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ગાંઠ કોઈપણ હોય,
સમયે ખુલી જવી જોઈએ.

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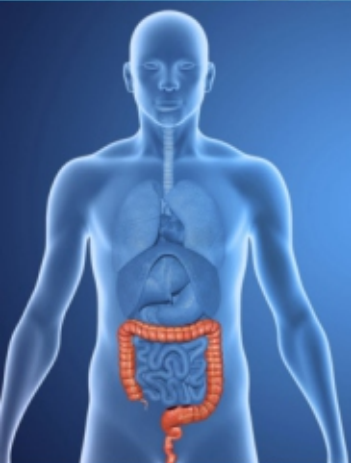
Chairman - HCG Group

Chairman's Message

At HCG, it has been our constant endeavour to redefine the future of healthcare, through specializing across infertility, tertiary care, cancer care and advanced diagnosis. We have been constantly designing, building and managing healthcare centres with a steadfast vision of bringing core clinical services under one roof. Our intent is to help patients achieve a longer and better life. With a widespread network, HCG makes advanced health care accessible to millions of people, who would otherwise have to undergo temporary relocation or travelling distances for treatment. While transforming the healthcare scenario of the country, HCG also adapts latest technologies to stay ahead.

In today's health scenario where we have a wide choice among hospitals and health care centres, we usually tend to ignore the clinical expertise & facilities of the hospitals. This in turn may lead to visiting multiple hospitals to gain holistic treatment. But, fortunately at HCG, we offer comprehensive healthcare under one roof. Evidence based medicine protocols are followed and treatments are planned according to the standard guidelines. Infection Control protocols and other quality benchmarks are proudly achieved. Doctors at HCG are highly trained, experienced and continuously undergo various International training programs to keep themselves appraised with the latest updates in the respective fields.

Taking into account of the increase in lifestyle related diseases, initiatives are taken to educate the community by various awareness programs. HCG also offers affordable health check up packages to encourage regular screening, so that disease can be detected at an early stage and quality of life can be maintained. We invite you all to be a part of our awareness programs and be the fire to ignite a bright light that will lead all of us to healthier future. You can follow us on social media or visit our website to know about the upcoming events.



Past, Present and Future of Radiation Therapy in Cancers of Rectum

Colo rectal cancers are common cancer worldwide with a majority of cases occurring in the developed countries. India has a low prevalence of Colo rectal cancer. If the cancer is diagnosed at a localized stage, the survival rate is 89%. If the cancer has spread to surrounding tissues or organs and/or the regional lymph nodes, the 5-year survival rate is 71%.

Historically just like other solid tumors these cancers were also treated by surgery alone. Kind of surgeries performed at that time were also not that adequate so as to provide a reasonable tumor control in contrast to what are being done now a days. As the understanding about this disease developed researchers tried various other approaches to improve the final outcome. They realized that surgery alone is not sufficient to control the disease specially in locally advanced diseases and hence they tried giving some additional (adjuvant) treatment in the form of radiotherapy and sometimes chemotherapy after surgery and the results were promising.

In the continuous efforts to improve the outcomes both in terms of better tumor control and improved quality of life researchers tried the reverse approach of giving these supplementary therapies upfront that is before surgery and again the results were better, the treatment tolerance and every other parameter including reduced long term complications favored this approach which is also known as neoadjuvant therapy.

But the biggest advantage with neoadjuvant radiotherapy was observed in a particular group of patients where the disease was lying low or close to the sphincter (a kind of valve which holds the stool) in the rectum and upfront surgery resulted in permanent colostomy bag that is removal of the tumor and permanent closure of the natural stool passage through anus rather the passage is diverted into a bag which

has to be kept hanging outside body. And this hanging bag has a huge impact on patient's quality of life because it adversely affects patients psychology. In this particular group of patients neoadjuvant radiation with or without chemotherapy resulted in significantly improved sphincter preservation rates and lesser number of patients requiring permanent colostomies. Here it is equally important to understand the fact that there are some clinical situations where the disease is so low lying that the disease can not be cured without closing the the natural passage forever but that's where the patients willpower to conquer this disease and a positive approach towards life plays its part

