Next we have a panel discussion based on a topic that we discussed before.
For as a moderator I invite Dr. Ula Sbatra from Delhi to moderate the session.
Good afternoon everyone and sorry you will have to bear with me for the next one hour
because I am standing in for Prabhath, I will try to do half the good job that it tries to do.
And for the panelists can I please invite Dr. Amman from Nagpur, Dr. Vijay from Bangalore, Akhil from Varanasi,
Dr. Suman Mital from Ripur, Dr. Dilip from Kochi and Dr. Thirpthi Bhai from Mumbai.
Since it is my slides which were made yesterday night at 2 o'clock
there is no one joke in this, there is no my initial reaction, no my final reaction on this.
We will start with Siddhi Bhad, no Bhakwas in this.
And the heartiest congratulations to Amitthi, having seen it is how difficult it is to publish our data.
I mean you know it is not only first of all we should have patience, after that you should have the zeal to write something.
After that the data has to be collected, it has to be sent and if you have an editor like Vannita it is a nightmare.
And to really publish of heartiest congratulations to the fantastic effort and I think everybody who is here should try to publish more and more.
It actually looks very very good because when I was looking at the Latin app data I saw Amit's presentation, I saw Akhil's presentation, so it is nice.
It is nice to get data out of your own group.
I mean so I think as youngsters over there, old people here, youngsters should take the lead and we should actually write something on that.
So this is the systemic efficacy data for ALC.
If you look at the crown trial, if you look at the elixir trial, if you look at the brigatanep, krazatanep data, the HR actually comes way down and we have actually seen that you know latinum is far far far better.
This is the most defining slide for me actually and whenever a patient comes to me I actually tell him congratulations.
When somebody actually gets diagnosed with ALC and we tell them you know you can actually throw a plane through the gap and this is what I tell them you know congratulations you have an ALC or positive disease.
At five years, sixty five percent of people, sixty percent of the people are still a PFS or PFS has not been reached at five years.
And imagine ALC with krazatanep was only 9.1 month. So this is something which is very very very nice actually.
So I will start with you Dr. Saman here. Are you convinced with the efficacy data of lord latinep in the first century?
Yes very much.
Very much fantastic. Convinced with the data, convinced with the data. We will only do IHC and V1 and V2 and we will say that we will come to you on that.
Okay so I think as a group we are all convinced with the efficacy data of lord latinep.
But let me and since it is not a Pfizer sponsored symposium, let us say let me be the devil's advocate.
I will show you some graphs over here. You looked at this graph where I showed you a beautiful picture over here.
But you also should see some more graph. Not all patients with respond to lord latinep.
So out of all the forty fifty patients that we have given lord latinep till now, there have been four or five who have not responded.
And then they come and tell me sir after the congratulation bholatah, I said bholatah.
So we need to temper down our expectations also. Not everybody will respond over here.
Can we somehow identify the early progress versus the late persisters?

I mean I think that is a job for the molecular pathologist who really differentiate amongst the do.
What after lord latinep? I was seeing the presentation after lord latinep, sixty one percent of patients actually got electinep and serotonin and presortinep across the trial also.
The point is will all these drugs work? Yes it is shown to be working but still we need to have more better understanding of that.
What about the dirty word, the toxicity profile and that is something which I am going to discuss in detail.
And as okay Amit's data showed here, if it is such a good drug then why not give crazotinep which is probably more patient cost friendly.
Maybe a new patent will go expire, something will come and use the latin with the second line.
So these are the four questions that I am going to pose to my panelists.
So let's start with the first one.
The patterns of progression with lord latinep and insights into subsequent anti-cancer therapy.
This was presented by Tony Mark at WCLC and if you actually look over here, see look over here, how many 20% of patients will progress within the first four to eight months.
So out of hundred, 20% will not respond and again if you see it is 70% that is at two years 30% of people will not respond to this.
So that is something which is very very we all look at you know Pfizer tells us to look at this graph.
What I will also like you to listen this curve.
So it's not a very steep curve but still 30% of people will not respond to lord latinep in the first two years which is something which you don't really tell the patient.
When a patient comes to you with positive IHC I actually tell them congratulations.
But we need to see that.
So this is almost like you know Sunwita Williams has not been brought back to earth.
It is we should be brought back to earth you know and say you can find 70% people will live.
So what they did in that study was they basically found out that unconfirmed I will positive and TP53 mutation related people were more in the people who do not respond to I will get the first thing.
How did that undermine unconfirmed I will positive.
This is here CTDN was either not applicable not tested or tested with no CTD in a directed.
So Dr. T is this the right definition of unconfirmed I will positive.
So I was positive IHC in this study and we also sent I mean the investigators would have sent a liquid biopsy.
If the liquid biopsy was showing not applicable people forgot to send sample.
No you mean at the baseline see DNA.
So what is in your opinion the concordance within a liquid biopsy and a tissue biopsy.
I'll reporting difficult question I know nobody.
No, no, but thing is that that in tissue you will have DNA based most of the labs other than like foundation one or garden.
They are doing DNA based I mean panel.
This would be either foundation or garden center lab test.
Yeah, so that is basically the DNA based fusion testing that they are doing.
So as of now if you see fusion testing on CF DNA there is no standard cut off or anything.
There are too many irregularities in that.
So I don't know how they have actually said this unconfirmed.
So and the second point I will come to that point and second point is a TP53 mutation.

