



# Newsletter

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## EDITORIAL

### WHEN DEATH IS SOUGHT (PASSIVE EUTHANASIA)

A philosophical, existential, ethical, legal, and medical debate regarding Passive Euthanasia has taken place over the last few months. The word Euthanasia is derived from the Greek word eu, meaning "good" and thanatos meaning "death," and signifies a "good" or "easy" death. Euthanasia has been further defined as "active" or "passive." Active euthanasia refers to a physician deliberately acting in a way to end a patient's life. Passive euthanasia pertains to withholding or withdrawing treatment necessary to maintain life.

On 7 March 2018 the Supreme Court of India legalised passive euthanasia by means of the withdrawal of life support to patients in a permanent vegetative state. The decision was made as part of the verdict in a case involving Aruna Shanbaug, who had been in a Persistent Vegetative State (PVS) until her death in 2015. Aruna Shanbaug was a nurse working at the King Edward Memorial Hospital, Parel, Mumbai. On 27 November 1973 when she was strangled and sodomized by Sohanlal Walmiki, a sweeper. During the attack she was strangled with a chain, and the deprivation of oxygen left her in a vegetative state ever since. She was treated at KEM since the incident and was kept alive by feeding tube. On behalf of Aruna, her friend Pinki Virani, a social activist, filed a petition in the Supreme Court arguing that the "continued existence of Aruna is in violation of her right to live in dignity". The Supreme Court made its decision on 7 March 2011. The court rejected the plea to discontinue Aruna's life support but issued a set of broad guidelines legalising passive euthanasia in India. The Supreme Court's decision to reject the discontinuation of Aruna's life support was based on the fact that the hospital staff who was treating and taking care of her did not support euthanizing her. She died from pneumonia on 18 May 2015, after being in coma for a period of 42 years.

The Supreme Court specified two irreversible conditions to permit Passive Euthanasia in its 2011 Judgement: (I) The brain-dead for whom the ventilator can be switched off (II) Those in a Persistent Vegetative State (PVS) for whom the feed can be tapered out and pain-managing palliatives be added, according to laid-down international specifications. In most of the countries, active euthanasia is illegal. The legal status of passive euthanasia including the withdrawal of nutrition or water, varies across the nations of the world.

The arguments supporting legalization of euthanasia are substantial. Proponents perceive it as an act of humanity toward the terminally ill patient. They believe the patient and family should not be forced to suffer through a long and painful death. According to the proponents of Euthanasia, it becomes ethical and justified when the quality of life of the terminally ill patient becomes so low that death remains the only justifiable means to relieve suffering. Lack of any justifiable means of

recovery and the dying patient himself making the choice to end his life are conditions which make euthanasia more justifiable. Given the possibility that these symptoms and circumstances may not be relieved, even with aggressive palliative care and social services, the decision to hasten one's death may seem rational. Withdrawal of life support, the classical form of "passive" euthanasia, actually involves taking an "active" step to hasten the death of a terminally ill patient and it is the patient's consent which lends legitimacy to the act. But there are concerns regarding a) discrimination against vulnerable groups, b) expansion to include non-terminally ill patients, and c) that requests may stem from mental illness or coercion by unscrupulous relatives.

The argument against euthanasia are guided by the Hippocratic Oath which states, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice that may cause his death." Moreover improperly managed physical and/or psychiatric symptoms may underlie a patient's wish for hastened death. Family members may subtly suggest that death, since inevitable, would be preferable if it occurred sooner rather than later because of the social and financial burdens involved in caring for terminally ill patients. Thus, patients with limited financial resources may be "coerced" into requesting Euthanasia by poorly managed or untreated physical and psychological symptoms, perceiving their only options to be either continued suffering or death.

Hinduism venerated enlightened people who voluntarily decided their mode of death. The Pandavas eulogized "Mahaparasthana" or the great journey through their Himalayan sojourn when they walked in pilgrimage, thriving on air and water till they left their bodies one after another. Fasting, self-immolation, and drowning at holy places are other examples of such venerated deaths. Such deaths by enlightened persons have never been equated with the popular notion of suicide in the Indian tradition. "Spiritual death" in the Indian context is synonymous with a "good death," i.e., the individual must be in a state of calm and equipoise. Spiritual death" or "iccha mritue" can only be possible when the evolved soul chooses to abandon the body at will.

