

DCF Newsletter

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Dear Friends

The civil society is feeling cheated and is showing its intolerance to corruption, scams, inefficiency and poor results. More and more people are standing against corruption. Medical fraternity also has to take a step forward and meet the challenge of winning the lost faith and trust of the community at large, by saying no to corruption and becoming patient centric.

Let us all work only for the benefit of our patients to our best capability and capacity. I am sure this Nishkam Karma will give all of us peace and bring us closer to – the Consciousness - PARAMATMA and will improve our efficiency and productivity.

Our passion and commitment to improve cancer cure rates and being focused on patient care is producing rich dividends.

On 1st July, we will be 17 years old and have gone through this beautiful journey by converting all the challenges into great opportunities. We are blessed to have the third generation world-class technology, excellent systems, dedicated manpower and thousands of smiling cancers survivors, who are our ambassadors to prove that cancer is curable.

Our VMAT technology is now fully functional.

We are starting Nursing Assistant Programme for home care provision in collaboration with IGNOU for our terminally ill patients.

Please visit our new website, watch the video on our updated facilities and give us your valuable feedback.

Looking forward to your valuable referrals.

Dr. S. Khanna
Executive Director

ARARE PRESENTATION OF HEREDITARY DIFFUSE GASTRIC CANCER MASQUERADING AS CANCER OF CERVIX

Unusual presentations of cancer are well recognized by oncologists world over and at DHRC we get to see a fair number of them. A 45 years old, Nepalese lady presented to the Gynae Oncology clinic of DHRC with complaints of bleeding per vagina, severe pain in the left lower limb and lumbo-sacral region for the last 6 weeks. She was carrying reports from one of the prestigious medical institutes of India, suggesting an adenocarcinoma of the cervix, FIGO clinical stage IIA. She had the following investigation reports.

- **USG (Abdomen and Pelvis)** Cervix replaced by 4-5 cm growth with a left adenexal mass and left parametrial thickening in its medial portion.
- **MRI (Abdomen and Pelvis)** 4-5 cm growth of cervix with a left adenexal mass.
- **CA 125** within normal limits (56 u/ml)
- **Guided FNAC of left adenexal mass-inconclusive for cancer.**
- **Punch biopsy of cervical** growth was reported as adenocarcinoma.
Since, there was a long waiting period and the lady was having severe bleeding p/v episodes, her son, a medical student in Bangladesh, brought her to our hospital for second opinion and further management. On her detailed clinical examination following findings were found -
- **Systemic examination showed a** 5 cm x 6 cm, irregular, hard lump with restricted mobility and suspicious of nature in the right breast. The left breast had features of fibroadenosis.
- **Per speculum, per vaginum and per rectal examination** revealed the cervix was replaced by a

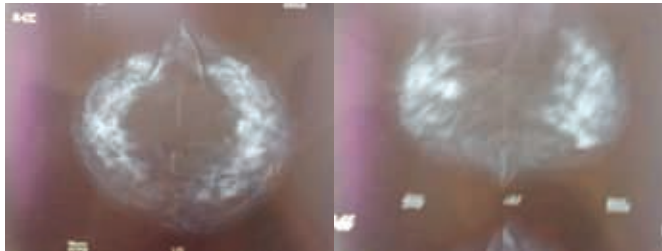
DHARAMSHILA HOSPITAL AND RESEARCH CENTRE

Dharamshila Marg, Vasundhara Enclave, Delhi - 110 096

4 cm x 5 cm growth involving all fornices and upper 1 cm of left vagina. A 3 cm hard irregular left adenexal mass was felt in the left fornix.

