



NewsLetter

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EDITORIAL

YOU WANT TO BE A CURATOR OR A HEALER??

In the last century, the role of physician has changed drastically for both better and worse. In the past, doctors were ill equipped even to diagnose, much less to cure most ailments. All they had were herbal remedies and painkillers. During last few decades however, the practice of medicine has changed dramatically by advances in doctor's ability to diagnose and treat diseases. We have diversified into specialty experts, organ experts, and disease experts. There is no question at all that curative power of the doctors are vastly greater today than even before. Unfortunately our power to heal people have diminished as dramatically as our power to cure disease has increased. This is because the knowledge of human nature that used to be the doctor's principal resource has been abandoned as irrelevant in an age of science. Science has become God and separated itself from patient.

What has been lost is the human dimension. To imagine a sense of what medicine used to be, we must look to cultures where traditional medicine still plays a role. Today white collared allopath repairs the patient and tends to be mechanical, while alternative therapists/non Allopath/family physicians treat their patients more than their disease, by being there for them, supporting them and loving them in addition to caring for their physical problems. They are able to redirect patient's lives, not just treat illnesses. They take down the facts of the patient's medical history, family history, dietary history etc. They notice worried looks of patient's face, tremble in his hands, puffy face, slurring speech and even the dreams he has, all potential signs of what really troubles him. On the other hand, we as sophisticated modern experts rely on CT scan, MRI'S PET scan and blood reports. For a family physician his most important diagnostic tool is his "touch" and his communication skill with patient. Patients have more confidence in family physician and they follow his instructions. They don't understand the medical jargon dictated by senior experts. Patients often tell the experts "please talk to my family physician and explain my problem to him". One of my patient said to me "you will treat me but he (family physician) will heal me. He is going to look after me after you have operated me."

One day I was sitting with a senior family physician when a man with ulcer cheek came to his clinic. There was foul smell from his cheek wound with maggots. I was repelled by the patient. But the family physician, found something lovable in him. He looked him over, searching for something good he could appreciate. He noticed that the man had new and very neatly tied shoelaces, so he related the man through his shoelaces and treated him in a loving way. He supervised patient's dressing and got all maggots removed from the wound. Man was grateful to the family physician but he said "I cannot pay your fee today." Family physician smilingly replied "never mind." But you need an oncologist's opinion and care for this wound. You see me in two days time for repeat dressing. By that time I would have talked to the oncologist and fixed up an appointment for you. Two days later, patient visited family physician; clean, well dressed, looking much better and he explained that two days back he had decided to go to the Railway track to commit suicide. He changed his mind after he met the loving physician. He said "I felt your acceptance and your love, you encouraged me to continue living. I want you to know what a difference your kindness made."

The painful lesson from this incident was learning how difficult our patient's lives are. Not all of them want to live. Some of them will find the will to live only if their doctors accept them, love them and heal them.

My appeal to all experts "be a facilitator of healing; you may not be the healer yourself. Revert to the roles of old doctors who touched and communicated with their patients.

Don't be mechanical curator; be a healer!

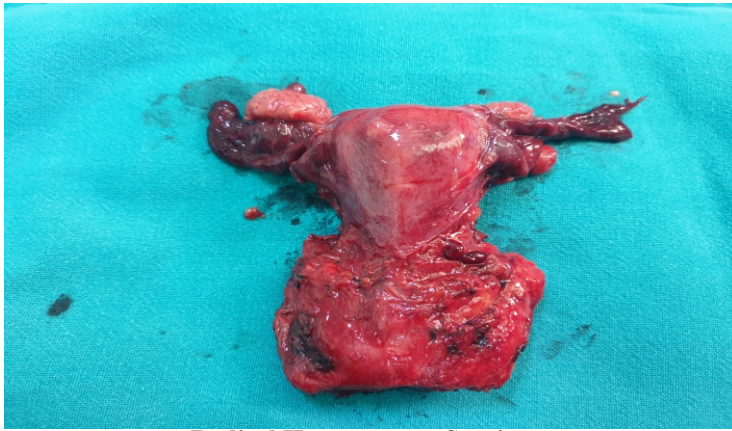


Dr. A. K. Dewan
Director - Surgical Oncology



**Supporting the Fighters,
Admiring the Survivors,
Honoring the Taken,
And Never, Ever Giving
Up Hope!**

RECENT UPDATES IN MANAGEMENT OF CERVICAL CANCER



Radical Hysterectomy Specimen

OVERVIEW: Cervical cancer is the second most common cause of cancer in women in developing countries and the third most common cause of cancer mortality.

