ANTALYA, TURKEY
March 22-24, 2009
Kervansaray Hotel,
Lara, Antalya, Turkey

8th INCTR Meeting on Cancer in Countries with Limited Resources
2009
About INCTR

INCTR is a non-profit organization whose founder members are the International Union against Cancer and the Institut Pasteur, Brussels. The goals of the organization are to assist in controlling cancer in developing countries through the development of infrastructure for cancer treatment and research. A key to improving capacity is education, which, in addition to specific educational programs, is an integral element of long-term collaborative projects relating to prevention, early detection, treatment and palliation. The close integration of locally relevant research with patient care also results in immediate benefits to patients or individuals at high risk for developing cancer. INCTR emphasizes international collaboration and works to improve communication among the wide range of professionals and volunteers working to control cancer throughout the world.

Cancer Control in Turkey

Turkey has a long tradition of cancer control efforts, the first activities being initiated in the 1940s. Since more than half of the Turkish population is less than 40 years of age, the cancer incidence of approximately 225 per 100,000 is lower than that in more developed countries. However, the cancer burden (presently some 150,000 new cases a year) is expected to increase by a factor of 3-5 by 2050 due to longer life expectancy, the tobacco epidemic and changes in lifestyle. To deal with this, Turkey has developed a National Cancer Strategy, which gives the highest priorities to cancer registration, cancer prevention and early detection. According to the Ministry of Health, in 2008 there were 84 cancer centres, 175 medical oncologists, 306 radiation oncologists and 74 pediatric oncologists in Turkey. The first week of April, has been designated “Cancer Week”, during which the Ministry of Health, cancer associations and cancer centres organize various activities designed to increase public awareness about cancer.

About Turkey

Home to more than 20 different fascinating civilisations, Turkey has a 10,000 year-old heritage, much of which is still being uncovered. Its rich history is very much part of the present, with temples, ancient theatres, churches, mosques, tombs, statues of deities, palaces and fortresses, and of course the many detailed and fascination museums which bring the past to life.

Welcome to Antalya

Antalya, the pearl of the Mediterranean, is an attractive city with shady palm-lined boulevards and a prize-winning marina. The snow remains on top of the Taurus and Bay mountains during the hot season yet you may swim in the warm waters of the Mediterranean on the same day. The summers are hot and rainless while the other months are warm and often rainy. In this area one can observe, as it were, the progress of history through the statues of gods and goddesses, temples, theatres, agoras, churches, mosques and tombs.

The Romans, Byzantines and Seljuks successively occupied the city before it came under Ottoman rule. Kaleici, has narrow, winding streets and old wooden houses about the ancient city walls. Traces of Byzantine, Roman and Seljuk architecture and culture can still be seen in the rustic old town. The award-winning Antalya Kaleici Marina and Leisure Center is considered one of the loveliest marinas in Turkey. The clock tower in Kalekapisi Square was part of the old city’s fortifications and the archaeological museum displays remains from the Paleolithic Age to Ottoman times, offering a glimpse of the area’s rich history.
Airport: Antalya International Airport is well served by many international airlines with non-stop and connecting flights from all major city of the world. Antalya Airport is just 12 km from the congress venue, Antalya Lara Kevansaray Hotel.

Climate and Clothing: Antalya has a Mediterranean climate. The weather in March is usually pleasant (15° to 25°). Light clothing is suitable with somewhat warmer clothing for the evening.

Time Differences: Turkey is 2 hours ahead of Greenwich Mean Time and 7 hours ahead of Eastern Standard Time.

Credit Cards: International credit cards are accepted in cash dispensers, hotels, restaurants, and most shops. The most common cards are VISA, EuroCard and MasterCard.

Electricity: In Turkey, electricity is supplied at 220V / 50Hz AC. The socket type is the European Standard.


Currency Exchange: The currency unit is Turkish Lira (TL). Foreign currency may be exchanged at the airport, in hotels, banks and at exchange offices.

Travel Requirement to Turkey: Passport and visa requirements may differ according to the country of origin. Please contact your travel agent or the Turkish Consulate or Embassy in your country for further advice.

Conference Hotel

The 2009 INCTR Meeting will take place at the:
Kervansaray Hotel,
Lara, Antalya, Turkey
www.kervansarayhotels.com
INCTR’s Strategies for Cancer Control

World Health Organization statistics show that the incidence and mortality from cancer is continuing to increase throughout the world. Accounting for 12.5% of global deaths, it is predicted that the number of new cancer cases per year will increase from approximately 10 million in 2000 to at least 15 million by 2020. Particularly disturbing is that the bulk of this increase will occur in developing countries which, particularly in the lowest income groups, are not able to cope with their existing cancer burdens due to severe limitations in human, physical and financial resources. Unfortunately, cancer continues to be under-emphasized as a health problem in low and middle-income countries and without immediate action to remedy this, its impact on the overall health and therefore economies of these countries will become ever greater.

Although cancer comprises a set of complex diseases and cancer control can, therefore, appear to be a daunting task, a great deal can be done to limit the morbidity and mortality of cancer even when resources are severely limited. Appropriate legislation – and enforcement - to reduce exposure to carcinogens (particularly tobacco), public education, ensuring that primary health care providers are informed, screening for early cancers, where this is feasible and cost effective, coupled to appropriate treatment (which, for early stage cancers is generally simple, inexpensive and highly successful) and palliative care when there are no curative options, are all possible to a greater or lesser extent even in the poorest countries. Unfortunately, most patients in developing countries present with advanced, untreatable cancer. Since the pattern of cancer and available resources differ dramatically from one country to another, even when socioeconomic development is similar, there is no substitute for planning at national or regional levels to identify priorities and initiate actions that are feasible in the context of available resources.

Clinical research, often seen as a luxury in developing countries, is in fact, essential in order to explore best practices in low resource settings. It also brings immediate benefits to patients by improving the quality of care and stimulating attempts to reduce abandonment of therapy and loss to follow up. Moreover, multi-institutional research, particularly when there is international collaboration, will increase communication and therefore joint learning among the participating investigators, while providing access, if indirect, for health professionals and patients alike, to the limited number of experts in developing countries and to external collaborators.

INCTR’s overall goal can be summarized as reducing mortality and morbidity from cancer in developing countries through a coordinated program entailing education, training and the conduct of long term collaborative projects related to early detection, diagnosis, treatment and palliative care - in short, capacity building. In the course of such projects, health professionals receive “on-the-job” training as well as opportunities to participate in workshops and training courses, thus improving the performance and professional circumstances of the health workforce while documenting the efficacy and efficiency of interventions. Good quality information – particularly when coupled to systematic review, will provide a regionally relevant corpus of evidence on which future interventions can be based, while simultaneously creating a cohort of knowledgeable investigators able to ensure sustainability and to identify knowledge gaps that can be filled by research. Wherever possible, such projects take advantage of opportunities to understand more about the factors that predispose to specific cancers or which may influence the outcome of treatment.

While model projects must be the starting point, they are developed with outreach and up-scaling in mind, the intent being to ensure national, regional and international impact. This will be greatly aided by the kinds of regional and international networks that INCTR is creating, including partnerships with other organizations able to provide expertise or resources not available within INCTR. The development of coordinated programs of training and education involving multiple institutions and maximizing the use of video-teleconferencing for interdisciplinary meetings, consultations and education are becoming increasingly feasible in the age of the internet and will result in savings of time and money, as well as benefits arising from improved communication, both within the oncology community and beyond.
# INCTR Meeting 2009

## Program at a glance

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting room name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Saturday March 21, 2009</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.00 - 18.00</td>
<td>Registration</td>
<td>Convention Center (Entrance)</td>
</tr>
<tr>
<td><strong>Sunday March 22, 2009</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07.00 - 09.00</td>
<td>INCTR Breakfast</td>
<td>Aquamarine Restaurant</td>
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<tr>
<td>08.00 - 08.45</td>
<td>Registration and Poster Mounting</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>08.45 - 11.30</td>
<td>Session 1 (Plenary Session): INCTR Inauguration, Opening Remarks and Award Lectures</td>
<td>Hall A (Main Hall)</td>
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<tr>
<td>11.00 - 11.20</td>
<td>Coffee Break</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>11.20 - 13.00</td>
<td>Session 2 (Plenary Session): INCTR Reports</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>13.00 - 14.00</td>
<td>Lunch</td>
<td>Aquamarine Restaurant</td>
</tr>
<tr>
<td>14.00 - 15.30</td>
<td>Session 3A (Simultaneous Sessions): Proffered Papers Adult Cancer</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>14.00 - 15.30</td>
<td>Session 3B (Simultaneous Sessions): Proffered Papers Pediatric Cancer</td>
<td>Hall B (Main Hall)</td>
</tr>
<tr>
<td>15.30 - 16.00</td>
<td>Coffee Break</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>16.00 - 17.30</td>
<td>Session 4 (Plenary Session) Panel Discussion: Ethical Issues in Research in Developing Countries</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>17.30 - 18.30</td>
<td>Members Forum (Open to INCTR members only – on site registration accepted)</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>18.30 - 19.30</td>
<td>Reception</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>20.00</td>
<td>INCTR Buffet</td>
<td>Aquamarine Restaurant</td>
</tr>
<tr>
<td><strong>Monday March 23, 2009</strong></td>
<td></td>
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<tr>
<td>07.00 - 09.00</td>
<td>INCTR Breakfast</td>
<td>Aquamarine Restaurant</td>
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<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Establishing a National Network for Retinoblastoma</td>
<td>Hall C</td>
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<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Supportive Care in Patients Undergoing Therapy</td>
<td>Hall D</td>
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<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Hospital Versus Home Based Palliative Care (INCTR PAX Program)</td>
<td>Hall E</td>
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<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Cancer Registration</td>
<td>Hall F</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Developing Sustainable Programs in Cancer Therapy</td>
<td>Hall G</td>
</tr>
<tr>
<td>09.00 - 10.00</td>
<td>Key Note Lecture: Building an International Online Cancer Research Community</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>09.45 - 10.30</td>
<td>Session 5 (Plenary Session): Education for Cancer Professionals</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>11.00 - 11.30</td>
<td>Coffee Break</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>13.00 - 14.00</td>
<td>Lunch and Poster Viewing</td>
<td>Aquamarine Restaurant</td>
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<tr>
<td>14.00 - 14.40</td>
<td>Keynote Lecture: Improving Palliative Care at a Global Level</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>14.45 - 17.30</td>
<td>Session 6A (Simultaneous Sessions): Pediatric Cancers</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>14.45 - 17.30</td>
<td>Session 6B (Simultaneous Sessions): Oral and Gastrointestinal Cancers</td>
<td>Hall B (Main Hall)</td>
</tr>
<tr>
<td>15.25 - 15.45</td>
<td>Coffee Break</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>17.30 - 18.00</td>
<td>Special Lecture: Diet, Physical Activity, Body Weight and Cancer Risk</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>20.00</td>
<td>Gala Dinner</td>
<td>Hall A (Main Hall)</td>
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<tr>
<td><strong>Tuesday March 24, 2009</strong></td>
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<tr>
<td>07.00 - 09.00</td>
<td>INCTR Breakfast</td>
<td>Aquamarine Restaurant</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Lymphomas in Developing Countries</td>
<td>Hall C</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Physicians’ Role in Nursing Education</td>
<td>Hall D</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Wilms’ Tumor and Pediatric NPC</td>
<td>Hall E</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Psychosocial Aspects of Pediatric Oncology</td>
<td>Hall F</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Empowering Women Financially and Educationally</td>
<td>Hall G</td>
</tr>
<tr>
<td>07.45 - 08.45</td>
<td>Meet the Expert Session: Development of Partnerships</td>
<td>Hall H</td>
</tr>
<tr>
<td>09.00 - 09.40</td>
<td>Keynote Lecture: Prevention of Smoking; the Role of the Health Provider</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>09.45 - 10.30</td>
<td>Session 7 (Plenary Session): AIDS Malignancies</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>10.55 - 11.15</td>
<td>Coffee Break</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>13.00 - 14.00</td>
<td>Lunch and Poster Viewing</td>
<td>Aquamarine Restaurant</td>
</tr>
<tr>
<td>14.00 - 14.40</td>
<td>Keynote Lecture: Mesothelioma in Turkey: An Environmental Hazard</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>14.45 - 17.00</td>
<td>Session 8A (Simultaneous Sessions): Workshop: Breast Cancer Control</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>14.45 - 17.00</td>
<td>Session 8B (Simultaneous Sessions): Workshop: Lymphoma Pathology in Developing Countries</td>
<td>Hall B (Main Hall)</td>
</tr>
<tr>
<td>15.25 - 15.45</td>
<td>Coffee Break</td>
<td>Foyer (Main Hall)</td>
</tr>
<tr>
<td>17.00 - 17.25</td>
<td>Awards for Best Posters: Adult and Pediatric Cancers</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>17.25</td>
<td>Closing Remarks</td>
<td>Hall A (Main Hall)</td>
</tr>
<tr>
<td>19.00</td>
<td>INCTR Buffet</td>
<td>Aquamarine Restaurant</td>
</tr>
</tbody>
</table>
## Day 1. Sunday 22nd March, 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 - 08:45 am</td>
<td>Registration and Poster Mounting</td>
</tr>
<tr>
<td>08:45 - 11:00 am</td>
<td><strong>Session 1 (Plenary Session): Inauguration and Award Lectures</strong></td>
</tr>
</tbody>
</table>
|               | **Chairpersons:** Ayhan Cavdar, Turkish Academy of Sciences Cancer Working Group, Turkey  
|               | Ian Magrath, INCTR, Belgium                                         |
|               | Manzoor Ahmad, College of Pathologists & INCTR, Pakistan            |
| 08:45 am      | **Opening Remarks:**                                                |
|               | Ayhan Cavdar, Turkish Academy of Sciences Cancer Working Group, Turkey |
|               | Yucel Kanpolat, Turkish Academy of Sciences Cancer Working Group, Turkey |
|               | Fikri Icli, Turkish Oncology Group, Turkey                          |
|               | Joe Harford, National Cancer Institute, USA                         |
|               | Ian Magrath, INCTR, Belgium                                         |
| 09:15 am      | **Award Ceremony:**                                                 |
|               | Each year, INCTR’s Special Panel of the Advisory Board selects two individuals who have made major contributions to cancer control in developing countries; one from a resource-poor country, and one from a resource-rich country. Each gives a lecture at the meeting. |
|               | **The Nazli Gad-El-Mawla Award.**                                    |
|               | For outstanding contributions to cancer control by an individual from a resource-poor country. |
|               | **Recipient for 2009: Twalib Ngoma, Ocean Road Cancer Institute & INCTR Tanzania, Tanzania** |
| 09:20 am      | **Introduction to Award Recipient**                                 |
|               | Massoud Samiei, International Atomic Energy Agency, PACT Program, Austria |
| 09:30 am      | **Award Lecture:** Burkitts Lymphoma in Africa: What Can We Do and Do Well? |
| 10:10 am      | **Introduction to Award Recipient**                                 |
|               | Franco Cavalli, International Union Against Cancer, Switzerland      |
| 10:20 am      | **Award Lecture:** Bridging the Childhood Cancer Mortality Gap between Economically Developed and Low-Income Countries |
| 11:00 - 11:20 am | **COFFEE BREAK**                                                   |
| 11:20 am - 13:00 pm | **Session 2 (Plenary Session): INCTR Reports**                      |
|               | **Chairpersons:** Emel Unal, Ankara University, Turkey               |
|               | Manzoor Ahmad, College of Pathologists & INCTR, Pakistan            |
| 11:20 am      | **INCTR Progress Report**                                           |
|               | Ian Magrath, INCTR, Belgium                                         |
11:45 am  Clinical Trials Office Report
   Melissa Adde, INCTR, Belgium
12:05 pm  PAX Program Report
   Fraser Black, Victoria Hospice & INCTR PAX Program, Canada
12:25 pm  Pediatric Oncology Workshop Report
   Aziza Shad, Georgetown University Hospital & INCTR USA, USA
12:45 pm  Discussion
01:00 - 02:00 pm  LUNCH
02:00 - 03:30 pm  Session 3 (Simultaneous Sessions): Proffered Papers
   (10 min. presentation, 5 min. discussion)
   A) Adult Cancer
   Chairpersons: Fikri Icli, Ankara University, Turkey
                Zeba Aziz, Jinnah Hospital, Pakistan
   02:00 pm  Pilot Study on the Integration of Cervical Cancer into the Health Program at the Local
             Government Level
             KO Ajenifuja, Obafemi Awolowo University Teaching Hospital, Nigeria
   02:10 pm  Early Detection Programs in Countries with Limited Resources; An Example from Egypt
             (The Cairo Breast Screening Trial)
             Essam Ezzat Ayad, Cairo University, Egypt
   02:20 pm  Neoadjuvant Chemotherapy (NACT) Followed by Surgical Cytoreduction in Advanced
             Ovarian Cancer (AOC)
             Chinmoy K Bose, Netaji Subhash Chandra Bose Cancer Research Institute, India
   02:30 pm  Histopathological Characteristics and EGFR/HER2-NEU Gene Expression of Metaplastic
             Breast Carcinoma in Pakistan
             Samina Manzoor, Shaukat Khanum Memorial Cancer Hospital, Pakistan
   02:40 pm - 3:30 pm  Discussion
   B) Pediatric Cancer
   Chairpersons: Inci Ilhan, Dr Abdurrahman Yurtaslan Oncology Training and Research Hospital, Turkey
                Shripad Banavali, Tata Memorial Center, India
   02:00 pm  The Turkish Pediatric Oncology Group Neuroblastoma 2003 (TPOG-NB-2003): Treatment
             Results of the High Risk Group
             Dilek Gunes, Dokuz Eylul University, Turkey
   02:10 pm  Treatment of Unilateral Wilms’ Tumor According to the GFAOP Protocol in Casablanca, Morocco:
             A Report of 85 Cases
             M’Hammed Harif, The University Hospital of Marrakech, Morocco
   02:20 pm  Retinoblastoma in Less Developed Countries: A Systematic Review
             Serife Canturk, Sevki Atasagun Nevsehir State Hospital, Turkey
02:30 pm  Treatment of Unilateral Retinoblastoma: Results of a Prospective Study in Argentina  
Guillermo Chantada, Hospital JP Garrahan, Argentina

02:40 - 03:30 pm  Discussion

03:30 - 04:00 pm  COFFEE BREAK

04:00 - 05:30 pm  Session 4 (Plenary Session) Joint Session INCTR/Good Clinical Practice Alliance.  
Panel discussion: Ethical Issues in Research in Developing Countries.  
Chairpersons: Francis Crawley, Good Clinical Practice Alliance - Europe & INCTR Ethical Review Committee, Belgium  
Tezer Kutluk, Hacettepe University, Turkey  
Rapporteurs: Sabine Perrier-Bonnet, Alliance Mondiale Contre le Cancer/INCTR, France  
Patricia Scanlan, Ocean Road Cancer Institute & INCTR, Tanzania

Ethical Principles vs. Good Research Practices in Resource-Poor Countries. The 2008 Revised Declaration of Helsinki and its Applicability

4:00 pm  Introduction to the Session and the Panel Members  
Tezer Kutluk, Hacettepe University, Turkey

4:05 pm  The 2008 Revised Declaration of Helsinki: Do Ethical Principles Make Sense in Research Practices?  
Francis P. Crawley, Good Clinical Practice Alliance - Europe & INCTR Ethical Review Committee, Belgium

4:15 pm  Ethical Principles in Oncology Research in Turkey  
Tezer Kutluk, Hacettepe University, Turkey

4:25 pm  Ethical Practices in Oncology Research in Turkey  
Ahmet Demirkazik, Ankara University, Turkey

4:35 pm  Issues, Principles and Practices: What Are the Challenges to Best Ethical Practices in Oncology Research in Resource-Poor Counties  
Angelo Rosolen, Università di Padova, Italy & INCTR Ethical Review Committee, Belgium

4:45 pm  Open Discussion with the Audience  
1) What are the ethical challenges encountered in cancer research in resource-poor countries?  
2) Does ethics promote or restrict good research practices?  
3) How can we improve the relationship between ethics and best practices?

5:25 pm  Closing Remarks  
Tezer Kutluk, Hacettepe University, Turkey  
Francis P. Crawley, Good Clinical Practice Alliance - Europe & INCTR Ethical Review Committee, Belgium

05:30 - 06:30 pm  Member’s Forum  
Chairpersons: Ian Magrath, INCTR, Belgium  
Manzoor Ahmad, College of Pathologists & INCTR, Pakistan  
Heads of INCTR’s Branches/Offices

An informal discussion in which INCTR associate members will have an opportunity to raise issues they consider to be important with respect to INCTR’s overall programs, projects, structure and management. Open only to INCTR associate members.
06:30 - 07:30 pm  RECEPTION
08:00 pm  INCTR BUFFET


07:45 - 08:45 am  Meet the Expert Sessions:

07:45 - 08:45 am  Establishing a National Network for Retinoblastoma  Carlos Leal, Instituto Nacional de Pediatria, Mexico

07:45 - 08:45 am  Supportive Care in Patients Undergoing Therapy  Shripad Banavali, Tata Memorial Center, India  Aziza Shad, Georgetown University Hospital & INCTR USA, USA  Patricia Scanlan, Ocean Road Cancer Institute & INCTR, Tanzania

07:45 - 08:45 am  Hospital Versus Home Based Palliative Care  Stuart Brown, Abbotsford Regional Hospital Cancer Cancer & INCTR PAX Program, Canada  Fraser Black, Victoria Hospice & INCTR PAX Program, Canada  Pradeep Vaidya, Tribhuvan University Hospital, Nepal

07:45 - 08:45 am  Cancer Registration  Joe Harford, National Cancer Institute, USA  Donald M. Parkin, University of Oxford, UK

07:45 - 08:45 am  Developing Sustainable Programs in Cancer Therapy  Arun Kurkure, Lady Ratan Tata Medical & Research Center, India  Ram Marwaha, Postgraduate Institute of Medical Education and Research, India  Sidnei Epelman, Santa Marcelina Hospital & INCTR Brazil, Brazil

09:00 - 09:40 am  Keynote Lecture: Building an International Online Cancer Research Community  Chairperson: Faik Sarialioglu, Baskent University, Turkey  Speaker: Stuart Bell, NCRI Informatics Initiative, National Cancer Research Institute, UK

09:45 am - 01.00 pm  Session 5 (Plenary Session): Education for Cancer Professionals  Chairpersons: Larry Lessin, Washington Cancer Institute, USA  Franco Cavalli, International Union Against Cancer, Switzerland

09:45 am  Approaches to Building Human Capacity for Cancer Treatment,  Massoud Samiei, International Atomic Energy Agency - PACT Program, Austria

10:05 am  The Evidence Base for Cancer Control in Developing Countries  Mark Lodge, INCTR UK, UK


10:45 am  Education and Training in Cancer Research Methods for Professionals in Developing Countries  Robert M. Chamberlain, MD Anderson Cancer Center, USA
11:05 am - 11:30 am  COFFEE BREAK

11:30 am  The Value of a Telemedicine Network in Education, Training and Consultation
Hassan el Sohl, King Faisal Specialist Hospital & Research Center, Saudi Arabia

11:50 am  Distance Learning Programs in Turkey; Present and Future
Ergin Soysal, Ankara University, Turkey

12:10 am  Developing Educational Resources for Cancer
Larry Lessin, Washington Cancer Institute, USA

12:30 - 13.00pm  Discussion

01:00 - 02:00 pm  LUNCH and POSTER VIEWING

02:00 pm - 02:40 pm  Keynote Lecture: Improving Palliative Care at a Global Level
Chairperson: Fraser Black, Victoria Hospice & INCTR PAX Program, Canada
Speaker: Kathleen Foley, Open Society Institute, USA

02:45 - 05:30 pm  Session 6A (Simultaneous Sessions): Pediatric Cancers
Chairpersons: Munevver Buyukpamukcu, Hacettepe University, Turkey
Aziza Shad, Georgetown University Hospital & INCTR USA, USA

02:45 pm  Management of Wilms’ Tumor
M’Hammed Harif, The University Hospital of Marrakech, Morocco

03:05 pm  Management of Pediatric Lymphomas in India
Shripad Banavali, Tata Memorial Center, India

03:25 - 03:45 pm  COFFEE BREAK

03:45 pm  Retinoblastoma – Treatment of Advanced Disease
Nurdan Tacyildiz, Ankara University, Turkey

04:05 pm  Management of Nasopharyngeal Carcinoma
Iyad Sultan, King Hussein Cancer Center, Jordan

04:25 pm  Developing Infrastructure for Pediatric Oncology in India
Digumarti Raghunadharao, Nizam’s Institute of Medical Sciences, India

04:45 pm  Pediatric Palliative Care
Gayatri Palat, MNJ Institute of Oncology and Regional Cancer Center & INCTR PAX Program, India

05:05 - 05:30 pm  Discussion

02:45 - 05:30 pm  Session 6B (Simultaneous Sessions): Oral and Gastrointestinal Cancers
Chairpersons: Hakan Akbulut, Ankara University, Turkey
Rengaswamy Sankaranarayanan, International Agency for Research on Cancer, France

02:45 pm  Epidemiology of Gastrointestinal Tract Cancers
Suayip Yalcin, Hacettepe University, Turkey
03:05 pm Prevention and Early Detection of Oral Cancer
Rengaswamy Sankaranarayanan, International Agency for Research on Cancer, France

03:25 - 03:45 pm COFFEE BREAK

03:45 pm Prevention and Early Detection of Upper Gastrointestinal Tract Cancers
You-Lin Qiao, Cancer Institute of Chinese Academy of Medical Sciences, China

04:05 pm Management of Stomach Cancer
Faruk Aykan, Istanbul University, Turkey

04:25 pm Prevention and Early Detection of Colorectal Cancer – is it Realistic in Developing Countries?
Yusuf Bayraktar, Hacettepe University, Turkey

04:45 pm Management of Colorectal Cancer
Zeba Aziz, Jinnah Hospital, Pakistan

05:05 - 05:30 pm Discussion

05:30 - 06:00 pm Special Lecture: “Diet, Physical Activity, Body Weight and Cancer Risk”
Chairperson: Bulent Berkarda, Istanbul University, Turkey
Speaker: Omer Kucuk, Emory University, USA

08:00 pm GALA DINNER

Day 3. Tuesday 24th March, 2009

07:45 - 08:45 am Meet the Expert Sessions

07:45 - 08:45 am Lymphomas in Developing Countries
Kikkeri Naresh, Hammersmith Hospital & Imperial College, UK
Franco Cavalli, International Union Against Cancer, Switzerland

07:45 - 08:45 am Physicians’ Role in Nursing Education
Patricia Scanlan, Ocean Road Institute & INCTR, Tanzania
Julia Challinor, University of California San Francisco, USA

07:45 - 08:45 am Wilms’ Tumor and Pediatric NPC
Aziza Shad, Georgetown University Hospital & INCTR USA, USA
Sameer Bakhshi, All India Institute of Medical Science, India
Iyad Sultan, King Hussein Cancer Center, Jordan

07:45 - 08:45 am Psychosocial Aspects of Pediatric Oncology
Claudia Epelman, Santa Marcelina Hospital, Brazil
Doug Ennals, Vancouver Island Health Authority and Hospital & INCTR PAX Program, Canada

07:45 - 08:45 am Empowering Women Financially and Educationally
Harold Robles, Medical Knowledge Institute - MKI, Netherlands
07:45 - 08:45 am  Development of Partnerships  
Simon Sutcliffe, British Columbia Cancer Agency, Canada  
Eva Brun, Lund University, Sweden  
Giuseppe Masera, University of Milan, Italy

09:00 - 09:40 am  Keynote Lecture: Prevention of Smoking: the Role of the Health Provider.  
Chairperson: Sevket Ruacan, Hacettepe University, Turkey  
Speaker: Fikri Icli, Ankara University, Turkey

09:45 am - 13:00 pm  Session 7 (Plenary Session): AIDS Malignancies  
Chairpersons: Kishor Bhatia, National Cancer Institute, USA  
Rejin Kebudi, Istanbul University, Turkey

09:45 am  Epidemiology of AIDS-Related Cancers  
Sam Mbulaiteye, National Cancer Institute, USA

10:05 am  Clinical Features and Management of Kaposi Sarcoma in Africa  
Margaret Borok, University of Zimbabwe, Zimbabwe

10:35 am  Pathology of AIDS Related Lymphomas in Africa  
Leona Ayers, Ohio State University, USA

10:55 - 11:15 am  COFFEE BREAK

11:15 am  Development of Treatment Networks for AIDS Malignancies in Developed and Developing Countries  
Mostafa Nokta, National Cancer Institute, USA

11:35 am  AIDS-Related Lymphomas in Africa  
Nicolas Abinya, University of Nairobi, Kenya

11:55 am  AIDS Malignancies in Brazil  
Ana Luiza de Castro Conde Toscano, Centro de Referencia e Tratamento em DST/AIDS, Brazil

12:15 - 01:00 pm  Discussion

01:00 - 02:00 pm  LUNCH

02:00 - 02:40 pm  Keynote Lecture: Mesothelioma in Turkey; An Environmental Hazard  
Chairperson: Izzetin Baris, Hacettepe University, Turkey  
Speaker: Salih Emri, Hacettepe University, Turkey

02.45 - 05.00 pm  Session 8A (Simultaneous Sessions) Workshop: Breast Cancer Control  
Chairpersons: Ahmed Elsawawy, International Campaign for Establishment and Development of Oncology Centers & INCTR Egypt, Egypt  
Richard Pestell, Kimmel Cancer Center & INCTR USA, USA

02:45 pm  Early Detection of Breast Cancer in Developing Countries, is it Effective?  
Indraneel Mittra, Sir Ganga Ram Hospital, India

03:05 pm  The National Breast Screening Program in Turkey  
Murat Tuncer, Hacettepe University, Turkey
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>03:25 - 03:45 pm</td>
<td><strong>COFFEE BREAK</strong></td>
</tr>
<tr>
<td>03:45 pm</td>
<td>Obstacles to Effective Treatment of Breast Cancer in Developing Countries</td>
</tr>
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<td><em>Nuran Bese, Istanbul University, Turkey</em></td>
</tr>
<tr>
<td>04:00 pm</td>
<td>Can Guidelines for Breast Cancer Treatment in Developing Countries Improve Outcome?</td>
</tr>
<tr>
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<td><em>Vahit Ozmen, Istanbul University, Turkey</em></td>
</tr>
<tr>
<td>04:15 pm</td>
<td>Preliminary Results of INCTR Survey of Breast Cancer Therapy in Four Countries</td>
</tr>
<tr>
<td></td>
<td><em>Zeba Aziz, Jinnah Hospital, Pakistan</em></td>
</tr>
<tr>
<td>04:30 pm</td>
<td>Establishing Comprehensive Breast Cancer Control Programs in Developing Countries</td>
</tr>
<tr>
<td></td>
<td><em>Surendra Shastri, Tata Memorial Hospital, India</em></td>
</tr>
<tr>
<td>04:45 - 05.00 pm</td>
<td>Discussion</td>
</tr>
<tr>
<td><strong>02.45 - 05.00 pm</strong></td>
<td><strong>Session 8B (Simultaneous Sessions) Workshop: Lymphoma Pathology in Developing Countries</strong></td>
</tr>
<tr>
<td>Chairpersons: Kikkeri Naresh, Hammersmith Hospital &amp; Imperial College, UK</td>
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<td><em>Nina Hurwitz, University of Basel, Switzerland</em></td>
</tr>
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<td>02:45 pm</td>
<td>Obstacles to Efficient Pathological Diagnosis in Developing Countries</td>
</tr>
<tr>
<td></td>
<td><em>Manzoor Ahmed, College of Pathologists &amp; INCTR, Pakistan</em></td>
</tr>
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<td>03:05 pm</td>
<td>Minimal Standards and Standardization in Histological Diagnosis</td>
</tr>
<tr>
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<td><em>Sevket Ruacan, Hacettepe University, Turkey</em></td>
</tr>
<tr>
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<td><strong>COFFEE BREAK</strong></td>
</tr>
<tr>
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<td>Pathology Training in Developing Countries</td>
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<tr>
<td></td>
<td><em>El-Nassir Lalani, Aga Khan University, Pakistan</em></td>
</tr>
<tr>
<td>04:00 pm</td>
<td>Improving Pathology Services in Africa</td>
</tr>
<tr>
<td></td>
<td><em>Lorenzo Leoncini, University of Sienna, Italy</em></td>
</tr>
<tr>
<td>04:15 pm</td>
<td>Role of New Technologies in Improving Diagnosis</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
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</tr>
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</tr>
<tr>
<td>04:45 - 05.00 pm</td>
<td>Discussion</td>
</tr>
<tr>
<td><strong>05:00 pm</strong></td>
<td><strong>Awards for Best Posters: Adult &amp; Pediatric Cancers</strong></td>
</tr>
<tr>
<td>Chairperson: Ama Rohatiner, St Bartholomew’s Hospital, UK</td>
<td></td>
</tr>
<tr>
<td><strong>05:25 pm</strong></td>
<td><strong>Closing Remarks:</strong></td>
</tr>
<tr>
<td>Ayhan Cavdar, Turkish Academy of Sciences Cancer Working Group, Turkey</td>
<td></td>
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<tr>
<td>Ian Magrath, INCTR, Brussels</td>
<td></td>
</tr>
<tr>
<td><strong>07:00 pm</strong></td>
<td><strong>INCTR BUFFET</strong></td>
</tr>
</tbody>
</table>
Awards Information

INCTR has introduced two awards that will be presented annually to individuals who have made outstanding contributions to cancer treatment or research in one or more developing countries. The purpose of these awards is not simply to recognize and honor the recipients, although this is certainly an important element, but also to demonstrate, by their example, that much can be accomplished even when resources are limited. It is hoped that their work and philosophy brought, through the award lectures, to a broader audience than would otherwise be the case, will inspire others to greater efforts.

