

# RAY *of* HOPE

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**Dr. BS Ajaikumar | Chairman & CEO | HCG Group**

Greetings from HCG!

It gives me great pleasure to take our readers through few of the case studies that showcase the fact that right expertise in alliance with state-of-the-art technology, can achieve desired outcomes and quality of life for our patients.

As a leader in healthcare, we would like to reiterate, that it is our duty to educate, inform the patient about the disease, and explain to them with patience, using the appropriate terminologies. The aim should be to make them aware of the treatment and the outcome in order to eliminate the fear.

At HCG, we take efforts to delve into complicated cases and deliver quality treatment. While we may not cure diseases all the time, we have made it possible to survive by adding more life to years. In due process, we are proud to achieve a better lifestyle for our patients.

Until next time, I wish you good health!

## CONTENTS

**PAGE NO. 3**  
ROBOTIC BLADDER REPLACEMENT  
SURGERY FOR BLADDER CANCER

**PAGE NO. 4**  
CARING FOR PATIENTS WITH METASTATIC  
CANCER IN AN ERA OF PERSONALIZED  
MEDICINE

**PAGE NO. 8**  
PHYRIGIAN CAP GALLBLADDER – MYRIAD OF SYMPTOMS  
WITH FINAL DIAGNOSIS OF ADENOCARCINOMA OF  
GALLBLADDER PHYRIGIAN CAP

**PAGE NO. 10**  
LATEST TREATMENT FOR UNUSUAL  
GASTROENTEROLOGY DISEASE IN A  
SURGICAL UNFIT PATIENT



# ROBOTIC BLADDER REPLACEMENT SURGERY FOR BLADDER CANCER

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The standard treatment for invasive and recurrent noninvasive bladder cancer is surgery in the form of radical cystectomy. This involves removal of the urinary bladder along with Prostate and Seminal Vesicles in men and the uterus with an anterior vaginal wall in women. Pelvic lymph nodes are also removed as a part of the surgery. After bladder removal, the urine has to be diverted. This can be usually done in three ways: one is by the formation of an ileal conduit where a 15 to 20cm segment of small intestine is isolated into which both ureters are implanted and the distal end is brought to the exterior in the right iliac fossa as a stoma. The patient has to wear a stoma bag throughout his/her life. While this is a common and quick method of diversion, the disadvantages include poor body image, stoma problems like odour, leakage, herniation etc and problems related to wearing and changing appliances. Another form of diversion is the rectal diversion called a Mainz-II pouch which involves implanting the ureters into the rectal pouch in continuity. In this method of diversion, the urine and faecal contents are mixed and passed through the anus together. This often leads to recurrent urinary infections and kidney function damage over time. Hence this diversion is no longer recommended routinely.

The most physiological form of urinary diversion is a neobladder, where a new bladder is formed out of the small intestine and anastomosed to the urethra. The patient passes urine normally through the urethra. This is a unique surgery, as in no other surgery of the body one organ is used to form another organ.

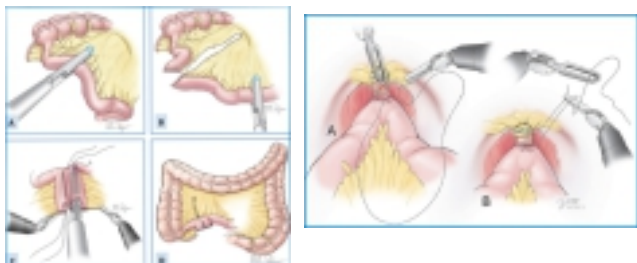
Radical cystectomy with urinary diversion is a supra major surgery and traditionally done by open surgery involving a large incision from umbilicus to symphysis. However, in recent years, cystectomy and neobladder have been increasingly performed by using robotic

technology. In the last decade, the usage of robotic cystectomy has increased ten times across most centres in the world.

