Rajiv Gandhi Cancer Institute and Research Centre
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Architect's Impression of RGCI & RC (post expansion)

News Letter

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EDITORIAL

WHAT IS GOOD DEATH?

Good death is one in which a person dies on his own terms, relatively free from pain, in a supported and dignified setting. In the 15th century in Western Europe, how to die Guides - known as Ars Moriendi (the art of dying) provided Christians with very specific deathbed rules of conduct. Family always figured prominently in this Ars Moriendi - to assemble around the bed, perform rituals, encourage the dying person and imbibe his momentous last words.

Is hospital ICU/room full of machines and tubes the best place to spend our final days before we rest in peace? Perhaps not. Vast majority of Americans (70%) do agree that if they are going to die, they would like to die at home. Yet only 25% do so. People want to die with their families around them. We talk of dignified life and never speak of dignified death.

No one wants heroic medical treatment to prolong life if death was imminent or if he was suffering terribly. According to sociologist Tony Walter," the good death is now the death we choose." It is shaped neither by the dogmas of religion, and nor by the institutional routines of medicine but by the dying individuals themselves." It is never too early to think about planning ahead for illness and death. Making plans when you are healthy means there is less to think about if you get sick.

What people most need on their deathbed is to be heard, to have their wishes considered and, whenever possible, fulfilled. Most Important aspects of a good death are

a) Pain free death during final journey. Pain relief means pain free physically, emotionally and spiritually. Medication including narcotic analgesics should not be denied to any patient for fear of complications. Relief of spiritual pain can be accomplished by dialogue with a religious person.

b) Resolution of interpersonal conflicts – interpersonal issues within families and friends need to be addressed. Few messages a person may communicate at the end of life are- I love you, Thank you, Forgive me etc.

c) Unfulfilled wishes – like" will I see my grandchild or call my daughter from USA". People may want to live long enough to achieve unfulfilled desires.

d) Review their life to find meaning:- we may articulate what brought meaning to the life of dying; this might bring meaning to their lives which might help them feel more at peace with their death.

e) Protect the patient from dehumanizing and demeaning measures – putting the patient on ventilator may delay naturally occurring death. We must avoid unwanted procedures – and insist on good palliative and hospice care.

f) Dying should decide how much social or solitude he wants at the end. He may like to be alone and amongst friends and family. There are people who have premonition about their death. They invite their loved ones and depart at their own will.

So a good death is possible. Dying person should be treated as living human being. The important thing for caregivers is to be mindfully present. The poet John Milton wrote" They also serve who only stand and wait." We are so addicted to actions that it may feel like we are doing nothing. But it is often very important to be a witness and listen or hold a hand. Good death is no oxymoron. It is within everyone's realm of possibility. We need only realize its potential and prepare ourselves to meet it mindfully, with compassion and courage.

Dr. Dewan AK
Medical Director

MANAGING THE AXILLA IN EARLY BREAST CANCER: SLNB & BEYOND

INTRODUCTION :

For almost a century and more , Axillary Dissection has been the gold standard in the management of Axilla in Breast cancer. The nineties saw the evolution of sentinel lymph node biopsy with the pioneering work of Morton (1991),Krag (1993)and Giuliano (1994) and since then there has been a paradigm shift in the management of clinically N0 Axilla. The Western world has been prompt in the adoption of SLNB in early breast cancer .The NCCN recommends that SLNB should be the preferred method of surgical axillary staging.

In India and developing countries, there has been a revolutionary rise in the number of women presenting with early breast cancer owing to increasing awareness and technologic advances in healthcare system.

APPROACH TO THE AXILLA :

Cancer surgery has been traditionally defined by radical resection with clear margins and regional lymph node dissection. Lymph node dissection determines staging ,contributes to local control and perhaps translates to survival benefit. So also axillary dissection has been an integral component of modified radical mastectomy .But ever since the Halstedian era there has been a revolutionary change from radical to conservative approach. A comprehensive axillary dissection may be justified in a clinically node positive axilla.

