

NewsLetter

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EDITORIAL

GOOD SURGEON → EXCELLENT SURGEON → GREAT SURGEON!!!

Good surgeon means good education and good training. The education and training should fulfil two main objectives. The first one is to develop good manual dexterity. A surgeon without adequate manual skills is not a surgeon. He should also acquire a wide range of clinical and scientific knowledge relevant to the chosen specialty. Not every trainee who develops high technical skills and acquires sound theoretical knowledge becomes a truly good surgeon. He should have high intellectual potential and good communication skills. He should participate in scientific research with regular publications which is one of the ways of self-improvement and of keeping up-to-date.

Surgeons - particularly those who are in the early stages of their career - might emulate to become truly excellent surgeons. The best surgeons have mentors (Gurus). Mentors guide us through a career path. They provide sage advice, personal counselling and support our growth. Mentors go beyond teaching; they impart wisdom. A good mentor sees the potential in the mentee and facilitates his development. Achieving excellence, becoming the best, is almost always associated with outstanding mentorship. My teacher (my Guru) used to say everyone should have Guru in ones life. Guru does not mean religious leader but a person who leads your life, in addition to surgery, even hand holding in surgery. Surgeons often equate excellence with the mastery of surgical technique, accompanied by other attributes, such as knowledge, poise, and common sense. These virtues separate a good technician from a good surgeon. Excellent surgeons know when to operate and when not to operate. They understand that decisions are more important than incisions of surgery. The ultimate goal of an operation is to benefit the patient, not the surgeon. Excellent surgeon does not believe in the narcissistic concept. "I have done, what others could not," Excellent surgeons follow the principle "first, do no harm", Henri Bismuth, an expert in the hepatobiliary field, said when talking about reckless surgeons, "I have never seen a surgeon dying in the operating room as a result of his reckless performance. But I have seen patients die, or feel pain, or undergo complications because of these reckless surgeons. "Excellent surgeons are not the ones who fight cancer regardless of the consequences brought about by this fight and who justify their decisions as necessary to eradicate a disease, even at the expense of their patients' lives. These surgeons know that a thorough informed consent does not equal the right to carry out procedures that can lead to serious complications for their patients.

Excellent surgeons may operate slowly, but think quickly. Excellent surgeons never seem to be in a hurry. Deliberate, precise movements, without any wasted motions and following the right planes, usually result in a faster conclusion of the procedure. Time should not be the driver; perfection should be. An excellent surgeon's ego should not be bruised when there is a need to stop, move back, and rethink when the patient's best interests are at stake. Such surgeons make operation look effortless. They do not seem rushed. Excellent surgeons are patient.

Complications worry all the surgeons but do not become an obsession. Excellent surgeon try to sort them out, learn from them, and avoid future ones. They generously share their knowledge. At the same time, they are aware that their knowledge is limited and are willing to study and learn from others. They are constantly learning and investigating, and transmit their knowledge to future generations. People who have nothing to learn from others have nothing to teach.

More than first-class technical skill, an excellent judgement is always required when performing an operation. Even the best surgeons can have operations go unexpectedly wrong leading to disaster. Calmness of the mind is then required, not rising panic, not blaming your assistant, not shouting at the scrub nurse. Such events may occasionally require humility and moral courage, by the need to call for further skilled assistance rather than pressing on with perhaps inadequate or inexperienced assistance. Massive bleeding is an example. However senior, however experienced, the great surgeon will feel no loss of face in asking for help from a colleague. Rightly, there is now great emphasis on the importance of team working. Team working in the operating room is the norm. A good team of a surgeon may have the same scrub nurse and the same anaesthetist and an assistant who had been attached to the him for several months, may be longer.