Things didn't end here, it was also tried to make this neo adjuvant treatment more patient friendly by giving the radiation dose in minimum number of sittings, because generally radiotherapy is a long treatment and lasts 5-6 weeks (25-30 sittings) on an average. So in subsequent studies the conventional long course radiation was compared with a short course radiation consisted of just 5 fractions or 5 sittings over just one week and it was followed by surgery within one week of completion of radiotherapy. Studies were also conducted to determine the ideal time after radiation for surgery, addition of chemotherapy in the waiting period and so on to get the best results.

Just when all these things were going on another concept came into existence, the concept of oligometastatic disease. Oligometastatic disease is a disease where the primary tumor has spread in distant parts of body but in very limited number and volume. While our general thinking was that when cancer has moved to a distant organ the outcomes will be bad but it was noticed that when this spread is not an extensive spread patients can still be offered a curative treatment and good number of patients



can be cured who were considered incurable in the past. Patients with rectum cancer and limited spread to lung or liver who were previously considered incurable are now offered curative therapies with chemotherapy, surgery and radiotherapy, the site of spread can also be addressed by either surgery or very high dose radiotherapy in the form of SBRT or Stereotactic Body Radiotherapy which involves delivering very high radiation dose in three to five sittings with promising results. Again the advantage is that the patient can complete this whole radiation schedule in a very short time and can move on quickly to his chemotherapy which will control the disease in rest of the body as well.

Very recently some researchers also studied about the possible omission of surgery in very few selected patients, who have achieved complete response after neoadjuvant radiation and chemotherapy. Especially those where the



disease is lying in the lower part and even after chemo and radiation their sphincter can not be preserved. So instead of subjecting a patient to permanent colostomy bag why not give a try by just observing them because there is already no clinical evidence of any disease. This approach is still experimental as we do not have enough scientific evidences yet in its favor, also there is a fear that a potential curative patient may land up in failure

While all these things were going on parallel researches were going on to improve the surgical techniques, better chemotherapeutic drugs and better radiation techniques and equipments. Today we are fortunate that we are living in an era where we have access to the highly sophisticated surgical equipments in the form of robots (Da Vinci Xi) and advanced and ultra modern linear accelerators like

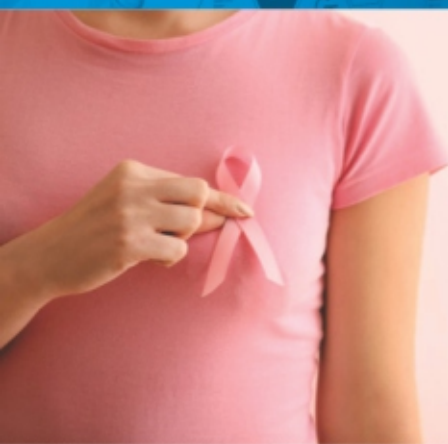
Truebeam and Tomotherapy. The advantages with robotic surgery is that now the operating surgeon has access to a much better magnified view of the surgical field and can access those areas also which were considered difficult with conventional minimal access surgeries. The post operative recovery is also very good. Linear accelerators or the radiation machines like Truebeam and Tomotherapy are capable of delivering precise dose of radiation with sub millimeter accuracy and thus they can minimize the damage to nearby normal and healthy tissues and eventually reduce the chances of long term side effects. These machines have contributed significantly in improving patients quality of life.

Radiomics a method that extracts a large number of features from radiographic medical images using data-characterization algorithms. These features, termed radiomic features, have the potential to uncover disease characteristics that fail to be appreciated by the naked eye. The hypothesis of radiomics is that the distinctive imaging features between disease forms may be useful for predicting prognosis and therapeutic response for various conditions, thus providing valuable information for personalized therapy. Radiomics is a rapid developing field of quantitative image analysis that may facilitate the prediction of lymph node status following neoadjuvant therapy. Radiomics could quantitatively analyze image information, which may help to detect some associations between local tumor information on imaging and surrounding nodal status. One of the fastest evolving branches involves linking imaging phenotypes to the tumor genetic profile, a field commonly referred to as "radiogenomics." Together radiomics and radiogenomics will completely change the future of cancer treatment in general and rectal cancer in particular.

