



# NewsLetter

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## EDITORIAL

### ARE WE LOSING CLINICAL TOUCH??

Over the last three decades, I have witnessed bewildering progress in medical science. In spite of all these advancements the patient is very often left in despair and confusion. He craves for the personal touch and a heart to heart talk with his doctor. A protocol based and algorithmic approach, chasing shadows, perusing lab data and above all paucity of time have estranged the patient - doctor relationship. Decisions are made by us in cozy cold, closed chambers very often without the patient in view. We deliberate inside in Tumor boards while the anxious patient waits outside and sends a prayer to the Almighty, hoping for the right decision to be made. The ritualistic methods of history taking, clinical examination, developing a working clinical diagnosis and finally deliberation and contemplation have become a relic of the past. They have been sacrificed on the altar of evidence based scientific medicine!

The sanctity and intimacy of physical examination legitimate the human connection and this is most powerfully mediated through touch. Touch is a primal and potent act, beyond skin to skin contact, and engages in the emotional domain called praxis. If we apply Newton's third law, touch is always reciprocal!! Touch has an affective dimension to care, the power of which extends beyond words. The power of laying hands in healing was known since the time of Asclepius, the legendary Greek God. The Bible reminds us that those who touched Jesus and those who were touched by Him were healed. Nowadays, touch has gained a different connotation. In today's era of marketing and gimmickry - it is a word that encompasses only the jargon - "**Stay-in-touch-marketing**". While we surge forward into the modern era of medicine, we need to clarify to ourselves that medicine is an art based on science. It cannot be practiced as an inanimate, heartless, scientific exercise. The utilization of the five senses along with the effective integration of cerebral faculties makes it the perfect recipe for a successful patient - doctor relationship and thereby satisfactory patient outcomes.

Learning physical examination techniques is central to medical training, and clinicians skilled in performing a physical examination are often held in high regard by their colleagues. Its use, however, is under threat—some would say even at risk of demise. Diagnostic imaging allows body parts, both accessible and inaccessible, to be visualized with a clarity that was unimaginable 30 years ago. Not only do echocardiography, positron emission tomography, and functional magnetic resonance imaging allow us to *see* the human body, they also show *how well* (or not) it is functioning. It is not surprising that use of diagnostic imaging is increasing and use of physical examination is decreasing. The usefulness of physical examination has been defined statistically by its ability to support diagnosis and estimate prognosis. The idea of touch is a form of connection and expression of presence. This connection is rarely spoken about in clinical practice but contributes to the development of trust between a health care professional and a patient.

Let me illustrate the Importance of Touch.

Fifty year nonsmoker attended surgical OPD with diagnosis of Non Small Cell Carcinoma (Adenocarcinoma) of right lung. CT scan of chest done one month back was reviewed. Bone scan and CT abdomen were reported to be normal; conventional imaging did not reveal any evidence of distant metastasis. Bronchoscopy did not reveal any endobronchial lesion. MRI brain was also within normal limits. Preanesthetic check up and cardio pulmonary evaluation was done. Patient was posted for surgery. Anaesthetist stripped the patient before intubation and noticed small subcutaneous nodules all over body. He notified it to the surgeon before intubation. Patient was clinically examined first time in OT and FNAC of nodule was done which was reported as metastatic adenocarcinoma. Patient even had supraclavicular nodes in addition to subcutaneous nodules throughout his body - a stage IV disease. Simple touch eg. Hand scan would have avoided expensive extensive investigations (CAT Scan)!!. **Hand scan is better than a CAT scan.**

Shortcomings in physical examination skills among residents have been documented in various studies due to declining clinical touch and increased dependence on technology. It is estimated that internists spend less than 12% of their time in direct patient care. Poor physical examination skills are a threat to patient safety as the possibility of diagnostic errors and oversights is increased. Moreover unnecessary investigations themselves are potentially harmful. In an era where there is growing concern of over utilization of health care resources and expense, poor physical examination leads to added costs. Promotion of modern imaging, lack of bedside teaching, and decreased interest in physical examination owing to time limitation has led to further neglect of physical examination competence. A thorough physical examination itself is certainly not a substitute for use of expansive technology. However, we encourage the appropriate application of thorough history and physical examination to guide the prudent use of technology. Enhanced clinical touch will enhance doctor-patient relationship, improve patient safety, fewer diagnostic errors and lower financial costs.