Each of the awards is named after a distinguished oncologist. They began their careers when there was so little knowledge about the causes of cancer, that people could only live in fear that they would one day be a victim; the diagnosis was usually hidden from those unfortunate enough to develop cancer because so little could be done for them. It is thanks to the resolution and fortitude of Dr Nazli Gad-el-Mawla, Dr Paul P. Carbone, and others like them, who worked in a epoch when cancer specialists were often accused of prolonging the misery of cancer victims through their efforts at treatment rather than helping them, that today, at least in the wealthier nations, more than half of those who develop cancer can be cured. Both Dr Nazli and Dr Carbone were responsible for training numerous young people, and so leave us a precious legacy through which their work will be continued.

**• The Nazli Gad-el-Mawla Award** is made for outstanding contributions to cancer control by an individual from a country with limited resources. Nazli Gad-el-Mawla was a pioneer Egyptian oncologist, who, as a member of a small group of oncologists working a the National Cancer Institute in Cairo in the 1960s and 70s, helped to build the institute into one of the premier cancer centers in the Middle East. She founded the Department of Medical Oncology in 1970 and within it developed a strong pediatric oncology program. She is known particularly for her work in the chemotherapy of cancer of the bilharzial bladder, which then accounted for some 25% of all cancer in Egypt, and in hematological malignancies. She was highly respected both by her colleagues in Egypt and also by the international community of oncologists in which she became increasingly active throughout her career. It is with the family’s consent that this award is given in the name of Dr Nazli Gad-el-Mawla.

**The 2009 Award recipient is Dr. Twalib Ngoma.**

**• The Paul P. Carbone Award in International Oncology** is made for outstanding contributions to oncology or cancer research by an individual from a resource-rich country. Paul P. Carbone was a pioneer American oncologist, who, as the Associate Director for the Clinical Oncology Program at the National Cancer Institute, Bethesda, played a critical role in the development of cancer chemotherapy. Subsequently, he continued his work as the Director of the Cancer Center at the University of Madison, Wisconsin. Throughout his career he recognized not only the needs of patients in developing countries, but also the contribution that scientific research conducted in such countries could and should make to the global efforts against cancer. Dr Carbone’s family have established the Paul P. Carbone MD Foundation for “the support of scientific, educational, and charitable endeavors that reflect Dr. Carbone’s practice of the art and science of oncology and his lifelong dedication to teaching and mentoring.” It is with their consent that this award is given in the name of Dr Paul P. Carbone.

**The 2009 Award recipient is Dr. Giuseppe Masera.**
Dr. Twalib Ngoma

Recipient of the Nazli Gad-el-Mawla Award 2009.

Dr. Ngoma is a Radiation Oncologist, the Executive Director of the Ocean Road Cancer Institute of Dar Es Salaam, Tanzania, an institution that he persuaded the government to establish by an act of Parliament in 1996. He is the current President of AORTIC (African Organisation for Research and Training in Cancer), in which capacity he is dedicated to putting cancer firmly on the priority list of African health ministers.

Dr. Ngoma graduated MD in 1978 and thereafter underwent extensive training in major centres in the United Kingdom, Germany and the USA in radiation oncology. He is considered one of Africa’s foremost radiation oncologists.

In a Tanzanian context, Dr. Ngoma is the Secretary for the National Cancer Strategy Steering Committee that is responsible for the development and implementation of the Tanzanian cancer control strategy. In this respect, he acts as Advisor to the Ministry of Health and Social Welfare for cancer. He is also the Team Leader for Palliative care for Cancer and HIV/AIDS patients in Tanzania.

Dr. Ngoma serves as the Head of the Tanzanian office of INCTR and participates in several INCTR research projects. He has served as Consultant to the World Health Organisation and the International Atomic Energy Agency Program of Action for Cancer Therapy (PACT). Tanzania was recently selected by PACT to be one of its six Model Demonstration Sites for the development of multidisciplinary capacity-building projects in cancer control – a collaborative program that is also managed by Dr. Ngoma.

Dr. Ngoma is a recipient of a UICC/sanoﬁ-aventis My Child Matters award for a Burkitt Lymphoma project aimed at facilitating early diagnosis, treatment and follow-up throughout the country. This project neatly interdigitates with an INCTR project for the treatment of Burkitt lymphoma. The early results of these studies have shown that treatment results and follow-up of children with cancer can be improved in a short space of time, even in low-resource settings.

Dr. Ngoma has published numerous articles and chapters in peer-reviewed journals and books and has presented at many international conferences worldwide.

Dr. Giuseppe Masera

Recipient of the Paul P. Carbone Award in International Oncology 2009.

Since beginning his career in 1964, Dr Giuseppe Masera has served in a variety of leadership roles before being appointed to his current position as Director of the Pediatric Clinic of San Gerardo Hospital, Monza (Milan), Italy. San Gerardo Hospital is a large (900 beds) teaching hospital affiliated to the School of Medicine of the University of Milan-Bicocca where Dr Masera is also a Professor of Clinical Pediatrics.

Early in his career, Dr. Masera became one of the founders of the Italian Association of Pediatric Hematology and Oncology (AIEOP). After being appointed full Professor of Clinical Pediatrics in 1984 he expanded his interests to include collaborations with international institutions. Dr Masera promoted a twinning project with Nicaragua in 1986 that resulted in a new hospital structure for pediatric hematology/oncology in Nicaragua’s capital, Managua. The collaboration also led to the creation of the Monza International School of Pediatric Hematology/Oncology (MISPHO) in 1996, in order to promote the training and updating of specialists in pediatric hematology/oncology in 15 Latin American countries. In addition, Dr. Masera supported the development of a working group with six countries in Central America (AHOPCA).

Dr. Masera continued his involvement with other international groups by supporting the initiation of the Ponte di Legno Working Group in 1999. The Ponte di Legno Working Group brought together representatives from 15 international groups, in order to undertake cooperative studies in childhood lymphoblastic leukemias.


Dr. Masera has authored more than 200 medical articles, primarily in international Journals. Several of his research studies involved looking at ways to improve the outcomes for children in low-income countries within Latin America as well as improving overall access internationally for children with cancer. Dr. Masera has been the recipient of many honors and awards.
<table>
<thead>
<tr>
<th>Presenting Author</th>
<th>Abstract Number</th>
<th>Title of Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdikarimov K.</td>
<td>1</td>
<td>Choice of Surgical Intervention Volume in Tumors of Proximal Part of Femoral Bone</td>
</tr>
<tr>
<td>Adesunkanmi ARK.</td>
<td>2</td>
<td>Surgical Outcome of Abdominoperineal Resection for Anorectal Cancer in a Nigerian Tertiary Institution</td>
</tr>
<tr>
<td>Afsar I.</td>
<td>3</td>
<td>Evidence Based Complimentary Care in Asia</td>
</tr>
<tr>
<td>Ajenifuja KO.</td>
<td>4</td>
<td>Pilot Study on the Integration of Cervical Cancer into the Health Program at the Local Government Level</td>
</tr>
<tr>
<td>Aksoylar S.</td>
<td>5</td>
<td>Assessment of Children with Non-Hodgkin’s Lymphoma Treated in a Single Center, Izmir, Turkey</td>
</tr>
<tr>
<td>Aksoylar S.</td>
<td>5bis</td>
<td>The Turkish Pediatric Oncology Group Neuroblastoma 2003 (TPOG-NB-2003): Treatment Results of the High Risk Group</td>
</tr>
<tr>
<td>Al- Ani MH.</td>
<td>6</td>
<td>ATRA (ALL Transretinoic Acid) Drug in Treatment of APL (Acute Promyelocytic Leukemia)</td>
</tr>
<tr>
<td>Al- Ani MH.</td>
<td>6bis</td>
<td>Nutritional Status of Acute Childhood Lymphoblast Leukemia (ALL) Pre and Post Induction Chemotherapy</td>
</tr>
<tr>
<td>Al- Hadad S.</td>
<td>7</td>
<td>Prevalence of Hepatitis in Pediatric Malignancy at Children Welfare Teaching Hospital</td>
</tr>
<tr>
<td>Anorlu R.</td>
<td>9</td>
<td>Causes of Gynecological Deaths in a Tertiary Hospital in Lagos - Nigeria</td>
</tr>
<tr>
<td>Anorlu R.</td>
<td>9bis</td>
<td>Screening for Cervical Cancer in a Primary Healthcare Clinic in a Sub-Urban Area of Lagos-Nigeria: The Challenges</td>
</tr>
<tr>
<td>Anwar N.</td>
<td>10</td>
<td>Detection of Estrogen and Progesterone Receptor mRNA IN IHC Negative Breast Cancer Pakistani Patients</td>
</tr>
<tr>
<td>Arya LS.</td>
<td>11</td>
<td>Linear Growth Faltering and Pattern of Growth Hormone Deficiency in Children of Acute Lymphoblastic Leukemia (ALL) Following Treatment with Prophylactic Cranial Irradiation</td>
</tr>
<tr>
<td>Asadzadeh FV.</td>
<td>12</td>
<td>Striking Differences in Breast Cancer Occurrence and Risk Factors: A Comparison Study Between Iran and The Netherlands</td>
</tr>
<tr>
<td>Babaie E.</td>
<td>13</td>
<td>Studying the Expression of Survivin and its Splice Variants: ΔEx3, 2B, 2α, 3B, 3α As New Molecular Markers in Breast Cancer</td>
</tr>
<tr>
<td>Balian R.</td>
<td>14</td>
<td>A State-of-the-Art Wellness Center in Armenia for Early and Accurate Detection of Breast and Cervical Cancer to Save, Prolong and Improve the Lives of Women</td>
</tr>
<tr>
<td>Barnoya M.</td>
<td>15</td>
<td>Development of a Brachytherapy Program for the Treatment of Retinoblastoma in Guatemala</td>
</tr>
<tr>
<td>Badar F.</td>
<td>16</td>
<td>Patient and Disease Characteristics of Non-Small Cell Lung Cancer Amongst Males at a Cancer Hospital in a Developing Country</td>
</tr>
<tr>
<td>Badar F.</td>
<td>16bis</td>
<td>Methodological Issues in Cancer Registration in a Developing Country - A Preview</td>
</tr>
<tr>
<td>Basak J.</td>
<td>17</td>
<td>Passive Smoking and Cancer: Prospective Analysis from a Hospital Based Cancer Registry of Eastern India</td>
</tr>
</tbody>
</table>

* The INCTR does not take any responsibility for the content of the abstracts
## Table of Contents and publication order of the abstracts *

<table>
<thead>
<tr>
<th>Presenting Author</th>
<th>Abstract Number</th>
<th>Title of Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolarinwa RA.</td>
<td>18 A</td>
<td>AIDS-Related Lymphomas: an Emerging Problem in Nigeria</td>
</tr>
<tr>
<td>Boulos S.</td>
<td>19 A</td>
<td>Early Detection Programs in Countries with Limited Resources an Example from Egypt (the Cairo Breast Screening Trial)</td>
</tr>
<tr>
<td>Bose C.K.</td>
<td>20 A</td>
<td>Neoadjuvant Chemotherapy (NACT) Followed by Surgical Cytoreduction in Advanced Ovarian Cancer (AOC)</td>
</tr>
<tr>
<td>Canturk S.</td>
<td>21 P</td>
<td>Retinoblastoma in Less Developed Countries. A Systematic Review</td>
</tr>
<tr>
<td>Chamberlain R.M.</td>
<td>22 A/P</td>
<td>Education and Training in Cancer Research Methods for Professionnals in Developing Countries</td>
</tr>
<tr>
<td>Chanda P.</td>
<td>23 A</td>
<td>Cervical Cancer Awareness and Screening Programme in Rural Bengal</td>
</tr>
<tr>
<td>Chantada G.</td>
<td>24 P</td>
<td>Treatment of Unilateral Retinoblastoma; Results of a Prospective Study in Argentina</td>
</tr>
<tr>
<td>Chen J.</td>
<td>25 P</td>
<td>Outcome of Allogeneic Stem Cell Transplantation for 26 Children with Myeloid Leukemia in Single Center</td>
</tr>
<tr>
<td>Devi B.</td>
<td>26bis A</td>
<td>The Use of Complementary and Alternative Therapy Amongst Cancer Patients in Kuching, Sarawak</td>
</tr>
<tr>
<td>Dey S.</td>
<td>27 P</td>
<td>Co-Relation of Passive Smoking and Lung Cancer in Pediatric Group: Study from India</td>
</tr>
<tr>
<td>Dey S.</td>
<td>28 A</td>
<td>Efficacy of IV Zoledronic Acid Compared to IV Ibandronic Acid in Patients with Bone Metastasis - a Study from Eastern India</td>
</tr>
<tr>
<td>Eftimova B.</td>
<td>30 A/P</td>
<td>Treatment of Chronic Cancer Pain with Sublingual Morphine</td>
</tr>
<tr>
<td>Egamberdiev D.</td>
<td>31 A</td>
<td>Results of Combined Gastrectomy in Locally Advanced Gastric Carcinoma</td>
</tr>
<tr>
<td>Egamberdiev D.</td>
<td>31bis A</td>
<td>Role of Helicobacter Pylori in the Occurrence of Gastric Cancer in the Uzbek Population</td>
</tr>
<tr>
<td>Ernst Y.</td>
<td>32 P</td>
<td>Diminishing the Abandonment of Very Poor Children Through Giving Them Money for Transportation and Strict Controls from Health Nets, this Corresponds to my Child Matter Project</td>
</tr>
<tr>
<td>Gafur-Akhunov M.A.</td>
<td>33 A</td>
<td>Dynamics of Skin Cancer Disease in the Republic of Uzbekistan</td>
</tr>
<tr>
<td>Gathere S.</td>
<td>34 A/P</td>
<td>Nasopharyngeal Cancer Incidence in Nairobi 2000-2006</td>
</tr>
<tr>
<td>Gharami F.H.</td>
<td>35 A</td>
<td>Incidence of Lung Cancer in the Active Smokers: an Experience from Eastern India</td>
</tr>
<tr>
<td>Gluzman DF.</td>
<td>36 P</td>
<td>15-Year Experience of Reference Laboratory on Diagnosing Pediatric Leukemias and Solid Tumors in Ukraine</td>
</tr>
<tr>
<td>Gunes D.</td>
<td>37 P</td>
<td>Clinical Characteristics and Tumors in Children and Adolescents with Neurofibromatosis Type 1</td>
</tr>
</tbody>
</table>

* The INCTR does not take any responsibility for the content of the abstracts
**Table of Contents and publication order of the abstracts**

<table>
<thead>
<tr>
<th>Presenting Author</th>
<th>Abstract Number</th>
<th>Title of Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hashemipour M.A.</td>
<td>38 A/P</td>
<td>Oral Complications and Dental Management of Chemotherapy and Radiotherapy</td>
</tr>
<tr>
<td>Hashemipour M.A.</td>
<td>38bis P</td>
<td>Epidemiological Aspects of Malignant Lymphoma of the Head and Neck in Iranians</td>
</tr>
<tr>
<td>Hassan J.G.</td>
<td>39 P</td>
<td>Hematological Malignancies (Leukemia and Lymphoma) in Basrah Pediatric Oncology Center</td>
</tr>
<tr>
<td>Hassan J.G.</td>
<td>39bis P</td>
<td>Asymptomatic Hypoglycemia Among Children with Acute Lymphoblastic Leukemia on Maintenance Therapy</td>
</tr>
<tr>
<td>Hazar V.</td>
<td>40 P</td>
<td>Primitive Neuroectodermal Tumors of the Central Nervous System in Children: Prognostic Factors and Treatment Results; A Single-Center Experience from Turkey</td>
</tr>
<tr>
<td>Hurwitz N.</td>
<td>41 A/P</td>
<td>Telepathology - Can it Overcome Limitations in Capacity?</td>
</tr>
<tr>
<td>Jin R.</td>
<td>42 P</td>
<td>Outcome for Childhood Acute Lymphoblastic Leukemia: a Report of 150 Patients Treated at Wuhan Union Hospital of China</td>
</tr>
<tr>
<td>Jin R.</td>
<td>42bis M</td>
<td>Proliferation of Leukemia Cells Induced by Ouabain and Research Related Signal Pathways</td>
</tr>
<tr>
<td>Kapoor G.</td>
<td>43 P</td>
<td>Treatment Outcome of Childhood Non Hodgkins Lymphoma in a Tertiary Care Cancer Center in Delhi</td>
</tr>
<tr>
<td>Karmakar MD.</td>
<td>44 A</td>
<td>Wheat Grass Juice in Supportive Care of Terminally Ill Cancer Patients - an Experience from West Bengal, India</td>
</tr>
<tr>
<td>Khan M.U.</td>
<td>45 A</td>
<td>Judicious Use of Recombinant TSH in Management of Differentiated Thyroid Carcioma in a Developing Country and Charity-Based Hospital Setting</td>
</tr>
<tr>
<td>Khayitov F.E.</td>
<td>46 P</td>
<td>The Rate of Dangerous Lymphoma Disease in Children During 2000-2007 in the Republic of Uzbekistan</td>
</tr>
<tr>
<td>Kirk P.</td>
<td>47 A/P</td>
<td>How should the INCTR/PAX Program Measure Success - A Review of Possible Palliative Indicators</td>
</tr>
<tr>
<td>Korir-Rugutt A.</td>
<td>48 P</td>
<td>Epidemiology of Childhood Cancers in Nairobi, Kenya</td>
</tr>
<tr>
<td>Koshi C.</td>
<td>49 A/P</td>
<td>Domicilliary PC Service - Unique Opportunity Window For Creating Cancer Awarness in Community and in Anti-Tobacco Campaign - A Preliminary Study</td>
</tr>
<tr>
<td>Koshi C.</td>
<td>49bis A/P</td>
<td>Making a Difference and Leading by Example Building Capacity to Manufacture Oral Morphine Preparations - The first in India by a Government Cancer Center</td>
</tr>
<tr>
<td>Laleli-Sahin E.</td>
<td>50 M</td>
<td>Effect of Proficient Use of Laboratory by Clinicians and it’s Impact on Cancer Economy</td>
</tr>
<tr>
<td>Love R.</td>
<td>51 A/P</td>
<td>The Nanaimo-Bhaktapur Hospice Palliative Care Twinning Project</td>
</tr>
<tr>
<td>Mansoor S.</td>
<td>53 M</td>
<td>Histopathological Characteristics and EGFR/HER2-NEU Genes Expression of Metaplastic Breast Carcinoma in Pakistan</td>
</tr>
</tbody>
</table>

* The INCTR does not take any responsibility for the content of the abstracts
# Table of Contents and publication order of the abstracts *

<table>
<thead>
<tr>
<th>Presenting Author</th>
<th>Abstract Number</th>
<th>Title of Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mansoor S.</td>
<td>53bis A/P</td>
<td>Bioethics Group as a Means of Introducing Bioethics Education in Pakistan</td>
</tr>
<tr>
<td>Mukhopadhyay S.</td>
<td>55 A</td>
<td>Cancer Control and Awareness Programmes in Rural Bengal of a Developing Country Using a Mobile Van</td>
</tr>
<tr>
<td>Mukherjee K.</td>
<td>56 A/P</td>
<td>Psychological Assessment of Cancer Patients - A Study of Tertiary Cancer Center in India</td>
</tr>
<tr>
<td>Mustafayev T.Q.</td>
<td>57 P</td>
<td>The Direct Results of Treatment of Non-Hodgkin's Lymphomas in Children in Primary Damage of Thoracoabdominal Lymphonodes</td>
</tr>
<tr>
<td>Nixon C.</td>
<td>58 A/P</td>
<td>Oncology Nurses Connect: An International Nursing Educational Collaboration</td>
</tr>
<tr>
<td>Nkégoum B.</td>
<td>59 P</td>
<td>Childhood Hodgkin Disease in Cameroon</td>
</tr>
<tr>
<td>Nkégoum B.</td>
<td>59bis M/Path.</td>
<td>Immunohistochemistry in Cancer Medicine: our Experience in Cameroon</td>
</tr>
<tr>
<td>Ntikim A.I.</td>
<td>60 A</td>
<td>The Need for Early Art for HIV Positive Patients with Cancer in Ibadan-Nigeria</td>
</tr>
<tr>
<td>Omach J.</td>
<td>61 A</td>
<td>Cancer Mortality in Nairobi Province, Kenya 2003-2005</td>
</tr>
<tr>
<td>Opoku Agyemang P.</td>
<td>62 A</td>
<td>Cancer Registration in Low-Resourced Settings: Practice and Recommendations</td>
</tr>
<tr>
<td>Opoku Agyemang P.</td>
<td>62bis A/P</td>
<td>Male Cancers Review at National Center for Radiotherapy and Nuclear Medicine</td>
</tr>
<tr>
<td>Oyekunle AA.</td>
<td>63 A/P</td>
<td>Introducing Stem Cell Transplantation Services in a Resource-Poor Setting</td>
</tr>
<tr>
<td>Pandey R.</td>
<td>64 A</td>
<td>Antiangiogenic Chemotherapy - Weekly Paclitaxel in Refractory Solid Tumors - Phase II Pilot Study From Eastern India</td>
</tr>
<tr>
<td>Polatova D.Sh.</td>
<td>65 A/P</td>
<td>Morphological and Immunohistochemical Aspects of Osteogenous Sarcoma</td>
</tr>
<tr>
<td>Rashid U.M.</td>
<td>66 M</td>
<td>No Association of Miscarriage and BRCA Carrier Status in Pakistan Breast/Ovarian Cancer Patients with a History of Parental Consanguinity</td>
</tr>
<tr>
<td>Ramzan A.</td>
<td>67 A</td>
<td>Evaluation of Hepatic Perfusion Disorders Using MDCT</td>
</tr>
<tr>
<td>Salawu L.</td>
<td>68 A</td>
<td>Survival Factors in CLL Patients in a Resource-Limited Setting</td>
</tr>
<tr>
<td>Saleem A.M.</td>
<td>69A</td>
<td>Laryngeal Carcinoma in Mosul</td>
</tr>
<tr>
<td>Savli H.</td>
<td>70 M</td>
<td>Gene Network and Canonical Pathway Analysis in Hematopoietic and Soft Tissue Originated Malignancies: A Microarray Experience of Medical Genetics Department of Kocaeli University in 2007-2008</td>
</tr>
<tr>
<td>Sazawal S.</td>
<td>71 M</td>
<td>Role of Jak2 Mutation in Patients with Splanchnic Vein Thrombosis: AIIMS Experience</td>
</tr>
<tr>
<td>Semichkovski L.</td>
<td>72 A</td>
<td>Intraoperative Prevention of Arm Edema in the Management of Patients with Early Breast Cancer</td>
</tr>
<tr>
<td>Shamvil Ashraf M.</td>
<td>73 P</td>
<td>Infection Related Deaths and Analysis of Risk Factors; Experience in a Single Pediatric Oncology Unit in Karachi, Pakistan</td>
</tr>
<tr>
<td>Stefan D.C.</td>
<td>75 P</td>
<td>Tuberculosis in Children with Cancer: Is Screening Necessary?</td>
</tr>
<tr>
<td>Sule S.</td>
<td>76 P</td>
<td>Risk Factors for Common Cancers and Lifestyle Choices in Nigeria: Knowledge, Attitudes and Practice Among Secondary School Students in Kaduna</td>
</tr>
<tr>
<td>Syme A.</td>
<td>77 A/P</td>
<td>The British Columbia Cancer Agency/INCTR Palliative Collaborative Group: An Innovative Partnership Between a Canadian Cancer Control Agency and the Indian Palliative Network</td>
</tr>
</tbody>
</table>

* The INCTR does not take any responsibility for the content of the abstracts
### Table of Contents and publication order of the abstracts *

<table>
<thead>
<tr>
<th>Presenting Author</th>
<th>Abstract Number</th>
<th>Title of Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tran C.K.</td>
<td>78</td>
<td>Overview of Childhood Cancers in Hochiminh City, Vietnam</td>
</tr>
<tr>
<td>Thavaraj V.</td>
<td>80</td>
<td>Plasma Levels of Retinol in Cases of Retinoblastoma and Age and Sex Matched Controls</td>
</tr>
<tr>
<td>Thavaraj V.</td>
<td>80bis</td>
<td>National Retinoblastoma (RB) Registry in India</td>
</tr>
<tr>
<td>Uysal K.</td>
<td>81</td>
<td>Retinoblastoma: Experience from a Single center in Turkey</td>
</tr>
<tr>
<td>Uysal K.</td>
<td>81bis</td>
<td>Treatment-Related Cardiotoxicity in Children and Adolescents with Cancer</td>
</tr>
<tr>
<td>Vaidya P.</td>
<td>82</td>
<td>Home Hospice Care in Developing Country</td>
</tr>
<tr>
<td>Vvedenskaya E.</td>
<td>83</td>
<td>Cancer Epidemiology and the Need for Palliative Care in a Russian Region</td>
</tr>
<tr>
<td>Xie X.</td>
<td>84</td>
<td>Study on the Relationship Between the Expression of the Gene Coding the Key Enzymes for Cytarabine Metabolism with the Outcome of Childhood Leukemia</td>
</tr>
<tr>
<td>Yalcin B.</td>
<td>85</td>
<td>Pontine Gliomas in Children: Experience of a Single Center</td>
</tr>
<tr>
<td>Zafad S.</td>
<td>86</td>
<td>B Cell Non Hodgkin's Lymphoma in Children and Adolescents Experience of a Single Unit</td>
</tr>
<tr>
<td>Zeba A.</td>
<td>87</td>
<td>Survival Outcomes of Locally Advanced Breast Cancer (LABC) Treated at Limited Resource Level as Defined by Breast Health Global Initiative (BHGI)</td>
</tr>
</tbody>
</table>

### CME Accreditation and Certificate of Attendance

Following accreditation approval by Accreditation Council of Oncology in Europe (ACOE), the program of the 8th INCTR Meeting was submitted to the European Union of Medical Specialists (UEMS) clearing house system, the EACCME, for European endorsement. The 8th INCTR meeting has been granted European endorsement by the UEMS and awarded 15 European Continuing Medical Education Credits (ECMEC).

EACCME endorsement has been provided with European accreditation status. This means that the ECMEC will be recognised within the different European States which have agreed to participate in this European system and by the American Medical Association (AMA).

Delegates are kindly requested to complete the general evaluation form before claiming their certificate of attendance.

The conference secretariat will not issue or mail certificate of attendance to participants after the conference.
ABSTRACTS
Abstracts 8, 54 and 74 were withdrawn by their authors.
CHOICE OF SURGICAL INTERVENTION VOLUME IN TUMORS OF PROXIMAL PART OF FEMORAL BONE

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AIM OF INVESTIGATION
To determine the volume of operative surgery in patients with tumors of proximal part of femoral bone.

MATERIALS AND METHODS
46 patients with tumors of the proximal femoral bone underwent different versions of surgical intervention. Men -31, women -15, mean age -31.9. 39 cases had a primary tumor, in 3 cases recurrent tumors, and in 4 cases metastatic tumors. 22 patients had pathologic fractures. Histologically, most cases had giant cell tumors: 27 of which 11 were malignant; in 6 cases Ewing’s sarcoma, in 5 cases chondrosarcoma, in 1 case osteosarcoma, in 3 case chondromyxoma, and 1 case metastasis of kidney carcinoma, upper jaw, mammary and thyroid glands. In 36 cases organ safe operations were performed, in 14 cases resection of proximal part of femoral bone with hip replacement, in 7 cases segmental resection of bone, intramedullary osteosynthesis with autoplasty, in 3 cases excochleation with cement plastic, in 4 marginal bone excision.

