

Accredited by :



December 2016

newsletter



Rajiv Gandhi Cancer Institute
and Research Centre



Vol. XX | No. 12 | Price: 50 Paisa

EDITORIAL

“YOU CAN BE A GOOD TEACHER?”

A good teacher wants to be a good teacher. Teaching has its own reward. The focus of teaching should be on students learning, not faculty teaching. Too often faculty members concentrate on what they want students to know. However, medical education is professional education and we who teach medical students should go beyond over conceptions of what we think they should know and instead should search for what they actually need to know as practicing doctors.

Good teachers don't talk as much as their less effective colleagues do. Good teachers involve the learners- asking questions, framing cases to solve, asking views of learners, pausing to allow students to think. Good teachers use words efficiently. They make concepts and principles simple and clear. While it is necessary for a teacher to be highly knowledgeable in his discipline, it is perhaps more important to show enthusiasm and interest in teaching that discipline. Students should have ready access to a good teacher, who is eager to help the students. Good teachers are always thinking about ways to improve what and how students learn. Good teachers think aloud with their students about problems.

Good teachers create an atmosphere where students are motivated by the intrinsic rather than the extrinsic factors (passing next exam, getting a high grade). In education, intrinsic motivation refers to an interest in learning because one cares about the discipline and patients. They want to improve their skills. The intrinsic motivation should triumph over the extrinsic.

Teacher need not be a lecturer. A resident or senior staff nurse could be a great teacher. I remember I learnt dressing of limbs from a senior nurse of Ortho Ward. A good teacher is a teacher who helps the students learn. The teacher's role goes well beyond information giving, with the teacher having a range of key roles to play in the education process.

An enormous part of my medical education came from residents with whom I worked most closely day in and day out. Senior residents were expected to participate fully in teaching and supervising other residents and students. Today interns and junior residents want to study books and not learn practical medicine. They prepare MCQ's from books. Surgical PG may not know how to put a surgical knot but he remembers various rare syndromes of rare diseases. Such residents can never become good doctors or good teachers, because they have never been good learners.

In all phases of education, student's achievement correlates with the quality of the teacher. Many colleges and schools attribute poor student's performance to large size class or poor infrastructure which is not true. Watching a great teacher at the top of his or her form is like watching a great surgical or artistic performance. Although infinitely difficult and painstakingly planned, great teaching appears effortless and seamless. One can easily believe that it is the simplest thing in the world- until one tries to do it. Greatness in teaching is just as rare as greatness in medicine, dance, law or any other profession. Qualities that make great teachers are not easy to inculcate or duplicate. You cannot achieve greatness by working from 08:30am to 03:00pm. A great teacher indicates to students that he sincerely cares about their learning.

The most important principle of good teaching is “Be enthusiastic about teaching and interested in well being of your students who could be residents, nurse, technicians or support staff.”

Dr. A. K. Dewan
Director - Surgical Oncology



HAPPY NEW YEAR

2017

CANCER, THE PATHWAY DISEASE THE IMPATIENT WAR AGAINST THE CHORUS OF BLACK DEATH

I am going to tell a story of shape shifting illness, which is most relentless and insidious enemy of humanity, known to medical profession for 3000 years or more and humanity is knocking at the door of the medical profession for a cure since then. Every year in India, around one million new cancer cases are diagnosed and around 6, 00, 000 to 7, 00, 000 people die from cancer, this death toll is projected to rise to around 1.2 million deaths per year by 2035, a new report on cancer care in India published in The Lancet Oncology reported.

The first description of cancer was given by Imhotep, Egypt physician ways back to 2625 BC. Several diseases rose and fell causing massive deaths and despair, sometimes washing away cities, small countries and significant fractions of humanity. But if cancer existed in the interstices of these massive epidemics, it existed in silence, leaving no easily identifiable trace in the medical literature, again to be seen after two millennia.

