# What OncoJourney is for you, what it measures, and which problems it removes

One clear picture of every cancer journey, so the first minutes of a visit go to decisions rather than to searching. **You decide; it never recommends treatment.**

## 1 What it is for you

### One picture per patient

Therapy lines, scans, labs, side effects, gene results and visits on one timeline, which you can rewind to any date. It reads your EMR, lab and radiology files, and also PDF reports, scans and phone photos (scan reading uses free OCR software).

### Who needs you first, and why

A ranked clinic list and a tumour-board packet. Every point has a reason you can read, such as "progression while on carboplatin + pemetrexed", plus what changed since the last visit.

### Numbers you can check

Response, survival, dose and marker figures come from fixed rules, not AI guesses. Anything read from a report is only a *proposal* until you accept it, and every step is logged.

## 2 Why this matters: the pressure on oncology time

**1.46 M**
new cancer cases in India in 2022, rising to about 1.57 million projected for 2025[1]

**35** patients
median per clinic day for Indian medical oncologists; a chemotherapy visit gets a median 7.5 minutes[2]

**≈2 : 1**
hours of EHR and desk work for every hour with patients[3]
US, non-oncology specialties

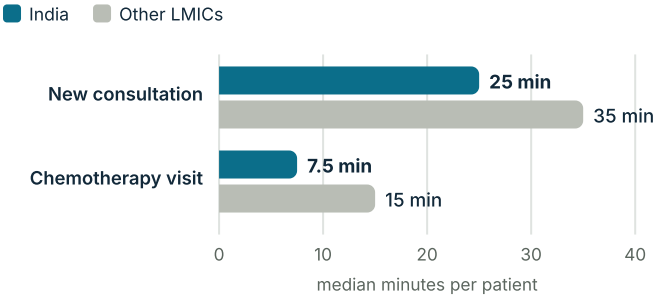
**−43%** / −44%
tumour-board preparation time after a digital tool, urology / gynaecology boards[5]
Another product, Netherlands

US oncologists reporting burnout rose from 45% (2013) to 59% (2023)[4]. These figures describe the problem; none is a result for OncoJourney, which has not yet been measured in a live clinic (see sections 7 and 8).

## 3 Two pictures of the problem and the answer

### Little time per patient

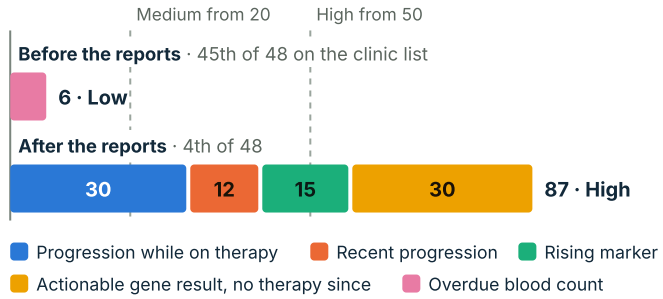
Median minutes per visit, Indian medical oncologists (survey of 82) versus other low- and middle-income countries (LMIC)[2]




Indian oncologists also see a median 35 patients per clinic day, against 25 elsewhere. A one-page brief per patient is aimed at exactly this gap.

### Why a patient moves up the clinic list

Priority points (0 to 100) for test patient S.8, **fictional data**, as of 30 Sep 2026, before and after her five reports were read and reviewed




One line in her scanned note was flagged "looks like an earlier result mentioned in passing", and the reviewer rejected it. Accepting it would have added 15 points and moved her to number 1. **Your decision changes the ranking, so it stays your decision.**

## 4 Bottlenecks and pain areas we are solving for

| Pain today | What OncoJourney does about it |
|---|---|
| **Records sit in many places: EMR, lab, radiology, PDFs, phone photos** | One timeline per patient. Reports, scans and photos become proposed records you approve; every record shows which system or document it came from. |
| **Clinic and tumour-board preparation is manual** | A ranked list with reasons and "what changed since last visit"; a board packet that lists the cases that meet your criteria and the questions to settle. |
| **Things slip between visits** | Alerts for an overdue scan, visit, marker or blood count (days overdue shown), a rising marker with no recent scan, a gene result with no therapy started since, a missing DPYD test before a fluoropyrimidine. |
| **"Can I trust it?" (AI black box, wrong data)** | Arithmetic by fixed rules; propose, approve, audit. The optional chat assistant must cite the records it used, and its answers are checked against them. Patient identifiers are removed before any language model sees text; the automated privacy check passed (30 checks). |
| **Patient data safety and the law** | Names, phone, email and uploaded files are encrypted (AES-256); the hospital number is kept only as a one-way key; sign-in locks after repeated failures; audit log; runs on your own machine. India's DPDP Rules were notified on 13 Nov 2025 and most duties start 13 May 2027[6]; your legal team decides what applies. |

**Decision support only. Not a substitute for clinical judgement.**

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## 5 What we measure: the oncology questions behind the numbers

All of these are calculated from the recorded data, for any "as of" date you choose.