RESULTS
Patient observation was from 4 month - 7 years. 4 patients have developed recurrent tumors, 7 patients have developed remote metastases.

CONCLUSION
Choice of surgical intervention volume in tumors of the proximal part of femoral bone has depended on histological structure of tumor, volume and length of osteopathy, cortical bone condition, and extent on surrounding tissue (muscle, vascular column). Implementation of organ safe surgery has been shown to be beneficial after neoadjuvant chemical therapy, with tumor extent less ½ of femoral bone length, small soft tissue component, and no signs of germination in the vascular column. Femoral disarticulation has been found in large small soft tissue tumors involving the vascular column and infiltration of subcutaneous fat, skin. However, the spread of tumor in the proximal direction with germination on bone and pelvic cavity is an indication to perform interiliac abdominal exarticulation of the extremity.
ABSTRACT 2

SURGICAL OUTCOME OF ABDOMINOPERINEAL RESECTION FOR ANORECTAL CANCER IN A NIGERIAN TEACHING HOSPITAL

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BACKGROUND
Anorectal cancer is a lifestyle-related illness with an increasing incidence in all developing countries in the last decade. Early presentation offers alternative line of management such as near total resection of rectum and colorectal or coloanal anastomosis either through the use of stabling machine or after pull-through. APR offers a good oncologic clearance in local advanced lesion but is unacceptable to the majority of people, especially in the developing countries where colostomy is often viewed as a taboo by patients and relatives. This attitude is responsible for a high default rate among patients slated for APR, and therefore later presentation with very advanced tumour and wide spread metastasis. This study is aimed at examining surgical outcome of abdomino-perineal resection for anorectal cancer in a Nigerian tertiary institution.

MATERIALS AND METHODS
This monoinstitutional descriptive study analyzed abdominoperineal resection (APR) rate, sex, age, subsite involvement, the diagnostic process, follow-up, and outcome of patients with anorectal cancers. This study was conducted at Obafemi Awolowo University Teaching Hospital Complex Ile-Ife, Nigeria and managed between January 1989 and December 2007.

RESULTS
During the eighteen year period, thirty eight cases of abdomino-perineal resection were done. This accounts for 23.0% of all patients that had anorectal cancer. The age of the patients reviewed ranges from 12 years to 74 years, with the median age of 59 years. More than half of the patients were female (55.6%). The median durations of symptoms was 12 months. All the patients presented with bleeding per rectum, whereas about 70-80% of the patients presented with tenesmus, altered bowel habit, faecal incontinence and anal pain. About 80% of patients had advanced disease at presentation. Half of the tumours were circumferential, most of them were well to moderately adenocarcinoma and only 2 cases of squamous and adenosquamous tumour. Eighteen (50%) patients had at least one postoperative complication; one (2.8%) postoperative mortality was recorded. Four (11.1%) patients had recurrence occurred within the first year of surgery. Operative blood loss, degree of differentiation of the tumour and operative stage (p=0.004 - 0.011) were found to have significantly affected the outcome of treatment.

CONCLUSION
Despite the advanced disease of our patients, the outcome of management appeared comparable with results from other centers in other developing countries.
The concept of holistic medicine is well recognized. Supportive care, however, takes a different perspective in Asian countries where mass populations tend to opt for it mainly due to economic reasons and cost-effectiveness. How far these are evidence-based, is discussed. The options from complimentary alternative medicine are diverse covering mind-body co-relation and restoration through to pain management. The appeal in this field is to be considered, apparently the socio-economic traditions and rituals; from praying to yoga, acupuncture to traditional chinese medicine, distance healing to touch therapy or mesmerizing and hypnotherapy etc. Mass media-created awareness urges people to go for safer alternatives. We analyze whether they really work.

The following are different fields taken into account: acupuncture, homeopathy, zen-meditation, biofeedback, spiritual healing, traditional Chinese medicine, Reiki, aromatherapy, hypnotherapy, yoga, Ayurveda, Relaxation techniques and herbal preparations.

Our overall conclusion indicates that each of them has strong influence-based effectiveness in their respective social environment. It can be easily promoted by cost-effective supportive care centers as the experts in respective area would be more effectively serving the mass population.
PILOT STUDY ON THE INTEGRATION OF CERVICAL CANCER INTO THE HEALTH PROGRAM AT THE LOCAL GOVERNMENT LEVEL

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BACKGROUND
Cervical cancer is the most common gynaecological malignancy in Nigeria (60%). It constitutes 2.9% of total gynaecological admission. Pattern of presentation over the 10 years has not changed with over 99% presenting at advanced stages in our institution (OAUTHC Ile-Ife). Awareness of cervical cancer is very low in Nigeria; less than 5% of women have ever undergone Pap smear screening. Patients get the results of their Pap smear in 3-4 weeks. Over 70% of Nigeria’s population resides in the rural areas with poorly developed health facilities. The country is divided into 774 local government areas. (A local government is like a US county.)

OBJECTIVE
The aim of this study was to determine the feasibility of integrating cervical cancer screening into the health program at the local government level in Nigeria.

METHODS
The study was done in Akoko-North west local government of Ondo state. It has a population of about 200,000. This study was done in collaboration with a local NGO (Homemakers Foundation). Two health workers (nurses and community health workers) were recruited from each of the 10 administrative wards of the local government. They were trained on the techniques of cervical cancer screening using the Visual Inspection with Acetic Acid, client’s recruitment and treatment with cryotherapy.

RESULTS
1100 women have been screened so far cases. Mean age of the women is 39 (20-59 yrs) and the mean parity was (1-7) of the women were traders and 22% were house wives. The squamo-columnar junction was visible in 80%, partially in 13% and not all in 7%. The VIA was positive in 9% of the women. Cryotherapy was performed in 73 women. Side effects were minimal and consisted mainly of cramps during treatment and watery vaginal discharge. These side effects were accepted by the women once prior explanation was given. Acceptability of treatment was high as over 98% of women who were screened positive agreed to be treated.

CONCLUSION
Cervical cancer screening can be successfully incorporated into the health program of the local governments in Nigeria using middle nurses and community health workers.
Non-Hodgkin’s Lymphoma (NHL) is the second most common malignancy of childhood in Turkey. This retrospective study describes the clinical-demographic characteristics, and outcome of children with NHL diagnosed at the Ege University, at the western part of Turkey.

From January 1988 to December 2007, 68 children, aged 18 months to 17 years (median 9.3 years) diagnosed as NHL. The male/female ratio was 3:1. The most frequent histological subtype was Burkitt’s lymphoma (54%). Lymphoblastic lymphoma was in 32% and the Large-cell lymphoma in 12% of the patients. The majority of patients had been diagnosed with advanced disease (stage III or IV of Murphy’s Classification).

Most (82%) of the patients were treated on BFM protocols (NHL-BFM 85/90/95). Fourteen of the 68 patients were excluded from final analysis because of lost the follow up within early period of therapy or they were treated by another center. The results of treatment of the remaining 54 patients were analyzed. Four patients died of tumor lizis (1 patient), surgery (1 patient) or infection (2 patients) within the first month of therapy. The response rate was 90%. Relapse was observed in 10 patients in median 5 months. The 10-year overall survival (OS) and event-free survival (EFS) rates were 71.5 and 60%, respectively. 10 year OS analysed histology wise was 72% and 70%, for B-cell and T-cell lymphoma respectively. Secondary tumor developed in one patient, 39 months after the diagnosis. LDH levels at diagnosis had a significant association with the probability of survival (p< 0.05).

These results show that premature death is a problem. Survival rates were acceptable for this time period.
ABSTRACT 5 bis

THE TURKISH PEDIATRIC ONCOLOGY GROUP NEUROBLASTOMA 2003 (TPOG-NB-2003) :
TREATMENT RESULTS OF THE HIGH RISK GROUP

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PURPOSE
To standardize treatment for high risk neuroblastoma according to the TPOG-NBL-2003 treatment protocol.

METHODS
The INSS staging and COG risk stratification systems were used. Patients were randomized to the conventional chemotherapy (CCT) and HDCT+ABMT arms at diagnosis. In CCT group patients received 4 chemotherapy courses (vincristine, ifosfamide, dacarbazine, adriamycin/cisplatin, cyclophosphamide, etoposide), followed by delayed surgery and 6 months of maintenance chemotherapy. HDCT+ABMT protocol consisted of 3 chemotherapy courses (vincristine, ifosfamide, dacarbazine, adriamycin / cisplatin, cyclophosphamide, etoposide), surgery, and a conditioning regimen(carboplatin, etoposide, melphalan). Radiotherapy to the primary site was given in most patients. 13 cis RA was given for 6 months in both groups.

RESULTS
Of the 290 eligible patients registered to the TPOG-NBL-2003 treatment protocol from 22 centers, 166 (57%) patients were in HRG group. 98 cases received CCT and 68 had HDCT+ABMT. Most of the patients (n: 162) had advanced stage disease. MYCN analysis was performed in 58% of patients in HRG and of these, 43% had MYCN amplification. Overall response rate was 66% in CCT, 79% in HDCT+ABMT groups. Relapsed and refractory diseases were observed in 40% of patients in CCT, and 42% of patients in HDCT+ABMT groups. Therapy related deaths occurred in 12% of patients in CCT, and 15% in HDCT+ABMT groups. The median follow up time was 13 and 12 months (1week - 5 years) in CCT and HDCT+ABMT, respectively. Three and 5 years EFS rates were 25%, 21% in CCT and 35%, 15% in HDCT+ABMT groups; and 3 and 5 years OS rates were 48%, 31% in CCT and 39%, 34% in HDCT+ABMT groups, respectively.

CONCLUSION
Survival rates were acceptable. But treatment-related toxicity was high and late relapses influenced the long term outcome. There was no significant difference in survival rates between groups.
ABSTRACT 6

ATRA (ALL TRANSRETINOC ACID) DRUG IN TREATMENT OF APL (ACUTE PROMYLOCYTIC LEUKEMIA)

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BACKGROUND
Acute promylocytic leukemia APL is a subgroup of acute myeloid leukemia designated as M3 by French American British classification (FAB). The disease is characterized by coagulopathy, with the association of specific cytogenetic feature of (15-17) translocation. APL constitute less than 10% of all pediatric AML cases ATRA with its differential action appears to be the inducer of complete remission in APL at diagnosis and relapse. This drug may be associated with side effects like ATRA syndrome.

AIM
To compare the outcome of therapy with ATRA & chemotherapy vs Chemotherapy alone in APL.

PATIENTS AND METHODS
Twenty two (23.9%) children with acute promylocytic leukemia were reported during the period 2001-2006 in the central teaching hospital Baghdad; the records were reviewed regarding the use of ATRA versus chemotherapy in the treatment of APL.

RESULTS
M:F 5:6, the peak age was 10-11 year with median of 7.5 y, 80.2% were anemic at presentation & thrombocytopenic.WBC was 6 x10^3. AML in our study formed 23.9% of all AML. Survival rate for children treated with ATRA & chemotherapy: 87.5% achieved remission. All children had achieved remission while early death occur in one child (12.5%), compared to chemotherapy treatment: 13 deaths (92.8%). For survival rate after complete remission treated with ATRA or chemotherapy are 37.5% & 7.14% respectively. Although ATRA provide an important benefit to patient with APL there are significant side effects that may be associated with its use such as ATRA syndrome in 25%. The recommendation is to use ATRA during induction and maintenance therapy and in post-remission period.
BACKGROUND
The nutritional status of a child on cancer therapy influences both tolerance of and response to treatment especially acute lymphoblastic leukemia.

AIM
The aim of the study was to assess the nutritional status in children with acute lymphoblastic leukemia (ALL) initially at presentation and to determine the change in body weight and amount of skeletal muscle wasting after induction of remission chemotherapy.

PATIENTS AND METHODS
Thirty-five cases of newly diagnosed ALL & eighty healthy children (as the control group) underwent somatometric measurement at initial presentation and after completion of induction chemotherapy.

RESULTS
Malnutrition (weight for age <80%) was documented in 20 cases (57%), but cumulative incidence of malnutrition (weight for age <80%, height for age <95%, weight for height <90%, triceps skin fold thickness < 5th centile, mid arm circumference < 5th centile) was found in 28 cases (77.1%). Eight cases (26%) lost weight during induction range (0.5-3 kg); most of them had complications (infection and bleeding) during induction chemotherapy. Seventeen cases (48%) had muscle wasting during induction. All those children who had lose weight also had skeletal muscle wasting; subcutaneous fat were increased in 27 cases (90%). 5 cases died during induction of remission.

CONCLUSION
Malnutrition exists in a significant proportion of children with ALL, especially in children with a complicated induction phase; while an increase in subcutaneous fat occurs in most children is probably due to oral steroids.
ABSTRACT 7

PREVALENCE OF HEPATITIS IN PEDIATRIC MALIGNANCY AT CHILDREN WELFARE TEACHING HOSPITAL

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BACKGROUND
Contrary to the recommendation of WHO, many blood transfusion in developing countries are donated by coerced or remunerated donors rather than voluntary donors; transfusion-transmitted infections continue to be a threat to the safety of the blood supply; in particular the risk is high for parenteral transmission of viral hepatitis in pediatric malignancy.

PATIENTS AND METHODS
256 patients (aged 3 months-15 5/12 year) with cancer were studied prospectively over 9 month’s period (September 1st 2007 - June 30th 2008); to estimate the prevalence of hepatitis, identify some variables that could affect the prevalence of hepatitis, and effect of vaccination in controlling hepatitis infection.

RESULTS
All the patients had a negative hepatitis screen at the time of diagnosis. Two hundred and two (78.9%) of them received 3 doses of hepatitis B vaccine according to national Iraqi immunization schedule & 231 (90.2%) were revaccinated during admission to the Hemato-oncology unit at Children Welfare Teaching Hospital (CWTH). Hepatitis screen for HBV infection was positive in 70 cases (27.3%), while HCV was positive in 19 cases (7.8%). History of clinical jaundice was reported in 45 cases (17.6%). Multiple blood transfusions (>3 times) had a significant association with positive hepatitis screen, while the number of vaccines given in the hospital had a significant impact on reducing hepatitis infection.

CONCLUSION
The study proved that there is a high prevalence of HBV in patients with cancer treated in CWTH, while that of HCV infection is relatively low.

RECOMMENDATION
The study recommended a strict implementation of hepatitis B revaccination program for all newly diagnosed cases of childhood cancer in the hospital and using nucleic acid as well as serological testing for the donors by National Blood Transfusion Center in Baghdad.
BACKGROUND
Cancer is one of the leading causes of death in the world. There are reports that the number of cases of cancer is on the increase in many developing countries.

OBJECTIVE
The aim was to determine the cause of gynaecological deaths in a tertiary healthcare institution in Lagos, Nigeria.

PATIENTS AND METHODS
A structured questionnaire was used to obtain information on socio-demographic characteristics, presenting symptoms, diagnosis at presentation, and duration of stay and cause of death in patients who died in the gynaecological wards of the Lagos University Teaching Hospital between 1st January, 2002 and 31st December, 2007.

RESULTS
There were 2,220 admissions into the gynaecological wards and 104 deaths (4.68%) during the period. Data were available in 94 (90.4%) for analysis. The mean age at death was 48.5±15.6 years (range 16 to 90 years). The common symptoms at presentation were lower abdominal pain (66%), vaginal discharge (38.3%), post-coital bleeding (23.4%), abdominal swelling (22.3%) and postmenopausal bleeding (20.2%). Only 12 (12.8%) had surgery, 16.0% and 60.6% had radiotherapy and palliative care respectively. The causes of death were cervical cancer (44.7%), ovarian cancer (31.9%), endometrial cancer (6.4%), choriocarcinoma (4.3%), septic abortion (3.2%), ruptured ectopic pregnancy (2.1%) and anaemia from uterine fibroid (2.1%). Almost a quarter (24.8%) died within one week of admission.

CONCLUSION
Cancer is the most common cause of gynaecological deaths in a tertiary hospital in Lagos-Nigeria. Cancer must be recognized as a very serious public health problem in Nigeria and indeed in other parts of sub-Saharan Africa.
ABSTRACT 9 bis

SCREENING FOR CERVICAL CANCER IN A PRIMARY HEALTHCARE CLINIC IN A SUBURBAN AREA OF LAGOS-NIGERIA: THE CHALLENGES

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BACKGROUND
The incidence and mortality from cervical cancer in developing countries is very high. A single-visit approach to cervical cancer screening using visual inspection and cryotherapy for prevention of this disease is being extensively studied in many places.

OBJECTIVE
We determined the challenges of integrating cervical cancer screening using visual inspection into a primary health care setting in Lagos.

METHODS
St Kizito Primary Healthcare Clinic (AVSI-Catholic Archdioceses of Lagos) in a suburban area of Lagos, offers low-cost services to approximately 150 women and children per day. Health talks on cervical cancer, breast cancer and hypertension are given on each clinic day to mobilize women for cervical cancer screening. Blood pressure checks, breast examination and visual inspection of the cervix with acetic acid and Lugol’s iodine, and treatment of positive cases with cryotherapy are done for informed and consenting women.

RESULTS
From June 2006 to April 2007, 4000+ women had been educated about cervical cancer and 1008 women had been screened. The challenges encountered include poor knowledge of the disease; infertility being more of a priority than cancer prevention; more younger women (<35 years) than older women (40-65 years) taking up services; poor attitude to disease prevention; poor follow-up and financial constraint. We observed a decline in the number of women who came for screening when infertility was de-emphasized.

CONCLUSION
There is need for improved awareness and knowledge of cervical cancer and its prevention. Cervical cancer prevention should be made affordable. All this can be achieved if there is the political will.
BACKGROUND
The level of estrogen receptor (ER) expression in breast cancer has been shown to carry important prognostic information and also to predict the likelihood of a response to hormonal therapy. ER expression is measured in newly diagnosed breast cancer as a matter of clinical routine, most commonly by immunohistochemistry (IHC) of fixed tissue. The status of hormone receptors, more specifically ER and PR, was determined using two techniques: IHC and Reverse Transcriptase PCR (RT-PCR) in the frozen tissues. The IHC was performed on snap frozen breast tumor samples followed by the comparison with results of the formalin fixed paraffin embedded tissue sections. The results of RT-PCR are also co-related with the results of IHC on both frozen and paraffin sections to exclude the possibility that the results are artifacts of inappropriate fixation and retrieval of the tissue.

MATERIALS AND METHODS
Forty eight tissue samples were examined for the expression of ER and PR. The RT-PCR was performed by extracting the total RNA from unfixed, snap frozen tissues, equalizing their concentrations for cDNA synthesis by reverse transcription. A multiplex PCR was carried out to determine the relative expression of ER$\alpha$, ER$\beta$ and PR. The IHC was performed on snap frozen tissue sample and then the results were compared to the paraffin embedded tissue sections. The results of RT-PCR are also co-related with the results of IHC on both frozen and paraffin sections to exclude the possibility that the results are artifacts of inappropriate fixation and retrieval of the tissue.

RESULTS
Of the 48 samples screened, 22 (46%) were ER/PR negative, 2 were ER negative but PR positive, 2 were ER positive and PR negative, and 22 were ER/PR positive, using IHC. The mean age of patients with ER/PR negative tumors was 44.5 years, whereas the mean of women with ER/PR positive tumors was 49.5 years. Thirty percent of the ER/PR negative tumors were histological grade 2 whereas most were grade 3 (70%). In contrast, almost 72% of the ER/PR positive tumors were grade 2, and 28% were grade 3. All the samples appearing positive in IHC on frozen and paraffin-embedded sections were positive in RT-PCR, 82% of the samples that were ER negative using IHC had detectable levels of ER mRNA and all the PR protein negative tissues had detectable levels of PR mRNA.

CONCLUSION
The ER/PR negative status was not due to the IHC staining and antigen retrieval protocols as there was almost 100% concordance between staining results obtained using both snap frozen and paraffin embedded tissue. ER$\alpha$ mRNA was more frequently detected in ER$\alpha$ protein positive tissues than ER$\alpha$ protein negative tissues; however PR mRNA was detected in all PR protein negative tissues. The results indicate that the absence of receptor protein is not due to the lack of gene expression but more likely related to the absence of a functional protein. Further studies are underway in order to determine the pathways that result in the presence of a non-functional protein.
Aim And Objectives
To assess the linear growth pattern, growth velocity and study the prevalence and pattern of growth hormone (GH) deficiency in children with ALL following completion of treatment with MCP841 protocol.

Materials And Methods
This case series included 30 children with ALL who had completed treatment with the MCP-841 protocol at AIIMS and were in continuous first remission for at least 2 years. Anthropometric data were measured at every 6 months for 18 months. Hormonal analysis and bone-age assessment was performed at time of enrollment and end of study period.

Results
Mean age of these children was 9.7 years (Range 3.3-17.9), with male to female ratio of 4:1. A total of 53% (n=16) had growth retardation at enrollment and 33% (n=10) of children were growth retarded at the end of the study indicating catch-up growth. No children had skeletal disproportion and the overall height velocity was normal during this period; one child (3.3%) was obese; 46.7% (n=14) of children were growth hormone deficient (GH level < 7ng/ml), boys (54.5%) being more frequently deficient than girls (33.3%). When patients were stratified into GH deficient and normal groups, bone age was retarded in GH deficient children, while there was no difference in height, height velocity and weight between the 2 groups. Six of 27 (22.2%) children had low TSH level (<0.5mU/l) and 5/6 of these also had associated GH deficiency indicating hypopituitarism or hypothalamic insufficiency; 11.1% (n=3) had high TSH (>0.5mU/l) indicating primary thyroid failure.

Conclusion
This study emphasizes the need of long term follow-up of ALL children, post-therapy for growth faltering and other endocrinological problems and appropriate intervention.
ABSTRACT 12

STRIKING DIFFERENCES IN BREAST CANCER OCCURRENCE AND RISK FACTORS: A COMPARISON STUDY BETWEEN IRAN AND THE NETHERLANDS

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BACKGROUND
Breast cancer is an important health burden worldwide. Current incidence rate of breast cancer ranges from 10 per 100,000 in Asian countries to more than 150 per 100,000 in Western countries. In most Asian countries breast cancer is diagnosed at a younger age, one decade earlier than their counterparts in Western countries. Our main objective is a comparison of incidence together with age-specific shape and distribution of associated risk factors in different populations with different risk levels of breast cancer: Iran and the Netherlands.

METHODS
Data on tumour characteristic from Iran were collected from the medical records and in the Netherlands from the national cancer registry. The distribution of breast cancer risk factors from these populations were obtained from the national statistical centre.

RESULTS
Based on the findings of this study the mean age of patients with breast cancer in Iran is 15 years earlier than Dutch patients. The proportion of young patients (younger than 40 years) in Iran is 5-fold greater than the Netherlands. The majority of Persian women were diagnosed with a late stage tumour. There is no considerable difference in the frequencies of positive hormonal receptors, i.e., estrogens receptor, progesterone receptor, and Her-2 among Dutch and Persian patients regardless of age, tumour stage or grade.

CONCLUSION
Our findings present a simplistic view of disparities in predominant risk factors and incidence rates of breast cancer in Iran and the Netherlands. But interpretation of these results is difficult. Findings show that reproductive factors and obesity can be attributed to the early age onset of breast cancer in Iran.
BACKGROUND
Survivin is a new member of the Inhibitor of Apoptosis Protein family (IAP) that plays an important role in the regulation of both cell cycle and apoptosis. Its distinct expression in tumoral cells versus normal adult cells introduces Survivin as fourth expressed transcriptome in tumors. Breast cancer is the most common malignancy among women and scientists’ efforts to classify it lead to various molecular subtypes and controversial results. Because of the lack of suitable molecular markers for diagnosis and prognosis of breast carcinomas, the aim of this study was to evaluate the potential usefulness of Survivin and its splice variants as molecular markers in breast cancer.

PATIENTS AND METHODS
Thirty five tumoral and 17 non-tumoral adjacent tissues were obtained from a total of 35 women. Transcription levels were measured by Semiquantitative RT-PCR and normalized by ß2m as an endogenous PCR control. Statistical analyses were performed with SPSS software using One-Way ANOVA and Mann-Whitney U tests.

RESULTS
Our data showed that 1) Survivin and its splice variants are differentially expressed in tumors rather than adjacent normal tissues. 2) The expression levels of Survivin, Survivin-ΔEx3, 3B and 3α were significantly (p<0.05) correlated with tumors. 3) Survivin-2α was detected in all tumoral tissues and introduced as the dominant expressed variant in this lesion. 4) Survivin-2B was expressed in a few samples. 5) The highest expression levels of Survivin and Survivin-ΔEx3 were detected in benign and malignant tumors, respectively. 6) The expression of Survivin was correlated with the early stages of tumors as well as Survivin ΔEx3 with advanced stages of breast cancer. 7) We detected the new variant 3α in breast cancer for the first time with its differential expression in tumors rather than adjacent normal tissues.

CONCLUSION
In conclusion, these results demonstrate the differential expression of Survivin, Survivin ΔEx3, Survivin-3B and Survivin-3α in breast cancer and confirmed the differential role of variants in cell cycle and apoptosis. Therefore, evaluating Survivin gene expression and its splice variants might be used as markers to stratify breast cancer patients for more optimal treatment modalities as well as a promising new target for therapy.
BACKGROUND
In the mid-1990’s breast screening equipment available in Armenia was decades old and grossly inaccurate. Breast cancer was often detected in advanced stages when treatment was no longer effective and radical mastectomies were frequently performed for non-malignant cysts. This dire situation was exacerbated further by the lack of preventive healthcare, cultural barriers and distrust of medical institutions. The government supported healthcare system, severely impaired by the collapse of the Soviet Union, was not capable of addressing the breast cancer crisis in Armenia, which was identified by Armenia’s Minister of Health in 1996 as the “leading cause of cancer deaths among women in Armenia followed by cervical cancer.” In April 1997, in response to this endemic crisis, the American American Wellness Center (AAWC) was established by AACA (a U.S. NGO), to provide breast imaging and diagnosis. Also, a Gynecology Department for basic GYN services and a Pathology Lab for Histology and Cytopathology were established at AAWC in 2001.

MISSION
To save, prolong and improve the lives of women in Armenia and the entire region through early and accurate detection of their breast and cervical cancer with appropriate counseling and referrals for treatment; to educate the public in preventative health care and the importance of annual mammograms and clinical check-ups, monthly breast self-exams (BSE) and yearly Pap smears.

ACCOMPLISHMENTS
To date, 114,606 patients (including 244 men and over 500 women from neighboring countries) have been screened with a total of 154,536 services provided. The lives of over 3,100 women have been saved and prolonged through early detection. Each day, 50 to 80 patients seek screening services at the Center with the numbers increasing each year. In the past eleven years - 150 Medical Outreach Missions have been conducted to 65 remote towns and villages to provide free breast and cervical screenings and education to underserved populations. All 36 staff members, including 14 medical professionals, have received extensive training from U.S. medical and technical professionals through 47 Medical Exchanges and 10 Medical Missions both on-site in Armenia and at partner institutions like USC Medical Center in California, George Washington Medical University & Washington Hospital Center in Washington, D.C. and Greater Baltimore Medical Center/John’s Hopkins University in Baltimore, MD. Annual Health Walks are organized each October to promote awareness. AAWC serves as a teaching center in Breast Health for medical students from Yerevan State Medical University and provides six-month residencies to Radiologists and has organized 5 Medical Conferences with U.S. medical professionals. AAWC has won the trust of the public and the respect of the medical community in Armenia for its quality medical services - which is very rare in that part of the world.
DEVELOPMENT OF A BRACHYTHERAPY PROGRAM FOR THE TREATMENT OF RETINOBLASTOMA IN GUATEMALA

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BACKGROUND
Twinning, the partnering of institutions in developed and developing countries, has provided means for supervised transfer of medical skills and technology. Such collaborations have been successful in the treatment of childhood leukemia. We have modeled our efforts after those successes.

PURPOSE
To report development of a brachytherapy program for the treatment of Retinoblastoma in Guatemala, Central America

METHODS
Building upon a pre-existing mentorship, brachytherapy was added as a treatment at a Central American Retinoblastoma referral center in April 2005. Applicators, radioactive sources, and dosimetry were provided. The first five surgeries were supervised; subsequent procedures were performed after internet consultation.

RESULTS
As of December 2007, 10 eyes (9 patients), treated with chemotherapy and focal treatments, underwent brachytherapy. 6 eyes had received EBRT. 8 eyes were successfully treated.

CONCLUSION
Proper mentoring and supervision allows implementation of complex retinoblastoma management in developing countries.

PRECIS
Brachytherapy was successfully instituted at a Central American referral Center for the treatment of retinoblastoma using the principle of twinning between partnership institutions.
ABSTRACT 16

PATIENT AND DISEASE CHARACTERISTICS OF NON-SMALL CELL LUNG CANCER AMONGST MALES AT A CANCER HOSPITAL IN A DEVELOPING COUNTRY

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BACKGROUND
Lung cancer is a commonly diagnosed malignancy worldwide. At the Shaukat Khanum Memorial Cancer Hospital and Research Center (SKMCH & RC), lung cancer ranked 5th and accounted for nearly 4.4% of all malignancies in adults from Dec. 1994 - Dec. 2006.

PATIENTS AND METHODS
During a 12-year period (Dec. 1994 - Dec. 2006), 1,166 lung cancer cases were registered at the Hospital: non-small cell lung cancer (NSCLC): 811; small cell carcinoma: 241; and other types: 114. Of the 811 NSCLC patients, males who had visited the Hospital twice or more were included in the study (N=421). Distributions of age, weight, performance status, history of smoking, histology, clinical stage at presentation, surgery, and survival (months) were determined. Overall Survival Interval (OSI) was computed from the date of registration till death or last contact.

RESULTS
Average age of 421 males: 59.4 years (26-88; standard deviation (SD): 11.4); average weight (n=248): 64.2 kg. (39-105; SD: 12.9). ECOG performance status: 0 in 58 (13.8%), 1 in 120 (28.5%), 2 in 107 (25.4%), 3 in 82 (19.5%), 4 in 15 (3.6%), and not evaluable in 39 (9.3%). Smoking history-present: 302 (71.7%), absent: 87 (20.7%), and unknown: 32 (7.6%). Histology: adenocarcinoma: 151 (35.7%), squamous cell: 173 (40.9%) large cell: 18 (4.3%), unspecified types of NSCLC: 63 (14.9%) and, rare & carcinomas, not otherwise specified: 16 (4.3%). Clinical staging: I in 16 (3.8%), II in 20 (4.8%), III in 162 (38.5%), IV in 169 (40.1%), and unstageable in 54 (12.8%). Status-died: 58 (13.8%), alive: 47 (11.2%), and unknown: 316 (75.1%). Stage-wise, average OSI of 367 stageable cases was recorded as: I-(n=16): 21.7, II-(n=20): 13.1, III-(n=162): 9.2, and IV-(n=169): 5.4 months.

