

# NewsLetter

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## EDITORIAL

### CONCEPT OF PALLIATIVE CARE

Palliative care is a health care specialty that is both a philosophy of care and an organized, highly structured system for delivering care to persons with life-threatening illness. WHO defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. "The goal of palliative care is, therefore, to improve the quality of life of both patients and families by responding to pain and other distressing physical symptoms, as well as to provide nursing care and psycho-social and spiritual support. This is why it is best administered by an interdisciplinary, multi-dimensional team, comprising of doctors, nurses, counsellors, social workers, and volunteers.

Every hour more than 60 patients die in India from cancer and in pain. It is estimated that in India the total number who need palliative care is likely to be 6 million people a year. In addition to the challenges posed by illnesses, many of the patients in India are extremely poor and do not have access to clean water, food, or even shelter. When chronic or life-threatening illnesses strike, it is a crippling blow for them and their families. There is therefore a crucial need for a system of care at home that can best be built by a community-based palliative care movement. The concept of palliative care is relatively new in India, having been introduced only in the mid-1980s. In India, the earliest facilities to deliver palliative care within cancer centers were established in some places like Ahmedabad, Bangalore, Mumbai, Trivandrum, and Delhi in the late 1980s and the early 1990s. In 1986, Professor D'Souza opened the first hospice, Shanti Avedna Ashram, in Mumbai, Maharashtra. At the same time, pain clinics were established at the Regional Cancer Centre, Trivandrum. Can Support was founded in 1997 in Delhi which provided the first free palliative care home care support service in North India. In Pune, Maharashtra, the Cipla Cancer Palliative Care Centre was established.

There are 138 organizations currently providing hospice and palliative care services in 16 states or union territories. These services are usually concentrated in large cities and regional cancer centers, with the exception of Kerala, where services are more widespread. The Kerala network has more than 60 units covering a population of greater than 12 million and is one of the largest networks in the world. Karunashraya Bangalore Hospice Trust established a 55-bedded hospice with a homecare service.

Home-based palliative care services are becoming increasingly popular with care being taken to the doorstep of the patient. Ideally, this is where people are most comfortable at the end of their lives, surrounded by their loved ones. It is also well suited to conditions in India where a family member is usually available and willing to nurse the sick person. The aim of home-based care is ultimately to "promote, restore, and maintain a person's maximum level of comfort, function, and health, including care toward a dignified death." Home-based care models are also generally person-centered and comprehensive, with the aim to take into account factors such as culture, religion, and value systems, and respect people's rights to privacy and dignity. It is also cost-effective as it does not entail doctors and nurses' fees and travelling to the

hospital repeatedly for follow up visits and unnecessary investigations and treatments. Increasingly, people are choosing hospice care at the end of life. Hospice care focusses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life. Like palliative care, hospice provides comprehensive comfort, care as well as support for the family, but, in hospice, attempts to cure the person's illness are stopped. Sometimes people don't begin hospice care soon enough to take full advantage of the help it offers. Perhaps they wait too long to begin hospice and they are too close to death. Starting hospice early may be able to provide months of meaningful care and quality time.

The rich may die in clean and hygienic surroundings or in hospitals tied to tubes and lines but they are likely to be in extreme pain. Pain management is a science poorly understood in India and even when drugs are available, they may be doled out in doses too small to be helpful. The irony of this particular problem is that India is the world's leading manufacturer of morphine, the drug of choice for managing excruciating pain. It produces most of the world's supply, yet exports over 90% of it, callously denying its own people. Terrified by its addictive properties, which are undisputed, the Indian Narcotic Drugs and Psychotropic Substances (NDPS) Act severely curtailed the medical use of Morphine, making it so difficult to obtain that most doctors never even bothered to apply for six licenses which were required. Its scarcity meant that no one knew how to administer it; its use is not taught in 80% of the country's medical colleges. However, an amendment to the NDPS Act was passed by Parliament, loosening the restrictions on morphine and paving the way for better pain relief for the terminally ill within the country.

