



EDITORIAL

CLINICAL INTUITION OR GUT FEELING

Healthcare professionals use their clinical intuition every day but are not inclined towards acknowledging that to the public. The limited medical literature available on clinical intuition refers to it as an involuntary, reflexive approach arising from the deeper levels of our consciousness. Clinicians claim that they use intuitive and analytical approaches that complement each other in diagnosis, treatment, and care. Though the intuitive approach is partially unreliable, clinicians do not want to do away with it. Senior doctors have always taken pride in the fact that they can trust their clinical judgment, mostly making the right decision at the right time.

We sometimes get frustrated watching physicians paralyzed by their indecision. It is not a lack of knowledge but the problem lies in the manner in which we approach "clinical thinking." There are two major ways in which we process information, "intuitive (type I)" and "analytic (type II)" Our Intuitive approach is automatic, and happens at an unconscious level. There is a real danger in thinking this way, to zero in on a specific diagnosis or problem and fail to consider other possibilities. The fact is that most physicians who trust their intuition are right most of the time. They are experienced mature doctors. Junior novice doctors work by evidence and knowledge of literature. Experience makes them intuitive. The other mode of clinical thinking is Type II, the Analytic process. This is a conscious, slower, and deliberate process that is usually more reliable than the Intuitive process. In this process, we take time to analyze all of the information, order confirmatory tests, consult with colleagues and consider all of the possibilities. Although more reliable, it requires a great deal of resources like CT and MRI scans, and numerous vials of blood. In truth, it is just not practical for every patient. We must trust our clinical, intuitive judgment because we cannot order all tests on every patient at all times. We must recognize when our biases creep into the decision making and learn to move from our intuitive mode to analytic mode.

Intuition or gut feeling involves unspoken elements which flow between doctor and patient. They are vital ingredients of successful patient management but are not easily measured, objective or evidence-based. 'Decisions involving people will always have emotional aspects'. Medical practice has developed out of an inarticulate mix of intuition and experience. Despite the present cost-conscious, sociopolitical environment of medicine, an understanding and sympathetic approach still needs to be taken by objective and scientifically trained clinicians. Too often patients suppress information, not realizing its significance, fearing to admit to underlying tensions, or worrying that the doctor is pressed for time. For example, although at least 30 minutes is needed for each new hospital out patient appointment the consultation can last less than 12 minutes, and in general practice the patient booking intervals can be only five to 10 minutes. Unfortunately too, if a patient hints at something that is not followed up, they might never allude to it again. Time constraints do not allow all possibly relevant factors to be explored therefore reducing the effectiveness of a clinical consultation. Doctors should learn to listen. If doctors know how to listen, then patients can teach them more than books ever can. For these reasons, reflective listening and intuition are part of the diagnostic and therapeutic process.

Medicine in contemporary society may be failing because doctors do not listen to pleadings behind the spoken word. Basing clinical action mainly on evidence for the effectiveness and efficiency of different therapies can give a feeling of safety and security and makes sense in many high-technology hospital-based specialties. In most clinical practice, however, the evidence base is not the only determinant of action. Therapeutic action should weigh all the clinical, emotional and personal factors as well as any associated social problems, mood swings and inherent stability of the individual if effective help and advice is to be given. The art of healing cannot be quantified. There are differences between knowledge and knowing. Emotional disturbance, insecurity and related depressions and anxiety are too often considered of less importance than physical problems and mainly treated with drugs.

At present we have considerable imbalance between that which is objective and measurable, what can be demonstrated and proved by test or previous experience, and what we instinctively and intuitively feel is right. Present emphasis is on diagnosis and therapy with 'evidence-based' medicine, based on measurable experience. If pursued to its extreme, this could lead to health care becoming debased to a commercial commodity in which health professionals are paid merely for knowledge and technical skills. This attitude could lead to something approaching inhumanity, and is far from our vocation as healers.