Cancer is an age related disease - sometimes exponentially so. The risk of breast cancer, for instance, is about 1 in 400 for a thirty year old woman and increases to 1 in 9 for a seventy year old. Nineteenth century doctors often linked cancer to civilization: The cancer, they imagined was caused by the rush and whirl of modern life, which somehow incited pathological growth in the body. The link was correct, but the causality was not; Civilization did not cause cancer, but by extending human life civilization unveiled it.

We are chemical apes having discovered the capacity to extract, purify and react molecules to produce new and wondrous molecules; we have begun to spin a new chemical universe around ourselves. Our bodies, our cells, our genes are thus being immersed and reimmersed in a changing flux of molecules - pesticides, pharmaceutical drugs, plastics, cosmetics, oestrogens, food products, hormones and even novel forms of physical impulses such as radiation and magnetism. Some of them inevitably will be carcinogenic. We cannot wish this world away; our task is to discriminate bonafide carcinogens from innocent and useful bystanders. It is rightly said cancer, resides at the interface between society and science.

Virchow called it neoplasia – novel, inexplicable, distorted growth, a word that would ring through the history of cancer. But the actual term of cancer was coined by Hippocrates way back in 400 BC from Greek word “KARKINOS”, meaning a crab, because the tumors reminded him of a crab with a central body from which several rays the legs, spread into the surrounding tissue.

Cancer cell is a desperate individualist in every sense. The cancer asphyxiates us by filling bodies with too many cells; Cancer is an expansionist disease; it invades through tissues, sets up colonies in the hostile landscapes, seeking “sanctuary” in one organ and immigrating to another (metastasis). A cancer cell is an astonishing perversion of the normal cell. Cancer is phenomenally successful invader and colonizer in part because it exploits the very features that make us successful as a species or as an organism.

Perhaps we have so much to learn from a cancer cell in terms of how to live. It has immortality and all the characters of an invader, yet it never gets acclimatizes to environment of excess and surplus richness of oxygen, it always depends on anaerobic glycolysis even in oxygen rich environment, a survival trait which, we humans can almost never achieve. This is called “Warburg effect”. To keep it simple, even though it has a seven storied, luxurious house and Rolls Royce series of cars, it instead of enjoying pleasures by staying in it, always moves from place to place and eats only boiled potatoes!

That's why cancer is not simply a clonal disease, but clonally evolving disease. Every generation of cancer creates a small number of cells that is genetically different from its parents, called as “Subclones”. When a chemotherapeutic drug or the immune system attacks cancer, mutant clones that can resist the attack grow out. The fittest cancer cell survives; Cancer is thus exploiting the fundamental logic of evolution.

Cancer cell lives desperately, inventively, fiercely, territorially, cannily and defensively at times, as if teaching us how to survive to confront cancer is to encounter a parallel species, one perhaps more adapted to survival than we ever are.

The question that bothers the patient is “Why me?”, the patient unable to understand and doctor unable to explain. The diagnosis of cancer – not the disease, but mere stigma of its presence – becomes a death sentence for the person. The prognosis of a person who has just been found to have pancreatic cancer is the same as the prognosis of the person with aortic stenosis who develops the first symptoms of congestive heart failure (median survival, 8 months). But the illness strips him of his identity. It dresses him in a patient's smock and assumes absolute control of his actions and a state even more invasive and paralyzing than the one cancer has left behind.

Why treatment of cancer is so difficult? Answer is simple, the deception. The language of cancer is grammatical, methodical and to say frankly, is beautiful. Genes talk to genes and pathways to pathways in a perfect pitch, producing a familiar yet foreign music that rolls faster and faster into a lethal rhythm. Underneath what might seem like overwhelming



diversity is a deep genetic unity. Cancer is really a pathway disease. But as the old proverb runs, there are mountains beyond mountains.

A dictionary of practical surgery of 19th century writes “In treating cancer, we shall remark, that little or no confidence should be placed either in internal remedies or drugs, except the total separation of the part affected”. Early chemotherapy was also erratic and experimental, like a beating the dog with a stick to get rid of its fleas. In this aspect, to say frankly, we made a tremendous progress in terms of therapy and humanitarian grounds, as today we have chemotherapy, where we can discharge patient in 2 to 3 days and subcellular target therapies like imatinib, with which we can treat on outpatient basis.