CONCLUSIONS
A history of smoking was recorded in nearly 72% of the patients and approximately 79% presented in an advanced stage (Stage III-IV). Survival corresponded with the disease stage. Information regarding tobacco smoking with its detrimental outcomes needs to be effectively communicated to both health professionals and the public so as to educate them and to enable significant reduction in incidence and/or prevention of lung cancer.
BACKGROUND AND OBJECTIVES
Reporting of cancer and follow-up issues are identified as areas in cancer registration where improvement is much needed in developing regions of the world. The purpose of this study is to get a preview of the magnitude of the problem by quantitatively analyzing a subset of the patients registered at the Shaukat Khanum Memorial Cancer Hospital and Research Center, Lahore, Pakistan.

PATIENTS AND METHODS
Four hundred and nineteen females presenting with breast malignancies in 2000 were identified. Age (5-year age-groups (20 onwards)), stage, histology, patient outcome, and family history of cancer were computed. For overall survival, intervals between the dates of presentation and last visit/death were calculated. File review ended in 2004; death was the outcome of interest. Survival was determined through the Kaplan-Meier method using the Statistical Package for Social Sciences (SPSS) version 10.

RESULTS
Average presenting age: 47.3 years (range 23-97). Commonest 5-year groups: 40-44/45-49 years (66/419 (15.8%) each) and 35-59 years (63/419 (15%)). Diagnosis stage: II 119/419 (28.4%), IV 106/419 (25.3%), III 95/419 (22.7%), I 24/419 (5.7%), and 0 2/419 (0.5%); unstageable 73/419 (17%). Histology: infiltrating ductal carcinoma (341/419 (81.4%)). Family history of cancer: 53/419 (13%). Patient status: dead 34/419 (8.1%), on follow-up 162/419 (38.7%), on palliative care 29/419 (6.9%), lost to follow-up 141/419 (33.7%), and with one or two visits only 53/419 (12.6%). Of the 34 deaths, 29 were confirmed at the hospital and information on 5 was obtained by telephone. Survival analysis included those who had died or were on follow-up (196/419 (47%)); 1-year survival: 90%, 4-year: 74%.

CONCLUSION
Follow-up issues seem to confound survival and bias the calculations. Efforts directed towards determining the incidence, mortality, and survival in the population can be fruitful once cancer cases and deaths are accurately reported by various facilities and the community at large.
ABSTRACT 17

PASSIVE SMOKING AND CANCER: PROSPECTIVE ANALYSIS FROM A HOSPITAL BASED CANCER REGISTRY OF EASTERN INDIA

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BACKGROUND
Tobacco smoking is the most intensively investigated environmental cause of cancer. Smokes came out of cigarettes, bidis, hookahs etc. contain nicotine, and other chemical compounds which are proved as dangerous carcinogens. Cancer causation by tobacco smoke is not attributable to any one chemical compounds but to an overall effect of the complex mixture of chemicals in smoke. Using tobacco active smokers can get affect their lungs and develop cancers in other organs such as larynx, oral cavity, pharynx, oesophagus, pancreas, kidney and bladder. Non-smokers who are exposed to environmental tobacco either by family members or in their workplace are also equally at risk of having lung, laryngeal cancers, other respiratory diseases and even breast cancer. It is seen that very high lung cancer rates occur in some regions of China and other Asian countries among non-smoking women who spend much of their time at home. This may be due to indoor pollution caused by tobacco smoke.

OBJECTIVE
This study aims to find out the incidence of cancer in passive smokers and to detect the awareness level of passive smoking in the society.

MATERIALS AND METHODS
This was a case-control study during period from September 2002 to December 2007 in Netaji Subhash Chandra Bose Cancer Research Institute, Kolkata. There were 4200 cases and 2100 controls that have been randomly interviewed following a structured questionnaire. Age group of whose is between 6-45 years. The cases have been collected among the in-patients & outpatients. The age and sex matched controls has been collected among the relatives of cases attended the hospital along with them.

RESULTS
Among 4200 cases of cancer of different organs 37% were nonsmoker and were exposed to constant passive smoking. Among the cases 26.71% were suffering from Lung cancer, 13.28% from Larynx, 12.44% from Breast, 16.12% from Uterus, 9.57% from ovarian cancer and 5.71% from oral cancers. The rest were suffering from Stomach, Gall Bladder, NHL and cancers of Spinal cord. The rate of Lung and Laryngeal cancer is much higher among passive smokers. On the other hand among 2100 controls 29.9% were active smokers and 70.1% were passive smokers. So among adult non-smokers constant exposure to environmental tobacco smoke (passive smoking) can be linked to lung cancer and cancers in other respiratory organs. Among children, few cases of lung cancer caused by passive smoking were noted.

CONCLUSION
In our study passive smoking related cancer was high. Doing this study it was seen that the general awareness level regarding passive smoking is very low among the population. The awareness level is much lower and the exposure is much higher among the population from lower socio-economic and lower education group. Demographic condition can also be related to lower awareness level.
BACKGROUND
Aggressive Non Hodgkin’s lymphoma (NHL), including primary central nervous system (CNS) lymphoma, lymphoblastic lymphoma and non-endemic Burkitt’s lymphoma have been recognized as AIDS defining cancers in most developed countries. However, HIV/AIDS epidemics appear not to have been associated with higher incidence of lymphomas in Africa. We therefore carry out this study to highlight the significance or otherwise of HIV/AIDS in a population of Nigerians with lymphomas.

PATIENTS AND METHODS
Since January 1993 to the present, all patients with haematologic cancers are routinely screened (following appropriate counseling) for HIV infection. Patients with a histological diagnosis of malignant chronic lymphoproliferative diseases (Non Hodgkin lymphoma (NHL), chronic lymphocytic leukaemia (CLL), Burkitt’s lymphoma (BL) and Hodgkin lymphoma (HL)) at the Obafemi Awolowo University Teaching Hospitals’ Complex, Ile-Ife from January 1993 to August 2008 were noted. Those patients confirmed to be HIV/AIDS positive among the cohort were retrospectively studied using their clinical case notes. Data obtained was analyzed using appropriate descriptive and inferential statistics.

RESULTS
A total of 391 patients were histologically confirmed to have lymphoma (NHL-109, (27.9%); CLL-76, (19.4%); BL-178, (45.5%) and HL-28, (7.2%)) during the study period. Nine patients (2.3%) were confirmed to be retroviral positive, all within the age bracket 24-60 (median = 50) years; 6 of these, 5 males and 1 female, ages 24-60 (median = 37.5) years, had NHL and another 3, all females ages 50 to 68 (median = 56) years had CLL. None of the patients with HL and BL were retroviral positive. Patients with NHL presented at advanced stage of the disease (at least clinical stage IIIb), and all those with CLL presented at stage C of the International Working Party Classification. All the patients with NHL succumbed to their disease within one to three weeks of admission into the hospital.

CONCLUSION
AIDS-related lymphomas occurs in 2.3% in this series, however it is surprising that no single case of AIDS-associated BL was seen, despite the fact that Burkitt’s lymphoma is endemic in this part of the world. There is also a strong need to follow-up AIDS patients on HAART, perhaps with longer survival and longer immunosuppression, more cases of AIDS-related lymphomas may emerge. All our patients presented at a very advanced stage of the disease with a significantly shortened survival.
ABSTRACT 19

EARLY DETECTION PROGRAMS IN COUNTRIES WITH LIMITED RESOURCES AN EXAMPLE FROM EGYPT (THE CAIRO BREAST SCREENING TRIAL)

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BACKGROUND
The Cairo Breast Screening Trial (CBST) was designed to evaluate the role of clinical breast examination (CBE) as a primary screening modality in the context of primary care coupled with the provision of adequate treatment for detected cases, in reducing both the morbidity and mortality from breast cancer.

MATERIALS AND METHODS
An initial pilot phase of the CBST involving 4116 women has been completed. In that phase a specialised medical centre in Cairo was selected as the headquarters of the study. An area around the centre was geographically defined. The target group was the approximately 5,000 women age 35-65 living in the selected area. Trained social workers conducted door to door visits to the houses in the blocks allocated to them, and invited women in the relevant age group to participate in the study. Those 4116 women who agreed to participate were administered an initial enrolment questionnaire, and invited to attend a primary health centre for CBE. Those found abnormal were referred to the hospital for investigation and treatment. In the second year, cluster randomization was performed and half the women were re-contacted, and invited to attend for screening. In the third year, those not contacted in the second year were visited at home and their health status determined. The study has been expanded within Cairo to two other areas and approximately 10,000 women age 40-64 are now under observation in these areas. Women are identified by social workers, and those in areas allocated to screening by cluster randomization (study group) are invited to attend a local primary health centre (PHC) for screening by CBE given by carefully trained female doctors and are taught BSE. Those found abnormal were referred to the hospital for investigation and treatment. In the second year, cluster randomization was performed and half the women were re-contacted, and invited to attend for screening. In the third year, those not contacted in the second year were visited at home and their health status determined. The study has been expanded within Cairo to two other areas and approximately 10,000 women age 40-64 are now under observation in these areas. Women are identified by social workers, and those in areas allocated to screening by cluster randomization (study group) are invited to attend a local primary health centre (PHC) for screening by CBE given by carefully trained female doctors and are taught BSE. Those found to have a suspicious breast abnormality are requested to attend the hospital for diagnosis, and those suspected to have breast cancer are biopsied and treated free of charge if the diagnosis is confirmed. The social workers also visited the women included in the control group & filled a questionnaire designated to determine whether or not they have had any breast problem administered. If so, they were asked if they had any documentation for that. Two screening rounds have been completed in area 2 and one in area 3.

RESULTS
The pilot study confirmed that breast screening, using CBE by female doctors detects a high rate of breast cancer; about 8 per 1000 at the first examination and 2 per 1000 among those who attended for re-screening. This suggests that a mortality benefit might be observed if a study with sufficient power proves feasible. In area 2 the initial detection rate was 6/1000 (3/1000) on re-screening) and in area 3 the initial rate was 5/1000, with a strong indication of a shift to earlier stage at diagnosis. It is apparent that a substantial segment of women in the community are resistant to attempts to involve them in screening programs. These women appear to comprise a high risk sub-group, with a prevalence of breast cancer at least as high as those who attend, on whom special surveillance and general public education efforts are justified.

CONCLUSION
Encouraging is the fact that 65% of the screen-detected cancers are stage II or less, whereas experience in the National Cancer Institute - Cairo suggests that only 20% are normally diagnosed in an early stage, while in the consolidated control groups in the trial the proportion is 26%.
ABSTRACT 20

NEOADJUVANT CHEMOTHERAPY (NACT) FOLLOWED BY SURGICAL CYTOREDUCTION IN ADVANCED OVARIAN CANCER (AOC)

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BACKGROUND
Advanced ovarian cancer (AOC) is treated by primary cytoreductive surgery followed by post-operative chemotherapy. However, suboptimal debulking leading to significant morbidity is a frequently occurring incidence in these patients. Paclitaxel and platinum, especially carboplatin, have provided very good results and as a result, neoadjuvant chemotherapy (NACT) has shown to be a good alternative.

OBJECTIVE
To see whether NACT (Paclitaxel and carboplatin) is helpful in treating AOC cases in terms of survival and quality of life. Our experience of treatment modality with NACT for AOC in a Non-Randomized, Open Label, Uncontrolled, Single Group Assigned, Safety/Efficacy Study is reported here.

METHODS
From 1/03 to 12/06 forty AOC patients (pts) considered not amenable for optimal cytoreductive surgery were treated with 3-6 courses of NACT (Paclitaxel and carboplatin). Patients were evaluated by a multidisciplinary clinical team. Laparoscopy with biopsy/FNAC/ laparoscopy with biopsy and CT scan were used to establish diagnosis and to evaluate probability of optimal debulking. Patients responding after with 3-6 courses of NACT underwent surgery followed by chemotherapy.

RESULTS
We included 40 patients. Median age: 58 (45-75). FIGO stage: III 27 pts (67.5%), IV 13 patients (32.5%). Histologic diagnosis: laparoscopy with biopsy, 5 pts (12.5%); ascites cytology, 25 pts (62.5%); laparotomy with biopsy, 10 pts (25%). Histological diagnosis: serous cystadenocarcinoma, 18 pts (45%); mucinous cystadenocarcinoma, 11 pts (27.5%); undifferentiated, 10 pts (25%); endometrioid, 1 pt (2.5%). All pts received platinum-based NACT (median number of cycles before surgery: 3; range 3-6). Surgery included total abdominal hysterectomy bilateral salpingo-ophorectomy with omentectomy and removal of obvious supra centimeter secondaries and was performed in 38 pts (97.5%). Ten pts experienced cCR (25%), 26 pts cPR (65%) and 2 pts SD (5%) after NACT. Two pts (2.5%) weren’t operated: 1 SD after NACT, 1 poor medical condition. Optimal cytoreduction (less than 1 cm) was achieved in 35/38 pts (92%). 2/38 pts (20%) presented postoperative complications. Median postoperative hospital stay was 10 days (5-21). The median follow up was 26.6 months. 3-year disease-free and overall survivals were 14 (35%) and 16 (40%) respectively. The median disease free interval was 23.4 months. Quality of life was judged according to Karnofsky performance index and was shown to be satisfactory in treated cases.

CONCLUSION
NACT for poor prognosis AOC pts achieves a remarkable optimal cytoreduction rate (90%) with acceptable morbidity. Overall survival seems not compromised and more importantly quality of life was satisfactory. NACT may be an acceptable alternative in certain AOC patients. Randomized studies underway will define the precise role of NACT.
ABSTRACT 21

RETINOBLASTOMA IN LESS DEVELOPED COUNTRIES. A SYSTEMATIC REVIEW

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INTRODUCTION
Little information is available about retinoblastoma in less developed countries (LDC). It is speculated that patients present with advanced disease which may be associated to socioeconomic factors in LDC.

METHODS
A systematic review of the publications dealing with clinical features and outcome from LDC from 1998 to 2007 was performed, retrieving articles through multiple databases in 6 languages. Data from "grey literature" were retrieved through Google scholar, local journals, books, protocols, abstracts, thesis and monographs. Data were systematically collected by a multinational, multilingual team that reviewed all the publications. A data base in English was constructed with the retrieved data. Results were correlated with socioeconomic indicators.

RESULTS
A meta-analysis of the 162 publications, including 12,371 patients from 45 LDC was performed. 58% of the papers were in other languages than English. Leukocoria is the most common presenting sign worldwide, but buphthalmia is the second presenting sign in countries with lower Human Development Index (HDI). There, survival is < 50% because of late diagnosis and treatment withdrawal which was > 25% in some LDC. Metastatic disease occurs in up to 30% in that setting. In higher intermediate countries, survival is > 80% and chemoreduction programs were implemented. Metastatic disease occurs in <5%. Factors associated with survival and metastasis at diagnosis on multivariate analysis were maternal mortality rate and HDI (p<0.0001). However, for treatment refusal, government health expenditure and infant mortality rate were also significant.

CONCLUSION
Much of the information from LDC is not available in English. Indicators of socioeconomic development and maternal and infant health were better predictors of outcome than the government health expenditure which was correlated with treatment refusal. It is urgent to develop strategies for early diagnosis and avoidance of treatment refusal in LDC for this curable neoplasm.
ABSTRACT 22

EDUCATION & TRAINING IN CANCER RESEARCH METHODS FOR PROFESSIONALS IN DEVELOPING COUNTRIES

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BACKGROUND
For more than ten years, researchers in cancer centers in Egypt and Tunisia have collaborated in epidemiologic research on IBC with researchers of the National Cancer Institute USA and universities. These studies have helped to create a stronger local research infrastructure in these cancer centers and developed the faculty’s interest and skills in cancer research.

METHODS
Through our collaborations with these researchers, we now realize that there is a clear need for improved cancer education so that medical professionals at all levels will benefit from more advanced training in research methods. These methods are not limited to epidemiologic research, but extend to treatment and translational research methods, health services research and evidence-based clinical outcomes research. Furthermore, although physicians at many cancer centers are well-trained for treating the patients they see, there is a lack of training of community-based doctors in early diagnosis, and patients in developing countries are typically diagnosed very late in their cancer development. Advanced training in research methods, including biostatistics, proposal development, writing and budgeting, skills at obtaining funding for research, and mentoring younger professionals are needed.

RESULTS AND CONCLUSION
To remedy this educational need, I suggest that a short course workshop be developed for professionals in developing countries that will focus on understanding of basic methods in cancer research. The workshop should be held in the host countries or region, to minimize travel expense and time away from practice. It would facilitate exchange of knowledge and information about cancer in developing countries, and will encourage the development of joint research proposals. This workshop would establish a foundation for future joint research studies between clinical oncologists and cancer researchers. A follow-up workshop at 6 or 12 months would provide hands-on mentoring for professionals who have developed their own research proposals that they plan to implement in their local cancer centers. Continuing mentoring over several years could be provided on a one-on-one basis as the projects develop, and much of this could be done by e-mail, webinars and e-learning.
ABSTRACT 23
CERVICAL CANCER AWARENESS AND SCREENING PROGRAMME IN RURAL BENGAL

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BACKGROUND
West Bengal is situated in the Eastern part of India and is under developed in medical facilities. Total population of Bengal is 6 crores (60 million). A total of 70,000 new cancer patients are detected every year whereas the total number of cancer patients is about 5 lacs (500,000). Cervical cancer is the commonest cancer in females in rural Bengal. About 80% of cases remain undetected. Even after detection only 20% of patients go for proper treatment.

OBJECTIVES
The aim of our study is to detect the incidence of Cervical Cancer, and their causative factors. We also intend to raise awareness about the early signs of Cervical Cancers so that it can be detected earlier and possible to cure.

MATERIALS AND METHODS
Once in every month in the year we organize a separate Cervical Cancer screening program along with our whole cancer awareness and screening program run by Netaji Subhas Chandra Bose Cancer Research Institute, Kolkata, India (Jan 2002 to Dec 2007). There is a team of 2 Gynaecologic Oncologists and 3 oncology Nurses who maintain the Cervical Cancer screening program. During the entire period we screened 42 thousand females and Pap smear was done for each doubtful case. Proper awareness about the signs of Cervical Cancer (foul Vaginal Discharge and pv bleeding) were given to them.

RESULTS
Total 1200 patients (2.86%) were positive for Pap smear out of all our screened patients. Cervical cancer scored 21.7% of all female cancers. About 53.8% had clinical symptoms during screening. Majority of the patients are asymptomatic during screening.

CONCLUSION
The Cervical Cancer screening program was very useful. The majority of the patients were asymptomatic and detected in early stage and cure was possible by appropriate treatment.
Background
Adjuvant therapy of patients with risk factors on pathological examination in unilateral retinoblastoma remains controversial. We report the results of a prospective study on 106 patients (2002-2007).

Methods
Patients (n=16) deemed to be candidates for eye salvage therapy were offered chemoreduction with Carboplatin and Vincristine and focal therapy. Those without possibilities for eye preservation therapy were enucleated at diagnosis (n=89). Adjuvant therapy was tailored to the occurrence of pathology risk factors. Patients with intraretinal (n=8), prelaminar optic nerve (n=5), choroidal (any degree) (n=37) and those with less than 20% of post-laminar optic nerve invasion (PLONI) without concomitant full choroidal or scleral invasion risk factors (n=11) did not receive any adjuvant therapy. Those with PLONI and additional risk factors (massive choroidal, scleral or deeper invasion (n=21) and all patients with invasion to the resection margin (n=5) or isolated scleral invasion (n=2) received adjuvant therapy with 4 cycles of Carboplatin 500 mg/m2/ days 1 and 2 together with Etoposide 100 mg/m2 days 1-3; alternating 4 cycles of Cyclophosphamide 65 mg/ kg, Idarubicin 10 mg/m2 and Vincristine 1.5 mg/m2. Patients with invasion to the resection margin of the optic nerve also received orbital radiotherapy (45 Gy). There was only one patient with metastatic disease in the CNS and received palliative care.

Results
With a mean follow-up of 31 months, the 5-year pEFS is: 0.94. There were 5 events. CNS relapse (n=3) and all died of disease. Systemic relapse (n=2) and 1 of them survived after high dose chemotherapy and stem cell rescue. Pathology risk factors of relapsing patients included: PLONI n=2, isolated focal choroidal invasion n=1, tumor at the resection margin of the optic nerve n=1, CNS metastasis n=1. Of the 16 patients in whom a preservation attempt was carried out, 7 eyes were preserved.

Conclusion
The survival of patients with unilateral retinoblastoma in our setting is excellent. After tailoring therapy to risk factors, 60% were spared from adjuvant treatment. For patients with very high risk features, our intensive regimen was highly efficacious.
ABSTRACT 25

OUTCOME OF ALLOGENEIC STEM CELL TRANSPLANTATION FOR 26 CHILDREN WITH MYELOID LEUKEMIA IN SINGLE CENTER

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BACKGROUND & OBJECTIVE
To clarify the role of hematopoietic stem cell transplantation in patients with myeloid leukemia.

METHODS
26 consecutive patients with AML and CML in a single institution between May 2001 - Sep. 2006 were included. Among them, 8 were chronic myeloid leukemia (CP=5, AP=2, BP=1) and 18 were AML (CR1=9, CR2=7, Non CR=2). The average age was 9.4 years old (range 2 – 17 years) and the average body weight 32.8 kg (range 11.5 – 79kg). Patients underwent allogeneic peripheral blood stem cell transplantation from HLA-identical siblings (n=2), mismatched family donors (n=4), and matched unrelated donors(n=20). All received myeloablative regimens with 16~20mg/kg busulfan and 200mg/kg cyclophosphamide. Cyclosporine (CSA) and methotrexate were used for aGVHD prophylaxis in patients with HLA-identical sibling donors. ATG 15mg/kg (Fresenius) was added for patients with matched unrelated transplant.

RESULTS
After an average follow-up of 20.5 months (9 – 55 months), 2 (7.6%) patients rejected grafts, 7 (27%) patients developed grade 3~4 aGVHD (all with CML), 5 patients having extensive cGVHD. At present, 9 patients have died of relapse (4/26) and TRM (GVHD 4/26 and infection 1/26) while 17 (65%) patients are still alive with disease-free survival.

CONCLUSION
Allogeneic stem cell transplantation is of benefit for the children with acute myeloid leukemia. GVHD associated with unrelated donor transplants can be controlled after take active prevention measures. As to whether the GVHD was more severe in children with CML than that of children with AML, more patients and collaboration with more institutions is needed to confirm such a conclusion.
INTRODUCTION
We investigated all index cancers with second malignancies, the commonest second malignancies and the interval of occurrence for 167 out of 17,337 new cases from 1985 to 2004.

METHOD
All histopathology slides were reviewed to confirm that the second malignancy was not metastatic disease from previous primary tumour. Basic demographic data, site of first index cancer, site and time of presentation of second malignancy were collected and analysed.

RESULTS
Colorectal cancer was the commonest index cancer to develop a second malignancy (34%, n=56). It was also the commonest second malignancy (83/167). For index breast cancer, 60% (29/48) of the second malignancy occurred in the opposite breast. A majority of second malignancies developed in less than 5 years for all index cancers. Nasopharyngeal cancer is the one exception where a second malignancy developed within 9 years from initial diagnosis. The overall risk of developing second malignancies for all index cancers is about 1% (n=167).

CONCLUSION
In Sarawak, with colorectal cancer as the commonest second malignancy, it is recommended that occult blood screening for colorectal cancer be carried out for all cancer patients on follow-up in order to detect it early. In addition, for breast cancers patients, yearly mammogram is recommended.
INTRODUCTION
This survey aims to explore the use of complementary and alternative therapy (CAM) amongst cancer patients who had treatment in the department of radiotherapy and oncology, their use prior to being diagnosed with cancer, during and after the cancer treatment and to know the most common form used.

METHODS
Three hundred patients of various ethnicity that attended the department’s clinic from March to July 2000, were recruited. After consent was taken, a questionnaire survey was carried out. Data was analyzed using SPSS. There were 116 males and 184 females who completed the questionnaires.

RESULTS
Prior to the diagnosis of cancer, 48% (n=143) of the respondents would use CAM. More females (62%) would use CAM compared to males. The most common CAM used was Chinese herbal medicine (n=64, 45%) with 42% using massage. Seventy percent of the CAM users were highly educated. Eighty percent of the respondents would see a physician for minor, major and chronic illness. Once diagnosed with cancer, 94% would seek treatment from a physician. Twenty-two percent used CAM during treatment and 20% after treatment. Four percent used CAM for cure and 23% used it as health supplement.

CONCLUSION
This is the first survey exploring the CAM use in Sarawak. Females, those with tertiary education and Chinese were more likely to use CAM. The results reveal that majority of patients would use CAM as complementary rather than as alternative treatment for cancer.
BACKGROUND
Cancer causation by tobacco smoke is not attributed to any one chemical compound but to an overall effect of
the complex mixture of chemicals in smoke. Non smokers who are exposed to environmental tobacco either
by family members or workplace are also equally at the risk of having lung cancer. It is seen that very high lung
cancer rates occur in some regions of China and other Asian countries among non smoking women who spend
much of their time at home. This may be due to indoor pollution caused by tobacco smoke. Even in paediatric
patients lung cancer is becoming a common phenomenon probably because of passive smoking.

OBJECTIVE
This study aims to find out the incidence of lung cancer in a paediatric age group in passive smokers.

MATERIALS AND METHODS
This is a case-control study during period from September 2004 to July 2007 in Netaji Subhash Chandra Bose
Cancer Research Institute, Kolkata. There were 12 cases of paediatric lung cancer and 12 controls that have
been randomly interviewed following a structural questionnaire. Age group is between 12-18 years. The cases
have been collected from inpatients and outpatients department. The age and sex matched controls were col-
lected from the relatives, attending the hospital along with the patients.

RESULTS
Among 12 cases of the lung cancer, 9 were non smokers and were exposed to constant passive smoking.
Among the control group 1 were smoker and other non smoker. In others there was no history of passive
smoking. Histologically all cases were squamous cell carcinoma (smoking related carcinoma) and all patients
belong to low and middle socio-economic group. The awareness level is much lower and the exposure is much
higher among the population from the lower socio-economic group.

CONCLUSION
In our study passive smoking related lung cancer in paediatric group was high.
OBJECTIVES
Ibandronic acid is a third generation bisphosphonate which acts by inhibition of osteoclasts. Zoledronic acid also has a similar mechanism of action. This study was designed to study superiority or inferiority of either agent over other in terms of efficacy in reducing bone pain and complications in patients with bone metastases.

METHODS
From April 2005 to March 2008, 190 patients of various malignancies with bone metastasis were enrolled and were randomized to receive monthly IV infusions of Ibandronate or Zoledronate and were analysed for pain relief, skeletal related events and adverse events.

RESULTS
Patients in both the arms were well matched for their diagnosis, stage of disease, burden of skeletal disease and performance status. Different diagnoses were, carcinoma breast (n=84), carcinoma prostate (n=46), myeloma (n=38), carcinoma lung (n=18), others (n=4). Median follow up was 15 months. At 15 months, mean increases in British Pain Inventory pain scores were lower with zoledronate compared to ibandronate (0.43 vs 0.88 [p=0.02]). Analgesic use as defined by 4 point analgesic scale was less with zoledronate as compared to ibandronate. Incidence of skeletal related events was not significantly different between two arms (33% for zoledronate vs 39% for ibandronate [p=0.2]). Median time to first skeletal related event was not reached in either arm. At 15 months of median follow up, percentage of patients with skeletal related events were 38% in zoledronate arm vs 42% in ibandronate arm (p=0.06). Zoledronate caused fever in 20 (9.5%) patients. Ibandronate caused hypocalcemia in 3 patients. No cases of osteonecrosis of jaw were observed.

CONCLUSION
Zoledronate is the preferred bisphosphonate in developing countries for its shorter infusion time and availability of cheap generic brands. This study also indicates that it may be slightly better than ibandronate in reducing bone pain and preventing skeletal related events.
BACKGROUND
Having studied the feasibility and efficacy of “Occidental” protocols, adapted to african conditions, in the Burkitt’s lymphoma treatment in African children, we present the results of management experience of our various protocols and two FAGOP LB protocols: GFA LMB 2001 and GFA CycloBurkitt 2005 initiated in children in Yaounde.

MATERIALS AND METHODS
In Chantal Biya Foundation in Yaoundé-Cameroon, previously untreated patients <18 years old with cytologicaly or histologicaly proven Burkitt’s lymphoma, were enrolled in the study in 3 periods: between April 1998 - April 2000 with various protocols consisted in COMP protocol (cyclophaphamide, oncovin, prednisone, metotrhexate), COPAD protocol(cyclophaphamide, oncovin,prednisone, adriamycine) and cyclophosphamide alone; between March 2001 - March 2004 with GFA LB 2001 protocol initiated in SIOP (cyclophosphamide, oncovin, prednisone, aracytine, metotrhexate) and between April 2005 – April 2008, and GFACycloBurkitt 2005 described by Hesseling (cyclophosphamide, metotrhexate IT) but modified by rescue protocol (LMB 2001) if no complete remision was obtained with three cyclophosphamide courses.

RESULTS
Clinical patients characteristics were following: sex-ratio M/F: 3/1; median age: 6 years; malnourished: 70%; mandibular and facial presentation observed in 70%; according to Murphy’s classification, 18% presented with stage 1, 8% with stage 2, 47% with stage 3, 27% with stage 4. Treated by chemotherapy, with 30 various protocols, the following results were obtained: 43% died, 15% were lost to follow up, 20% partial remission, 22% definitively healed, and 5% of recurrence. With 80 LB 2001 protocol: 16% died, 14% partial remission, 10% lost to follow up, 60% complete remission, 10% recurrence; With 70 GFA cycloburkitt protocol 15% died, 10% lost to follow up, 20% partial remission (often stage 3), 55% complete remission and 20% of recurrence (often stage 3). Socio cultural and economic difficulties were encountered. Toxicity of anemia and infection were frequent.