- Rest of clinical examination was unremarkable

Further investigation of the suspicious right breast lump, Since FNAC was reported as inconclusive for cancer and mammography showed highly suspicious findings with Bio-rad III/IV a trucut biopsy of the breast lump was done, this was reported as a metastatic carcinoma to the breast with no expression of estrogen or progesterone receptors (ER/PR negative). Probability of primary in the gastro intestinal tract was considered, PET-CT (whole body) was done, which showed a FDG avid lesions at multiple sites in stomach,

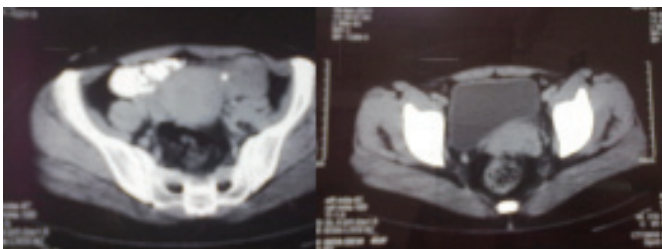


Mammography of right breast showing Bio-rad

ascending colon, left breast, cervix, lower uterus and left adenexa.

When reports were discussed with patient's relatives, they further reported that the patient's sister and brother had died of gastric carcinoma in past. They were counseled for genetic study of close family members.

After the final discussion in the Tumor Board at DHRC, with all investigation reports, it was decided



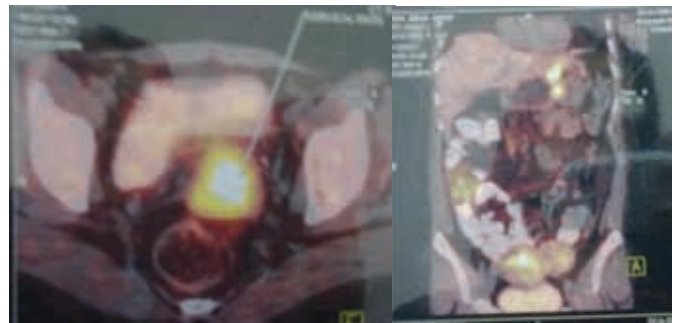
CT Scan of pelvis showing growth involving the lower uterine segment and cervix

CT Scan of Pelvis showing cervical lesion of 5 cms size with left medial parametrial stranding

that a palliative treatment plan, with haemostatic radiotherapy and palliative chemotherapy should be imparted rather than a Wertheim Hysterectomy as it was thought at provisional diagnosis of clinical stage IIA adenocarcinoma of cervix.

DISCUSSION

Metastases to the uterine cervix are rare. The commonest primary tumors metastasizing to cervix are primary endometrial carcinoma followed by breast. It is very rare to find a gastric carcinoma metastasizing to the cervix, with rarest of rare situation, where there is a strong suggestion that it has a distinct familial proclivity.



PET-CT Scan (Whole body) showed FDG avid lesion in stomach, ascending colon, lower uterine body cervix and left adenexa

Retrograde lymphatic spread is the probable mode of spread to the cervix from the stomach. Metastases to cervix are generally associated with Kruckenberg tumors of the ovaries, as presented in this case.

Cancer of cervix, is commonly a squamous cell carcinoma but recent trends show an increasing incidence of adenocarcinomas of the uterine cervix and currently 10-25 percent of primary uterine cervical malignancies.

If Patients with cervical carcinoma on histopathology are reported as adenocarcinomas, one can not over-emphasize the importance of a thorough clinical examination and supportive investigations, to rule out the presence of a primary tumor at a distant site. In the present case, this appraisal included thorough systemic examination, sonography, MRI of the abdomen, pelvis, X-ray chest, mammography, relevant tumor markers, FNAC, trucut biopsy from adenexal mass and breast lump and PET-CT.

The detailed family history of cancer in blood relatives was a pointer in this direction although genetic studies could not be done in this patient. It most likely is a case of Hereditary Diffuse Gastric Cancer (HDGCs), which represents 1 to 3 percent of all gastric cancers. About 53 percent of these are associated with CDH1 gene mutation. These familial cancers demonstrate autosomal dominant inheritance and a high penetrance. The 5-year survival is just 20%, if the diagnosis is made after the patient is symptomatic.