So one question which I will ask to ask from that side is I mean how do you test is IHC enough or you still go ahead and do NGS for your patients.
So I think nowadays we are doing NGS for every patient.
Fantastic.
So we are I practice it's done as a panel.
So in fact I'm not mistaken.
I do not want to take it.
I'm not going to test it.
I'm not going to test it.
So we do for adeno carcinoma of the lung we do it as a in-house testing.
So we send it as a panel.
So EGFR all across they are all done as a panel.
And if I ask for IHC they say why do you want IHC.
So you don't do so you are not doing IHC you are not doing IHC ma'am.
Same most of the time it's a 12 gene panel NGS that is done for most of the patients.
So IHC is not done most of the times.
Fantastic.
So I think what yes you had to comment on this.
I just wanted to say that there is a concept that if NGS is done and ALK is a part of it 100% times you will cover that.
So it is not it also depends on what panel is used.
So if it is amplicon based on a typical EML variant and ALK is covered only then you will detect.
So we have had cases in which NGS is negative but done on next seek and Sophia panel and everything and IHC is positive and patient has a stable disease on electinum.
Later when we like then we found that it's a very unknown partner like Stratton.
So even this happens.
So in case if your fusions are not detected and very high suspicion there is no harm in doing Alka IHC later also.
I would totally agree.
I mean that is one of the reasons why we have not gotten away with IHC in our setting A because the report comes in two days time.
Second you are not dependent too much on the molecular pathologist because with NGS let us accept it as medical oncologist.
We do not know the entire thing and forget medical oncologist since not many molecular people are here.
I can see with the molecular pathologist you know the size of the panel how much genes they are covering how much fusion partners they are covering.
We don't know.
So to me IHC should be the gold standard.
Also we should try to do NGS for them as a secondary part because then you will look at the TP53 you will look at the PIC3 CAAs you will look at the other thing which will then help you to prognosticate your patient about the efficacy of the latinid or electinid or crazotinid.
Is it a fair statement to make?
So this is what my thing is.
There are 30% of patients who will progress during first one or two years.
So every time congratulations is not the word at least after looking at this data I have tempered down a thing as a good, I see report.
That's what I tell them.
I don't tell them 100% of them and we need better biomarkers only P53 is not there.
But a complimentary IHC and NGS should be done for everyone at least in places where they can afford and stuff like that.
Yes, Dr. Dipri.
So in Tata it is either NGS or IHC and it is from the request from the physicians but whenever possible upfront NGS only some cases when we say that NGS is not possible tissue that time IHC.

But in that scenario I wanted to say that even in such cases if negative NGS we should later if available we should do.
And also RNA based NGS only DNA is not enough.
So that is also because for any fusion you need to have a look at the RNA based fusion that is one thing.
Now details of first subsequent anti-seismic therapy 61% of people who progress on Lord Latinev actually got electinev, presentenive, serytinev, Lord Latinev, regatinev.
That is also very very important. In spite of that the PFS 2 was better in the Lord Latinevam than it was in the crosotinevam.
So typically what about plan B I think that's a very it's a concern which is not really unfounded.
How do you manage a progression on Lord Latinev? What do you do?
You should do give chemotherapy. Give chemotherapy. Any immunotherapy or the port?
Very infrequent. ABCP very infrequent. No immunotherapy. I think.
No immunotherapy Dr. Samal.
Most of the time it is chemotherapy only. I would agree with everyone.
I really we should do a rebuyopsy. I think I was just being shown a report over there somebody on ALK has got a meta amplification as a hudun you amplification also.
I really do a rebuyopsy. But if rebuyopsy is not possible only chemotherapy generally immunotherapy does not work in ALK, RERA, non-small cell lung cancer, the immunotherapy plus
Beversaljima also does not really work in this setting. That is the thing over here.
So the drug is too good to be true. You know it works. 60% of people have not even had a five year at five year they have not even got a PFS on that.
So let's talk about the toxicity that the T word in toxicity. So how has your experience Dr. Samal been with the Lord Latina the toxicity profile?
So like lipid profile and CNS symptoms these are the two main things.
The main things that we are concerned about.
Is it how do you conceal a patient upfront or short with?
Same with that good thing, good drugs. So you have lot of benefit but when things are too good we have certain carry on with us.
So we have to take care of those things with the drugs lifestyle modification, maybe food modification.
So we have to balance. How was your experience there with ALK?
So when newly diagnosed I tried to go more and deep into his personal life like his profession whether how stressed he is marital life whether he is gone through any diet.
It is a life if you are not asking more problems they will come into you.
But it may matter because it depends on the other one.
You will go to a marriage counselor.
It may matter how he may talk to the drug and the cognitive effects also may be different.
And people who are working in a stressful environment may not be able to.
And I do tell them that this drug may cause such effects and it may affect your work.
And most of the people who are active who have seen are actively working IT professionals and they are under stress.
And how has the tolerability till now been?
So far I have been searching for it. I have not found it. The hyper-tribal is redeeming and will be more than 90% of people.
That is absolutely okay. Same or something else?
Similarly I think the hyper-lipetemia part is very well manageable with the statins.
And the CNS symptoms also I have not found it very frequently.
I will just try to, this is a graph which is very very important and if for all the young residents listening over here.

