



Newsletter

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EDITORIAL

Ethics or Medics in Palliative Care

(On the occasion of World Hospice Day 14th October 2017)

Sixty year lady with metastatic breast cancer after multiple lines of chemotherapy was told by her physician "We can offer new form of targeted therapy which is the only hope for disease control." Husband and daughter are prepared to sell their house and jewelry if there is some hope." There are many medical issues and ethical dilemmas that arise in provision of cancer care. What are the chances that patient can be cured in metastatic setting with liver, lung, brain involvement after failure of multiple lines of chemotherapy? How much information has been shared with patient's family and in what way, are other ethical issues. Is it ethics or medics which contributes to professional's decision making.

Medical ethics is primarily a field of applied ethics, the study of moral values and judgments as they apply to medicine. Medical ethics provide guidelines and codes for physicians as for their duty, responsibility and conduct. Medical philosophers have emphasized that a doctor should carry "a good clinical sense and discretion." From 18th century onwards, doctors and nursing professionals adopted Hippocratic oath and Nightingale pledge which is enshrined as "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone and I will practice my profession with conscience and dignity." Every doctor should read declaration of Helsinki (Oct 2008) and MCI guidelines and imbibe the stated values. Six values in medical ethics are

- a) Autonomy - Patient has the right to choose or refuse the treatment.
In the case stated above, has the patient been given the option of best supportive care and end of life care if she does not choose targeted therapy. Has the patient been explained about pros and cons of targeted therapy in terms of medical benefits, financial implications and impact on family.
- b) Beneficence - A doctor should act in the best interest of the patient.
- c) Non maleficence - first, do no harm.
- d) Justice - It concerns with distribution of health resources equitably.
- e) Dignity - Patient has the right to dignity.
- f) Truthfulness and honesty - Truth telling and informed consent.

The lady with metastatic breast cancer has been offered new targeted therapy which is very expensive forcing the family to sell their house and belongings. The chance of disease response (not cure) may be less than 15%. Is this the only option? The Oncology team may be reluctant to discuss the risks/benefits of such therapies and may not consider the option of palliative care or end of life care. Doctors often say that "We are just trying to do something!" They even tell the care givers "If you don't want this treatment, GharBaitho, Palliative care is not even discussed". This is not only bad medicine but unethical practice. This case also exemplifies the need for patient autonomy, beneficence and truth telling. It is known that timely institution of Palliative care alleviates the distressing symptoms in terminal stages of disease and improves quality of remaining life. The palliative care team may face conflicts in patients family refusing to stop useless toxic anticancer therapy. Hence effective communication (explaining progression of disease, impact of Palliative treatment on QOL) is the key to ethical Palliative care.

As Oncologists and part of palliative care team, we should understand patient's preferences and never force our opinions on patients. We must communicate with family and care givers in such a way that confidentiality and dignity for patient's last stages are maintained.

It is observed that pain relief is the most neglected aspect in medical care. There are several interlinked causes for this neglect. Lack of knowledge and skill in pain management, improper medication, nonavailability of Morphine, unfounded myths about opioids addiction and side effects are some of the complex hurdles. It is now recognized in most countries that relief from pain is a legal right and availability of morphine is a social responsibility. For ethical reasons, inability to relieve pain should be viewed as public health crisis and necessary steps should be taken to remove the hurdles.

Palliative care team members should carry out their responsibilities with honesty and dignity. There are practical ethical challenges which need to be resolved. Truth telling, place of care, confidentiality, continuity of palliative care till last days of life and advance directives are some of the key areas which confront palliative care team.

My plea to all Oncologists and palliative care team is "Be brave enough to keep values to the front of palliative care. Let us give autonomy its proper place within the richer concept of respect for patients."



Dr. A. K. Dewan
Director - Surgical Oncology

Voice Preservation / Rehabilitation in Patients with Carcinoma Larynx

The management of laryngeal cancer the so called voice box has multitude of things for both the surgeons and the patient to worry about. Even though oncological outcomes take the preference for the surgeon, voice preservation becomes significant from the patients perspective which has a great psychological implication. This concept shifted the management paradigm of carcinoma larynx from predominantly surgical to concurrent chemo radiation. However with growing knowledge of complications of radiation and the introduction of robotics there has been an increasing trend to utilize surgery in the management of early ca larynx. These developments have paralleled technological advancements as well as refinement in the surgical and anaesthetic techniques. We are able to maintain physiological functions of larynx namely speech, respiration and swallowing without compromising the loco-regional control of cancer in comparison to the more radical treatment modalities.

Surgical procedures for voice conservation in early laryngeal cancer

For voice conservation in carcinoma larynx the various important options we have are:

1. Open / External Approach: Partial Laryngectomy
2. Endoscopic Approach



Open Supraglottic Laryngectomy

Open / External Approach: Partial laryngectomy - this includes supraglottic laryngectomy, vertical partial laryngectomy, Supracricoid Laryngectomy with Cricohyoidopexy or Cricohyoidoepiglottopexy. All these surgical procedures aim to remove the diseased part/ subunit of

larynx and try to preserve the maximum part of larynx both structurally and physiologically.

Endoscopic Approach: this includes:

- **Trans Oral Laser Microsurgery:** CO2 laser is used to remove the diseased part/ subunit of larynx. The whole procedure is done by using instruments through mouth and thus avoiding any external scar. This helps in faster recovery and discharge from the hospital.
- **Microlaryngoscopy and Excision:** this procedure uses fine instruments and microscope for surgery.
- **Microdebrider Assisted Excision:** these are powered instruments which help in removal of tumor tissue.
- Coblation Assisted Excision

- **Trans Oral Robotic Surgery:** Da Vinci Robot system is used here to operate through oral cavity.