Intuition is a carefully learned skill which has to be developed within oneself as a therapeutic tool. Intuition, being in part an unconscious activity, is not readily accessible to objective measurement and is therefore more controversial. Indeed, it seems unlikely that medicine can ever be entirely free of value judgments. A great deal of learning, self-examination and reflection on previous clinical experience is therefore needed before a doctor can be fully conversant with the use of intuition in therapy. An intuitive approach to our clinical work encapsulates the rational and emotional aspects of patient support and ensures that the hidden part of a complaint is always kept in mind. For patients, we ourselves are still the most important medicine. In cancer treatment we must therefore always show that we care.

Caution for Intuitive doctors

1. Take time to listen. Intuition isn't magic.
2. Encourage second opinions. An intuitive doctor realizes medicine has hidden dimensions and accepts that another doctor may be able to tune into aspects of your case he has overlooked.
3. Keep up with science. Some doctors may rely too much on intuition. Each week, a wealth of new scientific information is available to doctors; you should take advantage of the latest studies. Intuition shouldn't be an excuse for not keeping up.



RGCON 2019 – 18TH ANNUAL INTERNATIONAL CONFERENCE THORACIC ONCOLOGY - “TRANSLATING RESEARCH INTO PRACTICE”

RGCIIRC organized its 18th Annual International Conference (RGCON) from 8th to 10th February 2019 at Hotel Crown Plaza, Rohini, Delhi. The theme of this international conference was **Thoracic Oncology - “Translating Research into Practice”**.

The conference offered three days of intense academic activities spanning didactic lectures, live workshops, panel discussions to proffered poster presentation.

The educational programme addressed the contemporary and critical issues, and recent advancements pertaining to the needs of practicing medical oncologist, surgical oncologist, radiation oncologist, pathologist and radiologist at all levels and postgraduate students.

The conclave turned out to be a huge success with an enthusiastic participation from all parts of India and abroad. The event provided the platform where delegates interacted with the International & national esteemed faculty and refined their knowledge in all the respective fields of Oncology. The conference provided an ideal forum where not only the latest happenings in the field of Oncology were discussed, it also unveiled an upcoming approach, research work and the scope of future advancements in Oncology practice.

The Raman Chadha Oration was delivered by Dr. Kumar Prabhsh, Professor, Medical Oncology, Tata Memorial, Hospital, Mumbai. Dr. K. K. Pandey Memorial session was delivered by Dr. Diego Gonzalez Rivas, Department of Thoracic Surgery, Coruña University Hospital, Coruña, Spain and Mr. K. K. Mehta Oration was delivered by Dr. Ramaswamy Govindan, Professor Department of Medical Oncology, Washington University Medical School, St. Louis (USA). On the 2nd day the abstracts were presented and on 3rd day the winners were felicitated at the valedictory function.

RGCON 2019 was organized by team consisting of **Dr. Munish Gairola**, Director, Radiation Oncology, **Dr. Ullas Batra**, Sr. Consultant & Chief of Thoracic Medical Oncology, **Dr. L. M. Darlong**, Sr. Consultant and Chief of Thoracic Surgical Oncology and **Dr. Sunil Pasricha**, Consultant, Histopathology.



SOIICON 2019 - 1ST ANNUAL INTERNATIONAL CONFERENCE OF SOCIETY OF ONCOLOGIC IMAGING INDIA (SOII)



SOIICON 2019, the 1st Annual International Conference of Society of Oncologic Imaging India (SOII) was held from 8th - 10th February 2019 at Hotel Crowne Plaza, Rohini, New Delhi. The theme of the conference was Thoracic Oncologic Imaging “Integrating Radiology into Oncology Practice” and highlighted the need and importance of radiologists getting involved in clinical decision making process. The multi-disciplinary approach of the meeting covered all aspects of thoracic oncologic radiology and the attendees loved every lecture and session as was evident by the packed hall. The highlight of the conference was a full session on Artificial Intelligence and Deep learning. A few sessions were jointly held with the RGCON 2019. The conference was a great success and included faculty and attendees from across the world including USA, Europe, Malaysia, Mauritius, Bangladesh, Nepal and all parts of India.

