risk
Patients falls in especially when we are using the newer regimens for the routine
regimens
We would ever edimate protocol we are used to the anti-metagenic regimen
so
So let's take one by one
Anything for high
Metagenic risk what is your anti-metric regimen?
The complete anti-metagenic
F-genogenin general you give yes, so I mean sort of
5 h t 3 plus nk 1 with dexam
again sort of
From a compliance point of view and from reducing infusional time we are using the
combination where it's available as one medicine as such
The one point I want to bring about here is that if I'm using a combination of
immunotherapy with chemo though
We have enough sort of data so say dexam and not because in that much impact right
now
I'm removing dexam and using olanzapine as well
So apart from the AC regimens and all where olanzapine is now being used when I
would like not to use dexam

I'm using a immunotherapy with chemo regimen. I'm removing dexam and using a triplet combination of ht3 and k1 and olanzapine
So
Do you say for example you are giving us cisplatin of
75 milligram per meter square do you add olanzapine to this?
Yes, yes, I
By and large we are using olanzapine in most patients especially again with GI malignancies as such because we know
It's an appetite stimulant but the dose which I think most of us
We are not going to the 5mg BD dose either 2.5 mg BD or 5 mg in the night dose. So using a reduced dose. So
And dr. Sandib how is your experience with carboplatin compared to the
Whether you change anything for carboplatin? No, carboplatin is actually comes in a moderate so
Not much of the actual
Amatogenic potential it goes in a moderate but even if I have seen not much of the amatogenic even
practically it comes in the low so the same and as a
We know delayed emesis not particular for carboplatin for delayed emesis. We are giving olanzapine for and
steroid if it is not content negative for day 2 to day 4 to our as you already pointed out over the delayed and the anti-semitic ohm. So
As I understand from analyst nk1
5h t3 decks or moderate and high
We tend to use olanzapine in patients where we want to either avoid steroids or sometimes especially when the
Imatogenic risk is more or even if we want some appetite stimulant effect we tend to use olanzapine we would be
Liberalline using it and we would generally dose reduce will not give 10 mg BD
I think
That's fair
Now the first abstract
by doctor just showed that
Can we give miter zapine which is somewhat similar to olanzapine but probably less cd2
So the abstract showed that
Without nk1
The response rate or complete response rate was reasonably good
So can we skip that drug and use miter zapine so
Apprepent this probably is not very applicable to our subset. We don't have very costly
Apprepent or for seperate pittant or
Nutipotent we have reasonably cost effective but in countries where it is very costly probably
Same so this was the chat which we discussed on
yeah, so the
guidelines for cisplatin and ac based has all four drugs which we discussed and
Olanzapine and examethasone are for four days and
Apprepent for three days and for carboplatin
The delayed emesis changes you need everything for first day only but most of the time with carboplatin
We have some other drug and which may mandate uses of steroid for longer duration
So, uh, what is your take on the study the CR rates, uh doctor suenin?
Would you be comfortable skipping still? I am not comfortable with skipping nk1 antagonist
especially for highly emetogenic
I think the four drug combination
Looks fine to me and Olanzapine even in low doses helps like 2.5 milligram inches
So I think uh this study would be more important for a country where the nk1 are

very costly
otherwise
The only other thing I would say of this study is it helps us to replace Olanzapine metasapine
If someone is having a lot of science
Yes, a sedation with Olanzapine
So I think even with our where we are using Olanzapine if the side effects is more we can possibly extrapolate
Olanzapine helps in appetite stimulation also
We don't know whether this would do or not
It uh, so we will move on to the second abstract which was not discussed and this is an uh indian study
so
uh
You had partly answered Dr. Mithin that uh in situations where you want to avoid dexamethasone because if you see
uh
Complete six cycles or beyond cycles that dosage of dexamethasone cumulative would be reasonably high
So in situations where you want to avoid dexamethasone in high risk anti-metogenic situation
uh based on the study
So this study had these protocols
AC, C splatting with radiations, C splatting without radiation
Carboplatin based or doxorobicin based most of them had AC or C splatting
uh as a regimen and
We all know that this would categorize these high imatogenic drugs
So what they have done is that uh
They have not given dexamethasone and added Olanzapine to otherwise the routine uh bracket and
the response
Complete response to nausea vomiting and total response everything was
uh good with without dexamethasone also
So the question would be in patients who are dexial eligible
Uh, would you be tempted to skip dexamethasone?
Yeah, we routinely do
Skip dexa because lot of adverse events hyperglycemia see a lot of fungal skin infections in females
uh, which are
intractable with topical
uh, anti-fungals I end up giving uh oral uh, antifungals so
I prefer to give
For seaprepitin on aprepitin on neptopitin with the palenas certain combination with Olanzapine
and try and avoid dexamethasone. There is a
retrospective published article by dr. Suha Sargre et al and uh, it was a good study and uh
The scinv, uh, CR rates were higher
Uh, I think you can let go of dexamethasone
I think one situation is so we were giving for a few patients with advanced head and neck where we were trying to downstage
Uh giving a combination of femoralismab with docetaxyl 5 a few base regimens and there when we skipped dexa
The side effects of docetaxyl with the capillary leaks in Rome and all was happening. So and again
uh, possibly with some medicines, it's not just the anti-emitic effect but the other effect where you can't skip dexa even if you're using
uh, but yes, uh, for example
Uh, I'm still not convinced whether I could I would remove it in ac regimens

