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BONE TUMOR & BONE FRAGILITY

From A to Z

May 3-4, 2019

Bellevue Medical Center

CME CREDITS

in collaboration with

FFN LOPS

FFN Fragility Fracture Network of the Bone and Joint Decade

JEVTANA®
(cabazitaxel)
Injection

Every 2nd counts

In mCRPC progression:

HESITANT TO GIVE HIM JEVTANA®?

HE MAY NEED A 2ND TAXANE.

Timely use of JEVTANA after docetaxel can deliver a significant improvement in overall survival (OS) without compromising quality of life.[1-4]

JEVTANA provided a 69% relative increase in the probability of survival at 2 years in the TROPIC study compared with mitoxantrone (27% vs 16%, respectively).[2*]

JEVTANA in combination with prednisone or prednisolone is indicated for the treatment of adult patients with metastatic castration-resistant prostate cancer previously treated with a docetaxel-containing regimen.

mCRPC=metastatic castration-resistant prostate cancer.
*Median OS in the TROPIC study was 15.1 months with JEVTANA vs 12.7 months with mitoxantrone. In an updated analysis of TROPIC, with a combined median follow-up of 13.7 months, the probability of survival at 2 years was 27% for JEVTANA vs 16% for mitoxantrone (HR=0.72, 95% CI: 0.61-0.84; *P*<0.0001). In the TROPIC study the most common toxic effects of JEVTANA were hematologic; the most frequent hematologic grade 3 or higher adverse events (AEs) were neutropenia, leukopenia, and anemia. The most common nonhematologic grade 3 or higher AE was diarrhea.[1]

References: **1.** de Bono JS, Oudard S, Ozguroglu M, et al. Prednisone plus cabazitaxel or mitoxantrone for metastatic castration-resistant prostate cancer progressing after docetaxel treatment: a randomised open-label trial. *Lancet.* 2010;376(9747):1147-1154. **2.** Bahl A, Oudard S, Tombal B, et al. Impact of cabazitaxel on 2-year survival and palliation of tumour-related pain in men with metastatic castration-resistant prostate cancer treated in the TROPIC trial. *Ann Oncol.* 2013;24(9):2402-2408. **3.** Bahl A, Masson S, Malik Z, et al. Final quality of life and safety data for patients with metastatic castration-resistant prostate cancer treated with cabazitaxel in the UK Early Access Programme (EAP) (NCT01254279). *BJU Int.* 2015;116(6):880-887. **4.** Hofheinz RD, Lange C, Ecke T, et al. Quality of life and pain relief in men with metastatic castration-resistant prostate cancer on cabazitaxel: the non-interventional 'QoLiTime' study. *BJU Int.* 2017;119(5):731-740.

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WELCOME LETTER

On behalf of the Bellevue Medical Center, The Organizing Committee and the Scientific Committee, It gives us a great pleasure to invite you all to participate in "The Bone Tumor and Bone Fragility From A to Z Congress" which will be held on May 3-4, 2019 at the Bellevue Medical Center, Beirut - Lebanon.

The objective of this unique conference is to promote the highest standards of healthcare in the management and support of patients. The program aims at equipping healthcare professionals with knowledge about recent developments, advance the effectiveness of healthcare practice and delivery and increase the quality of patient care.

This year, our Congress theme "Bone Tumor & Bone Fragility" will be reflected through the scientific program in a series of high-profile plenary presentations and symposia. Our aim is to bridge gaps and pave the future by hosting several highly qualified speakers who will be giving lectures on Musculoskeletal Tumor: Pearls and Pitfalls, Challenges in Bone Tumors Treatment, Bone Fragility in Lower Extremities and Bone Tumors in Children.

I sincerely hope that this conference will deliberate and discuss all the different facets of Bone Tumor and Bone Fragility and come up with recommendations that will lead to a better, healthier world.

I am convinced, the program will provide you with new information, better knowledge in Oncology, Orthopedic and Osteoporosis, ideas on how to improve your research and results and it will be a stimulus to further harmonize our medical standards and to successfully compete with our neighboring disciplines.

