



NewsLetter

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EDITORIAL

A GOOD, GREAT PATIENT!

The characteristics of a good patient include obedience, patience, politeness, listening, enthusiasm for treatment, intelligence, physical cleanliness, honesty and lifestyle adaptation (taking medication correctly and reporting to clinic when told). Time magazine described "a good patient" as someone who listens, follows directions, asks relevant questions, shows trust in his doctor and "massages" the doctor's ego. Good patients are calm and friendly. Good patients seek to nurture positive relationship with the hospital staff and try to avoid irritation to staff.

There is a story which illustrates the mindset of a patient. Once a man was told by his physician that he has one month to live because he has advanced cancer. This man went to the temple and prayed. He heard some voice "don't worry my child. Everything will be ok." Man went home peacefully after being assured by GOD that nothing is going to happen. In the meantime he met the surgeon, medical oncologist, nutritionist and alternative therapist who told him that they can treat him and he will be ok. He said "GOD has promised me cure and normal life. I am not ready for any anticancer treatment. "After one month man died and reached heavens. He said 'oh GOD! You promised me cure and here I am after 1 month, in front of you.' GOD smiled and replied "My child I sent whole of my magic tool box (surgeon, oncologist, alternative therapist and nutritionist) to you but you refused each and every one". Crux of the story is **you should have faith in the system, faith in your doctor, faith in the tool box and faith in yourself.**

There are few qualities that make a patient great.

1. Trust: Patient should have faith in healing process. Cancer recovery is not linear but riddled with ups and downs. Some patients become excited at the onset of new treatment. But there might be a plateau and a dip in vitality. And all that hope and enthusiasm for recovery begins to wane. Dips do happen, infact they are expected as part of road to recovery. What makes a patient great is his ability to see the light at the end of the tunnel. Trust means the ability to see this time – as a passing discomfort in an otherwise long cancer journey. When you adopt this mindset, the setback becomes a set-up for greater inner strength and ultimate healing potential. The great patient sees each dip as an opportunity to strengthen his faith and keep moving no matter what the result.

2. Self-Healing: in the past, the doctor was seen as provider of health. You got sick, you went to the doctor and got medicines. It was thought that doctor gave you your health. But this is not the way. We manage sick patients by restoring their ability to self-heal. When you clean the wound and dress the wound, it sets the stage for self healing. It may also need some lifestyle changes. Just as a farmer does not make his crops grow. What he does is fertilize the soil, plant the seeds and nurture them with water and fertilizers to create the best conditions that support the growth of life. While the oncologist provides specialized treatments (like water and nutrients to plants) that facilitates healing response. Patient must optimize his internal and external environment through

proper diet, rest and positive mindset.

3. Expectations: it is clear that health and healing come not from the physician but from nature. And nature sets its own pace. While we hope and do everything possible to set the stage for early recovery, we must respect the healing process. Our priority should be to provide the best possible soil (care) so that nature can do a good job. One of my colleagues remarked that every patient is good and great till the time he gets expected outcome. Patients have a strong expectation of what they need in their mind. Some treatments may do wonders for one particular patient but may not do so well for other patient. Each patient is highly unique.

Today the innovative medicine enables treatment to be so effective that there is a high level of personalization and expectation. Tremendous amount of time, effort and experience goes in evaluation of each patient to develop a program of personalized medicine. So in addition to trust, faith and commitment to the process – a great patient should be flexible in his expectation while trusting medical team's ability to provide the individualized care.

4. Customer Mind: in the present era of consumerism every patient feels, he is a customer. And the first role of customer service is "customer is always right." We live in the age of information and patients research google their own symptoms and try to find treatment options. Google has provided a unique medical marketplace. These models may work for day to day medical problems and basic lifestyle enhancements. But it breaks down when applied to complex chronic conditions like cancer. We as medical professionals can assure our patient that centuries of research and wisdom combined with decades of clinical experience is being applied to them (patients). A great patient is curious and inquisitive and understands that his treatment is backed by knowledge and clinical experience. He should not assume the role of a customer and consumer by picking and choosing which product he would like to have. Every product (cancer treatment) has a specific function. Learning, googling is wonderful but adopt the right mindset; the beginner's mind.

5. Beyond Medicine: Daily practices such as gratitude, prayer and meditation have proven to strengthen the immune system and hasten cell recovery. These actions impact patient's physiology and psychology. The body is an extension of mind. Healing and recovery are not just physical processes but also spiritual ones.