If somebody asks “can we get rid of cancer completely?” the answer is simple “No”. The only way to avoid cancer is not to be born. To live is to incur risk, because cancer is stitched into our genome.

However, the treatment of cancer is not so pessimistic in this ultra scientific era. One such grand victory in the history of cancer was a drug called as Gleevec (Imatinib mesylate). History of Chronic myeloid leukemia is now divided into pre gleevec era and post gleevec era. The rarely used word “CURE” in the treatment of cancer was first time used in the history of cancer, that too for a uniformly fatal disease. Today when a patient with CML is seen, he will be said that the disease is an indolent leukemia with an excellent prognosis, that he will usually live his functional life span provided he takes an oral medicine for the rest of his life.

Dr. Venkata Pradeep Babu Koyyala
DNB – Medical Oncology

NATIONAL TRAINING COURSE AT DHAKA, BANGLADESH



RGCIRC participated in National Training Course organized by International Atomic Energy Agency (IAEA) along with Bangladesh Atomic Energy Commission (BAEC) and Oncology Club, Bangladesh between 4th – 8th December 2016 at Dhaka Medical College, Dhaka for Radiation Therapy Technologists (RTT) of Bangladesh. The 25 RTTs were present to attend this course including theoretical classes and hands on training at the site available with radiotherapy equipments for clinical use for cancer patients.

The objective of the course was:

- Define the principles of 3DCRT and IMRT
- The roles of the RTT in the radiotherapy process specially in 3DCRT and IMRT
- QA and QC in modern radiotherapy
- Related imaging techniques and requirements



CONTINUING MEDICAL EDUCATION PROGRAM – IMA KARNAL



RGCIRC organized a CME Programme on Oncology in association with IMA Karnal on Saturday, 10th December 2016. Dr. Rajeev Kumar, Chief & Sr. Consultant - Breast Surgical Oncology delivered a talk on “**Breast Cancer: What a Physician should Know**” & Dr. L. M. Darlong, Head & Consultant – Thoracic Surgical Oncology spoke on “**Thoracic Cancer: What a Physician should Know**”. The talks were very well appreciated by doctors from Karnal.



Date of Printing - 26th December 2016
Date of Publishing - 30th December 2016

Posted at : Ashok Vihar Head Post Office, Delhi-110052
Registered with Registrar of Newspaper Under No. 68797/98
Postal Department Registration No. DL(N)/004/2015-17
Licensed to Post without prepayment under No.:"U"(DN)-162/2015-17

16th Annual
International
Conference

RGCCN
3rd-5th February 2017



**Rajiv Gandhi Cancer Institute
and Research Centre**

A Unit of Indraprastha Cancer Society
Registered under "Societies Registration Act 1860"

Theme: Breast Cancer in the Era of Precision Medicine

Venue: Habitat World, India Habitat Centre,
Lodhi Road, Delhi

Conference Highlights

- Conference Theme: **Breast Cancer in the Era of Precision Medicine**
- Live Surgical Workshops on
 - Robotic Nipple Sparing Mastectomy + Implant Reconstruction / Roll
by Prof. Alphonso Toesca, Italy
 - Open Nipple Sparing Mastectomy + Implant
by Dr. Golshan Mehra, USA
- Master Videos in Breast Cancer Surgery
- Brachytherapy Workshop
- Breast Imaging & Intervention Workshop
- Hands-on Workshop - VABB
- Oncology Nursing Workshop
- Breast Pathology and Genetics & Genomics Workshop

Last Date for Abstract Submission

7th January 2017

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Architect's Impression of RGCIRC (post expansion)



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. : 8744820804, Published from RGCIRC, Sector-5, Rohini, Delhi-110085

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If undelivered please return to :
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