



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

HOPE THROUGH TRUST

"If you work just for money, you will never make it. But if you love what you are doing and you always put the customer first, success will be yours".

I have become convinced that the relationship of doctor with patient is most important. To create a relationship of trust the doctor and patient must learn each other's beliefs. A doctor's confidence in a certain treatment can be negated by a patient's unspoken rejection of it. The belief systems of physician and patient interact; but patient's bodies respond directly to their beliefs not their doctors. Doctors tend to be more logical, statistical and rigid and less inclined to have hope than their patients. When physicians run out of remedies, they are likely to give up. They should never say, nothing can be done, even if it is only to sit down, talk and pray.

Doctors may prognosticate with optimism rather than making a horoscope of patient. In one hospital, one of the consultants predicted by statistics 3 months survival and even communicated if patient did not have chemoradiation, he will soon have Shradhanjali from his kins. Infuriated by doctor's comments, patient went to another hospital, chose not to have chemotherapy but only radiation. He then switched to alternative therapy and lived for more than 3 years. Doctor lost his clientele and his reputation. The doctor's habitual prognostication of how much time a patient has left is a terrible mistake. It must be resisted even though many patients keep asking "how long? How long? Patients who are passive and who like their doctors, often die right on schedule, as though to prove their doctor right.

All patients must be accorded the conviction that they can get better no matter what the odds. I do not call my patients survivors. They are fighters. Just think of the courage it took for someone to conquer a certain type of cancer that no one had ever conquered before. The exceptional patient, the fighter often gets angry at the doctor's high headed pronouncements of doom. Although telling people they will die by such and such date is destructive and has no place in medical practice; acceptance of death need not take away hope. Paradoxically, preparation

of death can promote the cause of life. One day, a cancer patient told me that he wanted to die. I said, tell your wife and your children and parents if they accept, then it is ok. Next day, the man was jubilant and ready to get discharged. He discharged his emotional outburst in front of his relations and felt so great. Getting well is not the only goal. Even more important is learning to live without fear, to be at peace with life and ultimately death.

A doctor can instill some measure of hope, the healing process sometimes starts even before treatment begins. Hope comes about largely as a result of the patients confidence and trust in the healer. This bond is forged in many ways. Certain essentials-compassion, acceptance, availability, a willingness to provide information – are obvious. That is why preoperative visits by the surgical team are so important. They not only help the patient through the surgery but also speed up recovery.

It's also essential that patients know they can express anger to their physician without hurting the relationship. Unexpressed anger hurts the patient and must be shared to establish a healing team. How poor the bond must be for a patient to believe that a doctor would respond adversely to a criticism on a professional level. I'm happy when patients express anger at me, because it means they feel safe with me that we have a good relationship and they are behaving like fighters.

I remember an elderly lady who came to casualty with Carotid blow out and exsanguinated due to bleeding in ICU. Her daughter Ms X expressed displeasure at the terminal event. One year later Ms X reported with her sister for oral cancer. I gave her all options for treatment and even said she may go do other oncology centre for treatment. She said "I have full faith in you, I know doctors at RGCI&RC will not deceive me. I am in safe hands." That is Trust.

Patients' don't care how much you know until they know how much you care!

Dr. Dewan AK
Medical Director

BEYOND CONVENTIONAL RADIOTHERAPY - SBRT, RADICAL TREATMENT FOR METASTATIC CANCERS

In 2008, doctors told a woman, now in her 80s, that she was not a candidate for surgery and there was nothing else they could do. Then she found her way to Yale and became one of the first patients here to be treated with stereotactic body radiotherapy (SBRT), which delivers high doses of radiation with pinpoint precision.

Just a few treatments wiped away her disease.

Advances in imaging and biological targeting have led to the development of stereotactic body radiation therapy (SBRT) as an alternative treatment of various metastatic sites with high dose radiotherapy. Key factors in SBRT are delivery of a high dose per fraction, immaculate patient positioning, target localisation, and management of breathing-related motion. This allows delivery of an ablative radiation dose with minimal toxicity, and may potentially improve local tumor control, and hence enhance clinical outcomes especially for tumours that are considered radioresistant.

