



# DCF NEWSLETTER

**DHARAMSHILA CANCER FOUNDATION AND RESEARCH CENTRE**

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Dear Friends,

Handling depressed cancer patients, who have lost all hope is a very daunting and challenging task. The treating team requires lot of grit, patience and positive energy. Above all the treating team also needs moments of ecstasy, joy and appreciation, to stay balanced and not get depressed. It was really a moment of ecstasy for all of us when we became first and the only cancer hospital of India accredited by NABH in November 2008. Getting a pat on the back for implementing quality and safety system is one thing and meeting hundreds of cancer survivors, treated by us, is another. We shared our moments of glory and joy with cancer survivors (5 – 14 years) on our 15<sup>th</sup> Anniversary day on 1<sup>st</sup> July 2009. Patients narrated their experiences and views on the hospital, its quality of services, continuous quality improvement and unstinting efforts of our staff and employees to provide personalized care with compassion. This pumped positive energy into all of us.

The next booster dose of energy came when we analyzed our data on source of referrals. Sixty percent of new patients (registrations) were referred by satisfied patients and their families / neighbours / friends and forty percent of our new patients were referred by Medical Professionals. That really is a bigger endorsement and a sense of achievement.

Our desire to diagnose the most common cancer of women (breast and cervix) at an early stage produced rich dividends. We started free screening of women above the age of 40 years and picked up 5 cases of breast cancer, 2 cases of cancer cervix, 2 cases of CA Cervix in situ, 10 high grade squamous intraepithelial lesions and 16 low grade squamous intraepithelial lesions. All of them have been treated successfully and thereafter advised regular follow ups.

I appeal to you to be instrumental in early detection to enhance cancer cure rates.

**Dr. S. Khanna**  
Executive Director

## SAVING LIVES BY TIMELY INTERVENTIONS

Sumit (name changed), a young boy of 21 years, diagnosed as a case of Acute Leukemia by a small nursing home was referred to one of the prestigious Tertiary Care Government Hospital of Delhi for further treatment. He became unconscious and developed left sided paralysis on 9<sup>th</sup> May 2009. CT Scan at the tertiary care hospital showed brain hemorrhage (Right Frontal Haematoma).

The family was advised to take the patient home, as nothing could be done to save Sumit. Family took him to couple of other private hospitals and finally brought him to Dharamshila Hospital and Research Centre (DHRC) on 9<sup>th</sup> May 2009 in the middle of night. At the time of admission, patient was in coma and could sluggishly move right side limbs in response to deep painful stimuli. He was decerebrating.

Within few hours of admission, Sumit developed respiratory distress and was put on the ventilator. The family was very keen, that no effort should be spared to save Sumit. The option of craniotomy and evacuation of haematoma was reviewed and prognosis explained to the family by the team of Medical Oncologist, Neurosurgeon and Anaesthesiologist of Dharamshila Hospital And Research Centre. Family was ready to take the risk and gave consent. Our team took the challenge and calculated risk. Right frontal craniotomy and evacuation of haematoma with duraplasty (under cover of single donor platelet transfusion) was performed by Dr. Pankaj Jha, Neurosurgeon, while Dr. Neha Agrawal, Anaesthesiologist took all extra precautions so that patient had peroperative and postoperative uneventful recovery.

Sumit responded very well. He became conscious and started responding to verbal commands. He was weaned off the ventilator after two days of assisted ventilation. Postoperatively, he started walking, talking and eating normally.

As per Dr. Parveen Kumar, Medical Oncologist, Sumit's bone marrow aspiration and flow cytometry reports were consistent with Acute Myeloid Leukemia (Blood Cancer). He was given chemotherapy albeit at a lower dose in view of the delicate clinical situation. His blood picture improved remarkably with above treatment and there were no blast cells in the peripheral smear after 20 days of starting chemotherapy. He was discharged on 1<sup>st</sup> June 2009 in a conscious, oriented state with no focal neurological deficit. CT scan of the head at the time of discharge is suggestive

of complete resolution of the haematoma with no midline shift, and leukemia is in complete remission. Moral of the story is not to give up, but accept challenges and act aggressively to save / add quality to precious lives.

Cancer cure rates can be improved, if the treating team is experienced, efficient and willing to take challenges. Cancer patients are usually written off without even giving them the chance of proper treatment. This is the major cause of high rates of cancer deaths.

**Dr. Praveen Bansal M.D., D.M.**  
*Consultant – Medical Oncology*

**Dr. Neha Agrawal MBBS, DA, DNB (Anaesthesia)**  
*Sr. Consultant & HOD – Anaesthesiology & Critical Care*

### NEAR-TOTAL LARYNGECTOMY: A VOICE CONSERVING OPTION FOR ADVANCED LARYNGEAL CANCER

Laryngeal cancer is the second common Head & Neck cancer in the United States, despite all the measures to curb, we in India also have high incidence because of habit of consumption of tobacco and Alcohol. The ultimate goal of every clinician treating laryngeal cancer is to remove the disease with the preservation of voice and swallowing. Early glottic and supraglottic cancers are treated by surgery or radiation therapy without affecting the phonatory function but this is difficult to achieve in larger transglottic lesions because the preferred surgical treatment for advanced laryngeal tumors remains total laryngectomy (TL), a surgical technique in which laryngeal speech is sacrificed. This is the reason majority of our Indian patients refuse treatment.