CONCLUSION
These results show that various protocols are not adapted, the FAGOP LB 2001 protocol is feasible and efficient in developing countries, GFA CycloBurkitt is possible and efficient in stage 1 and 2 like in Hesseling study, but results in frequent early relapses in stage 3.
# BACKGROUND
Sublingual Morphine (Novamorf) has now proved to be safe and effective in control of severe chronic cancer pain.

# MATERIALS AND METHODS
40 patients with variety of cancer types were taken in our study. In all of them Morphine was administered as sublingual tablets in doses from 20 miligrams to 120 miligrams daily (mean daily dose of Morphine was 83 miligrams) in the study period of four weeks. Pain scores (Visual Analogue Scale: VAS), degrees of satisfactory, safety and side effects (constipation, nausea) were assessed.

# RESULTS
In all patients’ pain control (by VAS) and sleep quality was improved, none developed respiratory depression-high range of safety. Regarding side effects: seven patients reported constipation and six patients nausea. Two of them stopped the treatment because of strong nausea and switched to another method of Morphine administration.

# CONCLUSION
Flexibility, high pain relief, improving quality of life, minor side effects safety and an easy way of administration offer advantages for oral Morphine in treatment of chronic cancer pain.

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BACKGROUND
Although the incidence of primary gastric carcinoma is decreasing, the majority of patients in Uzbekistan are still diagnosed with advanced tumor stages. In many cases surgical therapy can be performed only by multivisceral resections. The aim of this study was to evaluate the effectiveness of combined resection of the involved organs with regard to survival in patients with gastric cancer.

PATIENTS AND METHODS
There were retrospectively analyzed three groups of patients with locally advanced (T4N2M0) gastric cancer between April 1990 and April 2005. I-group included 66 patients, whom were performed several courses of system chemotherapy alone in the period from 1990 to 1995. II-group included 72 patients, whom were performed noncurative combined gastrectomy with lymphadenectomy < D2, between 1995 and 2000. In the III-group there were performed extended combined gastrectomy (lymphadenectomy > D2) to 84 patients, in the period from 2000 to 2005. A retrospective analysis shows that, operative and pathologic findings and clinical course in these groups were identical.

RESULTS
Radical (R0) resections were possible in 72.6% (n = 61), R1 in 27.4% (n=23) cases of the 3rd group. In the 2nd group R0 in 1.4% (n=1), R1 in 32% (n=23) and R2 in 66.6% (n=48). Kaplan-Meier survival analysis showed significantly better survival in those with curative extended combined gastrectomy. Mortality and morbidity rates associated with palliative resection were 8.7% and 33.3%, respectively, which did not differ statistically from the 7.4% and 35.3% in patients who underwent curative gastrectomy. Overall the median survival in the 1st group was 7.6 months. In the 2nd group median survival was 11.0 months and 3 year survival was 16.2%. In the 3rd group following R0 resection median survival were 17 months, 3-year survival 37.5% and 5-year survival 18.7%. Conclusion: Patients with locally advanced (T4N2M0) gastric carcinoma, even with lymph node metastasis, might have benefited from aggressive surgery with curative intent. Curative (R0) resection improves prognosis and even long-term survival can be achieved in selected individual cases. Palliative resections can be performed for local complications like bleeding or obstruction refractory to other therapies.
BACKGROUND
To study the role of Helicobacter pylori (H. pylori) in the occurrence of gastric cancer in the domestic population of Uzbekistan.

MATERIALS AND METHODS
We studied endoscopic data of 960 patients with gastric cancer in the Uzbek population with biopsies from 6 points of the pyloric canal. The age of the patients ranged from 13 to 76 years old. Men 686 (71.5%), women 224 (28.5%). Localization of the tumor in the proximal part of the stomach with the germination to esophagus was established in 412 (43.8%) patients; tumor of body and proximal part of stomach established in 331 (34.5%) patients; tumor of body in 101 (10.5%) and antral tumor in 116 (12.1%) patients. As a whole, proximal tumors were established in 78.3% and antral tumor in 12.1% cases. Histological differentiated adenocarcinoma – 256 (26.7%), low differentiated adenocarcinoma – 528 (55.0%), plain cell carcinoma – 46 (4.8%), and glandular plain cell carcinoma in 130 (13.5%) cases. As a whole intestinal type were in 81.7% and diffuse type were in 18.3% cases. H. pylori was studied morphologically and bacteriologically.

RESULTS
Our study showed that H. pylori. Bacteria was detected in 770 out of 960 patients: incidence rate – 80.2%. In 770 patients, that were diagnosed H. pylori, we identified acute antral gastritis in 225 (29.2%) patients, low expressed gastritis in 502 (41.9%) patients, ulcerative diseases of duodenum in 52 (5.4%) patients, expressed gastroduodenitis in 112 (11.7%) patients and without change in 69 (7.2%) patients. Out of 116 operated patients with antral gastric cancer H. pylori was detected in 72 (62.1%) cases and not revealed in 44 (37.9%) patients. Although in many studies H. pylori was reported as a number one carcinogen in the occurrence of gastric cancer, in our studies incidence of H. pylori in Uzbek population made 80.2%, incidence of antral cancer made 12.1%.

CONCLUSION
We think that, given question requires deeper study with provision for the domestic habits and psychologies of the Uzbek population.
BACKGROUND
The main reason for abandoning treatment, according to parents, was the lack of money for transportation to our Instituto Oncológico de Santa Cruz, Bolivia. UICC through its project “MY CHILD MATTERS” provided the necessary funds for transportation and the local Health Department collaborated with its Health Nets in the follow up and control of all children.

PATIENTS AND METHODS
From May 2007 to May 2008, 121 children from 0 to 16 years old, who were being treated on different cancer pathologies, received a bonus of US$20 - per month. Of these 121, 96 children are from Santa Cruz Department (78.5%) and 25 (21.5%) are from different places in Bolivia. The Medical Centers of the local Health Department near their homes were in charge of the follow up. We compared these rates with those from May 2006 to May 2007.

RESULTS
15 children (12.4%) abandoned the treatment; 4 of them from the city of Santa Cruz, 9 from Santa Cruz Department and only 2 from the rest of Bolivia. Health Centers that were in charge of the follow up reported that all of those abandoning treatments had changed their addresses and couldn’t be found any more. Last year 21% abandoned treatments, having not received a transportation bonus.

CONCLUSION
Money was of great help to diminish abandonment, but in terms of cost-benefit, our expectations were not fulfilled. Other causes such as ignorance, illiteracy, religious, ethnic, are very difficult to eliminate.
The main aim of our report is to analyze the dynamics of skin cancer during 1997-2007. Skin cancer is one of the more frequent occurred forms of malignant tumours. WHO data (2006) reported more than 1.5 million patients with skin cancer per year. One of the characteristic epidemiological features of skin cancer is that this disease occurs more frequently in fair people; particularly in Australia, USA and European countries. Low morbidity rates have been registered in Asian and African countries.

Cancer is widespread across the Republic of Uzbekistan and a decline in the morbidity rate has been noted. 11,252 patients with skin disease were under ongoing observation in the Republic of Uzbekistan in 2007. Primary cancers were detected in 11,42 patients (corresponding to 4.2 per 100 thousand people in 2007, compared with 7.5 per 100,000 in 1997. Skin cancer occupies the 6th place in the structure of cancer diseases. Rural populations suffered more often (60%) than urban ones. More than 60% of skin cancers are localized in the area of head and neck compared to the rest of the body. Skin cancer of extremities progressed more in areas after scarring from burns. In most cases (>75%) the histological structure of tumour was basically cellular cancer, particularly in old and aged people.

Studies showed that the detection of patients at early I-II stages (80%), III stages (17.3%) and IV stages (2.6%) has been improved by 2007. These findings were-52%, 35% and 12.4% respectively in 1997 year.

The 5-year survival rate has been improved -57.1% (51.2% in 1997) High morbidity rates per 100 thousand of people for skin disease have been reported: 5.5 in Tashkent city, Navoi region, 5.2 in Bukhara region, 4.9 in Samarkand region, 1.9 in Andijan region and 2.8 in Djizzakh region.

The above analysis shows that there is a continuous decrease of skin cancer in all regions of the Republic of Uzbekistan. In addition, early diagnosis and patient survival rates have been improved.
INTRODUCTION
Nasopharyngeal carcinoma (NPC) is the commonest tumour of the nasopharynx. Nasopharyngeal carcinoma has a highly variable incidence depending on the geographic areas. Kenya has been estimated to have a crude incidence rate of 2.2 males and females 1.1. The etiology of nasopharyngeal carcinoma (NPC) is multifactorial; race, genetics, Epstein-Barr virus (EBV) infection, and the environment all play a role. Recent data from the registry is therefore pertinent.

MAIN OBJECTIVE
To determine and describe the rates of NPC from the year 2000-2006 as seen at Nairobi Cancer Registry.

METHODOLOGY
Data was extracted from Nairobi Cancer Registry database from 2000 to 2006 using the CanReg4 registry software. Demographic features were also determined. Incidence rates and percentages of NPC and other head and neck cancers were computed for this period. Histological diagnoses of NPC were determined.

RESULTS
NPC accounted for 2.8% of all cancers and 14.9% of all head and neck cancers seen between 2000-2006. A major peak at 40-49 age range with a minor peak at 10-19 age range was observed. 12% of all NPC cases were below 21 years. The Age specific rates (W) were found to be 5.2 in males and 2.4 females. Most of the cases had late presentation and the commonest histologies were squamous cell carcinoma and anaplastic carcinoma.

CONCLUSION
NPC is a common head and neck cancers in Kenya. The age band at presentation is low and squamous cell carcinoma is the commonest histological diagnosis.
BACKGROUND
Tobacco smoking is the most intensively investigated environmental cause of cancer. Smoke comes out of cigarettes, bidis, hookahs etc. contains nicotine, and other chemical compounds which are proved as dangerous carcinogens. Cancer causation by tobacco smoke is not attributable to any one chemical compound but to an overall effect of the complex mixture of chemicals in smoke. The burden of tobacco related cancer is increasing alarmingly throughout the world, therefore merits highest priority in the war against cancer worldwide. Using tobacco, active smokers can affect the lungs and develop cancers in other organs such as larynx, oral cavity, pharynx, oesophagus, pancreas, kidney and bladder. The aim of our study was to investigate the use of tobacco, prevalence of exposure, awareness towards the risk of tobacco use and incidence of lung cancer in tobacco users.

MATERIALS AND METHODS
600 new patients with cancer of lung registered in Netaji Subhash Chandra Bose Cancer Research Institute were recruited for the study during the period of January 2002 – December 2007. Six hundred healthy male (age, religion and residential status matched) visiting controls were selected from the hospital outpatients during the same time period. Information on socio demographic data, details of the disease, tobacco use, and awareness towards the effect of tobacco were obtained through standardized questionnaires.

RESULTS
Out of 600 patients, 460 were male and 140 were female. Out of 460 male, the history of tobacco smoking was observed in 420 (91.3 %). Of the 140 females 32 (22.9 %) was smoker. Smokers were at a higher risk to the disease than the non-smokers. Disease directly correlated with the duration, number of tobacco products smoked, monthly income, family size and education level. Adjusted Odd Ratio (OR) observed for smokers for duration more than 20 bidis/cigarettes per day were 2.11%, 1.49%, and 3.48% respectively. Smoking was seen as more common form of tobacco than chewing. Awareness level towards tobacco chewing, active and passive smoking revealed poor response among the subjects.

CONCLUSION
Smoking related lung cancer is very high in this part of the country. Health education for antismoking and awareness generation towards tobacco hazards should be strongly recommended.
ABSTRACT 36

15-YEAR EXPERIENCE OF REFERENCE LABORATORY ON DIAGNOSING PEDIATRIC LEUKEMIAS AND SOLID TUMORS IN UKRAINE

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BACKGROUND
In Ukraine the malignant diseases of hematopoietic and lymphoid tissues rank first among childhood malignant diseases. Five-year survival rates of the pediatric cancer patients in Ukraine are lower than in the Western countries. Precise diagnosis of childhood leukemias as well as solid tumors should be the prerequisite for the use of up-to-date treatment techniques in the clinical practice of pediatric oncology.

PATIENTS AND METHODS
Blood and bone marrow smears, fine needle biopsy specimens, cerebrospinal fluid samples, samples of the pleural and peritoneal effusions, and imprints of lymph nodes of the pediatric patients with leukemia and solid tumors were examined cytologically and cytochemically. The pathologic cells were immunophenotyped by immunoenzyme cytochemical techniques (APAAP, ABC) employing a broad panel of monoclonal antibodies to lineage-specific, differentiation, and activation antigens of leukemic cells. The panel of monoclonal antibodies to tissue- and organ-specific antigens, oncofetal antigens, and the cytoskeleton proteins was used for differential diagnosis of small round blue cell tumors and other types of malignant neoplasms.

RESULTS
6796 children aged 0-14 were examined in the Reference Laboratory in 1992-2007. The patterns of the major biological forms of leukemias in accordance with FAB, WHO, EGIL, and ICD-10 classifications are presented. Upon detailed examination of the specimens referred to the Reference Laboratory as acute leukemia (AL) in about 7% of the cases the preliminary diagnosis of AL turned out to be faulty. In 6% of the cases the diagnosis has been principally changed (preliminary diagnosis of ALL has been replaced by one of AML variants or even AL-unrelated diseases). In half of cases being referred, the diagnosis has been defined more exactly. The differential diagnosis in the bone marrow metastases of neuroblastoma, rhabdomyosarcoma, and Ewing sarcoma / PNET was performed.

CONCLUSION
The precise diagnosis of the malignancies of hematopoietic and lymphoid systems as well as the metastases of small round blue cell tumors may be a prerequisite for improving five-year survival rate in the pediatric oncology in Ukraine.
BACKGROUND
To evaluate the clinical characteristics, some neuroradiologic findings and the incidence of tumors in children with Neurofibromatosis Type 1 (NF1).

PATIENTS AND METHODS
Medical records of 62 children with NF1 were analyzed retrospectively for age, gender, diagnostic criteria for NF1, presence of unidentified bright objects (UBOs) on MRI, complications and tumors related to NF1.

RESULTS
The median age of patients was 10 years (0.5–18), M:F ratio was 1.3. The frequencies of the diagnostic criteria were 100% for café au lait spots, 65% for freckling, 48% for neurofibromas ± plexiform neurofibromas, 40% for Lisch nodules, 8% for optic gliomas, 11% for osseous lesions, and 31% for first degree relative with NF1. The UBOs on MRI were observed in 57% of 37 patients. The most common complications were kyphoscoliosis (19.5%), and convulsion (11%). Benign tumors developed in 61% and most of these tumors were neurofibromas and plexiform neurofibromas. Malignant tumors developed in 18% of patients including optic glioma (n:5), central nervous system tumors (n: 4), malignant peripheral nerve sheath tumor (n: 2) and rhabdomyosarcoma (n: 2). Six children (9.6%) with NF1 had congenital anomalies including facial asymmetry (n:1), horseshoe kidney (n:1), congenital heart defects (n:1), syndactyly (n:1), proptosis, high arched palate, maxillary hypoplasia, and pes equinovarus (n:1), distant nipple (n:1). Two of these cases with anomalies developed malignant tumor (embryonal rhabdomyosarcoma and brain stem glioma).

CONCLUSION
In this series, the high incidence of UBOs on MRI was noteworthy. This neuroradiologic finding may serve as an additional diagnostic criterion for NF1, particularly in young children. High incidence of both benign and malignant tumors is of particular importance. A significant number of patients had minor or major congenital anomalies, a finding which could suggest the possible relation of malformations and cancer development. The potential complications of NF1 including tumor development necessitate multidisciplinary management of these patients.
Aggressive treatment for malignant disease may produce unavoidable toxicities to normal cells. The mucosal lining of the gastrointestinal tract, including the oral mucosa, is a prime target for treatment-related toxicity by virtue of its rapid cell turnover rate. The oral cavity is highly susceptible to direct and indirect toxic effects of cancer chemotherapy and ionizing radiation. This risk is due to multiple factors including high cellular turnover rates for the lining mucosa, a diverse and complex microflora, and trauma to oral tissues during normal oral function. While oral complications may mimic selected systemic disorders, unique oral toxicities emerge in the context of specific oral anatomic structures and their functions. The most common oral complications related to cancer therapies are mucositis, infection, salivary gland dysfunction, taste dysfunction, and pain. These complications can lead to secondary complications such as dehydration, dysgeusia, and malnutrition. In myelosuppressed cancer patients, the oral cavity can also be a source of systemic infection. Radiation of the head and neck can irreversibly injure oral mucosa, vasculature, muscle, and bone. This can result in xerostomia, rampant dental caries, trismus, soft tissue necrosis, and osteoradionecrosis. Severe oral toxicities can compromise delivery of optimal cancer therapy protocols. In cases of severe oral morbidity, the patient may no longer be able to continue cancer therapy; treatment is then usually discontinued. These disruptions in dosing due to oral complications can thus directly affect patient survivorship. The aim of this study is to investigate the oral complications of antineoplastic drugs and radiation therapies and dental management of oral complications during of cancer therapy.

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INTRODUCTION
The lymphomas are a group of malignant solid tumors involving cells of the lymphoreticular or immune system. The lymphomas are the 7th most common cancers in the United States. This malignancy is the second most common neoplasm of the head and neck after SCC. Also this disease is the most common pediatric malignancy in the head and neck and accounted for 50% to 59% of the cases in studies of head and neck malignant neoplasms in children. The aim of this study is investigation the incidence, sex, age, histologic types and site distribution of malignant lymphoma of the head and neck in the Kerman province during the time period from March 1991 to March 2002.

MATERIALS AND METHODS
The information of 306 patients with lymphoma diagnosed from March 1991 to March 2002 was collected actively from all histopathology departments around the Kerman Province. The patients were analyzed according to gender, age, location of the tumor and type of the tumor. Data included in the present retrospective study were analyzed by SPSS13.5 statistical software.

RESULTS
During this period, 306 cases (192 men [62.7%], 114 women [37.3%]) of lymphoma were diagnosed. In our study lymphoma of the head and neck accounts for approximately 2.3% of all malignant tumors (306/10571). The age range was 1-86 years with the overall mean age being 41.4 ± 1.3. The annual age standardized incidence risks of lymphoma in Kerman Province were 3.4 per 100,000 populations.

CONCLUSION
Despite a considerable volume of literature written about malignant lymphoma of the head and neck in many countries, the incidence of this cancer hasn’t as yet been thoroughly documented or analyzed in Iran. However, comparison between the findings of this study with the results obtained by other investigators shows a relative consistency.
HEMATOLOGICAL MALIGNANCIES (LEUKEMIA AND LYMPHOMA) IN BASRAH PEDIATRIC ONCOLOGY CENTER

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BACKGROUND
hematological malignancies (leukemia and lymphoma) are the most common childhood cancer in pediatric oncology center in Basrah.

OBJECTIVE
To study the characteristic features of hematological malignancies (leukemia and lymphoma) and to evaluate the outcome.

METHODS
A retrospective study was carried out to focus on clinical and biological characteristic of patients with various types of hematological malignancies (leukemia and lymphoma) who had been admitted to the oncology center at Basrah maternity and child teaching hospital over the period from the 1st of January 2004 to 31st of December 2007. The total of 294 patients was included in our study, their age ranged from less than one year to 16 years, with 179 males and 115 females.

RESULTS
Acute lymphoblastic leukemia accounts for the greatest percentage (55.1%) followed by non Hodgkin’s lymphoma (22.8%), then acute myeloid leukemia and Hodgkin’s lymphoma with the same percentage (9.5%), the least percentage was for chronic myeloid leukemia (3.1%) and the main clinical presentation of leukemia were fever, pallor, lymphadenopathy and bleeding, while in lymphoma the main clinical presentations were fever, lymphadenopathy and abdominal mass, most cases were from Basrah (center and northern area) with similar percentage (20.9%).

CONCLUSION
Acute lymphoblastic leukemia was the most common type of hematological malignancies and infection is the major cause of death in both leukemia and lymphoma with mortality rate among patients with leukemia due to non compliance or discontinuation of treatment is an important dilemma.
ASYMPTOMATIC HYPOGLYCEMIA AMONG CHILDREN WITH ACUTE LYMPHOBLASTIC LEUKEMIA ON MAINTENANCE THERAPY

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BACKGROUND
Knowledge of the adverse effects of maintenance chemotherapy, therapy in children with acute lymphoblastic leukemia being treated according to the MRC modified protocols.

OBJECTIVE
To figure out the asymptomatic hypoglycemia in a sample of children patients at a stage of maintenance therapy.

METHODS
This prospective study was carried out over 6 months from 1st January 2004 - 30th June 2004. A total sample of 30 patients aged between 1 and 15 years with acute lymphoblastic leukemia were studied, all of them were being treated according to MRC modified protocol and on maintenance therapy (6MP + MTX). 35 health, children matched for age and sex were randomly selected as controls. The sample was taken from the maternal and child teaching hospital.

RESULTS
Hypoglycemia were seen in 18 (60%) of patients with leukemia; 10 (55.5%) females and 8 (44.4%) males. Blood glucose level <3.33 mmol/L during 12 hours of overnight fasting.

CONCLUSION
Hypoglycemia is the most common adverse effect in children with acute lymphoblastic leukemia on maintenance therapy.
Despite multiple treatment approaches for primitive neuroectodermal tumor (PNET) of the central nervous system (CNS) in childhood, the treatment results are still not as satisfactory as expected. The purpose of this study was to evaluate prognostic factors and our treatment results.

All patients with PNET of CNS followed by Akdeniz University Faculty of Medicine, Department of Pediatric Hematology & Oncology between October 1996 and February 2008 were enrolled in this retrospective study.

Thirty patients (14 males, 16 females) were followed during the study period. The median age was 8 (range, 0.2-17). Two of them were under 3 years of age. Tumors were located in cerebellum in 27 patients. All patients were operated followed by only radiotherapy in one, only chemotherapy in 2 and both chemotherapy and radiotherapy in 26 and neither radiotherapy nor chemotherapy (only surgery) in one. While spinal seeding metastasis was observed in 6 patients at the time of diagnosis, there was no metastasis out of the central nervous system. During follow-up, relapse (4 primary tumor bed, 3 spinal seeding, 2 craniospinal) developed in 9 patients with a median 21 months (range, 4-46) from diagnosis. With a median follow-up of 36 months, event-free survival and overall survival were 64% at 2 years, 52% at 5-10 years and 74% at 2 years, 60% at 5 years, 55% at 10 years, respectively. None of the age, sex, tumor size, total excision, or risk status at the time of diagnosis were risk factors for prognosis. The presence of metastasis at the time of diagnosis has significant negative effect on survival (p=0.031).

The new treatment modalities are still needed for childhood PNET of central nervous system to reach better results.
INTRODUCTION
Correct treatment of malignant tumors is not possible without reliable pathologic diagnosis. Unfortunately, pathology has been severely neglected in developing countries. The incidence of malignant tumors in developing countries is similar to the western world. With growing awareness and improvement of health systems, oncologic treatment becomes more readily available in low resource countries. However, the difficulty to obtain a reliable pathologic diagnosis within a reasonable time span is a major obstacle for timely oncologic treatment.

METHODS
Telepathology can be considered as an ideal option to alleviate this bottle neck for treatment of malignant tumors. “iPath”, is a unique open source software, which is cheap and user friendly, therefore well suited for use in countries with limited resources. The equipment needed is a microscope with an attached digital, or video camera, and a computer with internet access. The costs of the whole set-up range between 8,000-12,000$ depending on the type of microscope. Prerequisites for successful telepathology are:

A. **On the submitters side:** timely preparation of histologic / cytologic slides, of reasonable technical quality and good quality digital photography of the histologic / cytologic slides for submission to “iPath”.

B. **On the consultants side:** familiarity with local conditions, and a timely and competent response.

C. **Reliability of tele-diagnosis** is heavily dependent on two factors: the quality of clinical information and a clear and efficient communication between submitter and consultant.

An assessment of diagnostic accuracy in telepathology showed an overall diagnostic accuracy of 85%, most of the remaining 15% were minor discrepancies. Poor quality of histologic or cytologic preparations, was a limiting factor for diagnosis, but this was also a problem, when the same preparations, were reviewed under the microscope. Another major factor leading to diagnostic errors is failure in communication: the consultant asks for more clinical data - no reply, or additional images are requested - no reply. Diagnostic errors in 40% out of the 15% incorrectly diagnosed cases identified in our study, were due to deficiencies in communication.

CONCLUSION
Telepathology is a suitable tool to help to overcome limitations in capacity for timely diagnosis, however, telepathology as conventional pathology needs an infrastructure, with trained professionals, and pathologists doing the online diagnoses. The level of telepathology depends on the quality of the infrastructure for the submission of cases and the human factor on both sides of the line, submitter and consultant. Depending on these factors it may vary from a most simple to a highly specialized and sophisticated diagnostic tool.
OBJECTIVE

To analyze the clinical outcome of 150 childhood acute lymphoblastic leukemia (ALL) patients and explore how to improve the event-free survival (EFS) rate in ALL.

METHODS

All of the eligible patients recruited into the ALL-XH-99 clinical trial. Event free survival (EFS) curves were calculated using the Kaplan–Meier method and were compared with the log-rank test. Statistics was done by SPSS 13.0.

RESULTS

Out of the 150 patients, 92.7% attained complete remission (CR) in a median time of 34 days. 35 patients discontinued treatment on account of financial difficulties. 115 patients received standard treatment. The overall EFS rate at 5 years was (69.0±5.0) % with median observation duration of 21 months. The EFS rates at 5 years in low-risk (LR), median-risk (MR) and high-risk (HR) groups were (82.0±6.0)% , (77.0± 15.0)% and (43.0±11.0)% , respectively (P < 0.05). Relapse occurred in 16 patients (13.9%) in a median time of 17 months: including 11 hematological relapses, 1 isolated central nervous system (CNS) relapse, 1 testicular leukemia combined with bone marrow relapse and second malignancy (acute myeloid leukemia), 1 bone marrow combined with CNS relapse, 2 second lymphoma after allogeneic transplantations. There were 5 deaths after induction remission (2 from fungal sepsis, 3 from bacterial sepsis leading to disseminated intravascular coagulation).

CONCLUSION

\( t (9; 22)/bcr/abl \) was the most important independent prognostic factor. ALL-XH-99 protocol was effective in improving the EFS rate. In the context of effective systemic and intrathecal chemotherapy, cranial irradiation can be eliminated in all patients.
ABSTRACT 42 bis

PROLIFERATION OF LEUKEMIA CELLS INDUCED BY OUABAIN AND RESEARCH OF RELATED SIGNAL PATHWAYS

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BACKGROUND
Cardiotonic steroids (CTS) can bind to Na+, K+-ATPase to activate complex intracellular signaling cascades regulating the proliferation, differentiation and apoptosis of cells. Through observing the effects of ouabain at different concentrations and specific signal pathway inhibitors on proliferation of various origins of leukemia cell lines, we intend to explore the pathogenesis of leukemia, the signal transduction functions of Na+, K+-ATPase and the signal pathways participating in the pathogenesis of leukemia further.

METHODS
By using MTT, the survival rates of leukemia cell lines were observed after treating with ouabain at different concentrations (1nmol/L, 10nmol/L) for 6 hours, 12 hours, 24 hours incubation and the specific pathway inhibitors Src kinase inhibitor PP2, MEK inhibitor PD98059 respectively. The expressions of Na+, K+-ATPase α1 subunit of leukemia cells were evaluated by RT-PCR and Western-Blot.

RESULTS
The results showed that 1nmol/L, 10nmol/L of ouabain could induce proliferation of lymphocytic leukemia B95 and Jhhan cell lines, together with megakaryocytic leukemia M07e and Meg01 cell lines. And these concentrations of ouabain could up-regulate the expression of Na+, K+-ATPase α1 subunit. The leukemia cells proliferation induced by ouabain could be blocked by PP2 and PD98059 with different extents.

CONCLUSION
It is concluded that Na+, K+-ATPase plays an important role in signal transductions through binding to ouabain, and they could activate complex signal pathways regulating proliferations of leukemia cells. The proliferation effects are mediated by activation of Src kinase and ERK1/2 dependent signaling pathway.
Non Hodgkins lymphoma (NHL) constitutes 6% of all pediatric malignancies and are highly curable. The objective of this study was to evaluate the demographic profile, histopathology, immunophenotype and outcome of these patients.

METHODS
A retrospective analysis of a consecutive cohort of 49 children with proven diagnosis of NHL from March 1997 to March 2007 was done. Treatment protocol was MCP 841 for children with T-lymphoblastic lymphoma and the rest were treated with short intensive multi-agent chemotherapy (like MCP 842, COPADM). The study was approved by the Institutional Review Board (IRB).

RESULTS
Forty nine children with newly diagnosed NHL were treated during this period. The median age was 9 years (range 3-17 yrs) and 38 (76%) were boys while 11 were girls. Staging work-up revealed stages 2, 3 and 4 disease to occur in 10 (20%), 14 (28%) and 24 (48%) patients respectively, while one child had primary CNS lymphoma. Histology and immunophenotyping revealed B and T phenotype to occur in 30 (61%) and 13 (26%) of patients, while 4 (8%) were large cell anaplastic and 1 (2%) was unspecified. Five patients abandoned treatment before completing induction. Out of 44 evaluable patients 38 (86%) achieved complete remission (CR), there were 3 induction deaths and 3/38 did not achieve CR. Overall survival (OS), and event free survival (EFS) was 68%, and 59% respectively with a median follow-up of 3 yrs. Relapse occurred in 10/38 (22%) patients. Of the relapses, 9/10 occurred prior to 2003. The most important prognostic indicator was the period of treatment between 2003-2007 when EFS & OS were 81% and 86% compared to 46% and 58% for the period 1997-2003.

CONCLUSION
Improvement in supportive care and counseling reduced abandonment and permitted strict adherence to protocol that resulted in the good outcome in the time period between 2003 and 2007.
In the ancient folk medicine in India wheat grass juice was used by anaemic patients to increase the haemoglobin level. Wheat grass juice has been proven over many years to benefit people in numerous ways, building the blood and restoring vitality, but there is no satisfactory explanation behind the reduced blood transfusion requirements as well as to increase haemoglobin after consumption of wheat grass juice. The aim of our study was to see the effect of wheat grass juice in terminally ill cancer patients to improve the quality of life.

