



# RAJIV GANDHI CANCER INSTITUTE & RESEARCH CENTRE

*Newsletter*

Price : 50 Paise  
Issue : Oct. 2011

Vol. XIV

No. 10

SECTOR-V, ROHINI, DELHI-85 • Tel. : 47022222 (30 Lines) 27051011-1015, Fax : 91-11-27051037

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Editor : Dr. A. K. Dewan

## EDITORIAL

### *Cancer Death .... A Challenge!!*

Death can be a challenge not only for the physician but also for the family and friends and ultimately for the dying person. Not willing is the worst outcome, whereas dying can be a healing for someone who is tired needing rest. More important the knowledge of our eventual death is which gives meaning, urgency and beauty to every day of our lives. Unfortunately we don't share information of death with patients; relation go a step further giving false assurances to patient as if he is never going to die.

The greatest gift of all is that we don't live forever. It makes us face up to the meaning of our existence. It also enables people who never took time for themselves in life to take that time, at last, before they die. One of my patients who refused any further salvage chemotherapy wanted to die. During my evening rounds, she received a phone call. She talked for several minutes and kept me waiting. After 10 min, she told me it was her grandchild from USA calling to say that he was coming to India. She said "Excuse me Doctor. Can you discharge me? I want to go to the airport and receive him". She put her wig, wore a lovely robe and prepared to receive her grandson. At that point, I said to her "Why do you want to die. You are still trying to be perfect grandma. It is not possible to do if you are dead. Put all this energy into yourself; you will not have trouble dying."

Situation is worst in hospitals where terminally ill cancer patients are put on ventilators and tied with tubes and catheters. They have lost control on themselves. They should be sent home rather than being hooked to machines. I told one

of the terminally ill cancer patients "why don't you go home and sit with your wife where you have spent four decades together. In hospital your wife is allowed to be with you for few minutes". He looked at me and started beaming and said "doctor, you are right. You arrange for home care team where I can consult medical team." This totally empowered him. He went home lived for six weeks. He proved to be wonderful teacher and healer for his family and for me. I ponder, my profession can be incredibly cruel in its relentless focus on keeping patient alive (vegetative) no matter what the consequences. We have to learn that death is not pathological; it is a natural part of living. Unfortunately, we as medical professionals have labeled death as unnatural in the interest of our limitations.

Of course, doctors and nurses are not the only enemies of a good death. Many people die in great anger, leaving behind them a legacy of bitterness, because of the inability to understand that dying is not just a physical process but an emotional, psychological and spiritual transition as well. I remember how one of my friends handled his terminal illness differently and gracefully. Of course, he was not a saint but had a beautiful smile for everyone, every time till the end. He made it easy for all those around him to love him and to care for him. By so doing he made this ordeal easier for himself because he could attract love and because his own view point was positive and in a way accepting ..... His care givers said that he taught them "How to die. For him Death was not the end but just the beginning of something new and beautiful."

**Dr. A. K. Dewan**  
Medical Director

RGCI & RC Newsletter

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## New Dimensions in Surgical Oncology: Robotic Thoracic Surgery at RGCI

North India's First Robotic thoracic esophageal mobilization and Robotic assisted Lobectomy were successfully carried out at RGCI in August and September 2011 using da Vinci Robot.

Robotic Thoracic esophageal mobilization was performed in a 41 year old lady with squamous cell carcinoma of lower third of esophagus. She was treated with Neoadjuvant Chemo-radiotherapy (preoperative CTRT) as she had bulky disease extending for a length of 6-7 cm in the lower esophagus from 32-38 cm. She was taken up for esophagectomy after completion of CTRT. Robotic mobilization of esophagus was performed using four 5-12 mm incisions (Ports) with negligible blood loss. Patient had quicker recovery because of less postoperative pain.

Second robotic thoracic procedure, Robotic assisted left upper lobectomy was carried out at RGCI in a 72 year old patient with carcinoma of the left upper lobe in September 2011. Three ports and a small utility incision were used for lobectomy. The same utility incision was used for specimen retrieval at the end of surgical procedure. Patient's recovery was faster with less pain and he was discharged within a week after surgery.

Thoracic cancers are the leading cause of cancer deaths in this country. Surgery is one of the main therapies for the treatment of lung and esophageal cancer. Additionally, surgery is necessary to assist in the diagnosis and staging of lung cancer. Video-assisted Thoracoscopic Surgery has helped simplify the diagnosis and treatment thoracic cancer. Using minimally invasive techniques, surgeons are able to completely evaluate the chest cavity in order to properly stage and treat patients. If Surgery is necessary, robotic VATS can be performed in many patients with lung and esophageal cancer.