Persistent infection with high risk Human papilloma virus (HPV) is responsible for 99.7% cases of cervical cancer with HPV 16 and 18 accounting for 70% cases.

The disease is characterized by a long preinvasive phase lasting for 10-15 years. Although 75 to 80 percent of sexually active adults acquire genital tract HPV, most HPV infections are transient.

Three prophylactic HPV vaccines are currently available in many countries.

- Bivalent vaccine targets HPV 16 and HPV 18.
- Quadrivalent vaccine targets HPV 6, 11, 16 and 18
- Nonavalent vaccine targets HPV 31, 33, 45, 52, 58 in addition to HPV 6, 11, 16 and 18

The tests used for cervical cancer screening include conventional cytology (Pap smear), liquid based cytology, HPV testing and visual inspection with acetic acid.

Early cervical cancer can be asymptomatic. The most common symptoms at presentation are abnormal vaginal bleeding (including post-coital bleeding) and vaginal discharge. Advanced cervical cancers may present with pelvic pain or lower backache, blood in urine or stools or passage of urine or stools per vaginum.

On physical examination, a lesion may or may not be visible in early cervical cancers. A thorough recto-vaginal examination is required to assess the size of growth and vaginal and parametrial involvement.

The diagnosis of cervical cancer is established by biopsy. For centres that have limited resources, staging is clinical. If resources are available, staging may additionally be based on an expanded list of imaging studies and on pathologic findings.

2018 FIGO staging of cervical cancer has the following changes:

➤ Diagnosis of microinvasive disease (Stage IA1 and IA2) is made on microscopic examination of a LEEP or cone biopsy specimen, which includes the entire lesion. It can also be made on a trachelectomy or hysterectomy specimen. The depth of invasion should not be greater than 3 mm or 5 mm, respectively, from the base of the epithelium, either squamous or glandular, from which it originates. The horizontal dimension is no longer considered in the 2018 revision as it is subject to many artifactual errors.

- Stage IB is divided into IB1, IB2 and IB3 stages
- IB1- Invasive carcinoma ≥ 5 mm depth of stromal invasion, and <2 cm in greatest dimension
- IB2- Invasive carcinoma ≥ 2 cm and <4 cm in greatest dimension
- IB3- Invasive carcinoma ≥ 4 cm in greatest dimension

- Stage IIc has been added to the staging system
- IIc- Involvement of pelvic and/or para-aortic lymph nodes, irrespective of tumor size and extent (with r and p notations) to indicate whether radiology or pathology has been used to allocate the case to stage IIc
- IIc1- Pelvic lymph node metastasis only
- IIc2- Para-aortic lymph node metastasis

TREATMENT:

- EARLY STAGE CERVICAL CANCER (IA1, IA2, IB1)
- Surgery is the mainstay of treatment
- In young women desiring fertility conservation or radical trachelectomy can be done
- Extrafascial hysterectomy for stage IA1, Type II modified radical hysterectomy with pelvic lymphadenectomy for stage IA1 with LVSI and IA2
- Type III radical hysterectomy with pelvic lymphadenectomy is the standard approach for IB1

- STAGE IB2 and IIA1
- Similar results with surgery or radiation therapy
- Surgery has a benefit of staging the disease precisely so the postoperative adjuvant therapy can be tailored accordingly, treating cancers which are possibly resistant to radiation and also ovarian function can be preserved in young patients
- Type III radical hysterectomy with pelvic lymphadenectomy
- Sentinel node mapping using methylene blue dye, radiocolloid or ICG is experimental and may have some role in stage IA, IB1 and IB2

• Route of surgery
LACC TRIAL: Minimally invasive radical hysterectomy was associated with poorer DFS and OS as compared to open procedure in patients with early cervical cancer.
However, further studies are required to confirm these findings.

