



NewsLetter

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EDITORIAL

WHAT IS TOTAL PAIN ?

Pain is common in cancer patients, particularly in the advanced stage of disease when the prevalence is estimated to be more than 70% contributing to poor physical and emotional well-being. The most comprehensive systematic review indicates pain prevalence ranging from 33% in patients after curative treatment, to 59% in patients on anticancer treatment and to 64% in patients with metastatic, advanced or terminal disease. Pain has a high prevalence earlier in disease in specific cancer types such as pancreatic (44%) and head and neck cancer (40%). Increased survival with either life-prolonging treatment or curative treatment results in increased numbers of patients experiencing persistent pain due to treatment or disease, or a combination of both. Approximately 5%–10% of cancer survivors have chronic severe pain that interferes significantly with functioning. Despite guidelines and the availability of opioids, undertreatment is common.

Pain is not purely a physical experience but involves various other components of human functioning including personality, mood, behavior, and social relations. In an attempt to describe the all-encompassing nature of pain within a "whole person" framework, Dame Cicely Saunders coined the concept of "total pain". She suggested that pain has psychological, social, emotional, and spiritual components that make up the "total pain" experience. This concept has been well accepted in the palliative care community. Physical pain may be caused by direct tumor effects, by treatment, by general debility, and by unrelated comorbidities. Spiritual distress is often overlooked in clinical assessments and includes existential questions the search for meaning and purpose, and anger at "fate," as well as specific faith issues in some patients. Social pain relates to the position the patient has within society and culture, financial issues, and the impact the pain has on the family and caregivers. Psychological pain is affected by fear, anxiety, and depression. Total pain is a holistic experience that extends beyond the psychological domain. Total pain recognizes the holistic nature of pain and the interplay of psychological and social well-being, spirituality, and culture. Symptoms rarely occur in isolation; rather, they cluster with other symptoms.

The complexity of treating patients with "total pain" is often compounded by the patients' inability to distinguish exactly which component is causing pain, because all they can express is that "they just hurt. For example, pain manifested physically can be caused by the combination of factors like a brother not visiting, a despondent feeling that "God has left me," and a bed sore developed during hospitalization. It is further highlighted that spiritual concerns also can result in nonresponsiveness to pain medication because it is a "very real component of their pain."

Fifty year man Mr.K was found to have recurrent lung cancer with extensive bony and cutaneous metastasis. He was in real agony and was on more than 100mg Morphine per day in addition to fentanyl patches and supportive measures. Relations were still giving rosy picture and did not want the man to know the truth. I discussed with the relations, the advanced nature of disease and possible ways in which pain can be relieved. Slowly truth was revealed to the patient in next 2 meetings. Man immediately came out with household problems, business issues and discussed about 24 years old daughter.

Once he knew that he has limited time, he settled his business, and property matters. He got his daughter married in two months time. He visited me and expressed his desire to stay with his wife in Hospice near Gangaji river in Uttarakhand. After a month in Hospice, he was seen

chanting Bhajans and he spent much of his time in library and meditation. In two months time, he was off morphine. Of course the disease took its natural course.

Mr. K's story demonstrates the need for healthcare professionals to assess and address a person's "total pain" to appropriately care for them. Along with the obvious physical dimension of pain, this patient was suffering socially, psychologically, and spiritually. His physical pain was treated pharmacologically. Psychological stressors also contributed to the patient's "total pain." In this case, psychological pain was defined by Mr. K's feelings of anxiety, fear, guilt, and anger. The psychological component of "total pain" also has been referred to as the emotional component. Research has found that such emotions, particularly fear, can actually lower the pain threshold. His constant preoccupation with what would happen to his family and his fear of dying, preyed on his peace of mind. In response to this, the counselor/nurse always sat aside his bedside and listened attentively to his concerns. A psychologist was also consulted and worked with Mr. K to help him deal with his anger and guilt.

The social aspect of pain is also much present here. His social pain is defined by the discomfort or unease caused by the thoughts of harm, pain, or distress to his family. As the family's breadwinner and head of the household, the change in role from provider to patient was particularly distressing for him given the social expectations from his cultural background. Many patients find it difficult to cope with a change or loss of a role. In this case, the meeting among Mr. K, his family, and the interdisciplinary team lifted an incredible burden from the patient and his family. Open communication with the patient, family and other members of the palliative team is crucial in alleviating part of Total Pain.

Finally, Mr. K had begun to question his faith. It is not uncommon for the psycho-spiritual suffering of patients with advanced cancer to heighten the distress associated with physical symptoms. Spiritual pain is difficult to capture in words but can be recognized in any physical or psychological symptoms like disorders of relationships, and spiritual symptoms like meaninglessness, anguish, duality, and darkness. This patient had lost hope of cure yet had not accepted his death fully. He was unclear of his purpose in life, now that he felt he had lost his role of head of the family. Saunders stated that the essence of spiritual pain involves a feeling of meaninglessness and a bitter anger at the unfairness at what is happening at the end of life. The spiritual advisors were able to successfully influence this spiritual aspect as well. Hope was reframed from being the hope of a cure to the hope for a peaceful, painless death with his family present.