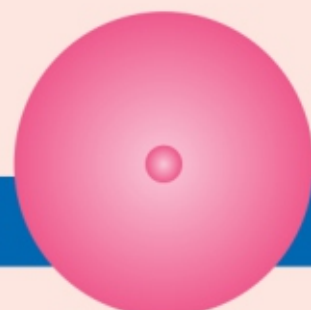
Medical science is a continuously evolving field and what sounds latest and advanced today will not sound the same forever. The good part is that we are moving in the right direction and our understanding about this disease and its treatment is polishing day by day, moreover we are adapting to newer and better treatment options with a single goal of giving best to our patients.



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BREAST RECONSTRUCTION



INTRODUCTION:

Breast reconstruction is a surgical process of rebuilding the shape and look of a breast, most commonly in women who had surgery to treat breast cancer. It involves using autologous tissue, prosthetic implant or combination of both with the goal of reconstructing a natural looking breast. This process often also includes the rebuilding of the nipple and areola, known as nipple-areola complex (NAC) reconstruction, as one of the final stages. Breast reconstruction is an option after unilateral mastectomy, bilateral mastectomy and breast conservation therapy with unsatisfactory cosmetic result. It provides psychological, social, emotional and functional improvements.

INITIAL RECONSTRUCTIVE EVALUATION:

Optimal management requires a multidisciplinary approach and collaborative effort between oncological surgeon, reconstructive surgeons, radiologists, pathologists, radiation therapist and medical oncologists.

History and physical examination:

- Disease status
- Oncologic history
- Future treatment plans
- Past surgical history
- Comorbid health problem
- Contralateral breast

Women who choose reconstruction face a complex decision making process with regard to

- Timing of reconstruction
- Type of reconstruction

TIMING OF RECONSTRUCTION:

1. Immediate reconstruction

Breast reconstruction is termed "immediate" when it takes place during the same procedure as the mastectomy. The timing of breast reconstruction after mastectomy has progressed from delayed to immediate because of advances

and refinements in breast reconstructive technique and recognition of beneficial psychological effects. Studies have shown cosmetic advantages, cost effectiveness, psychological benefits and no increased risk for complication or cancer risk with immediate breast reconstruction, it has become the preferred timing of reconstruction, with 75% of reconstruction being performed immediately. At the present time most women with breast cancer are candidates for immediate reconstruction. The most important advantage for immediate reconstruction is the potential for a single stage procedure. This also means that the cost of immediate reconstruction is often far less to the patient. It also reduces hospital cost by having fewer procedure and requiring a shorter length of stay in the hospital.

2. Delayed reconstruction

It is done in women requiring post-surgery adjuvant radiotherapy because radiotherapy can interfere with post-operative healing. Delayed reconstruction allows completion of all adjuvant treatments. It minimizes the effect of poorly perfused mastectomy skin flap on the quality of reconstruction. Disadvantages of delayed reconstruction include the need for subsequent surgery, lesser esthetic quality compared to immediate reconstruction and there are limited local reconstructive option following radiotherapy.

RECONSTRUCTIVE OPTIONS

The options for reconstruction includes partial and total breast reconstruction.

- For partial breast reconstruction: following breast conservation surgery option

includes:



A. Volume displacement technique: when less than 20% of breast volume is resected

B. Volume replacement technique: when more than 20% of breast volume is resected

• For total breast reconstruction, option includes:

A. Autogenous tissue:

e.g. - Abdominal-based flap like TRAM (transverse rectus abdominis muscle flap), DIEP flap

(deep inferior epigastric perforator flap),

- LD flap (latissimus dorsi musculocutaneous flap)
- Gluteal flap based on superior and inferior gluteal artery
- Lateral thigh flap
- Transverse upper gracilis flap (TUG Flap)

The development of musculocutaneous flaps and microsurgical tissue transplantation paved the way for modern autogenous tissue breast reconstruction.

