Rajiv Gandhi Cancer Institute
and Research Centre
A Unit of Indraprastha Cancer Society
Registered under "Societies Registration Act 1860"

NewsLetter

Vol. XXIII | No. 8 | Price: 50 Paisa

EDITORIAL

LEFT AGAINST MEDICAL ADVISE (LAMA)

LAMA has been defined in the broadest term as any patient who insists upon leaving against the expressed advice of the treating team. Escape, absconding, or elopement, means the patient leaves the hospital without notification. LAMA is a well recognized problem in medical practice. LAMA accounts for approximately 1% of discharges for general medical patients. Patients discharged AMA have longer eventual hospital stays and worse health outcomes. Physicians are often distressed by the clinical and ethical challenges of discharges AMA. How should physicians manage their conflicted obligations to respect patients? What are physicians obligations to their patients who leave accepting only partial or inadequate treatment plans or no treatment at all? Physicians who discharge patient AMA enjoy no definitive legal protection from the consequences of their patient's choices. In fact, good clinical judgment and careful documentation provides the best liability protection. Clearly, discharges AMA are problematic for patients, stressful for physicians, and resource intensive for health facilities. Patient's nonadherence to recommended treatment is often influenced by treatment side effects, costs, inconvenience, psychosocial burden, and the quality of the patient-physician relationship. Regardless of the setting for nonadherence, the variance between recommended and accepted treatments often stems from the fact that patients tend to make decisions based on values and broader interests, whereas physicians tend to emphasize more circumscribed medical goals. A patient's intention to leave AMA may trigger physicians and other hospital staff to question the patient's decision-making capacity.

The predictors of LAMA fall into two broad categories:

1. Patient Variables – socio-demographic characteristics, diagnosis, treatment history, behavior and attitudes toward treatment. Younger age, male gender, non-insurance, low socio-economic status, alcohol and drug abuse, psychiatric disease, persons with less social support (single), lack of primary care physician and past history of LAMA all have been reported as risk factors for LAMA.

2. Provider Variables include hospital setting, staffing patterns, admission and discharge policies, and physicians' clinical style and experience. It also includes failure to orient the patient to treatment, punitive or threatening atmosphere in the inpatient unit and failure to establish a supportive provider-patient relationship.

LAMA is a multifactorial etiology. These are dissatisfaction with their care, patients expected a shorter stay, need to take care of personal, family or financial affairs, patients felt better, patients are not improving and not receiving adequate nursing/medical care, preference for another hospital, beliefs that the condition was terminal, dislike of the hospital environment, and not wanting to be used for learning/teaching purposes or for financial difficulties. Most cases of leaving against medical advice reflect poor communication and lower trust between the physician and the patient. Poor communication contributes to dissatisfaction and disagreement in quality of care being utilization, including more return visits, and perhaps greater costs for the subsequent care of an initially inadequately treated condition. Overall costs of caring for an individual patient over time may be higher for patients who leave the hospital prematurely. Therefore, preventing discharge against medical advice is likely to benefit both patients and health care systems. Physicians should attempt to promote informed decision-making by discussing the likely harms of premature discharge, the likely benifits of inpatient treatment, and alternative to inpatient treatment including medically inferior options where these exist. Physicians are technically obligated to offer after care.

The medico-legal implications of LAMA need to be given serious consideration as the caregiver might not be protected from malpractice charges There is little evidence that LAMA provides any malpractice protection. Many hospitals have a release form for patients to read and sign prior to leaving hospital against medical advice. Hospital authorities should recognize that form signed by a patient who is leaving against medical advice designed to protect the hospital in the event of an untoward consequence might have no legal protective value. The legal standard for protection from lawsuits continues to be good clinical practice with thorough documentation. Use of LAMA paper is not a safe road to legal immunity. Poor documentation is a great enemy and is unfortunately very rampant in the profession. The patient's chart or file can be looked as a legal document that could be used at any time in a court of law for or against health care providers. The sicker the patient the more comprehensive and detailed should be the progress notes. Complaints about the lack of clear, sympathetic explanations point to deficiencies in communication. In some circumstances, the emotional needs of patients may be as important as their physical needs. Patients often blame doctors not so much for the treatments as for a lack of openness or willingness to explain. Words are as necessary as drugs in the treatment of patients. Specific advice about treatment and empathy with the patient for being in hospital may prevent a few leaving against medical advice. The role of social workers in the pre and post discharge management of patients requesting for LAMA cannot be over-emphasized.