The perfections of physical examination skills require continued efforts and practice to increase diagnostic yield. Indiscriminate use of technology does not translate into comprehensive high quality or safe patient care. Focus on clinical skills should begin during the learning phase of clinician's career. **"Medicine is learned by the bedside and not in the classroom. See and then reason and compare and control but see first"** (William Osler)



**Dr. A. K. Dewan**  
Director - Surgical Oncology

## ROLE OF ADVANCED IMAGING IN GASSERION NEUROLYSIS IN HEAD AND NECK CANCER WITH SKULL BASE INVASION

Among the acute and chronic pain syndromes, cancer-related pain is one of the most significant. The most worried symptom of cancer patients is suffering from pain. Survival is linked to symptom control and pain management which contribute to broad quality-of life improvement. Effective control of cancer related pain has long been one of the most important and pressing issues about oncology and health care systems because cancer pain dramatically affects not only patients but also their families. Cancer pain is often inadequately managed; as a result, many patients spend the last days of their lives suffering, with great discomfort and disability. Thus pain management is an essential part of oncologic management.

A 46-year-old female patient, a post-operated case of carcinoma left upper alveolus diagnosed in March 2018. Disease recurred in August 2018 proved on histopathology, for which she received chemoradiation. Later she developed severe excruciating left-sided facial pain. She was prescribed opioids for pain but developed opioids induced nausea and vomiting and hospitalized for 6 days. The patient received diagnostic infraorbital and supraorbital nerve block in her native place which did not relieve her symptoms.

Patient presented to the Rajiv Gandhi Cancer Institute for further management. The patient was referred to the pain clinic by oncology team. She had lancinating pain around the left side of face. The pain gradually increased over 10 months. On Numerical rating scale (NRS) her pain was 9/10. Her chief complaints are continuous dull pain above and below the left eye, with sudden, brief, paroxysmal episodes of intolerable burning and stabbing type of pain. This episodic pain lasted for 30-40 seconds. On examination, she had left 3,5,6 nerve palsy with ptosis. Magnetic resonance imaging (MRI) of Face and Brain revealed an enhancing infiltrative mass in left maxillary sinus extending in pterygo-maxillary fissure, pterygopalatine fossa, sphenopalatine foramen, Foramen rotundum, left cavernous sinus and Meckel's cave region. Clinical diagnosis of left-sided painful trigeminal neuropathy in ophthalmic and maxillary ( $V_1$  and  $V_2$ ) division was made. Her concern was to relieve her pain to improve her quality of life.

Neurosurgeon opinion obtained, the tumour was inoperable due to intracranial and cavernous sinus extension. Giving due consideration on her non-compliance with opioids, she was started on tablet oxcarbazepine 300mg once a day and 5mg Buprenorphine transdermal patch.

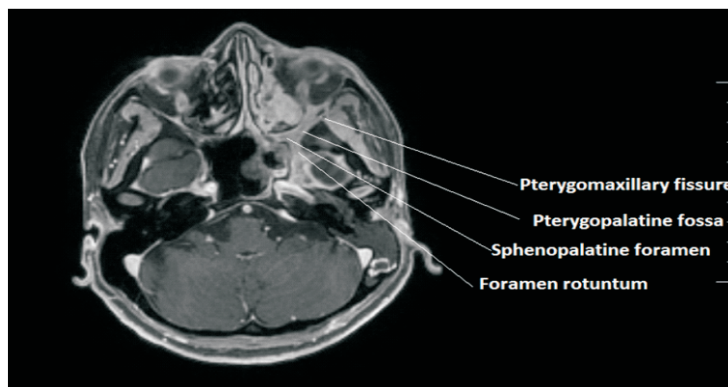
Mostly gasserion neurolysis is routinely done by most of pain physicians using x-ray or fluoroscopic guidance but in cases of advanced stages of head and neck cancer with skull base invasion fluoroscopy had its own limitations in terms of image quality and two-dimensional views. In contrast to this, computed tomography (CT) scan provides excellent and direct visualization of FO leading to correct placement of the needle, reducing complications and improving the results. Thus, sometimes in advanced malignancies, CT scores over fluoroscopy.

As we could not wait for the pharmacological effects of drugs to come decided to take the patient for gasserion neurolysis under CT guidance because of the distortion of skull base anatomy and to allay her suffering.

