Rajiv Gandhi Cancer Institute and Research Centre

NEWSLETTER

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EDITORIAL : CULTURAL PRACTICES AND CANCER

Cancer is a global health issue, affecting millions of people worldwide. While medical advancements have improved cancer diagnosis and treatment, cultural factors significantly influence cancer prevention, detection, and care. Cultural beliefs, values, and practices shape individuals' perceptions of cancer, affecting their willingness to seek medical attention, adhere to treatment, and engage in preventive behaviours.

Culture can impact the incidence of cancer in several ways:

1. Dietary habits: Cultural dietary preferences can influence cancer risk, e.g; high consumption of processed meat in Western culture increases colorectal cancer risk.

2. Lifestyle practices: Cultural lifestyle practices, such as physical activity levels or tobacco use, can affect cancer risk.

3. Health beliefs and practices: Cultural health beliefs can influence cancer screening and early detection, e.g; some cultures may view cancer as a taboo topic, leading to delayed diagnosis.

4. Environmental exposures: Cultural practices can influence exposure to environmental carcinogens, eg; indoor air pollution from cooking fuels in some cultures.

5. Genetic predisposition: cultural ancestry can affect genetic predisposition to certain cancers, e.g; BRCA mutation in Ashkenazi Jewish populations.

6. Access to healthcare: Cultural factors can influence access to healthcare services, including cancer screening and treatment.

7. Stigma and shame: Cultural stigma around cancer can affect disclosure, social support, and treatment adherence.

8. Traditional medicine: Cultural reliance on traditional medicine may delay or replace conventional cancer treatment.

9. Migration and acculturation : Changes in cultural practices and environmental exposure due to migration can affect cancer risk.

10. Socioeconomic factors : Cultural socioeconomic factors, such as education and occupation, can influence cancer risk and outcomes.

Understanding these cultural influences can help tailor cancer prevention and control strategies to specific populations, improving health outcomes and reducing disparities.

Culturally Sensitive Care.

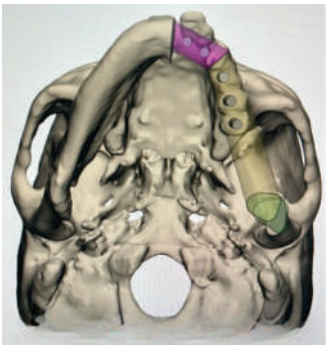
To address the cultural nuances in cancer care, healthcare providers must adopt culturally sensitive approaches. Healthcare providers should receive training on cultural differences and their impact on cancer care. Healthcare services should be accessible in patients' preferred languages. Healthcare providers should engage with diverse communities to promote cancer awareness and education. Care should be tailored to individual patients' cultural needs and preferences. Cultural values, cultural beliefs, social norms, faith/religion, sexual habits, and customs are the cultural factors affecting the self-care of cancer survivors.

Cultural needs are often overlooked in our modern healthcare system. Caring for children, elderly or the ill provide a deep sense of purpose and meaning to many. Yet, different cultures vary in how they approach caregiving in general, and can shape caregiving of those with cancer. As a caregiver of a cancer patient, it is important to recognize your own cultural roots and determine both what type of support you need and you can provide to your patients.

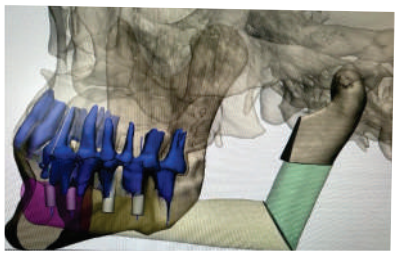
Healthcare professionals must advance beyond understanding cultural differences and the methods to overcome them to possess cultural humility. Cultural humility involves not only self-reflection about one's own background but also learning about the background of others paired with a willingness to acknowledge and honor the values, customs, and beliefs of other people. Healthcare requires healthcare professionals to have a willingness to learn from their patients and to adopt a more patient-centered approach to their care. Patient lives may depend on this willingness to learn from patients, especially for patients in need of cancer care. Patient of oral cancer may come with dysuria and may be having 2nd cancer in Prostate. The doctor should take time to listen carefully to the patient where a doctor's willingness to learn from the patient can make a real impact. Cultural beliefs are part of every patient's life and should be honoured in their journeys through care.

