

#### 4. H.D.R. Surface Mould Therapy

Surface mould therapy, which is used for the treatment of superficial surface tumour and has the advantage of control over depth of radiation and thereby sparing the tissue beyond certain depth. It did not become very popular at low dose rate because of associated radiation hazard. Introduction of HDR brachytherapy has renewed the interest of radiation oncologist in the application of surface mould therapy. It is delivered in a fractionated manner over a period of time using 5-8 Gys. per fraction for a total of 6-8 treatments given daily and gives excellent control. It is highly useful for treatment of superficial chest wall recurrences in post-mastectomy patients of carcinoma breast<sup>27</sup>.

#### Conclusion

HDR brachytherapy is slowly replacing all forms of low dose rate brachytherapy due to its inherent advantages and will be standard of care for the treatment of various cancers.

#### References

1. Paterson R. The treatment of malignant disease by radiotherapy. Edward Arnold: London, 1963.
2. Connell OD, Howard N, Joslin CAF, Ramsey NW et al. A new remotely controlled unit for the treatment of uterine carcinoma. Lancet 1965;2:570-571.
3. Williamson J, Thomasden B, Nath R eds. Brachytherapy physics. Medison WI, Medical Physics publishing, 1995.
4. Dale RG. The use of small fraction number in high dose rate gynaecological afterloading. Some radiobiological consideration. Brit. J. of radiology 1991;64:133-144.
5. Fowler JF. The radiobiology of brachytherapy HDR & LDR. Martinez AA, Orton CG, Mould RF (eds) Nucletron Colombia 1990;page 121-137.
6. Joslin CAF, Smith CW, Mallik A et al. The treatment of cervix cancer using high activity Cobalt 60 Sources. Br. J. Radiol. 1972;45:257-270.
7. Akine Y, Arimoto H, Ogino T et al. High dose rate intracavitary irradiation in the treatment of carcinoma of the uterine cervix: Early experience with 84 patients. Int. J. Radiation Oncology Biol. Phys. 1988;14:893-898.
8. Joslin CAF: High-activity source afterloading in gynecologic cancer and its future prospects. Endocuriether. Hyperther. Oncol, 1989;5:69-82.
9. Sood BM, Goirla G, Gupta S et al. Two fractions of high dose rate brachytherapy in the management of cervix cancer: Clinical experience with and without chemotherapy. Int. J. Radiation Oncology Biol. Phys. 2002;53:702-706.
10. Patel FD, Sharma SC, Negi PS et al. Low dose rate vs. high dose rate brachytherapy in the treatment of carcinoma of the uterine cervix: A clinical trial. Int. J. Radiation Oncology Biol. Phys. 1994;28:335-341.
11. Sarkaria JN, Petereit DG, Stitt JA et al. A comparison of the efficacy and complication rates of low dose rate versus high dose rate brachytherapy in the treatment of uterine cervical carcinoma. Int. J. radiation Oncology Biol. Phys. 1994;30:75-82.
12. Rotte K, et al. HDR brachytherapy for endometrial cancer. IN Mould RF Battermann JJ, Martinez AA, et al. Brachytherapy from radium to optimization, 1994:pp91-100, Veenendaal, The Netherlands, Nucletron International BV.
13. Sorbe BG, Smeds A-C, et al. Postoperative vaginal irradiation with high dose rate afterloading technique in endometrial carcinoma stage-I. Int. J. Radiation Oncology Biol. Phys. 1990;18:305-314.
14. Leung Tw, Wong VYW et al. High dose rate brachytherapy for carcinoma of the oral tongue. Int. J. radiation Oncology Biol. Phys., 1997;39:1113-1120.
15. Saw BC, Sunthralingam N: Quantative assessment of interstitial implants: Int. J. Radiation Oncology Biol. Phys., 1994;20:135-139.
16. Speiser BL, Spartling L: Remote afterloading brachytherapy for the local control of endobronchial carcinoma. Int. J. Radiot Oncol Phys 1992;25:579-587.
17. Chang ii, Horvath J, Peyton W, et al.: High dose rate afterloading intraluminal brachytherapy in malignant airway obstruction of lung cancer. Int. J. Radiot Oncol Phys 1993;28:589-596.