In conclusion the different aspects of "total pain" may or may not necessarily manifest as physical pain. In this case, the social and psychological aspects of his pain seemed to be more important contributors to "total pain" than physical aspects. Whether patients report pain, hurting, or suffering, it is important to assess these experiences through a multidimensional lens that allows for the appreciation of all possible causes and influences. In this way, Palliative care team is in a better position to understand the pain experience and provide optimal pain management.



Dr. A. K. Dewan
Director - Surgical Oncology

ANTEROLATERAL THIGH FLAP - A VERSATILE OPTION IN CANCER RECONSTRUCTION

Cancer surgery often results in loss of large amount of tissue that results in large defects and hampers patient's form and function. If this defect is not restored, not only the patient suffers agony of pain, ugliness and disability but also it delays the further cancer treatment like Radiotherapy and/or chemotherapy.



Image: Tongue Reconstruction

The cancer can affect any part of the patients body which after resection surgery results in site specific defect that poses unique challenge to the cancer reconstruction surgeon in terms of its size, tissue component, function and form. In India the commonest form of the cancer in males is of oral cavity that results from chewing & smoking of tobacco products. RGCIRC surgical oncology reconstruction dept also see major portion of the cases with defect in oro-mandibular region requiring reconstruction but other areas like chest wall, abdominal wall, upper and lower limb defects are also increasing in number.



Image: Foot Reconstruction

Anterolateral thigh flap (ALT flap) introduced by Song et al. in 1984 is a workhorse flap that is harvested from antero lateral part of the thigh. Vascular basis of this flap is Branch of Lateral circumflex femoral vessels. The flap is so versatile that many options can be available with ALT flap. Its size can be varied according to the need, It provides large amount of the skin that can be utilized to cover large defect with good tissue thickness. It can even be combined with the muscle (Vastus lateralis muscle) as a chimeric flap that can be utilized to fill a cavity and with a skin graft even a larger defect can be covered. For a small defect, a small portion of skin based on single perforator can be harvested. A very thin flap can be harvested by removing its deep fascia and subcutaneous fat for a defect that is superficial. Even an Adipo-fascial ALT flap can be harvested where the skin itself is not included in flap, only the subcutaneous fat and the deep fascia is taken as flap. This can be useful where the skin is not desired due to its hair bearing property (especially intraoral defects). The advantage is also the fact that the donor thigh defect is closed primarily in almost all of the patients with minimal functional disability leaving a straight line suture scar on the thigh.



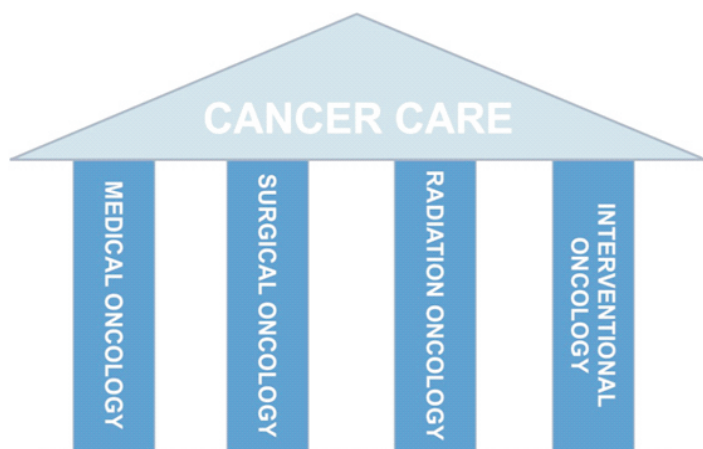
Image: Lip Reconstruction

In RGCIRC, over last 3 years we performed total 1274 microvascular free flap reconstruction out of which about 687 (~50%) were ALT free flap reconstruction surgeries. ALT flap has been used to cover various defects most common being Head and neck oncosurgical defects 654 cases. Out of these 654 cases 509 cases had only buccal mucosal defects, 71 cases had both buccal mucosal as well as outer skin defects where double skin paddle ALT flap was used for reconstruction. 41 cases had tongue defect reconstructed with ALT flap. 13 cases had lip defects, 3 cases had naso-orbital defects, 19 cases of total / partial laryngopharyngectomy defect, 1 case of auriculo temporal defect. Other cases include 2 chest wall defects, 2 abdominal wall defects, 2 upper limb defects and 17 lower limb defects. Overall complication rate includes complete flap loss 3% cases (21 cases), partial flap loss 2.3% cases (15 cases). Largest size of skin paddle flap size harvested was 28cm x 9cm and smallest skin paddle size taken was 5.5cm x 4cm. No donor site related complication noted in immediate postoperative period.