Robotic cystectomy involves 5 to 6 8mm ports in the abdomen through which robotic instruments are introduced for surgery. Apart from the general benefits of the robotic surgery like less blood loss, smaller incision, less pain, early recovery and reduced hospitalization, there are certain important specific advantages of the robotic approach in radical cystectomy and neobladder surgery. These include:

- Reduced incidence of ureteric stricture
- Reduced postoperative electrolyte & fluid disturbances
- Reduced incidence of ileus and early time to resume diet
- Reduced wound complications like incisional hernia
- Early administration of post operative chemotherapy if needed.

In the coming years, the use of robotics is going to increase in the surgery of radical cystectomy and neobladder; making it less complex and more beneficial to the patients.





# CARING FOR PATIENTS WITH METASTATIC CANCER IN AN ERA OF PERSONALIZED MEDICINE

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As per The Indian Council of Medical Research (ICMR) in 2016 the total number of new cancer cases is expected to be around 14.5 lakh and the figure is likely to reach nearly 17.3 lakh new cases in 2020. Over 7.36 lakh people are expected to succumb to the disease in 2016 while the figure is estimated to shoot up to 8.8 lakh by 2020. Data also revealed that only 12.5 per cent of patients come for treatment in early stages of the disease.

For a country like ours, where a vast majority of newly diagnosed cancer patients are in the advanced stage of disease, it seems imperative that a clear understanding of the intent of therapy and goals of care are defined.



In the year 2017, therapy for advanced cancer not only includes chemotherapy but also a wide spectrum of options including hormone therapy, targeted therapy (monoclonal antibodies, small molecule inhibitors) and immunotherapy. For the purpose of this article the latter two newer therapies will be included under the umbrella of chemotherapy.

Although these therapies are commonly categorized as being either curative or palliative, these terms no longer fully reflect their intended uses. With the influx of newer therapies, the benefit to the patient has increased in terms of quality of life and overall survival. Hence when we speak of palliative therapy, there is a

new school of thought of adding the term life extending therapies.

## 1. Curative chemotherapy

Curative chemotherapy is chemotherapy administered with the goal of achieving a complete remission and preventing the recurrence of cancer. In the case of newly diagnosed Hodgkin lymphoma, Non Hodgkin lymphoma, testicular cancer, and acute lymphocytic leukaemia, the term curative chemotherapy accurately reflects the expected outcome, that is, cure, and the reason for its utilization. Chemotherapy in advanced stages can be treated with a curative intent in certain disease states as mentioned above.

## 2. Palliative chemotherapy

Palliative chemotherapy is defined as chemotherapy that is given in the non-curative setting to optimize symptom control, improve quality of life and, ideally, to improve survival.

Palliative chemotherapy was first mentioned in the 1950s accompanying the first use of cytotoxic chemotherapy. By the early to mid-1960s, the use of palliative chemotherapy for solid tumours became routine. In those days, the term “palliative” was indeed focused on the reduction of pain and symptoms. There may have been a concomitant increase in survival, but in most cases this was relatively rare. Five decades later, the oncologist’s armamentarium is broader and, in many settings, patient outcomes have improved dramatically. This has led to the recommendation of adding a third terminology - Life extending therapies.

## 3. Life extending chemotherapy

For many metastatic tumours, even if incurable, survival with chemotherapy is now well over a year

and frequently much more. Colorectal cancer survival often exceeds 24 months with 10% of patients surviving more than five years. Breast and prostate cancer patients with metastatic disease also survive years. Life-extending therapy then refers to therapy whose primary intent is to extend a patient's life for a meaningful length of time. The real challenge is then to determine in each case what constitutes "meaningfully" enhanced survival. For example, if a patient were given chemotherapy to live long enough (in the order of several months or even years) to witness the birth of a grandchild, or marriage/graduation of their children rather than to palliate symptoms, it should be called life-extending chemotherapy.



## Terminology for modern therapy and their intent

### 1. Curative chemotherapy

**Intent:** Intent is cure; cure implies patient survival will not be restricted by his/her current cancer diagnosis, includes adjuvant therapy.