Search for an article by Todd Bauer, BA, UER.
I mean very nice way they have told about the management of side effects of toxicity profile to low latin.
This article should be downloaded. It should be kept in your next to your armchair whenever you are there.
So this basically says one, how many toxicity happens and what are the timeline when the toxicity happens.
So for the first two, three months you will get, if you have to get hallucinations or some kind of mood swings or some kind of cognitive impairment, you will get at that time.
Hyper-conrestrialemia you will get within the first two weeks, I mean I tell people 96% of the time you are going to get some hyper-collacialemia.
Good thing they may add here.
The cognitive functions are first noticed by the spouse.
Or for the, by the spouse or who has staying with the spouse?
Absolutely right. So I mean, I will come to the cognitive function.
Yes.
I will tell you a story on this. I will always ask you, I will tell you what the next time he told me, or it's not called called called called.
Now I have changed. I said, I will tell you what the matter is.
The level is changing.
You know, the levels keep on going on and changing on that.
They will know you, anything can happen over there.
No, no, no, no, the anger is far more easier.
Okay. So initially your cholesterol effects will come.
Then your side by side, CNS effects will come.
If somebody did not have a CNS adverse event by the first three months, very, very rare the CNS adverse event will come in the later part.
Major toxicity or weight gain, pyridulodema, which is there, which to me is actually much more severe than, you know, cholesterol and all which will come later on.
And we have seen people who have increased around 10 to 20 kg weight also.
So that is something now I have started telling them to do a salt restricted diet and do exercise and everything from upfront only.
So that's the third side effect, which I have been telling them very, very regularly.
So let's start with hyperlipidemia.
So the concerns with hyperlipidemia, Dr. Suman, people will ask you, incato cholesterol, palli, whatever, everybody, I mean, you know, at least the pre-veve factors.
All funjabis have hyper-cholesterol, hypoglycemia and everything.
So let's say you have a patient who has a great two cholesterol, let's say 250, triglyceride 287.
Will this come into your way, gi, osko, agigos, cholesterol, cup problem?
I mean, a cardiac side effect, najai, or you are okay with that.
No, definitely cardiac side effects and all the things which are associated with the hyper cholesterol, let me say, always a concern.
And we know it is early after we start the drug.
So we have to start counseling and lifestyle modification, maybe early introduction of the statins at the same time, managing the stress and all these things are very important.
So that while we are taking care of the lung cancer, but at the same time, you know, other comorbidity should not be increasing.
Dr. Vijay, I'll ask you, will a patient who has already a deranged lipid profile, will you start that patient on the latinib or not?
For the fear of money is not an issue, for the fear of cardiac side effects.
Most of the time it will mildly derange in my experience and I do go ahead and tell them that they have to proactively manage it and it often gets managed.
So I'll just come to you.

This is what, so you know, the problem with hyper cholesterol, IMIA, is is it a paper toxicity or is it a clinically relevant toxicity?
So what they did was they basically found out that A with longer follow-up and longer exposure to low latinib, the cardiovascular A's did not increase in the second time was, although more people with low latinib had hyper triflistideemia and hypercholesolimia,
the cardiovascular A's were actually lower with low latinib than the chryotanib.
A, because the more significant, if a side effects with chryotanib were with the thromboembolism, so that was also included.
Second, most of the patient were already started on statins.
So ultimately what they found out is even if you had a great one, great two lipid profile to start with, it did not make a difference.
At least a five year follow-up, there was no increase rate of a cardiovascular side effect and that's okay.
But as everybody has rightly said, you need to educate the patient and again a standard statement which I say for the patient is, what is good for your heart is good for your cancer.
So don't take oily foods, do be physically active, that is one statement which I normally say and that is what actually goes on over there.
How do you manage hyper triflistideemia? What is one drug which you will use, what is one drug which you will not use?
And then we will come to the Marita side effects and everything on off-load latinib.
So I would start with the statin.
Which statins? Mostly rosova statin.
I would start with.
I mean again absolutely fantastic point.
Start with rosova statin.
Please don't give a rosova statin.
A rosova statin is one drug which has actually got contraindicated because drug interactions are filed.
Normally we start with rosova statin 20 mg or 10 mg or 20 mg.
Then add a phenofibrate. Maintain a level of around a lipid.
A grade 1 CTC around 200 to 50 that is what we do.
Explain. Is that right?
Fantastic.
Now this is something called as the most importantly the chemical locha that happens with the latinib.
Initially when the latinib was introduced actually I felt everybody was jumping off the floor and everybody will go to the psychiatrist and become parable.
So that is what the, that is what was actually our thinking.
So I'll, since we take a very detailed history about the, okay before I do this, what Dr. Viges said was absolutely right.
For the cognitive effect and for the anger issues because you will be talking to the patient only for 4 minutes.
And if there is some problem or some guy who comes and tells me, is there a problem with me?
I'll obviously say no.
If you ask my wife, is there a problem with me?
She'll tell you what 2 pages, yes there's a problem with me, right?
So you need to talk to the spouse, the parents separately and we do educate them then listen.
This drug can cause anger management issues, behavioral issues, illness and this thing.
If there is an issue, come back and tell us.
So what he actually said was right and but again you know this is very sensitive conversation that you have, okay tell me.
Sir, when I first heard about the suicidal tendencies.
So there was one famous movie where a doctor is implicated when his patient