Dr. A.K. Dewan
Director-Surgical Oncology

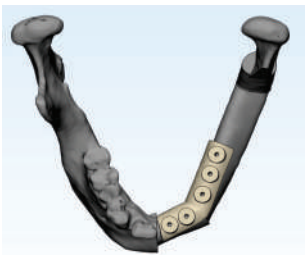
ADVANCEMENTS IN ORAL REHABILITATION: CAD-CAM FIBULA WITH PRIMARY DENTAL IMPLANTS



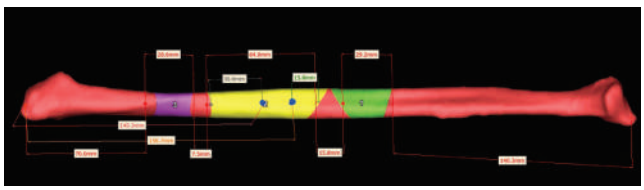
Squamous cell carcinoma (SCC) is a common type of head and neck cancer, originating in the squamous cells that line the mucosal surfaces of the oral cavity, pharynx and larynx. In recent advancements, reconstructive techniques such as CAD (COMPUTER AIDED DESIGN) –CAM (COMPUTER AIDED MANUFACTURING) assisted fibula flaps and primary dental implants have revolutionized in the field of oral rehabilitation.



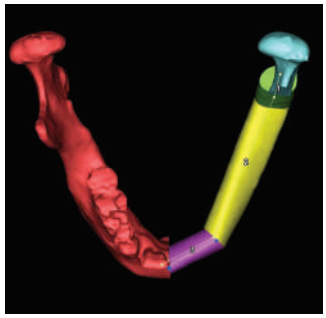
A 56 year old male patient presented in the surgical oncology department with the complaint of non-healing ulcer in the left lower alveolus. Initial assessment and biopsy showed squamous cell carcinoma moderately differentiated. The treatment involved a wide local excision (WLE) along with a left segmental mandibulectomy and left upper alveolectomy. Additionally, a left modified neck dissection (MND) type III was performed. Reconstruction was achieved using a CAD CAM assisted free fibula flap with the placement of primary dental implants.



Pre planning process begins with meticulous imaging, using CT scans to create 3 D models for virtual surgical planning. The extent of the mandibular resection and the design of the fibula graft and osteotomies were carefully mapped out. Another aspect of this planning phase is determining the optimal positions for the dental implants such as angulation, depth and the future prosthetic requirements within the fibula graft. This ensures that the dental implants will provide support for the prosthetic teeth leading to improved functionality and patient satisfaction.



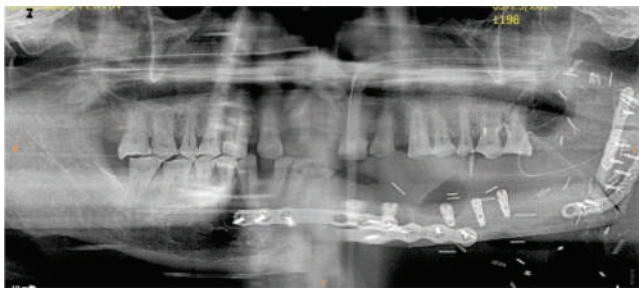
During surgery the resection was performed using the pre designed guides. The fibula was harvested and segmented according to the plan and extra orally five primary dental implants of size 4*10mm were placed within the fibular bone. This is the important phase to ensure the correct positioning and angulation of the implants.



The fibula segments with the dental implants were then placed to the surgical site and secured in place. A skin paddle was included for soft tissue reconstruction with meticulous planning to ensure adequate blood supply. The reconstruction was stimulated to ensure the fibula segments fit correctly and the fixation method was planned to provide stability.

The integration of CAD CAM technology with fibula flap and dental implants represents a significant advancement in reconstructive surgery. This approach enhances precision leading to improved functional and aesthetics outcomes for patients undergoing mandibular reconstruction.

Our newly established in house 3-D printing lab is a significant advancement which will substantially reduce the time and enhance the precision to provide customized treatment to the patients.



Dr Puneet Ahuja / Dr Sheetal Bhalla
(Department of Dental Surgery)
Dr Mudit Agarwal / Dr Abhishek Singh / Dr Shreya Rai
(Surgical Oncology Department)
Dr Rajan Arora / Dr Kripa Shankar / Dr Anchit
(Plastic & Reconstructive Surgery)

SECONDARY CYTOREDUCTIVE SURGERY IN RECURRENT OVARIAN CANCER: HOPE OR HYPE?

Ovarian cancer is one of the most lethal gynecologic malignancies, with most cases being diagnosed at an advanced stage and leading to a poor prognosis. While many women achieve a complete response to frontline therapy combining surgery and platinum-based chemotherapy, up to 80% of these patients will experience recurrence. The volume of residual disease post-surgery is a significant prognostic factor for both Progression Free Survival (PFS) and Overall Survival (OS). The rationale behind combining surgery and chemotherapy is that reducing tumor bulk lowers the risk of chemotherapy resistance by reducing tumor mutation potential and improving the delivery of antineoplastic agents and immunologic response to residual cancer cells.