Looking forward to a successful and fruitful congress and hoping to see you all there!

Prof. Ghassan Maalouf
President of the Congress

BONE TUMOR & BONE FRAGILITY FROM A TO Z

May 3-4, 2019 | Bellevue Medical Center

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Maroun Rizkallah

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BONE TUMOR & BONE FRAGILITY FROM A TO Z

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Friday 03 May 2019

08:00	Registration	
08:45	Welcome Note	
09:00 - 10:30	Session I: Muskuloskeletal Tumors: Pearls And Pitfalls	
	Moderators: Chawki Cortbawi - Fadi Farhat	
09:00 - 09:10	I Have A MSK Tumor; What Is The Work Up?	Alain Daher
09:10 - 09:20	How To Make Diagnosis In Patients With Bone Metastasis From Unknown Primary	Ralph Chebib
09:20 - 09:30	Whoops Surgeries: Considerations And Impact on Prognosis	Falah Bachour
09:30 - 09:40	Soft Tissue Sarcoma: Radiotherapy in the Era of Personalized Medicine	Tony Felefly
09:40 - 09:50	Role Of Chemotherapy In STS	Tarek Assi
09:50 - 10:00	Molecular Identities of Bone Tumors: Making Diagnosis and Surveillance Easier?	Georges Aftimos
10:00 - 10:10	Is The 2cms Surgical Margin UNIVERSAL?	Fadi Hoyek
10:10 - 10:20	Is Surgery in Spine Metastasis Always Palliative?	Nabil Okais
10:20 - 10:30	Discussion	
10:30 - 11:00	Coffee Break	
11:00 - 12:30	Session II: Challenges In Bone Tumors Treatment	
	Moderators: Georges Khoury - Hampig Kourieh	
11:00 - 11:10	What Should an Orthopedic Surgeon Know About Monoclonal Gammopathy Diseases	Fadi Nasr
11:10 - 11:20	Multiple Myeloma: State Of The Art Management in 2018	Colette Hanna
11:20 - 11:30	What Are The Challenges In Surgical Management of Primary Chondrosarcoma?	Chahine Assi Jad Mansour
11:30 - 11:40	Management of Primary Pelvic Bone Tumors	Johnny Abdelnoor
11:40 - 11:50	Which Benign Bone Tumor Could Degenerate?	Ramzi Moucharafiyeh

BONE TUMOR & BONE FRAGILITY FROM A TO Z

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Friday 03 May 2019

11:50 - 12:00	Role of Denosumab for the Prevention of Skeletal-Related Events in Patients with Bone Metastasis from Solid Tumors *Supported by an Unrestricted Granted from Amgen*	Hazem Assi
12:00 - 12:10	Bone Metastasis from Prostate Cancer: The Special Approach	Joseph Kattan
12:10 - 12:20	Is Chemotherapy Toxic for Bone Metabolism?	Jad Wakim
12:20 - 12:30	Discussion	
	Moderator: Falah Bachour	
12:30 - 13:30	Fix and Treat : Protect Your Bones *Symposium Sponsored by Eli Lilly*	Yasser Yaghi Fouad Fayad
13:30 - 14:30	Lunch Break	
14:30 - 16:00	Session III: Bone Fragility In Lower Extremities: We Should Act	
	Moderators: Jean Matar - Jeanine Menassa	
14:30 - 14:40	Is Reverse Shoulder Arthroplasty Gaining More Terrain in Frail Patients?	Rami El Abiad
14:40 - 14:50	How to Prevent Hip Nailing Failure in Elderly: Implants, Technique or Op Treatment?	Khaled Hussein
14:50 - 15:00	What are the Options in Intertrochanteric or Subtrochanteric Fracture Delayed Union	Elie Mansour
15:00 - 15:10	Atypical Femoral Fractures: Update of Management	Yasser Yaghi
15:10 - 15:20	What are The Particularities of Ankle Fragility Fractures in Diabetic Patients	Bachir Ghostine
15:20 - 15:30	Strategies to Prevent Bone Fragility in Elderly Patient	Patricia Fadel
15:30 - 15:40	Initiating Osteoporosis Treatment after Fracture: Fix and Treat or Should we Wait?	Ouidade Aitisha Tabesh
15:40 - 15:50	Bone Pain In Frail Adults, a Myth or a Reality?	Ghassan Mouhanna
15:50 - 16:00	Discussion	