committed suicide or murder of spouse.
So it was very much influenced but however the data shows that progressively low latinum is more effective.
And also the side effects are well managed with dose reductions and if we proactively monitor it, it will be.
So what are the major CNS side effects that you have seen with the, not on that?
But CNS side effects.
Basically more of a somnolence kind of this thing is what I have seen more.
So again this is which was there, first of all the CNS side effects will come within first 3 months.
So implication of that is normally with oral medicines we call the patient only once in a month or something.
With the latinum, please call them twice a month to start with for the first 3 months till the time you do a scan.
That is the first important thing.
Do a lipid profile, call them every 15 days.
First the first 3 months are the most important thing, call them at that time, talk to the wife, talk to the husband in detail and ask them about that.
The incidence of CNSase actually does not increase.
Most of the CNS adverse events do not require any medical intervention.
So what I also do is when a patient comes to us, we will tell them, listen, listen, listen, listen, listen, listen, listen, listen, listen.
They take your appointment, by the time you come at 48 hours would have passed.
By that time the mood would have actually stabilized.
So the first thing is that that time only you do the patient, if there is a side effect like this, change, stop the medicine and come to us.
Having said that, there have been a couple of people who have actually been over thinking about that and the patient has also landed up in the secretary board but very very far and few in between.
Most of them, you just stop the drug, you stop the drug and you ask them to call.
And then you start the drug at a lower dosage. A lower dosage, I mean, be absolutely okay in starting the drug at a lower dosage and that should take care of this.
If it does not work, you can probably give us some kind of mild surgery day when SSRI, that is absolutely okay. Yes, actually you want to make a point.
So have we created any counseling sheet for the patients?
So that is very important.
So we attach a low latin counseling sheet for every patient who is being started on the road.
And actually going forward, since they are not many patients on the latin, it is always, you will always have a counselor in your hospital.
It may not be a bad idea just to send them for a counseling.
If you tell the counselor to tell the patient that these kind of side effects may happen and if there is an issue, please come back and tell us.
So that is also very very important.
But the important thing is, stop the drug, restart at one level lower and absolutely nothing really happens on your nose.
So, not latin, yes, yes, not really.
Like seeing so many side effects and difficult for follow up, how feasible it is in a routine scenario in India for example.
It is not difficult at all. The drug is the efficacy is still that good.
And this happens only 3 to 4% of people.
It does not really happen that commonly asked.
So like how frequently in first line do we start on lower latin?
That depends on the cost.
I mean, for me, 85% of the time, I will start on lower latin.
Even if it is not a Pfizer sponsored symposium.
And the Rosh knows it very very very very very very.
And what about Varanasi?

Varanasi, how much?
I will show you the data in that symposium about how much I will give you.
Okay, I will show you here only.
So this is the data that came from the T-image group and you know, a median PFS in second line of around 16 months in the worst of 22 months.
This is our data which we showed over there.
So this is what the difference actually is.
If you give lower latin up over here, this is here it is.
This is second generation data.
This is only chemotherapy.
So if you give chemotherapy, your median OS is around 40 months.
If you give second generation to start it, there is 61.5 months.
But if you give lower latin up, it is somewhere over here.
Some more interesting data which come over here is we have actually analyzed it right by TTF1.
So if you are TTF1 positive, you will do great.
If you really want negative, you will do better than chemotherapy.
But the data is absolutely that this one graph which is there.
This is also something important.
Intercontinental progression.
This is Lord latin in the one which is the same graph.
This is second generation and this is first generation.
So Lord latin actually prevents against the cumulative incidence of I will take care of which gets.
This is also important.
This is the evidence which I wanted to show.
This was our cohort in 2013-2017.
This was the median OS.
Then we started moving to second generation.
This is the one.
And now we have moved over to Lord latin and that is one.
So if you know the drug, you should, you know, and give the drug properly, explain to the question properly,
you can have the best of the both the words.
You can give the best drug and you can educate the patient about the toxicity profile also.
So anybody, you want to start with the Crozotanib and then go to Lord latinib or you are happy with it.
And this is not a phisophis, that is one that is impossible.
That actually will do.
So definitely if economy is not an issue, so definitely Lord latinib first.
But many times at least in our place we do face where patient do not have any money.
So we have to start with that Crozotanib.
But the anger people will not ask about the money.
Yeah, but we need to ask.
With you, I will ask you.
So what is your proportion?
How much, I mean, are you sold on the signs of that?
Yes, Lord latinib, yes.
I think fair enough.
So, okay, this is also the number of data that we got.
It is not the number of lines actually that the patient receives which will determine the survival.
It is using your best drug earlier and better.
So that is, you know, I mean my statistics, I ask me sir,
I have to ask you, I have to ask you, but I said, it's a nice drug.
I am going to ask you, best drug, probably that will actually translate into a more better survival advantage than this.

So this is also which came out from this.
This is the last two seconds.
This was a drug which was for latinib, which was compared with the Crozotanib and one more drug which was covered with that.
Again, these drugs are Chinese drugs, they are well made drugs.
So he is telling me not to discuss.
The only thing which is coming out of this is,
why is Crozotanib the favorite whipping boy of al-Korea in non-sparza lung cancer?
Any drug comes, you will, you know, Crozotanib, kolayki, wasky, banhajat, heh.
So I mean, you know, Crozotanib should be renamed as Mandiragantak.
I mean, I think they should not even think of a protocol amendment because I think when most of these studies were going on in second generation drug spread.
So this for me is Crozotanib and I am so glad that Pfizer is not looking after it.
So my conclusions here is latinib is very efficacious.
However, it is a unique and different safety profile.
All practicing on cortisol should be aware of this.
However, 30% of patients will still progress within the first two years.
We need to do NGS need to identify this biomarkers early.
We need trials which compare a second generation followed by third generation versus the sequencing strategy.
The benchmark has been set high, but yet they'll mangay more.
So with this, I hope the alcova trial and the next trial which is coming up will give us more answers.
But even till then, I think whenever a patient gets diagnosed with alc positive IHC,
my only word to them still is congratulations.
Only I say 70% of people will respond well.
So with this, thank you. Thank you for being a sport and being very nice.
Thank you.
Thank you, sir. You stay on the rise.
So next session is sponsored by Roche and this is a panel based discussion on role of eccentric lung cancer.
Modulator is Las Batrasar.
Women's area.
I guess the panelists to be on the rise.
Dr. Satijit Power from Pune.
Dr. Harsh Sahu.
Myself.
Dr. Chandrakanth.
Dr. Pradeep Vintrapati.
Dr. Shailesh Prabhupa.
Dr. Shailesh Prabhupa.
Dr. Shailesh Prabhupa.
Dr. Shailesh Prabhupa.
Dr. Shailesh Prabhupa.
Dr. Shailesh Prabhupa.
In the meantime, let's have some inputs and discussion with our DM and DnV residents.
So what is the peculiarity of small cell cancer?
Which precludes, which differentiates it from multiple other cancers, small cell cancer.
What's the most important differentiation chemosensivity?
So it's a chemosensivity, but is it a radio sensitive disease as well?
Yes.
So radio sensitive diseases are most of the time chemosensitive as well.
Take example of, give another example.
Yeah?
Jumps of tumors.
But if you see another example, like osteosarcoma, that is chemosensivity, but not