Dr. Arvind K. Chaturvedi
Organizing Chairman
SOIICON 2019

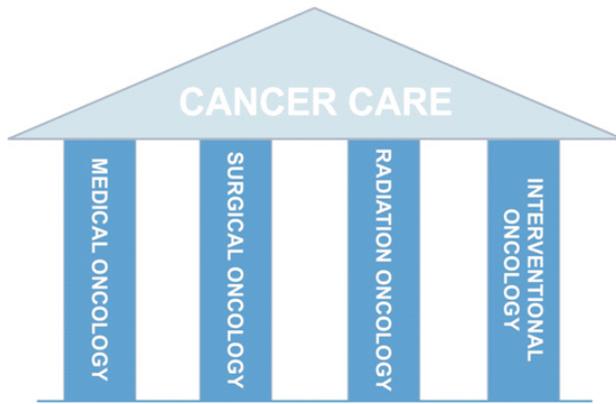
Dr. Abhishek Bansal
Jt. Organizing Secretary
SOIICON 2019

CME – IMA BAREILLY

RGCIIRC organized a CME in association with IMA Bareilly on Saturday, 9th March 2019 at IMA Bhawan, Bareilly, UP. Dr. Kundan Singh Chufal, Sr. Consultant and Chief of Breast and Thoracic Radiation Oncology delivered a lecture on Organ Preservation Approaches in Oncology: from Cure to Quality of Life and Dr. Mudit Aggarwal, Sr. Consultant – Head & Neck Surgical Oncology spoke on Robotic Surgery in Head & Neck Oncology in the said CME.



INTERVENTIONAL RADIOLOGY AND INTERVENTIONAL ONCOLOGY THE FOURTH PILLAR OF CANCER CARE



Interventional Radiology (IR) is a specialty where trained radiologists perform minimally - invasive procedures in various organs of the body, using small devices such as needles, catheters & wires. Their training in imaging techniques like ultrasound, CT, MRI, angiography etc. helps them to use these modalities to guide them to perform these procedures accurately and with high precision. In fact they were the first ones to ever perform an angiography on a patient's heart!

Interventional oncology (IO) is a type of cancer care performed by interventional radiologists. With advancements in various equipments & techniques, it has established itself as an essential fourth pillar of Oncology care in the Western world and is rapidly gaining popularity in India as well. Most of the Interventional Radiology procedures do not require any incision, general anesthesia, or overnight admission. Therefore they are quick, cost-effective and with very few complications.

Cancer is a disease which remains with most of the patients & their families, for a long period of time and IRs are there to help them in more ways than one during their journey. Starting right from the beginning with providing a tissue for diagnosis using small needles to obtain biopsy; IRs can be involved at every step of the way. Be it minimally invasive ways to treat tumors [like radiofrequency ablation (RFA) / microwave ablation (MWA)]; managing complications like bleeding or pus formation; blocking blood supply of tumors with or without medicines (embolization / TACE / TARE) or providing palliative care in the form of pain relief, feeding accesses or end of life care; IRs & IOs are well trained & equipped to perform these tasks with minimal patient discomfort.

Besides cancer care; many conditions like fibroids, varicocele, infertility, varicose veins, leg ulcers, bleeding from various sites (coughing / vomiting of blood, blood in stools) etc. can be exclusively managed by IRs without much toxic side effects and mostly as daycare procedures. Patients with chronic kidney disease can be helped immensely with procedures to provide a new access or save an existing access for dialysis. Patients with jaundice due to obstruction can be treated with placement of tubes and stents.

To summarize; IRs & IOs perform a myriad of procedures which can help treat patients with all kind of diseases affecting various organs of the body; while maintaining or improving their quality of life. In this age of individualized patient care, interventional procedures are integrated as minimally invasive therapies into a comprehensive patient care plan along with other disciplines.

**Dr. A. K. Chaturvedi, Dr. S. Avinash Rao,
Dr. Vaibhav Jain and Dr. Abhishek Bansal**
Department of Radiology

Case Vignette



Rajiv Gandhi Cancer Institute & Research Centre, Niti Bagh

WATCH THE SKIN WHILE WE TREAT CANCER!



Sixty five years lady normotensive, non-diabetic presented to our OPD with complaints of lump in the left breast for last 3 months. PET CT showed locoregional disease. Left modified radical mastectomy was done.

Patient was planned and started on Docetaxel and Cyclophosphamide based adjuvant chemotherapy cycle 1 day 1 was given on 04/01/19 which she tolerated well.

