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EDITORIAL

Doctor – Doctor Relationship

The doctor – doctor relationship appears to be important next to the doctor – patient relationship because of its bearing on quality, efficiency and availability of medical care. At present Doctor – doctor relationship is under severe stress. Doctors are caught in the pursuit of money and prestige. It is not uncommon to hear doctors saying

“Aap ye test isi lab se karanye”

“Aap ka ilaaz toh bilkul galat ho gaya hai.”

Negative criticisms only affect the interests of others and tarnish the image of your own professional colleagues.

When patient comes to you for a second opinion, you start challenging the competence of other doctor. The patient has come to you to get the best advice. Don't give him the worst of your profession. What will be the result? He will lose faith in the medical profession. He will do medical shopping and will move from one doctor to the other doctor with bad taste for medical professionals. Never criticize the other professional to establish your superiority. Remember “good judgement is usually the result of experience but experience has usually resulted from previous bad judgement.” The patient has come to you or has been referred to you because you are believed to be more competent in that subject. Desist from using him or her as a medium to spread criticism of fellow professionals. If patient has been seen by locum doctor in your absence, never criticize the locum. Rather be thankful to the doctor who looked after your patient in your absence.

Positive criticism can be made in an environment where doctors seek peer review for analysis of current medical practice. It is perfectly appropriate to quote a misdeed if the purpose is to change the quality of professional practice.

You may (without naming the person or the institution) criticize unethical practices in organ transplantation, inhuman drug trials etc. It may be necessary to publically oppose irrational statements made by some medical professionals. You must attempt to change medical practice for the better. This does not mean negative criticism.

There are situations where you may feel entrapped in professional criticism like editing a manuscript, opinion in consumer forums, etc. You must express your opinion confidently without confrontation; without maligning your colleague. Express your opinion to correct the problem and not enter into an enmity.

Here are some thoughts to improve doctor – doctor relationships.

1. Trust your colleagues. All relationships are trust relationships. Relationships between patient & doctor and doctor & doctor are all trust relationships. Trust results from being trustworthy.
2. Treat people with respect on your way up because you will be meeting them on your way down. Our life is like an echo; we get back what we give.
3. The doctor – doctor relationship can be improved if doctors practice in groups – which could be multispecialty group or single specialty group (like anesthesia, cardiology or oncology etc.). Group practice will bring about efficient use of doctor's time in quality patient care. They can spend quality time to their family, extracurricular activities, research work and continuous education. Relationships will improve in group practice.



INCIDENTAL CARCINOMA GALLBLADDER

INTRODUCTION –

Gallbladder cancer is the most common cancer of the biliary tract and fifth most common cancer of the gastrointestinal tract. The clinical pessimism, as once proposed by Blalock et al still persists for carcinoma gallbladder due to its late presentation, early lymphatic & haematogenous metastasis and direct invasion of liver, it's high propensity to seed peritoneal surfaces after tumour spillage & cause tumor implants in the biopsy tract, laparoscopic port sites & abdominal wounds and also because of lack of established guidelines for extent of surgery & lack of good adjuvant treatment. The five year survival in most large series is less than 10-15% and the median survival is less than six months. Most long-term survivors are those in whom carcinoma gallbladder was diagnosed incidentally after cholecystectomy for gallstone disease. So it is important to understand the natural history, biology and appropriate management of this group of patients.

DEFINITION –

Incidental carcinoma gallbladder is defined as carcinoma gallbladder first diagnosed on histopathological examination of resected gallbladder with no preoperative or intra-operative suspicion of malignancy.

EPIDEMIOLOGY -

Carcinoma gallbladder is found in 1-2% of patients undergoing surgery for biliary tract pathology. In a large international survey incidental gallbladder cancer was found in 0.35% of all cholecystectomies done for benign disease.

CLINICAL PRESENTATION –

Most patients present following cholecystectomy done for gallstone disease, when histopathology report comes out to be carcinoma gallbladder. Sometimes carcinoma gallbladder is missed even on routine histopathology and patients present later with jaundice, port site metastasis or with evidence of dissemination, and on reviewing the histopathology slides gallbladder carcinoma is found. One should also take note of the per-operative findings especially whether gallbladder got opened inadvertently during cholecystectomy and there was bile spill or not, as these patients have high incidence of getting disseminated early.

INVESTIGATIONS-

Most important investigation which decides further management of incidental gallbladder cancer is histopathology report. Three things are important in histopathology – T stage, involvement of cystic duct margin & cystic lymphnode. Contrast enhanced CT scan should be done to restage the patient, especially if there is delay between initial cholecystectomy and proposed re-resection. Though the sensitivity of CT for detecting lymphnodes is poor, if evidence of enlarged inter-aortocaval lymphnode is there, then there is no benefit of doing re-resection and FNAC from the suspicious lymphnode should be taken. Magnetic resonance imaging has no obvious advantage over CT. Laparoscopy might be useful in detecting peritoneal and small peripheral liver metastasis. But Fong et al do not favour laparoscopy because of possibility of dense adhesions due to prior surgery.