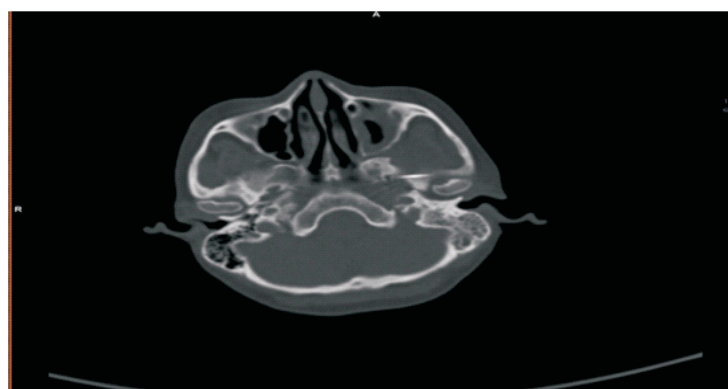
The patient was counseled and informed written consent was taken. The coagulation profile checked and she was called next day nil per oral. Intravenous access secured and antibiotic administered. Check CT base of skull was done to look for the feasibility of foramen ovale (FO). The patient was placed in a supine position with the head in a neutral position on a CT scanner bed. The needle entry point was marked with a marker and local infiltration anesthesia was performed with 1% lidocaine after routine disinfection and draping. A 22 G, 10cm long spinal needle was directed towards FO from a lateral approach in cranial direction and tip of the needle is placed in the super medial aspect of FO with the help of radiologist. Persistence of dye was checked with 0.1ml of contrast and 0.1 ml of 0.5% lignocaine. This doubly ensured us about the location as well as the spread of injectant. It was followed by 0.1 ml of glycerol and 0.1 ml of dexamethasone. She was advised to sit for 2 hours. The patient observed for four hours and discharged from daycare and called for follow up after 5 days. On follow up she marked her pain as 1/10 and quoted 'ab rona nahi padta aur acachha lagta hai'.

### CONCLUSION

1. Pain management in cancer patients is important but difficult task.
2. When anticancer therapy provides no relief or recurrent pain is refractory to further palliative measures, it is essential to treat the pain symptomatically.
3. Advanced image-guided technique can increase the precision of the analgesic procedures, improving the results and reducing the complications.
4. Thus CT guided identification of foramen ovale can be labeled as a Novel method of locating FO for precise percutaneous techniques to the trigeminal ganglion in advanced head and neck cancers.



MRI image showing Tumour extension into cavernous sinus



CT image showing NEEDLE into Foramen ovale

**Dr. Bablesh Mahawar**  
Consultant Pain Management &  
Palliative Care

## WELCOME TO RGCIRC FAMILY – DR. JASKARAN SINGH SETHI !!



Dr. Jaskaran Singh Sethi has joined as Sr. Consultant - Radiation Oncology. He is well known Radiation Oncologist with more than 17 years of experience in the field of radiotherapy & cancer treatment. He is a graduate from MS Medical Institute and MD from Oswal Cancer Treatment & Research Foundation, Ludhiana. He has worked as faculty at SGRD Institute of Medical Sciences, Amritsar, before joining the private healthcare system. He has undergone trainings & fellowships at University of Brussels, Belgium & at All India Institute of Medical Sciences, New Delhi. He is proficient in treatment planning and delivery of the latest techniques. He has special interest in stereotactic body radiotherapy, radiosurgery and management of motion during radiation therapy treatments.

He is also NABH & NQAS assessor.

## CME – IMA EAST DELHI BRANCH



RGCIRC organized a CME in association with IMA East Delhi Branch on Friday, 05th December 2019 at IMA Building, Karkardooma, Delhi. Dr. Leena Dadhwal, Consultant – Surgical Oncology delivered a lecture on “Recent Advances in Surgical Oncology” and Dr. Manish Sharma, Consultant – Medical Oncology spoke on “Approach & Work Up of a Patient with Suspected Malignancies” in the said CME. The CME was very well appreciated by the gathering.

## *Rajiv Gandhi Cancer Institute & Research Centre, Niti Bagh, South Delhi*

### CHANGING TRENDS OF SURGICAL TREATMENT OF CANCER BREAST.

Breast cancer is the commonest cancer in urban women in India. One out of twelve women will develop breast cancer in their life time. Due to advancement in screening and awareness in general population and doctors, now patients are reporting even in early stage, sometimes with no palpable lumps too.

There are recent advancement in surgical management, chemotherapeutic agents, radiation techniques and targeted therapies so much so that the cosmesis of breast is conserved without compromising oncological outcome.

There are trends in conserving breast tissue along with axillary nodes (sentinel nodes) to decrease the morbidity of lymphedema of arm. With the development of oncoplastic techniques, the cosmesis of breast is better preserved and patients are much more satisfied with their quality of life.



**Image 1 - Dotted lines**

To illustrate the importance of early detection in surgery, we have shown in these images a patient's results of surgery, when she presented with early malignancy – a small lesion in the breast (dotted lines in the image 1). The images also show the look after removal of the lump (image 2) and the final look after closure (image 3). Even after complete removal of the breast the trend is moving towards immediate reconstruction, with autologous tissue or by use of implant.



**Image 2 - Look after removal of lump**



**Image 3 - Final look after closure**

**Dr. Leena Dadhwal**  
Consultant - Surgical Oncology,  
RGCIRC, Niti Bagh



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