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News Letter

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Rajiv Gandhi Cancer Institute and Research Centre

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EDITORIAL

DIAGNOSIS, PROGNOSIS AND PROTOCOLS

The Triple Assault

Oncologists devastate their patients by launching triple assault of diagnosis, prognosis and protocol. Young doctors interpret the results of tests and convey the diagnosis as "Stage IV lung cancer with poor prognosis". Many of the oncologists even give chemotherapy protocols and hand over leaflets of product information. That is great reading to be handed over to a patient when he has just been told that he has cancer. Patient tries reading a chemotherapy protocol. Protocol talks of the product pharmacology, how it is administered and its side effects. There is not a single word in it suggesting that it will help – it gives only destructive information. No wonder patient might feel he would rather die a quick death than submit to the tortures described in these documents. There are brave souls who submit themselves to suffer from virtually every one of the possible side effects.

Unfortunately, when doctors look at their patients, they see only the disease in them. Many of them need to be reminded that there is a human being in the room with them. Patient is not just a disease like NHL or sarcoma or squamous cell carcinoma of lung but a person. A medical college teaches everything, we need to know about writing prescription but nothing about understanding people.

Doctors take down the facts of patient's medical history without paying much attention to the patient. But we must never forget that the look of the patient's face, the tremble in his hand, the falter in his speech, the drooping eyelids and the hidden signs of what troubles him. Much of the communication between doctor and patient is non verbal. Many times we see patients from other states and countries with language barrier. We may show our concern through non verbal forms of communication.

It is well accepted that the practice of medicine has changed dramatically by advances in the doctor's ability both to diagnose and treat disease. Unquestionably the curative powers of the physician are vastly greater than ever before. But our power to heal people and their lives seem to have diminished. The patient is repaired but not healed and he is not a better person than he was before.

Every doctor thinks cure as healing power. Every patient they lose represents a profound failure and curing becomes an addiction. Since all doctors are bound to lose some of their patients, they develop a sense of failure as tally of loses rises. Is medicine not a failure oriented profession where we measure our success not only with cure rates, but also with morbidity and mortality? Because we emphasize on disease rather than people.

Let us cure the disease and care for the person. Let us understand the human angle of the disease. Disease is more than just a clinical entity. It is an experience and a metaphor with a message that should be listened to. We should be willing to treat more than their disease, by supporting them (emotionally) and loving them in addition to caring for their physical problem. We may be able to redirect their lives, not just treat illness.

Few years back I received thanks letter from one of relations of a patient, "I am indebted to you for providing my Mataji with the most effective medicine – sincere care, positive attitude and concern – God bless you and I thank you for your kindness, concern and above all for being my mother's friend".

Dr. Dewan A K

GASTROCON 2012

"GASTROCON 2012", the 2nd National annual gastro conference was organized by RGCI &RC, Delhi on 25th and 26th Aug 2012, at Hotel Crowne Plaza, Rohini. The focus was on " Recent advances in HPB malignancies". It provided latest updates on various aspects of liver, gall-bladder and pancreatic cancers. The program included CME and Live endoscopy workshop. It was a great success and was attended by 650 delegates from all over the country & abroad.

The inaugural function was presided over by Mr R K Chopra,Chairman RGCI &RC, Mr DS Negi, CEO, Dr AK Dewan, Medical Director, and organizing secretaries -Dr. Arvind Khurana, Senior Consultant Gastroenterology & Dr. Shivendra Singh ,Senior Consultant and Chief, GI Oncosurgery and Liver transplant.

First session focussed on various aspects of HCC management with lectures from experts such as Dr SK Sarin, Dr Subhash Gupta, Dr AS Soin, Dr G Chaudhari, Dr SSBaijal, Dr SK Sharma ,DrAK Chaturvedi and Dr VineetTalwar. This session ended by lively panel discussion covering various clinical case scenarios in HCC management.

Second session on 25th August focussed on periampullary and pancreatic cancer with talks from eminent faculty such as Dr S Shrikhande, Dr SSSikora , Dr PuneetDhar, Dr SK Gupta and Dr SwarupaMitra. Dr. S. Shrikhande (Head, GI Oncosurgery, TMH Mumbai) gave anexcellent talk over how to decrease morbidity associated with Whipple's Pancreaticoduodenectomy and how to decrease mortality in postoperative period. Dr. S SSikora(Head, GI Surgery, Manipal Hospital, Bangaluru) highlighted the role and technique of vascular resection in Carcinoma Pancreas.

Highlight of the second day of conference was live endoscopic workshop by Dr. A. K. Khurana, Dr.RandhirSud ,Dr. Malay Sharma, Dr.Vikram Bhatia, Dr.VipulRathore&Dr.RajeshPuri. They demonstrateddiagnostic endoscopic ultrasound(EUS), EUS-FNAC, metallic biliary stenting, spyglasscholangioscopy and EUS-Guided celiac plexus neurolysis. Dr. VipulRathore from Endoscopy Asia, Mumbai and Dr. Vikram Bhatia highlighted the role of EUS in diagnosis and treatment of HBP malignancies.Dr. Shaesta Mehta from TMH discussed about the epidemiology of gall bladder cancer.

