



NewsLetter

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EDITORIAL

Alcoholism in Medical Professionals

Medical professionals, such as doctors, nurses and paramedics save thousands of lives every day, having committed their career to the wellness of others. However, many healthcare professionals find themselves the victims of substance abuse in combination with alcohol. Studies report that at least 10 to 12 percent of healthcare professionals will develop a substance use disorder during their career, including at least 1 in 10 physicians, and 1 in 5 nurses. These numbers are higher than the general population; however, they may be even larger than this because medical professionals are notorious for under reporting substance abuse disorders. Healthcare workers often work demanding 12 hour (or longer) shifts, which can drain them of all their energy making alcohol seem like a quick and easy mood elevator. Exposure to high-stress situations, such as emergency crises, and emotional exhaustion can cause medical professional to see comfort in the form of alcohol. In addition to attempting to sooth stress and sadness with alcohol, medical professional often turn to other mind-altering substances as well. The availability of prescription drugs can create temptation for recreational use. Drugs like benzodiazepines and opioids can be used to "relax" during taxing shifts, and stimulants can provide energy to combat shift burnout. Unfortunately, medical professionals sometimes mix alcohol and other drugs creating an even more dangerous combination. Approximately 70% alcoholics are smokers compared with 10% of general populations. Doctors and nurses who abuse alcohol are typically considered high-functioning alcoholics. Medical Professionals drink an unhealthy amount of alcohol but still balance a successful career of personal life. High functioning alcoholics are also more likely to deny that they have a problem. However, there are identifiable signs, including frequent absences or breaks during a shift, alcohol on breath, slurred speech, hidden bottles, frequent hangovers, mood swings, irritability, isolation, poor hygiene and aggressive behavior (at work or domestic disturbance). If yourself or medical professional you love are exhibiting such signs of alcohol dependence, please contact a treatment professional to learn about rehab options. Treatment can end the cycle of abuse, while saving their career and the lives of their patients. The risk posed by alcoholism and medical professionals is dependent on the type of work the medical professional does. Surgeons for instance, need to complete surgical procedures with minimal to no injuries. Alcohol abuse can impact the quality of a surgeon's work, especially if they are intoxicated or experiencing withdrawal while at work. Other risks, medical professionals can have on the job as a result of alcohol abuse include misdiagnosis of health conditions, administering the wrong dosages of medication, unprofessional temperament, shift absence, mistake in making incisions, Inability to focus and putting patients life at risk.

In one of the publications it was reported that among 100 alcoholic doctors followed over a 21-year period, 10 died of non-alcohol related causes and eight died of alcohol-linked causes. There was a 9% incidence of oral or oesophagopharyngeal cancer. Of 56 doctor currently known to have survived, 29 have retired and 27 are still working as doctors. Three doctors have been drinking normally for an average of 17 years.

Doctors, nurses and other professionals experience highly distressing experience on a daily basis, but abusing alcohol only proves to be a short-term solution with very dangerous consequences. An important warning sign is clearly regular, heavy drinking. The ceiling for low-risk alcohol use advocated by the U.S. government is one standard drink per day for women and two standard drinks per day for men. Because of age-related changes in the body, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends that men and women older than 65 years may consume not more than one drink per day.

Alcohol dependence is treated in two stages: withdrawal and detoxification, followed by further interventions to maintain abstinence. Considerable evidence show that long-lasting neurobiological changes in the brains of alcoholics contribute to the persistence of craving. At any stage during recovery, relapse can be triggered by internal factors (depression, anxiety, craving for alcohol) or external factors (environmental triggers, social pressures, negative life events). Psychosocial treatments concentrate on helping patients to understand, anticipate, and prevent relapse. Other approaches include behavioral treatment, Motivational Enhancement and Cognitive-Behavior Therapy (CBT). The aim of CBT is to teach patients, by role-play and rehearsal to recognize and cope with high-risk situations for relapse and to recognize and cope with craving.

Thirty to 60 percent of alcoholics maintain atleast one year of abstinence with psychosocial therapies alone. However, more than 20 percent of alcoholics achieve long-term sobriety even without active treatment. Anti-craving medications, the most promising of these medications are the opioid receptor antagonist - naltrexone (Revia), and acamprosate, a glutamate antagonist. Aversive pharmacotherapy, Disulfiram (Antabuse, 250 to 500 mg daily), a drug with a moderate record of adverse effects which has been available since the late 1940s, blocks the metabolism of acetaldehyde and causes unpleasant flushing reaction if taken with alcohol. Fluoxetine (Prozac), a selective serotonin reuptake inhibitor, has been found to be effective in decreasing depressive symptoms and the level of alcohol consumption in depressed alcoholics. The family physician should play a critical holistic role in treatment and prevention, working with the patient and family, even when other specialists may be involved.