18. Gollins SW, Burt PA, Barber PV et al. High dose rate intraluminal radiotherapy for carcinoma of the bronchus outcome of treatment of 406 patients. Radiother Oncol 1994;33:31-39.
19. Taulelle M, Chauvet B, Vincent P et al. High dose rate endobronchial brachytherapy: results and complications in 189 patients. Euro. Respi. J. 1998;11:162-168.
20. Kelly JF, Delclos ME, Morice RC et al. High dose rate endobronchial brachytherapy effectively palliates symptoms due to airway tumours; the 10 year M.D. Anderson Cancer Centre experience Int. J. Radiat Oncol Phys, 2000;48:696-702.
21. Gejerman G, Mullokandov EA, Bagiella E et al. Endobronchial brachytherapy and external beam radiotherapy in patient with endobronchial obstruction and extrabronchial extension. Brachytherapy. 2002;1:204-210.
22. Sharma SC, Behra D, Beriwal S, et al. Evaluation of addition of endobronchial brachytherapy for the symptoms relief in locally adanced bronchogenic carcinoma. A prospective, randomized study. J. Clinical Radiotherapy & Oncol., 2002;2:14019.
23. Ranjan Sur RK Sharma SC, Deepinder PS et al. Radiation therapy of esophageal cancer role of high dose rate brachytherapy. Int. J. radiot Oncol Biol. Phys. 1992;22:1043-1046.
24. Jager J, Langendijk H, Pannebakker M et al. A single session of intraluminal brachytherapy in palliation of oesophageal cancer. Radiotherapy & Oncology. 1995; 37: 237-240.
25. Ranjan KS, Victron C, Bernard SA, Sharma V, et al.: Prospective randomized trial of HDR brachytherapy as a sole modality in palliation of advanced esophageal carcinoma - An international atomic energy agency study. Int. J. Radiot Oncol Biol. Phys; 2002;53:127-133.
26. Sharma V, Mahantshetty U, Dinashaw A, et al: Palliation of advanced/ recurrent esophageal carcinoma with high dose rate brachytherapy. Int. J. Radiot Oncol Biol. Phys. 2002;52:310-315.
27. Sharma SC, Negi PS, Singh DP, et al. High dose rate surface mould brachytherapy for superficial localized chest wall recurrences in postmastectomy carcinoma breast patients. J. Clin. Radiation Oncology. 1997;12:1-6.

#### ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH

The need for uniform ethical guidelines for research on human subjects is universally recognised. It has acquired a new sense of urgency as the critical issues in the area of biogenetic research involving human subjects have become acute. Apart from the mandatory *clinical trails* on new drugs, a number of *diagnostic procedures, therapeutic interventions and prevention measures* including the use of vaccines, are being introduced which involve human subjects. Further the advent of *new medical devices and radio-active materials* and therapeutic benefits of *recombinant DNA products* have added a new dimension to the ethical issues that need to be considered before evaluating these for their efficacy, utility and safety.

Any research using the human beings as subjects shall bear in

mind the following **principles** of : i) **essentiality**, (ii) **voluntariness**, **informed consent**, (iii) **non exploitation**, (iv) **privacy and confidentiality**, (v) **precaution and risk minimisation**, (vi) **professional competence**, (vii) **accountability & transparency**, (viii) **maximisation of public interest** and **distributive justice** (ix) **institutional arrangements** (x) **public domain** (xi) **totality of responsibility** and (xii) **compliance**.

Recent advances in the field of **Assisted Reproductive technologies, organ transplantation, Human genome analysis, and gene therapy** promise unquestionable benefits to mankind. At the same time, they raise many questions of law and ethics, stimulating public interest and concern.

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