In a clinically N0 axilla, the possibility of lymph node positivity in final HPE is 20 – 30 %. In the rest of the 70-80 % of the patients comprehensive axillary dissection is probably an overtreatment. Axillary recurrence post ALND is about 1%. A recent meta analyses failed to demonstrate a survival benefit for ALND in cNo patients with early breast cancer. Moreover the early and late complications of ALND include erythema, seroma, shoulder dysfunction, damage to neurovascular structures, lymphedema, pain & paresthesia.

Observation on the other hand is undertreatment with axillary relapse rates as high as 15%–37%which is reduced to <5% by radiotherapy.

Staging a No axilla is comprehensive and includes clinical examination, imaging and surgery. Clinical examination is least accurate in staging axilla. USG,MRI& PET have been studied for preoperative evaluation of the axilla. But none of the imaging modalities have been proved to be accurate enough for staging the axilla.

SENTINEL LYMPH NODE BIOPSY:

Attempts to identify the sentinel lymph node or the first lymph node in the lymphatic hierarchy to harbor tumor by various groups became successful. Cabanas was the first to describe the sentinel lymph node in the lymphatic drainage of penis. Morton worked on colloidal gold to elucidate lymphatics in cutaneous melanoma. Guiliano in 1994 came up with blue dye mapping in breast cancer. Even though the concept of sentinel lymph node was introduced for melanoma it has been extensively studied and validated in early breast cancer with clinically negative axilla. More than 60 studies validated by a back up of ALND confirms the overall success rate of 96 % and a false negative rate of 7%.

TECHNIQUES OF SLNB :

The various techniques for sentinel lymph node biopsy are

1.Dye technique :

Various blue dyes have been studied extensively and found safe and effective for SLNB. Isosulfan blue has been recommended for routine use of SLNB. The blue dye is injected intraoperatively just after induction either in subareolar or periareolar location. After 10 -15 minutes, axillary incision is given and the sentinel lymph node is identified as the blue node. Sometimes more than one blue node is identified. The blue nodes are harvested and sent for frozen section .If negative then it is unlikely that other axillary lymph nodes harbor metastasis.

2. Radiocolloid technique:

In the radiocolloid technique radioactive technetium is injected few hours before surgery. Preoperative lymphoscintigraphy confirms the uptake in the sentinel lymph node in the axilla .Then intraoperatively the axilla is explored. The sentinel lymph node is identified as the hot node with the help of a Geiger Muller counter that traces radioactivity. The hot node is harvested and evaluated by frozen section.

3.Combined technique :

In the combined technique, both the blue dye and radiocolloid is used .The blue and hot nodes are dissected and evaluated for metastasis. The combined technique has been found to be more effective than either the dye or radiocolloid alone.

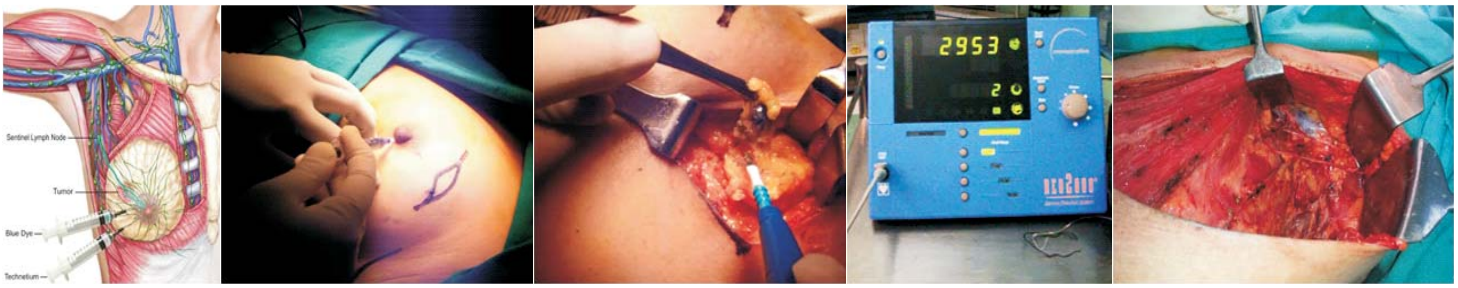

FIG 1 : SENTINEL LYMPH NODE BIOPSY

In the last decade the recommendation has been ALND for clinically positive axilla and SLNB for clinically negative axilla with ALNB only if SLN is positive. Preoperative evaluation of the axilla is useful to triage axillary surgery. The NCCN recommends US guided FNAC /

Core biopsy of clinically positive axillary lymph node. If negative then SLNB should be considered.If positive then axillary dissection is recommended.

