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EDITORIAL

DIFFICULT PATIENT IS A GREAT SURVIVOR

Manisha was a real champion amongst all my cancer patients. Real fighter with sarcoma with pulmonary metastasis who later developed brain metastasis, had multiple operations, salvage chemotherapies, targeted therapy and radiation in last 7 years. She always believed "your disability is your opportunity". She put that philosophy to work on her own disability. She used to come to my clinic with number of questions noted in her diary. She used to question her blood tests, imaging and treatment. She probably had an active immune system. Nurses never liked that attitude of questioning that is fighter's attitude. Nurses on the other hand liked submissive patients who will never question any tests. One of the central line nurse said "what an angel". He never questions. He even had Colonoscopy by mistake but never created a fuss! You can imagine what type of immune system that patient will have!

Unfortunately most doctors and paramedics want their patients to be submissive. They call such patients "Angels". To be a good patient means be docile and surrender and do what the system wants. But that is not good for survival. We need to look to another word "Curious" for survival techniques. Curious has the same root as "cure" and that means a doctor should be glad when patient comes in with a list of questions, a request for options and an insistence on knowing how he can participate in his own healing. But the patient who does that is not a good patient for doctor. Difficult patient may get emotional, make noise and seem difficult to deal with. But such patients make success stories !!.

More and more patients are learning to participate in their own healing. It is not uncommon to hear patients say "I have come across many doctors and few pass interview tests." Cancer patients do medical shopping like window shopping by a common man. They will choose a doctor who is a patient listener and responds to most questions. I love to deal with patients who are inquisitive and come with specific written questions. They are difficult patients, they take time, but they are wonderful survivors.

Patient may believe that his doctor or nurse knows more about medicine than he does. But in some cases, patient's instincts may be right. Here is an example. Nurse was going to push 80 units of Insulin. Inquisitive patient questioned the type of injection and then the dose of Insulin. Nurse showed him the dose prescribed but patient persisted with cross checking with doctor. Doctor's records showed that the dose was actually 8.0 units rather than 80 units. There was prescription error. In this case, the patient expressed concerns led to the discovery of the error. If a patient is not satisfied or any answer from doctor or nurse does not make sense or resolve patient's concerns, don't get irritated. Patient may persist with queries. Patient may be right. An inquisitive patient is a safe patient.

I remember a young lady expressing her concerns "I am a strong, healthy tennis player with better than average endurance. All the protocols and procedures will be enacted on me with no say of mine. I need to be heard, I don't want to be disfigured. I want to be sewn rather than stapled." I was amazed at the woman's willingness to confront authority and express such strong opinion about the type of surgery. She had well researched her options. Sometimes patients reject your opinions. I usually explain my thinking, perhaps by telling them how I would treat the condition if I were a patient myself. If patient does not agree, I will offer 2nd opinion from the consultant or in tumor board or even in other hospital, corporate or Govt. I will also say "I care about you, let me see you again in 1 week's time or see me after treatment at any place of your choice." My patient stays with me because I let them know that we are working together as a team.

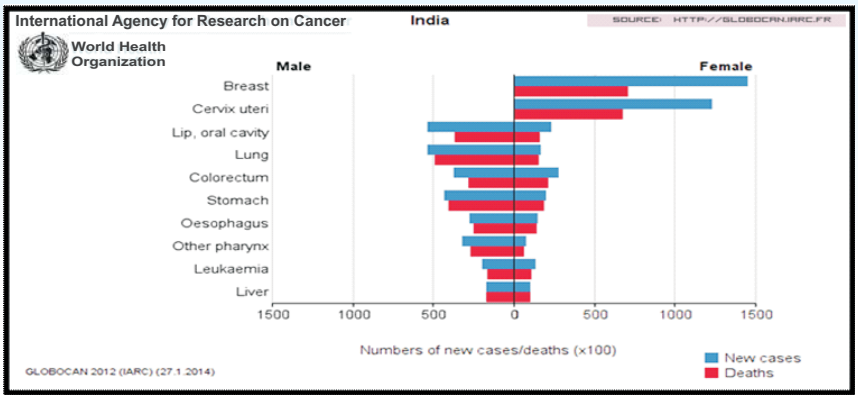
My appeal to doctors – please accept touring or shopping patients or questioning patients and see them no matter how much you may disagree with them. When you do, 100% will ultimately accept you and your therapy, because they will know that you care !!

Word for patients "Give the doctors their place, for the GOD created them. Medication is only a gift from God !!

Dr. A. K. Dewan, MCh.
Sr. Consultant, Surgical Oncology

OCTOBER IS BREAST CANCER AWARENESS MONTH

Breast cancer is the most common cancer in women in India. It accounts for 25 - 31% of all cancers in women. According to an ICMR research, in India every 1 in 28 women develop breast cancer during their life time. Cervical cancer which once dominated the Indian scenario has now been left behind by breast cancer in terms of both incidence and mortality.