When your patient is equipped with above qualities he can be a great and an outstanding patient!



Dr. A. K. Dewan
Director - Surgical Oncology

INTERVENTIONAL ONCOLOGY – THEFOURTH PILLAR OF CANCER CARE

Interventional oncology (IO) is an emerging subspecialty of interventional radiology that “uses image-guided procedures to enhance cancer care,” according to a recent paper published in *The Oncologist*.¹ IO has advanced over the past few years as improved hardware, imaging technologies and new procedures are being developed. IO aims at using minimally invasive techniques to diagnose/ treat tumors. Its role in the management of cancer has been growing and has now established itself as the fourth pillar of Modern Oncology care” (the other three being medical, surgical, and radiation), as is evident by its increasing role in cancer treatment guidelines. Most of the IO procedures require only local anesthesia or mild sedation and the patient can be discharged the next day.

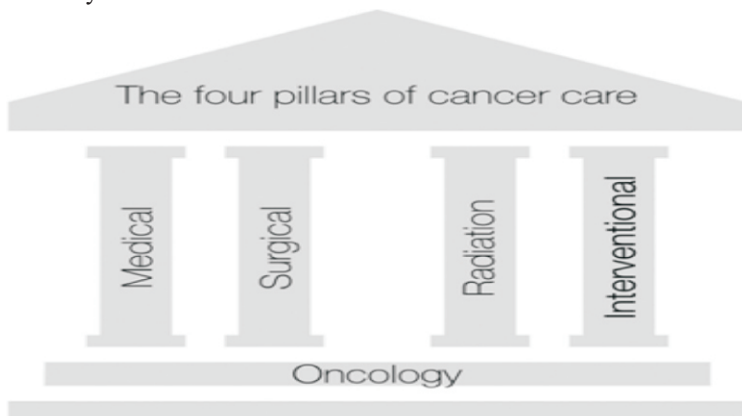
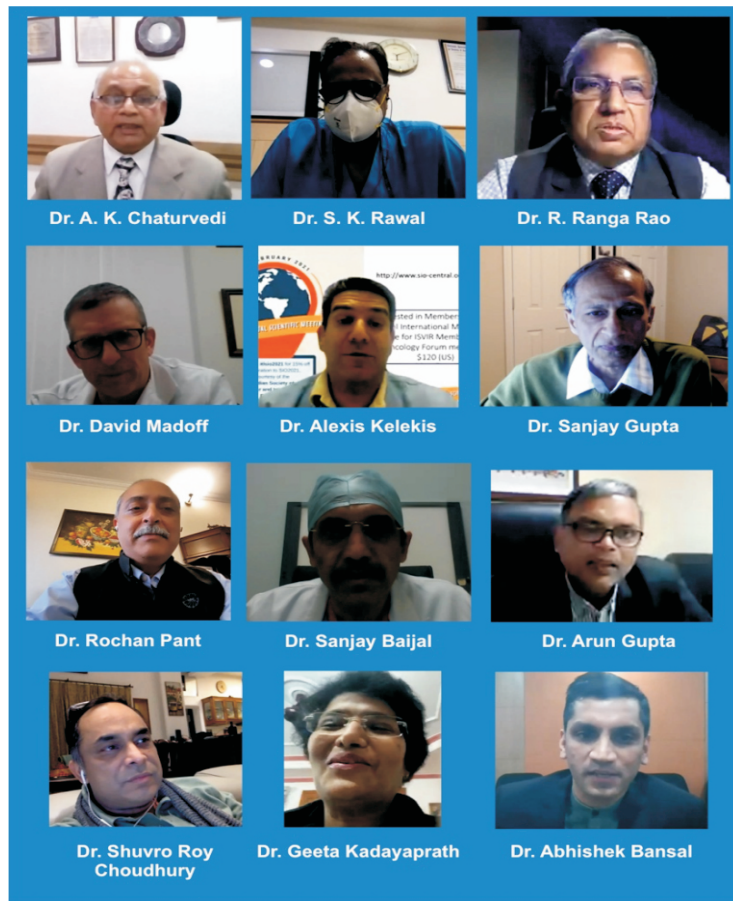


Fig. 1: Interventional oncology plays a key role in integrated cancer care. The four pillars of cancer care: medical oncology, surgical oncology, radiation oncology, and interventional oncology.¹

More patient centered and personalized treatment approaches have also led to further development of IO.² IO is focused on three main areas in cancer management: diagnosis, therapy, and symptom palliation.¹ A major advantage of IO is localized effect on the tumor or a single organ in the body with minimal systemic side effects.³ Numerous studies have shown that cancer patients treated in multidisciplinary environments benefit greatly from the combined expertise. Interventional Radiologists are seen as playing a major role in multidisciplinary cancer teams where they provide innovative solutions to improve combined therapies and to treat complications.⁴ IO has evolved in the treatment of liver malignancies, both primary and secondary in the form of liver directed therapies including chemoembolization / radioembolization and ablative therapies. The ablative therapies have further advanced with increasing role in lung, kidney and bone neoplasms as well.

