



Rajiv Gandhi Cancer Institute and Research Centre

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

Architect's Impression of RGCI & RC (post expansion)



News Letter

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EDITORIAL

HOW DO YOU VIEW YOUR DISEASE?

Do we view our disease as failure or punishment or a gift. Our mental attitudes affect first our susceptibility to disease, then our ability to overcome it. Viewing disease as a sign of personal inadequacy or culpability is both cruel and false. My experiences with patients have made me understand that I am not in control of the outcome. I am in charge of my attitude and what I give to my life and how I treat myself. It is thus important to work for goals which are attainable. I can hope for a miracle but I cannot make one happen. I am not a failure or a bad person if one doesn't happen.

God will provide everything I need, not everything I want. If I don't get what I want, I am not a failure. I quote here (anonymous) "God grant me the courage to change the things I can, the serenity to accept the things I cannot and the wisdom to know the difference". It is important to know that the mortality rate for the condition known as **life** is 100%. We all die; that is no failure. Not living fully is the only failure. Remember there are probabilities and possibilities, statistics and individuals.

Another misconception we have about disease is that it is a punishment for our sins. Generally this guilt has no basis in reality but has been instilled in us by our parents, teachers and the peers. We as doctors need to be trained to look for the reasons behind illness even when the reasons are psychological. When Jesus saw a paralyzed man, he said "Your sins are forgiven" and not "get up and walk". Any doctor would apply braces or operate the patient to make him walk. When people asked Jesus, why did you say your sins are forgiven and didn't make the patient walk? Jesus knew the

importance of healed life. He said cure is often the by product of healing. He healed and cured through forgiveness and faith.

We are used to the idea of disease as a punishment or a failure and not a gift. But disease may serve as a redirection or I often describe it, as reset button. There may be complete metamorphosis of life once you develop a disease like cancer. Cancer may prove to be a blessing because through it, patient may learn how to handle his life, how to speak out his feelings to others, how to throw away the junk forever and have more contentment in his life. People may learn to live from day to day. People may make the most of everyday and live each day to the max.

People's outlook on living may change. One of my patients said "I am glad to have been permitted to learn to live with, rather than simply die from my cancer" I want to measure my life in terms of what it was and what it is now. I am glad to recognize each day as splendid, unforgettable miracle."

People find God as an enduring part of their new found identity as spiritual beings. Cancer patients often say that this grief has made them grow in spiritual sense. Had they not grown spiritually, they would have left a longtime ago.

Disease is not a punishment or a failure or a sin but it is an opportunity to change.

Remember God's gifts come in strange packages!!

Dr. A. K. Dewan
Medical Director

THYROID CANCER SYMPOSIUM



A symposium on 'Differentiated Thyroid Cancer : beyond primary and conventional management' was organized by the Institute on 31st August, 2013 at Hotel Crowne Plaza, Rohini, Delhi. Dr. P. S. Choudhury, Director Nuclear Medicine was the Organizing Secretary. This half day symposium mainly focused on recurrent thyroid cancer and consisted of plenary lectures, debates and a panel discussion. In the lectures the speakers deliberated on the nuances of surgery in a recurrent setting, the complications expected and current concepts of lymph node dissection in this disease followed by the utility of radioactive iodine and importance of long term follow up as practiced in this institute comparing it with international data. Debates were very interesting and interactive, where it was brought out where and when to attempt revision thyroidectomy or ablation of an intact lobe with radioactive iodine post thyroidectomy and the optimum method of patient preparation with recombinant TSH (rH-TSH). Quality of life issues which are pertinent to any form of treatment were discussed in conjunction with rH-TSH. The last most interactive session was the panel discussion on few challenging cases in recurrent thyroid cancer which was well appreciated by the audience.

Dr. P. S. Choudhury
Director Nuclear Medicine

FELICITATION CEREMONY

Dr (Col) A K Bhargava, Director Anaesthesiology, was felicitated on 27th Aug 2013 with the “**Life Time Achievement Award**” by the **Indian Society of Anaesthesiologists (Delhi Branch)** at R&R (Army Hospital), Delhi for his dedicated services in the speciality for 38 yrs and in the Army Medical Corps for 32 yrs.





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CME

ON ADVANCES IN MEDICAL PHYSICS

Under the Aegis of AMPI (Northern Chapter)
Saturday, 5th October 2013
Sapphire Ballroom II, Hotel Crowne Plaza, Rohini, Delhi

Chief Guest - **Dr. G. K. Rath, MD, FAMS**
Professor, Dept. of Radiation Oncology and Chief, DRB/IRCH, AIIMS, New Delhi

Highlights of the CME

- Un-flattened Photon beams in the modern era
- High-end technology in IGRT / SRS / SBRT

Who Should Attend
Interdisciplinary Practicing Physicians

- Radiation Oncologists ■ Medical Physicists ■ Radiotherapy Technologists

Organizing Secretary
S. N. Sinha, Chief Medical Physicist

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VIDEO ASSISTED THORACOSCOPIC SURGERY FOR EARLY STAGE LUNG CANCER

What is Video Assisted Thoracoscopic Surgery?

Video Assisted Thoracoscopic Surgery (VATS) is a minimally invasive surgery of chest performed under videoscopic guidance through small keyholes and without conventional open thoracotomy. Although simple thoracoscopy to examine the pleural space and perform simple wedge resection has been practiced for a long time, advanced thoracoscopic techniques for anatomic lung resection began in the early 1990's. In recent times there have been several technological advances in laparoscopic and thoracoscopic equipments & surgical instruments. VATS is slowly becoming the gold standard for surgery for thoracic cancers. Although there may be a surgeon preference in technique, mostly the same surgical & oncological principles are applied to thoracoscopic resection as with conventional open surgery; i.e. complete surgical resection with negative margins and mediastinal & hilar lymph node dissection.