Conclusion - By careful examination, detailed investigations and planning, the inadvertent surgery could be avoided and correct prognostication was offered in this rare case of a Hereditary Diffuse Gastric Cancer with metastatic adenocarcinoma to the cervix. The importance of metastatic work up and thorough clinical examination and history can not be overemphasized in any cancer patient before definitive treatment planning.

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CLINICAL RADIATION ONCOLOGY TRAINING AT MANNHEIM MEDICAL CENTRE, GERMANY

Dharamshila Hospital And Research Centre has recently acquired a new Elekta Synergy Linear Accelerator capable of IMRT, IGRT, SRS, SRT and SBRT. The clinical and technical application training of this machine is usually scheduled at a teaching Hospital in Germany. I thus got the privilege to visit Mannheim Medical Centre, Germany for clinical training on Elekta Synergy.

Mannheim Medical Centre, Germany is affiliated to University of Heidelberg, Germany, the oldest university of Germany. The department of Radiation Oncology



at this hospital is equipped with CT simulator, 3 Linear Accelerators, intraoperative Brachytherapy for breast, head and neck and pelvic tumors and interstitial Brachytherapy with iodine seeds for prostate cancer.

I got a first hand experience of treatment planning with VMAT on Monaco planning system. It was enlightening to know the protocols and planning methodology being used at this centre. All the patients undergo CT simulation as a routine and are planned for radiotherapy with utmost care and compassion. Respiratory gating is used for tumors of lung, breast and chest wall.

The treatment is planned with Oncentra Masterplan, for 3D-conformal radiotherapy and with 5 different inverse treatment planning systems (Corvus, Oncentra

Masterplan and preciseplan exclusively for static IMRT, Ergo++ for VMAT treatments and Monaco for both static and VMAT treatments).

I saw IGRT being performed with stereotactic ultrasound and with X-ray volume imaging (Cone Beam CT, Elekta XVI on Elekta synergy).

Treatments were recorded with the MOSAIQ Electronic Medical Record (EMR) of the patient. MOSAIQ oncology PACS archives all critical data.

IMRT was used for the treatment of almost all patients of Head and neck, prostate and stomach. Tumor relapses near the spine were also treated with IMRT. IGRT protocols are strictly followed for all IMRT patients.

I also saw Extracranial frameless SRT performed with image guidance (IGRT). In addition, LDR brachytherapy for prostate cancer is also available.

The department actively collaborates with other departments within the framework of Comprehensive Cancer Centre. This was very similar to the tumor board meeting which we routinely conduct at our hospital wherein every new cancer patient's management plan collaboratively is arrived at after a joint meeting with Radiation, Medical and surgical oncologists together with oncopathologist and oncology imaging experts.

We at Dharamshila Hospital, have the same setup for Radiotherapy treatment and planning. In addition, we also have Nucletron HDR Brachytherapy facilities which are not there at Mannheim Medical Centre. It is indeed a pleasure to realize that we have the same world class technology which is available at most of the top institutes all over the world. We have been treating our patients with IMRT for the last 6 years and IGRT with VMAT is also now fully functional. That brings us at par with some of the best Radiotherapy departments across the globe. And we sincerely hope that the treatment outcome of our cancer patients will now also be at par with the best internationally accepted standards.

Dr. H. M. Agrawal

MD (Radiation Oncology)

Consultant - Department of Radiation Oncology

DCH UPDATE

PARTICIPATION AND ORGANIZATION OF CONTINUOUS MEDICAL EDUCATION PROGRAMMES AND SCREENING CAMPS

VENUE	DATE	TOPIC	SPEAKERS
Hotel Melrose Inn, Aligarh	11th June, 2011	Management of Post Menopausal Bleeding – Gynae Oncology Perspective	Dr. Kamlesh Mishra
		Role of Radiation in the Management of Cervical Cancer	Dr. H. M. Agrawal
Jaypee Siddhartha Hotel, Karol Bagh.	23rd July, 2011	Recent Trend and Advances in Radiation Oncology	Dr. H. M. Agrawal
		Early Diagnosis and Management of Lung Cancer	Dr. Meenu Walia
SCREENING CAMPS			
VENUE	DATE	NAME OF CAMP	DOCTORS
Rajul Nursing Home, Aligarh	11th June, 2011	Cervical Cancer Screening	Dr. Kamlesh Mishra, Dr. Sadhana
In-house Cancer Screening for Men and Women	5 days a week around the year	Screening of Women and Men above 40 years	Dr. H. M. Agrawal