Over the past few years, as the scope of IO has expanded and many hospitals across the world are establishing subdivisions of IO and our institute, Rajiv Gandhi Cancer Institute and Research Centre (RGCIRC) has always been a pioneer when it comes to Oncology care, and it holds true for the establishment of the sub-division of IO. Our institute has an exclusive IO Cath Lab that is providing services to the hospital round the clock. On January 29, 2021 a new milestone was achieved with support from the Management, RGCIRC and under the chairmanship of Dr. Arvind K. Chaturvedi, a grand virtual launch event was organized for the launch of “Interventional Oncology” in association with Oncology Forum. The Indian Society of Vascular and Interventional Radiology (ISVIR) and the Society of Interventional Oncology (SIO) were the launch partners. World renowned experts in the field of IO gave the opening remarks and the event was a great academic feast with most important IO topics discussed by the world authorities.

The Society of Interventional Oncology (SIO) is a global non-profit association that supports and promotes the field of IO. The mission of SIO is, “To advance IO by developing evidence supporting IO therapies, educating IO practitioners, and improving patient access to IO therapies.”



Eminent Faculty at the Launch of Interventional Oncology

As we move into the era of artificial intelligence and robotic technologies, the scope and utility of IO is only going to increase further.

1. Schoenberg, S.O., Attenberger, U.I., Solomon, S.B. and Weissleder, R.. Developing a Roadmap for Interventional Oncology. *The Oncol*. 2018; 23: 1162-70.
2. Bapst, Blanche & Lagadec, Matthieu & Breguet, Romain & Vilgrain, Valérie & Ronot, Maxime. Cone Beam Computed Tomography (CBCT) in the Field of Interventional Oncology of the Liver. *Cardiovasc Intervent Radiol*. 2015. 38: 1180-6.
3. T. Helmberger. Interventional Oncology – where are we now? – And where we should head for? *Radiologia (English Edition)*. 2019. 61: 1-3.
4. Adam, Andreas; Kenny, Lizbeth M. "Interventional oncology in multidisciplinary cancer treatment in the 21st century". *Nature Reviews Clinical Oncology*. 2015; 12(2): 105–13.

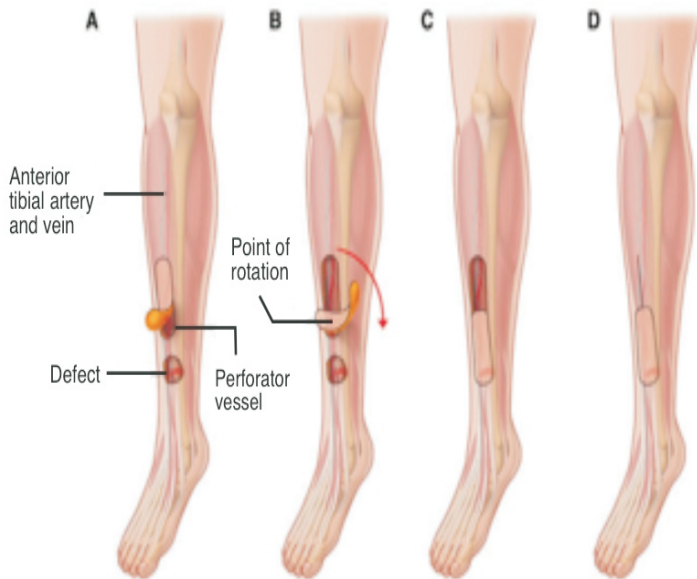


The Interventional Oncology Cath Lab Team of RGCIRC

Dr. Abhishek Bansal
Consultant - Interventional Oncology

CHALLENGING CLOSURE OF DEFECTS FOLLOWING STS EXCISION OF CALF REGION; BRINGING THE ATTENTION OF ONCOSURGEONS

Introduction: When it comes to the closure of defects following excision of STS of calf where primary closure might not be an option. Delayed closure, as well as grafting of a wound are well documented options and should be attempted in both the simple wound, those where early recovery is required. Local rotation advancement flaps give better postoperative recovery rates where more complex reconstructive failure would be disastrous. These perforator based local flap have been observed to have better recovery outcomes and makes the patient able to finish adjuvant treatment timely in such cases



Pre-requisites: Both of these options require an adequate blood supply to the wound area and relatively reliable surrounding tissue. Where the blood supply is poor, or where there is a requirement of soft tissue depth, the use of reconstructive flaps is generally required. This technique is limited by the reliability of the surrounding tissue, but may offer a potential donor site for both direct closure and local flap coverage.