Last session focussed on carcinoma gall bladder and hilarcholangiocarcinoma. Session started with presentation by Dr Shivendra Singh on asymptomatic gall stones. This stimulated lively discussion with the audience, but conclusion was that at present there is no evidence to support prophylactic cholecystectomy for asymptomatic gall stones. Dr Shivendra showed video on Segment 4b+5 resection for gall bladder cancer highlighting the technical aspect as well as evidence in support of it as against simple wedge resection of GB fossa. Dr. A.K Khurana highlighted the palliative treatment options in "Hilar- Block". He discussed both the endoscopic as well as percutaneous modalities in detail. This was followed by lectures by Dr SubodhVarshney, Dr AK Agarwal& Dr DC Doval. Dr MilindJavale, medical oncologist from MD Anderson Cancer Institute gave a Key note lecture "Gall Bladder Cancer- lessons learned from complex gall bladder cancer". Conference ended with panel discussion on hilarcholangiocarcinomamoderated by Dr Praveen Sharma. The case capsules were very well formulated and provoked a lot of active participation from the audience.

At the end of the day, it was on extremely gratifying experience for the organizers for having done justice to all the delegates, faculty and sponsors from various parts of India. The scientific content as well as workshop was well applauded by everybody. They all found meeting useful and were able to take away new idea & pearls of wisdom which will help them to improve the care of patients suffering from HPB cancers.

SURGICAL RESECTION FOR HEPATOCELLULAR CARCINOMA

Dr N Selvakumar, Clinical Associate; Dr Shivendra Singh, Senior Consultant & Chief, GI Oncosurgery& Liver Transplantation

Surgery, including liver transplantation (LT), remains the most efficient treatment forpatients with hepatocellular carcinoma (HCC). However, <30% of patients with HCC are eligible for surgery, mainly because of the multiplicity of the lesions which often occurs in a background of chronic liver disease.Over the past 10 years, there has been considerable progress in the diagnosis and surgical treatment of HCC. The tumors are more often identified at an early stage, in particular through the screening of high-risk patients. Surgery is safer, with an acceptable overall mortality rate in cirrhotic patients (<5%). Though good long-term survival is achieved after adequate anatomical resections in upto 50% cases,but resection is associated with a high incidence of tumour recurrence, because of the presence of underlying chronic liver disease (a precancerousstate). Therefore,asLT removes both the tumour(s) as well as the precancerousunderlying chronic liver disease, it appears to be the treatment of choice for small HCCs. However, due to limited availability of grafts, donor risk in living donor liver transplantation and the cost of the LT, it cannot be advised to every patient. So, liver resection is a viable option in selected patients with salvage transplant reserved for tumour recurrence.

HCC without chronic liver disease

In most of the cases, HCC develops in the setting of cirrhosis, but in 5–15% of patients there is no underlying chronic liver disease. HCC in patients with normal liver are detected only when they achievelarger sizeor become symptomatic. Major hepatectomy, the only known curative option, is well tolerated in the absence of underlying liver disease and the good regenerative capacity of the remnant liver. The long-term results of resection of HCC in such cases are much better than in patients with cirrhosis, with expected disease-free 5-year survival rates as high as 50%. These favourable results have been observed in both fibrolamellaras well as in nonfibrolamellar HCCsuggesting that the absence of underlying liver disease is a major factor in short- and long-term prognosis.

HCC with chronic liver disease

Liver resection is usually contraindicated when anyone of these criteria is present (a) extrahepatic metastasis (b) decompensated chronic liver disease (Child C status)or (c)-Presence of ascites. Resection in multiple, bilobar, large HCC and with vascular invasionis more controversial.

Patients with HCC and tumour involving IVC and portal vein, have a poor prognosis. Major vascular involvement is generally associated with a large tumour for which not many other treatment options are available. It has beenshown that inselected group of patients with normal liver function and good performance status, extensive liver resection alongwith removal of the vascular thrombus, can achieve favourable survival results.

Bilobar HCCs may represent advanced disease with intrahepatic metastasis from onelobe to the other or may represent multifocal HCCs. However, inpatients with good liver function, the presence of a small and solitary lesion in the contralateral lobe cases should not contraindicate the resection of the main tumour, and in selected cases major hepatic resection along with wedge resection or local ablative therapy (if the lesion is not superficial can be offered.