Twelfth 5-year plan made a special provision for Palliative care. For palliative care there will be dedicated 4 beds at the district hospital. Doctors, nurses, and health workers will be trained in basic palliative care. One of the doctors in the District hospital needs to have a 2 weeks training in palliative care. WHO recommended three foundation measures for developing Palliative care—Governmental policy, Education, and Drug availability. They are important for establishing a sustainable Palliative care, and achieving meaningful coverage. A milestone was achieved in Palliative care when MCI recognized MD in Palliative Medicine and this helped to develop as a specialty of P.C in our country. IAPC has worked for this for many years.

For majority of clinical problems patient care is disease-oriented. Palliative care is not disease-focused approach but patient-centered philosophy, where the needs of the patient and the patient/family goals are essential to planning care. The goal of palliative care should continue to focus on the relief of suffering and the improvement of the quality of life for patients with advanced illness.

In India, medical insurance does not play a significant role in hospice and palliative care provision. Services are funded in a range of ways including: central government; state government; NGOs; indigenous-fund raising; private companies; private individual and international donations.

Indian palliative care movement has innovated and produced services such as the NNPC, and set up an exemplar model of community-based palliative care for other low-resource countries world-wide. The innovation, enthusiasm, and commitment of volunteers, families, activists, and palliative care practitioners are clearly the driving force of Indian palliative care.



**Dr. A. K. Dewan**

Director - Surgical Oncology

Venous thromboembolism (VTE) comprises of two closely related disease entities: deep vein thrombosis (DVT) and pulmonary embolism (PE). In one third of patients venous thrombosis is accompanied by symptomatic PE. Risk of PE is relatively high in patients with advanced chronic diseases, such as malignancies. Most cancer patients have blood coagulation abnormalities leading to VTE. The mortality in untreated PE is high (30%) but appropriate treatment may decrease it to 2–18%. CT Pulmonary Angiography (CTPA) is the modality of choice for diagnosing and stratifying such patients. PE has classically been divided into “massive,” “submassive,” and “low-risk” categories and Interventional radiology plays a vital role in the management of both massive and submassive PE.

Massive PE is defined as acute PE with hemodynamic changes, including sustained hypotension (systolic blood pressure  $<90$  mm Hg for a minimum of 15 minutes or requiring inotropic support), pulselessness, or continued bradycardia (heart rate  $<40$  bpm with signs or symptoms of shock). Submassive PE is defined as acute PE with evidence of right heart strain or myocardial necrosis but without sustained hypotension (systolic blood pressure  $\geq 90$  mm Hg);

In the absence of any contraindications, all patients with acute PE should receive prompt initiation of appropriate anticoagulation therapy.

## Systemic Thrombolysis

Parenteral systemic thrombolytic agents may be indicated in patients who require more aggressive therapy than anticoagulation alone. Given the risk–benefit balance of systemic thrombolysis, careful selection of candidates for thrombolysis is crucial. Contraindications to thrombolytic therapy include recent cerebrovascular accident, intracranial trauma or surgery within the last 2 months, active intracranial disease, or recent major surgery, among many others

## Catheter-Directed Therapy (CDT)

The American Heart Association (AHA), European Society of Cardiology (ESC), and American College of Chest Physicians (ACCP) guidelines recommend consideration of CDT for massive and sub-massive PE in cases for which systemic thrombolysis is contraindicated or has failed. CDT includes several techniques such as mechanical and aspiration thrombectomy, catheter-directed thrombolysis, ultrasound accelerated thrombolysis. CDT has the benefit of using lower thrombolytic doses and direct intraclot administration of thrombolytic therapy.