Thus Antero-Lateral Thigh (ALT) flap is truly the most versatile option in Cancer Reconstruction surgeon's armamentarium that enables him cover virtually any defect of any dimension.

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Dr. Kripa Shanker Mishra, Dr. Mohammed Sahil Niyazi**
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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. 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.

IRs can help cancer patients all along during their journey with the disease. Starting right from the beginning with providing a tissue for diagnosis, or treating 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, and end of life care.

Besides cancer care; many conditions like fibroids, varicocele, infertility, varicose veins, jaundice, dialysis access, 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.

To summarize; IRs & IOs provide individualized patient care with quality of life preserving, minimally invasive therapies integrated into comprehensive patient care along with other disciplines.

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

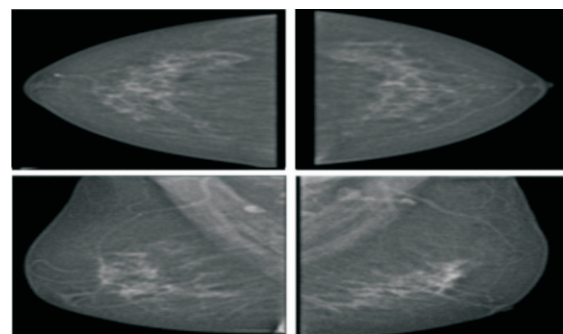
Case Vignette

Rajiv Gandhi Cancer Institute & Research Centre, Niti Bagh

PERSEVERANCE & AWARENESS PAYS

62 years old, post menopausal lady, with no co morbidities presented to us, three months back, with H/o trauma to the right nipple followed by recurrent, spontaneous, unilateral, blood or altered blood discharge of a few days' duration. Her B/L Mammography done was normal (BIRADS I). USG B/L breasts revealed cystic lesions in both breasts (BIRADS II). Nipple discharge cytology was paucicellular, reported as benign papillary lesion (category C2). She was treated conservatively and kept on follow up.

She was reviewed with MR Mammography after a month, when her discharge was persistent. MR Mammography revealed a focal linear altered signal intensity in retroareolar region just behind nipple with post contrast enhancement (BIRADS III). Having once given conservative treatment, it was decided to excise the lesion. USG guidance, during surgery, revealed a single filled duct just behind the nipple extending to 8 O' clock position of right breast. The retroareolar lesion could be cannulated & the whole duct and the lobule were excised into including a part of the nipple skin. The final histopathology was DCIS (Ductal Carcinoma in Situ) with good margins and strongly positive Estrogen receptor. Patient is now undergoing radiotherapy (to conserve the breast) followed by hormonal treatment as risk reduction therapy.



M R Mammogram

Take Home Message:

Despite a BIRADS 1 in Mammography, Nipple discharge can be a sign of cancer, specially if spontaneous, recurrent, unilateral, bloody or clear serous. Hence, it must be surgically excised.

Dr. Leena Dadhwal
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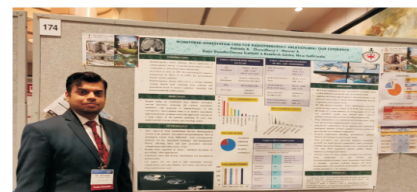
13TH ANNUAL GLOBAL EMBOLIZATION ONCOLOGY SYMPOSIUM TECHNOLOGIES (GEST) NEW YORK, USA



Dr. Abhishek Bansal, Consultant - Interventional Radiology, RGCIRC presented his paper on **"Role of Transarterial Embolization in Massive Upper Gastrointestinal Bleeding in Unresectable Gastric Carcinoma Patients"** at the 13th Annual Global Embolization Oncology Symposium Technologies (GEST) Meeting from 9th to 12th May 2019 at New York, USA.

ANNUAL CONFERENCE – INTERNATIONAL ANAESTHESIA RESEARCH SOCIETY (IARS) 2019

RGCIRC participated in annual conference of International Anaesthesia Research Society held from 16th to 20th May 2019 at Montreal, Canada. Dr. Akhilesh Pahade (Attending Consultant, Department of Anaesthesiology) presented a poster on **"Monitored Anaesthesia Care for Radiofrequency Ablation of Oncological Lesions: Our Experience"** which was co authored by Dr. Itee Chowdhury, Sr. Consultant – Anaesthesiology.



PAIN MANAGEMENT TRAINING PROGRAMME IN RGCIRC



The Department of Pain Management, RGCIRC successfully organized its first in house fortified three days certified training programme from 29th to 31st May 2019. This 3 days course was organized for doctors of all specialities and nurses who desired to learn about cancer pain. It entailed interactive session by the faculty of RGCIRC. The topics were covered on cancer pain, assessment and types of pain, History taking, Pharmacotherapy in cancer pain, videos on interventional pain management with multimodal team based Holistic approach. The course was highly gratifying and we received excellent feedback. This training programme will be held quarterly hence forth.

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