GRAND ROUNDS IN ONCOLOGY 2022

2ND - 4TH SEPTEMBER

Venue: Hotel Conrad, Pune

Oncology Group of Pune

CME CREDIT APPLIED

Navigating a safe journey through contemporary, real world oncological dilemmas

- Case dissections with the very best in the business
- Boots on the ground solutions
- Masterclass
- Current data summations by actual researchers – clinicians in the field
- Poster competitions for tomorrow's oncologists & much more...

You are invited to indulge and delve deep into this shared fountain of knowledge.

GRAND ROUNDS IN ONCOLOGY 2022

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OGP Oncology Group of Pune

GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Dear colleagues

It gives us great pleasure to invite you for the Grand Rounds in Oncology 2022, to be hosted from the **2nd to 4th September 2022** by the Oncology Group of Pune (OGP). **This conference will be held at Hotel Conrad, Pune**

OGP is a conglomerate of 120+ members practicing oncology in and around Pune. Most are life members, bonded together with monthly meetings for mutual knowledge exchange, data sharing and joint problem solving in this challenging field of ours.

The Grand Rounds in Oncology 2022 promises to be two and a half days of an academic gourmet, and we have taken the trouble of curating content which is very boots-on-the-ground and real world relatable. The format is in the form of case presentation and medical sleuthing, and the detectives in this oncological “who-done-it” are the best of the best from all over the country, a heady mix of the famous and respected and the up and coming; dashing current and future leaders in oncology. Equal emphasis is given to surgical, medical and radiation oncology, as well as histomolecular pathology and nuclear medicine. In short, there is something for everyone associated with cancer diagnostics and therapeutics.

Pune, this Oxford of the East, is salubrious in September. Our monsoons are fading and the temperature is in the late twenties. Lord Ganesha will be visiting and the air is festive.

Ladies and gentlemen, Pune welcomes you with open arms.

Regards,
Organising Team
Grand Rounds in Oncology 2022

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GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Organising Committee

Chairpersons

Dr. Sanjay Deshmukh
Director, Surgical Oncology,
Ruby Hall Clinic,
Pune

Dr. Minish Jain
Director, Medical Oncology,
Ruby Hall Clinic,
Pune

Organising Secretaries

Dr. Shona Nag
Director-Oncology,
Sahyadri Group of Hospitals,
Pune

Dr. Chetan Deshmukh
Sr. Consultant
Medical Oncology,
Deenanath Mangeshkar
Hospital & Research Centre,
Pune

Dr. Debanshu Bhaduri
Sr. Consultant
Surgical Oncology,
M N Budhrani Cancer Institute,
Pune

Treasurers

Dr. Manish Bhatia
Sr. Consultant Surgical Oncology,
M N Budhrani Cancer Institute,
Pune

Dr. Sachin Hingmire
Sr. Consultant Medical Oncology,
Deenanath Mangeshkar
Hospital & Research Center,
Pune

Scientific Committee

Dr. Girish Phadke (Chairperson)
Dr. Sujai Hegde
Dr. Anupama Mane
Dr. Padmaj Kulkarni
Dr. Sonali Pingale
Dr. Bhooshan Zade
Dr. Swapnil Karnik
Dr. Sujit Joshi
Dr. Rahul Kulkarni

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GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Friday Day 1,
2nd Sep. 2022 – HALL A

Time : 1:30 pm – 9:00 pm

1:30 pm - 2:00 pm	**Session Supported by Ethicon** VATS Lobectomy & Science of Stapling Speaker : Dr. Satyanand Shastri
2:00 pm - 2:30 pm	**Session Supported by Bard**
2.30 pm - 3.30 pm	**Conference Inauguration in HALL B (Pathology Session)**
	Session 1 : Masterclass - Surgical Video
	Session Lead : **Dr. Girish Phadke, Dr. Sujai Hegde**
	Chairpersons : Dr. Shriniketan Kale Dr. Anant Mane
3:30 pm - 3:45 pm	Nodal dissection in thyroid cancers - Rationale and methods Speaker : Dr. Shivakumar Thiagarajan
3:45 pm - 4:00 pm	TEP - Techniques and trouble shooting Speaker : Dr. Prathamesh Pai
	Chairpersons : Dr. Sudeep Sarkar Dr. Atul Yadgire
4:00 pm – 4:15 pm	Nodal dissection in esophageal cancer - Concepts and approach Speaker : Dr. Suraj Pawar
4:15 pm – 4:30 pm	Vascular control in VATS surgery - lung and mediastinal tumours Speaker : Dr. George Karimundackal

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GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Friday Day 1,
2nd Sep. 2022 – HALL A

Time : 1:30 pm – 9:00 pm

4:30 pm – 4:45 pm	Vascular reconstruction in pancreatic cancers- Extent and limits Speaker : Dr. Shailesh Shrikhande
	Chairpersons : Dr. Ajay Punpale Dr. Pradeep Sharma
4:45 pm – 5:00 pm	Intersphincteric dissection and coloanal anastamosis- options Speaker : Dr. Praveen Kammar
5:00 pm – 5:15 pm	Sentinel node biopsy - comparison of techniques Speaker : Dr. Anupama Mane
5:15 pm – 5:30 pm	Oncoplasty- Basic to extreme Speaker : Dr. Shalaka Joshi
	Chairpersons : Dr. Manoj Lokhande Dr. Kiran Bagul
5:30 pm - 5:45 pm	Total Peritonectomy and HIPEC - Setting New Parameters Speaker : Dr. Sanket Mehta
5:45 pm – 6:00pm	Extended rectal resections- options for recurrent cancers Speaker : Dr. Ashwin D'souza
6:00 pm – 6:15 pm	ICG in Surgical Oncology - Here to stay Speaker : Dr. Md Basheeruddin Inamdar

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2ND TO 4TH SEPTEMBER

Friday Day 1,
2nd Sep. 2022 – HALL A

Time : 1:30 pm – 9:00 pm

	Chairpersons : Dr. S. G. Deshpande Dr. Ramesh Dumbre
6:15 pm – 6:30 pm	Vascular control in RCC - Minimum to maximum Speaker : Dr. Vivek Venkat
6:30 pm – 6:45 pm	Multiorgan resection - when and how Speaker : Dr. Shraddha Patkar
6:45 pm - 7:00 pm	IVC resections - Indication and methods Speaker : Dr. Mahesh Patel
7:00 pm – 7:15 pm	Q&A Dr. Girish Phadke & Dr. Sujai Hegde
HALL A (Surgical Video)	
7:15 pm – 8:00 pm	**Session Supported by Roche** Unresectable HCC-Can we take this bull by the horn? Moderator: Dr. Bhushan Nemade Panelists : Dr. Jayant Gawande Dr. Lt Col Bhupesh Guleria Dr. Parimal Lawate Dr. Shraddha Patkar Dr. Mukul Mutatkar Dr. Kunal Gala

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Friday Day 1,
2nd Sep. 2022 – HALL A

Time : 1:30 pm – 9:00 pm

8:00 pm – 8:30 pm	**Session Supported by Novartis** Consistent superior overall survival with Kryxana Speaker : Dr. Shriniwas Kulkarni
	Personalised therapy to the further improve outcomes in BRAF mutated mNSCLC Speaker : Dr. Mangesh Mekha
8:30 pm - 9:00 pm	**Session Supported by Dr.Reddy's** Role of anti-angiogenics in MCRC Speaker : Dr. Nagesh Sirsath
9.00 pm Onwards	**Conference Dinner**

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OGP Oncology Group of Pune

GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Friday Day 1,
2nd Sep. 2022 – HALL B

Time : 12:30 pm – 9:00 pm

12:30 pm - 1:30 pm	**Registration & Lunch**
	Session 2 : Histopathology & Molecular Genomics of Solid Tumours
	Session Lead: Dr. Swapnil Karnik, Dr. Sujit Joshi
	Chairpersons : Dr. Charusheela Gore, Dr. Ashwini Mane
1:30 pm - 2:00 pm	Slide Seminar Speaker : Dr. Shilpa Prabhudesai
2:00 pm - 2:30 pm	Chase the case-GUT- Slide Seminar Speaker : Dr. Santosh Menon
2:30 pm - 3:30 pm	**Conference Inauguration**
2:40 pm - 3:25 pm	Dr. R. V. Agrawal Memorial Oration “What I have unlearned about Cancer over the past 40 years as an Oncopathologist” Speaker : Dr. Anita Borges
	Chairpersons : Dr. Arijit Sen, Dr. Sachin Patil
3:25 pm - 4:00 pm	Towards cracking the nuts in Head & Neck Pathology Speaker : Dr. Shubhada Kane
	Chairpersons : Dr. Dattatreya Phadke, Dr. Avinash Pradhan
4:00 pm – 4:30 pm	Navigating Curves & Bends Speaker : Dr. Tanuja Shet
4:30 pm – 5:00 pm	Krebs, Castleman and more…….. Speaker : Dr. Jay Mehta

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OGP Oncology Group of Pune

GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Friday Day 1,
2nd Sep. 2022 – HALL B

