



Newsletter

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EDITORIAL

ARE YOU DEVELOPING BURN OUT SYNDROME?

Mrs Presha was my house surgeon when I was a resident in Dr. RML Hospital. She was very dedicated, hard working, liked by all seniors. Her dedication to patient care was inspired by her grandmother, who dealt with cancer while Presha was a college student. She felt that her patients must always come first. She made a personal connection with every patient. She wanted things to be perfect for her patients. Between her responsibilities as an oncologist and a young mother, she was on the run every minute and felt like she never had a moment for herself. She became Sr. Resident and then a faculty member. Not satisfied in Govt. job, she joined Pvt. Institution and worked harder. She became head of the Department where she was working. It was not unusual to see her in irritable mood, fighting with anaesthetists and her own colleagues; impatient, exasperated and burdened by work, every clinician experiences at some point.

Undeniably she was developing **burn out syndrome**. Burnout has been defined as a syndrome of emotional exhaustion, depersonalization, and a sense of low personal accomplishment that leads to decreased effectiveness at work. Burnout seems to occur mainly in professions involving an interaction with people, such as physicians, nurses, social workers, and teachers. Syndrome of burnout seems to develop in several stages. It starts with the **honeymoon** phase and is characterized by enthusiasm, after some time this becomes associated with experiencing the stresses of the job. This is followed by a **stage of stagnation** characterized by the onset of stress. Life becomes limited to work and taking care of business, while family, social life and personal priorities are neglected. Then a **stage of chronic stress** develops which leads to frustration. Individuals get the feeling of failure and a sense of powerlessness. This then leads to the **stage of apathy**, where despair and disillusionment occur. People do not see a way out of the situation and become resigned and indifferent. The **final stage is habitual burnout**.

Burn out happens when you avoid being human for too long.

Symptoms of burnout cause significant physical or emotional problems. Burnout seems to be associated with musculoskeletal diseases among women and with cardiovascular diseases among men. A recent landmark study of members of the American College of Surgeons revealed factors that were independently associated with increased burnout. These included having children younger than 21, purely incentive-based pay, having a spouse who works as a healthcare professional, as well as increasing nights on call, years in practice, and number of hours worked per week. Widespread implementation of electronic medical record (EMR) systems is also a major contributor to burnout. Another large study revealed that the increasing bureaucratic tasks associated with clinical practice and working and feeling "like a cog in a wheel," are significant causes of burnout. In addition, delivering bad news to patients can contribute to burnout among oncologists who feel inadequately trained in communication skills. Poor work-life balance is also associated with conflicts at home. Younger age and being an early career oncologist has consistently been associated with higher rates of burnout. Living alone and female oncologist have been identified as risk factors for burnout.

The onset of burnout can be insidious, thwarting early recognition, but it is not an irreversible event. Burned-out surgeons are more likely to ruminate on their mistakes, to assign a disproportionate amount of blame to

themselves. Burnout has also been very closely associated with low career satisfaction. The risk of alcohol misuse, suicidal ideation, and depressive symptoms significantly increase in surgeons. In addition, burnout is associated with multiple chronic health conditions, an increased risk of motor vehicle accidents, and lower physical quality of life.

Approaches to treating burnout syndrome should be guided by the severity of the symptoms. Measures such as changing life habits and optimizing work-life balance are strongly recommended. These measures concentrate on three important pillars: relief from stressors, recuperation via relaxation and sports, and "return to reality" in terms of abandoning the ideas of perfection. A first strategy focuses on *relationships*. It refers to an understanding of the importance of spending quality time with family and friends. A second element that seems to promote well-being in some people is religious belief and/or spiritual practice. A third element deals with work attitudes. This has two components. The first one refers to finding meaning and fulfilment in work, the second one to actively choosing and limiting the type of medical practice such as working part-time, being involved in education and/or research. A fourth strategy consists of self-care practices, in which an individual actively cultivates personal interests. Examples of such practices are exercise, self-expression activities, adequate nutrition and sleep, professional counseling, etc. Finally, the fifth component is adapting a specific life philosophy. This is developing a philosophical approach to life that is based on a positive outlook where one identifies own values and acts accordingly with emphasis on the balance between personal and professional life.

Self-care is how you take your power back.

What can the organization do for burnout syndrome amongst their doctors? The organization is responsible for having realistic workload/productivity expectations, providing an efficient practice environment, giving oncologists input into the decisions that affect their practice, providing opportunities for individual oncologists to focus at least some of their time on the aspects of work that are most personally meaningful e.g. teaching, clinical trials, quality improvement, or administration rather than treating them as homogenous "clinicians." The fact that the physician provides a personal cell phone number for patients to use for after working hours also implies an inefficient system or an unhealthy culture for the oncologists in the practice. Once the organization recognizes the importance of physician well-being to achieving its mission, it can begin to proactively address this challenge. Before initiating changes, organizations should consider anonymously assessing the prevalence of burnout and professional satisfaction among their physicians.