because that's some place where
Uh, I still think that dexa when we have skipped dexa are patients even on
Olanzapine have reported the acute emesis to be a little more
Uh, so I'm not that comfortable, but uh, yes, most regimens we are removing it now
So, uh, can we say that in at least to be now have a confidence that in patients
where we want to avoid dexamethasone, Olanzapine would
Uh, be a reasonable choice to add on and skip dexa
I would agree to your points that in situations where we are able to give
dexamethasone or dexamethasone is indicated safe
for example in texas you want to
Uh, give because infusion reactions, uh, capillary leaks so in that situation s
such also we are going to give but in situations where you can
You want to avoid dexamethasone, Olanzapine can probably take care of
Is studying as a dexamethasone in both the things?
Force periputant was the
Enkeone receptor has the options
Olanzapine and paul palisatine this uh ci and v p o d trial
Yeah, yeah, Olanzapine was the dexamethasone was not there in one
dexamethasone versus the force periputant
Olanzapine and a palisatone was there in both the arms
Okay, okay, so I missed that but I what I feel is one the regimens for same only
dexamethasone
It is the Olanzapine and paulisatine both are
dexa versus force periputant
Okay, okay, okay
so probably uh once so
Uh, if you want to skip dexa you have to use
Force periputant
Enkeone so
That is then probably similar to the midas of in
Okay, so basically in situations where you want to avoid dexamethasone the other
background has to be the come has to be complete
uh and
Oions keeping dexamethasone you get reasonably equivalent
uh complete response in nausea in vomiting
uh for both acute and delayed and uh
as per guidelines uh we tend to
add Olanzapine to all three regi three drugs because we had a
Study showing that there is incremental benefit of giving Olanzapine and highly
metabolic this is AC and cisplatin based regimens
Uh, so now this is the third abstract
where uh
A new drug is given for cancer kachaxia now this is a very complex problem and uh
difficult to treat problem in
day to day practice. Um, how do you uh generally evaluate a payment? How would you
treat a patient of kachaxia sundae?
So
Cachaxia it's actually really difficult. There is a some uh
data and in the showing that the patient with the
steroids so health or even Olanzapine has some uh potential for the uh
Stimulant so that we usually use in or uh
End is like 160 mg. That's also some uh data shows some trial shows that there is a
benefit
So till now i'm using that one
Uh, not upfront, but the first sign of kachaxia
Uh doctor swinny anything else you want to add uh regarding the abstract which was
presented by doctor sangeeta
I I I you know
So

For kachaxia first thing would be anything which is reversible
We would address that like this vegia or nutritional
Uh, we do nutritional assessment and supplement whatever is missing abbeminal pain malabsorption
We address all that and after that we would probably consider for some pharmacological intervention as you pointed out corticosteroids
Progesterins Olanzapine they have shown some benefit uh some with evidence some with
Uh retrospective data that they do improve some would have improve appetite some would improve weight
But most of them are not able to improve muscle mass
uh, so
eventually in klinic Olanzapine something which we now liberally give
uh
Majestrol as you told is something which we
uh
Tend to give but probably these two are the only formula pharmacological intervention
And we know in practice it helps in some for some uh weeks or so, but it is not a Veryly easily managed
Uh situation. So now this is a drug which has shown a significant improvement in weight even in 5% weight gain
Uh, the 400 milligram dose in most of the patients it has shown a weight gain of 3 kg or more. So this is something
Uh, which probably we need to learn and we need
Uh, this support you can answer khxia happens in very terminal situation. So the cost of the drug whenever it comes is also something
Which we need to ponder on but uh, this drug improves weight also and it has
It causes betterment of muscle mass also which was not seen with the drugs which we generally use
Uh, with Olanzapine we have seen that it improves appetite, but uh, not the khxia
Any other points on khxia which you want to address any of the panelists?
Uh, I think this study included uh
Non-small cell lung cancer and pancreatic and colorectal but in
Indian scenario what we see routinely khxia and herena cancer isophagus and stammer
So I don't know how much pertinent it is for other uh that situation uh, significant part is uh, the dysphagia or
Inability to swallowing so that is probably which we need to address first and then
I think in most of the malignancies in terminal situation the khxia sexin and which uh, we as a physician are also helpless what to do
In first visit we will learn zapine in second visit we would give andes and third and fourth visit probably we will come to know that nothing is helping
so
If this really helps, I don't think from an Indian psychology, I think that's something we have all understood
Family will still ask what foot to eat if you tell them that you're going to give an injection to increase weight
They're not going to take they will still come to should we make any changes in diet and that's a practical
This thing that is a yeah, I would agree that uh, family will always want to add something in the diet and something like that. That's it
Thank you. I think
We are using this combination of because of the refus uh
We were talking to the giving exercise for other people that people today but
but for day two days they are giving for the patient because the dynamic is limited so it's not being uh, given to one more because
So actually there are studies which have shown that if you're giving the doses which are recommended in anti-misses
the