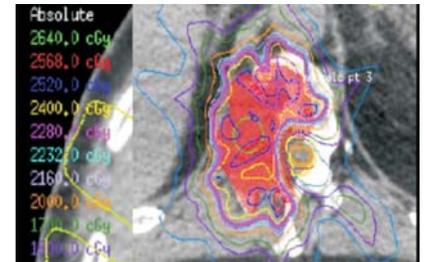
We typically assume that metastases originate from the primary tumor but perhaps metastases can generate more metastases and so just leaving oligometastatic disease especially from some indolent tumours, alone when it appears stable may mean that we miss a window of opportunity for cure.

Some of such commonly occurring situations are as under.

Image-Guided Ablative Therapy for Skeletal Metastasis

In patients with only a limited number of metastases, and with good performance status, local therapy, besides causing pain control and preventing fractures, might definitively eradicate these areas and potentially convert the therapy to curative intent.

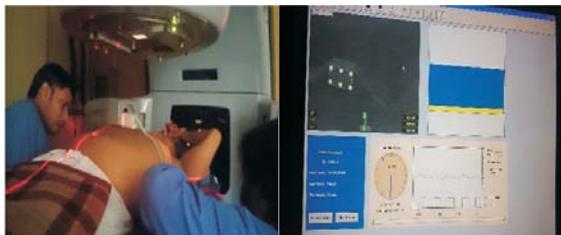
Both single- and multiple fractions SBRT for spinal metastasis is safe and feasible. Fractionated SBRT may be suitable in patients with a large tumor volume or when the dose to the spinal cord cannot meet the accepted dose constraint with single-fraction SBRT or in patients with recurrence in the area that was previously treated with radiation. Various dose schedules have been used in literatures.



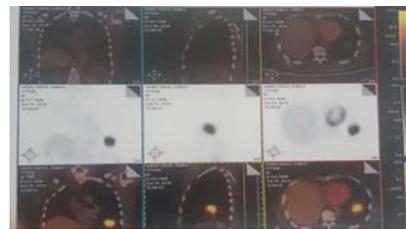
SBRT for spinal mets

Stereotactic Body Radiotherapy (SBRT) in lung oligometastatic

The total dose prescribed varies according to tumor site and maximum diameter of the tumour. Dose prescription suggested is upto 48 Gy in 4 fractions for peripheral lesions, 60 Gy in 8 fractions for central lesions and 60 Gy in 3 fractions for peripheral lesions with diameter ≤ 2 cm.



Set up of Respiratory gating for SBRT for a Lung metastasis patient



Pet CT of a patient of Lung Carcinoma (Triple Malignancy). Series below shows the disease before SBRT. The top series shows pet CT taken 2 months post SBRT. No side effects were seen

SBRT for abdominal lymph node metastases (Local control and toxicity)

The rationale of administering abdominal SBRT with curative intent to patients with limited nodal metastatic disease is the same as for selected patients with liver or lung metastases. There is no consensus on optimal dose, number of fractions, or planning constraints. The highest dose in literatures has been upto 60 Gy while the number of fractions between 3 and 6.

SBRT for adrenal gland oligometastases

Adrenal gland metastases from non-small cell lung carcinoma (NSCLC) are present in 5 to 10% of patients at initial presentation. Surgical resection is the main treatment option. According to Casamassima et al., SBRT may be considered as an ablative therapy that is not influenced by factors such as the primary tumour, type of oligometastatic adrenal disease (synchronous vs. metachronous, unilateral vs bilateral) and PTV. Treatments are generally well tolerated and survival similar to surgical resection for solitary adrenal metastases.

SBRT for liver oligometastases

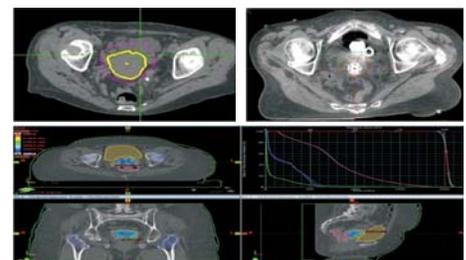
The liver is a common metastatic site for a variety of primary malignancies including colorectal, lung, breast, bladder, oesophageal, head & neck and pancreatic cancers, and cholangiocarcinoma. Surgery is still the standard of care for such lesions. SBRT has the advantage of delivering higher tumoricidal doses to the target and sparing uninvolved liver and surrounding critical organs, thus reducing the likelihood of RILD.