The autogenous flap includes: 1. Pedicled flap (e.g. LD flap, TRAM flap)

2. Free flap (e.g. gluteal flap)

3. Perforator flap (e.g. DIEP flap fig. 1, TUG flap)

B. Prosthetic device

e.g. – saline implant

- Silicone gel implant
- Silicone implant with saline filling
- Tissue expander

Modern breast reconstruction began in 1964 with the introduction of prosthetic device, the saline breast implant. Since that time, implants have evolved and the silicone polymer shell remains essentially unchanged. The implant shell can be filled with saline, silicone or combination of both.

The advantage of implant reconstruction are:

- Surgical simplicity
- Use of cosmetically similar adjacent tissue for coverage of the implant
- The lack of donor site morbidity
- Reduced operative time and most rapid post-operative recovery.

The main disadvantages of implant reconstruction are that tissue expansion requires frequent clinic visit for expansion (usually every 1 or 2 weeks for 1 or 2 months) and a second surgery to place the reconstructive implant.

C. Oncoplastic surgery

It combines the latest plastic surgery technique with breast surgical oncology. When a large lumpectomy is required that will leave the breast distorted, the remaining breast tissue is mobilized to realign the nipple and areola and restore a natural appearance to breast shape. The opposite breast will also be modified if required to create symmetry.

Oncoplastic surgery is a good option for patients who are candidates for breast conservation therapy or lumpectomy, and are also candidate for breast reduction or mastopexy (breast lift). These types of procedures are ideal for large breasted women, when resection involves more than 20% of breast volume, when tumor location is central, medial or inferior.

Oncoplastic technique can be volume displacement or volume replacement depending upon the volume of breast tissue is removed. All these procedures are done before radiation to prevent the contracture of the lumpectomy defect and distortion of nipple areolar complex.

D. Autologous fat grafting

Fat grafting also called as autologous fat transfer is emerging as a new breast reconstruction technique. In fat grafting, fat tissue is removed from other part of body usually thigh, belly, buttock by liposuction. The tissue is then processed into liquid and injected into breast area to recreate the breast.

Another form of fat grafting, called lipofilling, has been used to fix minor difference in the shape, balance or position of reconstructed breast compared to other breast. The advantages of fat grafting are- it uses own body tissue instead of an implant, however the injected fat may be reabsorbed by the body and there is loss of some or all of breast volume over time.

NIPPLE-AREOLAR RECONSTRUCTION

The focus of all breast reconstructive procedure is creation of breast mound. A breast mound provide the women with symmetry in clothing and a bra and for many women, this is satisfactory and they desire no further operative intervention. Other women would like completion of their reconstruction to mirror the normal contralateral breast, which requires the creation of nipple-areolar complex.

The nipple can be reconstructed via various local flap techniques using the skin of the reconstructed breast mound. The areola reconstruction can be performed with the help of full thickness skin graft or to use medical tattoo pigment.

SURVEILLANCE FOLLOWING BREAST RECONSTRUCTION

Reconstructed breast are easy to monitor for local

recurrence because recurrence is most often within the skin. Biopsy should be performed of any form of suspicious mass without delay. Ultrasound and magnetic resonance imaging are the most commonly used radiographic modalities. Recurrence is usually managed with surgical excision, adjuvant chemotherapy or radiation therapy.



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સ્ટેજ ૪નું કેન્સર : આશા અને સફળતાની સ્ટોરી