Few surgeons are great masters! Great surgeons lead the surgical procedure and support all the members of the surgical team. In this collaborative setting, team members feel protected amid the stress and empowered to speak up and contribute. Respect and mutual support for every member of the team brings out the best in every member. The great surgeons, as leaders of their team, will take full responsibility for the actions of their team when things go wrong. When things go right, excellence in leadership requires that surgeons identify those who made "the right thing" happen. Never miss an opportunity for public praise. Such surgeons enjoy their work. Passion for a profession is like falling in love. For them surgery is not a job that must be done to survive. It is a choice. The great surgeons know their limits. Experiencing fear before a complex procedure is a normal and helpful feeling. Fear keeps you focused and alert. Only the reckless feel no fear. Managing fear when facing risks is key to excellent performance in surgery. The great surgeons realize that fear is part of a surgeon's life. The great surgeons consistently audit their results. They are fully aware of both their abilities and limitations. Through introspection, they are motivated to seek continuous self-improvement. The relentless pursuit of perfection in everything we do is the hallmark of a surgeon.

The mature and great surgeons establish trusting relationships with their patients and their families. Patients are people - people with needs that extend beyond the mere treatment of a physical illness. The great surgeons feel the pain of their patients and the concern of their relatives as if it were their own. The great surgeons listen more than talk. The great surgeons are grateful and humble. The great surgeons do not know that they are the "best" and do not strive to be considered the best. Rather, they know they can always improve and are receptive to knowledge that will benefit their future patients. These surgeons are grateful to their mentors and constantly honour their memory by passing on their example to future generations. Once surgeons have lived a life in surgery and reach a certain age, it can be difficult to humbly accept retirement. The great surgeons know when to leave the operating room for good. It is always better to do so one year too early than one day too late. Great surgeons find ways to balance two important aspects of life, focusing on their patients while at work and living lives of fulfilment with family and friends when out of the hospital. The nourishment of the soul provided by these moments will be reflected at work, yielding excellence.

The ability to communicate with patients and their relatives in a quietly confident way, at all times being honest and understandable is part of the

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RISK ADAPTED THERAPY IN HEMATOLOGY AND HEMATO-ONCOLOGY

These are times of evidence based and risk adapted treatment approach in every segment of medicine. There has been gradual evolution in diagnostics and therapeutic strategies over past decades to come to this era of risk adapted approach to treatment. With advances in diagnostics, we are now able to have a better classification and risk stratification of various hematological malignancies. Similarly, treatment strategies have evolved in such a way that now we treat some good risk patients with less intensified approach to minimize toxicities while maintaining efficacy of the treatment regimes and intensifying the treatment in only those with high risk disease.

Treatment of aggressive lymphomas: Commonest example of aggressive lymphoma is diffuse large B cell lymphoma (DLBCL) and high grade B cell lymphoma (HGBCL). Currently DLBCL is further classified into several subcategories based on its gene expression profile or immunohistochemical patterns which are surrogate to molecular features. These subclasses are germinal centre type (DLBCL-GC) which is considered a good prognostic class compared to other one, the activated B cell (DLBCL-ABC) type which has got a poorer prognosis. Another advance in the management of DLBCL and High grade B cell lymphomas is identification of re-arrangement of cMyc and BCL2/BCL6 genes detectable by Fluorescent in-situ hybridization (FISH) technique. Based on cMyc and BCL2/BCL6 gene rearrangements, DLBCL and high grade B cell lymphoma can be classified into double hit/ triple hit lymphoma (DHL/THL) and non double hit lymphoma. Double hit/ triple hit lymphomas are highly aggressive and are associated with poorer prognosis. Therapy is usually intensified in such patients to achieve better results.

High grade T cell lymphomas (except lymphoblastic lymphoma which is treated with ALL like therapy) are also treated with intensive chemotherapy and Autologous bone marrow/ hematopoietic stem cell transplantation in selected patients with high risk features.

This way, it is very much needed these days to identify high risk features by molecular testing. Intensification of therapy is warranted in selected patients with high risk features to achieve outcomes comparable to good risk patients while less intensified treatment approach is maintained for those with good risk disease to minimize toxicities while maintaining good outcomes.