radio sensitive.
So you should be understanding that it's not always true.
All chemosensitive diseases are radio sensitive.
What is the rationale that when you're doing a transplant, that means a rotation plus T for osteosarcoma,
and you want to utilize the flap, the bone graft.
So you are radiating it and utilizing it as a dead tissue.
Anything anybody is aware of that?
Exa.
ECRT.
ECRT.
So what's the dose of radiation utilizing that anybody aware?
ECRT dose.
Radiation dose.
It's 100 gradients.
So 100 gradients is delivered to make that tissue dead, completely dead, and it's use a damn plant.
So it's own implant being utilized as a dead tissue, so it's the best possible implant.
You can ask two more questions.
You can ask them about dura valu mabens, or something like that.
Drakskali, Drakskaf, of course, what knowledge, Jaravic, Sadhvad, Zadhara, knowledge, Jaravic.
I'll give you an example.
I'll discuss this in a little bit, in a lot of induced toxicities.
It's important to have counseling.
Counseling with patients who are in the area of Kiaotha, or T-Mish, or any other person,
who have been in the area of the area of the area of the area of the area of the area of the area.
So I want to ask you, does it work?
Yes, yes, sir.
So I'm looking at this, every Wednesday, patients go,
L-postopatients who accumulate Kiaotha,
together counseling.
How does it help a patient?
So same group of patients, they are enrolled in Lung Connect program as well.
So what is the advantage?
All the Lung L-postopatients are coming together, they are also interacting with each other.
For example, one patient has procured, or some other drug.
We had utilized Compassionate Access program also recently.
So advantage Kiaotha is the same time pay, same patients counseling, and they are also interacting with each other.
What we were discussing.
So basically, this is one of the things which we are utilizing in high areas where there are high patient input.
Same type of patients go, Exa-Bulathe, EGF-RK patients week, three days, because EGF-R positivity rate at our centers is 46%.
So out of 100 patients being tested, 46 are EGF-R positive.
This is due to NGS actually, where EGF-R mutations we detect, and at the same time, they are being concealed together.
How many just say, discuss Kiaotha, EGF-RKs, and look, commutation, P53, right?
Which are mutations, name mutations, and you are very important for us.
STK-11 for immunotherapy, okay? Any other mutation which you are aware of?
Anybody aware of PCC mutation? PCC?
Yes?
C-helix? Yes.
Yes, go on and say.

Yes.
Oh, I think it's short now with the other.
Okay.
So there we will just try to set.
Two important mutations which I wanted to highlight.
One is PCC mutation for EGF-R. Another one is M-TAP deletion.
M-TAP deletion is a very new mutation, and we are going to have a trial for M deletion detection, and then M-TAP directed therapy as well.
This is first time in the word actually, and thankfully India will be a part of this, and now the center will be a part of this trial.
Okay. I think we will look at the...
This is not the mic, it's not working.
Okay. Has it come?
Are there a miss-it-come? Okay.
So, when we talk about the small cell lung cancer, it is actually the least preferred cousin, you know?
I mean, I was just telling Dr. Vonita, you don't have to say,
it's not in the way that we have to be able to do it.
And so, there is a small cell.
You know, the non-small cell are not TATA kind of aluminum, and AIMs kind of aluminum.
TATA kind of aluminum.
Not so academic institutes are like the small cell lung cancer on that.
But, see, the MRI within IGA somewhere down the line, we will also show good results actually over there.
We will show you the cartoons later.
So, I have a case to start with over here, which you can see.
It's a 55-year-old male who has come back with a lung mask.
Okay. Here we go. It has come.
So, this is, you know, when we talk about lung cancer and small cell lung cancer, my first reaction is actually like this.
Anybody can... Dr. Shailesh Shail, anything to see in this...
In this... In relation to small cell lung cancer.
I can see the background small cell carcinoma.
That is exactly what... How I feel.
So, this is like the non-small cell lung cancer.
This is all innovations, all pharma and everything which is there.
And this is a small cell lung cancer.
You know, somewhere in the background, we'll ask, we'll look up at her, that's where we...
My subsequent reactions on that was, you know, have patients, all the things that are difficult before they become better.
And even the first ISRO when they sent a, you know, thing to the moon,
the first one was actually got in the Bullock cart and everything and see where we have now finally turned out to be.
So, we have a 55-year-old male who is a current smoker.
He has come to us with a history of cough with expectoration, hemaptases,
a CT scan showed a right lung mass with a high-level lymphoma body.
By up, C was small cell lung cancer and we got a pet scan done,
which basically showed a metabolic active soft tissue lesion along the segmental bronchi.
Along with that, there were some high-level and sub-cannal lymph nodes and there was also a lesion in the brain.
So, in the right parietal lobe, 2.2 to 2.0 centimeter, good amount of edema.
This was the pet scan finding. See a very, very, very small lesion over here, actually nothing very significant.
We got a MRI brain done, which basically said, you know, there was again 2.5 by 2.5 centimeter lesion,
which is query meta-sases, query meningema and, you know, the radiologist's