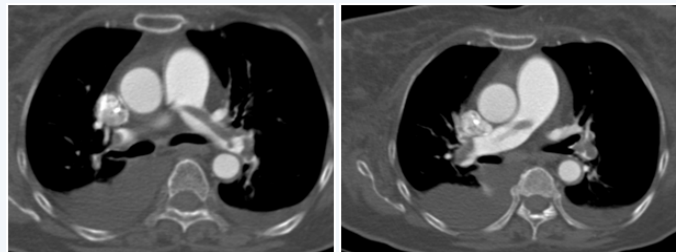
In the setting of massive PE, there may be insufficient time or additional co-morbidities which preclude the systemic thrombolysis. In such settings, CDT can be used as a first-line treatment option. CDT therapy can achieve more rapid lysis while reducing the overall thrombolytic drug dose. While systemic thrombolysis uses 100 mg of tPA infused over 2 hours, CDT uses infusion rates of 1 to 2 mg tPA per hour for a total dose of  $\leq 30$  mg. CDT has the potential to provide the benefits of thrombolysis while decreasing the risk of major bleeding. It also allows for direct measurement of PA pressures and CO, providing an objective assessment of hemodynamic response to treatment.

We share our experience with two such patients who presented

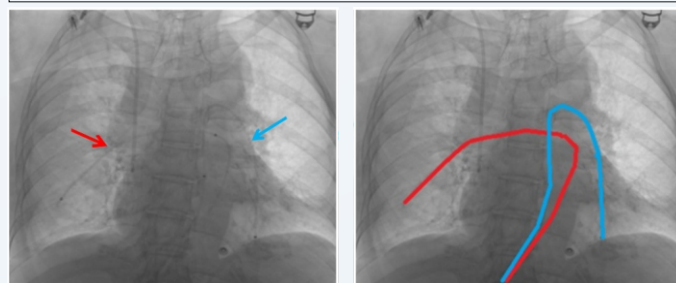
with sub-massive PE and were admitted in the Intensive Care Unit of our hospital and were treated successfully with CDT.

### Case No.1

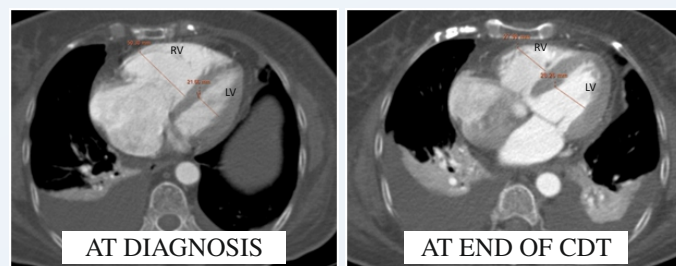
A 68 year old lady being treated for MUO (Adenocarcinoma) on palliative chemotherapy developed sudden onset breathlessness and found to have sub-massive PE with right heart strain. We performed catheter directed thrombolysis with direct infusion of t-PA into the thrombus in both pulmonary arteries and the patient was shifted out of the ICU the next day of completing the thrombolysis with complete resolution of right heart strain.



CTPA showing saddle embolus in both main pulmonary artery trunks



Fluorospot showing multiple side hole infusion catheters in each pulmonary arterial system  
Red: Right Pulmonary arterial system | Blue: Left Pulmonary arterial system



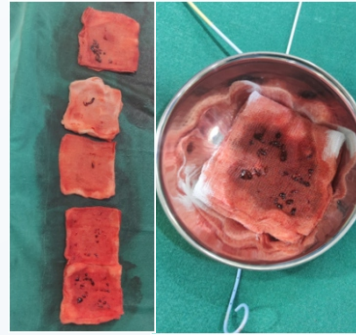
CTPA demonstrating the normalization of RV/LV ratio from 2.4 at the time of diagnosis to  $<1$  at end of CDT. RV/LV: right to left ventricle diameter ratio

### Case No.2

A 79 year old gentleman who was treated for Carcinoma prostate in 2007 and was now being treated Adenocarcinoma right lung since June'20. He was shifted to our hospital ICU from elsewhere with a diagnosis of massive PE not improving on anticoagulation and systemic thrombolysis. So, we decided to do mechanical aspiration thrombectomy in which we used a suction catheter to suck out the thrombus. The patient was shifted out of the ICU the very next day and is following up in OPD walking by his own self in contrast to the ACLS ambulance into which he was brought into the hospital.