કેન્સરનું નિદાન રોગીની સાથે સાથે તેમના પરિવારજનો અને પ્રિયજનો માટે પણ દુઃખદ હોય છે. આ પરિસ્થિતિમાં નકારાત્મક બાહ્ય પરિબલો દૂર રાખીને સારવાર કરવી એ એક દર્દી તરીકે મુશ્કેલભર્યું હોય છે. આ લેખ તેવા દર્દીઓની વાત છે કે જેમને ડૉક્ટર દ્વારા કહેવામાં આવ્યું હતું કે તેમને **સ્ટેજ ૪નું કેન્સર** છે છતાં તેમણે પોતાની ઈચ્છા શક્તિ અને મનોબળથી એક અસાધ્ય રોગ સામે સાહસથી લડ્યા અને રોગ સામે જીત મેળવી. કેન્સર સામેની લડત દરેક દર્દીઓ માટે અલગ અલગ હોય છે. કેટલાક દર્દીઓ માટે કેન્સર માત્ર ઈલાજ છે પરંતુ કેટલાક દર્દીઓ માટે તેનો અર્થ છે કે તેઓનું પોતાનું જીવન સંપૂર્ણ ગરીમા અને ખુશીઓ સાથે જીવવું એટલું જ નહીં પરંતુ પોતાના બાળકો, પતિ-પત્ની, માતા-પિતાની સાથે જ્યાં સુધી જીવવું શક્ય હોય ત્યાં સુધી આનંદ સાથે જીવવું.

કેસ : ૧

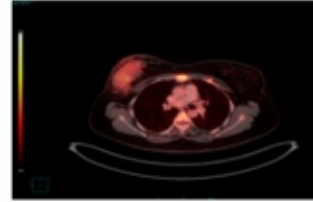
એક બાળકની માતા અને વ્યવસાયે શિક્ષક તેવી ૩૬ વર્ષીય મહિલાને જુલાઈ ૨૦૧૭માં થોડા મહિનાઓ પહેલા ઑફિસમાં જોડાયા હતા. તેમને થોડા મહિનાઓ પહેલા ગાંઠનો અહેસાસ થયો હતો પરંતુ તે ગાંઠ નાની અને પીડા રહિત હતી અને બીજી તરફ તેઓ દિકરાની પરીક્ષામાં વ્યસ્ત હોવાને કારણે તેમણે આ અંગે ખાસ વધુ ધ્યાન આપ્યું નહીં, પરંતુ આખરે તે ગાંઠ વધવાની શરૂ થઈ ગઈ અને તેમના સ્તનની ચામડીના રંગમાં પણ ફરક દેખાવા લાગ્યો ત્યારે તેમને અહેસાસ થયો કે હવે નિષ્ણાતની મદદની જરૂર છે.

તેમણે આ ગાંઠનું મેમોગ્રામ અને પી.ટી.ઈ.- સિટી સ્કેન અને બાયોપ્સી કરાવ્યું જેમાં તેમને હોર્મોન પોઝિટિવ સ્તન કેન્સરનું નિદાન થયું હતું અને જ્યાં સુધી તેમને આ અંગે જાણ થાય ત્યાં સુધી તે શરીરના અનેક હાડકાઓમાં ફેલાઈ ગયું હતું. જ્યારે તેણી દુઃખી થઈને તેના પતિ સાથે હોસ્પિટલમાં બેઠી હતી ત્યારે તેના નિદાન, ઉપચારના વિકલ્પ અને સારવારના લક્ષ્યો અંગે ચર્ચા કરી રહી હતી. તેમને સમજાવવામાં આવ્યું હતું કે તેમને **સ્ટેજ ૪નું કેન્સર** છે, જે અસાધ્ય છે પરંતુ તેઓ સિસ્ટેમેટિક થેરપી સાથે પોતાનું જીવન જીવી શકે છે અને પોતાની સાથે પરિવારની સંભાળ કરવામાં પણ સક્ષમ રહેશે. તેમને હોર્મોન થેરપી અને નવી ટાર્ગેટેડ થેરપીની ગોળીઓ (letrozole + CDK4/6 inhibitor) આપવામાં આવી હતી, જે તમણે ઓગસ્ટ ૨૦૧૭થી શરૂ કરી હતી.