favorite words, clinical correlation is suggested.
So, what will you do? So, very small mass, otherwise localized disease and also has a lesion in the brain, which they are not sure.
Patient is absolutely asymptomatic. What will you do?
So, I'll assume that the brain lesion is of primary lung only.
You will assume that the brain is of primary lung only. Fantastic. Dr. Shaleesh sir.
And why will we assume this? Because it is a... Okay.
I am not very sure whether on an MRI you cannot differentiate this.
I think you should be able to differentiate between the mening...
Sir, the reporter Rajeev Gandhi can... You know, the lesser cousin of Tata Memorial.
I think I will take it as a metastasis. Metasis is only.
How about you? Metasis is only. Metasis is only.
Fantastic. So, let us resume. Okay, this is a metastasis. So, you have a small lung lesion over here, which is potentially curable.
And you have a single solitary lesion in the brain. Now, what will you do?
Do you want to start? Patient is absolutely asymptomatic.
Do you want to start with systemic treatment upfront? You want to go ahead with whole brain RT?
You want to do a cyber knife, you know, radiation oncologist's very... very... very...
...for cyber knife or surgery of the brain followed by SRS, followed by systemic treatment plus minus chemoim, you know, or anything which comes to your mind.
So, what happens in this disease is that we know that this is a chemo sensitive disease and we want to treat it systemically as soon as possible.
So, what we do? We will try to start systemic treatment and then definitely add treatment. It can be SRS, it can be anything.
If patient doesn't have any symptom and there is no much edema, I think SRS is a good option.
You say, though, but I am not going to tell you, you don't want to say any word for radiation. Okay.
What will you do? Small cells, sir. Small cells. Agreed. Platinum first.
Platinum first. Fantastic. But since the patient had a perilisial edema and the radiologist, we did discuss this case in tumor board.
They were not sure whether it was a meningioma or this and we wanted to change this.
We actually underwent surgery of the brain lesion and the... you know, we were trying to be aggressive.
We did discuss a lot in detail and they said, nahi aragar meningioma, how can you actually go ahead and give CTR to this.
So, that is where we felt probably we did surgery. It came as small cell C alone.
So, let's start about small cell C alone. A number of cycles, so I am going to start with you only four or six.
If tolerating well up to six. If tolerating well up to and who decides solubility patient or us.
So, then six cycles. Okay. Fantastic. And also the response, like, if the necessary C R, the disease burden is low, then stop at three or four.
So, for the residents, I mean, the difference between four to six basically is that whatever response you have to get what Chandakhan said was right, you will get in the first four cycles.
The additional response after two more cycles will not really come. So, it is almost like, so what we do is, we also give six. That is there.
But we will see, you know, after four cycles the patient has stable disease and the patient has good significant residual disease and the tolerability is okay.
We will go ahead with two more. Else we will say, okay, fine, four, okay and tolerability is not good. So, that is what.
But by and large, as long as you have given four cycles, it is absolutely okay. Six may not be better. Four is reasonably okay.

Sometimes if you are using with IO, then four is most of the time we are trying to stop.
If you are using with IO, four is absolutely okay with that. Choice of platinum, what will you give your wife? Which platinum? Not this one. This one.
Okay. So, what platinum, I know, I am sure none of us know the various platinum differences in this. So, six platinum, carbon platinum, in a positive setting.
Does it make a difference or you are okay with ito-carbo?
Carbo is fine. Carbo is fine. We know that it is a platinum somewhat faster on set of action but in the end, both of the cities.
And in all we have become so by and large, there was not much difference between cis-platin and carbon platinum.
I mean again, 9% of our patients received. I think, I mean again, I will put my hand up and say we give you to apply the present carbon platinum.
It is very rarely that we give cis-platin to our patients. It is actually ito-carbo over there.
You have to write many approaches. You can do extensive, you can give three drug, four drug, one drug, six drug plus minus.
I know nothing basically works in this. So, that is something which is there.
So, there was a study from Japan which says IO plus chemo is slightly better. I know ticant plus cis-platin was better.
But when you compare it in a larger trial, this was not really found to be sufficient. So, now we will start with this.
We will start with here. I do convince with the role of immunotherapine, small cell lung cancer. Do you think it really works?
Yes. Fantastic. And if you are not sitting in a large symposium, will you be convinced with the data of that?
Yes. Fantastic. Dr. Shailesh.
Yes. Suppose the patient has to pay from his own pocket.
See, you have to tell the figures to the patient. If you tell the figures of 10.3 and 12.3, let the patient take the call.
And how many patients take that call, sir?
No. They will tell you what is better. So, I mean, as per science, yes, I will go for it.
I think more importantly, I think I am sure most of us will discuss the median OS advantage.
Actually, it will not be more than four to six months, even in the ten months in the keynote trial.
But what we do tell the patient is if you respond, there is a 10 to 15% of patients who will be long-term survivors.
The tail of the tail is something which we actually go back and tell the patient.
10% is right, right?
10% is right, right? 5 years is something which is there. So, this was the IM power 13.3 trial data.
Four cycles of Atizo-Carbo, which was basically given. OS was improved.
Again, important here is this 12-year survival of 51.7 versus 38.2.
And more importantly, which I am going to show you right now is, you know, Akhil was speaking right now and said,
did we even think about a six-year survival? So, now I will come to the moment.
So, you have been more experienced than all of us combined together, sir.
Did you even get a six-year survival before the advent of immunotherapy, sir?
In small cell, I don't think so. I have ever seen a patient. I have ever seen.
So, I think small cell, which was by and large, at 18 months, 30 months of arrival, has now, we are thinking in terms of an overall survival option.
This was an umbrella study. So, what they did was IM power 13 people who were in the Atizo-ITro car bomb.
So, after two years or three years when the Rosh company wants to close the trial because they want to get the trial results published,
they put them into an extension study. That extension study is basically called as umbrella.