Advantages of Video Assisted Thoracoscopic Surgery

Just as laparoscopic abdominal and pelvic surgery has almost replaced open abdominal surgery, similarly, minimally invasive thoracoscopic surgery is gradually becoming an alternative to open thoracotomy for lung, esophagus and mediastinal tumors. This way radical resections are performed through keyhole approach avoiding opening of the chest with big incisions. The main advantage is less postoperative pain, quick recovery, shorter hospital stay and improved shoulder function. There is improved pulmonary function and less chance of chest complications compared to open thoracotomy. Operative outcomes such as blood loss, total operative time and peri-operative complications all favour minimal invasive approaches. Moreover improved patient recovery facilitates early delivery of adjuvant chemotherapy. Although several small studies have shown similar oncologic outcomes comparing open thoracotomy and VATS in early stage lung cancer, in terms of adequacy of surgery and long term survival. A recent meta-analysis of twenty studies with over three thousand patients comparing VATS and open thoracotomy showed distinct advantage in intra-operative blood loss, chest drain time, hospital stay and overall complication rates with VATS. Five year survival rate was significantly higher with VATS than with thoracotomy. Overall, VATS therefore achieves better surgical and oncologic outcome and is a preferred surgical approach for early stage lung cancer.

Indications & Contraindications of Video Assisted Thoracoscopic Surgery

The most common indication of VATS is thoracoscopic wedge resection of pulmonary metastases; commonly from bone & soft tissue sarcomas and limited metastases from other malignancies such as breast, colorectal and genitourinary tract cancers (Figure 1). Solitary Pulmonary Nodules (SPN) suspicious for malignancy on imaging (PET / CT Scan) or positive for malignancy on histology are also best suited for VATS wedge resection or lobectomy. Another indication for VATS is video assisted lobectomy for early stage lung cancers along with systematic mediastinal & hilar lymph node dissection.

Most suitable cases for VATS lobectomy are small 5-6 cm size tumors, peripherally placed without any endobronchial lesions and without pleural adhesion, chest wall invasion or fixed mediastinal lymph nodes.



Figure 1. Soft tissue sarcoma with Pulmonary Metastases



Figure 2. Solitary Pulmonary Nodule

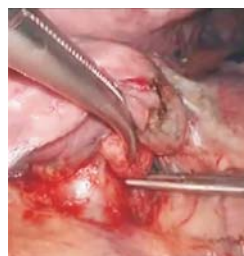


Figure 3. Thoracoscopic dissection of main vessels



Figure 4. Robot Assisted Thoracoscopic Surgery

Contraindications include locally advanced lung cancer with fixed peribronchial or hilar lymph nodes and use of preoperative chemotherapy or radiotherapy. Prior thoracotomy, advancing age, presence of emphysema and other co morbidities are not a contraindication to VATS lobectomy. In fact patients with larger BMI, older age and higher ASA benefit from VATS more than with thoracotomy.

Technique of VATS

Patient is placed in full lateral decubitus position with flexion of the table at the level of the hip and the table bent down so that the patient's chest is parallel to floor. This allows for splaying of ribs and widens the intercostal space to improve thoracoscopic

access and vision. Single lung anesthesia is established using a double lumen endobronchial tube. Commonly three or four ports are used. A 30° HD thoracoscope is used as it gives a panoramic view of the surgical field with minimal clash of instruments (Figure3). Dedicated thoracoscopic instruments with extra long length with fulcrum at the port site are used for dissection. Articulating straight staplers are used for controlling vessels, bronchus and dividing fissure. Subsequent surgical steps of VATS lobectomy are almost similar to conventional open surgery and may vary depending on patient anatomy, tumor size and surgeon preference.

Robotic Surgery – Present and Future of Thoracic Surgery

Robotic Surgery is actually robot assisted minimal invasive surgery, where instead of directly moving surgical instruments the surgeon manipulates instruments through computer control on a surgeon console. The last 5-10 years have seen a rapid evolution in minimal access surgery with a transition from laparoscopic or thoracoscopic surgery to wide spread use of surgical robotic system. Besides 10X magnification and 3D binocular vision, the da Vinci® surgical robot system offers seven degrees of endowrist movement and a stable platform for the operating surgeon compared to laparoscopic or thoracoscopic surgery using the straight stick like instruments.

Patient who are eligible for VATS lung resection would also be suitable for robot assisted surgery. Patient positioning and anesthesia is similar to conventional VATS arrangement. Standard technique includes use of a camera port, three instrument ports and a utility incision for application of staplers and tissue retrieval (Figure 4).

Several institutional studies have shown that robot assisted surgery is feasible and safe. The results of morbidity and mortality are similar to VATS lobectomy. Patient benefits with shorter hospital stay, less pain and early return to normal activity. Upstaging of stage I lung cancers is relatively higher with robot assisted surgery compared to VATS and open surgery due to more meticulous mediastinal lymph node dissection.

The main advantage of robotic surgery is that in addition to minimally invasive approach, there is additional 4 degrees of endowrist instrument movement, 3D magnified view to operating surgeon, elimination of fulcrum effect and reduced human tremor and improved ergonomic position for the operating surgeon and shorter learning curve.

Summary

Minimal invasive thoracoscopic surgery is more favorable than conventional open thoracotomy, with quick post operative recovery, shorter hospital stay, lower complication rates and better 5 year survival outcomes.

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