Mechanical suction catheter in left pulmonary arterial system



On table removal of big chunks of clots from the pulmonary arterial system with immediate clinical improvement in the patient's vitals

#### References:

1. Bremer W et al. Role of Interventional Radiologist in the Management of Acute Pulmonary Embolism. *SeminInterventRadiol.* 2020;37(1):62-73.
2. De Gregorio MA et al. Interventional radiology treatment for pulmonary embolism. *World J Radiol.* 2017;9(7):295-303.

Multidisciplinary team management is crucial to saving the lives of patients diagnosed with PE. Interventional Radiology plays a crucial role in the pulmonary embolism response teams, which are becoming essential to appropriately manage PE patients.

**Cath Lab Team**  
Department of Interventional Radiology  
RGCIRC, Rohini

### Rajiv Gandhi Cancer Institute & Research Centre (RGCIRC), Niti Bagh, South Delhi

#### AN ALTERNATIVE FLAP IN A PATIENT OF CEREBROVASCULAR ACCIDENT WITH ORAL CANCER

64 years old hypertensive, post CVA male patient (on blood thinners since Sept 2020) presented with nonhealing ulcer right lateral aspect of lower lip mucosa (pT4N2M0) which was diagnosed as well differentiated squamous cell carcinoma. He was planned for partial glossectomy, neck dissection and free flap reconstruction. The neurosurgeon had given clearance on high risk due to increased chances of intracranial bleed in view of the multiple microbleeds/ calcifications in B/L cerebral and cerebellar regions in the recent MRI, restricting the use of heparin in intra and post-operative period. In view of this, the surgical reconstruction was changed from radial artery forearm free flap to pedicled



deltpectoral flap (for skin) and nasolabial (for mucosa). It was a good alternative with reasonably good final functional and cosmetic result.

**Dr. Leena Dadhwal**  
Consultant – Surgical Oncology  
RGCIRC, Niti Bagh, South Delhi

### CONGRATULATIONS TO DR. ABHISHEK BANSAL



Dr. Abhishek Bansal, Consultant, Department of Radiology and Interventional Oncology, was awarded the **"Young Doctor of the Year 2021"** award by Shri Satyender Kumar Jain, Hon'ble Health Minister, Government of NCT of Delhi and Dr. Sahajanand PD Singh, National President Elect, Indian Medical Association at the 3<sup>rd</sup> Annual Conference of Delhi Doctors Forum on Sunday, 19<sup>th</sup> September 2021.

The award reads, "By virtue of his exemplary skillful contribution for the promotion and propagation of knowledge, skills through enthusiastic zeal to lead youth and the medical profession".

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### 3<sup>RD</sup> ANNUAL CONFERENCE OF DELHI DOCTORS FORUM



RGCIRC participated in 3<sup>rd</sup> Annual Conference of Delhi Doctors Forum on Sunday, 19<sup>th</sup> September 2021 at Hotel Eros, Nehru Place, New Delhi. The theme of the conference was **General Practice to Specialized Medicare**. Dr. Rupinder Sekhon, Sr. Consultant & Chief of Gynae Oncology delivered a lecture on **Cervical Cancer: The Changing Paradigm** and Dr. Manish Sharma, Consultant - Medical Oncology, RGCIRC Niti Bagh spoke on **Two Decades of Cancer Research in Progress**. The lectures were very well appreciated by the gathering.

### CME – IMA JANAKPURI



RGCIRC organized a CME in association with IMA Janakpuri on Saturday, 11<sup>th</sup> September 2021 at Hotel Radisson Blu, PaschimVihar, New Delhi. Dr. Vandana Jain, Consultant – Gynae Oncology delivered a lecture on **Cervical Cancer Screening & HPV Vaccine** and Dr. Abhishek Bansal, Consultant – Interventional Oncology spoke on **Interventional Oncology: Minimally Invasive Treatment Options**. The CME was very well appreciated by the gathering.

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Rajiv Gandhi Cancer Institute and  
Research Centre, D-18, Sector - 5,  
Rohini, Delhi - 110085

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Editor: Dr. A. K. Dewan