The numbers of breast cancer cases in all age groups is rising rapidly The blame seems to lie with India's economic development and rapid urbanisation, leading to the westernisation of Indian women. Essentially, this means that urban Indian women marry late, have fewer children, and breastfeed them less, all of which increase the risk by increasing their exposure to oestrogen, and therefore their risk of developing the cancer, over their lifetime. Urban Indian women also tend to have more western diet, leading to obesity which increases the risk of post-menopausal breast cancer. Menopause renders the ovaries, a main source of oestrogen dysfunctional, but in overweight, post -menopausal women, androgen transforms into oestrogen in fat tissues

Age Shift: Breast cancer now more common in young women

In India the average age of developing a breast cancer has undergone a significant shift over last few decades. Indian women tend to get this disease quite early compared to their counterparts in the Western world. While the majority of breast cancer patients in West are Postmenopausal and in their 60s and 70s, the picture is quite different in India with pre-menopausal patients constituting about 50% of all patients.

According to GLOBOCAN (WHO), for the year 2012 (latest) an estimated 70218 women died in India due to breast cancer, more than any other country in the world. (Second China – 47984 deaths and third US – 43909 deaths)

SOURCE : HTTP://BLOGOCAN.IRRC.FR

International Agency for Research on Cancer
World Health Organization

– / +

Year: 2012

Metric CSO : Breast	Country	Count	ASR/P
Incidence - Female	India	144,937	25.8
	United States of America	232, 714	92.9
	China	187,213	22.1
Morality - Female	India	70,218	12.7
	United States of America	43,909	14.9
	China	47,984	5.4
Prevalance (5yr) - Female	India	396,991	92.6
	United States of America	970,693	753.7
	China	697,327	129.3

We can see from the above figure, in terms of incidence, USA tops the list followed by China. Even though both these countries have much more women suffering from breast cancer (than India), their death rate is not as high (as India). The reason? Most women here present in a fairly late stage; either because of their lack of awareness, or, in many cases, their doctor's lack of awareness. Breast awareness means that a woman must be 'aware' or 'familiar' with the structure of her breasts by examining them regularly, so that she can herself detect any small change that may have happened, and which could possibly be an early sign of a cancer. Breast Awareness also includes, being 'aware' about the various 'symptoms' and 'signs' of breast cancer, so that, while performing their monthly self examinations, she can keep in mind those symptoms. It also includes awareness about screening with clinical breast examination & mammography after the age of 40.

There is no way we can prevent breast cancer totally, but we can definitely detect it early and treat adequately. Only and only with early detection, can we achieve a longer survival.

As part of our commitment to raise awareness, we at RGCIRC dedicate whole October month to breast cancer screening. It is our annual campaign to increase awareness about the disease and to promote screening. Free Awareness talks and Screening camps are arranged at various places as part of outreach activities. In the OPD, screening mammography is done at 50% discount throughout the year and clinical breast examination is offered free of cost.

Dr. J. G. Sharma / Dr. Indu Aggarwal
Department of Preventive Oncology

SURGICAL MANAGEMENT OF ELOQUENT AREA BRAIN METASTASES

Brain metastasis is a significant cause of morbidity and mortality in cancer patients and its incidence is increasing as a result of advanced imaging techniques and improved survival of cancer patients due to better contemporary treatments available. Moreover brain metastases are being detected in primary malignancies not usually known to spread to brain. Surgery followed by whole brain radiotherapy (WBRT) has been the main modality of treatment for single or limited intracranial metastasis. This is supported by randomized trials and various treatment guidelines.

Stereotactic radio surgery (SRS) has come up and advocated by many as first line treatment for single/multiple metastasis or in combination with surgical resection. The ability of SRS to deliver focused radiation to a specified area of brain and theoretical advantage of avoiding risks associated with surgery and deleterious neurocognitive effect of WBRT makes it an attractive choice, specially in lesions located in eloquent region of brain. However, recent studies have highlighted the complications (around 20-40%) such as new neurologic deficits, worsening cerebral edema, persistent seizures and radiation necrosis associated with SRS which negates its projected harmless profile.

The treatment of eloquent area metastatic lesion remains a challenge for clinicians. Traditionally these lesions are approached with caution and less invasive approaches due to the risk of creating new deficits or worsening the existing ones. But as the survival of such cancer patients has increased, it has generated more interest in pursuing aggressive surgical treatment of eloquent area lesions coupled with post operative radiotherapy, specially with the availability of techniques such as intraoperative imaging and neuronavigation.