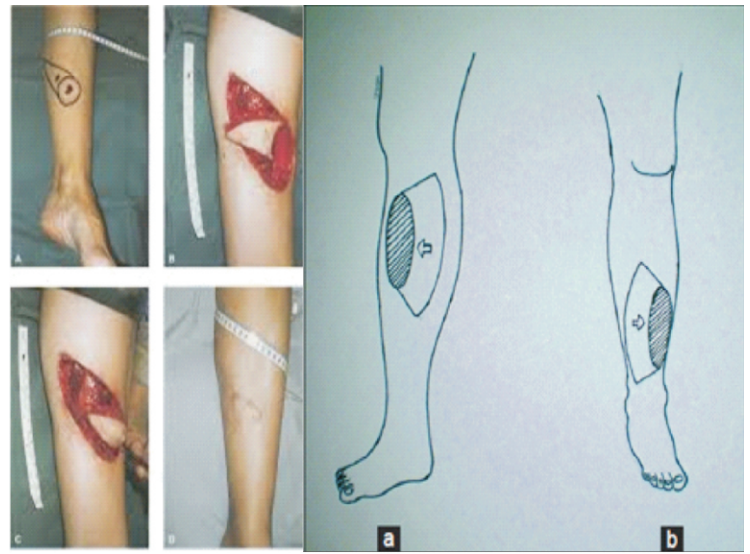
Choice of Reconstruction

1. Upfront cases / treatment naïve cases: Traditionally the use of local flaps proximal based or distal based have been used to cover calf defects and reliability on local fascio-cutaneous flap have also contributed to their increased use throughout the limb

2. Recurrent cases: Where defects are supposed to be larger, combination of both local perforator based flap, and distal free flaps can result in acceptable oncological outcome and role of plastic surgeon plays an important role.

3. Melanoma of calf: This entity unlike other pathological subtypes of STS may pose a challenge when it comes to reconstruction using local flaps.

4. V-Y flaps: As described by Blasius, are another option, particularly around the ankle and calf especially lateral compartment defects and can provide a sensate flap to the region

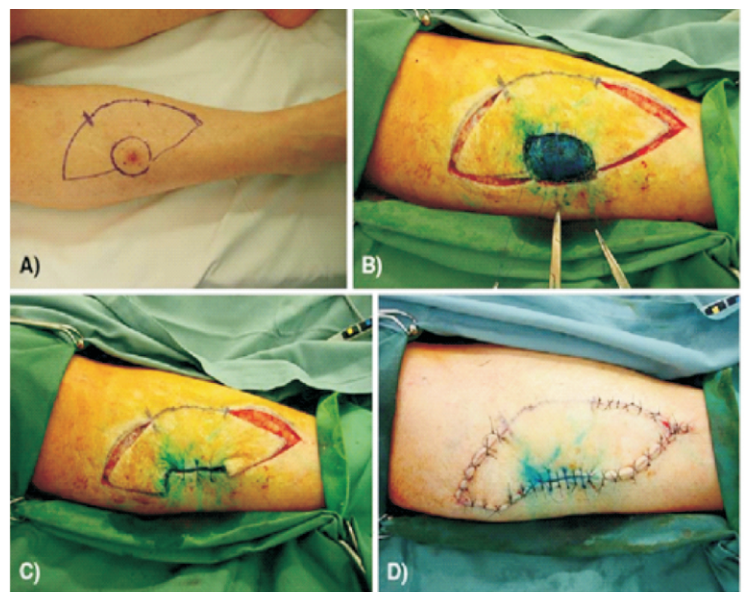


Precautions

1. Proper preoperative land marking of perforators of the region.
2. Intraoperative hand held Doppler to confirm vascularity of the harvested perforator based fascio-cutaneous or muscle based flaps.

