



# NewsLetter

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## EDITORIAL

### DOCTOR! WHEN DO YOU WANT TO RETIRE?

I have had a very successful, very satisfying and very busy academic career. I have been asked how long I would continue to practice. My answer is "As long as it's fun." "No tiring, no retiring. Age is not a number but a state of mind." What is the right time for a doctor to retire? This is an oft-asked question. In any job, corporate or otherwise, it is mandatory to retire at a certain age. I think the wisdom of that is that you have a certain level of mental and physical fitness to function well.

In India, neither the MCI nor the Govt. has put in place any process to monitor if ageing doctors and surgeons are able to perform intelligently and with due diligence. In fact the Medical Council of India (MCI) has recommended raising the retirement age for medical teachers to 70. With a growing physician shortage, it will be very tempting to keep these old warhorses in harness. And really, we need them. Every time a physician retires, we lose 30, 40, or 50 years experience.

The question then arises, when must a doctor retire? The obvious answer is, when his physical and mental faculties start failing. In India, there are no norms. I know many doctors who continue to practice into their 80s, and surgeons who continue to operate well into old age. Many take assistants to help and increase their expertise as well. Most doctors do not receive a pension, and find it difficult to retire and make their financial ends meet, unless they are among the lucky few who have amassed great wealth.

Rosenberg, an 89-year-old cancer specialist (USA) who had developed a cure for Hodgkin's Disease had said. "I am quite elderly, and I know what I know and I know what I don't know. It is very upsetting that they make it difficult for me to get my hospital privileges," He also said many younger physicians who were alcoholics or drug addicts were still allowed to function with their privileges intact.

Several factors have been identified that influence delay in retirement among physicians. These include flexibility of work hours, intensity of work hours, work satisfaction, other career opportunities (or lack thereof), resource adequacy, sense of intrinsic self-worth, convenience, financial incentives, relationships with coworkers, length of training and late entry into the workforce, attachment to work and related strong work identity, and the 4% rule. The 4% rule says that a person will need approximately 25 times his/her annual expenses in order to retire with a comfortable lifestyle over a 30-year period (anticipating that investments will yield 4% per year). For many physicians, it is difficult to save enough money to afford to retire comfortably using this equation; and the 4% rule can be affected adversely by substantial market downturns, and by longevity greater than 30 years. There also are factors that influence early retirement among physicians. They include work dissatisfaction, inflexibility, bureaucracy, electronic medical records, burnout, and desire for personal time. Gender is not a major factor. Then experience should be beneficial. However, when physicians start relying on impressions at the expense of comprehensive evaluation, then problems arise.

It is also helpful for organizations to offer retirement education and Organizations should avoid mandatory retirement ages. They are responsible for many challenges associated with retirement including patient care continuity, maintenance of deserved reputations for expertise. Other issues that figure into retirement timing include cognitive decline, physical decline, dexterity, frailty, and increased error rate. Experience can be an asset or a deterrent. If physicians remain thorough, diligent, and guidance, including access to financial advice. Organizations also are served well by creation of postretirement opportunities including peer support, teaching, mentoring, administration, and other nonclinical activities. This approach maintains access for younger physicians, patients, and administrators to the experience and wisdom of older physicians. energetic, and succession of physicians in the institution/hospital.

One of the big fears that people have is loss of identity. We spend our lives building up our professional identity. To a greater or lesser extent, it defines who we are and it can be difficult to walk away from. Many of us also have the feeling that we are the best and the world will stop if we stop, or that "my patients need me." The sad fact is that the vast majority of us are average and the number of people who are matchless and exceptional are very few. Even those few are not irreplaceable.

Whatever stated principles, most private institutions are coldly pragmatic about issue of retirement. The whole idea of mandatory retirement is simply a way of easing some older physician out while retaining others who still have value to the institution. Why retire the aged goose who is still laying golden eggs? Assessment of competence is flexible, after all. We are not regular humans. We are fortunate government/Pvt funded machines of empathy and altruism whose only purpose is to serve humankind in a masochistic grind until we die on our feet in service.

Like almost all doctors, I saved lives and alleviated suffering to the best of my ability. I knew every day I went to work has been an honour and privilege, but it has some expense. We are "only little human beings" doing our best. We have been tutored that medicine is a life of service, of sacrifice and of putting the needs of others before the needs of ourselves. But as is the case for any good scientific study, there needs to be an end point. We must be the one who choose that end point.

I want to live by the adage that it is better to be asked why you retired rather than being asked when are you going to retire.