The other alternative is Radiation and chemotherapy, part of the so-called organ-sparing protocols, have also resulted in effective outcomes but 30-40% may require salvage surgery for recurrent disease and post radiotherapy conservative procedures cannot be performed because of poor healing resulting in high fistula rate and assessment of oncologically safe margins is not adequate. So these patients land up in Total Laryngectomy with high postoperative complications, so primary surgery with voice conservation is preferred modality of treatment. There is a report by Hoffmann et al that for supraglottic cancers survival is poorer with Concurrent chemo radiotherapy as compared to primary surgery followed by radiotherapy.

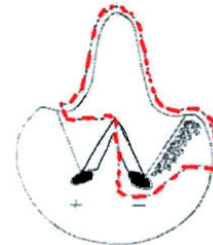
In 1980, Pearson and colleagues described an alternative to the standard TL in patients with stage T3 glottic cancers. Following pathologic examination of an excised larynx, they noted that in certain pathology specimens, the total larynx was often not involved in the disease process. As such, these researchers discovered that the uninvolved column of endolarynx could be preserved and converted into a sphincteric tube serving as a speech valve.

Studies have shown that near-total laryngectomy (NTL) in select T3 and T4 laryngeal tumors provides a high rate of disease control comparable with that of the total laryngectomy. The NTL spares non tumor involved larynx, which is subsequently used for reconstruction. A patient

who undergoes NTL speaks using an internal myomucosal shunt, which is lung powered. It does, however, require a tracheostomy for breathing.

Near-total laryngectomy (NTL) is indicated in patients with advanced (T3, T4) laryngeal cancers when the postcricoid and interarytenoid areas are free of disease and the contra lateral arytenoids is salvageable. The contraindications of this procedure are tumor in the interarytenoid, postcricoid region, and bilateral arytenoids.

**The area which is resected in NTL is outlined in the Figure 1**



A 54 years old male, also a chronic smoker, came to our hospital with the complaints of change in voice for last six months and irritation in throat while having food for 3 months. Flexible direct laryngoscopy (Fig.2) revealed ulceroproliferative lesion on the Right supraglottic area (Aryepiglottic fold + Epiglottis) with fixity of right vocal cord. Interarytenoid area and postcricoid area was free. Biopsy revealed moderately differentiated Squamous cell carcinoma. CT scan of neck revealed Right supraglottic mass with paraglottic extension with few lymph nodes at right level II, CXR did not have any evidence of disease. Clinically it was staged as T3N1M0. The patient was discussed in the tumor board and both options of surgery and chemo radiotherapy were given to the patient. Patient chose for surgery provided he can be rehabilitated for voice production. Patient was given option of NTL/TL+ Provox voice prosthesis insertion and taken up for surgery. Intraoperative frozen section was sent from interarytenoid area for involvement which was negative, so we proceeded with NTL and bilateral level II, III, IV neck dissection. Postoperative recovery was uneventful. He was started oral feed after 10 days, he had mild aspiration which settled in few days, his voice rehabilitation was started after 2 weeks. Final Histopathology revealed T3N2M0 Squamous cell carcinoma grade II, all margins were free. Patient is on adjuvant radiotherapy. To see him and listen to his voice kindly, log on to you tube video link i.e. <http://www.youtube.com/watch?v=2aKkbcOCfTo&NR=1>



Fig 2 Preop D Lscopy view of disease

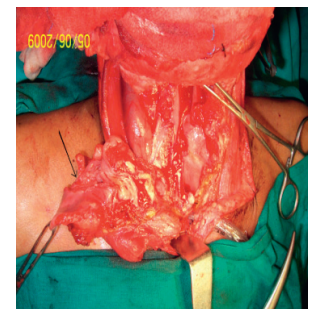


Fig 3 Preop D Lscopy view of disease

The Ultimate outcome should be oncologically safe resection margins, with good voice production for communication; this depends on in part on the surgeon's skill and the extent of resection and subsequent reconstruction.

**Dr. Mudit Agarwal**

MS (BHU), MRCS (Edinburgh),  
M.Ch. (Surgical Oncology), UICC Fellow  
Consultant Surgical Oncologist

## HPV VACCINATION AND CERVICAL CANCER PREVENTION

Cervical Cancer is responsible for more than any gynecologic-related deaths world wide than any other malady, making it the most important preventable disease in women's health today. Worldwide each year 4,93,243 women are diagnosed of cervical cancer of whom 2,40,000 women die of this disease (WHO). India contributes more than 1/4 of the global cervical cancer burden. Each year about 1,32,082 cases of cervical cancer are diagnosed and more than 74,118 women die of this disease, making cervical cancer the most common cancer of women in our country today.