**Examples :** BEP for testicular cancer; ABVD for Hodgkin lymphoma; Adjuvant therapy for localized breast cancer.

### 2. Palliative therapy

**Intent:** Intent is not to cure; expectation is this treatment will improve patient quality of life regardless of other outcomes (e.g., survival benefit)

**Examples :** Second-line chemotherapy after FOLFIRINOX for advanced pancreatic cancer  
Chemotherapy for advanced bladder cancer.

### 3. Life-extending chemotherapy

**Intent:** Intent is to extend survival but not long enough to meet definition of cure for patient with the tumor that is being treated; survival may still be restricted by

his/her current cancer diagnosis.

**Examples :** FOLFOX+ bevacizumab for metastatic colon cancer; First- to third-line therapy for metastatic breast cancer  
Small molecular inhibitors for EGFR/ ALK positive metastatic lung cancer.

**Abbreviations:** ABVD, doxorubicin/ bleomycin/ vinblastine/dacarbazine; BEP, bleomycin/ etoposide/ cisplatin; FOLFIRINOX, leucovorin/5-fluorouracil/ irinotecan/oxaliplatin; FOLFOX, leucovorin/5-fluorouracil/oxaliplatin.

Patients face difficult decisions about chemotherapy near the end of life or in advance stages of diagnosis. Patients, palliative care providers and oncology clinicians should be logical partners in caring for patients with serious cancers for which symptom control, medically appropriate goal setting, and communication are paramount.

Chemotherapy and even modern therapies have their own side effects, albeit much more manageable and less toxic than before. One of the beauties of old time medicine was that decisions were much simpler because there was not much to choose from. You either took the most aggressive treatment available or you did not opt for any therapy. But now, there is a discussion regarding intent of treatment, which therapy to use first, how to sequence therapies, how to match your treatment recommendations with the patient's priorities, which can be exhausting for the treating oncologist as well as the patient. It is also important to know when to stop.

In conclusion, communication with the patient and family, and clearing goals of care early in the treatment process is of utmost importance. In this era of personalized medicine, treatment is patient driven and not disease driven.

# HER VICTORY RALLY

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## HCG CANCER CENTRE ORGANIZED BIKE RALLY TO SPREAD CANCER AWARENESS

“World Cancer Day” is celebrated every year on the 4th Feb to raise cancer awareness. To support this special day, HCG Cancer Centre, Ahmedabad organized a “Bike Rally” event on the 3rd Feb, Sunday. Our Chief Guest DCP -Zone II Ahmedabad, Ms. Panna N Momaya & Dr. Bharat Gadhavi, Regional Director of HCG Group flagged off the mass awareness rally from HCG Cancer Centre.

Around 100 people participated in this rally including cancer survivors, supporters, doctors, and hospital staffs along with bikers group from ahmedabad.



## #21DaysChallenge

To celebrate World Cancer Day, HCG Cancer Center took a special initiative to create awareness. The team placed “Healthy Galla” (Pan Parlour like setup) at corporates. This program was designed to inspire people to quit tobacco. Also to encourage people to join Tobacco Cessation Clinic who are willing to quit tobacco.



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# PHYRIGIAN CAP GALLBLADDER – MYRIAD OF SYMPTOMS WITH FINAL DIAGNOSIS OF ADENOCARCINOMA OF GALLBLADDER PHYRIGIAN CAP

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Adenomyomatosis (ADM) of the gallbladder (GB) is a relatively common disease with an incidence of 2-5% among specimens obtained from patients at cholecystectomy (1). It is pathologically defined as an epithelial proliferation and hypertrophy of the GB muscularis with an outpouching of the mucosa into the thickened muscular layer (Rokitansky-Aschoff sinus). However, in recent years, patients with ADM and gallbladder cancer have been reported (2). Here we report such a case where the patient presented with myriad of symptoms.

## Case Report

A 65 year old female with no co morbidities presented with severe abdominal pain and on investigations diagnosed with Gallstone Pancreatitis with high serum amylase. Ultrasonography finding was also suggestive of some Gallbladder deformity and so Magnetic Resonance imaging with Computerised tomography was done. Findings were suggestive of Phyrigian Cap thickening with multiple Gallbladder calculi. Initially management was conservative and after 4 weeks of resolution of pancreatitis, surgery was planned.