Recurrent Ovarian Cancer (ROC) is generally considered incurable due to progressive resistance to chemotherapy. Still, the standard treatment for ROC is chemotherapy. In platinum-sensitive cases, while objective response rates are relatively high, complete response rates are lower. Secondary Cyto-Reductive Surgery (SCRS) aims to enhance disease control by potentially increasing PFS and OS, but it involves risks and may delay the initiation of standard chemotherapy. Despite extensive experience with secondary cytoreductive surgery (SCRS), evidence supporting its survival benefit has been mixed, leading to controversy over patient selection. Effective patient selection is crucial for balancing these risks and benefits.

Factors such as platinum sensitivity, disease-free interval (DFI), number of recurrence sites, and optimal cytoreduction are significant for predicting survival benefit. AGO Score developed by AGO-OVAR, assesses the likelihood of achieving complete gross resection (CGR) based on ECOG performance status, previous complete resection, and ascites presence. Validation studies have shown mixed results, with some patients achieving CGR despite negative AGO scores. Another scoring model, iMODEL created by Tian et al., uses a linear regression of six factors to predict CGR, with validation showing good sensitivity and moderate specificity. It incorporates FIGO stage, residual disease after primary cytoreduction, DFI, ECOG status, CA125 levels, and ascites presence, and a score of 4.7 or lower is considered favorable.

Various randomised studies have evaluated and reported the efficacy of SCRS in ROC.

1. GOG-0213: This multicenter trial evaluated the addition of bevacizumab to chemotherapy and the impact of SCRS. While SCRS did not show significant OS benefit compared to chemotherapy alone, achieving CGR did improve survival compared to residual disease.

2. SOC-1: Conducted in China, this trial compared SCRS followed by chemotherapy to chemotherapy alone, using the iMODEL score and PET imaging for patient selection. Interim analysis showed a PFS benefit for the SCRS group, but OS data is not yet mature.

3. DESKTOP III: A European trial that demonstrated a significant OS and PFS benefit for adding SCRS when compared to chemotherapy alone. This trial validated the AGO score and highlighted the critical role of achieving CGR.

A pooled analysis of these trials has revealed a significant improvement in both OS and PFS for SCRS compared to palliative chemotherapy alone. The analysis emphasized the importance of achieving CGR, as failure to do so was associated with poorer outcomes.

Future research should focus on refining patient selection models to better predict which patients will benefit from SCRS, potentially incorporating more detailed molecular and genetic profiling. The role of maintenance therapies, such as PARP inhibitors and bevacizumab, should be more thoroughly examined in conjunction with SCRS to determine their impact on OS and PFS. Continued follow-up and analysis of long-term outcomes from recent trials will be essential to fully understand the impact of SCRS on overall survival and quality of life.

In summary, while SCRS shows promise in improving outcomes for certain patients with ROC, the mixed results of recent trials highlight the need for careful patient selection and further research to optimize treatment strategies.

Dr Shubham Jain
Senior Consultant, Department of Surgical Oncology
RGCIRC Niti Bagh

CME ON ONCOLOGY IN ASSOCIATION WITH DOCTORS OF LUDHIANA, PUNJAB

RGCIRC organized a CME on Oncology in association with Doctors of Ludhiana, Punjab on Friday, 09th August 2024 at IMA House, Defence Colony, Bhai Randhir Singh Nagar, Ludhiana, Punjab. Dr. Jaskaran Singh Sethi, Sr. Consultant & Chief of GI, HPB & Pediatric Radiation Oncology Services, RGCIRC delivered a lecture on **Cybercide – Precision Beyond the Scalpel** and Dr. K. M. M. Vishvak Chanthar, Chief of Breast Surgical Oncology, RGCIRC spoke on **Breast Cancer Awareness and Early Detection: Key to Conquering Breast Cancer**.

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CME ON ONCOLOGY IN ASSOCIATION WITH DOCTORS OF HALDWANI, UTTARAKHAND

RGCIRC organized a CME on Oncology in association with Doctors of Haldwani, Uttarakhand on Saturday, 10th August 2024 at Fortune Walkway Mall, Nainital Road, Haldwani, Uttarakhand. Dr. Mudit Agarwal, Unit Head & Sr. Consultant, Head & Neck Oncology, RGCIRC delivered a lecture on **Robotic Surgery in Head & Neck Oncology** and Dr. Kundan Singh Chufal, Sr. Consultant & Unit Head, Radiation Oncology, RGCIRC spoke on **Recent Advances in Radiation Oncology: from Cure to Quality Life**.

110TH FOUNDATION DAY OF DELHI MEDICAL ASSOCIATION (DMA)

RGCIRC participated in 110th Foundation Day of Delhi Medical Association (DMA) on Sunday, 11th August 2024 at DMA House, Daryaganj, New Delhi. Dr Amitabh Singh, Sr. Consultant, GenitoUro - Oncology Services delivered a lecture on **Robotic Surgery in Uro Oncology**. The lecture was very well appreciated by the gathering.

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