A great proportion of patients with chronic liver disease continue to present with advanced large tumors. Large tumor size alone should not be considered as a contraindication for hepatic resection. It is proven that hepatic resection for HCCs >10 cm in diameter without macroscopic venous invasion is a safe and an effective option. However, the postoperative regenerative process can be impaired in the presence of cirrhosis, especially in the presence of small size of the future liver remnant (FLR) (<40% of the functional whole liver volume) Therefore, the use of preoperative portal vein embolization (PVE), the aim of which is to induce hypertrophy of the FLR, was developed to improve the safety and tolerance in major liver resections of both normal and injured liver parenchyma.

Preoperative evaluation for resection

In addition to the evaluation of tumour status and to avoid postoperative liver failure, the preoperative liver functional reserve assessment in cirrhotic patients is critical for patient selection .Liver resection for HCC is only done in patients with Child A status and selected Child B patients. However, even in ChildA cirrhotic patients, with apparently normal liver function, the risk of liver surgery is increased and more sophisticated quantitative liver function tests are needed to select patients for resection. The indocyanine green clearance (ICG) test isthe best availabletest for predicting mortality after hepatectomy. It is generally recommendedthat ICG retention at 15 minutes should be<15% to select patients with chronic liver disease for major resection. Other factors predicting postoperative liver failure are: (a) a volume of FLR estimated on CT volumetry below 40% of the whole liver volume; (b) a grade 4 fibrosis assessed by biopsy of the nontumorous liver; (c) a high portal pressure assessed by grade 2 or 3 esophagealvarices or measured by HVPG, and (d) the presence of a superimposed active hepatitis assessed by preoperative elevated transaminase level more than twice normal.

Results of liver resection

The largest series of resected patients is from the Liver Cancer Study Group in Japan, which has reported 1-, 3-, 5-, and 10-year survival rates of 85%, 64%, 45%, and 21%, respectively, in 6785 cirrhotic patients treated by hepatic resection between 1988 and 1999. Comparable results have been reported by other groups worldwide without differences between Western and Asian studies. Survival rates may be as high as 60% at 5 years in Child A patients with well-encapsulated tumors of ⩽ 2 cm in diameter. Although <10% of patients fit these selection criteria, such results, obtained in patients with good liver function who underwent anatomical resection, could be favorably compared with those of liver transplantation.

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Fig 1- a, b-Hypervascular lesion on arterial phase in Segment IVa and VIII with washout in delayed phase ; c- Cut surface after completion of central hepatectomy.

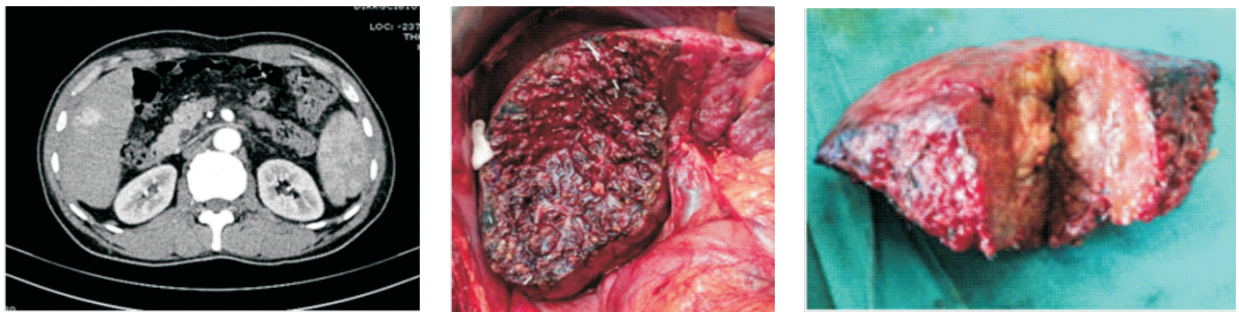

Fig 2- a-HCC in seg 6 in HBV related chronic liver disease patient, b-Cut surface after completion of bisegmentectomy 5 & 6; c- Resected specimen

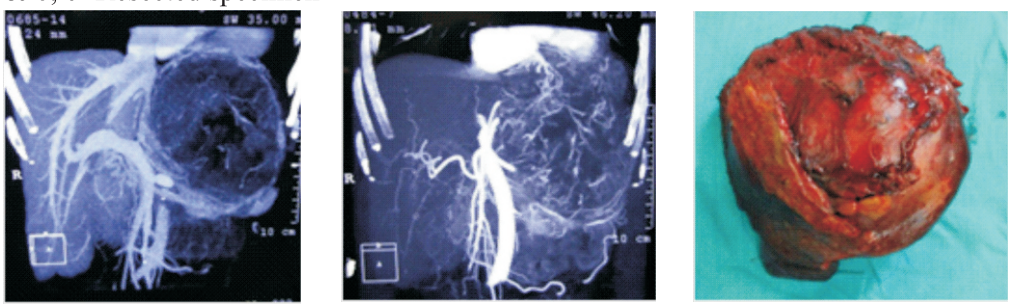

Fig 3- a,b- Large HCC involving segment 2 & 3; c- Resected specimen

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