Time : 12:30 pm – 9:00 pm

5:00 pm - 5:30 pm	**Tea Break**
	Chairpersons : Dr. Kalpana Kulkarni Dr. Baba Shinde
5:30 pm – 6:00 pm	On the horns of dilemmas: Everyday issues in Uropathology Reporting Speaker : Dr. Paromita Roy
6:00 pm – 6:30 pm	Think broad: Lessons learnt from GIT & Hepatobiliary Tumours Speaker : Dr. Prasenjit Das
	Chairpersons : Dr. Aditi Dastane Dr. Rujuta Ayachit
6:30 pm – 7:00 pm	The dynamic strides in our approach to managing lung neoplasms-Diagnostics & allied management Speaker : Dr. Kunal Sharma
7:00 pm – 7:30 pm	Molecular Diagnostics in Solid Tumours Speaker : Dr. Aparna Dhar
9.00 pm Onwards	**Conference Dinner**

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GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

INAUGURAL CEREMONY

SATURDAY

Sep 3 2022

5:10 pm - 6:20 pm

Invited Chief Guests

Dr. Narendra Jadhav
Former Member of
Parliament-Rajya Sabha

Dr. Rajendra Badwe
Director,
Tata Memorial Centre,
Mumbai

Venue

Hotel Conrad, Pune

OGP
Oncology Group of Pune

GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Inauguration Ceremony Schedule

5:10 pm - 5:15 pm	Welcome of all Dignitaries **Mr. Anuj Gurwara**
5:15 pm - 5:18 pm	Welcomes & explores the evolution of the OGP and its purpose **Dr. Sanjay Deshmukh** Organising Chairperson
5:18 pm - 5:19 pm	OGP Promo AV
5:19 pm - 5:22 pm	Introduction to GR 22 **Dr. Shona Nag** Organising Secretary
5:22 pm - 5:27 pm	Lighting of the lamp
5:27 pm - 5:29 pm	Introduction of Dr. Narendra Jadhav **Dr. Chetan Deshmukh** Organising Secretary
5:29 pm - 5:44 pm	Chief Guest's speech **Dr. Narendra Jadhav**
5:44 pm - 5:47 pm	Reminiscing on Dr. S R Shinde, his life and times **Dr. Debanshu Bhaduri** Organising Secretary
5:47 pm - 5:49 pm	Introduction of Dr. Rajendra Badwe **Dr. Girish Phadke** Chairperson, Scientific Committee
5:49 pm - 6:19 pm	Dr. S. R. Shinde Memorial Oration **Dr. Rajendra Badwe**
6:19 pm - 6:20 pm	Vote of thanks **Dr. Minish Jain**

OGP Oncology Group of Pune

GRAND ROUNDS IN ONCOLOGY 2022

2ND TO 4TH SEPTEMBER

Saturday Day 2, 3rd Sep. 2022

Time : 9:00 am – 9:00 pm

	Session 3 : Breast Cancer
	Session Lead : **Dr. Shona Nag, Dr. Anupama Mane**
	Chairpersons : Dr. Sudeep Gupta Dr. Viraj Borgoankar
9:00 am - 9:40 am	**Session Supported by RPG Life Sciences** Case based Panel Discussion on young TNBC Moderator : Dr. Nita Nair Panelists : Dr. Seema Gulia Dr. Nikhilesh Borkar Dr. Geeta Kadayaprath Dr. Vikram Maiya Dr. Varsha Hardas Dr. Tanuja Shet Dr. Aparna Dhar
	Chairpersons : Dr. Pranjali Gadgil Dr. Sachin Hingmire
9:40 am - 10:20 am	Case based Panel Discussion on ER+ve postmenopausal with Oligomet advanced breast cancer Moderator : Dr. Nitesh Rohatgi Panelists : Dr. Poonam Patil Dr. Rima Pathak Dr. Aparna Dhar Dr. Tanuja Shet Dr. Nikhilesh Borkar

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2ND TO 4TH SEPTEMBER

Saturday Day 2, 3rd Sep. 2022

Time : 9:00 am – 9:00 pm

10:20 am - 10:45 am	Chairpersons : Dr. Sudeep Gupta Dr. Vikas Palkar
	Real world data in breast cancer and practice changing papers in 2021-22 Speaker : Dr. Bhawna Sirohi
	Session 4 : Lung Cancer
	Session Lead : **Dr. Sanjay Deshmukh, Dr. Minish Jain**
	Chairpersons : Dr. Sanjay Desai Dr. Digvijay Patil
10:45 am - 11:25 am	Case Panel Discussion: T2N2 NSCLC: Options for Treatment Moderator : Dr. Prabhat Malik Panelists : Dr. George Karimundackal Dr. R. K. Deshpande Dr. Kumar Prabhash Dr. Anushil Munshi Dr. Bharat Bhosale Dr. Kunal Sharma
11:25 am - 12:05 pm	Chairpersons : Dr. Ashish Vaidya Dr. Ramesh Dumbre
	Case Base Panel Discussion:- Locally Advanced Ca Esophagus Moderator : Dr. Rajesh Mistry Panelists : Dr. Anil Tibdewal Dr. Maheboob Basade Dr. Sumeet Basu Dr. Suraj Pawar Dr. Sharad Desai Dr. Amit Bhatt

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Saturday Day 2, 3rd Sep. 2022

Time : 9:00 am – 9:00 pm

12:05 pm - 12:35 pm	Chairpersons : Dr. Sudesh Phanse Dr. Bhushan Nemade Debate Moderator : Dr. R. K. Deshpande Debate : NACT+RT Vs NACT in locally advanced esophageal cancer (Adneo) For NACT+RT : Dr. Anusheel Munshi For NACT : Dr. Ashish Singh
12:35 pm - 12:50 pm	Chairpersons : Dr. Manoj Parashar Dr. Mahendra Navare Year in review in lung cancer Speaker : Dr. Kumar Prabhash
12:50 pm - 1:05 pm	Year in review in esophageal cancer Speaker : Dr. George Karimundackal
1:05 pm - 2:05 pm	**Lunch Symposium**
1:05 pm - 1:20 pm	Redefining medical management in HER2 negative early breast Cancer Speaker : Dr. Shona Nag
1:25 pm - 1:45 pm	Evolving role of immunology in ES- SCLC Speaker : Dr. Jayant Gawande
1:45 pm - 2:05 pm	Real World Evidence Osimertinib as SoC in the management of EGFRm NSCLC Speaker : Dr. Bharat Bhosale

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Saturday Day 2, 3rd Sep. 2022

Time : 9:00 am – 9:00 pm

	Session 5 : GI – HPB
	Session Lead : **Dr. Debanshu Bhaduri,** **Dr. Sachin Hingmire**
	Chairpersons : Dr. Ajay Boralkar Dr. Sharan Basappa Hatti
2:05 pm - 2:50 pm	The day the plumbing clogged. Case and evidence evaluation of Colorectal Cancer Moderator : Dr. Sadiq Sikora Panelists : Dr. Kamran Khan Dr. Dodul Mondal Dr. Prasenjit Das Dr. Nagesh Sirsath
	Chairpersons : Dr. Jatin Desai Dr. Jaising Shinde
2:50 pm - 3:35 pm	The way of all flesh. Case and evidence evaluation of Pancreatic cancer Moderator : Dr. Shailesh Shrikhande Panelists : Dr. Bhawna Sirohi Dr. Dodul Mondal Dr. Vikram Choudhary Dr. Prasenjit Das Dr. Kunal Gala Dr. S. K. Srivastava

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Saturday Day 2, 3rd Sep. 2022

Time : 9:00 am – 9:00 pm

	Chairpersons : Dr. Shishir Shetty Dr. Deepak Chhabra
3:35 pm - 4:20 pm	She came riding a Zebra. Case and evidence evaluation of Neuroendocrine tumors Moderator : Dr. P Jagannath Panelists : Dr. Puneet Dhar Dr. Anita Borges Dr. Sandip Basu Dr. Dipanjan Panda
4:20 pm - 4:50 pm	Shall we dance : HIPEC in GI malignancies Debate Moderator : Dr. Kamran Khan It is the real deal : Dr. Rahul Chaudhary It isn't delivering : Dr. Snita Sinukumar
4:50 pm - 5:05 pm	To boldly go where no one has gone before : Current trends in GI-HPB Oncology Speaker : Dr. Bhawna Sirohi
5:10 pm - 6:20 pm	**Conference Inauguration**
6:20 pm - 6:50 pm	**Session Supported by Zydus**
6:50 pm - 7:05 pm	**Session Supported by Eli Lilly** What information will help improve our treatment decisions in EGFRm+ advanced NSCLC? - RELAYing RELAY Speaker : Dr. Ashish Singh

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Saturday Day 2, 3rd Sep. 2022

Time : 9:00 am – 9:00 pm

7:05 pm - 7:20 pm	**Session Supported by Eli Lilly** Cancer does not take a day off then why should a CDK 4/6 inhibitor Why is chose Abemaciclib for my HR+/HER2- MBC patients with poor prognostic factors Speaker : Dr. Poonam Patil
7:20 pm - 7:50 pm	**Session Supported by MSD** Redefining Survial Expectations in NSCLC_Keynote_189_and_ Keynote_407 & Speaker : Dr. Mehboob Basade
7:50 pm - 8:20 pm	**Session Supported by Merck/Pfizer**
8:20 pm - 8:40 pm	**Session Supported by BMS** Long term survival outcomes with Nivolumab in mNSCLC Speaker : Dr. Ashish Singh
8:40 pm - 9:00 pm	**Session Supported by BMS** Immune Checkpoint Inhibitors in 1L Gastric Cancer, GEJC and EAC Speaker : Dr. Prabhat Bhargav
	End of the Day