Treatment by professionals are available to assist healthcare professionals in achieving sobriety. Rehab is highly effective in restoring the individual to healthy state, while reducing the rate of relapse. Treatment facilities can provide treatment and detox. They provide information on avoiding triggers, keeping careers and reputations intact.



Dr. A. K. Dewan
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ROLE OF RADIATION THERAPY IN THE MANAGEMENT OF LOCALLY ADVANCED BORDERLINE RESECTABLE AND UNRESECTABLE PANCREATIC CANCER

Incidence of Pancreatic cancer in India varies from 0.5 to 2.4/1,00,000 persons per year among women to 0.2 to 1.8/1,00,000 persons per year among men. It is a malignancy associated with high mortality all over the world. Even in developed countries like US, it is the fourth leading cause of cancer related deaths. Epidemiologic estimates suggest that it will surpass breast and prostate cancer to become the second leading cause of cancer-related death in the US by 2030.

The primary treatment for pancreatic ductal adenocarcinoma (PDAC) is Surgery but unfortunately it is not feasible in about 75-80 % of the patients at presentation. Even among those who undergo resection, the reported median survival is 15-23 months, with a 5-year survival of approximately 20%.

It has been recognized that the prognosis for patients undergoing surgical resection for (PDAC) is highly dependent on margin status, with total gross excision and histologically negative margins (R0 resection) being associated with the best outcomes. Survival for patients who undergo total gross excision but have histologically positive margins (R1 resection) have a reduced survival in most series. Most significantly, patients who undergo resection with residual gross tumor (R2 resection) have a prognosis similar to patients treated with non-operative therapy.(1)

Before, starting treatment, pancreatic cancers are classified into resectable, borderline resectable and unresectable. Borderline resectable pancreatic cancers (BRPC) are those tumors “that have limited involvement of the mesenteric vessels such that resection is technically possible, but which carry a high risk of margin-positive resection unless neo-adjuvant treatment is employed before surgery.”(2) The NCCN guidelines define BRPC based on the tumor's venous (superior mesenteric vein and portal vein) and arterial (common hepatic artery, celiac axis and superior mesenteric artery) characteristics.

Both chemotherapy and radiotherapy and their combinations have been utilized as neo-adjuvant therapies (NAT) in BRPC and locally advanced pancreatic cancers. As per a recent publication of a multicentric study in Japan, those who underwent resection after NAT showed significantly longer median survival time (MST, 53.7 months) than those who underwent upfront surgical resection (MST, 17.8 months) or no resection (MST, 14.9 months). On multivariate analysis in patients who underwent surgical resection, NAT was an independent factor associated with better prognosis.(3)

Radiation therapy techniques have changed from conventional fields to intensity modulated radiotherapy (IMRT) and stereotactic body radiotherapy (SBRT) with the advancement in technology. In a trial conducted by Masui et al, comparing conventional 3-Dimensional conformal RT with IMRT, it was found that IMRT was associated with better local control and a prolonged median survival (32 months vs 13.8 months).

One of the biggest technical challenges in delivery of Radiation is motion of the tumor and the adjoining organs at risk with respiration. Now many techniques for motion management are available. Goto Y et al recently published clinical results of dynamic tumor tracking IMRT in 11 patients, which revealed median overall survival of 23.6 months and locoregional progression free survival rates of 90.9% at one year and 37.9% at 2 years, with severe GI toxicity in only one patient.

SBRT is also gaining popularity in the treatment of BRPC. SBRT makes it possible to give a high hypofractionated radiation dose to the target tumor volume, with minimal dose to the surrounding normal organs like stomach and small bowel (duodenum). The SBRT treatment is usually given in 3-5 sittings as compared to the standard RT which is delivered in 5 to 6 weeks.

In a retrospective review of 8,450 patients with locally advanced pancreatic cancer using the National Cancer Database, receipt of SBRT had higher rates of median overall survival (13.9 months vs 11.6 months) and 2-year overall survival (21.7% vs 16.5%) in comparison with Conventional Fractionated RT.(4) Furthermore, pooled results from current literature proved that tumor local control was almost 80% after one year treatment with SBRT. Gastrointestinal toxicity rates caused by higher doses of SBRT could be eliminated with the utilization of stereotactic MRI guided radiotherapy (SMART), allowing SBRT to achieve high doses of hypofractionated radiation without damaging surrounding radiosensitive normal structures.(5)