**Dr. A. K. Dewan**  
Director - Surgical Oncology  
RGCIRC



## LOW DOSE, LOW COST IMMUNOTHERAPY IN HEAD AND NECK CANCERS

Head and neck cancers are very common in India due to frequent habit of chewing tobacco and betel quids. The outcome of advanced head and neck squamous cell carcinoma (HNSCC) is particularly poor and these patients are usually recommended expensive targeted therapies and immunotherapies which are standard of care in today's practice. Financial hardship caused by cancer care is far more common than we think. There is growing evidence of financial problems among people with cancer.

A study from tertiary cancer hospital from India has found that an ultra-low dose of the immunotherapy drug nivolumab in combination with metronomic therapy can more than double the number of patients still alive 1 year later. It is potentially more affordable because the dose used here is 6% of what is typically used as per guidelines which decreases the cost of therapy to 5% to 9% of the cost of full-dose immunotherapy regimens.

The results have larger implications: the potential to put the expensive immunotherapy drug within reach of many more people with different kind of cancer.

This phase 3 clinical trial which included 151 people with advanced and metastatic HNSCC either upfront or recurrent setting. The patients were randomised in 1:1 fashion to receive methotrexate, erlotinib and celecoxib with or without low-dose nivolumab. The dose of nivolumab in the immunotherapy group was 20 mg 3 weekly, instead of 240 mg which is the

typical dose used as per guidelines. 43% of patients in the immunotherapy group and 16% in the standard treatment group were still alive at 1 year. Median survival of patients in the immunotherapy group was 10 months, compared with 7 months for those in the standard treatment group. This is pretty remarkable as the magnitude of survival benefit has occurred with 6% of the FDA - approved dose of nivolumab. The overall response rate in immunotherapy group was 59% as against 45% in the standard treatment group.

Although the direct comparison of low dose and the full dose of nivolumab is not available but, the survival benefit of the low dose is similar to what's been seen in studies of the full dose.

This new study also raises the possibility that lower doses of other immunotherapeutic agents could be effective for HNSCC as well as other kinds of cancer. The same idea could even be applied to other kinds of cancer therapy. With lower doses and lower costs more patients could be benefited and many deaths prevented.

**Dr. Manish Sharma**

Consultant – Medical Oncology  
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## 8<sup>TH</sup> ACADEMIC LECTURE SERIES OF RGCIRC

RGCIRC organized a lecture on Wednesday, 18<sup>th</sup> January 2023 at Indraprastha Hall, RGCIRC, Rohini, Delhi. Dr. B. S. Ajaikumar, Radiation and Medical Oncologist, Doctorpreneur, Thought Leader, Philanthropist, Executive Chairman: Health Care Global Enterprises Ltd. delivered a lecture on Doctors as Entrepreneurs. The lecture was attended by more than 150 staff members of RGCIRC including Directors, Sr. Consultants, Consultants, Attending Consultants, Resident Doctors, Staff Nurses and other staff members.



## 9<sup>TH</sup> ACADEMIC LECTURE SERIES OF RGCIRC

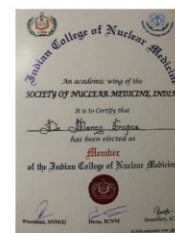


RGCIRC organized an academic lecture on Friday, 20<sup>th</sup> January 2023 at Indraprastha Hall, RGCIRC. Dr. Enrique Grande, Director – Medical Oncology, MD Anderson, Spain delivered a lecture on Role of Avelumab in GU Cancers: When, Where & Why? The lecture was attended by more than 120 staff members of RGCIRC including Directors, Sr. Consultants, Consultants, Attending Consultants and Resident Doctors.

## CONGRATULATIONS TO DR. MANOJ GUPTA



Dr. Manoj Gupta, Sr. Consultant, Nuclear Medicine Department has been elected as a Member of the Indian College of Nuclear Medicine (MICNM) during the convocation proceedings at the 54<sup>th</sup> Annual Meeting of the Society of Nuclear Medicine India (SNMICON'22), AIIMS, Delhi on 8<sup>th</sup> – 11<sup>th</sup> December 2022.