She developed severe erythema and desquamation of hands and feet along with erythema and puffiness of face with cycle two on day 6 leading to severe physical and psychological distress.

She was diagnosed as hand and foot syndrome and managed with topical steroids, hydration and emollients in consultation with dermatologist.

As maintaining dose density of the adjuvant chemotherapy was required and Docetaxel was suspected as the responsible drug, we changed it to Paclitaxel. She responded favorably and could complete the rest of cycles with ease.

The take home message: Hand foot Syndrome though rare is possible with taxanes. The drug needs to be discontinued if it is severe. A trial of sister drug (Paclitaxel instead of Docetaxel) could be useful to maintain the dose density and overall outcome in such patients.

Dr. Sajjan Rajpurohit
Consultant – Medical Oncology

Date of Printing: 25th March 2019

Date of Publishing: 30th March 2019

Posted at: Ashok Vihar, Head Post Office, Delhi - 110052

Register with Registrar of Newspaper Under No.68797/98

Postal Department Registration No. DL(N)/004/2018-20

Licensed to Post without Prepayment Under No.: "U"(DN)-162/2018-19

OPG (ORTHOPANTOMOGRAM) AT RGCIRC



OPG has been installed in RGCIRC in the Cath Lab Complex, C – Block, New Building, 1st Floor, with the sole purpose of getting the panoramic view of the mouth, teeth and the bones of the upper and lower jaw on a single film.

The Dental Department has always been in the fore front in providing quality care to the patients. The OPG unit is specifically designed to rotate around the patients head during the scan. It takes approximately 20 seconds.

Equipment

CS 8100 Carestream (KODAK) with sensor technology CMOS, exposure time 2 to 12.5 seconds suitable for child and adults both and easily accessible for patients standing or sitting, and in wheelchairs. It is different from the small x-rays taken for the individual teeth.

A diagnostic capability of OPG includes:

It demonstrates the number, position and growth of all the teeth including those that have not yet erupted.

The scan can provide information on wisdom teeth, bone loss, jaw trauma, dental pain or be used as a part of a general dental check-up or for surgical planning.

It reveals problems with the jawbone and the joint which connects the jawbone to the head, called the temporomandibular joint.

- It can be used for the patients with limited mouth opening where small x-rays cannot be taken
- It can show bony erosion in oral malignancy cases
- It can show the condition of internal fixation plates and screws in panoramic view.
- It reveals the global view of osteonecrosis of the jaws



Dr. Puneet Ahuja
Dr. Sheetal Bhalla
Department of Dental Surgery

Mr. D. S. Negi (C.E.O)
Dr. S. K. Rawal
(Medical Director)
Dr. A. K. Chaturvedi
Dr. D. C. Doval
Dr. Gauri Kapoor
Dr. Anurag Mehta
Dr. Rajiv Chawla
Dr. S. A. Rao
Dr. P. S. Chaudhury
Dr. Dinesh Bhurani
Dr. Munish Gairola
Dr. Vineet Talwar
Dr. I. C. Preamsagar
Dr. Rupinder Sekhon
Dr. Shivendra Singh
Dr. Rajeev Kumar
Dr. Sumit Goyal
Dr. Ullas Batra
Dr. Rajan Arora
Dr. R. S. Jaggi
Dr. L. M. Darlong
Dr. Kundan Singh Chufal
Dr. Swarupa Mitra
Dr. Mudit Agarwal
Dr. Lalit Sehgal
Dr. Vaibhav Jain
Dr. Manish Pruthi
Dr. Sunil Kr. Khetarpal



To:

If undelivered please return to:
Rajiv Gandhi Cancer Institute and
Research Centre, D-18, Sector - 5,
Rohini, Delhi - 110085

Printed and Published by Mr. Pramod Maheshwari on behalf of Indraprastha Cancer Society and Research Centre and printed at R.R. Enterprises, 18 - A, Old Gobind Pura Ext., Street No. 2, Parwana Road, Delhi - 110051, Tel: +91 - 8447494107,
Published from Rajiv Gandhi Cancer Institute and Research Centre, D - 18, Sector - 5, Rohini, Delhi - 110085

Editor: Dr. A. K. Dewan