STAGING – AJCC-UICC TNM CLASSIFICATION (2007)-

T Stage-

- TX Primary tumor cannot be assessed
- T0 No evidence of primary tumor

- Tis Carcinoma in situ (confined to mucosa)
- T1a Tumor invades lamina propria
- T1b Tumor invades muscular layer
- T2 Tumor invades perimuscular connective tissue
- T3 Tumor perforates serosa or directly invades the liver and/or one other adjacent organ
- T4 Tumor invades main portal vein or hepatic artery or invades multiple extrahepatic organs

N Stage-

- NX Regional nodes cannot be assessed
- N0 No regional nodal metastasis
- N1 Metastasis to nodes along the cystic duct, common bile duct, hepatic artery and/or portal vein
- N2 Metastasis to periaortic, pericaval, superior mesenteric artery, and/or celiac artery lymph nodes*
- M0 No distant metastasis
- M1 Distant metastasis

Stage Grouping-

Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage IIIA	T3	N0	M0
Stage IIIB	T1-3	N1	M0
Stage IVA	T4	N0-1	M0
Stage IVB	Any T	N2*	M0
	Any T	Any N	M1

* Denotes changes from 6th edition classification

TREATMENT-

Treatment plan for incidental gallbladder cancer patients is mainly guided by the T-stage of tumour on histopathology, involvement of the cystic duct margin and any evidence of metastasis on investigation. Fong et al have shown that radical re-resection is reasonable treatment for incidental carcinoma gallbladder, depending on T-stage. They found no difference in survival of patients with T2 tumours undergoing radical resection as compared to patients undergoing radical resection as the first surgical procedure. Also resectability rate in patients with prior surgical exploration is not different from patients without prior surgical exploration. Though residual tumour is seen in 40-76% of cases at the time of re-exploration, it is important to inform the patient that radical surgery is needed even if there is no gross residual disease and even histopathology might not show any residual disease. Radical resection should be done as early as possible, preferably within weeks rather than months.

Though modified Nevin staging is best in predicting prognosis among various staging systems, T-staging by AJCC criteria is most practical for deciding the treatment of incidental carcinoma gallbladder as only T-stage and not N-stage is known in most of these patients.

For T1a lesions simple cholecystectomy is sufficient if cystic duct margin is negative. If cystic duct margin is positive then re-resection of cystic duct stump or excision of common bile duct is required. Five year survival of T1a carcinoma gallbladder after simple cholecystectomy is 64-100%.

For T1b tumours, some groups advocate simple cholecystectomy and others recommend radical resection. Ouchi et al reported survival benefit for patients with T1b stage undergoing extended cholecystectomy over patients undergoing simple cholecystectomy alone - 5-yr survival of 100% vs 42%.



Similar results have been reported by other authors also. Various Japanese series have reported 5-yr survival of 73-100% for T1b after extended cholecystectomy. So at present the data is more in the support of radical re-resection for T1b tumours.

For T2 lesions simple cholecystectomy is not sufficient as it uses subserosal plane for dissection of gallbladder, which means that it leaves a positive margin. Yamaguchi et al found that margin was positive in 11/25 patients undergoing simple cholecystectomy for T2 lesions and patients with positive margins had very poor 5-yr survival in comparison with patients with negative margin – 0% vs 65%. Also it has been shown that 46% of T2 lesions are associated with lymphnode metastasis. So for T2 lesions it is recommended to do radical re-resection. Studies have shown that radical resection improves 5-yr survival from 20-40% after simple cholecystectomy alone to 70-90% after radical resection.

For T3 lesions also radical resection is recommended. 5-yr survival of these patients in various Japanese series is between 44-63.6%. Even MSKCC has reported 5-yr actuarial survival of 67%.

T4 lesions rarely present as incidental carcinoma gallbladder. Mostly these are either diagnosed on preoperative investigation or peroperatively. Fong et al have reported survival benefit in these patients also after radical resection.

Radical resection includes segment 4b+5 resection (preferable) or enbloc resection with at least 2cm liver wedge around gallbladder bed and regional lymph node dissection. Lymph node dissection includes retropancreatic, hepatic artery, hepatoduodenal and periportal lymph nodes. Though there is consensus regarding extent of lymph node dissection, there is no consensus on extent of liver resection. Most people now favour anatomical resection of segment 4b & 5 over wedge resection because it is difficult to maintain constant thickness around liver bed during wedge resection. Analysis of German cancer registry have also shown that there is trend towards better survival after segment 4b+5 resection as compared to wedge resection. Even Segment 4b+5 resection is insufficient for patients with T3-4 lesions if sufficient resection margin can't be achieved or if the tumour is located in the body or neck of gallbladder which is very close to right portal pedicle. In these patients right trisegmentectomy is required. Right trisegmentectomy is also needed if there is scar tissue in the porta hepatis which can't be differentiated from malignant tissue easily. Even frozen section is not practical because of large number of frozen sections required.