## INTRODUCTION—

Cancer of the cervix is one of the commonest causes of female cancer-related deaths among women all over the world. Most of them are treated with Surgery or Concomitant Chemoradiation, with a disease-free survival (DFS) in Federation of Gynecology and Obstetrics FIGO stage IIB-IV of 61-76 per cent, suggesting that many patients will present with recurrence

The recurrence rates of cervical cancer are 11% to 22% and 28% to 64% in (FIGO) stage IB-IIA and IIB-IVA disease, respectively. Despite intensive treatments, the prognosis of recurrent cervical cancer continues to be poor, with a 5-year overall survival rate less than 5%. The treatment for recurrent or metastatic diseases have conventionally been palliative, with chemotherapy.

However, there are mounting evidence that patients with few and small metastatic sites may benefit from local ablative procedures. In principle, local ablations impact local control and overall survival.

Local ablation directed treatment have already been established as standard-of-care in other primaries with oligometastatic disease (OMD), like colorectal and renal cell carcinomas and in lung carcinomas. These options have not commonly been considered for cancer cervix patients with OMDs

## RELOOK AT OLIGOMETASTASIS—

Recently, in order to standardize reporting, metastatic or recurrent diseases have been classified based on the number of lesions, sites of involvement. Those with limited number of metastasis (usually <3-5) and involvement have been classified as oligometastatic disease (OMD), and have been thought to have a better prognosis than those with more numbers of metastasis.

**ESTRO-EORTC** group has classified OMD considering the timing of presentation of metastases, receipt of any systemic therapy before appearance of lesion and response of metastases to the systemic therapy. Moreover, a coordinated effort (**ESTRO-ASTRO consensus**) is in the process to define this patient population better so that they may benefit from curative treatment measures.

## OLIGOMETASTATIC CARCINOMA CERVIX—

The decision making is challenging for cancer cervix patients who are oligometastatic de novo or oligo recurrent. Although de novo oligometastatic patients are being treated with various modalities like SBRT, and Surgery for the metastatic sites, followed by chemotherapy, no consensus exists among oncologists.

Dilemma exists regarding treatment directed for the metastatic sites, for the primary cervix alongside, the dose and fractionation of radiation, the sequencing and so on.

The incidence of picking up a metastasis at diagnosis ranges from five to eight per cent, the commonest sites being lung (21-39.3%), para-aortic lymph nodes (PALN) (11%), bone (16.3%), liver (12.2%), abdominal cavity (8%), brain (1.4%) and supraclavicular node (SCLN) (7%). Incidence of inguinal nodal metastasis at diagnosis is <2 per cent.

## Approach to Oligometastatic Cervix Carcinoma—Nodal, Visceral

## RADIOTHERAPY IN CERVICAL CANCER WITH OLIGO NODAL METASTASES

In a study by Kim HS, patients of carcinoma cervix, who had distant nodal

metastases at presentation, receiving Concomitant Chemoradiotherapy (CCRT) followed by Brachytherapy (BT) had better PFS and OS and complete response (CR) rates as compared to those receiving Chemotherapy alone.

In similar studies, patients of metastatic cancer cervix have also been treated with definitive RT to sites of OMD, including SCLN, mediastinum, lung and PALN, the median OS was 50.7 months and PFS was 21.7 months with <3 per cent grade  $\geq 3$  toxicity. However, there was no consensus in these studies about the RT dose to the OMD sites, RT fractionation if any to the pelvis, nor about the target volume that were included.

## RADIOTHERAPY IN CERVICAL CANCER WITH OLIGO VISCERAL METASTASES

Management of Carcinoma cervix patients with OMD in the viscera, evidences are sparse. The number of nodules, possibility of surgical resection (SR), time interval between the appearance of metastases and initial treatment and receipt of Chemotherapy do affect the outcomes. It has been suggested that the following conditions must be met before selecting a patient for curative treatment: the maximum number of five metastases should not be surpassed, and all of them must be safely treatable, whereas a controlled primary is optional.

In limited visceral metastases, resection or SBRT of metastases has traditionally been the treatment of choice with the majority of evidence comes from colorectal, lung, renal cancers showing excellent outcomes. But in spite of good LC in treated site, distant progression is a rule. Hence, combining systemic therapy with local treatment—Surgery or SBRT is justified. However, the sequencing of these therapies is important for adequate tumour control and survival.

In a study published in 2017 evaluating the role of SBRT in various OMD sites (lung, liver and nodes) in 45 patients, 9 out of them with cervix primaries, the CR was 64 per cent with no patients progressing after achieving CR at a median follow up of 40 months with no grade 3 or more acute or long-term toxicity.