WHEN PATIENT IS IN SURGERY WITH AN OSTEOPOROTIC FRACTURE

HELP TREAT THE UNDERLYNG CONDITION

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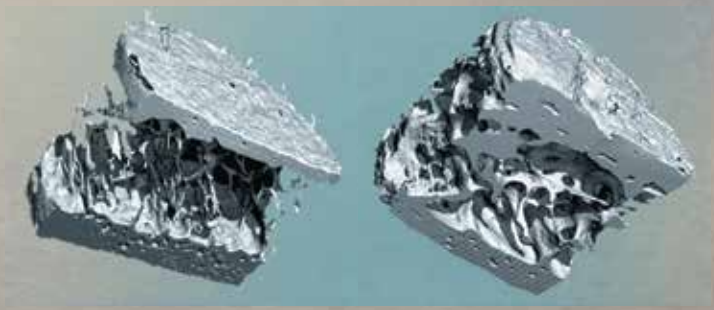

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1. Adapted from Jiang et al., J Bone Min Res 2003;18(11):1932-1941.

TERIPARATIDE is indicated for:

1- Treatment of postmenopausal women with osteoporosis at high risk for fracture.
2- Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture
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Solution for injection in pre-filled pen. Teriparatide
1. NAME OF THE MEDICINAL PRODUCT FORTEO 20 micrograms/80 microliters solution for injection in pre-filled pen. 2. QUALITATIVE AND QUANTITATIVE COMPOSITION Each dose contains 20 micrograms of teriparatide. One pre-filled pen of 2.4 ml contains 600 micrograms of teriparatide (corresponding to 250 micrograms per ml). Teriparatide, rhPTH(1-34), produced in E. coli, using recombinant DNA technology, is identical to the 34 N-terminal amino acid sequence of endogenous human parathyroid hormone. 3. PHARMACEUTICAL FORM Solution for injection in a pre-filled pen. Colourless, clear solution. 4. CLINICAL PARTICULARS 4.1 Therapeutic indications. Treatment of osteoporosis in postmenopausal women and in men at increased risk of fracture . In postmenopausal women, a significant reduction in the incidence of vertebral and non-vertebral fractures but not hip fractures has been demonstrated. Treatment of osteoporosis associated with sustained systemic glucocorticoid therapy in women and men at increased risk for fracture 4.2 Posology and method of administration. The recommended dose of FORTEO is 20 micrograms administered once daily by subcutaneous injection in the thigh or abdomen. Patients must be trained to use the proper injection techniques . A User Manual is also available to instruct patients on the correct use of the pen. The maximum total duration of treatment with FORTEO should be 24 months . The 24-month course of FORTEO should not be repeated over a patient's lifetime. Patients should receive supplemental Calcium and vitamin D supplements if dietary intake is inadequate. Following cessation of FORTEO therapy, patients may be continued on other osteoporosis therapies. FORTEO should not be used in patients with severe renal impairment . No data are available in patients with impaired hepatic function . 4.3 Contraindications • Hypersensitivity to the active substance or to any of the excipients. • Pregnancy and lactation • Pre-existing hypercalcemia • Severe renal impairment. • Metabolic bone diseases other than primary osteoporosis (including hyperparathyroidism and Paget's disease of the bone). • Unexplained elevations of alkaline phosphatase. • Prior external beam or implant radiation therapy to the skeleton. • Patients with skeletal malignancies or bone metastases should be excluded from treatment with teriparatide. 4.4 Special warnings and precautions for use In normocalcemic patients, slight and transient elevations of serum calcium concentrations have been observed following teriparatide injection. Serum calcium concentrations reach a maximum between 4 and 6 hours and return to baseline by 16 to 24 hours after each dose of teriparatide. Routine calcium monitoring during therapy is not required. Therefore if any blood samples are taken from a patient, this should be done at least 16 hours after the most recent FORTEO injection. FORTEO may cause small increases in urinary calcium excretion, but the incidence of hypercalciuria did not differ from that in the placebo-treated patients in clinical trials. FORTEO has not been studied in patients with active urolithiasis. FORTEO should be used with caution in patients with active or recent urolithiasis because of the potential to exacerbate this condition. In short-term clinical studies with FORTEO, isolated episodes of transient orthostatic hypotension were observed. Typically, an event began within 4 hours of dosing and spontaneously resolved within a few minutes to a few hours. When transient orthostatic hypotension occurred, it happened within the first several doses, was relieved by placing subjects in a reclining position, and did not preclude continued treatment. 4.8 Undesirable effects. The most commonly reported adverse reactions in patients treated with FORTEO are nausea, pain in limb, cramps,vertigo, headache, sciatica, dizziness, palpitations, anaemia,dyspnea,increased sweating, hypotension, Hypercholesterolemia, fatigue, chest pain, depression. 5. PHARMACEUTICAL PARTICULARS. Shelf life 2 years Chemical, physical and microbiological in-use stability has been demonstrated for 28 days at 2-8°C. Once opened, the product may be stored for a maximum of 28 days at 2°C to 8°C. Other in-use storage times and conditions are the responsibility of the user. Special precautions for storage: Store in a refrigerator (2°C – 8°C) at all times. The pen should be returned to the refrigerator immediately after use. Do not freeze. Do not store the injection device with the needle attached.