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Sunday Day 3, 4th Sep. 2022

Time : 7:30 am – 1:45 pm

7:30 am - 8:40 am	Poster Discussion
8:40 am - 9:00 am	**Session Supported by BMS** Optimizing treatment for R/M SCCHN with immune checkpoint inhibitors Speaker : Dr. Prasad Narayan
	Session 6 : Head and Neck Cancers
	Session Lead : **Dr. Manish Bhatia, Dr. Girish Phadke**
	Chairpersons : Dr. Sharad Desai Dr. Nagesh Madnoorkar
9:00 am - 9:40 am	Management of Locally Advanced Oral Cavity Cancer Moderator : Dr. Kaustubh Patel Panelists : Dr. Sarbani Laskar Dr. Vinaykant Shankhdhar Dr. Sanjay Vaid Dr. Shubhada Kane Dr. Ajay Singh Dr. Mandar Deshpande
	Chairpersons : Dr. Mehul Bhansali Dr. Fahim Goliwale
9:40 am - 10:10 am	Management of Locally Advanced Thyroid Cancer with Local Organ infiltration Moderator : Dr. Anil D'Cruz Panelists : Dr. Kaustubh Patel Dr. Sandip Basu Dr. Sanjay Vaid Dr. Shubhada Kane Dr. Monali Swain Dr. Vijay M Patil Dr. Ashwani Sharma

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2ND TO 4TH SEPTEMBER

Sunday Day 3, 4th Sep. 2022

Time : 7:30 am – 1:45 pm

10:10 am - 10:30 am	Chairpersons : Dr. Jayesh Raval Dr. Sudeep Sarkar
	Year in Review – Robotics in Head & Neck Oncology Speaker : Dr. Ashwani Sharma
10:30 am - 11:00 am	Chairpersons : Dr. Navin Bhambhani Dr. Rajeev Yande
	Debate Moderator : Dr. Gautam Sharan Debate: Early Glottic Cancers - LASER or Radiotherapy For Laser : Dr. Deepak Parikh For Radiotherapy : Dr. Sarbani Laskar
11:00 am - 11:30 am	**Session 7 : GYN/GU Cancers**
	Session Lead : Dr. Chetan Deshmukh
	Chairpersons : Dr. Satish Sonawane
	Debate Moderator : Dr. Hemant Tongaonkar Debate - Early prostate cancer In favour of Robotic Sx: Dr. Ganesh Bakshi In Favour Of SBRT : Dr. Debnarayan Dutta
11:30 am - 12:00 pm	Case Based Panel Discussion 1: Oligometastatic RCC Moderator : Dr. Himesh Gandhi Panelists : Dr. Shivde Subodh Dr. Prasad Narayanan Dr. Paromita Roy Dr. Debnarayan Dutta

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Sunday Day 3, 4th Sep. 2022

Time : 7:30 am – 1:45 pm

	Chairpersons : Dr. Parag Biniwale Dr. Ramesh A. Bhosle
12:00 pm - 12:30 pm	Case Based Panel Discussion 2: Endometrial Cancer Moderator : Dr. Shailesh Bondarde Panelists : Dr. Prashant Nyati Dr. Nilesh Lokeshwar Dr. Gautam Sharan Dr. Pramod Tike Dr. Srividya Sethuratam
12:30 pm - 1:00 pm	Case Based Panel Discussion 3: Ovarian Cancer Moderator : Dr. T. P. Sahoo Panelists : Dr. Vashistha Maniar Dr. Rohini Kulkarni Dr. Shilpa Prabhudesai Dr. Bharat Bhoslae
	Chairpersons : Dr. Hemant Tongaonkar Dr. Rajesh Saoji
1:00 pm - 1:15 pm	YIR Gynaecological Cancers Speaker : Dr. Amol Akhade
1:15 pm - 1:30 pm	YIR Genitourinary Cancers Speaker : Dr. Bhushan Nemade
1:30 pm - 1:45 pm	**Conference valedictory followed by Lunch**

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INSTRUCTIONS FOR PRESENTERS: POSTERS DISPLAY

We look forward to seeing your poster on display during the meeting and thank you in advance for your co-operation in following these guidelines.

❖ ONSITE ATTENDANCE

- As presenting author, your presence is requested onsite in Pune.

❖ PREPARING YOUR POSTER MATERIAL

- Printing and hanging your Poster on the related Poster board is mandatory for all delegates who have had their abstract accepted for Poster presentation.
- Please add clearly the FINAL ACCEPTANCE NUMBER (FAN) to your poster.
- If you don't know your FAN, please check in poster list in the programme.
- It is strictly mandatory that the first and presenting author includes a disclosure statement on the Poster, even if only to confirm that if he/she has no conflicts of interest to declare. Co-author disclosures are not mandatory on the Poster.
- Feel free to add your e-mail address to the poster: This will allow other attendees to contact you in case of any questions.
- If the study has received funding, this must also be acknowledged on your poster: "Study sponsored by..."
- Please rename your file before the upload as: "FINAL ACCEPTANCE NUMBER (FAN)- Presenter's name" To avoid any compatibility problems, do not use special characters (e.g., «, Ö, Ø, ñ, ε, ®, ý}, {etc.) in the file name.
- QR (Quick Response), AR (Augmented Reality), text key codes are allowed. However, although OGP accepts that these may go to a commercial/branded website, we suggest avoiding links to websites containing blatant

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INSTRUCTIONS FOR PRESENTERS: POSTERS DISPLAY

product advertising. If you intend adding a QR, AR or a text key code to your poster, please add the following disclaimer notice: "Copies of this poster obtained through QR, AR and/or text key codes are for personal use only and may not be reproduced without written permission of the authors".

- Posters may not present a commercial bias or use clearly identifiable commercial templates. The Grand Rounds in Oncology 2022 reviewers will be responsible for advising the Scientific Committee of any inappropriate commercial bias, promotion or branding unless clearly stated in a balanced and objective manner.

❖ DESIGN

- Layout:
  - Format of the Poster is horizontal (landscape). The maximum Poster size is 190cm width x 90cm height.
  - Keep data on the slide simple and ensure a logical order of the content. A clear and well-structured arrangement is the most attractive and the easiest to read.
- Text:
  - Your guiding principle should be "As much as necessary, as little as possible". The text should be concise and to the point, key facts may be highlighted.
- Colours:
  - Colours should be used sparingly. Choose colour combinations that make your text easy to read (preferably dark background – light fonts; avoid red and green).
- Images:
  - It is recommended that you collect your illustration material well in advance. Do not select too many images and concentrate on those which support your key points and conclusions optimally.

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INSTRUCTIONS FOR PRESENTERS: POSTERS DISPLAY

- Content:
  - Should follow standard poster presentation norms
  - In case of data series, original research, in the form of IMRAD
  - In case of case reports, follow standard case presentation format and flow
  - All posters must lead with an abstract
  - All poster content must be clearly visible at least three feet away. (Smallest line visibility)
  - Poster size is non negotiable; accordingly, design your poster carefully.

❖ POSTER DISPLAY INFORMATION

- The poster must be attached to the board bearing the final abstract acceptance number (FAN) between 09:00 and 11:00 on Saturday, 3 September 2022. Posters will remain on display for the duration of the Congress.
- Poster boards allow for the use of double-sided tape only. The organisers will provide double-sided tape in the poster area.

❖ POSTER HANGING AND REMOVAL TIMELINE

- Please follow the timeline provided below and note the time when you must hang and remove your poster.

❖ NO-SHOW POLICY - The abstract's first and presenting author who, without notice, is absent during the Poster Display session when his/her poster is due to be presented is likely to forfeit his/ her chance of displaying his/ her poster in the first instance

❖ IMPORTANT NOTICE - In order to respect Grand Rounds in Oncology 2022 compliance policy for scientific balance and impartiality, the organisers will assign auditors to all presentations given during the official Grand Rounds in Oncology 2022 programme.

Kindly email abstract and poster to

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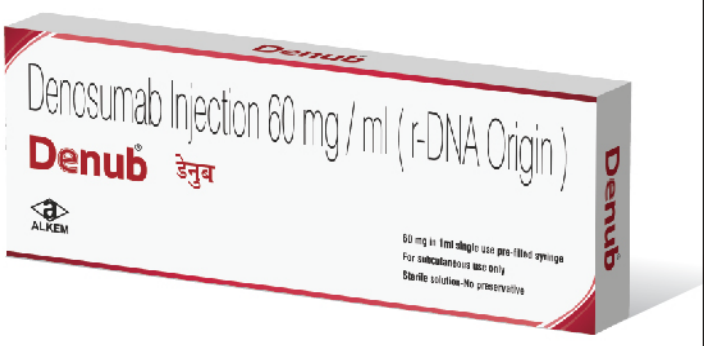

1. Neunert, C., Terrell, D.R., Arnold, D.M., Buchanan, G., Cines, D.B., Cooper, N., Cuker, A., Despotovic, J.M., George, J.N., Grace, R.F. and Kühne, T., 2019. American Society of Hematology 2019 guidelines for immune thrombocytopenia. Blood advances, 3(23), pp.3829-3866. ** : Data on File