That's called the rollover study because then they are not a part of the trial.
They just get the companion access or expansion access program.
And what they basically found out was, I think they took 18 patients.
So, out of all these people initially, which was around 201, 18 people were eligible for this.
What they basically found out was that there was no body.
We always think liver mates say, though, it's called survival, nanyoga.
But if you look at here, there were two patients with liver mates and two patients with brain mates also who went on to the extension study.
And what basically found out was something which is very, very good over here.
A five-year survival of 12%. Nothing great. This is almost like CA pancreas surviving for three years.
But then CA pancreas never used to survive for 10 to 12 months in R times or something.
And again, this is a six-year update.
And if you look over here, a three-year update, 16, 13, 12, 1.
So, if you actually go beyond that first two, three years, then probably you will be able to survive for a long time.
And this to me, this is what I exactly does the patient that forget the numerical two-month increase in the OS.
It is the number of the tail of the tail, which is going to be very, very important.
Dr. Bhavan Dhabasar impressed with these results.
Absolutely. Absolutely. And at least a small percentage of patients will be surviving.
10% of people who can actually basically survive.
Without additional major toxicity that we see in practice.
Without toxicity, it's fantastic.
So, to make these immunotherapeutics more effective, that's the next...
The biomarkers, study... Microbiome.
Microbiome. We have to bring in microbiome over there.
It should be renamed as Shadowcon of Medical Oncology.
Never miss a chance of promotion of microbiome in everything.
Same year, I can.
So, there are many drugs.
And this has not only happened with Atizo, it has happened with Duroal.
So, although that the only three-year follow-up is there.
And with Atizo, we have a six-year follow-up, which is actually there.
So, Dr. Chandakanth, can we now utter the seaward, long-term cure or control in the context of small cell lung cancer also?
Well, it's impressive.
You know, five-year has been crossed and these patients are likely to live.
So, unlikely they will progress.
And just to put things into perspective, a subset analysis and it just comes to my mind.
PDL1 negative people in keynote 189, the five years of average, actually 9% at Enochar Sonoma.
So, it's 9% for PDL1 negative, 19% for 1 to 49 and 29% for more than 50.
So, by and large, if you give immunosome, my take is when, you know, small cell lung cancer was being discussed initially two years back, I showed up and said, I would want to give immunotherapy.
They said, for a two-month OS advantage, why do you want to give?
I think it's not the two-month OS advantage.
It is the potential for this long-term cure that is very, very important.
The next step, as Dr. Arkele has rightly said is, we need to find the biomarkers for finding out which patients will really get this.
For the whole immunotherapy story, median is not the right way to schedule.
It is not the right way to schedule.
It is a tale that is important.

We need to relook at the way we are doing.
So, this patient, our patient got surgery, then got SRS to the brain, then got after four cycles, he got a partial response to treatment over here.
So, now is where we have done the promotion for ROSH.
So, we are done with that.
Now, let's come to science.
Dr. Shailesh, sir.
Now, the patient has a very small lesion, small lymph nodes over here.
SRS showed the surgery to the brain. SRS is over.
Will you want to consider giving?
And now that we know there is a data for Adriatic, we didn't know at that time.
Do you think we should go ahead and give thoracic consolidation RT also to this patient?
And do you?
I remember, sir, three, four years back when my radiation on call is accurate, told us to think about consult thoracic RT.
I said, Kavath career, small cell and cancer.
I mean, are you out of your job?
No, we should plan for a consolidation RT for this.
But also important to note that we should keep a close observation on the lung toxicity because the IO and everything is on call.
Correct.
That goes without saying.
So, is the thoracic for you?
Is the thoracic RT to a residual disease site being planned in your institute or you just laugh it away like I did?
No, sir.
So, there is a data for that.
It improves PFS.
So, you are okay with giving thoracic RTs, okay?
We were the only one.
Okay.
So, after you have got four cycles of IO chemo, we have this option.
We can continue IO.
We can give PCI and continuation of IO.
PCI and thoracic RT, I don't know.
PCI is not really the right word over here actually because you already have a disease in the brain.
I mean, that's the problem of being a medical in because you want to over complicate things, you know?
So, I don't know.
So, what we did again?
So, again, we were discussing over there in the other session.
What about Chandakhand?
You are well, you are thinking about do you give PCI to everyone?
Forget this case over there.
Let's say there is somebody with the extensive, small cell lung cancer.
You have given six cycles of a diesel, carbo, ito.
And the patient is doing well.
Do you go ahead and do a PCI or do you do an MRI brain surveillance?
An extensive stage PCI.
PCI, okay?
If we are giving IO maintenance, then we don't usually give PCI though it is allowed by the protocol of the trial, but we don't give.
So, why we will not give?
So, in the era of the IO, there is no trial of PCI which has shown any benefit till now, but there is no trial which has not shown.
Not shown, but also.
So, that is also valid.