## PELVIC RADIATION IN PATIENTS WITH DE NOVO METASTATIC DISEASE

The primary aim of delivering local treatment to the primary disease is to eradicate the local disease which could translate into clinical and survival benefits. Stenger *et al* studied 3169 patients of upfront metastatic cervical cancer treated with Chemotherapy alone versus Chemoradiation to the pelvis. Pelvic RT showed significant benefit in survival (23.2 vs. 10.1 months). Further, the median survival was longer in patients receiving RT and brachytherapy. European Society for Medical Oncology (ESMO), European Society of Gynaecological Oncology (ESGO) and European Society for Radiotherapy and Oncology (ESTRO) guidelines also recommend treating pelvis (gross disease) with elective irradiation of immediate nodal level) and Chemotherapy in localized metastatic disease.

## TRENDS OF PRACTICE WORLDWIDE

Results from a survey by the EMBRACE Research Study group showed that all the participants agreed on delivering local RT in OMD, with 68.2% of respondents recommending chemo-radiation and brachytherapy for the primary pelvic site, 31.8% considered additional systemic therapy. 77.3% centers recommended the use of stereotactic ablative radiation therapy to oligo-metastasis sites.

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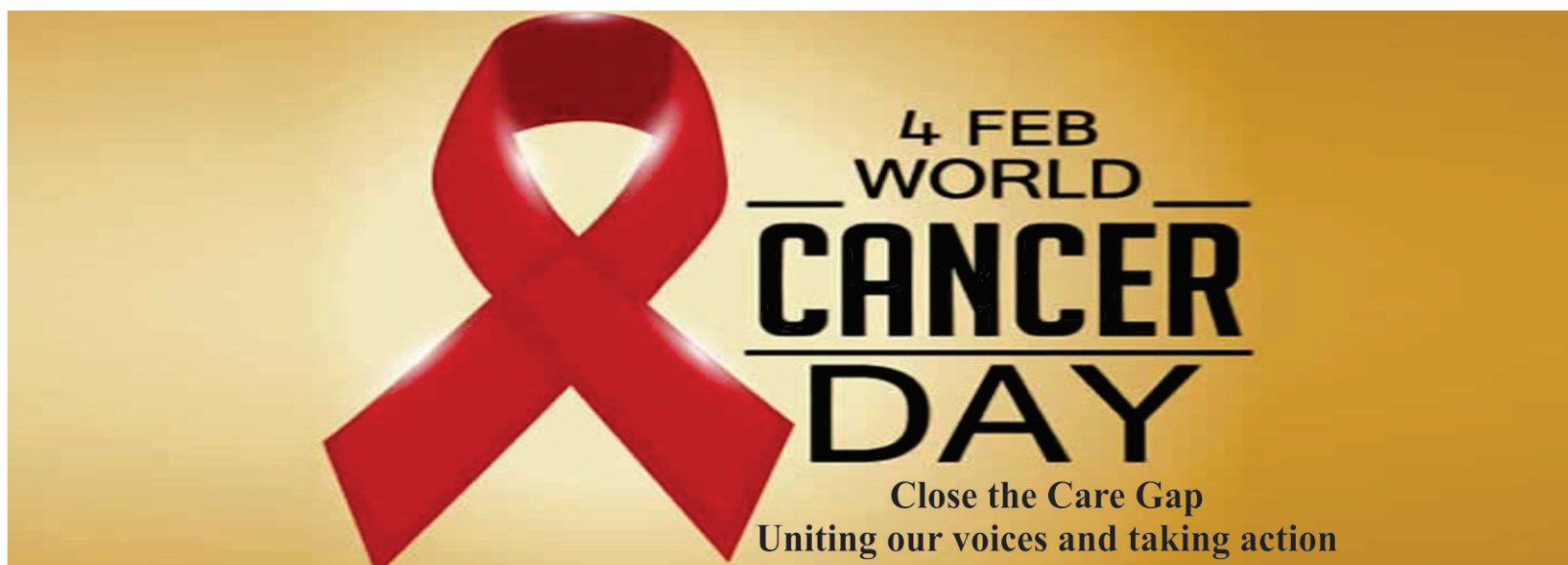
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**CONCLUSION :** Thus, although we have started agreeing that oligo metastatic carcinoma cervix patients need a more radical approach to treatment, there is no consensus about the modalities of the treatment to be offered and in what sequence and dose. Intense treatment with RT to the pelvis and the oligo metastatic sites, especially with SBRT, has shown promising outcomes with improved OS and PFS.

More research is needed to generate a treatment protocol for oligo metastatic de novo or oligo recurrent carcinoma cervix patients.

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