The question as to the role of physician still remains. Physicians are responsible for the care of patients. Our ability to fulfill this responsibility of care is quite susceptible to the economic and political environment that affects health care delivery. I believe that political and legal intrusions into the sacred doctor-patient relationship have historically been a negative influence on care. Ultimately, there is really only one fundamental human question: is life worth living? The answer to that question, is ultimately a personal one. Let the physician act as gatekeeper in this highly controversial issue. Let us ensure good quality palliative care to all terminally ill cancer patients and then ask the same question again "is this life worth living".



**Dr. A. K. Dewan**  
Director - Surgical Oncology

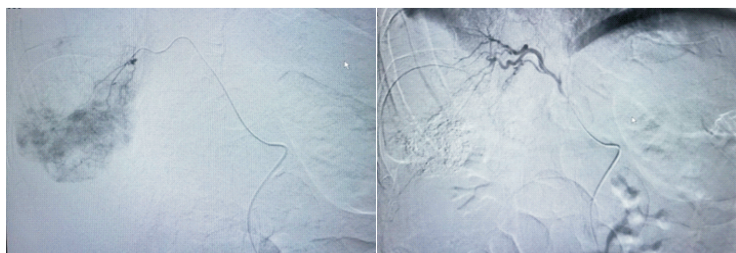
## ROLE OF DSA GUIDED PROCEDURES (VASCULAR INTERVENTIONAL ONCOLOGY) IN CANCER CARE: THE FOURTH PILLAR OF ONCOLOGY

Interventional Oncology, the youngest and most rapidly growing offshoot of interventional radiology, has successfully established itself as an essential and independent pillar within the firmament of multidisciplinary oncologic care, alongside Medical, Surgical, and Radiation Oncology. In this age of individualized cancer care, Vascular Interventional Radiology procedures are integrated as minimally-invasive therapies into a comprehensive oncologic care plan with other disciplines.

Digital Subtraction Angiography (DSA) assisted interventional oncology procedures use x ray or fluoroscopy guidance in a specialized angiography suite to treat and palliate cancerous tumours while minimizing possible injury to other body organs. The toolbox of angiography directed service in an oncological set up builds upon common services for cancer patients, such as venous and enteral access to emergency life saving procedures like vascular embolization for life threatening bleeding from tumour in any site of body as well as state of the art intravascular antitumor therapy.

While the surgical resection of tumours is generally accepted to offer the best long-term solution, it is often not possible due to the size, number or location of the tumour. DSA assisted intravascular therapies (Embolization) may be applied to shrink the tumour, making a surgical or interventional treatment possible. Some patient groups may also be too weak to undergo open surgery. Endovascular treatments can be applied in these complex cases to provide effective and milder forms of treatment. Interventional oncological techniques can also be used in combination with other treatments to help increase their efficacy. Chemotherapeutic drugs can also be administered intra-arterially, increasing their potency and reducing the systemic effects of these medications. Many of these procedures can be performed on an outpatient basis, freeing up hospital beds and reducing costs.

### Embolization Therapies for Tumours



**Fig:** Super selective hepatic angiography showing tumour blush due to hyper vascular Hepatocellular Carcinoma in segment VI of liver. Post TACE there is complete devascularisation of tumour.

**Bland Embolization of Liver Tumours:** delivery of sub-millimetre micro particles through a catheter inserted in the femoral artery in groin and advanced into the hepatic artery under X-ray guidance to get access into the tumor vasculature and occlusion for the purpose of tumour shrinkage.

**Transarterial Chemoembolization (TACE):** delivery of intra-arterial chemotherapy to the liver tumours through a catheter in combination with embolic material to produce ischemia.

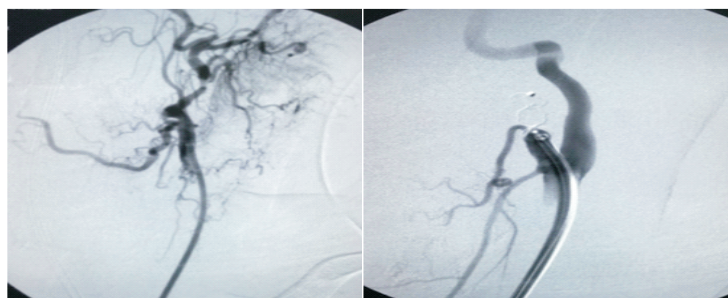
**Drug Eluting Bead Chemoembolization (DEB-TACE):** delivery of micro particles that are themselves loaded with the chemotherapy agent, like doxorubicin and allow for prolonged elution into the tumour microvessels.