It attempts to overcome the short comings of the laser microsurgery in technically challenging cases where visualisation is inadequate due to difficult anatomy. Robotic Supraglottic laryngectomy is now accepted worldwide for managing early laryngeal cancers.

Voice rehabilitation post laryngectomy

Total laryngectomy is still the most preferred management modality for advanced laryngeal malignancies with cartilage invasion. The patient undergoes various functional alterations following laryngectomy apart from psychological trauma and trauma of surgery. This includes loss of smell, taste, changes in pattern of respiration, permanent stoma to take care of and most importantly the loss of ability to talk. The importance of ability to talk is not realized till it is lost. Here at RGCI we do take care for this loss of speech by giving various options for voice rehabilitation after completion of our treatment.

There are 3 options for voice rehabilitation post laryngectomy:

1. Trachea esophageal puncture
2. Esophageal speech
3. Electrolarynx

Trachea esophageal puncture: It is considered as gold standard for voice rehabilitation. In this procedure a biomedical grade silicone device is placed surgically. This device communicates the trachea (wind pipe) and esophagus (food pipe) and it has a valve which allows air to pass through it from trachea to esophagus. The patient is trained on how to use it in daily life by putting a finger over the stoma. The voice which patient gradually produces is intelligible and closely resembles laryngeal speech.

Esophageal speech: the patient swallows air and expels it out which causes vibration of pharyngeal mucosa and thus he is able to speak. This needs training and thus speech therapy plays an important role in its development. Some patients are able to use this voice optimally.

Electrolarynx: This uses an external battery operated vibrating device which is placed over neck. Patient uses these vibrations and muscles of neck along with lip and tongue to articulate and produce speech.

Laryngeal cancers are treatable even in advanced stages. Laryngectomy does not always mean loss of voice. Standard surgical techniques have withstood test of time and given good results.

Dr. Rajeev Kumar, Sr. Consultant - Surgical Oncology
Dr. Suhas K. R., Consultant - Surgical Oncology

Visit by US Nursing Delegates



Nursing Department of RGCIRC under the esteemed guidance of Dr. Gauri Kapoor, Medical Director – RGCIRC, Niti Bagh and Director - Pediatric Hemato Oncology and Ms. Kathleen Glenda Jacobs, Chief of Nursing, hosted and welcomed US Delegates, Ms Julia Challinor, Associate Adjunct Professor from University of California, San Fransisco and Ms. Annette Galassi, RN from Armand Global Consulting Firm. The main objective of their 4 day visit (from 19th June 2017 to 22nd June 2017) was to observe the standards, policies, procedures and quality of care delivered to patients in Developing Countries like India. A brief introduction was given about the hospital and a detailed discussion was done about Nursing Education and Training Department. They visited different departments for orientation.



Ms. Julia focused on Pediatric Oncology Nursing wherein, she interacted with patients as well as nursing staff and addressed patient centered care according to their age group including their psychosocial aspects. Ms. Annette targeted adult oncology nursing and collaborated with Dr. Sumit Goel to attend case to case round and showed her concern related to chemotherapy protocols and safe handling. Ms. Annette took an interactive session for staff nurses on Safe handling and disposal of chemotherapeutic drugs. Also, she discussed side effects and its management of chemotherapeutic drugs. Both of them gave valuable inputs on reduction of workload on staff nurses and reduction of errors at their end. They shared their rich experience to modify the curriculum for 12 days of Nursing Induction Training Program for both adult and pediatric nursing, highlighting the importance of aggressive chemotherapy training for Induction nurses. Vote of thanks was given by Dr. Sudhir Rawal, Medical Director, Dr. Gauri Kapoor and Ms. Kathleen Glenda Jacobs for their esteemed presence and dedicated efforts.

CME - IMA Ghaziabad

RGCIRC organized a CME in association with IMA Ghaziabad on Friday, 18th August 2017 at IMA Bhawan, Raj Nagar, Ghaziabad, Uttar Pradesh. Dr. Gauri Kapoor, Medical Director – RGCIRC, Niti Bagh & Director – Pediatric Hematology Oncology delivered a lecture on “Approach to a Child with Neck Nodes – Tips for the Family Physician” and Dr. Sumit Goyal, Sr. Consultant – Medical Oncology spoke on “Approach to a Patient with Suspected Cancer” in the said CME.



CME – IMA South Delhi Branch

RGCIRC organized a CME on Oncology in association with IMA South Delhi Branch on Saturday, 26th August 2017 at Hotel Crowne Plaza, Okhla, New Delhi. Dr. Sajjan Rajpurohit, Consultant – Medical Oncology, delivered a lecture on “Immunotherapy for Cancer” & Dr. Leena Dadhwal, Consultant - Surgical Oncology spoke on “Recent Advances in Ca Breast” in the said CME.

CME - IMA Jalandhar, Punjab

RGCIRC organized a CME in association with IMA Jalandhar on Friday, 1st September 2017 at The Regent Park Hotel, Jalandhar. Dr. Ullas Batra, Sr. Consultant and Chief of Thoracic Medical Oncology delivered a lecture on “Approach to Lung Cancer” and Dr. Amitabh Singh, Consultant – Surgical Oncology spoke on “Robotics in Uro Oncology” in the said CME.



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Diwali



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