During January 2003 to July 2008 we selected 520 solid organ cancer patients in our palliative care unit of Netaji Subhash Chandra Bose Cancer Research Institute in order to see the effect of wheat grass on improvement of haemoglobin level, serum protein & performance status on terminally ill cancer patients. The age range of the patients was 20 year to 88 year (median age 42 years). The different types of cancers were Lung (25%), Breast (20%), Oesophagus (11%), Colon (9%), Ovary (8%), Hepatocellular carcinoma (6%), Stomach (6%) and others (15%). 30ml of juice was given to all our 456 cancer patients for continuous 6 months. Assessment of haemoglobin, white cell count, serum total protein and albumin were done at 3 and 6 months of wheat grass therapy.

The mean levels of haemoglobin, white blood cell count, platelet count, serum total protein, albumin and performance status were 7.8 gm%, 4000/cumm, 1.3 lacs/cumm, 5.8 gm%, 2.4gm% and 50% respectively. Sixty six patients (14.5%) required transfusion support & those patients were excluded from the study. Other 390 patients (84.5%) were evaluated 3 and 6 months after being given wheat grass juice. The mean values for haemoglobin, total protein & albumin were improved significantly (p value < 0.005) and we observed a mean of 9.3 gm%, 6.4 gm/dl and 3 gm/dl after 3rd month; after 6 months the values were 9.1gm%, 6.4 gm/dl and 3.2gm/dl respectively. White blood cell & platelet count were the same in both cases. The performance status was improved from 50% to 70% (Karnofsky) after 3 and 6 months wheat grass treatment.

We concluded that wheat grass juice is an effective alternative of blood transfusion. Its use in terminally ill cancer patients should be encouraged.
Background
Recombinant TSH use has increased over the past decade. However, due to its expense it is used judiciously in developing countries in treating differentiated thyroid carcinoma. We present our five year experience from 2003-2008 in a charity-based hospital setting.

Materials and Methods
14 patients (10 females; 4 males) 14-71 years (Mean age 39.1); with differentiated thyroid carcinoma were given recombinant TSH for ablation and treatment from July 2003 to June 2008. 11 patients had Papillary carcinoma; 3 had Follicular carcinoma. 6 patients had stage I, 2 stage II, 3 stage III and 3 stage IV disease. 7 patients had rhTSH aided I-131 ablation therapy; 7 treated for irresectable and/or distant metastatic disease. TSH of all these patients did not rise adequately either after surgery/XRT or due to functioning distant metastatic disease. RAI administered [range 100mCi (3700MBq)-170mCi (6290MBq)]; Mean dosage 140.71mCi(5206.3MBq). Baseline TSH, Thyroglobulin(Tg)/Anti-Thyroglobulin(Anti-Tg) levels were done. 0.9mg of rhTSH was given on Day 1 & 2; TSH recorded at 24 hours post injection. RAI therapy was given if TSH was >30microIU/ml. Patients were followed on 3-monthly outpatients with Tg/Anti-Tg levels and subsequent I-131 whole body scans (WBS). Mean follow up was 32.1 months. If the valid Tg levels came down to negligible levels at 3 months Complete Response (CR) was documented; if Tg levels dropped but not to a negligible level it was termed Partial Response (PR); if no significant difference noted Stable Disease (SD) and if increased Progressive Disease (PD). Subsequent WBS was done at 6 or 12 months post rhTSH aided RAI therapy. If positive the patient underwent another RAI therapy with thyroxine withdrawal.

Results
12 patients had baseline valid Tg levels (<0.5->30,000ng/ml). Baseline TSH levels (0.718-10.8microIU/ml). After the first rhTSH injection it rose to (34.8->75) and after second injection to (33.1->75). 4 patients had a positive WBS which turned negative in 3 patients after subsequent RAI therapies. All patients are alive; 7 had CR, 4 PR, 1 SD, 1 PD who now is in CR after repeated RAI therapies. 1 patient was too soon to assess. Therefore, the Overall Response Rate (ORR) at 3 months post rhTSH RAI therapy was 85% while ORR to date is 92%.

Conclusion
In our five year experience judicious use of rhTSH in aiding ablation and treatment is effective; especially in patients whose TSH fail to rise after surgery/XRT or due to functioning metastatic disease.
BACKGROUND
To analyze the rate of dangerous lymphoma diseases in children throughout the regions of the Republic of Uzbekistan.

MATERIALS
1055 children have been diagnosed with lymphoma throughout the Republic of Uzbekistan in 2000-2007. Non-Hodgkin’s lymphoma was diagnosed in 610 (57.8%) patients and Hodgkin’s lymphoma in 445 (42.2%) patients. In all cases diagnosis was made through patients reports, family history, clinical and paraclinical and morphological test results. Non-Hodgkin’s diagnosis was determined in 8.1% cases aged from 0-3 yrs, in 50.6% cases aged from 4-6 yrs, in 20% cases aged among 7-10 yrs patients, in 21.3% cases aged 11-14 yrs. Hodgkin’s lymphoma was determined in 12% cases aged from 0-3 yrs, in 26.1% cases aged from 4-5 yrs, in 42.2% cases aged 7-10 yrs, in 19.7% cases aged from 11-14 yrs. If we see the incidence of Non-Hodgkin’s lymphoma disease throughout the regions of the Republic, the most suffering from this diseases are in 113 (18.5%) cases, next place 80 (13.1%) patients in the Qashqadarya region, 64 (10.5%) patients in Bukhara, 50 (8.13%) patients in the Tashkent region, 45 (7.4%) patients in Andijan and Samarkand. It was determined that the least incidence of this disease among children was in 14 patients (2.3%) in the Navoi region and, in the Republic of Karakalpakstan, in 15 patients (2.5%) in the Sirdarya region. Non-Hodgkin’s lymphoma was diagnosed in 41 (6.6%) patients in Namangan region and Surkhandarya region, 38 (6.1%) patients in Khorezm region, 26 (4.5%) patients in Djizzakh region, and 24 (3.9%) patients in Tashkent city. The most cases of morbidity from Hodgkin’s lymphoma was in the Khorezm region (70 (15.7%) patients), 49 (11%) patients in Namangan, 44 (9.9%) patients in Samarkand, 38 (8.5%) in Surkhandarya region, and 34 (7.7%) patients in Fergana region. It has been observed the least rate morbidity with Hodgkin’s lymphoma in Navoi region, Syrdarya region, and the Republic of Karakalpakstan in 16 (3.6%) children. Paediatric Hodgkin’s lymphoma has been diagnosed in 31 (7.0%) patients, in Tashkent region, 29 (6.5%) patients in Andijan region, 28 (6.3%) in Qashqadarya region, 27 (6.0%) patients in Bukhara region, 25 (5.6%) patients in Tashkent city and 22 (5.0%) patients in Djizzakh region.

RESULTS
The average morbidity rates for malignant lymphoma disease for 8 years are equal to 133 patients. Of these 76 (57.2%) are patients with Non-Hodgkin’s lymphoma, and 57 (42.8%) patients with Hodgkin’s lymphoma.
HOW SHOULD THE INCTR/PAX PROGRAM MEASURE SUCCESS - A REVIEW OF POSSIBLE PALLIATIVE INDICATORS

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BACKGROUND
The INCTR/PAX Program has been supporting the provision of palliative care in developing countries since 2002. This work has included the development of regional Palliative Care Centres, educational support through workshops, telemedicine and clinical guidelines and via consulting & advisory services. Work to date has focused on centres in Nepal (Bharatpur, Kathmandu and Bhaktapur Cancer Hospital) and in Hyderabad, India with newer initiatives beginning in Dar es Salaam, Tanzania and in Nicaragua and Brazil.

METHODS
The usual indicators of success in the palliative setting include the following: number of patients seen, number of educational sessions delivered, number of health care professionals attending, increases in opioid consumption, improved symptom control and changes to restrictive laws and government policies regarding opioids. However the outcome measures need to be relevant to the setting and easily assessed without the need for extensive databases or personnel.

SUMMARY
The INCTR/PAX Program has developed a Program Evaluation Tool. We will suggest a panel of indicators which we believe are the most useful and reflective of meaningful change, transferable and easily measured.
BACKGROUND
Nairobi Cancer Registry (NCR) was established at KEMRI in 2001, reporting cases diagnosed and treated in Nairobi and its environs. Childhood cancers are a major concern. This paper presents data on childhood tumours within a 6-year period (2000 – 2005).

MATERIALS AND METHODS
Data was abstracted from the NCR database and analyzed using CanReg4 software and a Microsoft Excel spreadsheet. Childhood cancers are categorized according to the International Classification for Childhood Cancers (ICCC), which groups the cancers into 12 categories according to the morphological diagnosis. Results are further categorized according to sex (Male/Female) and age-group (0-14 years).

RESULTS
A total of 605 malignant tumours were recorded between the year 2000 and 2005 comprising 349 (57.7%) males and 256 (42.3%) females. In the male group, the most common cancers were lymphomas accounting for 32.7% with Age Specific Rates of 62.5 per million. Retinoblastoma accounted for 16% and leukaemias 11.7% respectively. Burkitts lymphoma was the most common male lymphoma with 43 cases (37.7%). In the female group, the most prevalent cancers were the leukaemias accounting for 19.1%, lymphomas 15.6% and retinoblastoma 13.7% respectively. There were 21 cases of Burkitt lymphoma, representing 52.5% of female lymphomas. Overall in all categories the most common cancer were retinoblastoma (91 cases [56 male and 35 female]), Burkitt’s lymphoma (64 cases [43 male and 21 females]) and Lymphoid leukemia (58 cases [30 male and 28 female]) respectively.

CONCLUSION
These results show that childhood cancers are as common in Kenya as in other African countries. Lymphomas are the most prevalent group with Burkitt’s lymphoma being the most common in this category. Retinoblastoma is the most common overall childhood tumour with the most affected age-group being 1–4 years. Lymphoid leukaemia Hodgkin and Non-hodgkins lymphomas, nephroblastoma, osteosarcoma and rhabdomyosarcoma are some of the more common childhood cancers. However, these cases were abstracted within the urban population of Nairobi and are therefore not representative of the entire country. More resources need to be channeled to the Nairobi Cancer Registry to ensure more complete coverage so that high quality statistics can be used to monitor trends over time.
ABSTRACT 49

DOMICILLIARY PALLIATIVE CARE SERVICE - UNIQUE OPPORTUNITY WINDOW FOR CREATING CANCER AWARENESS IN COMMUNITY AND IN ANTI-TOBACCO CAMPAIGN - A PRELIMINARY STUDY

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BACKGROUND
Tobacco related cancers constitute the majority among our home care patients. This study seeks to integrate cancer control strategy and anti-tobacco campaign through the medium of Domiciliary Palliative Care and understand its efficacy. The Home Care Programme is identified as an ‘Opportunity Window/Outpost’ for this. Albeit unstructured being a preliminary study, it can be used to measure the ‘reach quotient’ of the cancer awareness message. As a ‘quit-line’ it seeks to achieve tobacco cessation in the community.

MATERIALS AND METHODS
Our Palliative Care to Homes (nicknamed PC2H) program, which is NGO, supported takes Palliative Care to the homes of those patients who are too poor or sick to travel and conducts peripheral rural clinics on designated days. Visits by the Home Care Team create a ‘Signature Effect’ in the neighborhood. Cancer Survivors accompany the team to reinforce the message. The visits are utilized to teach on warning signs of cancer and deleterious effects of tobacco. Doubts, which people may harbour, about causation, treatment and prognosis of cancers are cleared. Handouts are distributed when available. The cancer victim and the family that expresses solidarity with him are the best campaigners against tobacco and are encouraged to do so. The unique cluster dwelling of rural households, extended families with its opinion leaders who assemble where the team arrives form the right nidus to disseminate the cancer awareness message.

RESULTS
45% of cancers in males and 15% of cancer is females are tobacco related. Over 1000 house visits are made yearly that include re-visits and around 1500 patients are seen in rural clinics. Five to eight times this number can be reached with the message of cancer awareness and deleterious effects of tobacco. The impact of an earlier visit is assessed on subsequent visits. On an average five patients report bi-monthly with a ‘cancer scare’ attributable to the home care program. In a particular village 12 contiguous households became tobacco free as a result of a visit to the house of a patient who had advanced oral cancer. A ‘ripple effect’ helps in sustaining and spreading anti-tobacco and cancer awareness message.

CONCLUSION
Taking Palliative Care to the doorstep of the cancer patient in resource scarce countries through NGOs is a laudable step. Those too poor or sick to travel and their families benefit from this gesture. Creating cancer awareness in community, achieving cancer control, identifying patients with warning signs of cancer, and achieving tobacco cessation through it is a bonus. Where legislation and government measures fail the home care team, cancer victim and family succeed. Being patient focused and community centered this concept addresses many facets of India’s National Cancer Control Program (NCCP) and represents a model worthy to be emulated in developing countries.
BACKGROUND
Oral morphine is the mainstay in cancer pain management going by the prescribed WHO guidelines. Opioid availability continues to be a problem in many countries and Indian States; availability, purchase, transport, and narcotic licensing procedures being major hurdles. The Regional Cancer Centre, Trivandrum, India is one among the 24 Regional Cancer Centers (RCC) in the country with around 11000 new patients registered yearly. It has a busy Palliative Care Dept, consuming around 8 kg of oral morphine yearly. Oral morphine tablets used earlier were purchased. Pain relief and Palliative Care is one of the main agendas of the National Cancer Control Programmes (NCCP) of the Government: of India and the objectives of the venture are: 1) To accomplish self-sufficiency in morphine availability 2) Supply morphine at affordable costs and free to the poor 3) Assure un-interrupted morphine supply to the satellite centers of the RCC 4) Set a model for the rest of the centers in the country to emulate.

MATERIALS AND METHODS
The Regional Cancer Centre has a geographical proximity to the State College of Pharmaceutical Sciences both being in the same campus. The capital city Trivandrum, where the RCC is located houses the offices of the State Drugs Controller, Excise Commissioner besides the various Govt. Departments. Backed by a community that is well versed with the sufferings of the beleaguered cancer patient, the RCC Trivandrum took the decision to bring all concerned officials to the negotiating table. With a highly supportive Government the various hitherto existent beaurocratic road blocks were removed. Licensing procedures were eased. Licence was granted for purchase of raw opium from the Government: owned factory at Gazipur and to manufacture morphine in the prescribed manner.

RESULTS
Although the RCC at Trivandrum was manually manufacturing morphine solution since the 1990s, through an interim license, the present cGMP or current Good Manufacturing Practice demanded adherence to bench marks in production of pharmaceutical products. On a war footing the Regional Cancer Centre rectified those aspects found deficient. cGMP mandated the switch from manual to automatic/semiautomatic equipments for liquid and capsule manufacture and a host of other changes were made to comply with cGMP. An epochal event happened, on May 16th 2007: the RCC Trivandrum became the first Government Cancer Center in India to manufacture oral morphine capsule and solutions after the necessary licence was granted.

CONCLUSION
The RCC story is an example of triumph of ‘mind over matter’ and can be replicated elsewhere if there is grit and determination. It is a saga of a relentless journey in pursuit of bringing succour to the patient suffering from a painful life limiting illness. We are slowly achieving self sufficiency. Presently fifty 5mg capsules are sold for around Rs 20 (<1/2 US$) to those who belong to the paying category and a bottle of Liquid morphine for Rs 80. Patients belonging to the ‘F’ category (free) are given both free. Where there is a will there is a way.
BACKGROUND
Good economic approaches for developing countries with limited resources require evaluation of methods with respect to targeted diagnosis rather than coast. This requirement is strengthened especially for cancer due to expensive treatment regimens. Evaluation of cancer economy should not only engage in diagnosis and treatment stages but also consider productive life span. This necessitates timely, effective intervention that can be provided with correct diagnosis. Although molecular testing are relatively expensive, their specificity and sensitivity provide a chance of early diagnosis providing to be coast effective in the long run.

MATERIALS AND METHODS
Coast and risk/benefit analysis of molecular testing using a late diagnosed Lymphoma case history was carried out with regards to criteria below:

Diagnosis
- Routine laboratory tests
- Specialized Laboratory tests
- Imaging

Treatment
- Drug coast
- Hospitalization during treatment
- In home care expenses

Decreased reproductive life span

RESULTS
These calculations show a clear economical gain with the use of molecular techniques especially when decreased reproductive life span is considered.

CONCLUSION
Early diagnosis for cancer always provides a better life expectancy and a more productive life span; therefore even expensive testing like molecular diagnostics can result in economical savings and should be considered as preferred use of limited resources of developing counties.
BACKGROUND
INCTR has been working with the Nepal medical community for 6 years to assist in developing palliative care in their country. They have established relationships and trust in this community and laid important groundwork including sensitization and awareness, opioid availability, and participated in various workshops and seminars. Beginning in 2006 the hospice and palliative care community in Nanaimo, B.C. Canada established a twinning partnership with Bhaktapur Cancer Care Hospital’s palliative care program in Bhaktapur, Nepal. Building on relationships that INCTR has established in Bhaktapur, Nanaimo Hospice is endeavouring to sustain and support palliative care in Bhatapur Cancer Care Hospital (BCCH) as well as encourage the future development of hospice outreach in the community.

METHOD
The purpose of this partnership is to share friendship, resources and to learn from each other’s experiences and cultures in order to enhance compassionate care and comfort to the dying and their families. Nanaimo Hospice sends modest and reliable financial support to BCCH to assist with staffing and medication, as well as other needs on their palliative care ward. Through email communications, site visits and education they are developing a mutually supportive and encouraging relationship between two grass-roots community agencies engaged in caring for the dying and their families. This is team-building on a global level.

RESULTS
After two years of partnership Nanaimo Hospice has established a positive and encouraging relationship with BCCH, enabling their fledgling palliative care program to become more established and effective. They are now working on future plans for education and community outreach. Nanaimo Hospice is now encouraging other Canadian hospices to establish twinning partnerships. Two other Canadian hospices are now actively involved in this endeavour. Nanaimo hospice hopes to see many such grass-roots partnerships established across the globe in the future, keeping each project small, sustainable and relational - growth by duplication.
ABSTRACT 52

TREATMENT OF UNILATERAL WILMS’ TUMOR ACCORDING TO GFAOP PROTOCOL IN CASABLANCA, MOROCCO. A REPORT OF 85 CASES

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BACKGROUND
In 2001, the pediatric oncology and haematology department in Casablanca joined the GFAOP group (Groupe franco-africain d’oncologie pédiatrique). In a first step, the aim of this group was to improve the management of pediatric Wilms’ tumor and B cell NHL. We report here the treatment results of unilateral Wilms’ tumor in our unit.

MATERIALS AND METHODS
From February 2001 to December 2007, 85 children with unilateral Wilms’ tumor were admitted. The diagnosis was based on physical exam, abdominal ultrasound and/or abdominal CT scan. The metastatic work-up consisted on chest x-ray with or without chest CT scan. The patients were treated according to a modified SIOP 93-01 protocol.

RESULTS
The mean age was 3.2 years (range: 5 months to 11 years). There were 16 metastatic cases at diagnosis. Seventy five patients were evaluable. Other patients (10) were lost to follow-up (7 during pre operative chemotherapy and 3 during post operative treatment). Local stage was assessed in 73 patients with stage I in 25 cases, stage II in 16 cases and stage III in 32 patients. Six patients died of treatment modalities and 9 relapsed, among them, 2 are in second remission. With a median follow-up of 36 months, the EFS and the OS are 75% and 77% respectively.

CONCLUSION
Comparing to our previous series, we have reduced the number of patients who are lost to follow-up, the number of patients in stage I is very low and the survival is quite the same. Our efforts must be focused on reducing the rate of toxic deaths.
Background
Breast cancer is a heterogeneous disease embracing a large diversity of pathological entities and a range of clinical behavior. Histopathological characteristics of breast tumor mirror the influence of a variety of biological processes. The pathological evaluation of breast tumors provides the source for prediction of recurrence risk and treatment modality. Metaplastic breast carcinoma (MBC) represents an infrequent form of malignancy that constitute between 0.2 and 5% of all breast cancers. Pakistan has one of the highest rates of breast cancer among Asian populations and it has been previously shown that Pakistani breast cancer patients has a distinct clinical and pathological pattern (Rashid et al. Int J Cancer. 2006;119:2832-9). Since little is known about the pathological characteristics of MBC in Pakistan, this study aims to explore HER-2/neu and EGFR overexpression in this population.

Methods
A total of 34 biopsy proven MBC patients were identified at the SKMCH & RC, Lahore, Pakistan between June 1999 and February 2008; 26 with paraffin embedded tumor blocks available underwent pathologic confirmation. All cases were immunohistochemically examined using ER, PR, EGFR and HER-2/neu antibodies. Data about the histological subtype, tumor size, and grade were also collected.

Results
MBC cases (n=26) were diagnosed at a median age of 46 years (range 25-80) and presented with a median tumor size of 5.5 cm (range 2.2-19). Seven MBC histological subtypes were recognized i.e. adenocarcinoma with spindle cell differentiation (n=14:53.8%), carcinoma with chondroid metaplasia (n=4: 15.4%), squamous cell carcinoma (n=3: 11.5%), carcinoma with squamous differentiation (n=2; 7.7%), carcinoma with osseous metaplasia (n=1; 3.8%), carcinoma with chondroid and osseous metaplasia (n=1; 3.8%) and carcinoma with giant cells (n=1:3.8%). All tumors were of high grade. All MBC cases were negative for ER (100%); whereas majority of tumors were negative for PR (96%) and HER-2/neu (88.5%) expression. However, EGFR was overexpressed in thirteen tumors (50%).

Conclusion
Our study shows that MBC is a rare tumor which presents with large tumor size, higher tumor grade, lack of ER/PR/HER-2/neu expression and EGFR overexpression in Pakistani population. Knowledge of the EGFR overexpression in MBC cases may help physicians to tailor therapeutic modalities.
Background
Biomedical ethics is an essential component of good medical practice and research, which is lacking in medical education in Pakistan. In Pakistan, there is no formal education in biomedical ethics at undergraduate or postgraduate level. Responsibility falls on the shoulders of medical institutions to impart bioethics education to its physician and researchers. The model of Bioethics Group (BG) has been used to provide bioethics education to a diverse group of healthcare professionals at three institutions in Pakistan, Aga Khan University (AKU), Sindh Institute of Urology and Transplantation (SIUT) and Shaukat Khanum Memorial Cancer Hospital and Research Centre (SKMCH&RC).

Materials and Methods
AKU took the lead in introducing bioethics education through BG in 1997. SIUT started its BG in the year 2005 and SKMCH&RC in 2008. The basic concept of BG is the same in all these institutions which is self-education. The administrative structure of the group includes a chairperson, a coordinator and members. Its members are drawn from faculty, trainees, nurses, researchers and administrators and voluntary membership is encouraged. The group meets once a month and articles of interest or case scenarios related to bioethics are discussed and analyzed in the light of principles of biomedical ethics. At SKMCH&RC, articles related to issues such as organ trade, physician-pharma relationship, euthanasia, ethical dilemma, has been used as teaching tools. In future, movie clips and short videos will be used for discussion. Other activities of BG include ethics grand rounds, ethics consults, capacity building, and serving as a resource of bioethics for regional institutions.

Results
BG has been a successful tool for imparting bioethics education to a diverse group of health care professionals. At AKU, bioethics groups have been in existence for more than a decade and has resulted in sensitization of individuals to ethical issues. At SIUT, the Centre of Biomedical Ethics and culture (CBEC) and has been holding monthly meetings in which staff and faculty from SIUT participate along with several people from other institutions as well. At SKMCH&RC, BG has become very popular in a very short period of time and there is increasing awareness of bioethics amongst its health care professionals.

Conclusion
BG has been successfully used as a tool of enhance awareness to bioethics at different institutions. It is an easily replicable model which can play an effective role in initiating and promoting bioethics at different institutions.
BACKGROUND
The total cancer burden in India, a developing country is 20 lacs (2 million) and there is an increment of 10 lacs (1 million) new cancer patients per year, which is 1/10 of total cancer burden in the world. The majority of the cancer in this part of the country are tobacco and diet related. It is estimated that, by proper preventive measures we can reduce the current level of increment of 1 million to 100.000 annually by 2020.

OBJECTIVE
The aim of our state based non-Governmental cancer control programme is to reduce the cancer burden by proper awareness of signs of cancer & early detection & early appropriate treatment.

MATERIALS AND METHODS
During the period of January 2002 – December 2006 a cancer screening and awareness programme had been conducted in various district of West Bengal twice in every month by Himadri Memorial Cancer Welfare Trust & Netaji Subhash Chandra Bose Cancer Research Institute. We mainly deal on oral cancer (by examining the oral cavity), any history of tobacco intake, breast cancer (by self breast examination) and cervical cancer (by Pap smear examination). The cases that are detected as positive are referred to our hospital for planning of the appropriate treatment and advanced cases are advised for Pain and palliative treatment in our Institution.

RESULTS
Usually in all localities people participated willingly (more than 80%), the female attendance was usually more. The average female cancer incidence was 60%. Cervical cancer was commonest cancer of rural West Bengal whereas oral cancer is commonest among male. There were tobacco habits in 80% of males & 20% of females. Red meat eating was seen in the total population. We have screened total 48,000 population and we got 3840 (8%) cancer patients in different stages of disease. Total 58% were female and 42 % were male. Total 75% male and 35% female cancers were tobacco related; either through smoking or chewing. Of the female the incidence of cervical and breast cancer were 29.99% and 23.99% respectively. Of the male oral and lung cancer incidence were 35.98% and 29.98 % respectively. Total 65% of cancers were detected in the early stage and 35% in the advanced stage.

CONCLUSION
The cancer of rural Bengal in the majority of cases is life style related and can be prevented by proper awareness. So the cancer detection and awareness camps are very useful in rural area and ultimately can reduce the huge burden of cancer.
BACKGROUND
Various studies reveal that a high prevalence of depression is common with patients with cancer. Investigators have found a relatively high prevalence rate of depression in patients with certain types of cancer and some reports have suggested an association between depression and increased morbidity in cancer patients. Adolescents who have been treated for childhood cancer not only have the substantial physical, cognitive, emotional and interpersonal problems but also have the added burden of integrating a life threatening disease into their experiences. The aim of our study was to see the prevalence of psychological problem in cancer patients and the effect of psychotherapy in the patients.

MATERIALS AND METHODS
During period from November 2003 to December 2007 we analyzed 1500 cancer patients including survivors of childhood cancer in their adolescent period with their families in the psycho-oncology department of Netaji Subhash Chandra Bose Cancer Research Institute during period of 1 year. The age range of the patients was from 16-70 years (median age 44). We examined their family functioning, mental health, self-esteem, and the social competence of the survivors of cancer. A detailed history along with their Mental Status Examination was taken. Major Depression according to DSM IV criteria was evaluated by the help of the Beck Depression Inventory and the Hamilton Rating Scale for Depression. There was a female preponderance in the study.

RESULTS
Mild depression was seen in 770 patients (51.33%), mainly in younger females. Only 7% (105 patients) had moderate anxiety neurosis; 154 (10.26%) of the teenage patients thought that their families were less attentive than was the case with their counterparts. These adolescents were maladjusted & also violent towards society. One hundred twenty patients (12%) were reluctant to obey commands. Others 291 patients (19.4%) were of normal psychological function. Only 75 (5%) patients required medication; others responded well with psychotherapy.

CONCLUSION
Sixty percent of cancer patients have mild psychological problem during treatment and the majority responded with psychotherapy. Hence we recommended psychotherapy strongly in frequent intervals during and after treatment.
INTRODUCTION
Modern pediatric oncology uses different schemes and variations of polychemotherapy in combination with beam therapy to treat non-Hodgkin's lymphomas in children. This aim of this study is to their efficiency and to evaluate the primary damage to thoracoabdominal lymphonodes in children.

MATERIALS AND METHODS
We observed 36 patients with primary damage of thoracoabdominal lymphonodes in non-Hodgkin's lymphomas. The patient's age ranged from 6.5 years old. They were 24 boys (66.7%), 12 girls (33.3%). The tumours of all patients (100%) had been verified histologically. Of these 22 (61.1%), were B-cellular NHL, 15 (38.9%). were T-cellular All patients received 4 courses of polychemotherapy by RCHOP+MA (vincristin 1.4 mg/m² iv. on 1st and 7th days, cyclophospham 1000 mg/m² iv. on 1 and 7 days, doxorubicin 60 mg/m² iv. on 2 and 6 days, prednizolone 50 mg im. from 1 to 14 days, alexan (citarabin) 100 mg/m² iv on 4th day, metotrexat 12 mg on the 4th day endolumbal, alexan-30 mg on 4th day endolumbal, dexametasone 2mg on the 4th day endolumbal. The beam therapy was made after 4 courses on the abdominal cavity by SRD (single ray dose) 1.2 Gr, TRD (total ray dose) 18 Gr on medastium by SRD (single ray dose) 1.8 Gr, TRD (total ray dose) 36 Gr. After the beam therapy chemotherapy was given (up to 4 courses using the RCHOP scheme). The efficiency of the therapy was studied using USD, CT and MSCT. The analysis of direct results showed: observation over 36 month - full regression 19 (52.8%); remission 27 (75%). 17 (47.2%) patients died within the first 3 years and 19 (52.8%) patients lived more than 3 years. The main cause of patients was leukemization (generalization of the process) in 13 (36.1%) and metastasis in 4 (11.1%) on the brain.

CONCLUSION
The results we obtained confirm that the correct treatment choice, with strict control of stages and main prognostic factors, delivers good results and prolongs patient’s survival rate.
ABSTRACT 58
ONCOLOGY NURSES CONNECT: AN INTERNATIONAL NURSING EDUCATIONAL COLLABORATION

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BACKGROUND
Oncology nurses require specialized education and training to ensure the provision of safe, efficient and evidence-based care. In August of 2008, a team of nurses from Children’s Hospital Boston collaborated with nursing leadership at Ocean Road Cancer Institute (ORCI) to organize a two-day nursing educational workshop at ORCI in Dar es Salaam, Tanzania. This presentation will describe planning, implementation and evaluation of this international nursing collaboration.

MATERIALS AND METHODS
A two-day oncology educational workshop was conducted at ORCI on August 12th and 13th, 2008, and was attended by thirty nurses from ORCI and two from Rwinkwavu Hospital in Kigali, Rwanda. The conference was conducted by five nurses from Children’s Hospital Boston and the nurse manager at ORCI. Topics included an overview of childhood cancer, chemotherapy administration and supportive care management, pediatric health assessment, growth and development, pain management strategies, infection control, and communication skills. A pre-conference assessment and post-conference evaluation was completed by all the nurses who attended.

RESULTS
African nurses identified in the pre-conference assessment the desire to increase their knowledge around aspects of oncology nursing care including nursing assessment, safe handling of chemotherapy, pain management, palliative care, managing side effects, and communication skills. The post-conference evaluation indicated that the conference met their learning needs, but that ongoing education is both necessary and desired by the nurses at ORCI to provide safe, effective oncology nursing care to their patient population.