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PHARMACEUTICAL FORM AND COMPOSITION: UJVIRA™ Injection is lyophilized powder for concentrate for solution for infusion. 160 mg single dose lyophilized powder for infusion & 100 mg single dose lyophilized powder for infusion. **THERAPEUTIC INDICATION:** UJVIRA™ is indicated for the treatment of patients with HER2-positive, unresectable locally advanced or metastatic breast cancer who had previously received trastuzumab and a taxane, separately or in combination. It is also indicated for the adjuvant treatment of patients with HER2-positive early breast cancer with residual invasive disease in the breast and/or lymph nodes after receiving neo-adjuvant taxane-based and HER2-targeted therapy. **POSOLOGY AND METHOD OF ADMINISTRATION:** UJVIRA™ should be administered as an intravenous infusion. Do not administer as an intravenous push or bolus. It should be given at a dose of 3.6 mg / kg body weight with 3 weekly intervals (21 Day cycle). The first dose should be administered over 90 minutes intravenous infusion. Patients should be observed for fever and chills or other symptoms related to infusion. **SUBSEQUENT DOSES:** If the previous dose was well tolerated, the 3.6 mg / kg body weight dose can be administered over 30 minutes intravenous infusion. If dose reduction is done due to drug related adverse effect, then the dose should not be re-escalated in subsequent cycles. **CONTRAINDICATIONS:** There are no known contraindications to UJVIRA™. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE:** Infusion-related reactions and hypersensitivity characterized by one or more of the following symptoms have been reported with trastuzumab emtansine- flushing, chills, pyrexia, dyspnoea, hypotension, wheezing, bronchospasm and tachycardia. It is recommended to monitor serum transaminases and bilirubin prior to initiate the treatment with UJVIRA™ as hepatoxicity risk is associated. UJVIRA™ administration may lead to reductions in left ventricular ejection fraction. Evaluate left ventricular function in all patients prior to and during treatment with UJVIRA™. It is recommended that platelet counts are monitored prior to each trastuzumab emtansine dose. Patients with significant thrombocytopenia should be monitored closely while on trastuzumab emtansine treatment. **PREGNANCY:** UJVIRA™ should be avoided during pregnancy as it can cause fetal harm when administered to a pregnant woman. **NURSING MOTHERS:** Women should discontinue breast-feeding prior to initiating treatment with trastuzumab emtansine. Women may begin breast-feeding 7 months after concluding treatment. **ADVERSE EVENTS:** Some reported adverse events included vomiting, pyrexia, cough, thrombocytopenia, aspartate aminotransferase increased and pain. **STORAGE:** Store vials between +2°C and +8°C. **RECONSTITUTED SOLUTION:** It is recommended to use immediately. If not used, it can be stored between +2°C and +8°C up to 24 hours. Do not freeze.
Please refer to the full Prescribing Information before using UJVIRA™

#Based on analysis from R&D batches
IV: Intravenous, ADC: Antibody-Drug Conjugate, MoA: Mode of Action HER2+: Human Epidermal growth factor Receptor 2 positive, EBC: Early Breast Cancer, MBC: Metastatic Breast Cancer,
Reference: 1. Data on file.

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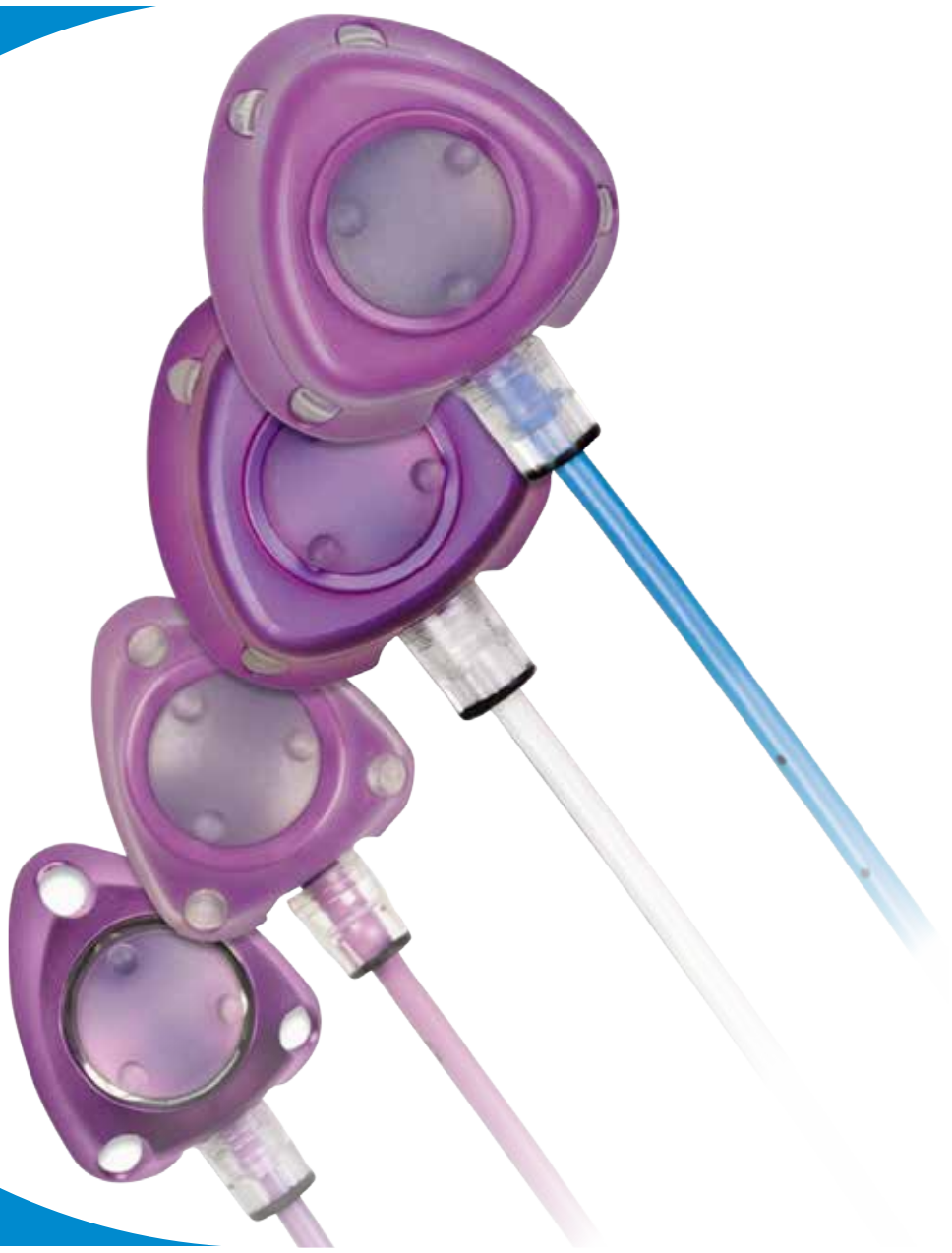

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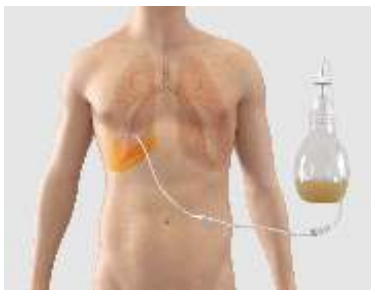