Z0011 & BEYOND :

The American College of Surgeons Oncology Group (ACOSOG) published the results of Z0011 study recently and the results have been changing practice. The trial recommends that a certain population with breast cancer with T1/T2 lesion undergoing breast conservation surgery and whole breast radiation with ER/PR tumors with one or two SLN positivity (low nodal burden) do not require further axillary dissection because there is no oncological difference. Secondly Intra operative assessment of SLNB has lost significance since the Z0011. But if Z0011 is put into practice then the big question is how to determine adjuvant systemic therapy for patients eligible for Oncotype DX or Mammaprint?In conclusion managing the axilla has to be tailored according to the individual tumor biology and genomic landscape.

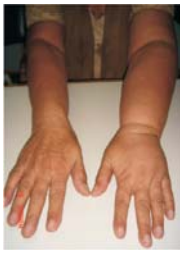

FIG 2 : LYMPHEDEMA LEFT UPPER LIMB

ALND – Auxillary Lymph Node Dissection, SLND – Sentinel Lymph Node Dissection

Dr. Kapil Kumar / Dr. Ashish Goel / Dr. S Veda Padma Priya
(Team Breast, Thoracic & Musculoskeletal Surgical Oncology)

ANNUAL CONFERENCE OF INTERNATIONAL SOCIETY OF DISEASES OF ESOPHAGUS

Dr. Kapil Kumar, Sr. Consultant & Chief of Breast & Thoracic Oncology and Dr. Ashish Goel, Consultant - Surgical Oncology, RGCI & RC attended the annual conference of International Society of Diseases of Esophagus in Vancouver, Canada on 22nd - 24th September 2014.

The conference was attended by over 400 delegates from around the world and had scientific deliberations on Esophageal Cancer as well as Esophageal Motility Disorders and GERD.

Dr. Kapil Kumar presented the experience of Radical Esophagectomy following neoadjuvant CTRT at RGCI & RC. He also made a presentation on the Role of PET-CT for response assessment after pre-op CTRT. Dr. Ashish Goel presented on stapled cervical esophagogastric anastomosis.

Besides initial experience of Robotic Assisted esophagectomy after Pre-op Chemoradiation at RGCI was highlighted as poster alongwith "VATS Esophagectomy for Multicentric Esophageal Cancer", " Robot Assisted Esophagectomy after "Preop ChemoRadiation" &

ANNUAL DAY CELEBRATION OF RGCI & RC - 18TH FOUNDATION DAY

The 18th Foundation Day of RGCI & RC was celebrated on Saturday, 18th October 2014. The cultural extravaganza was attended by almost 1000 members of the RGCI & RC family.

As per tradition, an extremely entertaining cultural program was presented by RGCI & RC's own staff. The programme was highly appreciated by the audience. Dance drama like Chaturanjini, Krishna and Indradhanush received a thumping applause from the audience. Awards for Outstanding Performance throughout the year were given away for academic & non-academic activities for the year 2013 – 2014.

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The Institute paid homage to Late Sh. Madan Aggarwal, erstwhile Governing Council Member, with a short film capturing his life's journey and his contributions towards making RGCI & RC a premier cancer care centre of the Country.

This year, RGCI & RC felicitated its four oldest serving senior consultants, Dr. A. K. Chaturvedi (Director, Radiology), Dr. D. C. Doval (Director, Medical Oncology & Research), Dr. A. K. Dewan (Medical Director and Chief of Head & Neck Surgical Oncology) and Dr. Sudhir Kumar Rawal (Director, Surgical Oncology) for their remarkable contribution & efforts in elevating cancer care at RGCI & RC to the level of leading centres of the world.

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Editor : Dr. A. K. DEWAN