Plan was Laparoscopic Cholecystectomy with frozen section. The specimen was retrieved in a specialised Endo bag without any spillage.

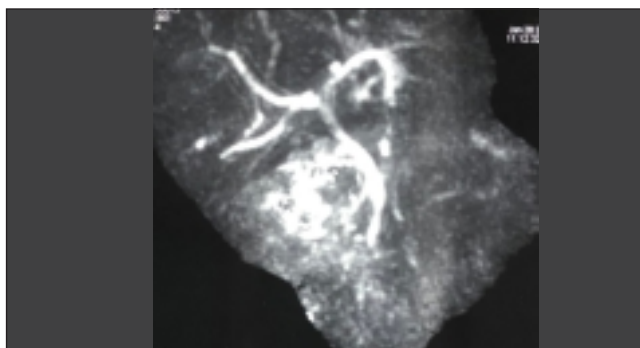


Fig 1 MR Findings s/o Phyrigian Cap Gallbladder

Frozen section revealed Adenocarcinoma of the Gallbladder. Intra operatively decision was done to do Extended Cholecystectomy.

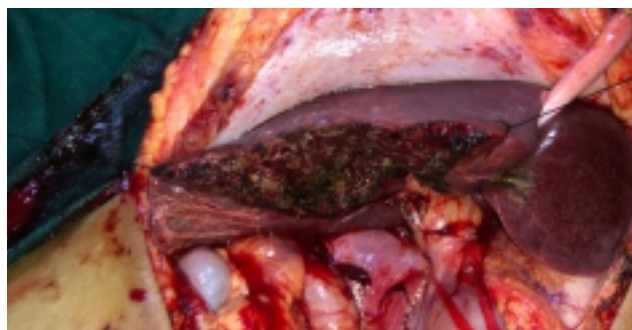


Figure 2 is the specimen after Laparoscopic Cholecystectomy



Figure 3 shows the cut section image of the Gallbladder.

Extended Cholecystectomy is the radical resection of Gallbladder along with hepatectomy ( wedge resection ) with regional lymphadenectomy.(Figure 4)



Final Histopathology revealed Adenocarcinoma Gallbladder with regional lymphnode Hepatoduodenal free of tumour.

Stage pT3N0

Patient was discharged on 4th Post operative day and further treatment in the form of Adjuvant Chemotherapy is planned.

### Discussion

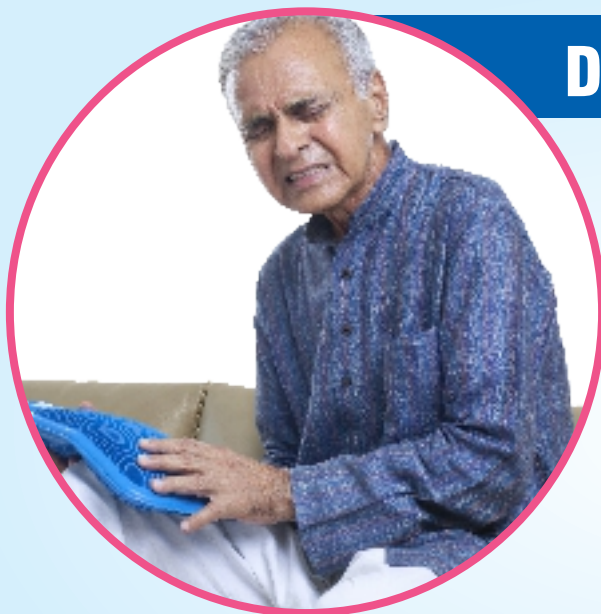
Gallbladder cancer (GBC) is an uncommon disease in the majority of the world despite being the most common and aggressive malignancy of the biliary tree. A Phrygian cap is a congenital anomaly of the gallbladder with an incidence of 4%(3). It can simulate a mass in the liver during hepatobiliary imaging and is sometimes mistaken for pathology. A Phrygian cap, however, has no pathological significance and normally causes no symptoms. A case presented here suggests a Phrygian cap mass, found by imaging and later cured by surgery. The importance is the proper line of treatment with multidisciplinary approach giving patient the utmost benefit.