CONCLUSION
International collaboration among oncology nurses provides the opportunity for education and planning around process improvements, which may lead to enhanced patient care and safety. Nurses who attended the oncology nursing conference at ORCI clearly identified the need for ongoing education. Future directions include planning for scheduled distance learning sessions through internet, and development of an oncology nursing training program for nurses from developing countries.
ABSTRACT 59

CHILDHOOD HODGKIN DISEASE IN CAMEROON

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BACKGROUND
Cameroon is a low-income country located in Central Africa. With about 17 millions inhabitants, it is a blank area on the world cancer map because cancer registration is scarce or nonexistent. The prevalent childhood cancer is Burkitt’s lymphoma and with the advent of AIDS, Kaposi’s sarcoma is now common in Cameroonian children. The aim of this study is to present the anatomo-clinical aspects of childhood Hodgkin lymphoma at the University Teaching Center in Yaoundé, Cameroon.

MATERIALS AND METHODS
This is a single institution report on childhood Hodgkin’s lymphoma. We examined the cases observed within the last 10 years (1997-2007).

RESULTS
Six cases of Hodgkin disease were observed in our institution during the last 10 years amongst children aged 0-15 years. In five cases, lymph node was the primary site of involvement while one case of primary central nervous system involvement was also seen. Most of the patients presented with stage IV disease. Two children survived 24 months after chemotherapy and the other were lost to follow up. None of the children were HIV positive in this series.

CONCLUSION
This single institution study shows that Childhood Hodgkin disease is still a rare disease in Cameroon where Kaposi’s sarcoma is becoming common.
IMMUNOHISTOCHEMISTRY IN CANCER MEDICINE: OUR EXPERIENCE IN CAMEROON

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BACKGROUND

Immunohistochemistry (IHC) refers to the process of localizing proteins in cells of a tissue section exploiting the principle of antibodies binding specifically to antigens in biological tissues. It takes its name from the roots “immuno,” in reference to antibodies used in the procedure, and “histo,” meaning tissue (c.f. immunocytochemistry). In developed countries, immunohistochemical staining is widely used in the diagnosis of abnormal cells such as those found in cancerous tumors. Specific molecular markers are characteristic of particular cellular events such as proliferation or cell death (apoptosis). IHC is also widely used in basic research to understand the distribution and localization of biomarkers and differentially expressed proteins in different parts of a biological tissue. Visualising an antibody-antigen interaction can be accomplished in a number of ways. In the most common instance, an antibody is conjugated to an enzyme, such as peroxidase, that can catalyse a colour-producing reaction. Alternatively, the antibody can also be tagged to a fluorophore, (immunofluorescence). The latter method is of great use in confocal laser scanning microscopy, which is highly sensitive and can also be used to visualise interactions between multiple proteins. Most of these techniques can be used on paraffin-embedded specimens.

MATERIALS AND METHODS

In Cameroon, the above techniques are not available. We established a collaboration with a few laboratories in developed countries; mainly in Switzerland and France. Paraffin blocks of diagnosed cancers have been sent abroad since January 2000. Immunohistochemistry has been performed free of charge.

RESULTS

A series of 103 cancer patients was included in this study. There were 40 malignant lymphomas, 20 cases of early stage Kaposi’s sarcoma, 20 soft tissue tumours, 15 breast cancers, 5 brain tumours, 3 urethral cancers. There were no HER-2 cases and no sentinel node biopsies were performed in this series. The delay of sending specimens and receiving results via the Internet was one month. Apart from classifying and clarifying their diagnosis, none of these patients received specific treatment after their immunohistochemistry result.

CONCLUSION

Even performed free of charge, immunohistochemistry does not permit specific treatment for Cameroonian cancer patients because they can’t pay for drugs such as monoclonal antibodies. We hope the situation may change in the future. The delay of sending specimens and receiving results via internet was one month.
BACKGROUND
At the University College Hospital, Ibadan, Nigeria HAART is commenced in HIV positive patients with malignancy if the CD4 T lymphocyte count is below 200 cells/ul. This study was carried out to evaluate the treatment outcome of HIV positive patients with cancer managed at the Radiotherapy unit of the hospital.

PATIENTS AND METHODS
Thirteen HIV positive patients with malignancies were monitored by the investigators. Relevant clinical data collected included sex, HIV status, type of malignancy, CD4 counts, History of ART, ECOG performance status, prescribed oncology treatment (radiotherapy/Chemotherapy), regularity of oncology treatment and follow up conditions. Patients excluded during the period of study were those with ECOG performance status less than 2, those with no histological confirmation of malignancy and those with indeterminate HIV status. Viral load assay was not consistent in the patients.

RESULTS
Thirteen HIV positive patients with malignancies were evaluated. Six patients had cancer of the uterine cervix, three had nasopharyngeal carcinoma, two had non Hodgkin’s lymphoma (NHL), one had Kaposis’ sarcoma while the remaining one had squamous cell carcinoma of the right jaw. The performance status of 4 patients was ECOG 1, while 9 had ECOG 2. Two patients with cancer of the cervix had initial CD4 counts of 450 and 500 cells/ul respectively. They were able to complete radiotherapy and chemotherapy without HAART. Two other patients with cancer of the cervix were already on ART. Their initial CD4 counts were 350 and 370 cells/ul respectively. They completed their therapy. Seven patients had initial CD4 counts between 250 and 320 cells/ul. All of them had values below 200 on the first repeat after one month. They were recommended to start HAART. Chemotherapy was suspended except radiotherapy until the CD4 count was at least 200. Three of these patients died while 4 are alive but with recurrent / persistent diseases. One patient with NHL had initial CD4 count of 150 cells/ul. This increased to 170 after one month of HAART but he died before chemotherapy. One patient with Kaposis’ sarcoma had initial CD4 count of 180 cells/ul. He was commenced on radiotherapy and HAART. He died after few fractions of radiotherapy.

CONCLUSION
Based on these observations, we recommend that HAART should be commenced on all HIV positive patients diagnosed with malignancy with an initial CD4 count below 450 cells/ul in our environment and CD4 count should be monitored in such patients monthly till completion of treatment.
BACKGROUND
The incidence of cancer is reportedly on the increase in developing countries including Kenya. WHO estimates that by 2030, more than 50 % of all cancer related deaths globally will be reported from developing (low-income) countries. The objective of this study is to determine cancer mortality in Nairobi, Kenya during the period 2003 – 2005.

MATERIALS AND METHODS
Data was extracted from Nairobi Cancer Registry and the register of deaths for Nairobi for the period 2003 - 2005. Population statistics for Nairobi were obtained from the 1999 CBS population census and projections.

RESULTS
During the period under review, a total of 5,461 new cases of cancer were reported in Nairobi Province. Over the same period, 61,489 deaths (including stillbirths) were registered. Of the total deaths registered for the period, 3.42 % (2103) were due to cancer. Of these deaths, cancer of the oesophagus was the leading cause of death accounting for 10.4 % (177+) of all cancer-related deaths. Haematological malignancies made up the second most common cause of death accounting for 8.6 % (146+) and followed by breast and cervical cancers both at 6.9 % (118+). The age band 50 – 54 years accounts for 10.3 % (175+) of all cancer deaths and is followed by 60 – 64 years band at 8.7 %.

CONCLUSION
This study shows that 3.42 % of all registered deaths in Nairobi for the period under review were related to cancer. Further studies are encouraged in this area.
BACKGROUND
In Africa there are very few cancer registries to provide comprehensive data on the distribution of neoplastic disease, and descriptive epidemiology for prevention, health service planning, resource allocation, and intervention programs. Ghana is setting up a population-based cancer registry to improve the understanding of how cancer affects the country and to be better prepared to address current and future needs.

OBJECTIVE
Discuss the design and implementation of population-based cancer registration in Ghana.

METHODOLOGY
A departmental-based cancer registry was initiated in 2004 at the National Center for Radiotherapy and Nuclear Medicine, Kumasi, which was then extended to a hospital-based cancer registry for the Teaching Hospital where the centre is located. It is now being further extended to cover the entire geography of the Ashanti Region of Ghana as the Kumasi Population-Based Cancer Registry using IARC Canreg4 tools.

RESULTS
In the interim, the registry is being used to evaluate treatment and outcomes; to assist public health and screening intervention programmes; and in collaboration with other departments of the teaching hospital and institutions to conduct several cancer-related research works. However, the feasibility and gradual implementation of the Kumasi Population-Based Cancer Registry has compelled us to strategically replicate the design in two additional geographical areas of the country, thereby covering the Southern, Middle and Northern Ghana; Accra, Kumasi, and Tamale Population-Based Cancer Registries respectively.

LIMITATIONS
It is difficult to generate incidence and mortality rates due to lack of valid denominators. Lack of financial support limits the cancer registry’s execution of objectives like staffing, training among others.

CONCLUSION
With standardised and consistent definitions being put in place, data from these three cancer registries would be comparable and can be aggregated for an effective Central National Cancer Registry which can then act as driver for policy development and program evaluation for the urgent need of a National Cancer Control Program in Ghana. We would be able to examine how best practices in cancer prevention, treatment, and care are being applied; and also identify where research efforts need to be focus to address those things that we do not yet know or understand.
ABSTRACT 62 bis

MALE CANCERS REVIEW AT NATIONAL CENTER FOR RADIOTHERAPY AND NUCLEAR MEDICINE

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BACKGROUND
Male cancers are generally given low priority in cancer control due to the high incidence and mortality of female breast and cervix cancers in Ghana. However, there is the need to probe into male cancers and begin to addressing challenges before we are unable to cope with the big growth in cancer in the years to come because of the lack of basic infrastructure.

OBJECTIVE
The objective of the study is to review male cancer cases diagnosed and treated at the NCRNM in 2007.

METHODOLOGY
Male cancers diagnosed and treated at the NCRNM data were extracted from the medical records. Data on patient demographic, tumour and treatment were recorded, analysed and results presented.

RESULTS
Male cancers constituted 22.8% (n=117) of cancers diagnosed and treated at the NCRNM. Mean age was 47.6 years (min age: 2, max age: 87). Proportion of cancers according to the ICD-O (3) topographies, prostate cancer was the predominant site representing 20.5%, Lymphoma 7.7%, Bladder 6.8%, Bones 6.8% and Soft tissues 6.8%. Body system-wise, the distribution of the male cancers are: Head and Neck, 31.6% being the leading cancers followed by Genito-urinary, 30%; Bones and Soft Tissues, 13.7%; Lower GIT, 8.5%; and Lymphoma, 7.7%. The basis of diagnosis was 61.5% histology verified and 38.5% clinical diagnosis. Chart below shows any treatment which was given to the male cancer patients. The occupational distributions of the patients are: public servants (with pensioners), 33; farmers, 22; children and students, 22; traders, 12; and other occupations, 28.

CONCLUSION
35 (30%) patients were registered but did not receive either of the major treatments given at the center. It was observed that male breast cancers significantly accounted for 3.4% (n=4), requiring further studies and interventions. There is also an urgent need for a population-based cancer registry in the region to provide vital statistics on prostate cancer for international comparisons.
ABSTRACT 63

INTRODUCING STEM CELL TRANSPLANTATION SERVICES IN A RESOURCE-POOR SETTING

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BACKGROUND
In most developed economies, stem cell transplantation (SCT) has become a reasonably safe procedure for the treatment of several malignant and non-malignant diseases. However, SCT centres are virtually non-existent in most resource-poor settings like Nigeria and the literature on the challenges faced in its introduction in similar settings is scanty. Consequently, our centre recently decided to explore the challenges, with a view to setting up a functional SCT unit.

METHODS
We embarked on sensitising our colleagues, training our personnel, and setting up the required infrastructure.

RESULTS
We found that opinions are still divided among our experts, largely due to inadequate public infrastructure to sustain such sensitive procedures. Also, public awareness of SCT remains limited. Our specialists also view the challenges posed by graft-versus-host disease (GVHD), post-transplant infections, relapse, and organ toxicity with heightened pessimism.

DISCUSSION
We noted that despite the many advances achieved in SCT, several European countries still retain research status for SCT; so that an investment in SCT must be accompanied by an equal commitment to genuine medical research for optimal gains. Local opportunities at SCT in other resource-poor settings have helped to develop local expertise and research infrastructure, boost confidence and drive innovation and ultimately improve results. Moreover, Nigerians referred for SCT abroad usually face the additional obstacle of finding matching donors, for which the odds are highly inordinate.

CONCLUSION
A comprehensive National Health Insurance Scheme would further boost efforts at SCT, but we may need to explore the opportunities inherent in public-private-partnership for the purposes of setting up our first SCT unit; just as it was done successfully in India where SCT can now be procured at a tenth of the cost in the West.
Aims
Efficacy, safety, effect on quality of life and survival functions of metronomic weekly schedule of paclitaxel were investigated in refractory solid tumors.

Materials and Methods
From Jan 2006 to Oct 2008, patients with heavily pretreated advanced refractory solid tumors, after progression on all routine therapies (including 3 weekly paclitaxel where it was indicated), were offered weekly paclitaxel (4/6 weeks) till disease progression or intolerance. They were analysed for response (RECIST criteria), toxicity, survival and quality of life.

Results
The conditions were carcinoma of the ovary (n=22), carcinoma of the stomach (n=20), carcinoma of the breast (n=18), sarcoma (n=5), head and neck tumor (n=9), carcinoma of the lung (n=8), carcinoma of the cervix (n=6) and one each had carcinoma of the penis, carcinoma of the endometrium and adrenocortical carcinoma. 22 (24.17%) patients had received one line of chemotherapy, 28 (30.76%) had received two lines of chemotherapy, 17 (18.86%) had received three lines of chemotherapy while 16 (17.58%) patients had received four lines of chemotherapy. 32 (32.32%) patients received 6 weeks of paclitaxel, 38 (41.7%) received 12 weeks, 16 (17.58%) received 18 weeks, 4 (4.39%) received 24 weeks while 1 (1.09%) received 40 weeks of paclitaxel. 59 (65%) patients showed a response out of which 6 (10.2%) showed complete response, 22 (36.7%) showed partial response and 11 (17.6%) had stable disease. 20 (35%) patients had progressive disease. Of note was a durable response in a patient of metastatic angiosarcoma. Common grade 3/4 toxicities noted were sensory peripheral neuropathy in 19 (20.8%) patients, neutropenia in 10 (10.9%), fatigue in 8 (8.8%) and cystoid macular edema of the eye in 1 (0.01%) patient. All adverse events were reversible. The median overall survival was 44 weeks (95% CI – 36.9 to 48.1). Median progression free survival was 30 weeks (95% CI – 27.6 to 34.1). The quality of life was good as most of the patient had responses and treatment was administered on a day care basis without much toxicity.

Conclusion
Metronomic weekly schedule of paclitaxel is well tolerated with good responses in refractory solid tumors. There is good rationale to use this schedule of paclitaxel as a targeted antiangiogenic therapy in early stage disease.
INTRODUCTION
Cases of osteogenous sarcoma most often occur in children and young people. Disease course and treatment in various age groups are different. Children have less favorable prognosis. Assessments of prognosis, disease course and therapeutic effectiveness, indicate that genetic and immunohistochemical characteristics are important. So in order to get good results from treatment, it is necessary to study molecular and genetic tumor phenotypes.

BACKGROUND
Definition of genetic and morphological signs like immunohistochemical tumor markers in cells cycle: p-53 and Ki-67 in patient with osteogenic sarcoma.

MATERIAL AND METHODS
We investigated 81 patients with osteogenous sarcoma; 50 males (20 patients aged up to 16 years, 30 patients aged up to 30 years); 31 females (15 patients aged up to 16 years, 16 aged up to 30 years). Histological specimens were preparing by the usual methods. Monoclonal antibodies (“Novocastra” and “Dako” Denmark) were used for immunohistochemical detection of p – 53 and Ki – 67. Analysis of specific stain made using a light microscope (“Leica” Germany).

RESULTS
In the young patients the quantity of Ki – 67 and p – 53 was positive at 1.1 and 1.5 less than in teenagers. The intensity of genes Ki – 67 and mtp – 53 was as follows: medial and strong expression Ki – 67 occur in more than 60% teenagers and 48% of young patient’s mtp – 53 - 40% in teenagers and up to 16% in young patients. Quantity analysis can be useful to determine the degree of tumor aggression and its sensitivity to treatment.

CONCLUSION
In 60% of teenagers osteogenous phenotype was more aggressive, and so requires a correction of treatment.
Pakistan has one of the highest rates of consanguinity in the world (range 60-70%). Miscarriages may occur more frequently in BRCA carriers from consanguineous parents since their offspring are more often homozygous by descent compared to those of unrelated parents. To explore this question, we studied the rates of miscarriages in Pakistani BRCA mutation carriers and non-carriers with a history of parental consanguinity.

**Methods**

Female index patients from 165 breast/ovarian cancer families were identified at the SKMCH & RC, Lahore, Pakistan between June 2001 and November 2004. All patients were screened for germline mutations in the BRCA1 and BRCA2 genes. The patients and mutations have been previously described1. Four additional families carrying a recently identified deleterious BRCA mutation were also included in this study. A total of 128 patients comprising 29 BRCA carriers and 99 non-carriers with at least one pregnancy were included in this study. Wilcoxon’s signed rank test was performed to test if carriers and non-carriers were independent of the number of pregnancies and its outcome (number of live births and number of miscarriages, respectively). Student’s unpaired t-test was used to test for independency of age at diagnosis and carrier status. All other variables were dichotomized and tested using Fisher’s exact test. All statistical analyses were performed using SAS, Version 9.1.

**Results**

The mean age at diagnosis of breast and ovarian cancer among carriers and non-carriers did not show any significant difference (t-test, p=0.082 and p=0.194, respectively). Furthermore, no difference was found between the two groups in the mean number of pregnancies, live births, miscarriages, and in the proportion of study participants with and without miscarriages. No association was noted between miscarriage and parental consanguinity, disregarding BRCA carrier status (miscarriage among related couples versus miscarriage among unrelated couples: Fisher’s exact test, p=0.463; miscarriage among married first and second cousins versus miscarriage among unrelated couples: Fisher’s exact test, p=0.435). When BRCA status was considered, there was no statistically significant difference (p>0.05) between the occurrence of miscarriage among related and unrelated study participants. Even when the analysis was restricted to marriages between close relatives (first or second cousins), no significant association with miscarriages could be shown.

**Conclusion**

Our findings suggest no significant difference in the occurrence of miscarriage between BRCA carriers and non-carriers when parental consanguinity is taken into consideration.

EVALUATION OF HEPATIC PERFUSION DISORDERS USING MDCT

Amila Ramzan, Najam Uddin, Zia S Faroqui

BACKGROUND
The unique dual blood supply of liver makes it an ideal organ to be studied using MDCT. The rapid image acquisition allows two-phase (hepatic arterial phase and portal venous phase) evaluation of the hepatic parenchyma and this improves tumor detection and tumor characterization in a single CT study. When vascular compromise occurs, there are often changes in the volume of blood flow in individual vessels and even in the direction of blood flow. These perfusion disorders can be detected with MDCT and are generally seen as an area of high attenuation on hepatic arterial phase images that returns to normal on portal venous phase images; this finding reflects increased arterial blood flow and arterioporal shunting in most cases.

MATERIALS AND METHODS
100 patients were retrospectively studied between the year 2007 and 2008. The study was conducted in the Radiology department of SKMCH & RC. Biphasic scanning during HAP and PVP followed by delayed phase imaging was performed using MDCT.

RESULTS
The mean age was 40 years (range 30-55 years). The male to female ratio was 2.5:1. Different types of hepatic lesions including tumors, particularly HCC, hemangiomas, portal venous obstruction, inflammation, hereditary disorders and others showed various patterns of blood flow changes that appeared as areas of altered attenuation than the rest of hepatic parenchyma, in different phases of blood flow.

CONCLUSION
With its capability for dual-phase contrast-enhanced studies, MDCT can demonstrate alterations in the dynamics of hepatic blood flow. Such flow-related changes will be demonstrated with greater frequency because of the increasing use of MDCT to study the hepatic parenchyma. It is important to understand the physiology and pathophysiology of liver hemodynamics. Arterial and portal venous supplies to the liver are not independent systems and knowledge of MDCT.
INTRODUCTION
The aim is to investigate the usefulness of some clinical and laboratory parameters in assessing the prognosis and survival of CLL patients in a resource-limited setting.

PATIENTS AND METHODS
Between September 1986 and March 2007, seventy-nine previously untreated patients with full clinical and laboratory data were retrospectively studied. Data extracted included demographic parameters, clinical features at presentation, haematological parameters; and management outcome. Diagnosis was based on clinical findings and blood and bone marrow cytological findings. Patients were staged using Binet's system.

RESULTS
Within the study period of 20.5 years, a total of 79 patients were managed, aged 30 to 81 (median = 60 years). Of these 34 were males and 45 were females (ratio = 0.8:1). The majority (88.1%) of the cases were CLL, 10.1% were CLL/PL and only 1.3% being HCL. About 86.1% were aged 50 years or more. Massive splenomegaly and hepatomegaly were recorded in 70.9% and 29.1% of patients, respectively. Minimal lymphadenopathy was found in 62% of patients. More than 63% of the patients presented with a stage C disease. Symptomatic anaemia was recorded in 74.7% of cases. The mean ± SD of WBC and platelet counts were 11185±12279/µL and 110189 ± 74974µ/L, respectively. Haematocrit correlated negatively with WBC (r = -0.357, p = 0.001) but positively with platelet count (r = 0.281, p = 0.012). The spleen correlated positively with the liver (r = 0.371, p = 0.001). No significant difference in mean survival based on differences in age (<50 or >50 years), spleen or liver sizes (<10 or >10cm), haematocrit (<20 or >20%), WBC (<50000 or >50000) or platelet counts (<90000 or >90000), and extent of lymphadenopathy (1 or no nodal region/2 or more nodal regions). Logistic regression showed that a younger age, male sex, higher haematocrit, and lower platelet count improved survival, while lower WBC, moderate hepatomegaly and splenomegaly conferred survival advantage.

CONCLUSION
It could be concluded that massive splenomegaly is a common finding in the majority of our patients and that younger age, male sex, higher haematocrit, moderate platelet count, and fewer lymph node regions conferred survival advantage on our cohort of patients.
BACKGROUND
In spite of recent advances in the range and availability of imaging techniques, management of the N0 neck in patients with oropharangeal squamous cell carcinoma (SCC) remains controversial. Our aim in this study is to identifying tumor characteristics suggestive of lymph node metastasis.

MATERIALS AND METHODS
SURGICAL CASES: A series of 100 patients undergoing surgery as the primary treatment of oropharyngeal (SCC) at the Al-Rashid Military Hospital, Baghdad-Iraq, between June 1994 and June 2002, formed the material of the study. None of the patients had received preoperative radiotherapy, chemotherapy, or previous surgery, other than recent diagnostic biopsy. The series comprised 75 males (75%) with a mean age of 57 years (SD 11.4, range 30-80 years), and 25 females (25%) with mean age of 64 years (SD 11.9, range 40-85 years). The site of the primary tumour was the tongue in 40 (40%); floor of mouth in 30 (30%) and oropharynx in 30 (30%). The clinical stage of the primary tumour was in T1 in 15 patients (15%), T2 in 50 patients (50%), T3 in 24 (24%) and T4 in 11 (11%). Cervical node metastasis was diagnosed histologically in 41 patients (41%) in these 100 patients staged N0.

RESULTS
The number of positive nodes in the 41 neck dissection ranged from 1 to 6 (mean 1.6, SD 1.18) and in total 61 positive nodes were detected. 20 nodes (33%) were at level I and had a mean dimension of 11.6 mm. The 41 nodes (67%) at levels II-IV had mean dimension of 11.6 mm.

CONCLUSION
In this retrospective study 59% of patients received no benefit from an elective neck dissection because they were pathologically N0. The present study shows that we can put in place some criteria regarding the possibility of false N0 in oropharyngeal tumor and hence the need for elective neck dissection in relation to the primary site and T stage of the tumor.
BACKGROUND
We performed gene expression analysis in hematopoietic tissue, ovarian cancer, prostate cancer, cervical cancer; breast cancer, endothelial cell lines, pre-eclampsia and HELLP syndrome, using microarray technology in University of Kocaeli.

MATERIALS AND METHODS
ABI (Applied Biosystems, Foster City, CA, US) and Agilent (Agilent Technologies, Palo Alto, CA) platforms were used as microarray chips. Obtained data were analysed by using GeneSpring (GeneSpring 6.1, Silicon Genetics, Redwood City, CA) and Ingenuity Pathway Analysis (IPA) (Ingenuity Systems, Mountain View, CA, USA) software programmes for gene network and canonical pathway analysis. Array results were confirmed using Quantitative Real Time PCR (LightCycler, Roche Diagnostics GmbH, Mannheim, Germany) and TaqMan® Low Density Array Human Apoptosis Panel (TaqMan®, Applera, Norwalk, U.S.A).

RESULTS
Our results represents the first gene network analysis in Turkey. Here we define the importance of bringing samples to the microarray laboratory in safe conditions and value of RNA integrity number.

CONCLUSION
This technology is very useful to suggest new pathognomonic-prognostic markers and new therapeutic targets.
BACKGROUND
Splanchnic veins thromboses which include portal vein thrombosis and thrombosis of the hepatic veins causing Budd Chiari syndrome frequently present complications of an undiagnosed myeloproliferative disorder (MPD). The recently identified Janus kinase 2 (JAK2) V617F somatic mutation that occurs in MPD patients, is a risk factor for portal, hepatic and mesenteric venous thrombosis, independent of the presence of overt MPDs. Screening of JAK2 mutation may be useful in identifying patients who should be carefully observed for the subsequent development of overt MPDs. In view of this, we studied JAK2 V617F mutation in patients with splanchnic vein thrombosis.

MATERIALS AND METHODS
30 patients with splanchnic vein thrombosis and without cirrhosis of liver were screened by ARMS technique for JAK2 mutation. These patients attended the Haematology and Gastroenterology Department, All India Institute of Medical Sciences, New Delhi, India. The distribution of cases was as follows; 15 portal vein thrombosis (PVT), 10 Budd Chiari syndrome (BCS), 3 mesenteric vein thrombosis (MVT) and two cases having both PVT and MVT.

RESULTS
The JAK2 V617F mutation was identified in 5/10 cases with BCS (50%) and 3/15 patients with PVT (20%). None of the patients with MVT were positive for JAK2 mutation. Overall 8/16 patients (50%) with splanchnic vein thrombosis were positive for JAK2 V617F mutation. Patients with JAK2 V617F mutation had higher median TLC as compared to those who were negative for JAK2 mutation (15x10^9/L vs. 7.8x10^9/L). The median platelet count in patients with JAK2 positivity was 202 x 10^9/L and 195 x 10^9/L in patients who were JAK2 negative.

CONCLUSION
This study shows presence of JAK2 mutation in splanchnic vein thrombosis and its association with higher leukocyte count and platelet count. This observation needs to be confirmed in a larger number of patients. Hence screening for the JAK2 V617F mutation may be useful to identify patients that should be carefully observed for the subsequent development of overt MPD.
INTRODUCTION
Arm edema remains the main problem in the rehabilitation of patients with breast cancer (BC). The incidence of arm edema is 10-15% following surgery alone and up to 60-85% following surgery combined with irradiation. The existing methods of arm edema prevention in patients with BC are used exclusively postoperatively, are expensive, non-effective in advanced arm edema and do not exert a long-term effect in all the patients. Lately, a trend has become evident toward minimal lymph node dissection (LND) in patients with BC. However, using wire localization for lymph node mapping requires the purchase of gamma detectors and radioisotopes, mandatory additional staff training, radiation safety discussion, and the development of relevant treatment guidelines.

PATIENTS AND METHODS
We have developed an original method of intraoperative prevention of arm edema in surgery of patients with early BC based on the method of modified regional LND and consisting of the step-by-step preparation of the axillary fat with lymph nodes around neurovascular structures. It requires preserved arm innervation and backup collateral blood flow between the systems of superior and inferior vena cava (Patent of BY No. 10402). The surgical technique is easy to learn and involves no additional costs.

RESULTS
We have used the new surgical technique in the management of 124 patients with stage 0-I IA (cT0-2N0-1M0) breast cancer. The average age of the patients was 52.2 years (range of 21-78 years). 126 operations were performed: lumpectomy with LND – 77 (61.1%); modified radical mastectomy – 49 (38.9%). The mean number of lymph nodes in the preparation was 12.1 (range of 2-27). The rates of false-positive and false-negative results of preoperative assessment of the lymph node status were 9 (7.1%) and 28 (22.2%), respectively. 87 (70.2%) patients had postoperative radiation therapy. The median follow-up was 19.8 month (range of 1-48 month). 2 cases (1.6%) of arm edema and 8 cases (6.5%) of plexopathy were diagnosed. The study is in progress.

CONCLUSION
The modified LND in patients with early BC is an effective method of intraoperative arm edema prevention and could be an preferred alternative to sentinel lymph node biopsy in the countries with developing economy.
BACKGROUND
Infection remains a major cause of morbidity and mortality among children treated for cancer in a developing country where various factors contribute to high rate of sepsis. We retrospectively reviewed all infective deaths in children treated at Children Cancer Hospital from October 2005 to estimate the infection-related death rate and analyze associated risk factors.

MATERIALS AND METHODS
From October 2005 to September 2008, 449 children were put on active treatment protocol. 249 (65%) were male and 155 (35%) female. Age groups included less than 2 years (16%), 2 to 5 years (24%), 6 to 9 years (23%), 10 to 14 years (26%) and more than 14 years (11%). Major malignancies treated were Leukemia 195 (43%), Non-Hodgkin Lymphoma 68 (15%), Hodgkin Disease 43 (10%), and other Solid Tumors 143 (32%). Charts of expired patients were reviewed for cause of death and those died due to infection were analyzed for risk factors like age, sex, type of malignancy, socioeconomic status, neutropenia, and microbiological data.

RESULTS
The overall infection related mortality was 49/449 (11%). The age group showing high infective deaths were 2 to 5 and 10 to 14 years. Female had slightly higher mortality than male (29% vs 20%). AML (28%), B NHL (24%) and ALL (17%), were among the most high risk malignancy for infection related deaths. Most of these deaths were nosocomial and sepsis with pneumonia was major killer. Duration and intensity of neutropenia was a significant factor. Deaths in solid tumor (3%) were seen due to delay in seeking medical advice.