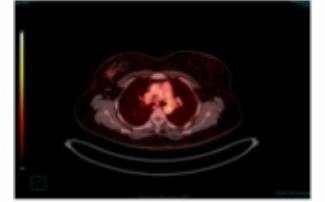
૬ મહિનાની સારવાર કરાવ્યા બાદ તેમણે ફરી એકવાર પી.ઈ.ટી. સિટી સ્કેન કરાવ્યું (ચિત્ર-૧). પી.ઈ.ટી. સિટી સ્કેન દ્વારા તેમને પુષ્ટિ મળી કે તેમની ગાંઠ લગભગ મૌખિક દવાઓ (મોં દ્વારા લેવાતી દવા)થી અદ્રશ્ય થઈ રહી છે, આ વાત જાણીને તેણી ખુબ જ ખુશ હતી. તેઓએ વાળ ખરવાની સમસ્યા ન લાગતા સારવારને સંપૂર્ણ ધીરજથી પૂર્ણ કરી. કોઈ નોંધપાત્ર આડઅસરનો અનુભવ ન થતાં

તેમણે શિક્ષક તરીકે નોકરી શરૂ રાખી અને સાથે સાથે પરિવારને પણ સંભાળતા રહ્યા.

તેઓ જુલાઈ ૨૦૧૭થી આજ સુધી સારવાર લઈ રહ્યા છે (આજે ૩ વર્ષથી વધુ સમય) અને સ્થિતિ સુધારા પર છે. તેઓ આજે પોતાના જીવનનો સંપૂર્ણ આનંદ માણી રહ્યા છે અને તે વાતની ખુશી પણ છે કે જ્યારે તેમણે ઈચ્છા કરી ત્યારે સારવાર શરૂ કરવી શક્ય થઈ.



સારવાર પહેલા

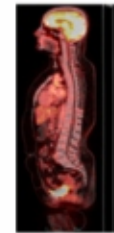


સારવાર પછી

ચિત્ર-૧ : સ્તનમાં ઈજા : પી.ઈ.ટી. સિટી સ્કેનના ફોટા
letrozole+ CDK4/6 inhibitor ની પહેલા અને પછી



સારવાર પહેલા



સારવાર પછી

ચિત્ર-૧ : બૉન મેટાસ્ટેસીસ : પી.ઈ.ટી. સિટી સ્કેનના ફોટા
letrozole+ CDK4/6 inhibitor ની પહેલા અને પછી

કેસ-૨

૫૬ વર્ષના એક સરકારી અધિકારીને એપ્રિલ, ૨૦૨૦માં કેટલાક અઠવાડિયાથી ગળવાની મુશ્કેલી સાથે ક્લિનિકમાં સલાહ માટે આવ્યા હતા. તપાસ કરતા જાણવા મળ્યું કે તેમને અન્નજળી અને પેટના વંકશન પર ગાંઠ છે અને તે પહેલાથી ફેફસાંમાં ફેલાઈ ગયું છે. ફેફસાંની બાયોપ્સી તપાસમાં જાણ થઈ કે તેમને ખરેખર **સ્ટેજ ૪નું ગેસ્ટ્રો-એસોફેજીઅલ કેન્સર** છે. વધુ મોલેક્યુલર ટેસ્ટમાં જાણવા મળ્યું કે ગાંઠને કારણે HER2 એમ્પ્લીફિકેશન બંધ થઈ ગયું છે. તેમને ઉચ્ચ ક્ષમતા ધરાવતી કિમોથેરપી અને ટાર્ગેટેડ થેરપી (© હર્સોપ્ટિન, જે સામાન્ય રીતે સ્તન કેન્સરની સારવાર માટે ઉપયોગ થાય છે)ની છ સાયકલથી સારવાર કરવામાં આવી. પી.ઈ.ટી. સિટી સ્કેન દ્વારા થતા મૂલ્યાંકનથી જાણવા મળ્યું કે તેઓ રોગ મુક્ત છે (એટલે કે તેમની



ગાંઠ સંપૂર્ણ રીતે દૂર થઈ ગઈ). હવે તેઓ ટાર્ગેટિડ થેરપી અને કીમોથેરાપીની સારવાર લઈ રહ્યા છે. થોડા અઠવાડિયા પહેલા તેમનું છેલ્લું સ્કેન કરવામાં આવ્યું હતું અને જેમાં કોઈ રોગ જાણમાં આવ્યો નથી. તેઓ સાથે સાથે સંપૂર્ણ સ્વસ્થતાથી સરકારી નોકરી પણ કરી રહ્યા છે અને તેમને કેન્સર અંગે કોઈ અન્ય આડઅસરનો અનુભવ પણ નથી કરી રહ્યા.