The following are few suggestions for preventing LAMA:

1. A careful, thorough, and well-documented examination at the time of LAMA is the best defense.
2. The severity of the illness should be assessed as well as the severity of the risk if the patient leaves AMA.
3. Maintenance of a patient-physician alliance is important for follow-up care.
4. Before LAMA the physician should ensure that the patients have been informed about risks, benefits and alternatives.
5. Buzz words – **COMMUNICATE, DOCUMENT, EMPATHIZE AND INFORMED CONSENT** before LAMA.

Dr. A. K. Dewan
Director - Surgical Oncology

TRANS-ORAL ROBOTIC SURGERY (TORS) FOR RARE ADENOID CYSTIC CARCINOMA OF BASE OF TONGUE: 2 CASES

Introduction:

Adenoid cystic carcinoma (ACC)is a rare malignancy of salivary gland which accounts for 1-2% of all head and neck malignancies. ACC of head and neck is characterised by slow growth rate, multiple recurrences and late distant metastasis. Neck metastasis is rare and the lung is the most common site of distant metastasis. The most common intra-oral site for ACC is hard palate followed by base of tongue. ACC usually arises from subepithelial layers of minor salivary glands and presentsas submucosal mass that explains why the tumours are diagnosed late, when they become large and advanced.

In ACC of base of tongue (BOT), where surgery is the primary modality of treatment with adequate margins. Conventional surgery entails lip spilt approach with mandibulotomy which produces moderate to severe swallowing and speech impairment. Trans oral robotic surgery (TORS) has been used for the removal of early oropharyngeal squamous cell carcinoma as TORS have several benefits like limited surgical morbidity, good functional outcome, shorter hospital stay and improved cosmetic outcome as compared to traditional open surgeries.We report two such cases of rare ACC of BOT which were removed by TORS.

Case 1:

A 55 yrs male hypertensive patient presented with foreign body sensation in throat for 1 month. On DL scopy, there was exophytic mass 3x4cm involving left BOT and it extended laterally to GTsulcus, medially just crossed midline but not extending to oral tongue and vallecula. On CECT neck, there was enhancing thickening measuring 35x38x37mm at left BOT, left tonsil and left oropharyngeal wall with partial obliteration of left vallecula. There was no focal lung lesion on CT scan of chest. Biopsy was reported adenoid cystic carcinoma. TORS resection of left base of tongue and left tonsil with B/LSND(I-IV) was performed on 09/06/2018. The defect was closed by pectoralis major myofascial flap (PMMF).

Case 2:

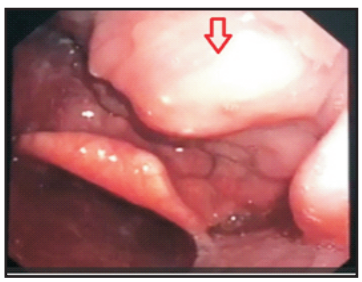

Fig 1: Mass lesion in left BOT

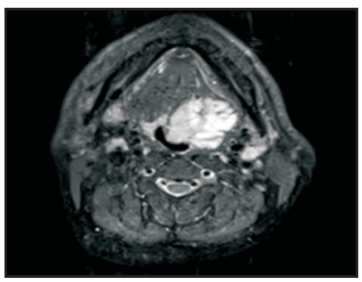

Fig 2: T2W MRI showing enhancing lesion in left BOT

A 27 yrs male patient without any comorbidity presented with dysphagia for 3 weeks. On examination (fig. 1), there was exophytic lesion sized 3x2cm in left BOT extending laterally to GT-sulcus, medially just crossed midline, anteriorly till circumvallate and posteriorly vallecula was not involved. On CEMRI (fig. 2), lobulated enhancing mass was noted in left base of tongue sized 3.7x3.5x2.9cm crossing midline, laterally abutting tonsil and anteriorly extending to adjacent oral tongue. Hyoglossus muscle was involved with abutment of mylohyoid muscle. No cervical lymphadenopathy was noted. Incisional biopsy done under GA was reported adenoid

TORS resection of left BOT with left posterior partial glossectomy,left FOM excision and B/L SND(I-IV)was done on 17/7/18.The defect was closed by microvascular anterolateral thigh (ALT) myocutaneous free flap.