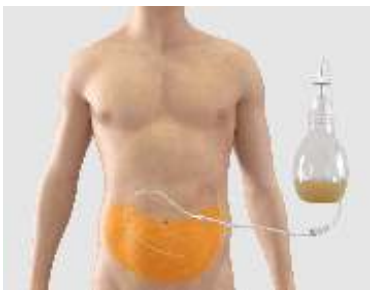

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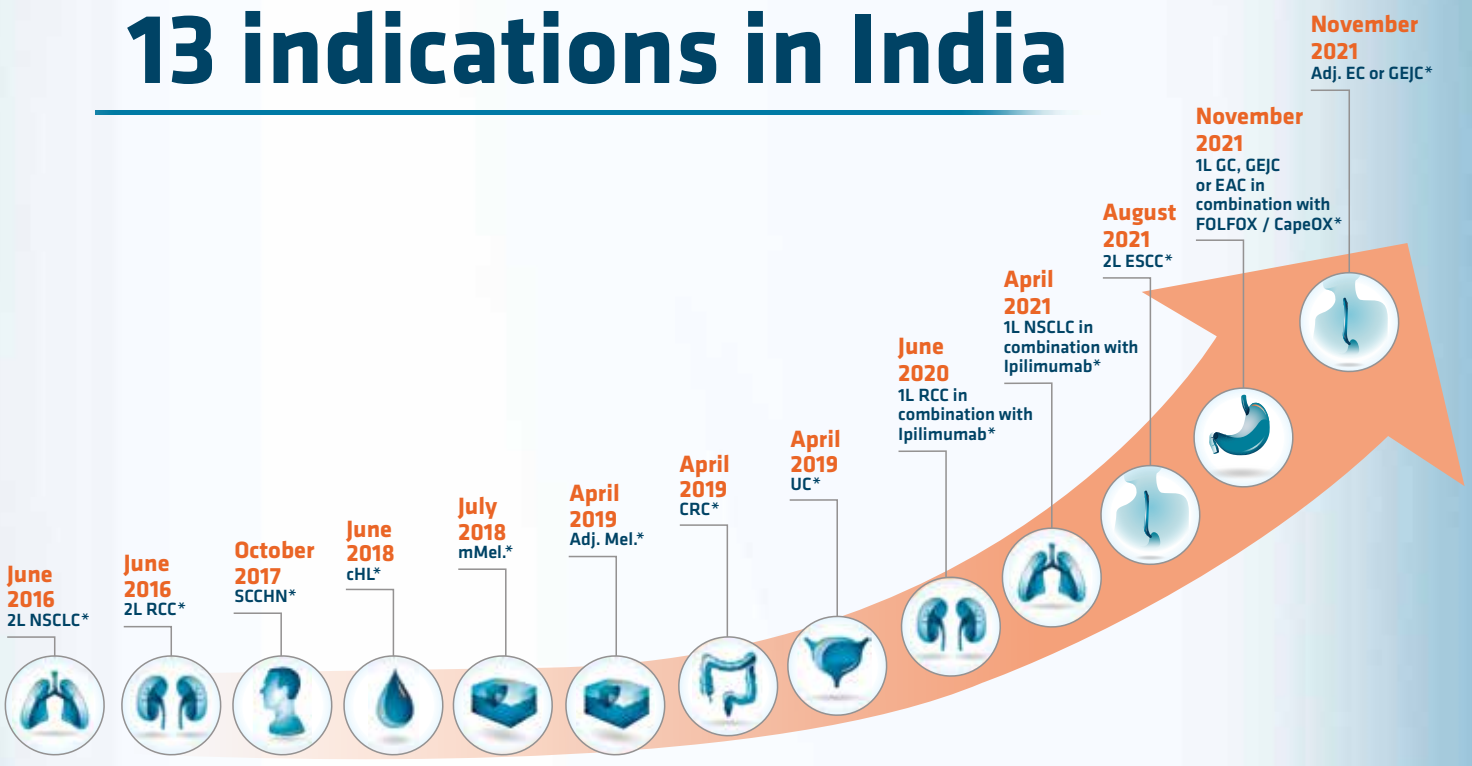

IO: Immuno-Oncology; NSCLC: Non-small Cell Lung Cancer; RCC: Renal Cell Carcinoma; SCCHN: Squamous Cell Carcinoma of the Head and Neck; mMel.: metastatic Melanoma; Adj. Mel.: Adjuvant Melanoma; CRC: Colorectal Cancer; UC: Urothetial Carcinoma; cHL: Classical Hodgkin Lymphoma; ESCC: Esophageal Squamous Cell Carcinoma; Adj. EC/GEJC: Adjuvant treatment of resected Esophageal Cancer or Gastroesophageal Junction Cancer; GC: Gastric Cancer; GEJC: Gastroesophageal Junction Cancer; EAC: Esophageal Adenocarcinoma; FOLFOX: Folinic acid, fluorouracil, and oxaliplatin; CapeOX: Capecitabine plus oxaliplatin

*Please refer to complete indication wording mentioned below in API.
OPDYTA® (Nivolumab) India Prescribing Information version 13 dated 22nd Jun 2022

Abridged Prescribing Information (API): To be sold by retail on the prescription of a Registered Oncologist only. OPDYTA® 10 mg/mL concentrate for solution for infusion. Composition: One vial of 4 mL contains 40 mg of nivolumab; One vial of 10 mL contains 100 mg of nivolumab. **Therapeutic Indications:** Non-Small Cell Lung Cancer (NSCLC): As a single agent for the treatment of locally advanced or metastatic NSCLC after prior chemotherapy; Nivolumab, in combination with ipilimumab, is indicated for the first-line treatment of adult patients with metastatic NSCLC whose tumors express PD-L1 (≥1%) as determined by a validated test, with no EGFR or ALK genomic tumor aberrations. Nivolumab, in combination with ipilimumab and 2 cycles of platinum-doublet chemotherapy, is indicated for the first-line treatment of adult patients with metastatic or recurrent NSCLC, with no EGFR or ALK genomic tumor aberrations; Renal Cell Carcinoma (RCC): As a single agent for the treatment of patients with advanced RCC after prior therapy in adults and for the treatment of patients with intermediate or poor risk, previously untreated advanced renal cell carcinoma, in combination with ipilimumab; Squamous Cell Carcinoma of the Head and Neck (SCCHN): As monotherapy for the treatment of recurrent or metastatic SCCHN after platinum-based therapy; Melanoma: As a single agent for the treatment of patients with BRAF V600 wildtype unresectable or metastatic melanoma, as a single agent for the treatment of patients with BRAF V600 mutation positive unresectable or metastatic melanoma, For the treatment of patients with melanoma with lymph node involvement or metastatic disease who have undergone complete resection, in the adjuvant setting; Classical Hodgkin Lymphoma (cHL): For the treatment of adult patients with cHLthat has relapsed or progressed after – autologous hematopoietic stem cell transplantation (HSCT) and brentuximab vedotin / 3 or more lines of systemic therapy that includes autologous HSCT; Urothelial Carcinoma (UC): For the treatment of patients with locally advanced or metastatic UC who have disease progression during or following platinum-containing chemotherapy OR have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy; Colorectal Cancer (CRC): As monotherapy for the treatment of adult and pediatric (12 years and older) patients with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic CRC that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. Esophageal Squamous Cell Carcinoma (ESCC): for the treatment of patients with unresectable advanced, recurrent, or metastatic ESCC after prior fluoropyrimidine- and platinum-based chemotherapy; Gastric Cancer, Gastroesophageal Junction Cancer, and Esophageal Adenocarcinoma (GC, GEJC or EAC): Nivolumab, in combination with fluoropyrimidine- and platinum-containing chemotherapy for the treatment of patients with advanced or metastatic gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma; Adjuvant treatment of Resected Esophageal or Gastroesophageal Junction Cancer (EC or GEJC): As monotherapy for the adjuvant treatment of completely resected esophageal or gastroesophageal junction cancer with residual pathologic disease in patients who have received neoadjuvant chemoradiotherapy (CRT). **Dosage and administration: Nivolumab as monotherapy (NSCLC, RCC, SCCHN, melanoma, cHL, UC, CRC)** - 3 mg/kg administered intravenously every 2 weeks over 30 minutes. **Nivolumab as monotherapy for ESCC, EC and GEJC:** Weight-based dosing- 3 mg/kg every 2 weeks over a period of 30 minutes Or Flat dosing- 240 mg every 2 weeks or 480 mg every 4 weeks. For adjuvant treatment, the maximum duration of nivolumab is 12 months. **Nivolumab in combination with fluoropyrimidine- and platinum-containing chemotherapy GC, GEJC and EAC:** 360 mg Nivolumab intravenously over 30 minutes in combination fluoropyrimidine- and platinum-containing chemotherapy every 3 weeks or 240 mg nivolumab intravenously over 30 minutes in combination with fluoropyrimidine and platinum-based chemotherapy every 2 weeks until disease progression or unacceptable toxicity. The maximum treatment duration for nivolumab is 24 months. **Nivolumab in combination with ipilimumab and platinum-based chemotherapy (NSCLC):** The recommended dose is 360 mg nivolumab administered as an intravenous infusion over 30 minutes every 3 weeks in combination with 1 mg/kg ipilimumab administered as an intravenous infusion over 30 minutes every 6 weeks, and platinum chemotherapy administered every 3 weeks. After completion of 2 cycles of chemotherapy, treatment is continued with 360 mg nivolumab administered as an intravenous infusion every 3 weeks in combination with 1 mg/kg ipilimumab every 6 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression. **Nivolumab in combination with ipilimumab (RCC):** Combination phase: nivolumab 3 mg/kg over 30 minutes every 3 weeks for the first 4 doses in combination with ipilimumab 1 mg/kg over 30 minutes, followed by the single-agent phase. Single-agent phase: 3 mg/kg every 2 weeks over 30 minutes. The first dose of nivolumab monotherapy should be administered 3 weeks following the last dose of the combination of nivolumab and ipilimumab. **Nivolumab in combination with ipilimumab (NSCLC):** The recommended dose of nivolumab is 3 mg/kg administered intravenously over a period of 30 minutes every 2 weeks combined with ipilimumab 1 mg/kg administered intravenously over a period of 30 minutes every 6 weeks until disease progression, unacceptable toxicity, or up to 24 months in patients without disease progression. **For all combination therapy** When administered in combination with ipilimumab, with ipilimumab and chemotherapy, or with other therapeutic agents, nivolumab should be given first followed by ipilimumab (if applicable) and then chemotherapy or other therapeutic agents on the same day. **Safety related information Contraindications:** None. **Warnings and Precautions: Recommended treatment modifications for nivolumab or nivolumab in combination with ipilimumab** *Immune-related pneumonitis:* Withhold for grade 2 and permanently discontinue for grade 3 or 4 pneumonitis. *Immune-related colitis:* Withhold for Grade 2 diarrhoea or colitis. Withhold Nivolumab monotherapy for Grade 3 diarrhoea or colitis. Permanently discontinue nivolumab + ipilimumab for Grade 3 & 4 diarrhea or colitis. Permanently discontinue nivolumab monotherapy for Grade 4 diarrhea or colitis. *Immune-related hepatitis:* Monitor for change in liver function. Withhold for grade 2 and permanently discontinue for grade 3 or 4 elevation in aspartate aminotransferase (AST), alanine aminotransferase (ALT), or total bilirubin. *Immune-related nephritis* and *renal dysfunction:* Monitor for changes in renal function. Withhold for grade 2 or 3 and permanently discontinue for grade 4 serum creatinine elevation. *Immune-related endocrinopathies:* Monitor for changes in thyroid function. Initiate thyroid hormone replacement as needed. Monitor for hyperglycemia. Withhold for symptomatic grade 2 or 3 and permanently discontinue for grade 4 hypophysitis. Withhold for grade 2 and permanently discontinue for grade 3 or 4 adrenal insufficiency. Withhold for symptomatic grade 2 or 3 and permanently discontinue for grade 4 hypothyroidism or hyperthyroidism. Withhold for grade 3 and permanently discontinue for grade 4 diabetes. *Immune-related skin adverse reactions:* Withhold for grade 3 rash or suspected Stevens- Johnson syndrome (SJS) or toxic epidermal necrolysis (TEN) and permanently discontinue for grade 4 rash or confirmed SJS/TEN. *Other immune-related adverse reactions:* Withhold for grade 3 (first occurrence) and permanently discontinue for grade 3 myocarditis, grade 4 or recurrent grade 3, persistent grade 2 or 3 despite treatment modification, inability to reduce corticosteroid dose to 10 mg prednisone or equivalent per day. When nivolumab is administered in combination with ipilimumab, if either agent is withheld, the other agent should also be withheld. If dosing is resumed after a delay, either the combination treatment or nivolumab monotherapy could be resumed based on the evaluation of the individual patient. *Complications of allogeneic hematopoietic stem cell transplant (HSCT) after Nivolumab:* Monitor for transplant-related complications, including GVHD. Fatal cases have been reported in clinical studies. *Infusion reaction:* Discontinue for severe and life-threatening infusion reactions. Patients with mild or moderate infusion reaction may receive nivolumab or nivolumab in combination with ipilimumab with close monitoring and use of premedication according to local treatment guidelines. *Increased mortality in patients with multiple myeloma [not an approved indication] when a PD-1 blocking antibody is added to a thalidomide analogue and dexamethasone:* Treatment of patients with multiple myeloma with a PD-1 blocking antibody in combination with a thalidomide analogue plus dexamethasone is not recommended outside of controlled clinical trials. **Drug Interactions:** Inhibition or induction of cytochrome P450 (CYP) enzymes or other drug metabolizing enzymes by coadministered medicinal products is not anticipated to affect the pharmacokinetics of nivolumab. The use of systemic corticosteroids and other immunosuppressants at baseline, before starting nivolumab, should be avoided. However, these can be used after starting nivolumab to treat immune-related adverse reactions. **Pregnancy:** Not recommended during pregnancy and in women of childbearing potential not using effective contraception unless the clinical benefit outweighs the potential risk. Women should be advised to use effective contraception for at least 5 months following the last dose of nivolumab. **Nursing Mothers:** Discontinue breastfeeding. **Pediatric Use:** The safety and efficacy have not been established. **Geriatric Use:** No dose adjustment is required for elderly patients (≥65 years). **Hepatic Impairment:** No dose adjustment is required in patients with mild or moderate hepatic impairment. **Renal Impairment:** No specific dose adjustment is necessary in patients with mild to moderate renal impairment. **Adverse Reactions:** Fatigue, rash, musculoskeletal pain, pruritus, diarrhea, nausea, cough, dyspnea, constipation, decreased appetite, back pain, arthralgia, upper respiratory tract infection, pyrexia, headache, abdominal pain, vomiting, neutropenia, hypothyroidism. Nivolumab is associated with immune-related adverse reactions. Most of these, including severe reactions, resolved following initiation of appropriate medical therapy or withdrawal of Nivolumab. **Overdose:** Closely monitor for signs and symptoms of adverse reactions and institute appropriate symptomatic treatment. **Storage:** Store in a refrigerator (2°C-8°C). Do not freeze. API based on prescribing information version 13 dated 22nd Jun 2022. Issued - 28th Jul 2022. **Before prescribing, consult full prescribing information.**