**Transarterial Radioembolization :** microspheres loaded with a radioactive isotope (Yttrium-90) are injected into the blood vessels feeding a tumour and deliver a lethal dose of radiation into the vessels feeding the tumour thereby causing cell death. This therapy is primarily used for advanced hepatocellular carcinoma with portal vein tumour thrombus and liver metastasis from colorectal primary tumours where TACE can't be used.

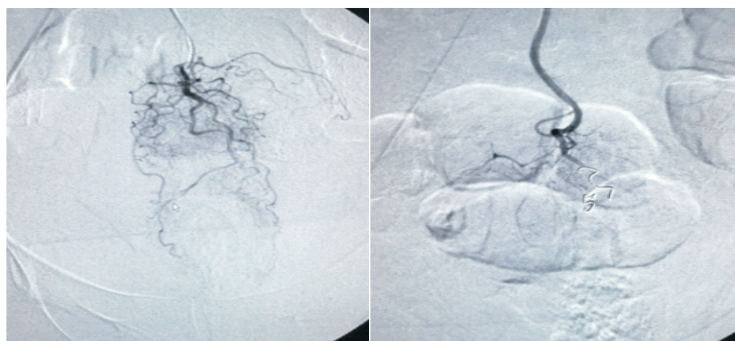
**Intra-Arterial Chemoinfusion (IAC):** high dose chemotherapy administered directly into the tumor-feeding arteries. This is an emerging therapy in retinoblastoma.

**Portal Vein Embolization (PVE):** delivery of bland embolic material into the portal vein of the hepatic lobe containing the tumor of interest to induce hypertrophy in the contra lateral hepatic lobe for the purposes of improving outcomes from planned surgical resection.

**Radiation Lobectomy:** Injection of small radioactive beads loaded with yttrium-90 into the hepatic artery feeding the hepatic lobe in which the tumor is located. This is done with the intent of shrinking the tumour as well as inducing growth in the contra lateral hepatic lobe, similar to portal vein embolization.



**Fig:** External carotid angiogram showing multiple abnormal arterial branches supplying a bulky infraparotid neck region tumour with history of recurrent massive bleeding. Endovascular occlusion of external carotid artery near origin led to control of haemorrhage.



**Fig:** Abnormal tumour blush on superior rectal artery angiogram in a case of recurrent endometrial carcinoma with rectal infiltration presenting with massive bleeding per rectum. Post endovascular reduction of abnormal vascularity, no more bleeding was observed.



**Emergency Life Saving Procedures:** In clinical situations, like Gastro Intestinal haemorrhage from bleeding intra abdominal tumour, massive bleeding into aero digestive tract from head and neck malignancy, hemoptysis from lung lesions etc, endovascular procedures performed in cathlab can be employed to rapidly occlude the vessels responsible for bleeding and thereby help save life when other managements fail.

**Pre Operative Embolization for Reducing Tumour Vascularity:** Before surgery for hyper vascular tumours, like metastatic renal cell carcinoma to skeletal sites, bulky spinal tumours and pelvic bony lesions etc, the tumour blood supply can be reduced by injecting micro particles into the feeding arteries and thereby reducing intra operative blood loss.

**Palliative Techniques:** Interventional oncology has long been used to provide palliative care for patients. These procedures can help reduce cancer-related pain and improve patients' quality of life. Tumours can intrude into various ducts and blood vessels of the body, obstructing the vital passage of food, bile, blood or waste. The interventional radiological treatment known as stenting can be used to re-open blockages, for example bile ducts in cases of gall bladder /cholangiocarcinoma or any other malignancy as well as urinary tract in pelvic malignancies, thereby considerably relieving the patient's adverse symptoms. In difficult to manage nclinical situations

like post chemotherapy hypersplenism, endovascular procedures like partial splenic embolization is an effective approach to restore hematological parameters.

Cancer is a multifaceted disease group that requires a multidisciplinary approach to treatment. Numerous studies have shown that cancer patients treated in multidisciplinary environments benefit greatly from the combined expertise. With this objective, endovascular procedures are seen as playing a major role in multidisciplinary cancer teams where they provide innovative solutions to improve combined therapies and to treat complications.