Surgical Procedure:

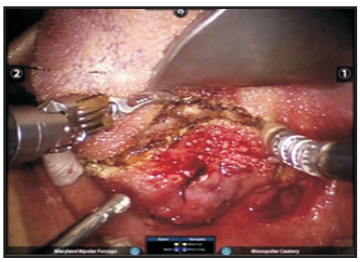

Fig 3: TORS resection of left BOT lesion

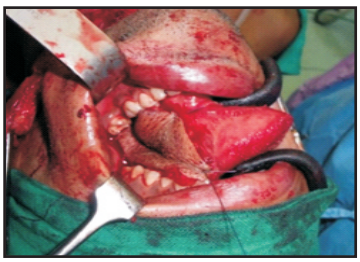

Fig 4: BOT reconstruction by ALT flap

The patient was intubated with nasotracheal tube.FK retractor was used for exposure of oropharynx. A tongue stich with silk was used to keep the tongue protruded. **da Vinci Si** robot was used with upward facing 8mm 30^0 camera better visualization. Robotic arms were docked in the mouth. The wide area around the tumor with 1cm margin was mapped. The tumor was excised using robotic instruments, monopolar cautery spatula and Maryland bipolar forceps. In both the cases, the defect crossed midline and extended till FOM. The defects were repaired with locoregional or free flaps. The tumor specimen was sent for frozen section and accordingly margins revised to get adequate negative margin of at least 5mm. Neck dissections were performed before primary excision and left facial and lingual arteries were ligated to better hemostasis during primary excision. Temporary tracheostomy was done in both the cases because of more than 50% of base of tongue was resected.

Post - Operative Course:

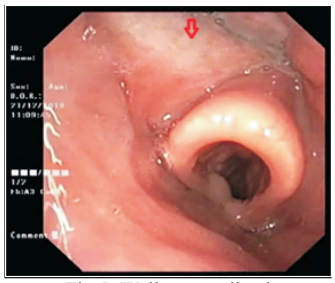

Fig 5: Well mucosalized flap post one year

The post-operative courses were uneventful. Tracheostomy was removed on POD5 and orally liquid diet started from POD4 which gradually changed to soft diet from POD10. Speech and swallowing assessment were performed and were found near normal without signs of aspiration. The histopathology of the tumor specimens were reported as grade II ACC pT2N0M0 with clear margin without LVI/PNI (case 1) and grade I pT3N1M0 with clear margin with PNI+(case 2). Both the patients had received adjuvant RT with dose of 60Gy in 30 fractions. The patient continued on oral diet during and after RT. After one year of post-op follow up, their speech, swallowing and tongue movements are excellent with no evidence of disease.

Conclusion:

As surgery is the primary modality of treatment in adenoid cystic carcinoma, TORS should be used in resecting these tumors of base of tongue to achieve adequate margin and good functional outcome instead of morbid lip splitting mandibulotomy approach.

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Department of Head & Neck Surgical Oncology

THREE DAY PALLIATIVE CARE TRAINING PROGRAMME IN RGCIRC

The Department of Pain and Palliative Care Management of RGCIRC, Rohini, Delhi, successfully organized its first in house three days national level, certified palliative care training programme from 25th to 27th July 2019 at RGCIRC, Rohini, Delhi . This three days course was held for doctors from all specialities and nurses who desired to learn about palliative care. It entailed interactive session by the faculty of RGCIRC with an emphasis on personal patient goals. The topics covered were gentle sensitisation on what is palliative care, management of pain in palliative patients, palliative care emergencies, end of life care and practical issues related to death 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.