Not many centres are pursuing surgical treatment for such lesions. We at RGCIRC, being a dedicated neuro-oncology centre, treat such eloquent area brain lesions with surgical management followed by adjuvant treatment. Lesions of the eloquent cortex undergo stereotaxy assisted microsurgical resection. Prerequisite for neurosurgical treatment is stable systemic disease and left expectancy more than 6 months as discussed with treating oncologist. All patients are discussed in the institutional multidisciplinary board and consensus obtained regarding surgical management. Craniotomy site for surgical resection is decided with frameless or frame based stereotactical localization. Best and safe trajectory for approaching the lesions is decided after studying the different MRI sequences and consultation with the neuroradiologist. Our results show improvement in around 90 % of the patients along with stable deficit in the rest, matching the results reported in literature. All patients receive whole brain radiotherapy or SRS after surgery, according to the discretion of treating radiation oncologist. Few exemplary images are shown in Fig. 1 and 2. Complete microsurgical resection of eloquent area metastasis is feasible and beneficial. Careful patient selection and subsequent surgical treatment can lead to significant improvement in the quality of the life of such patients.

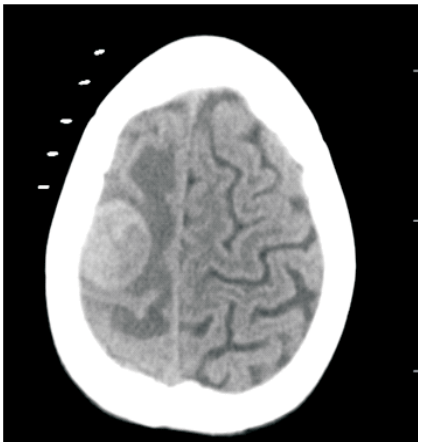


Fig.1a Preoperative CT head showing right motor strip lesion

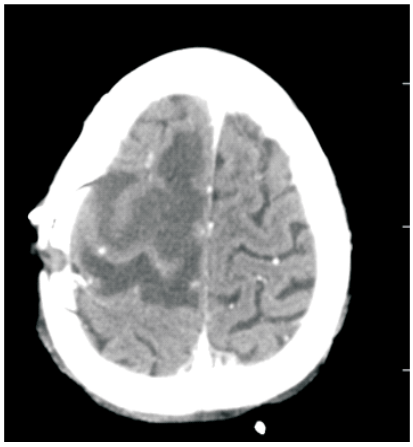


Fig. 1b Postop CT head showing complete excision of lesion

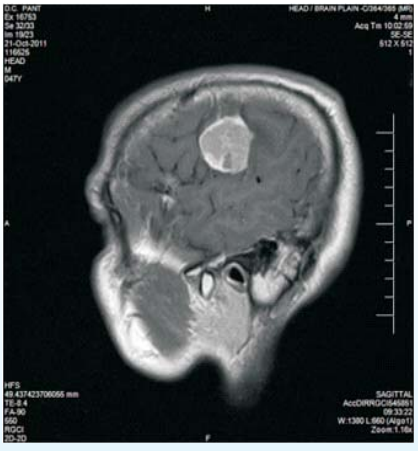


Fig. 2a Preoperative MRI brain showing left speech area lesion

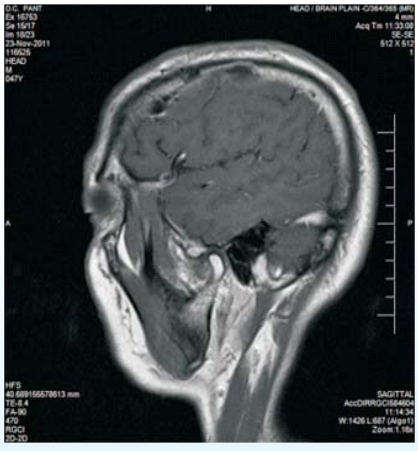


Fig. 2b Postop MRI brain showing complete excision of lesion

Dr. Ramandeep Singh Jaggi
Consultant – Neuro Surgery

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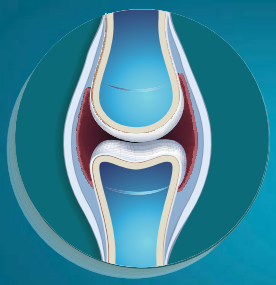

Osteosarcoma Update 2016

Connect, Collaborate, Conquer...

SAVE THE DATE 12th & 13th November 2016,
Hotel Crowne Plaza, Rohini, New Delhi

Who Should Attend

Orthopedic Surgeons, Oncologists, Radiologists and Pathologists

Highlights of The Conference

- Lectures by eminent internationally renowned faculty
- Addressing the contemporary and critical issues in treatment of Osteosarcoma
- Interactive case based discussions
- Focus on needs of beginners as well as the seasoned

Registration Fee

For Delegates:
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For Post Graduate Students: ₹750/-

For International Delegates:
USD 100

Abstract Submission Information:

- Abstracts for posters are to be submitted online through mail only (osteosarcoma2016@gmail.com)

Guidelines for Poster:

- Poster size: 1m*0.75m (39.37*29.53 inches), Portrait format (height more than width)
- Header of the poster should include Title, Author(s) and Institution(s) with presenting author underlined

- Registration fee will be waived off for accepted abstracts

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Architect's Impression of RGCIRC (post expansion)

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