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Saturday 04 May 2019

08:00	Registration	
08:30 - 10:00	**Session IV: Bone Tumors in Children**	
	Moderator: Joseph Habanbo - Fady El Karak - Elie Bechara	
08:30 - 08:40	When is Physeal Sparing Possible? What to Do When The Growth Cartilage is Spared but there is Joint Effusion?	Ismat Ghanem
08:40 - 08:50	Challenges of Limb Reconstruction in Pediatric Population	Said Saghieh
08:50 - 09:00	The Primordial Role Of Chemotherapy in Bone Sacromas in Children	Naim Bejjani
09:00 - 09:10	The Importance of Multidisciplinary Approach in this Population	Miguel Abboud
09:10 - 09:20	Aneurysmal Bone Cyst: Adam's Apple?	Elie Saliba
09:20 - 09:30	Histiocytose X: The Permanent Differential Diagnosis?	Toni Hayeck
09:30 - 10:00	Discussion	
10:00 - 10:30	**Coffee Break**	

BONE TUMOR & BONE FRAGILITY FROM A TO Z

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Saturday 04 May 2019

10:30 - 11:40	Session V: Bone Fragility: Making Fractures Treatment More Challenging	
	Moderators: Jean Jacques Yaacoub - Falah Bachour	
10:30 - 10:40	Are Cancer Patients More Prone to Fragility Fractures?	Maroun Rizkallah
10:40 - 10:50	Does Conservative Management in Proximal Humerus Fracture Yield Equivalent Results to Surgical Treatment?	Chawki Cortbawi
10:50 - 11:00	Is Total Elbow Arthroplasty Indicated in Distal Humerus Fracture	Marwan Baaklini
11:00 - 11:10	Evidence Based Management Of VCf. Is There a Clear Consensus?	Philippe Younes
11:10 - 11:20	What Are The Predictors of Spinal Fixation Failure in Elderly Patients?	Amer Sebaaly
11:20 - 11:30	The Future of Surgical Fixation in Fragile Osteoporotic Bone	Rida Kassem
11:30 - 11:40	Discussion	

Notes

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