Result or efficacy of immunotherapy is not hampered, but as what dr. Nithin told you always have an option to
Replace it with olems up in and skip dexamethasone
For the delayed emesis for the second day third day fourth day dose, but based on regimen you have to take a call it is difficult
No, so, uh, I am giving steroids as per recommendation
Uh
Anti-metagenic recommendation with immunotherapy. So I'm so again if you're using pachyclotaxil
Um on the day of chemo
It's very important that steroid is not given before the administration of immuno
So anything there are many studies now which have shown that any usage of steroids for whatever reason you have asked my patients also who come in
If they have taken steroids before immuno your T cells are already dampened and they're not going to come out into circulation
Uh, so usage of steroids before administration of immuno is a negative prognostic factor along with the usage of antibiotics in my personal
practice
I don't use steroids for most conditions in which i'm giving immuno. I use the regimen of
ht3 and k1 and olanzapine and it's working well except if i'm using
um
Taxine like dossy-taxil because of the capillary leak reaction which when i've avoided in two three patients on day two day three
They do have a lot of uh, diarrhea feet swelling and all that so it is okay to try without steroids when you're using especially
Pactly carbo but again with pactly carbo
I would use not dex i would you actually have started using hydro cortisone from a viewpoint of allergic reaction because there you are worried about the allergic reaction
So I don't use dexaf or anti-ms's but instead just before giving pactly I use 50 to 100 mg of hydroct
One more thing i want to add here the taxines there are a different type of taxines like the albumin boy or
Equally, there they have mentioned that uh, dex uh need not to give so we can consider using the different type of
Taxines rather than the conventional taxines to avoid the dex uh and that works
So, uh, with immunotherapy
People would try to avoid dexaf or veneva feasible
Uh, you have ole ends up in the other background you have to give and probably change of texin
Uh, is something which can be tried, but I would say that uh giving steroid will not
Uh change your efficacy in most of the situation when you are giving in a sequential way because in sequence
You would generally give io first followed by your all chemotherapy
So in keynote phi 2 2 another thing that it was they gave
Are you first followed by six hours of gap and then the pre-medication and the chemotherapy
Uh, there are multiple
Metabolists so
collecting all these studies they have
Told that if you are giving in imitogenic dose, it is not going to hamper your efficacy
So it is largely okay, but why not to avoid whenever there is feasible so also make sense why not to avoid
Also pakletaxel there is data enough to show that in the first two cycles you can use the trial mg
And subsequently patient hasn't had any reaction hypersensitivity reactions then

you can
Know that used to 4 mg
There is data to skip dexai in later for three or four cycles you can not give dexaf or infusion reaction
I think the one thing is what
Movina said was with regard to the timing of immunotherapy even from a lot of studies have shown that giving immunotherapy before 11 12
11 a m 12 p.m
Leached to a better advantage than this thing because of the
Chrono-tasticity of the T cells and all that but in india it's very difficult because that keteruda free while will come only after 1 p.m
With that release of otp and all that so generally
We have been doing it without any scientific knowledge and just our own this thing that once we give the immuno
We wait about two three hours and then give the dexadose if we are giving it and then give the
immunotherapy waiting for six hours
Becomes this thing but again like I said there is like there are both sides
It's just that at the back of our mind
We do not want to give immunosuppression when we are giving this but by and large there are many studies
We'd say that if you have administered the steroid after immunotherapy
They may not be that much detrimental impact, especially if you're not going to 12 mg 16 mg, but staying at 4 mg
Okay, so
Thank you, thank you
Thank you, sir, and thank you to all the panelists