But the thing is that if you are planning PCI again, you need to plan a hippocampal sparing PCR that this can be consumed.
So, what is the concern regarding PCI?
Cienistoxit is basically.
Because now that the people are living more and more, so there is a growing body of thought which says that maybe 10% will live.
So, but then no PCI doesn't mean that you call the patient in six months time and then get away with the brain.
You need to get MRI brain done every three months and then go ahead.
So, what is your protocol Dr. Shalish?
I mean, do you go ahead?
We give PCI actually to everyone because it is slightly resistant to change now.
But let's see how it goes.
I advise, I mean, because the number of patients of small cell VC is quite less.
So, but I am a advisor to the case.
What about thoracic RT?
How many people we do?
You do thoracic RT to the resident doctor.
Dr. Dabasal?
If there is a residual disease, you should go ahead with thoracic RT.
If there is a residual disease.
We don't give thoracic RT.
But if you are giving RIO, you don't want to get thoracic RT.
But since our 99% patients are not affording RIO, most will end up.
Those who have good response will end up receiving thoracic.
So, again, for medical oncologist, you know, when I saw this data, we were also surprised that, you know, why are you giving RIO?
I mean, honestly, small cell lung cancer was such a bad disease that whether I finish up with six cycles and PCI something will come back again.
But there is actually a data that, you know, you can give some thoracic RT to.
If there is only an intra-thoracic disease which is limiting and no plural revision, you can go ahead and give a thoracic RT.
But then discuss with your, with your radiation oncologist and make a plan.
And all these plans have to be done prior and not at the end of this thing.
So, we can go ahead with that.
This is exactly the patient which was, and this is, if you see here, this was the disease and we have given RT to him.
This patient went ahead and actually got colitis, a great two colitis.
And we had to shock medicine in between.
And then he did not require, he just required some steroid enema and recovered.
And now he's on atisulism, maintenance at approximately around two years from the time that he has got this.
So that is, for all people that we used to think of, you know, anybody who is this?
Sir, no.
This is Vicky Kaushal.
This was small cell lung cancer like this before.
And this is Vicky Kaushal right now.
So, Hamaara number VIAga, X3 image, non-TIMH, one of the number VIAga.
And that is what I normally say.
So, this is our data of small cell lung cancer.
We have given atisulism after around 35 patients.
Brain meds were there in eight people.
Absan in 27.
Acoch PS was good in 23, 0 to 2.
12 did not have a good amount of disease control rate around 82%.
Median PFS was 4.93.
Median OS was 10.5 months.
Which is probably because there were 12 patients with the PS of 3 and 4.
That was also important.

A one year OS of 43% in a two year, 18 months OS of 33% is something which is very, very, very important.
And this is the graph that we have.
This is the median OS of 10.5 and 4.3 that we are seeing.
So, it is not difficult to get the similar kind of results that you are getting in the long term.
We have four patients now out of this 35 who are actually doing very, very good.
So, I think we should be considering immunotherapy in all the affordable and eligible patients with this.
So, that said about small cell lung cancer and I think we have five more minutes.
We have a patient who is a non-smoker, cervical lymphotoneopathy,
and was diagnosed with EGFR mutant non-small cell lung cancer.
He got OSY Mertoneth after 18.6 months of PFS because in the morning I also spoke about AZ.
So, we can't displease them also.
So, we will get exactly the same OS as was there in the trial, 18.6 months.
The patient has progressed and the systemic progression.
We got an NGS done.
There is no actionable mutation.
What next?
We'll start with this.
So, what will you give to this patient and what do you normally give?
If physical or post-source the progression, I will be mentored by PLS chemo therapy.
I am mentored by PLS chemo therapy.
Fantastic.
And before I am mentored, I was available.
Then one option is ABCP.
ABCP is an option.
So, how do you decide between ABCP and Mariposa?
So, Mariposa is a really affordable patient.
Affordability is an issue.
Dr. Sallysa.
I think if the patient has predominantly something like liver metastasis,
I would go for more for ABCP as compared to ami-ventum-app plus chemo.
Okay.
Your point?
Ami-ventum-app plus chemo?
So, we have one, two Mariposa and one ABCP.
What I have used in practice is ABCP mostly.
Is ABCP?
Three is to one.
Okay.
Mariposa.
Mariposa.
Three is to two.
Chandraka, do you have the deciding one when we chop this?
You can see ABCP and I chop right away.
Yes, I will discuss more data with that.
As there is no...
Probably the NGS is good one.
As there is no mutation, neither the EGF or a remit.
And I would go for ABCP and this patient.
So, Dr. Sperdas of the
P-F-S, please do a biopsy, that is very, very important.
EGFR positive subgroup was site in IM power 150
and there was a PFS benefit, which was there.
And this is not the only trial.
The other trials are also there which have basically shown

that there is an increase in PFS and slightly increase in numerical increase in OS.
If you give a VEGF drug over there,
so, this was the patient who got six months of foredrug and then two drug.
The cost will become an issue with ABCP.
I think it is far more easier to manage over here.
So, what are the ideal patients, actually I will come to you over this.
Is it an ideal patient?
Maybe you will do and biopsy and if it comes met, you will go more towards that.
It is a cost. How do you decide that?
That is a valid...
That is the only mechanism which we have met alteration present
go for drug which are available to any victim.
You are not having a ventumab or something over there.
But if there is no met still...
You can go ahead with...
No, sir.
No, sir. No.
We are just presuming because that is a bi-specific antibody.
There is some retrospective cohort which says that somebody with a met amplification
will do slightly better.
But if you have met amplification, you can actually give OSU,
or a cap-matter, also that is also a reasonably...
Okay, this is the one which I was showing on.
If you look at all the trials, you know, IM power 150 and orient and atlas and harmony A,
the PFS value actually for the IOP plus anti-DK combination is actually better.
I would say if there is any role of immunotherapy plus anti-angiogenic agent in...
In EGFI, we did non-small cell lung cancer.
This is here. This is the one where we should actually aim for.
So, just to say...
Best test to enroll in a trial.
Best test to enroll in a clinical trial and we have a trial coming up over there.
So, if you are in North, you can send it for RGCI.
If you are in North, you can send it to ATAMA.
Okay, so for me, there is a time plane place for everything and there is a place and time for ATZO
and there is a place and time for BEB.
In EGFI, we did non-small cell lung cancer also.
With this, thank you.
I have finished before time.
Thank you. Thanks, sir.
Thank you.
Thank you.