7356-IN-220012 Expiry Date – 20 July 2023

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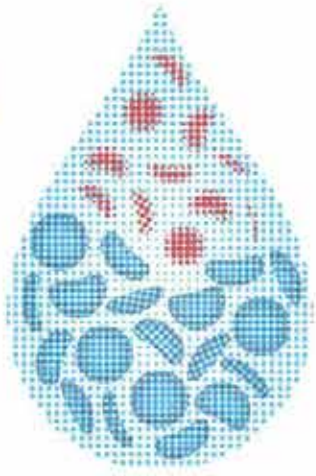

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4.5 YEARS mOS[3]
53.7 mo mOS with KRYXANA plus fulvestrant*
vs 41.5 mo mOS with placebo plus fulvestrant*
in postmenopausal HR+/HER2- aBC patients

MONALEESA-7:
NEARLY 5 YEARS mOS[4]
58.7 mo mOS with KRYXANA plus AI/tamoxifen#
vs 48.0 mo mOS with placebo plus AI/tamoxifen
in premenopausal HR+/HER2- aBC patients

*Included first-line (de novo or progression >12 mo after completion of [neo]adjuvant ET), early adjuvant relapsers (≤12 mo after completion of or during [neo]adjuvant ET) and those progressing following ET in the metastatic setting (second-line).[5]

#KRYXANA is not indicated for concomitant use with tamoxifen.

aBC, advanced breast cancer; AI, aromatase inhibitor; ET, endocrine therapy; HR+, hormone receptor positive; HER2-, human epidermal growth factor receptor 2 negative; mOS, median overall survival; mo, months; vs, versus.

REFERENCES:

1. Im S-A, Lu YS, Bardia A, et al. Overall Survival with Ribociclib plus Endocrine Therapy in Breast Cancer. N Engl J Med 2019;381:307-316.
2. Hortobagyi GN, Stemmer SM, Burris HA, et al. Overall survival results from the phase III MONALEESA-2 trial of postmenopausal patients with HR+/HER2− advanced breast cancer treated with endocrine therapy ± ribociclib. Presented at: European Society of Medical Oncology; September 16-21, 2021.
3. Slamon DJ, Neven P, Chia S, et al. Ribociclib plus fulvestrant for postmenopausal women with hormone receptor-positive, human epidermal growth factor receptor 2-negative advanced breast cancer in the phase III randomized MONALEESA-3 trial: updated overall survival. Ann Oncol. 2021;32(8):1015-1024.
4. Tripathy D, Im S-A, Colleoni M, et al. Updated overall survival (OS) results from the phase III MONALEESA-7 trial of pre- or perimenopausal patients with hormone receptor positive/human epidermal growth factor receptor 2 negative (HR+/HER2−) advanced breast cancer (ABC) treated with endocrine therapy (ET) ± ribociclib. Presented at: San Antonio Breast Cancer Symposium; December 8-12, 2020; San Antonio, TX. Poster PD2-04.
5. Slamon DJ, Neven P, Chia S, et al. Phase III randomized study of ribociclib and fulvestrant in hormone receptor-positive, human epidermal growth factor receptor 2-negative advanced breast cancer: MONALEESA-3. J Clin Oncol. 2018;36(24):2465-2472.

The images are for representation purpose only.

BASIC SUCCINCT STATEMENT (BSS)