CONCLUSION
Infection-related deaths are unacceptably high in our setting. Measures to reduce hospital related infection and health education are essential to reduce infection-related mortality and improve overall survival.
BACKGROUND
It is estimated that up to a third of the world's population is infected with *Mycobacterium tuberculosis* (*M.*tuberculosis); the vast majority are living in tuberculosis endemic areas. The Western Cape Province of South Africa has an extremely high incidence of tuberculosis with a reported tuberculosis notification rate of more than 1000/100 000 population in 2006. Children under 15 years of age constitute between 15% and 20% of this tuberculosis burden. In a recent study we showed that the children with cancer have a 22 times greater chance of developing tuberculosis than the children of the same age group in the general population.

MATERIALS AND METHODS
All children (less than 13 years of age) consecutively diagnosed with cancer at Tygerberg Hospital, Cape Town, from September 2007 through June 2008 were included in the study. After confirmation of the cancer diagnosis all patients were routinely screened for *M.tuberculosis* infection and disease. Investigations included history, physical examination, chest radiograph, tuberculosis skin test (TST), in conjunction with interferon gamma release assays (IGRA) Quantiferon and T-SPOT.TB, as well as screening for active disease prior to the initiation of cancer therapy.

RESULTS
During the study period, 34 children were diagnosed with 12 different types of malignancies. The median age was 7.1 years. Four (11.8%) children reported a positive contact history. None of the children were HIV infected. As expected, the value of the chest radiograph for detecting latent tuberculosis was minimal. TST was positive in 3 cases; in two of these, there is concordance with the results of the IGRA. QUANTIFERON and T-SPOT.TB, as well as screening for active disease prior to the initiation of cancer therapy.

CONCLUSION
In the absence of a "gold standard" for diagnosing LTBI, it is impossible to determine from these data any reliable figures for the sensitivity and specificity of IGRA for detecting latent tuberculosis. It is remarkable however that, in our paediatric oncology setting, a large percentage of the results were not useful for evaluating the patient's status, as they were either indeterminate or showed low cell count. An important contributor to poor test results is the lymphopaenia seen in numerous patients, even before chemotherapy. T-SPOT.TB appeared less useful than QUANTIFERON, as 5 instances of true negative QUANTIFERON results tested as indeterminate or low cell count with T-SPOT.TB.
BACKGROUND
Cancer is increasingly becoming a public health problem in Nigeria, the commonest cancers being those of the breast and cervix in women and those of the liver and prostate in men. As the risk factors for cancers include many habits that are started in youth many cases of cancer may be prevented by making good lifestyle choices while young in order to avoid risk factors wherever possible. This study was conducted to assess the knowledge, attitudes and practice of adolescents and young adults in a secondary school with regard to risk factors for common cancers in Nigeria with a view to minimizing their risk of developing cancer later in life by facilitating positive lifestyle choices.

MATERIALS AND METHODS
A structured questionnaire was given to senior secondary school students in Kaduna, northern Nigeria by one of their teachers between September 2005 and March 2006. Responses were provided anonymously as the questionnaire had no identification features.

RESULTS
A total number of 500 questionnaires were distributed and 405 (81%) were completed and returned. The age range of the respondents was 12 – 22 years with a mean age of 16.2 years. About 97% of the respondents had heard about cancer with breast cancer being the most known cancer by the students (59%) followed by lung, skin and blood cancers. Knowledge of possible cancer risk factors was low; even for the most known cancer by the respondents (breast), 65% of the students did not know the risk factors involved. However, risk factors for liver, lung and skin cancers were correctly perceived by the students. The most common cancer risk factors practiced by the students are early sexual exposure, promiscuity/multiple sex partners, smoking, and alcohol ingestion.

CONCLUSION
Cancer awareness among secondary school students is very high; however, the knowledge of cancer risk factors as well as healthy lifestyle choices is rather low. There is a need to incorporate cancer risk factors and healthy lifestyle choices in the health educational and promotional activities in secondary schools in order to promote healthy lifestyle choices among adolescents.
ABSTRACT 77

THE BRITISH COLUMBIA CANCER AGENCY/INCTR PALLIATIVE COLLABORATIVE GROUP: AN INNOVATIVE PARTNERSHIP BETWEEN A CANADIAN CANCER CONTROL AGENCY AND THE INDIAN PALLIATIVE NETWORK

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BACKGROUND
Beginning in July 2006, a joint collaboration of the American Cancer Society (ACS), the International Network for Cancer Treatment and Research (INCTR) and Pallium India developed the first palliative care program in the state of Andhra Pradesh (population 65 million) at the Mehdi Nawaz Jung Institute of Oncology and Regional Cancer Centre (MNJ) in Hyderabad, the only Regional Cancer Centre for the state and the main tertiary referral site, accepting approximately 10,000 new patients per year. The MNJ Palliative Care Program, in addition to treating patients and families, conducting research, and providing training to health professionals, has developed a Pediatric Palliative Care Program, a Home Based Care Program and is working with local HIV/AIDS agencies.

METHODS
In early 2007, members of the INCTR/Palliative Access Program (INCTR/PAX) met with representatives of the British Columbia Cancer Agency (BCCA) Pain and Symptom Management/Palliative Care Program (PSMPC) to explore areas of common interest. The BCCA provides a province-wide, population-based cancer control system for the residents of British Columbia and the Yukon, a combined population of approximately 4.5 million. The BCCA/INCTR Palliative Collaborative Group was created as a result of this meeting with a mandate to improve access to palliative care for those living with cancer in countries where such access is limited, in collaboration with the INCTR/PAX Program. The Palliative Care Program at MNJ was selected as our first collaboration with the focus being on support for development of palliative care throughout India with MNJ as the regional base of expertise. Educational support and mentorship through external faculty support, development of curricula, teleconferencing and provision of educational materials, as well as targeted fundraising are the main activites we have been engaged in.

RESULTS
We will describe the results of the first 24 months of this innovative collaboration between a Canadian Provincial Cancer Control Agency, the INCTR and the MNJ Institute of Oncology Regional Cancer Palliative Care Program with an emphasis on the mutual benefits, lessons learned and plans for future work.
BACKGROUND
Hochi Minh city (HCMC) formerly known as Saigon city is located at the heart of the southern part of Vietnam with 2092km² of area surface and over seven million people. Cancer is one of the leading causes of death for children after infectious diseases and malnutrition. The Pediatric Hematology & Oncology Department came into existence in May 2000. The basic data of pediatric malignancies is really indispensable for the HCMC Cancer Control Programme. The purpose of our study aims to examine the epidemiological aspects of the 10 most common species of childhood cancers in the past 5 years (2001-2005).

MATERIALS AND METHODS
All new cases of cancers in children younger than 15 years of age that were enrolled at 30 hospitals and medical centers in HCMC from 2001 to 2005. We adopted the International Classification of Diseases for Oncology 2nd Edition (ICD-O-2) and referenced the International Classification of Childhood Cancers (ICCC). This is a retrospective survey and a comparative analysis with other Asean reports.

RESULTS
There were 2545/133246 new cases of pediatric malignancies, approximately over 500 cases per year with #10-12% increasing rate yearly. The incidence rate was 1.91% of all cancers. The boy/girl ratio was 1.32/1.0 and ASR: 88.4 / per million of children / per year. Onco-hematology accounts for 45% and the solids tumors 55%. There was a predominance of preschool children group (50.7%) with the most common incidence of acute Leukemias, Retinoblastomas, Neuroblastomas, Soft-tissue sarcomas, Renal tumors, G.C.T and Hepatoblastomas. The top 10 pediatric malignancies in both two sexes were Leukemias (CR:27.7%), Lymphomas (CR:14.38%), Brain tumors (10.0%), Neuroblastomas (8.33%), Retinoblastomas (CR:6.25%), Soft-tissue sarcomas (CR:5.86%), Kidney tumors (CR:4.75%), Germ cell tumors (CR:4.2%), Hepatic tumors (CR:2.95%), Bone sarcomas (CR:2.24%). In comparison with the frequency of the common cancers in children in Hanoi, there was no significant difference. Leukemias in children were the leading cancer burden in Vietnam. Retinoblastomas have still been a major cause of blindness of children younger than 3-5 years of age. In comparison with the report of the Singapore Children Cancer in 1997-2005: G.C.T (4th range, CR: 7.9%) was higher and Retinoblastoma (9th range, CR: 2.7%) lower than in HCMC.

CONCLUSION
Childhood cancers in HCMC are rare / infrequent, (1.91% of all cancers). Leukemias, Retinoblastomas, Neuroblastomas, CNS tumors are still considered as the most devastating diseases of children in Vietnam. The Pediatric Hematology & Oncology Department has been facing difficulties in diagnosis and therapy.
BACKGROUND
Cervical cancer is still the leading cancer in many developing countries and the first cause of cancerous mortality among female cancers. In Vietnam, according to the population based cancer registration during 4 years 2001-2004 at Cantho, the ASR of cervical cancer were 20,3/100000 and rated as the most common cancer among females.

AIMS
We carried out this study in order to: - Evaluate the proportion of cervical cancers diagnosed in early stages, in order to illustrate the status of this malignant disease in the area. - Study the clinical, paraclinical and pathological diagnosis of cervical cancer - Study the surgical therapeutic procedure and the results of treatment on the cervical cancer of early stages.

MATERIALS AND METHODS
Randomized descriptive study of 146 cases/786 cervical cancer patients hospitalized, classified into early stages (IA- IIA) and primarily treated in surgery at Can Tho Oncology Hospital from 06/2000 to 6/2008.

RESULT
Predominant age of patients was from 40 to 59 yr (63.5%); mean age was 49 yr; the youngest patient was 23 yr; the oldest was 75 yr. 18,7% were post menopausal patients. Proportion of early stages/total cervical cancers is 18,5%: stage IA: 4,6%; IB:7,5% and IIA: 6,4%. Suggested clinical diagnosis based on the first clinical manifestation: intermenstrual bleeding: 73%; postcoital bleeding: 9,5%… combined with other favorizing factors: age of first coitus, number of sexual partners, number of children, lifestyle (socioeconomic status, cigarette smoking…). Cytology or/and histopathology diagnosis and staging based on Pap-smear with cytological exam: HSIL: 13.3%, Microinvasive: 40%, Invasive: 46,7%; Colposcopy: inflammation: 14,3%, budding: 63,5%, ulcerative: 9,5% and biopsy of the cervix: epitheliocarcinoma: 85,7%, adenocarcinoma: 14,3%; Post-operatory pelvic nodal metastasis: 18,4%; unsafety of cutting field: 3,5%. Essential surgical treatment is Wertheim-Meigs' Operation. Adjuvant therapy of 22,7% (32 cases): chemotherapy:18,3% (15 cases); Radiotherapy: 4,4% (7 cases). DFS of 3 years: 77,9%, of 5 years: 62,3%; OS of 3 years: 81,5%, of 5 years: 74,2%

CONCLUSION
The low proportion of early staged cervical cancers in CanTho, in comparing with others authors, illustrated the status of this malignant disease in a highly populated area of Mekong Delta region and the cervical cancer screening programme were extremely necessary as well. The clinical diagnosis based on the first clinical manifestation associated with family status, lifestyle; few cases were revealed through the general health examination. The primarily surgical treatment, considered as the essential management for the early stages, justified that patients were diagnosed in early stages, and that they could be radically treated with high proportion of DFS and OS of 3 or/and 5 years. The early detection is the best measure for decreasing the mortality of this disease.

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HYPOTHESIS
Is the increased incidence of RB found in India due to increased vitamin A deficiency in Indian children? Only 21.4% of Indian Children aged 12-35 months received a Vitamin A prophylaxis in the last 6 months.

BACKGROUND
A number of epidemiological studies have found that Vitamin A is associated with a reduced risk for human cancers.

METHOD AND CONTROL
20 age and sex matched Control normal children randomly selected and 66 retinoblastoma cases belonging to the same socio-economic group were tested for plasma retinol levels. Sample collection: Early morning 3 ml of fasting blood samples were collected in heparinised tube. The tubes were wrapped in black paper to protect from light. The plasma was collected after centrifugation done in a dark room. The plasma samples were again wrapped in dark paper and kept in deep freezer below -70° C till analysis. Retinol estimation: Estimations of Retinol was done in dark room. Quantification was done using High Performance Liquid Chromatography technique with PDA detector and Thermo Surveyor Pump with on-line degasser (Thermo Electron Corp, USA). Spectral analysis was done at 32 nm using PDA detector. Chromatographic Conditions: Analytical column used was RP-18 Purosphere Star cartridge column (55 X 4 mm; 3µm). Calibration plot for retinol using Sudan III as an internal standard

RESULTS
The mean age of the groups were matched. The mean ±SD of retinol levels in the control and retinoblastoma cases were 116.1±56.39 and 120.5±82.6 ng/ml respectively. The Levine’s test for equality of variances when equal variances assumed t value was -.225 and P value NS

CONCLUSION
The plasma retinol values were not statistically significant in retinoblastoma cases and normal controls. We plan to look at the β-Carotene and Retinol binding proteins levels which reflect the Vitamin A stores in the two groups.
BACKGROUND
One of the Research areas identified by the Indian Retinoblastoma Group and Task Force in RB was to have a RB registry.

OBJECTIVES
To enumerate all the Retinoblastoma cases at the national level. To study the trend in the incidence /prevalence of RB. It is a Hospital based Clinical registry. We can participate in clinical research like risk factors of RB, epidemiological case control studies. Genetics studies could be planned, we could also evaluate therapy and hospital facilities etc.

METHODS
Nine centers have been identified across the country. Each Site will have a Principal Investigator, Co-investigators (Chemotherapist, Radiation Oncologists, Ocular Pathologist, Ocular Oncologist, Medical Officer, Data entry operator and a Social Scientist).

NATIONAL RB REGISTRY PROFORMA
The core Proforma has four parts: Demographic, Histopathological, Management and Follow up and Survival Data. The Proforma will be coded and entered manually and will be filled in under the supervision of the PI.

WEB BASED SOFTWARE
Web development with software and finger printing. Registry data will be made online. Each site will be given login ID. All sites will be able to access data. Server will be AIIMS. In house soft ware will be developed for appointment / scheduling of patients / follow up of patients.

FOLLOW UP
To follow up minimum 10 addresses / 7 telephones no. of their relatives/friends/referring physician will be collected from each patient. Paid reply cards will be used. Home visits in the NCR will be done. In house software will be developed for follow up. Patient friendly atmosphere.

QUALITY CONTROL
The validity and consistency checks for the Proforma parameters will be done. IARC quality control Program will be used to validate data. Exercise on reabstraction and coding on a random sample of case will be done. Ensure valid codes are entered. Editing if necessary will be entered into the web.

TRAINING MODULES
Training work shop will be held to the Medical officer, social worker and data entry operator before the registry starts functioning.

PUBLICATION OF THE REGISTRY DATA
A publication will be taken out at the end of three years in the form of a book.

STATISTICAL ANALYSIS
The analysis of the data will be done by EPI info/SPSS by a statistician. Survival will be done by Kaplan Meier curves.

FUTURE OF REGISTRY
The registry will be taken over and continued to run by the RP Centre, AIIMS. A sub registry on Genetics of RB will be started once the registry functions well. The registry will also extend to the SAARC countries.
To evaluate the clinical characteristics and treatment modality of children with retinoblastoma (RB) who were admitted to our center.

Patients and Methods
Children who were diagnosed as RB from 1990 to 2008 were evaluated retrospectively. Medical records were analyzed for age, gender, family history, laterality, presenting signs, stage of the tumor according to the Reese-Ellsworth (RE) system, and the treatment modality.

Results
There were 31 children with RB, and 9 (29%) of them had bilateral disease. Median age of diagnosis was 9 months (4–40) for bilateral and 26 months (4–110) for unilateral RB; M/F ratio was 1.4. One case with unilateral RB was 9 years old, while others (n:30) were < 5 years of age. Three (9%) children had a positive family history for RB. The duration of symptoms was < 4 months in 20 (64%), 6-12 months in 8 (26%), and > 12 months in 3 (10%) cases with a median duration of 3 (1–24) months. Presenting signs were leukocoria (58%), strabismus (32%), visual impairment (13%) and proptosis (13%). Only 11 (35.5%) of patients were seen at initial presentation, 20 (64.5%) of patients had been referred from other hospitals who were previously treated. In unilateral RB group, 13 had RE-stage V (7 RE-Va, 6 RE-Vb), 6 had RE-III and 3 had RE-II RB. The RE stage of eyes in patients with bilateral RB were RE-stage V in 14 (7 RE-Va, 7 RE-Vb), RE-IV in one, and RE-II in three eyes. So, 67.5% of the 40 eyes showed RE-stage V tumor. Two cases had CNS metastasis, one also having bone metastasis. Forty eyes were treated in 31 cases. Primary surgery (24 enucleation, 1 evisseration) was performed for 25 eyes of 23 patients. Seven patients received primary chemoreduction. Consolidation with local therapy was given in 5 cases. Adjuvant chemotherapy after surgery was given in 13 cases. External beam irradiation was given to 11 patients. Globe conservation could be achieved only in five patients. Median follow up time was 29 months (1-104). Acute myeloblastic leukemia as a second malignant tumor related to etoposide developed in one case with bilateral RB. Ten (32%) patients alive without disease; four (13%) patients alive with disease; five (16%) patients died of disease, and 12 (39%) patients lost to follow up.

Conclusion
Almost 70% of cases had at least RE Stage V disease, and 1/3 of the cases had bilateral disease. Globe salvage rate was low in this series. A significant number of patients had been previously admitted to several centers for diagnosis and treatment which could interfere with early diagnosis and optimal treatment.
BACKGROUND
Anthracyclines are potent anticancer drugs used in a large number of childhood cancers. A particular limitation of anthracycline therapy is dose-dependent cardiotoxicity. We aimed to determine the cardiotoxicity of these agents in children treated with anthracyclines, but without dexrazoxane.

PATIENTS AND METHODS
Children and adolescents with lymphoma or solid tumors (n: 330) were evaluated, and 109 (33%) of these cases, treated with anthracyclines ± chest radiotherapy (RT) were analyzed for cardiotoxicity. Seven patients were excluded, 102 patients were included in the study.

RESULTS
Forty six cases had lymphoma and 56 (55%) had solid tumors. The median age at tumor diagnosis was 10 years (0-18), and 65% were males. One patient had cardiac involvement of the malignant disease. Two patients had pre-existing heart disease (secundum ASD + MVP in one and mitral insufficiency in another) and 11 had family history of heart disease (CHD and/or cardiac insufficiency) at the time of tumor diagnosis. All received anthracycline(s); 27 had (26%) also mediastinal RT, 11 (11%) received pulmonary RT. None received dexrazoxane since it is not available in the market. Baseline and follow up for cardiotoxicity was evaluated by physical examination, chest X-ray, ECG and ECHO. Exercise testing, radionuclide angiography and endomyocardial biopsy was not performed in this group. The median cumulative doxorubicine dose was 200 mg/m² (30-525 mg/m²). Eleven cases received > 440 mg/m² doxorubicine, only one developed cardiotoxicity. In all cases, the duration of anthracycline infusion was ≥ 1 hour. The median follow-up was 53 months (3-91 months). Cardiotoxicity was detected in 13 (13%) of the cases. All the patients in this group received ≤ 450 mg/m². Five (5%) patients had acute, 7 pts (7%) had chronic, and one case had both acute and chronic toxicity. In the chronic cardiotoxicity group (n:8) EKG and ECHO showed left ventricular dysfunction (n:3), left ventricular hypertrophy (n:1), mitral and aortic valve insufficiency (n:1), cardiomyopathy (n:1) and persistant ventricular extrasystole (n:2). Two patients died of cardiotoxicity: one died of cardiomyopathy and the other one who developed acute cardiotoxicity died suddenly at the early post-operative period.

CONCLUSION
One third of our patients received anthracyclines and the rate of cardiotoxicity was 13%. Prevention of this fatal complication is the most critical issue. In the meantime, anthracycline dose limitation remains the most effective tool in limiting the severity of cardiac damage however, it is not always helpful as in our experience. We need effective cardioprotective strategies including new drugs which are as potent as doxorubine, but showing a “heart-friendly” antitumor effect.
BACKGROUND
Palliative care is best provided at home if possible. But in a developing country not all homes are convenient for palliative care. Management of palliative care at home is challenging but satisfying.

MATERIALS AND METHODS
The records of 339 patients of the home care program managed by Hospice Nepal were studied for the past three years. Hospice service was provided inside the Kathmandu valley.

RESULTS
There were 161 males and 178 females and the most common diseases were hepato-biliary cancers followed closely by lung and stomach cancers. Pain was the commonest symptom followed by vomiting and swelling. Most number of visits is 18 times in six months followed by 6 times in 50 patients. Patients received oral procedures followed by catheter insertion or change. Half the patients preferred home care because of the finance, transport problems and lack of relatives to care for them. Forty percent of them preferred to die at home due to religious belief.

CONCLUSION
In developing countries, patients prefer hospice home care mostly due to reasons not related to their disease, but due to finance and religious region.
ABSTRACT 83

CANCER EPIDEMIOLOGY AND THE NEED FOR PALLIATIVE CARE IN A RUSSIAN REGION

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BACKGROUND
The main purpose of the study was to analyze cancer epidemiology, identify the need of cancer patients for palliative care and use these data for palliative care advocacy. The Nizhny Novgorod Region is one of the 10 Regions in Russia with the highest cancer incidence and mortality. 34 people die every day from cancer. Lung cancer incidence has increased by 63.0% in the last 11 years.

PATIENTS AND METHODS
We studied cancer incidence and death rates by sex, age, cancer site and stage, the 1-year and the 5-year relative survival rates in the region (1995-2005). To identify the local need for palliative care we used the methodology developed by Professor Irene Higginson (Kings College, UK, 1997).

RESULTS
The overall cancer incidence rates have increased 9.4 percent since 2000. 23.38% cancers were diagnosed in advanced stage. More than 7,500 cancer patients need palliative care annually. It is estimated that 25 specialist palliative care beds are required for a population of 250,000 based on the needs of cancer patients in the Region. For the population of 3.3 million this equates to 330 beds. Over 4,000 cancer patients need the skills of a specialist home care team and up to 1,800 need the expertise of a specialist inpatient palliative care unit. About 22,500 people may need specialist psychological care; over 15,000 family members require psychosocial support during the course of their relatives’ illness and their own bereavement.

CONCLUSION
Palliative care provision for cancer patients and their families today is of vital importance and must become an integral part of the Regional cancer service. Several specialist palliative care units have been already started. The time to act is now.
**ABSTRACT 84**

**STUDY ON THE RELATIONSHIP BETWEEN THE EXPRESSION OF THE GENE CODING THE KEY ENZYMES FOR THE CYTARABINE METABOLISM WITH THE OUTCOME OF CHILDHOOD LEUKEMIA**

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**BACKGROUND**

Ara-C is one of the major drugs in the chemotherapy for childhood acute lymphoblastic leukemia (ALL) as well as acute myeloid leukemia (AML). Ara-C should be transformed to be the activated form of Ara-CTP in the leukemia cells by a series of enzymes reaction, and deoxycytidine kinase (dCK) is a key enzyme in these reactions. Meanwhile, Ara-C will be metabolized to be Ara-U and lose its anti-tumor activation. As the key enzymes of Ara-C metabolism, dCK and CDA activities and their gene expression levels may influence Ara-C anti-tumor activation and the outcomes of the childhood AL treated with Ara-C contained protocols. The aim of this study was to detect the gene expressions of dCK and CDA in bone marrow cells from childhood patients with leukemia and to research the correlation between dCK and CDA gene expression levels with the different types of childhood AL and the outcome of the patients.

**METHODS**

By using semi-quantitative reverse transcriptase chain reaction (RT-PCR) technique to determine the expression of dCK and CDA mRNA in 48 cases of childhood AL consisting of 44 cases of new diagnosed patients (16 T-ALL, 12 B-lineage ALL, 16 AML) and 4 cases of relapsed patients (2 ALL and 2 AML). The expression difference of dCK and CDA mRNA between ALL and AML were evaluated using statistical methods.

**RESULTS**

The levels of dCK mRNA in new diagnosed ALL patients (1.9161±0.1290) were much higher than that of the relapsed patients (0.8031±0.0375), P<0.05. The expression of dCK mRNA in the ALL (1.9161±0.1290) were significantly higher than that of in the AML (0.8374±0.0955), P<0.05. The levels of dCK mRNA were not difference between new diagnosed AML and the relapsed cases P>0.05. The levels of dCK mRNA were not correlated with different subtype of ALL (T-ALL and B-lineage ALL),P>0.05. The levels of CDA mRNA were not correlated with the ALL and AML (P>0.05), and no difference between the new diagnosed and relapsed patients (P>0.05).

**CONCLUSION**

The study results showed that the expression level of dCK mRNA were significantly different in different types of childhood leukemia, and correlated with the outcomes of the patients. The expression level of dCK mRNA seems to be a much important prognostic factor and may be an available guidance in the individualized chemotherapy for childhood hematopoietic malignancies. However, the relationship between the expression level of CDA with Ara-C anti-tumor activation may not as evident as that of dCK.
BACKGROUND AND AIM
Pontine gliomas account for 80% of brainstem gliomas and despite treatment, less than 20% of patients can survive 2 years. We aimed to review our experience with childhood pontine gliomas.

PATIENTS AND METHODS
Hospital files of children who had a diagnosis of pontine gliomas at Hacettepe University Faculty of Medicine Department of Pediatric Oncology between 1975-2007 were analyzed. Demographic characteristics, presenting complaints, physical findings, diagnostic investigations, chemotherapy and radiotherapy practices and outcomes were noted.

RESULTS
98 children with pontine gliomas were diagnosed between 1975-2007. Diagnostic methods were CT in 37 patients (37.7%), MRI in 45 (45.9%), ‘CT + MRI’ in remaining 16 (16.3%). The great majority of the tumors were diffusely infiltrative. Median age at diagnosis was 8 years (2-14) (M/F: 53/45). Most common symptoms were strabismus (26.5%), ataxia (20.4%), headache (15.3%), weakness (13.2%), double vision (9.1%), speech difficulties (9.1%). Six patients underwent surgical interventions: four subtotal, one had gross-total resections and another had a biopsy: 3/6 high-grade, 3/6 low-grade astrocytomas. Chemotherapy protocols were: MOPP (46.5%), ‘cisplatin + etoposide’ (32.6%) and ‘CCNU-based regimens’ (16.3%). At a median of 5 months (0.1-216) two patients were alive for 4 and 216 months respectively. Excluding the single patient with longest survival no patient survived >27 months. Irradiated patients (n= 73, median EFS= 5 months) had significantly better survival than patients who received no therapy (n= 25, median EFS= 0.1 month). Patients who received chemotherapy in addition to radiotherapy (n= 43, median EFS= 6 months) survived significantly longer than others (n= 55, median EFS= 1 month).

CONCLUSION
Ultimate outcome was fatal nearly in all cases with pontine gliomas. Radiotherapy and chemotherapy provided relatively longer event-free survival, and should be offered to all cases. New therapy modalities should be investigated and tried for these very poor prognosis tumors, and all cases should be treated with an intention to cure.
**BACKGROUND**

The aim of this prospective study conducted by the GFAOP group (Groupe Franco Africain d’Oncologie Pédiatrique) was to improve the therapeutic results of Burkitt lymphoma and diffuse large B cell lymphomas which are still a challenge in developing countries. We report here the results of the Casablanca unit.

**MATERIALS AND METHODS**

Patients aged less than 20 years were included. The diagnosis was confirmed by cytology and/or biopsy. Pre-treatment investigations consisted of chest X ray, abdominal ultrasound, bone marrow aspirate and cerebrospinal fluid cytology. Patients were treated according to SFOP LMB 89 protocol.

**RESULTS**

From March 2001 to December 2007, 127 patients entered the study. The mean age was 7.45 years (range 2-10 years) with a sex ratio (M/F) of 2.43. The primary site was the abdomen in 86 cases (67.7%), the head and neck in 37 cases (29%) and other sites in 4 cases. Considering the LMB prognosis groups, 109 cases (86%) patients were of group B, 5 cases (4%) group A and 13 cases (10%) group C. One hundred and nine patients (86%) achieved complete remission. Eight patients relapsed from whom 1 case is in 2nd CR with 36 months follow up. Seven patients (5.5%) were non responders and died. Thirteen patients (10.2%) died from toxicity (3 from lysis syndrome, 9 from infection and 1 during surgery). The overall survival and event free survival are 74.8% and 73.2% respectively.

**CONCLUSION**

This study showed an increase in the cure rates compared to the previous series (5 years relapse free survival rate of 56%). However, improvement of supportive care is necessary to reduce the high rate of toxic death.
ABSTRACT 87

SURVIVAL OUTCOMES OF LOCALLY ADVANCED BREAST CANCER (LABC) TREATED AT LIMITED RESOURCE LEVEL AS DEFINED BY BREAST HEALTH GLOBAL INITIATIVE (BHGI)

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BACKGROUND
The primary purpose of our study was to determine the outcome of our LABC patients treated at limited resource level within the context of Breast Health Global initiative (BHGI) guidelines. Secondary objectives were to correlate predictive and prognostic features with event free survival (EFS) and overall survival (OS) and determine patterns of care delivered in this setting.

MATERIALS AND METHODS
237 consecutive patients with Stage III breast cancer treated in limited resource settings from January 1998-December 2005 were evaluated. Demographic data included age, socio-economic status (SES), and tumor size, number of involved lymph nodes, stage III sub-categories, grade, estrogen and progesterone receptor status, treatment profiles and responses. Survival outcomes at 5 and 10 years were calculated.

RESULTS
49 (20.7%) patients received neo-adjuvant chemotherapy. Only one patient achieved pathologic complete remission (pCR) after neo-adjuvant chemotherapy. By Cox regression analysis significant predictors of EFS and OS were tumor size \( p<0.01 \) (CI 95% 1.06-1.59) and \( p<0.3 \) (CI 95% 0.86-1.50), positive receptors \( p<0.01 \) (CI 95% 0.91-2.14) and \( p<0.05 \) (CI 95% 0.98-3.26), positive nodal status \( p<0.04 \) (CI 95% 1.0-1.55) and \( p<0.0001 \) (CI 95% 1.37-2.64). EFS at 5 and 10 years were 32% and 11%, OS was 58% and 37% at 5 and 10 years.

CONCLUSION
Treatment of LABC patients at limited resource level was resource intensive and varied for our vulnerable population with poor survival outcomes. Optimal level of care can only be achieved with aggressive health care policies, economic advancement and access to diagnostic and treatment services. Significant poor prognostic markers for survival outcomes were the number of involved lymph nodes and receptor status.
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