Human Papilloma Virus (HPV) infection is now a well established cause of cervical cancer. Human papilloma virus is a double stranded DNA virus of papovaviride family. More than 100 types described; 30 infect ano genital tract. High risk types of 16, 18, 31, 33, 35, 45, 51, 52, 56, 58, 59 and 68 are associated with neoplasia. HPV 16 and 18 in 70% of cervical cancer cases world wide and 45 and 31 with a further 10% of cervical cancer case. Low risk types 6, 11, 42, 43, 44 associated with genital warts (condyloma) and do not cause cancer. Almost 100% cancer cases of cervix are associated with HPV, 90% cases of anal cancer, 40% cases each of vulva, vagina, penis and about 12% cases of oral cavity and pharynx are HPV related cancers.

Cervical Cancer ranks the first most frequent cancer among the women between 15-44 years. According to WHO/ICO information centre on HPV and cervical cancer, India has the population of 365.71 million women ages 15 years and older who are at risk of developing cervical cancer. About 6.6% of women in general population are estimated to harbor cervical infection at a given time and 76.7% of invasive cervical cancer in India are attributed to HPVs 16 & 18. Human papilloma virus spread primarily through sexual intercourse. Infection can occur in as little as one month after the first sexual contact.

Though HPV is a necessary cause of cervical cancer but is not a sufficient cause. Other Cofactors are necessary for progression from cervical HPV infection to cancer. High parity, tobacco smoking, longterm use of oral contraceptives and coinfection with HIV have been identified as established co-factors; co-infection with chlamydia trachomatis and herpes simplex virus type -2,

immunosuppression and certain dietary deficiencies are other probable co-factors.

With the knowledge of HPV (Oncogenic types) as the causative agent of cervical cancer, two types of vaccination strategies have been aimed at prophylactic vaccine is Virus Like Particle (VLP) L1 vaccine which prevents HPV infection before it occurs and therapeutic vaccine which eliminates existing HPV infection. Therapeutic vaccines are still under trial and are not available globally. The cervarix™ (GlaxoSmithkline) against HPV 16 and 18. The Gardasil® (MSD) against HPV types 16 and 18, 6 and 11 both these prophylactic vaccines are approved for use in India. Vaccines are effective against human papilloma virus 16 and 18 responsible for causing cervical cancer in about 70% of all cervical cancer cases but in phase II as well as in phase III trials these have also shown the additional protection against human papilloma virus types that cause more than 20% of all cervical cancer cases and these have demonstrated efficacy of more than 90%. The most effective time to vaccinate girls and young women is before they become sexually active. The vaccine is ideally administered before potential exposure to HPV through sexual contact. Centers for disease control and prevention's advisory committee on immunization practices (ACIP) recommended vaccination of young girls and adolescents between the age of 9 to 26 years. Emerging data suggest that the vaccine may be safe and effective in boys, young men and adult women upto the age of 27 – 45 years. Screening for HPV DNA or antibodies are not needed before vaccination. Women with abnormal pap tests or genital warts can be vaccinated. The need for the booster dose has not been established yet.

HPV vaccine is given in three doses at 0, (1), 2, and 6 months by intramuscular injection (0.5ml prefilled syringe) single dose. This requires the refrigeration at 2 – 8 °C. These are safe as there is no viral DNA in the vaccine and tolerable. The common side effects are injection site reactions, redness, swelling and soreness of mild to moderate severity. These are not recommended for pregnant women due to limited safety data.

Following HPV vaccination these women are required to undergo regular screening programme with PAP test as vaccine does not offer 100% protection, hence a need for counselling every woman undergoing primary prevention with HPV Vaccination.

Prophylactic HPV Vaccine offer effective primary prevention for cervical cancer and seems promising towards the reduction of the cervical cancer burden globally especially in developing countries.

**Dr. Rama Joshi**

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### Facilities Available

#### THERAPEUTIC

- Linear Accelerators with IMRT
- Microselectron HDR with TCS
- Three treatment Planning Systems(3D)
- Spiral C.T. Simulation
- Full range of routine and high risk surgeries
- Chemotherapy
- Blood and Blood Component Therapy
- Intensive Care
- Dialysis
- Rehabilitation
- Pain Relief and Supportive care
- 350 Beds

#### DIAGNOSTIC

- Whole-Body, High Speed, Dual Slice C.T. Scanner

- Nuclear Scans (Bone, Thyroid, Thallium and Others)
- Mammography
- Ultrasonography with Colour Doppler (with all probes)
- Echocardiography
- Conventional Radiology
- TMT, ECG, Spirometry
- Videoendoscopies (Full range)
- Cytology including FNAs & guided FNAs
- Histopathology with frozen
- Immunohistochemistry Tumors Markers
- All other Lab Investigation

#### EDUCATION AND RESEARCH

- DNB Programmes in Medical Oncology, Surgical Oncology and Radiation Oncology
- Diplomas for Technicians

- Scientific Conferences
- Continuous Medical Education Programmes
- Participation in International-National Research Projects including completion of gene therapy project.

#### PREVENTIVE AND SUPPORTIVE SERVICES

- Annual Health Checkups
- Cancer Screening Clinics
- Free Cancer Detection Camps
- Cancer Education (Public Lectures)
- Boarding and lodging facilities for outstation patients and attendants.
- Blood Bank