- STAGE IB3 and IIA2
- Surgery is feasible but about 80% patients will require adjuvant treatment leading to high morbidity due to dual treatment, so the preferred treatment is concurrent chemoradiation (CCTRT)
- NACT followed by surgery can be done in resource limited settings with limited radiation facilities, specially in young patients with large tumors and adenocarcinomas

- STAGE IIB-IVA
- CCTRT is the standard of care
- OUTBACK TRIAL is exploring the role of adjuvant chemotherapy after CCTRT

- STAGE IVB
- Palliative chemotherapy
- GOG 240 demonstrated survival benefit with Bevacizumab (anti-VEGF monoclonal antibody) in recurrent and metastatic cervical cancer

ADJUVANT TREATMENT AFTER SURGERY:

- Intermediate risk factors- tumor size more than 4 cm, LVSI, deep stromal invasion. Presence of any two factors requires postop radiation (PORT)
- High risk factors- positive margins, positive parametrium, positive nodes. Presence of any one factor requires CCTRT

INVASIVE CERVICAL CANCER AFTER INADVERTENT SIMPLE HYSTERECTOMY:

PET-CT is usually done to assess the extent of disease and depending upon the histopathological and imaging findings patients usually require PORT or CCTRT.

In selected patients, radical parametrectomy and pelvic lymphadenectomy can be done in centres where expertise is available.

MANAGEMENT OF RECURRENT DISEASE:

Local pelvic recurrence post-surgery can be treated with CCTRT or with pelvic exenteration.

Pelvic exenteration can also be used to treat central pelvic recurrence or residual disease post CCTRT for locally advanced cervical cancer in appropriately selected patients after ruling out extra pelvic disease or distant metastasis by a PET-CT or a PET-MRI scan.

Distant metastasis is usually treated by palliative chemotherapy

Our institute being a tertiary care cancer centre is routinely performing complex surgeries like radical hysterectomy, radical parametrectomy and Exenterative procedures both by open and robotic techniques.

Though we were routinely performing robotic radical hysterectomy for cervical cancer before the results of LACC trial came out, we have now shifted our practice in favour of open surgery, and robotic surgeries for cervical cancer are performed in patients with tumor size less than 2 cm after appropriate counselling.

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MOVING FROM A MUTILATING SURGERY TO BREAST RECONSTRUCTION IN ADVANCED BREAST CANCER: A SHIFT TO APPROACH....

The Halsted-Meyer Theory: Halsted proposed the concept of Radical mastectomy based on the idea that at first, breast cancer spread only locally or “centrifugally” by first invading contiguous tissue and then spreading through lymph ducts to close-by lymph nodes, where the cells were “trapped” for some time.

From Halstedian era of radical mastectomy to modified radical mastectomy(MRM) to breast conservation surgery(BCS) , as the surgical techniques have evolved since then it has always been observed in the researches that this evolution have contributed to functional and cosmetic outcome. Nonetheless it has changed psychological outcome too due to an improved psychosocial body image.

The breast being the symbol of:

1. Femininity
2. Beauty and
3. Motherhood, it further becomes important to pay attention to the diseases of the breast especially when the breast cancer is concerned.

An Onco-Surgeon's perspective: To keep his / her oncosurgeon's mind 'ON' while operating in order to ensure complete removal of cancer from a localized or locally advanced breast cancer (LABC) irrespective of the loss of volume of the breast tissue. This will certainly help us to offer her improved disease free survival as far as loco-regional control is concerned. We can always plan reconstruction in the same sitting (preferred) with proper preoperative planning in discussion with the patient.

Here, the combined approach by an onco-surgeon and a plastic surgeon plays a very important role in:

1. Counseling of the patient
2. On table-surgical planning and
3. Improved onco-surgical and cosmetic outcome. This approach builds up the patient's confidence also.

Preoperative planning: The First and most important part of the surgical planning of the breast cancer patient is the proper:

1. Clinical examination.
2. Comparison of both the breasts and their anthropometry measurement.
3. Review of her medical records.
4. Proper clinical staging at presentation.

For locally-advanced inoperable breast cancer cases, neoadjuvant chemotherapy is recommended followed by interval or sequential surgical treatment. Decision to operate upon in such cases should be reviewed and discussed with the patient. All the surgical treatment options and their relevance should be briefly explained to the patient. Available surgical options are:

- 1.MRM alone
- 2.BCS with or without flap reconstruction OR
- 3.MRM with DIEP free flap reconstruction in first sitting followed by

nipple areola complex (NAC) reconstruction in second stage, which is usually preferred after the completion of adjuvant chemoradiation.