| Your question | What OncoJourney shows | How it is worked out |
|---|---|---|
| **Is it working?** | Tumour response: CR, PR, SD, PD | RECIST 1.1 from lesion sizes; flags when the reported call and the calculated call differ |
| **How long does each line hold?** | Progression-free survival per line, overall survival, time to next treatment | Progression-free survival counts from the start of each line, overall survival from diagnosis; patients with no event yet are shown as "censored" |
| **Are we giving the planned dose?** | Cycle delays, dose reductions, relative dose intensity | Dose given against dose planned, over the time taken |
| **Is a marker moving before the scan?** | CEA, PSA, CA 125 change from baseline; doubling time; rising marker with no recent scan | Dated results over a rolling window |
| **What is the toxicity?** | Adverse events by grade, unresolved grade 3 or worse, repeated high-grade events, recovery time | Grades as recorded; thresholds in settings |
| **What is overdue?** | Restaging scan, clinic visit, marker, blood count, follow-up status, with days overdue | Intervals your team sets (default: scan 90 days, visit 42, marker 42, blood count 28) |
| **Was a result acted on?** | Actionable gene result with no therapy since; DPYD test before fluoropyrimidine; cautions when a therapy meets a recorded comorbidity | Rules your clinicians review and edit |
| **Who first?** | Clinic priority 0 to 100 (High from 50, Medium from 20) with every reason listed; tumour-board packet | Point weights in a settings file, visible and adjustable |
| **Can I trust the record?** | Record quality score; share of records from each source (EMR, RIS, LIS, report); impossible date orders | Checked on every view |
| **How is my cohort doing?** | Kaplan-Meier curves with confidence bands, response rates, waterfall and swimmer plots, adverse-event table | All your patients; small groups are merged so nobody can be singled out |

## 6 What you may not have asked for

- **Show-your-working.** Every priority point has a reason, and every record made from a report points to the sentence it came from.
- **Your own outcomes.** Survival, response and toxicity for your own patients, without a separate registry project.
- **Beside your EMR, not instead of it.** Start with CSV files on day 1; connect hospital systems later by configuration, not new code.
- **Rules are yours.** Thresholds, weights and caution rules sit in files your team can read, change and sign off.
- **Proof of effect.** Time saved has not been measured in a live clinic yet. The 3-month pilot is designed to measure it (below).

**In summary: what oncology truly looks for in a buyer**

**Time back in clinic**, shown on their own patients, not on a slide.

**Safe, accountable support.** A clinician decides; every number and alert shows its reason and its source.

**Fits what they already run** and keeps patient data inside the hospital.

**A low-risk start** and a support team that stays after the pilot.

## 7 What oncology buyers look for, and where we stand

| Buyer criterion | Status |
|---|---|
| **Clinical safety, accountability.** Decision support only; a person approves; audit trail | Built |
| **Time saved per clinic day.** The core return; no measured result yet | Prove in pilot |
| **Trust: explainable, sourced, correctable.** Reasons and source sentences shown. A wrong saved record is fixed by support with approval and an audit entry; an in-app "correct this record" is not built yet | Built Gap |
| **Privacy, security, data stays on site.** Encryption, on-premise, audit; hospital legal review still needed | Built |
| **Fits existing systems.** CSV on day 1; settings-based connectors; not yet tested at a live site | Prove in pilot |
| **Evidence from your own patients.** Cohort outcomes appear as data is loaded | Prove in pilot |
| **Low-risk start.** Free 3-month pilot on your own laptop; a paid licence on the hospital's cloud only if you continue | Offer ready |
| **Support and upkeep.** Developer support guide; 559 automated tests pass | Built |

## 8 How we will prove it in 3 months

**Minutes to prepare**
Stopwatch for one clinic list or board, before and after, same clinic.

**Items caught**
Overdue scans, markers and unacted gene results found, and how many were acted on.

**Trust**
Proposals accepted, edited or rejected, from the audit log.

**Data quality**
Corrections needed and record-quality score over time.

**Your view**
Five-question survey at week 4 and week 12.

**Sources.** [1] Sathishkumar K et al. Cancer incidence estimates for 2022 & projection for 2025, National Cancer Registry Programme. Indian J Med Res 2023;156:598-607 (1,461,427 cases in 2022; 2025 male plus female totals 1,569,793). [2] Medical oncology in India: Workload, infrastructure, and delivery of care. Indian J Med Paediatr Oncol 2019 (survey of 82 Indian medical oncologists; "other LMICs" is that paper's comparison group). [3] Sinsky C et al. Ann Intern Med 2016 (57 US physicians in family medicine, internal medicine, cardiology, orthopaedics). [4] Schenkel et al., ASCO survey (328 oncologists in 2023), JCO Oncology Advances, reported by The ASCO Post 11 Feb 2025. [5] Digital tumour board solution, UMC Utrecht, BMJ Health & Care Informatics 2025;32(1):e101332 (single-arm observational study, 32 weeks). [6] DPDP Rules 2025 notified 13 Nov 2025, summary by HLC. OncoJourney figures come from running the product code on fictional test patients; no real patient data is shown.


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