With the acquisition of high end Angiography suite (Siemens Artis Zee Pure) in the department of Diagnostic and Interventional Radiology in RGCIRC, we are routinely performing these procedures with excellent outcomes and at reasonable costs.

**Dr. Dibyamohan Hazarika (MD, PDCC)**

Consultant

**Dr. S. Avinash Rao (MD)**

Director

Department of Diagnostic and Interventional Radiology

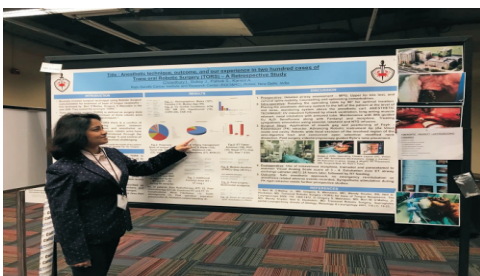
## CONGRATULATIONS TO DR. L. M. DARLONG



Dr. L. M. Darlong, Sr. Consultant and Chief of Thoracic Surgical Oncology was awarded the '**Best Case Report in Innovation for 2017**' award of IJTC (**Indian Journal of Thoracic and Cardiovascular Surgery**) for article "**Chest Wall Reconstruction Using Steel Wire in a Case of Chondrosarcoma Rib: A Novel Technique of Neo-Rib**". Ind J Thorac Cardiovasc Surg 2017,33(2):187-189".

The award was presented at the Annual Conference of IACTS (Indian Association of Cardiovascular and Thoracic Surgery) held on Sunday, 2<sup>nd</sup> February 2018 at Visakhapatnam, Andhra Pradesh.

## IARS 2018 ANNUAL MEETING AND INTERNATIONAL SCIENCE SYMPOSIUM



RGCIRC participated in **International Anesthesia Research Society (IARS) Annual Meeting and International Science Symposium (Anesthesiology)** held on April 28 – May 1, 2018 at Hyatt Regency, Chicago, Illinois, USA. Theme of the conference was **Improving Health through Discovery and Education**. Dr. Itee Chowdhury, Sr. Consultant – Anesthesiology gave a presentaiton on Anesthesia Technique, Outcome and Our Experience in Two Hundred Cases of Transoral Robotic Surgery "A Retrospective Study" in the said conference.

## ADVISORY MEMBERS MEETING AT VIENNA, AUSTRIA



RGCIRC participated in Advisory Members Meeting held on 7th – 11th May 2018 at Vienna, Austria. Dr. Arvind K. Chaturvedi, Chair - Radiology and Chairman Tumor Board at RGCIRC was invited by International Atomic Energy Agency (IAEA), United Nations to Vienna to advise on matters of Early Cancer Detection in Low Resource Countries. This is an honor for RGCIRC.

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## CME - IMA KAITHAL

RGCIRC organized a CME in association with IMA Kaithal on Saturday, 5th May 2018 at Hotel Mannat, Kaithal, Haryana. Dr. L. M. Darlong, Sr. Consultant and Chief of Thoracic Surgical Oncology delivered a lecture on "Thoracic Surgery - Changing Paradigms" and Dr. Swarupa Mitra, Sr. Consultant & Chief of Gynecological and Genitourinary Radiation Oncology spoke on "Updates in Radiotherapy - Stereotactic Radiosurgery in Lung Carcinoma" in the said CME.



## THE FIRST THERANOSTIC CONFERENCE AT THE AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTER (AUBMC)



RGCIRC participated in Theranostic Conference organized by International Atomic Energy Agency (IAEA) held on 10th – 11th November 2017 at American University of Beirut Medical Center (AUBMC), Beirut, Lebanon with the theme "See What You Treat." Dr. Partha Choudhary, Director – Nuclear Medicine delivered 03 lectures in the said conference. The IAEA endorsed the 2 day conference, which was designed to highlight research and clinical work in theranostics, focusing on current capabilities and the future outlook in Lebanon and the Middle East. The conference also included local nominating clinical specialists (e.g., urologists, medical oncologists, radiation oncologists, and surgeons), who actively participated in discussions on the utility and limitations of imaging in various clinical settings. Dr. Hossein Jadvar (University of Southern California, USA), Dr. Homer Macapinlac (MD Anderson Cancer Center; Houston), Dr. Medhat Osman (St. Louis University; USA) and Dr. Diana Paez, (International Atomic Energy

Agency [IAEA]; Vienna, Austria) were the other speakers in the conference.

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