Treatment of Multiple Myeloma: Multiple myeloma is also called Myeloma. Myeloma was once considered a deadly and incurable disease and was usually treated with cytotoxic chemotherapies. Over past two decades, there has been development of many anti-myeloma drugs with specificity for myeloma cells (malignant plasma cells) and lesser cytotoxicity to normal tissues. These drugs are Proteasome inhibitors like Bortezomib, Carfilzomib and Ixazomib and Immuno-modulators with anti-angiogenic properties like Thalidomide, Lenalidomide and Pomalidomide most of which are available for Indian patients very easily and at affordable cost. Apart from these two major classes of drugs, now we have certain targeted therapies- immunotherapies like anti CD 38 monoclonal antibody (Daratumumab, Isatuximab), Anti SLAM F7 antibody (Elotuzumab) and anti BCMA antibody (Balantamab). Moreover, CAR-T cell therapy is promising and is in developmental phase in India. With cytotoxic therapies of past, complete remissions were uncommon and would be to the range of 30% even after an Autologous Bone Marrow Transplantation and an early relapse in majority of patients.

But nowadays, with wide availability of novel agents, we are able to achieve complete remission and even deeper remissions in a significant majority of patients and that can be further improved with an Autologous Bone Marrow Transplantation and further maintenance therapy. Apart from expansion of this therapeutic armamentarium, there has been progress in understanding of cytogenetic and molecular patterns of myeloma and its prognostic and therapeutic implications. Now a day, FISH technique is widely available to identify cytogenetics aberrations specific to myeloma and we can identify high risk myeloma (for example, those with 17p [p53] deletion, 1q gain and others like t4:14, t14:16) with help of FISH. Taking together the clinical features and cytogenetic abnormalities, we can design treatment in such a way to achieve better results in even those with very high risk myeloma. Acute leukemias: acute myeloid leukemia (AML) and acute lymphoblastic leukemia (ALL) are most aggressive and deadly of hematological malignancies. Both AML and ALL are heterogenous diseases and varied widely in prognosis depending on cytogenetic and molecular profile. So, there are AML which are classified as good risk or standard risk (examples- AML with t8:21, inv16, normal karyotype with NPM1 mutated without FLT3 mutation or AML with normal karyotype with CEBPA double mutated) while others as high risk AML (examples- AML with complex karyotype or monosomal karyotype, t v:11q, monosomy 7/-7q, monosomy 5/5q-, AML with FLT3-ITD etc). Similarly, prognosis of ALL too depends upon several clinical and cytological factors. There are patients with good risk ALL (example- young age, lower WBC counts at presentation, hyperdiploid karyotype) while others with high risk ALL (example- advancing age, higher WBC counts at initial presentation, cytogenetic/ molecular features like t9:22/ BCR-ABL or t4:11/AF4:MLL). Patients with high risk leukemias not only show resistance to chemotherapy but also have a higher probability of relapse early in the course. Patients with good/ standard risk leukemias are usually treated with chemotherapy alone while patients with higher risk leukemias are usually offered chemotherapy to achieve initial disease control and then Allogeneic bone marrow transplantation as a consolidative therapy to minimize risk of relapse. We can use targeted drugs along with chemotherapies in patients having specific molecular aberration. For example, patient of ALL with BCR-ABL fusion are high risk and are treated with chemotherapy along with targeted drug (Imatinib/ Dasatinib which targets BCR-ABL gene) and this way achieve deeper remissions and better outcome. Similarly, FLT3 mutation (FLT3 ITD) confer chemo resistance in AML and nowadays is treated with targeted drug (Midostaurin/ Sorafenib) along with chemotherapy to achieve better outcome.

Bone marrow/ hematopoietic stem cell transplantation (BMT): A BMT is recommended for patients having bone marrow failure syndrome or with high risk hematological malignancies at high risk of relapse. There have been immense progresses in field of BMT over past decades. Several notable advances are matched unrelated donor transplants, haplo-identical transplants, non-myeloablative and reduced intensity transplants. This way, most of patients in need of a BMT can be taken including those with advancing age or those not having a suitable HLA matched stem cell donor in family.

So in nutshell, we have come a long way to this era where we have sophisticated methods to dissect cytogenetic and molecular details of hematological malignancies, plan therapy as per risk stratification and use targeted therapies and bone marrow transplantation to get optimal outcome.

Dr. Narendra Agrawal
Sr. Consultant, Department of Hemato-Oncology

NEURO & SPINE ONCO UPDATE 2022

Over the last few years, new techniques have revolutionised the treatment of brain and spinal cord tumours achieving total tumor removal and preservation of functions.