Early diagnosis is essential for improved prognosis; however, indolent and nonspecific clinical presentations with a paucity of pathognomonic /predictive radiological features often preclude

accurate identification of GBC at an early stage. As such, GBC remains a highly lethal disease, with only 10% of all patients presenting at a stage amenable to surgical resection. Among this select population, continued improvements in survival during the 21st century are attributable to aggressive radical surgery with improved surgical techniques.

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# LATEST TREATMENT FOR AN USUAL GASTROINTESTINAL DISEASE IN A SURGICAL UNFIT PATIENT

Dr. Jignesh Patel | Consultant - Gastroenterologist | HCG Hospitals, Ahmedabad

85 year old female had Chronic Diarrhoea with passing stool in Urine because of small Rectovesical fistula. Colonoscopy with biopsy done. There is no evidence of Crohn's Disease, MRI pelvis done suggestive of multiple left sided Colonic Diverticulae but patient is not fit for surgery. We had planned to place an Ovesco clip by colonoscopy. This endoscopic suturing device close the connection between urinary Bladder and rectum (colon). Now stool passage in Urine stops and she is coming out from Urinary sepsis. This is possible without operation.

## Review about Endoscopic closure devices

Nonsurgical closure of the GI wall may be desired in the setting of inflammatory or neoplastic fistulae, dehiscence of surgical anastomoses, and spontaneous or iatrogenic perforations. Closure is also necessary after natural orifice transluminal endoscopic surgery.



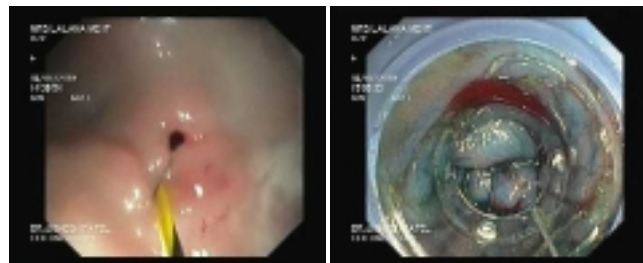
Figure 1. Over-the-scope clips: applicator caps; 3 sizes.

Figure 2. Over-the-scope clips: type a (rounded) (left), type t (pointed) (middle), and type gc (longer pointed) (right).

An over-the-scope clip (OTSC) (Ovesco) has been developed for the closure of small mural defects and bleeding ulcers. The device includes an applicator cap, a nitinol clip, and a hand wheel.

The applicator cap, with a mounted nitinol clip, is affixed to the tip of the endoscope in a manner similar to that of variceal band-ligation cap. The clip fits into the cylindrical cap in the open position. Caps are available in 3 diameters to accommodate various

endoscope diameters: 11 mm (designed for endoscope diameters 9.5-11mm), 12 mm (for endoscope diameters 10.5-12mm), and 14 mm (for endoscope diameters 11.5-14 mm).



Several case series have demonstrated successful use of the OTSC in the closure of acute GI perforations, anastomotic leaks, and chronic GI fistulae.

## Safety Data

A single perforation was reported after placement of the OTSC for bleeding duodenal ulcer. Mucosal lacerations have been reported after advancement of the OTSC. Although it is very safe, some technical problems can be solved by expertise.

## Conclusion

Several new devices offer the prospect of robust and durable endoscopic closure of acute and chronic GI wall defects, including spontaneous and iatrogenic perforations, anastomotic leaks, and chronic fistulae. They may also allow satisfactory closure of enterotomies created for NOTES procedures. The OTSC and overstitch system are currently marketed in the United States, now available in India. Case series have demonstrated the effectiveness of the OTSC in the closure of acute defects.



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