Follow-up of patients after liver SBRT is a challenge as the early treatment response (before 3 months) may be difficult to interpret on CT or MRI images because of radiation induced changes in the form of veno-occlusive diseases. But these changes are not associated with changes in overall liver functions.

Stereotactic Body Radiotherapy as an Alternative to Brachytherapy in Gynecologic Cancer

Brachytherapy plays a key role in the treatment of most gynecologic cancers. However, some patients are unable to tolerate brachytherapy for medical or other reasons or unfavourable anatomy. For these patients, stereotactic body radiotherapy (SBRT) offers an alternative form of treatment which entails high doses of external radiation delivered in a very conformal fashion.

While SBRT is commonly used in medically unresectable early-stage lung cancer and has a growing use in other pathologies, there are very little data regarding the role of SBRT used in place of BB.



Comparing Brachytherapy plan and SBRT plan for cervical cancer

SBRT in reirradiation

Most of the recurrences occur in the previously irradiated field and it is impossible to deliver enough dose by conventional radiotherapy to control the disease. Surgery is often impossible due to the previous irradiation and the location of the recurrence. Reirradiation is often a complex situation and SBRT seems to be a safe and efficient option to treat tumor recurrences even if not in a curative intent. This is an attractive alternative in Recurrences in Head and Neck Carcinomas, pelvic carcinomas. In the latter, recurrence with lateral pelvic invasion or in proximity of the iliac vessel, local treatment cannot be achieved. Without treatment, local progression often causes pain and impacts the quality of life.

Dr. Swarupa Mitra

Consultant & Chief of Gynecological and Genitourinary Radiation Oncology Services

TOBACCO - THE NATION'S LEADING KILLER

Tobacco is a leading preventable cause of death, killing nearly 6 million people worldwide each year. India is the second largest consumer of tobacco globally and accounts for approximately one sixth of the world tobacco related deaths. Most of these deaths occur in the productive years of life as a consequence of an addiction acquired in youth.

Tobacco problem in India is peculiar with consumption of variety of smokeless and smoking forms. There are almost 275 million tobacco users in India. Among adults (age 15+) over one third of the Indian population use tobacco products with 48% of males and 20% of females using some form of tobacco. So-called smokeless tobacco- such as gutkha, zarda, paan masala, khaini etc. is the most common form of tobacco use in India. According to Global Adult Tobacco Survey (GATS) 26% of adults in India consume smokeless tobacco, 33% of men and 18.4% of women.

Health Hazards of Tobacco

Tobacco is the only legal product that kills when used exactly as indicated by the manufacturer. Tobacco is deadly in any form or disguise. It is a leading cause of cancer. About 40% of cancers in males and 20% in the females are due to tobacco consumption. Almost 90% of lung cancers and more than 85% of oral cancers are tobacco related. India has the highest incidence of oral cancer globally with 75,000 to 80,000 new cases being reported every year due to practice of consuming smokeless tobacco. Not only lung and oral cancer risk but cancer of almost all body organs increases with the tobacco consumption including oesophagus, larynx, kidney bladder, liver, pancreas, cervix, stomach, colon, rectum etc. Smokers have an increased risk of heart attack, stroke, chronic obstructive pulmonary disease (COPD), diabetes, osteoporosis, cataract etc.

However, those who consume tobacco are not the only ones exposed to its negative effects. Millions of people, including one half of the world's children, are exposed to second-hand tobacco smoke, known also as passive smoking. Pregnant women exposed to second hand smoke are at risk of having baby with low birth weight. Children exposed to second hand smoke are at an increased risk of sudden infant death syndrome (SIDS), ear infection, cold, pneumonia and bronchitis.

Tobacco smoke contains more than 4000 chemicals at least 69 of them can cause cancer. It contains chemicals like hydrogen cyanide, carbon monoxide, arsenic, aromatic amines, benzenes, cadmium, formaldehyde, etc. Nicotine is a chemical that is naturally present in the tobacco plant and is primarily responsible for a person's addiction to tobacco product. The addiction to smoking and other tobacco products that nicotine causes is similar to the addiction produced by using drugs such as heroin and cocaine.