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FACILITIES AVAILABLE

Oncology OPDs	
Medical Oncology	G.I. Oncology
Radiation Oncology	Neuro Oncology
Surgical Oncology	Tumour Board
Gynae Oncology	Pain Clinic
Uro Oncology	Psycho-Social Counseling

Cancer Screening

Specialities/Superspecialities/OPDs	
Cardiology	Internal Medicine
Dental	Nephrology & Urology
Dermatology	Neurology & Neuro Surgery
ENT	Ophthalmology
Endocrinology & Diabetology	Orthopaedics
Gynae and Obst.	Paediatrics & Paed. Surgery
Gastroenterology	Plastic Surgery
Gastro Intestinal Surgery	Psychiatry
General & Laparoscopic Surgery	Pulmonology

Physiotherapy & Occupational Therapy

Audiology & Speech Therapy

Health Checkup Packages

Radiodiagnosis and Imaging	
Gamma Camera for Nuclear Scans	
Digital Spiral CT Scanner	
Mammography	
Ultrasonography	
Digital Radiography	
CT and Ultrasound guided procedures	

Cardiopulmonary Lab	
ECGs, TMT, Pulmonary Function Tests (PFT), Holter Test, Echocardiography with Colour Doppler	

Lab Investigations	
Cytology	Tumour Markers
Histopathology	Haematology
Cytopathology	Biochemistry
Frozen Sections	Clinical Pathology
Immunohistochemistry	Microbiology
Cytochemistry	Serology

Radiation Oncology	
IGRT, IMRT, 3D Conformal Treatment	
Stereotactic Body Radiation Therapy (SBRT)	
Stereotactic Radio Surgery (SRS) and Stereotactic Radio Therapy (SRT)	
Volumetric Modulated Arc Therapy (VMAT)	

Remote After loading HDR Brachytherapy

Treatment Planning Systems	
(Eclipse, CMS Xio, Monaco, ERGO ++ Plato Sunrise)	

Surgical Oncology	
Neuro Oncology	
Head and Neck Oncology	
Breast Oncology	
Thoracic Oncology	
Gynae Oncology	
Musculo-skeletal Oncology	
Plastic, Cosmetic and Reconstructive Surgery	
G. I. Oncology	
Uro Oncology	

Seven Operation Theatres Complex

Endoscopy Suite

Post Op. Wards and Surgical ICU

Chemotherapy	
Normal & High Dose including Dose-intense & Dose-dense	
Infusional Multiple & Single Drug	
Bolus Chemotherapies	
Intra-arterial Chemotherapy	
Targeted Therapies	
Immunotherapy / Biological Therapies	
Hormonal Therapies	
Neutropenic Care	
Nutritional Therapy	
Palliative and Supportive Care	

Pharmacy

Blood Bank	
Packed Red Cells	Whole Blood
Single Donor Platelets	Fresh Frozen Plasma
Platelet Concentrate	Stem Cells

Wards	
Super Deluxe	Deluxe
Semi Deluxe	Single
Double	Semi Paying
Economy	Indigent

ICU (Medical & Surgical)

Academics	
DNB Programmes (Medical, Radiation & Surgery)	
Fellowship Programme for Head & Neck Oncology and Onco Pathology	
Post Basic Diploma for Nursing Oncology	
Diploma Courses for Technicians	
Outreach Programmes on Cancer Awareness, Education & Detection	
Continuous Medical Education	
Cancer Information Literature	

Research

Support Services	
Prayer Room, Peace Room	
Guest House	

Dietary Services	
Cafeteria, Kitchen, Dining Hall etc.	