### History

In 1985 a robot, the PUMA 560, was used to place a needle for a brain biopsy using CT guidance. In 1988, the PROBOT, developed at Imperial College London, was used to perform prostatic surgery. The ROBODOC from Integrated Surgical Systems was introduced in 1992 to mill out precise fittings in the femur for hip replacement. Further development of robotic systems was carried out by Intuitive Surgical with the introduction of the da Vinci Surgical System

### How It Works

The da Vinci Surgical System comprises three components: a surgeon's console, a patient-side robotic cart with 4 arms manipulated by the surgeon (one to control the camera and three to manipulate instruments), and a high-definition 3D vision system. Articulating surgical instruments are mounted on the robotic arms which are introduced into the body through cannulas.

Thoracic ports are placed as for any thoracoscopic esophagectomy and the Robotic arms are introduced into the chest cavity. Seated only a few feet away from the operating table, surgeons view the patient's anatomy through a screen that produces a 3-D image magnified ten times. The robot that operates on the patient is controlled by an expert surgeon who carefully maneuvers a pair of knobs to control the instruments. Robotic technology employs fine operating instruments which simulate the motion of the human wrist. Hand motions are scaled through a computer interface to eliminate tremor allowing for incredibly precise maneuvers. On the patient's end, the robot's arms are fitted with five to 12 millimeter surgical instruments and a small camera scope that provides a detailed view of the patient.

While robotic procedures are now commonplace in the west for many kinds of cancer treatments, the use of this technology in thoracic surgery is very new and challenging.

The da Vinci Surgical System enables surgeons to perform surgery through dime-sized incisions rather than the 6-12 inch incisions common in traditional surgery. Using traditional methods to remove

portions of cancerous lung tissue, surgeons must cut between the ribs in order to access the lung. This leaves patients with a large incision on the side of the chest and a long and painful recovery.

### Benefits of the da Vinci Surgical System

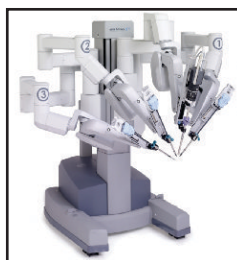
The da Vinci Surgical System's binocular robotic camera provides three-dimensional visualization, while the system's robotic arm gives surgeons the access and control they need to successfully perform a number of minimally invasive thoracic surgical procedures.



Endowrist Instruments



OT Set up



Da Vinci Robot



Robotic assisted Lobectomy in Progress



3D Vision



Surgeon's Master Controls



Surgeon Console

By using the da Vinci system, surgeons are able to avoid making a large incision in the chest, similar to that required for open-heart surgery. Because there are several small incisions, instead of a single large opening in the chest, patients usually realize a number of benefits that include:

- Shorter hospital stays.
- Less pain.
- Quicker recoveries.
- Reduced chance of infection and other complications.
- A quicker return to normal activity.
- Less scarring.
- Decreased inflammation of body tissue.
- Less bleeding and reduced need for blood transfusion.
- Indications of Robotic Thoracoscopic Surgery in Thoracic Malignancy





1. Mediastinal masses: Thymomas/ Myasthenia gravis etc.
2. Cancer of the Esophagus (Esophagectomy)
3. Thoracoscopic Lobectomy
4. Thoracoscopic biopsies/decortications/staging

Previously, patients required large sternotomies in order to remove the thymus gland and its tumours and mediastinal masses. Minimally invasive incisions and robotic technology now allows routine removal of the thymus gland for tumors or in the treatment of myasthenia gravis through smaller incisions in a less invasive manner. Minimally invasive techniques and robotic technology enable patients to return to normal activity quicker and experience less pain.

### Dr. S. M. Shuaib Zaidi

MBBS, MS, DNB, MCh (Surgical Oncology), FTS (Japan)  
Consultant Surgical Oncologist and Robotic Thoracic Surgeon  
Division of Thoracic Oncologic Surgery

## GYNAECON- 2011



Gynaecon-2011 organized by Rajiv Gandhi Cancer Institute & Research Center (RGCI&RC), Delhi focused on recent Advances and controversies in Gynae Cancer. The CME and live surgical workshop held on 1st and 2nd October 2011 was attended by 100 delegates from all over the country. Gynae-Onco workshop was a big success and added a feather in the cap of RGCI&RC.

The advent of minimally access surgery which is still more demanding however gives advantage to patients & this field is evolving fast at Rajiv Gandhi Cancer Institute and Research Centre. Unit of Genito Urinary Oncology has evolved over the last 15 years and innumerable such surgeries have been performed, with the addition of 4 Arm daVinci HD system these surgeries are being done by minimal access approach.

The CME commenced with a welcome address by Dr A K Dewan, Medical Director of RGCI&RC. This was later followed by an introduction to the conference by Dr. Sudhir Rawal, Organizing Chairperson and Director of Surgical Oncology.

### Live Surgical Workshop

The main attraction of operative session was surgery performed by Dr. Kenneth D Hatch, Professor Department of Obstetrics/Gynaecology, University of Arizona School of Medicine, Tucson, Arizona. Dr. Hatch has been president of the Society of Gynecologic Oncologists.