RGCIRC's INFECTION CONTROL TRAINING PROGRAMME

The Department of Infection Control, RGCIRC successfully organized its first in house three days certified training program from 27th to 29th June 2019. The 3 day course was organized for nurses of all specialties, technicians and pharmacists who desired to learn about Infection Control and the benefits of the same. It entailed interactive sessions by the RGCIRC faculty & outside trainers. A few topics covered were Standard and Universal Precautions, Personal Protective Equipment (PPE), Bio Medical Waste (BMW) and Multi Drug Resistant Organisms (MDRO) apart from the other major topics. Topics were also incorporated with Role plays, Skits and Two way interactions. The course was highly gratifying and we received excellent feedback. This training programme will be held quarterly henceforth.

Case Vignette

***Rajiv Gandhi Cancer Institute & Research Centre,* Niti Bagh**

WHY MULTIDISCIPLINARY CARE IMPROVES PATIENT OUTCOMES

A 30 years old female patient presented to our Medical Oncology OPD with complaints of severe lymph edema of left upper limb. Patient was evaluated outside and diagnosed to have Metastatic Carcinoma left breast – Invasive Ductal Carcinoma. Genetic evaluation showed – Triple Negative BRCA 1+ Metastatic IDC Breast. She underwent treatment - Left Stellate Ganglion block with T2-T3 sympathetic Block in view of lymphedema and CRPS. She further underwent chemotherapy followed by oral targeted therapy in the form of PARP inhibitors. Patient did well for 9 months with a good PFS & QOL. After that patient presented to our Emergency Department with seizures, vomiting and severe headache. Brain imaging revealed meningeal disease. Lumbar puncture and cytology showed atypical malignant cells, favouring Carcinomatosis Meningitis which means spread of disease to membranes of the brain . Patient experienced severe headaches, fever, nuchal rigidity. Patient was started chemotherapy directly in fluid of the brain along with Systematic therapy. We also gave Stereotactic Cranio-Spinal irradiation along with various Palliative and Pain Management interventions. Patient was managed with a Multimodality team approach including Medical Oncologists, Radiation Oncologists, Pain & Palliative Management -which not only improved the overall PFS but gave a good QOL to the patient, majority of which was outside the Hospital premises along with her family for the next twelve months. We also counseled the family for hereditary nature of disease. This Case report highlights how-Multidisciplinary Approach can modify the outcome of a patient in this rare but devastating complication of Metastatic Breast Cancer.

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Date of Printing: 25th August 2019

Date of Publishing: 30th August 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

CME ON BREAST ONCOLOGY

The Department of Radiology, RGCIRC organized a CME on Breast Oncology on Saturday, 10th August 2019 at RGCIRC, Rohini, Delhi. Dr. S. Avinash Rao, Director – Radiology delivered a lecture on Vacuum Assisted Breast Biopsy (VABB) and Dr. Rishu Singla, Consultant – Radiology spoke on Breast Biopsy and FNAC: Who Wins the Match ? Radiologists from Rohini & Pitampura, practicing around RGCIRC participated in the said CME. The CME was very well appreciated by the gathering.

DELHI MEDICAL ASSOCIATION (DMA) - 105TH FOUNDATION DAY CELEBRATION & AWARD CEREMONY

RGCIRC participated in 105th Foundation Day Celebration & Award Ceremony of Delhi Medical Association (DMA) held on Sunday, 18th August 2019 at DMA Auditorium, Daryaganj, New Delhi. Dr. Manish Pruthi, Consultant – Musculoskeletal Oncology delivered a lecture on Bone & Soft Tissue Tumors – Impact on Society in the said event.

CME – ALLAHABAD MEDICAL ASSOCIATION

RGCIRC organized a CME in association with Allahabad Medical Association (AMA), Allahabad on Sunday, 18th August 2019 at Allahabad Medical Association (AMA) Convention Center, Prayagraj, UP. Dr. Gauri Kapoor, Medical Director – RGCIRC, Niti Bagh and Director – Pediatric Hematology Oncology delivered a lecture on Cord Blood Preservation and Stem Cell Therapy, Dr. A. K. Dewan, Director – Surgical Oncology spoke on Can We Save Organs in Cancer?, Dr. Kamal Singh, Director – Mohak Hospital, Allahabad spoke on Cancer Survivorship and Dr. Shashwati Sen spoke on Fertility Preservation in Cancer Patients in the said CME. The CME was attended by more than 230 delegates.

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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

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