Conclusion: The salvage of the limb is preferred over amputation. Soft tissue coverage must be wound and area specific, involving the patient and a multidisciplinary approach.

The reconstruction procedures offer options and the improvement in both pedicled flaps and free flaps. The choice of reconstruction should be determined by reliability, rather than ease of a procedure and should be the least disabling. The reconstruction procedures should offer enhanced recovery in order to complete adjuvant treatment within the defined time period.



Dr. Seema Singh
Consultant – Surgical Oncology
RGIRC, Niti Bagh

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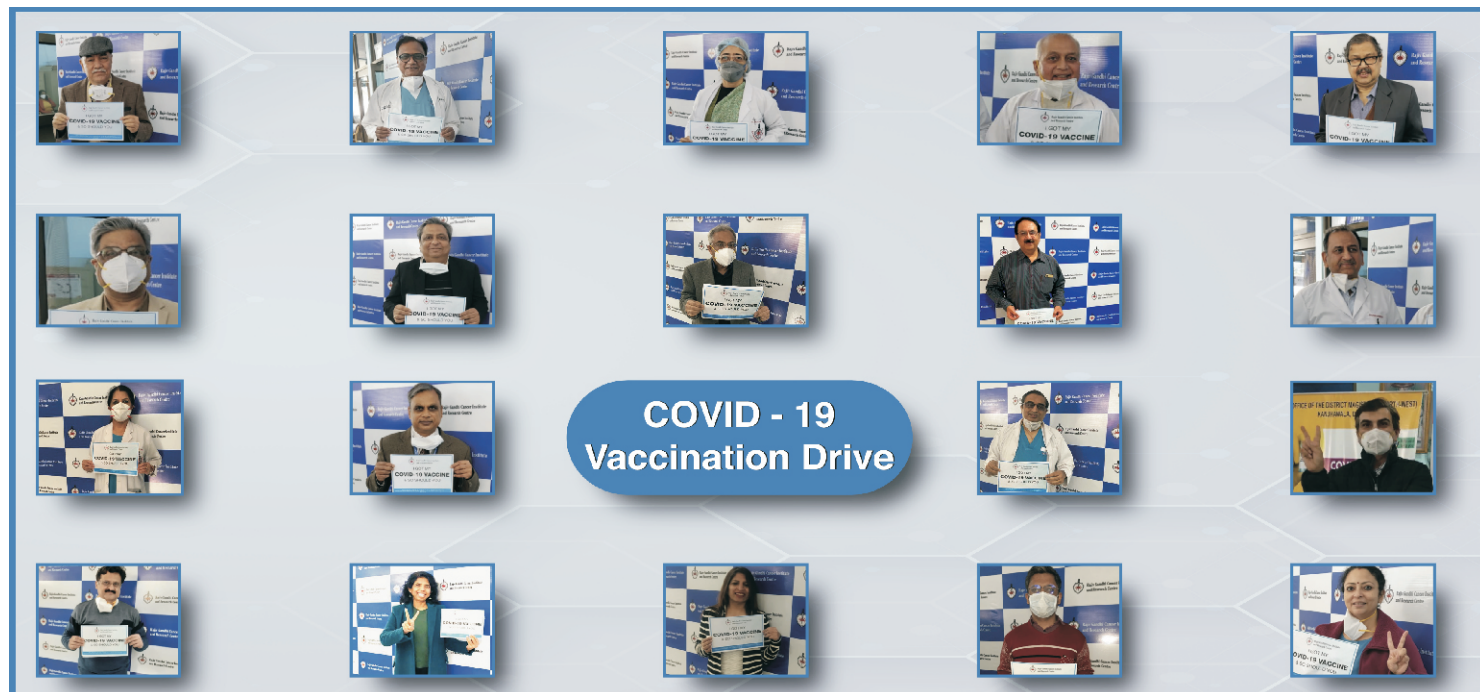
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WEBINAR WITH IMA SAHARANPUR

RGCIRC organized a webinar in association with IMA Saharanpur on Friday, 29th January 2021 through Zoom. Dr. Kundan Singh Chufal, Sr. Consultant and Chief of Breast and Thoracic Radiation Oncology delivered a lecture on Artificial Intelligence (AI) and Its Role in Oncology: Can AI Help Medical Management to Be Efficient? and Dr. Manish Sharma, Consultant – Medical Oncology spoke on Two Decades of Cancer Research Progress in the said virtual meeting. The webinar was well appreciated by the gathering.

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Editor: Dr. A. K. Dewan