Common bile duct resection is generally not required for achieving lymph node clearance but it might be needed if cystic duct margin is positive or if there is tumour in gallbladder neck with direct infiltration into bile duct. It might also be needed if there is excessive scarring in the hepatoduodenal ligament due to prior surgery, precluding adequate lymphnode dissection. Some people also advocate bile duct excision in papillary type of gallbladder cancer as these have higher risk of tumour seedings along the bile duct.

Other major concern is the management of laparoscopic port sites and open cholecystectomy wounds because carcinoma gallbladder has very high propensity to seed and grow along biopsy tract, drain tracts, in abdominal wounds, in laparoscopic tracts and as peritoneal deposits. Many studies have shown that there is higher incidence of laparoscopic port site recurrences than scar recurrence after open surgery – 0-21% vs 0.6-1.6%. So it is recommended to excise port site and previous wound of open cholecystectomy at the time of re-resection. Whether this is beneficial or whether port site recurrence represents disseminated disease is still unclear.

COMPLICATIONS –

Overall morbidity of radical resection for carcinoma gallbladder is around 5-54% and mortality is around 0-21%. Morbidity is higher in patients undergoing bile duct excision or major liver resection or hepatopancreatoduodenectomy. Most common complications are bile leak, biloma, liver failure, intra-abdominal abscess and respiratory failure

PROGNOSIS-

On multivariate analysis T and N stage of disease were found to be independent predictors of adverse long term outcome. Prior surgery was not found to affect the prognosis. Other factors which have been shown to affect prognosis are histologic grade, positive surgical margins and lymphatic, perineural or vascular invasion.

CONCLUSION –

Gallbladder cancer (T1b & beyond) diagnosed on histopathology after cholecystectomy for gall stone disease should be assessed for radical re-resection, as it improves long term survival.

Dr. Shivendra Singh

Senior Consultant & Chief
GI Oncosurgery & Liver Transplant Services

ONAM CELEBRATION RANGOLI held on 9th Sep. 2011 at RGCI & RC





Welcome Dr. Shivendra Singh

Senior Consultant & Chief,
GI Oncosurgery & Liver Transplant Services

Graduate and Post Graduate from K G Medical College Lucknow. He completed his M.Ch. (Gastrointestinal Surgery) from GB Pant Hospital & Maulana Azad Medical College, New Delhi. After completing his MCh, he worked as an Assistant Professor in GI Surgery at GB Pant Hospital, New Delhi. Later, he joined Institute of Liver & Biliary Sciences, New Delhi in 2007 and was working as an Associate Professor in HPB Surgery & Liver transplantation before moving to RGCI. He was involved in setting up & starting successful Liver Transplant program at ILBS.

He has 15 international publications in indexed journals. He was awarded French Government scholarship for training in Advanced laparoscopic GI Surgery at Montsouris Institute, University of Paris. **He has special interest in management of liver & pancreatic tumors, radical surgery for gall bladder cancer, laparoscopic surgery for GI malignancies and liver transplantation.**

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GASTROCON 2011 REVIEW



Gastrointestinal malignancies are one of the most common malignancies seen in our population. Most of these malignancies are diagnosed late either due to delay by the patient in taking their symptoms seriously and seeking medical advice or delay on the part of clinician in suspecting cancer. The department of gastroenterology, RGCI & RC organised one day CME cum Live Workshop on 11.09.2011. The conference was held in hotel Crowne Plaza, Rohini while the workshop was conducted in RGCI & RC and live telecast was done in the hotel. The conference started with address by our CEO Mr. D.S. Negi and Medical Director Dr. A.K. Dewan followed by lamp lighting ceremony. The main focus of the conference was recent developments in the field of endoscopic management of GI cancers, newer imaging techniques and role of endoscopic ultrasound in diagnosing and staging of cancer. There was special emphasis on cancers of oesophagus, gall bladder and rectum. There was live demonstration of latest endoscopic techniques by renowned faculty consisting of Dr. Amit Maydeo from Mumbai, Dr. Randhir Sud from Medanta, Dr. Chandrasekar from Chennai, Dr. A.K. Khurana from RGCI and Dr. Vikram Bhatia from ILBS. The highlight of the conference was timely start and finish with smooth workshop and active participation. The conference was attended by 225 delegates and faculty of 40. The conference ended by vote of thanks by the organising secretary Dr. A.K. Khurana.

To, _____

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