In nutshell, the syndrome of burnout affects physical, academic, and social performance at the same time. Burnout provokes aggressiveness, decrease in performance, quality, and competence in the job, Burnt-out employees do not want to help others. When the emotional resources are depleted, employees feel that they cannot give more of themselves. These negative aspects are related to emotional exhaustion. These harsh and callous perceptions can lead to a phenomenon where the helping staff thinks that the patient deserves the problems that he is having.

If you don't want to burn out, stop living like you are on fire. (Brene Brown)



Dr. A. K. Dewan

Director - Surgical Oncology RGCIRC

RECENT UPDATES IN MANAGEMENT OF CERVICAL CANCER

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.

The various risk factors for cervical cancer are low socio-economic status, oral contraceptive usage, cigarette smoking, early onset of sexual activity, multiple sexual partners, high risk sexual partner, early age at first birth, history of other sexually transmitted infections and immunosuppression.

Cervical cancer screening along with HPV vaccination are the two main strategies which can greatly reduce the incidence and mortality due to cervical cancer.

Prophylactic HPV vaccination should target women before initiation of sexual activity, focusing on girls aged 9-14 years.

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 IIIC has been added to the staging system

- IIIC- 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 IIIC
- IIIC1- Pelvic lymph node metastasis only
- IIIC2- 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, radio colloid 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 post-op 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.

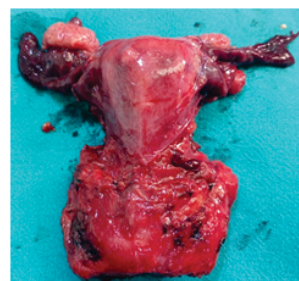
MANAGEMENT OF RECURRENT DISEASE

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.



Radical Hysterectomy Specimen

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.

Dr. Vandana Jain

Consultant – Gynae Oncology, RGCIRC, Delhi

CME – IMA DEHRADUN



RGCIRC organized a CME in association with IMA Dehradun on Saturday, 28th January 2023 at Hotel Madhuban, Dehradun, Uttarakhand. Dr. Sudhir K. Rawal, Medical Director, RGCIRC, Rohini & Chief of Genito-Uro Oncology Services, RGCIRC delivered a lecture on **Robotic Surgery: Past & Present and Future** and Dr. A. K. Dewan, Director – Surgical Oncology, RGCIRC spoke on **What is New in Oncology**.

16TH CHEMOPORT TRAINING PROGRAMME

Department of Surgical Oncology, RGCIRC successfully organized the 16th training course in Chemoport Insertion on 01st February – 02nd February 2023 at Indraprastha Hall, RGCIRC, Rohini, Delhi. This 2 days course was held for doctors from various oncology centres who desired to learn this technique. It entailed interactive session by the faculty of RGCIRC as well as hands on training in the operating rooms. The topics covered were Chemoport Insertion, Hickman's Catheter Insertion, Pediatric Port, Arm Port, Peritoneal Port Insertion and snaring of fractured Port catheter. The course was highly gratifying and we received an excellent feedback.

10TH ACADEMIC LECTURE SERIES OF RGCIRC

RGCIRC organized an academic lecture on Saturday, 04th February 2023 at Indraprastha Hall, RGCIRC. Dr. Ashok K. Hemal delivered a lecture on **Staff & Physician Burnout**. The lecture was attended by more than 120 staff members of RGCIRC including Directors, Sr. Consultants, Consultants, Attending Consultants, Resident Doctors, Staff Nurses, etc.



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CME – IMA JANAKPURI



CME Programme organized by RGCIRC in association with IMA Janakpuri on Saturday, 04th February 2023 at Hotel Radisson Blu, Paschim Vihar, Delhi. Dr. I. C. Premsagar, Sr. Consultant & Chief of Neuro & Spine Oncology Services, RGCIRC delivered a lecture on **Management of Headache** and Dr. Jaskaran Singh Sethi, Sr. Consultant & Chief of GI, HPB & Pediatric Radiation Oncology Services, RGCIRC spoke on **Radiotherapy – Energy at Work**.

11TH ACADEMIC LECTURE SERIES OF RGCIRC



RGCIRC organized a lecture on Wednesday, 08th February 2023 at Indraprastha Hall, RGCIRC, Rohini, Delhi. Dr. Vineet Talwar, Director – Medical Oncology, RGCIRC delivered welcome address & introduction. Dr. Lara Lipton, Medical Oncologist, Cabrini Health, Western Health, Melbourne, Australia spoke on **Newer advances and Role of Immunotherapy in Management of Advanced Biliary Tract Cancers**. The lecture was attended by more than 150 staff members of RGCIRC including Directors, Sr. Consultants, Consultants, Attending Consultants, Resident Doctors etc.

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