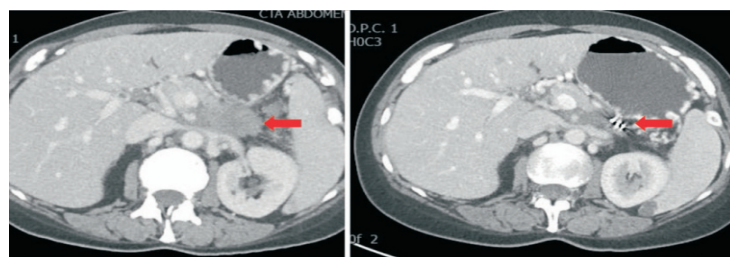
The use of proton and carbon ion therapy is being explored as a novel treatment modality for pancreatic cancer. Unlike the photons, the protons deliver the maximum radiation dose to a certain depth and it immediately stops after its bragg peak. The tumor can be precisely targeted using proton beams of different energies, thereby sparing normal tissue in the entry and exit pathways of the beam. Dosimetric studies have shown some advantages over photon beam but their clinical significance is not yet known fully.

In another multi-institutional study, 72 patients with locally advanced pancreatic cancer were treated with carbon ion therapy in combination with precedent or concurrent gemcitabine. Median overall survival was 21.5 months (95% CI: 11.8-31.2 months), while concurrent chemotherapy and the higher prescribed dose of radiation were statistically significant factors regarding overall survival.

Although novel agents, such as FOLFIRINOX and nab-paclitaxel, have been added to neo-adjuvant treatment sequencing for pancreatic cancer, challenges still exist in improving survival outcomes and disease local control. Some trials like the randomised LAP07 and meta analysis by Chang et al have shown that the addition of chemoradiotherapy to chemotherapy did not improve the overall survival in locally advanced pancreatic cancer or reduce treatment toxicity.

A randomized phase II ESPAC-5F trial is assessing the effectiveness and safety of chemoradiotherapy with gemcitabine or capecitabine following gemcitabine plus capecitabine chemotherapy in patients with locally advanced pancreatic cancer. If encouraging, this trial will determine the experimental arm of a phase III study comparing radiation therapy against chemotherapy alone.

The role of NAT in borderline/unresectable pancreatic cancers is evolving but with the current available literature, it is evident that these therapies improve the OS of patients who are able to undergo surgery subsequently. These options provide a hope in improving outcomes in appropriate subset of patients.



Pre NAT

Post NAT

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CONGRATULATIONS TO DR. VENKATA PRADEEP BABU KOYYALA



Dr. Venkata Pradeep Babu Koyyala, Consultant – Medical Oncology got selected along with 5 Oncologists from different countries among global applications for European Society for Medical Oncology Fellowship in Palliative Care. He was awarded the fellowship in Barcelona ESMO International Congress in August 2019. He completed the fellowship successfully in Princess Margaret Cancer Center, Toronto, Canada till November 2019. He thanked the Institute for giving this opportunity to represent RGCIRC on international platform. Mr. D. S. Negi (CEO), Dr. Vineet Talwar (Director – Medical Oncology), Dr. Doval (Chair – Medical Oncology) and Dr. Sumit Goyal (Sr. Consultant – Medical Oncology) have congratulated him.

CONGRATULATIONS DR ANKUSH JAJODIA



Dr. Ankush Jajodia, Senior Resident in department of Radiology was awarded the prestigious Dr. Arcot Gajraj Gold Medal in Radiodiagnosis by National Board of examinations, Delhi. He also has been the recipient of Gold Medal for attaining first position in Diploma Radiology from Goa University.

He has been selected by the European Society of Radiology for Onco-radiology fellowship at Institute of European Oncology (IEO) Milan, Italy and advanced molecular imaging by Korean society of Radiology in Seoul National University. Dr. Jajodia has made significant contributions by publishing RGCI work in many national and international journals.

*From the Desk of the
Medical Director*



Rajiv Gandhi Cancer Institute & Research Centre, Niti Bagh

PATIENT CENTERED COMMUNICATION: TALKING ABOUT ...

Patient focused communication is particularly important in the context of a serious illness like **cancer**. It has been reported that effective **communication** during **cancer therapy** contributes to better patient outcomes. On the other hand **communication** breakdowns may often lead to patient distress as well as interfere with care.

An effective Physician communication helps develop rapport and trust with the patient and family and helps gather medical history. It also includes giving information to the patient about the illness, addressing patient's emotions and eliciting any concerns. As the diagnosis of cancer results in significant fear, uncertainty, and commitment to often arduous, expensive, and complex treatments, imparting information to the patient has the following advantages:

- Reduces anxiety and grants patients a sense of control and security
- Creates realistic expectations and promotes self-care and participation and Improves compliance
- Therefore in keeping with current trends where patients are actively seeking health related information from the internet, this model of care assumes greater importance and emphasizes the importance of the clinician's relationship with the patient and the patient's family as a **therapeutic tool**, endorses shared decision making as a **key component of treatment**.



RGCIRC, Niti Bagh

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