KRYXANA®

Presentation: Film-coated tablets (FCT) containing 200 mg of Kryxana. **Indications:** Kryxana is indicated for the treatment of women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative locally advanced or metastatic breast cancer in combination with an aromatase inhibitor or fulvestrant as initial endocrine-based therapy, or in women who have received prior endocrine therapy. **Dosage and administration: Adults:** The recommended dose of Kryxana is 600 mg (3 x 200 mg FCT) taken orally, once daily for 21 consecutive days followed by 7 days off treatment resulting in a complete cycle of 28 days. **Special populations:** ♦Renal impairment: Mild or moderate: No dose adjustment. Severe: Starting dose of 200 mg is recommended. ♦Hepatic impairment: Mild: No dose adjustment. Moderate or severe: Starting dose of 400 mg is recommended. ♦Geriatrics (≥65 years): No dose adjustment. ♦Pediatrics: Safety/efficacy have not been established. **Contraindications:** ♦Hypersensitivity to ribociclib or to any excipient. **Warnings and precautions:** ♦**Neutropenia** was the most frequently reported ADR with Kryxana. Febrile neutropenia reported in 1.4% patients on Kryxana in phase III clinical studies. Based on the severity of neutropenia, Kryxana may require dose interruption, reduction, or discontinuation. A complete blood count should be performed before initiating therapy and should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles and then as clinically indicated. ♦**Increases in ALT and AST** have been reported, the majority of without concurrent elevations of bilirubin. Liver function tests should be performed before initiating therapy with Kryxana. LFTs should be monitored every 2 weeks for the first 2 cycles at the beginning of each of the subsequent 4 cycles and then as clinically indicated. Based on the severity of transaminase elevations, Kryxana may require dose interruption, reduction, or discontinuation. ♦**QT interval prolongation** has been reported with Kryxana. Kryxana should not be used in patients with a significant risk of QTc interval prolongation. The ECG should be assessed prior treatment. Treatment with Kryxana should be initiated only in patients with QTcF values <450 ms. An ECG should be repeated at approximately Day 14 of the first cycle, at the beginning of the second cycle and then as clinically indicated. Monitoring of serum electrolytes including potassium, calcium, phosphorous, and magnesium should be performed prior to treatment initiation, at the beginning of the first 6 cycles and then as clinically indicated. Abnormalities should be corrected before the start of Kryxana therapy. Based on observed QT prolongation during treatment, Kryxana may require dose interruption, reduction, or discontinuation. Kryxana is not recommended in combination with tamoxifen. ♦**Severe cutaneous reactions:** toxic epidermal necrolysis (TEN) has been reported with Kryxana. If signs and symptoms suggestive of severe cutaneous reactions appear, Kryxana should be immediately and permanently discontinued. ♦**Interstitial lung disease (ILD) / Pneumonitis:** ILD/pneumonitis has been reported with CDK4/6 inhibitors including Kryxana. Patients should be monitored for pulmonary symptoms indicative of ILD/pneumonitis. Based on the severity, patients may require treatment interruption, dose reduction, or permanent discontinuation. **Pregnancy, lactation, females and males of reproductive potential: Pregnancy:** Kryxana may cause fetal harm when administered to a pregnant woman. Patient should be advised of the risk to a fetus if Kryxana is used during pregnancy or if patient becomes pregnant while taking Kryxana. **Lactation:** A decision to discontinue either Kryxana or nursing should be made taking into account the importance of Kryxana to the mother. Do not breastfeed while taking Kryxana and for at least 21 days after the last dose of Kryxana. **Females and males of reproductive potential:** ♦**Pregnancy testing:** For females of reproductive potential pregnancy status should be verified prior to initiating treatment with Kryxana. ♦**Contraception:** Sexually active females of reproductive potential should use effective contraception (methods that result in < 1 % pregnancy rates) when using Kryxana during treatment and for 21 days after discontinuation. ♦**Infertility:** Impairment of fertility in males of reproductive potential indicated in animal studies. **Adverse drug reactions: Very common (≥10%):** Infections, neutropenia, leukopenia, anaemia, decreased appetite, headache, dizziness, dyspnoea, cough, back pain, nausea, diarrhoea, vomiting, constipation, stomatitis, abdominal pain, alopecia, rash, pruritus, fatigue, peripheral oedema, asthenia, pyrexia, abnormal liver function tests, leukocyte count decreased, neutrophil count decreased, haemoglobin decreased, lymphocyte count decreased, platelet count decreased, ALT increased, AST increased, creatinine increased, phosphorous decreased, Gamma-glutamyl transferase increased, albumin decreased, glucose serum decreased. **Common (≥1 to <10%):** Lymphopenia, thrombocytopenia, febrile neutropenia, lacrimation increased, dry eye, hypocalcaemia, hypokalaemia, hypophosphataemia, vertigo, syncope, dysgeusia, dyspepsia, hepatotoxicity, erythema, dry skin, vitiligo, dry mouth, oropharyngeal pain, peripheral oedema, electrocardiogram QT prolonged, potassium decreased, bilirubin increased. **Adverse drug reactions from post-marketing experience (frequency not known):** toxic epidermal necrolysis (TEN). **Interactions:** ♦**Concomitant** use of strong CYP3A inhibitors should be avoided. Alternative medications with less potential to inhibit CYP3A should be considered. Patients should be monitored for ADRs. If concomitant use of a strong CYP3A inhibitor cannot be avoided, the Kryxana dose should be reduced to 200 mg. Grapefruit or grapefruit juice should be avoided. ♦**Concomitant** use of strong CYP3A inducers should be avoided. Alternative medications with no or minimal potential to induce CYP3A should be considered. ♦**Caution** is advised when Kryxana is co-administered with CYP3A substrates with narrow therapeutic index; their dose may need to be reduced. ♦**Co-administration of Kryxana** with medications with known potential to prolong the QT interval should be avoided. Kryxana is not recommended for use in combination with tamoxifen.
Packs: Kryxana strip of 21 film coated tablets.

Before prescribing, please consult full prescribing information available from Novartis Healthcare Private Limited, Inspire BKC, Part of 601 & 701, Bandra Kurla Complex, Bandra (East), Mumbai – 400 051, Maharashtra, India. Tel +91 22 50243335/36, Fax +91 22 50243010.
For the use of Oncologists only.
India BSS dated 9 Sep 2020 based on international BSS dtd 25 Nov 19 effective from 9 Nov 2020.

Kryxana Digi poster/ONCO/KRYXANA/309368/02/10/2021

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OVERALL SURVIVAL AT ITS CORE

The **FIRST** and **ONLY** immunotherapy to demonstrate overall survival in the first-line setting for locally advanced or metastatic urothelial carcinoma (UC) as a maintenance treatment[1-9*]

Initial CT may help decrease the tumor burden. **BAVENCIO** maintenance therapy may result in enhanced antitumor activity while avoiding cross-resistance and cumulative toxicity[1-5]

JAVELIN Bladder 100 Trial: 1L maintenance therapy with BAVENCIO + BSC vs BSC alone[#7]

mOS, Overall Population

21.4 MONTHS mOS BAVENCIO + BSC vs **14.3 MONTHS** mOS BSC alone

Hazard ratio (HR): 0.69 (95% CI: 0.56, 0.86); 2-sided *P*=0.001

OS rate at 12 months

79.1% (95% CI: 0.72, 0.85) **BAVENCIO + BSC** vs **60.1%** (95% CI: 0.52, 0.68) BSC alone

NCCN Category 1 RECOMMENDATION[8,9] ESMO Category IA

Benefit across subgroups including type of 1L CT regimen, response to CT, PDL1 status and overall population[6,7]

References

CT, chemotherapy; IO, immunotherapy; OS, overall survival; UC, urothelial cancer.

*Bavencio is indicated as monotherapy for the first-line maintenance treatment of adult patients with locally advanced or metastatic urothelial carcinoma (UC) whose disease has not progressed with first-line platinum-based induction chemotherapy.

#For patients with locally advanced or metastatic UC whose disease has not progressed with 1L platinum-based induction chemotherapy

1. Grivas P, Monk BJ, Petrylak D, et al. Immune checkpoint inhibitors as switch or continuation maintenance therapy in solid tumors: rationale and current state. Targeted Oncol. 2019;14(5):505-525 ; 2. de Biasi AR, Villena-Vargas J, Adusumilli PS. Cisplatin-induced antitumor immunomodulation: a review of preclinical and clinical evidence. Clin Cancer Res. 2014;20(21):5384-5391 ; 3. Galluzzi L, Buque A, Keepp O, Zitvogel L, Kroemer G. Immunological effects of conventional chemotherapy and targeted anticancer agents. Cancer Cell. 2015;28(6):690-714 ; 4. Bavencio India PI, Jun 2021 ; 5. Collins JM, Gulley JL. Product review: avelumab, an anti-PD-L1 antibody. Hum Vaccin Immunother. 2019;15(4):891-908. doi. org/10.1080/216455 15.2018.1551671; 6.Powles T, Kopyltsov E, Su P-J, et al. Patient-reported outcomes from JAVELIN Bladder 100: avelumab first-line maintenance + best supportive care (BSC) vs BSC alone for advanced urothelial carcinoma. Poster presented at: European Society for Medical Oncology (ESMO) Virtual Congress 2020; September 19-21, 2020 ; 7. Powles T, Park SH, Voog E, et al. Maintenance avelumab + best supportive care (BSC) versus BSC alone after platinum-based first-line chemotherapy in advanced urothelial carcinoma: JAVELIN Bladder 100 phase III results [Abstract LBA1]. Presented at: American Society of Clinical Oncology (ASCO) 2020 Virtual Annual Meeting; May 29 to June 2, 2020; 8. NCCN Guidelines V2. 2021 9. eUpdate Bladder cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. 16 July 2020

Bavencio® (Avelumab) Abbreviated Prescribing Information:

Warning: To be sold by retail on the prescription of a "Registered Oncologist Only"