Then came the most awaited Live Surgery session by Dr. Rawal who showed his dexterity on Robotic VEIL and Dr. K Hatch gave a lucid depiction of nerve sparing Laparoscopic Radical Hysterectomy. The audience just loved to watch the mesmerizing Robotic Surgery done by Dr Rawal.

The message of live surgical workshop was to the youngster with regards to tissue respect and importance of minimally invasive surgery to patients.

The operative session was nicely moderated by a team of expert surgeons, Dr. Rupinder Sekhon, Senior Consultant, RGCI&RC, Dr Neena Singh and Dr. Harsha Khullar.

### Scientific Session Day 1

The first theoretical scientific session started with "early diagnosis of Ca Cervix and role of HPV" by Dr. N Bhatla, Professor, Department of Obstetrics Gynaecology, AIIMS.

Video presentation was made by Dr. Kenneth Hatch on the Role of Exenteration in Gynae Onco Cancer. This was followed by a power packed debate on "NACT is treatment of choice in locally advanced Ca Cervix."

The panel discussion moderated by Dr. Uma Singh was well conducted with a healthy rebuttal from intelligent panelists.

In the evening there was grand inauguration of the workshop with ceremonial welcome of the delegates and faculty members. The function was presided over by Dr. S K Rawal, Dr A K Dewan, Mr. R K Chopra, Chairman RGCI&RC, Mr. D S Negi, CEO RGCI&RC and culminated with Bharatnatyam dance and sumptuous dinner.

### Scientific Sessions – Day II

The day II began with brain storming sessions on "Role of Intraperitoneal Chemotherapy in Ca Ovary" by Dr Kenneth Hatch.

Dr. Neeta Singh highlighted the "Role of Fertility Sparing Surgery in Ca Ovary".

After a finger licking lunch, the audience was glued to chairs by a controversial panel discussion on Ca Cervix (Surgery vs Radiation) which was coordinated by Dr. Sanjiv Misra. Among the panelists were Dr. K Hatch, Dr Neeraja Bhatla, Dr. Rama Joshi, Dr. Manoj Sharma, Dr B R Srivastav, Dr. Hukku.

Dr. Hemant Tangaonkar detailed debate in favour of and Dr Lalit kumar against concept of "NACT should be given to all Ca ovary patients." The audience fully enjoyed the pros and cons of NACT and praised the consensus elaborated by the speaker. Dr. Arun Chaturvedi, Dr. D C Doval and Dr. Rupali Dewan gave sparkling remarks while chairing the session.

The evening was concluded by a fabulous discussion on Impact of obesity in surgical treatment of Gynecological cancers. It had scintillating comments by Dr Hatch and was enlightened by chairs like Dr S K Rawal, Dr Shalini Rajaram and Dr Shveta Giri.

At the end of the day it was an extremely gratifying experience for the organizers for having done justice to all delegates from India and abroad. This conference also enriched everyone on the recent trends in gynecologic surgeries.

This was great learning experience and an opportunity to know the latest in the field of Gynae Oncology.

**Dr. S K Rawal** - Director of Surgical Oncology & Chief of GU Surgical Oncology;

**Dr. Rupinder Sekhon** - Senior Consultant

**Dr. Shveta Giri** - Consultant-II



## DENTAL DEPARTMENT INAUGURATED AT RGCI & RC !

Posted at : Ashok Vihar Head Post Office, Delhi-110052  
Registered with Registrar of Newspaper Under No. 68797/98  
Postal Department Registration No. DL(N)06/004/2009-11  
Licensed to Post without prepayment under No.: "U"(DN)-162/ 2009-11

The Department of Dental Surgery was formally inaugurated on 5th October 2011 by our CEO Mr. D.S. Negi, Medical Director Dr. A. K. Dewan and other esteemed guests. The Dental Surgery department aims to add a new dimension of patient care with primary focus on patients with oral cancer. The department is equipped with an advanced dental chair, digital x-ray system, intra-oral cameras and other auxiliary equipments. The department will



focus on pre-surgical dental treatment, pre-radiotherapy, post radiotherapy treatment, post-surgery treatment and during the rehabilitative phase of the patient. The department specializes in surgical, interim, definitive obturators, mandibular guidance appliances, extra-oral prosthesis, occlusal correction for recurrent cheek and tongue bites, dental guards and many other customized prosthesis for oral cancer patients. Dr. Puneet Ahuja, Dr. Aparna Bansal and Dr. Ankur Gupta are working for the department of Dental Surgery.

## CELEBRATION OF 15TH ANNUAL DAY OF RGCI&RC. MAMMOTH AUDIENCE ATTENDED THE FUNCTION.



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Printed & Published by Mr. K. K. Mehta on behalf of Indraprastha Cancer Society & Research Centre and Printed at Raju Art Printers, 18-A, Old Gobind Pura Extn., Street No. 2, Parwana Road, Delhi-51, Tel. : 9871006333  
Published from RGCI&RC, Sector-V, Rohini, New Delhi-110085 • Editor : Dr. A. K. DEWAN