To spread awareness about these new techniques, department of neurosurgery organised **Neuro & Spine Onco Update 2022** on Saturday, 12th March 2022 at Indraprastha Hall, RGCIRC, Rohini, Delhi.



Chosen experts from two of India's largest and dedicated Neuro-onco set-ups namely Tata Memorial and RGCIRC besides leading lights from major hospitals including AIIMS, GB Pant Hospital, RML hospital and Safdarjung Hospital delivered talks and shared their experiences. Leading private hospitals like BLK, Max, Apollo, Fortis, Medanta, Paras and Artemis etc were also a part of the faculty.

Awake craniotomy was done for brain tumor using neuronavigation, ultrasound and neurophysiology monitoring. The patient undergoing surgery remained active – talking, singing and moving limbs. During the surgery there was two way interaction between the surgeons and the delegates.

Experts also discussed radiation therapy including radiosurgery using Cyberknife which RGCIRC is getting this year.

Neuropathologists from different parts of the country provided an update on latest WHO classification of CNS tumours and its clinical applications.

RGCON 2022: FRONTIERS IN URO ONCOLOGY



RGCIRC organized the 20th Annual International Conference from 15th to 17th April 2022 at Hotel Crowne Plaza, Rohini, Delhi. The theme of this international conference was **Frontiers in Uro Oncology**.

As one-of-its-kind conclave of the medical fraternity, RGCON had faculty from all leading hospitals from India besides the startling presence of 15 faculties from International and National major cancer care centres around the world including Memorial Sloan Kettering Cancer Centre, USA and Singapore National Cancer Institute.

RGCON 2022 had overwhelming physical participation this year. More than 450 delegates participated in the conference. The scientific program included live workshops, lectures, and panel discussions / debates and was designed to include diagnostic as well as therapeutic vistas in Uro- Oncology.

The conference was inaugurated by Dr. Randeep Guleria, Director, AIIMS, Delhi, Mr. Rakesh Chopra, Chairman, RGCIRC, Delhi, Mr. D. S. Negi, CEO, RGCIRC, Delhi, Dr. Sudhir K. Rawal, Medical Director – RGCIRC, Rohini & Chief of Genito-Uro Oncology, RGCIRC, Delhi, Dr. Munish Gairola, Director - Radiation Oncology, RGCIRC, Delhi, Dr. Vineet Talwar, Director, Medical Oncology, RGCIRC, Delhi and Dr. Amitabh Singh, Consultant, Department of Genito-Uro Oncology, RGCIRC, Delhi.



This meeting included three orations which were The Dr. Raman Chadha oration was delivered by Dr. Mihir Desai from Los Angeles, Dr. K. K. Pandey oration was delivered by Dr. James A. Eastham from New York and Mr. K. K. Mehta oration delivered by Dr. Enrique Grande from Spain.

All the three departments of medical, surgical and radiation oncology at RGCIRC jointly held RGCON 2022. The teams were led by Dr. Sudhir K. Rawal, Dr. Vineet Talwar and Dr. Munish Gairola and their respected teams.

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EDITORIAL

hallmark of a master surgeon. Arrogance or seeming superiority should be abhorred. Communication and team working are necessary components of good leadership, a quality which is also part of the persona of the master surgeon, who is also likely to be a good teacher - avoiding humiliation of a student or trainee in front of others.

Knowledge has been handed to us, and we must pass it on. Taking time to

pass it on is the rent that we pay for the privilege of being here. You may be a technically very good surgeon; an excellent surgeon but try to be a great surgeon and a master teacher!!

Pahle Sajjan Bano, Phir Surgeon Bano!



Dr. A. K. Dewan

Director - Surgical Oncology

CME WITH INDIAN MEDICAL ASSOCIATION (IMA) SOUTH DELHI BRANCH



RGIRC organized a CME in association with IMA South Delhi Branch on Friday, 25th March 2022 at India Habitat Centre, Lodhi Road, New Delhi. Dr. Gauri Kapoor, Medical Director - RGIRC, Niti Bagh & Director - Pediatric Hematology & Oncology delivered a lecture on **Importance of General Practitioners in Early Diagnosis of Cancer in Children: Clinical Clues** and Dr. Manish Sharma, Consultant - Medical Oncology spoke on **Breast Cancer - An Overview**.

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