Role of Health Professionals in Tobacco Control

Health Professionals have a prominent role to play in tobacco control. Be a role model for rest of the population. Opportunities for screening and tobacco use cessation advice are largely missed by health care service providers. There is an urgent need to incorporate tobacco cessation interventions as part of standard practice, so that all patients are given an opportunity to be asked about their tobacco use and to begin advice and counseling to quit tobacco. They can educate the population on the harms of tobacco use and exposure to second hand smoke. They can add their voice and weight to national and global tobacco control efforts like tax increase campaigns, banning of various tobacco products etc. No country in the world has made significant progress in curbing the tobacco epidemic without its doctors. It is time for us to take a leadership role in advocating for comprehensive tobacco control laws.

“World No Tobacco Day” provides a chance for us to further our efforts to call attention to the high risk of cancers and other debilitating diseases caused by tobacco, often to young people in the most productive years of their life. Detection and treatment of cancers will not be sufficient to combat the toll of the disease. Government must urgently implement strong preventive policies like increased taxation and restrictions to access of tobacco products, enforcement of bans on advertising and productions of tobacco products, especially those targeting children and vulnerable population and the effective use of all communication vehicles to educate and empower the public. The display of large pictorial warnings on tobacco product packs is a proven cost effective mechanism to increase public awareness. Tobacco industry interference in government decisions is one of the biggest barriers to effectively protect people from the health threats posed by tobacco products. Delaying anti-tobacco campaigns will take a heavy toll on the Indian population particularly poorer and less educated. Change is never easy, but each year we don't act, adds million of preventable deaths to the toll.

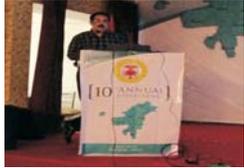
SAY NO TO TOBACCO, IT'S NOW OR NEVER

MAKE EVERYDAY A WORLD NO TOBACCO DAY

Dr. Jai Gopal Sharma / Dr. Indu Aggarwal
(Team Preventive Oncology)

BREAST CANCER CONFERENCE AND UPDATE 2015, KOLKATA

The Kolkata Breast Health and Welfare Association hosted Breast Cancer Conference and Update 2015 on May 2, 2015 in Kolkata. The conference witnessed senior national faculty from the field of Surgical, Medical and Radiation Oncology along with Pathologists. Dr Vineet Talwar, Senior Consultant, Medical Oncology moderated the session on adjuvant therapy, both Chemotherapy and hormonal therapy in early breast cancer. The deliberations included lucid interactions amongst the panelist and the audience during the proceedings of the meet and unusual clinical situations were discussed with faculty.



10TH ANNUAL CONFERENCE OF THE ASSOCIATION OF ONCOLOGIST OF NORTH-EAST INDIA (AONEI), SIKKIM

Dr. Vineet Talwar, Senior Consultant Medical Oncology, delivered a lecture on recent Advances in Management of Metastatic Renal Cancer as faculty in the 10th Annual Conference of the Association of Oncologist of North-East India (AONEI) on April 4 - 5, 2015 in Gangtok, Sikkim.

CME – IMA, BAREILLY

RGCIRC organized a CME on Oncology, in association with IMA, Bareilly on Friday, 17th April 2015. Dr. P. S. Choudhury, Director – Nuclear Medicine delivered a talk on “Imaging in Breast Cancer” & Dr. S. K. Gupta, Sr. Consultant – Medical Oncology spoke on “How to approach lump in breast which turns out to be Malignant”. The talks were attended by more than 100 doctors.



CME – IMA, FARIDABAD

RGCIRC organized a CME on Oncology, in association with IMA, Faridabad on Saturday, 9th May 2015. Dr. Gauri Kapoor, Director – Pediatrics Hematology Oncology delivered a talk on “Childhood Cancer and Cord Blood Stem Cell: Tips for the General Practitioners” & Dr. L. M. Darlong, Head & Consultant – Thoracic Surgical Oncology spoke on “Uniportol Thoracoscopy for Lung Cancer”. The talks were attended by more than 75 doctors.



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