Options for autologous tissue reconstruction:

1. Pedicled flap (LD flap, TRAM flap)
2. Free flap (DIEP flap)

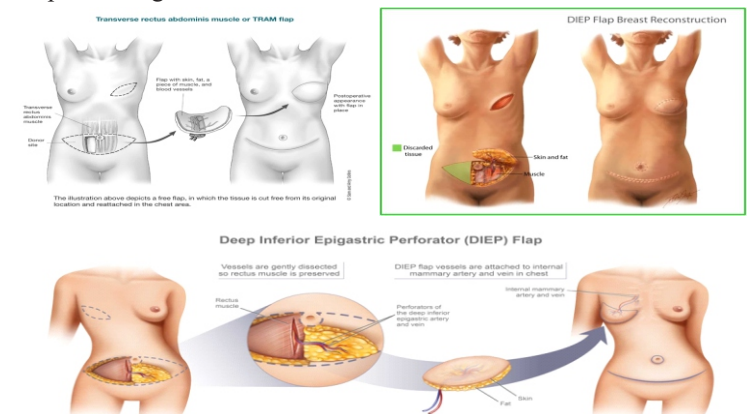
Should we offer free flap reconstruction option in LABC cases after MRM?

Yes, Schneiders in 1977 introduced the latissimus dorsi flap. Endoscopy can be used to mobilize latissimus dorsi flaps and minimize dorsal scarring preferred for reconstruction after BCS to fill the defect.

Holmstrom in 1979, proposed The DIEP flap, which makes large-volume transfer possible, with preservation of the abdominal muscle. This gives good, acceptable and comparable cosmetic outcome after MRM. However, the operating time is longer than for other breast reconstructions. But, this one of the most preferred choice by surgeon and patients when it comes to the resultant body image and cosmetic outcome without compromising oncological outcome.

Several types of expanders and prostheses have been used for breast reconstruction but they are not preferred for breast cancer cases.

The choice of breast reconstruction technique depends on the anatomical characteristics of the patient and the skill and experience of the plastic surgeon.



Conclusion: Post mastectomy autologous breast reconstruction, offers better cosmetic and psychological outcome. Studies have suggested that it doesn't influence loco-regional recurrences and also doesn't interfere with the detection of recurrences even if it happens. Imaging in follow-up period is widely available tool to monitor the oncological outcome.

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TRIBUTE TO DR. V. SHANTA



Dr. V. Shanta executive chairman of Cancer Institute, Adyar, the doyen of oncology in India, a great teacher and the hope of millions of cancer patients, passed away on 19.01.21. Born on March 11, 1927, in a distinguished family of Nobel laureates CV Raman and S Chandrasekhar, she devoted herself to the field of oncology. She lived in a small house within hospital complex. She made cancer treatment affordable and accessible to poor cancer patients.

She was a source of inspiration for many health care professionals. She won several awards including Ramon Magsaysay award and Padma Vibhushan. An alumna of Madras Medical College, she joined Cancer Institute founded by Dr. Muthulakshmi Reddy – the first woman medical graduate of India and a legislator. Dr. Muthulakshmi's son Dr. S. Krishnamurthy and Dr. V. Shanta played an exemplary role in nurturing cancer Institute, Adyar from a cottage hospital of 10 beds to a leading comprehensive cancer Institute of repute.

I feel proud to be postdoctoral student of cancer Institute (Adyar) under the able guidance of Dr. S. Krishnamurthy and Dr. V. Shanta; who were great teachers. Purpose of teaching is not to create student in his / her own image, but to develop student who can create his own image. They were ideal teachers in true sense. "Ideal teachers are those who use themselves as bridges over which they invite their students to cross, then having facilitated their crossing, joyfully collapse; encouraging them to create bridges of their own". (Nikos Kazantzakis)

Dr. V. Shanta and Dr. S. Krishnamurthy were two oncology pillars of my life. They not only taught me how to and when to do surgery but the emphasis was when not to do surgery. She was strong, unrelenting, set the bar high so that her students could rise. She got the best out of us and planted the seeds in me for hunger to learn. Although I did my M.Ch, Surgical Oncology in 1992-94. I visited Cancer Institute (Adyar) very often. I always made it a point to meet her, and she will give me chocolates or some fruits as Prasadam.

"I believe that a great teacher is a great artist. Teaching is the greatest Art since the medium is the human mind and spirit" (John. Steinbeck).

Dr. A. K. Dewan

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