Before prescribing BAVENCIO®, please consult full prescribing information. **Presentation: BAVENCIO® 20 mg/ml** Concentrate for solution for Infusion. Excipients: Mannitol, Glacial acetic acid, Polysorbate 20, Sodium hydroxide, Water for injection. **Indications:** Bavencio is indicated as monotherapy for the treatment of adult patients with metastatic Merkel cell carcinoma (MCC). Bavencio is indicated as monotherapy for the first-line maintenance treatment of adult patients with locally advanced or metastatic urothelial carcinoma (UC) whose disease has not progressed with first-line platinum-based induction chemotherapy. Bavencio in combination with axitinib is indicated for the first-line treatment of adult patients with advanced renal cell carcinoma (RCC). **Dosage and administration:** Treatment should be initiated and supervised by a physician experienced in the treatment of cancer. The recommended dose of Bavencio as monotherapy is 800 mg administered intravenously over 60 minutes every 2 weeks. Administration of Bavencio should continue according to the recommended schedule until disease progression or unacceptable toxicity. The recommended dose of Bavencio in combination with axitinib is 800 mg administered intravenously over 60 minutes every 2 weeks and axitinib 5 mg orally taken twice daily (12 hours apart) with or without food until disease progression or unacceptable toxicity. For information on the posology of axitinib, please refer to the axitinib product information.Patients have to be premedicated with an antihistamine and with paracetamol prior to the first 4 infusions of Bavencio. If the fourth infusion is completed without an infusion-related reaction, premedication for subsequent doses should be administered at the discretion of the physician. **Special Populations:** Elderly: No dose adjustment is needed for elderly patients (≥ 65 years). Paediatric population: The safety and efficacy of Bavencio in children and adolescents below 18 years of age have not been established. Renal impairment: No dose adjustment is needed for patients with mild or moderate renal impairment. There are insufficient data in patients with severe renal impairment for dosing recommendations. Hepatic impairment: No dose adjustment is needed for patients with mild hepatic impairment. There are insufficient data in patients with moderate or severe hepatic impairment for dosing recommendations. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients listed in section 2. **Special warnings and precautions:** Infusion-related reactions. Patients should be monitored for signs and symptoms of infusion-related reactions including pyrexia, chills, flushing, hypotension, dyspnoea, wheezing, back pain, abdominal pain, and urticaria. For Grade 3 or Grade 4 infusion-related reactions, the infusion should be stopped and avelumab should be permanently discontinued. For Grade 1 infusion-related reactions, the infusion rate should be slowed by 50% for the current infusion. For patients with Grade 2 infusion-related reactions, the infusion should be temporary discontinued until Grade 1 or resolved, then the infusion will restart with a 50% slower infusion rate.
Immune-related adverse reactions: Most immune-related adverse reactions with avelumab were reversible and managed with temporary or permanent discontinuation of avelumab, administration of corticosteroids and/or supportive care. For suspected immune-related adverse reactions, adequate evaluation should be performed to confirm etiology or exclude other causes. Based on the severity of the adverse reaction, avelumab should be withheld and corticosteroids administered. If corticosteroids are used to treat an adverse reaction, a taper of at least 1-month duration should be initiated upon improvement. In patients, whose immune-related adverse reactions could not be controlled with corticosteroid use, administration of other systemic immunosuppressants may be considered. **Immune-related pneumonitis:** Patients should be monitored for signs and symptoms of immune-related pneumonitis and causes other than immune-related pneumonitis should be ruled out. Suspected pneumonitis should be confirmed with radiographic imaging. **Immune-related hepatitis:** Patients should be monitored for changes in liver function and symptoms of immune-related hepatitis and causes other than immune-related hepatitis should be ruled out. **Immune-related colitis:** Patients should be monitored for signs and symptoms of immune-related colitis and causes other than immune-related colitis should be ruled out. **Immune-related pancreatitis:** Patients should be monitored for signs and symptoms of immune-related pancreatitis. **Immune-related myocarditis:** Patients should be monitored for signs and symptoms of immune-related myocarditis. **Immune-related endocrinopathies:** Immune-related thyroid disorders, immune-related adrenal insufficiency, and Type 1 diabetes mellitus have been reported in patients receiving avelumab. Patients should be monitored for clinical signs and symptoms of endocrinopathies. Avelumab should be withheld for Grade 3 or Grade 4 endocrinopathies until resolution. Thyroid disorders (hypothyroidism/hyperthyroidism): Patients should be monitored for changes in thyroid function (at the start of treatment, periodically during treatment, and as indicated based on clinical evaluation) and for clinical signs and symptoms of thyroid disorders. **Adrenal insufficiency:** Patients should be monitored for signs and symptoms of adrenal insufficiency during and after treatment. **Type 1 diabetes mellitus:** Patients should be monitored for hyperglycaemia or other signs and symptoms of diabetes. **Immune-related nephritis and renal dysfunction:** Patients should be monitored for elevated serum creatinine prior to and periodically during treatment. Hepatotoxicity (in combination with axitinib) Patients should be more frequently monitored for changes in liver function and symptoms as compared to when avelumab is used as monotherapy. Avelumab should be withheld for Grade 2 hepatotoxicity until resolution and permanently discontinued for Grade 3 or Grade 4 hepatotoxicity. Corticosteroids should be considered for Grade ≥ 2 events. **Fertility, pregnancy and lactation:** Women of childbearing potential/Contraception. Women of childbearing potential should be advised to avoid becoming pregnant while receiving avelumab and should use effective contraception during treatment with avelumab and for at least 1 month after the last dose of avelumab. **Pregnancy:** There are no or limited data from the use of avelumab in pregnant women. It is not recommended to use avelumab during pregnancy unless the clinical condition of the woman requires treatment with avelumab. **Breast-feeding:** Breast-feeding women should be advised not to breast-feed during treatment and for at least 1 month after the last dose due to the potential for serious adverse reactions in breast-fed infants. **Fertility:** The effect of avelumab on male and female fertility is unknown. **Undesirable effects:** The most common adverse reactions with avelumab were fatigue (32.4%), nausea (25.1%), diarrhoea (18.9%), decreased appetite (18.4%), constipation (18.4%), infusion-related reactions (17.1%), weight decreased (16.6%), and vomiting (16.2%). The most common Grade ≥ 3 adverse reactions were anaemia (6.0%), dyspnoea (3.9%), and abdominal pain (3.0%). Adverse reactions reported for avelumab as monotherapy in patients with solid tumours, including metastatic MCC, or locally advanced or metastatic UC are **Infections and infestations:** Very common: Urinary tract infection; **Blood and lymphatic system disorders:** Very common: Anaemia; Common: Lymphopenia; **Endocrine disorders:** Common: Hypothyroidism; **Metabolism and nutrition disorders:** Very common: Decreased appetite; **Nervous system disorders:** Common: Headache, dizziness, neuropathy peripheral; **Vascular disorders:** Common: Hypertension, hypotension; **Respiratory, thoracic and mediastinal disorders:** Very common: Cough, dyspnoea; Common: Pneumonitis; **Gastrointestinal disorders:** Very common: Nausea, diarrhoea, constipation, vomiting, abdominal pain; Common: Dry mouth; **Skin and subcutaneous tissue disorders:** Common: Rash, pruritus, rash maculo-papular, dry skin; **Musculoskeletal and connective tissue disorders:** Very common: Back pain, arthralgia; Common: Myalgia; **General disorders and administrative site conditions:** Very common: Fatigue, pyrexia, oedema peripheral; Common: Asthenia, chills, influenza like illness; **Investigations:** Very common: Weight decreased; Common: Gamma-glutamyl transferase increased, blood alkaline phosphatase increased, amylase increased, lipase increased, blood creatinine increased; **Injury, poisoning and procedural complications:** Very common: Infusion related reaction. **Renal cell carcinoma:** In this patient population, the most common adverse reactions were diarrhoea (62.8%), hypertension (49.3%), fatigue (42.9%), nausea (33.5%), dysphonia (32.7%), decreased appetite (26.0%), hypothyroidism (25.2%), cough (23.7%), headache (21.3%), dyspnoea (20.9%), and arthralgia (20.9%). **Blood and lymphatic system disorders:** Common: Anaemia, thrombocytopenia; **Immune system disorders:** Common: Hypersensitivity; **Endocrine disorders:** Very Common: Hypothyroidism; Common: Hyperthyroidism, adrenal insufficiency, thyroiditis; **Metabolism and nutrition disorders:** Very common: Decreased appetite; Common: Hyperglycaemia; **Nervous system disorders:** Very common: Headache, dizziness; Common: Neuropathy peripheral; **Vascular disorders:** Very common: Hypertension; Common: Hypotension, flushing; **Respiratory, thoracic and mediastinal disorders:** Very common: Dysphonia, cough, dyspnoea; Common: Pneumonitis; **Gastrointestinal disorders:** Very common: Diarrhoea, nausea, constipation, vomiting, abdominal pain; Common: Dry mouth, colitis, Hepatobiliary disorders; Common: Hepatic function abnormal; **Skin and subcutaneous tissue disorders:** Very common: Rash, pruritus; Common: Rash pruritic, rash maculo-papular, pruritus generalized, dermatitis acneiform, erythema, rash macular, rash papular, rash erythematous, dermatitis, eczema, rash generalized; **Musculoskeletal and connective tissue disorders:** Very common: Arthralgia, back pain, myalgia; **Renal and urinary disorders:** Common: Acute kidney injury, **General disorders and administrative site conditions:** Very common: Fatigue, chills, asthenia, pyrexia; Common: Oedema peripheral, influenza like illness; **Investigations:** Very common: Weight decreased, alanine aminotransferase (ALT) increased, aspartate aminotransferase (AST) increased; Common: Blood creatinine increased, amylase increased, lipase increased, gamma-glutamyl transferase increased, blood alkaline phosphatase increased, blood creatine phosphokinase increased, blood thyroid stimulating hormone decreased, transaminases increased; **Injury, poisoning and procedural complications:** Very common: Infusion related reaction. **Interactions:** No interaction studies have been conducted with avelumab. Avelumab is primarily metabolized through catabolic pathways, therefore, it is not expected that avelumab will have pharmacokinetic drug-drug interactions with other medicinal products. **Effects on ability to drive and use machines:** Patients should be advised to use caution when driving or operating machinery until they are certain that avelumab does not adversely affect them. **Storage:** Store in a refrigerator (2°C - 8°C). **Do not freeze.** Store in the original package in order to protect from light.

Date of Information: June 2021

For further information refer to full prescribing information or write to:

Merck Specialities Pvt Ltd., Godrej One, 8th Floor, Pirojsha Nagar, Eastern Express Highway, Vikhroli (East) Mumbai – 400079

And

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References: 1. Szewczyk MT, Majewska GM, Cabral MV, Hölzel-Piontek K. Osmose Study: Multinational Evaluation of the Peristomal Condition in Ostomates Using Moldable Skin Barriers. Poster presented at ECET, Paris, France, June 2013.

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