કેસ-૩

૭૪ વર્ષિય એક વૃદ્ધ પાછલા ૨ મહિનાથી ગળામાં દુખાવા અને સોજાની ફરિયાદ સાથે ફેબ્રુઆરી ૨૦૧૮માં સલાહ માટે ક્લિનિકમાં આવ્યા હતા. પી.ઈ.ટી. સિટી સ્કેન તપાસમાં ગળાની લસિકા ગ્રંથીની ગાંઠો ફેલાવવાની સાથે એક મોટી પેરોટિડ ગાંઠ હોવાનું જાણવા મળ્યું હતું. ત્યારબાદ તેમણે પેરોટિડ અને ગળાના ભાગમાં કીમો થેરાપી અને રેડિઓ થેરાપીથી સારવાર કરાવી અને એપ્રિલ ૨૦૧૮માં તેમની સારવાર પૂર્ણ થઈ હતી.

તેમની સારવાર પૂર્ણ થયા બાદ લગભગ ત્રણ મહિના સુધી સુખદ અનુભવ કરી રહ્યા હતા પરંતુ પછી તેમને ડાળા થાપા (હિપ)માં દુખાવો થવા લાગ્યો હતો. આ અંગે પી.ઈ.ટી. સિટી સ્કેન તપાસમાં જાણવા મળ્યું કે અનેક હાડકામાં ગાંઠો ફેલાવો થઈ ગયો છે. ઉપચાર અંગે ચર્ચા કર્યા બાદ તેમને અદ્યતન કેન્સર નિદાનની સલાહ આપવામાં આવી હતી. ઓગસ્ટ ૨૦૧૮માં કીમોથેરાપી (સિસ્પ્લેટિન અને ડોસિટેક્સલ) શરૂ કરવામાં આવી હતી. કીમોથેરાપીની ત્રણ સાઇકલ પછી પણ તેમને થાપામાં સતત દુખાવાની ફરિયાદ રહેતી હતી, જેના માટે તેમને નિયમિતપણે દવાઓ પણ લઈ રહ્યા હતા. આ પરિસ્થિતિમાં તેઓ યોગ્ય રીતે ભોજન લેવામાં અને નિયમિત શારીરિક પ્રવૃત્તિ કરવામાં પણ અસમર્થતાનો અનુભવ કરતા હતા. તેમણે સિટી સ્કેન કરાવ્યું જેમાં અલ્ટ્રાસોનિક પેરોટિડ ગાંઠ, ડાળા ખભામાં નરમ પેશી અને હાડકાના જખમમાં વધારો જણાવવામાં આવ્યો, જેથી તેમની કીમોથેરાપી બંધ કરવામાં આવી અને તેના વિકલ્પ તરીકે તેમને ઈમ્યુનોથેરાપી (નિવોલુમેન)નો વિકલ્પ આપવામાં આવ્યો.

નવેમ્બર ૨૦૧૮ સુધીમાં તેમને નિવોલુમેનની ૬ સાઈકલ આપવામાં આવી હતી. ઈમ્યુનોથેરાપી પછી તેમને થાપાના દુખાવામાં રાહત મળી સાથે ખભાના સોજામાં પણ ઘટાડો જોવા મળ્યો હતો અને તેમના

ગળાનો સોજો દૂર થઈ ગયો હતો (ચિત્ર-૩). હવે તેઓ સામાન્ય પ્રવૃત્તિઓ કરવા માટે સમર્થ હતા અને તેમને કોઈ પણ પ્રકારની આડઅસર જોવા મળી નહોતી.

તેમણે નવેમ્બર ૨૦૧૮માં સિટી સ્કેન કરાવ્યું હતું, જે અગાઉના સ્કેનની તુલનામાં ગાંઠના કદમાં ઘટાડો દર્શાવે છે. તેમની ઈમ્યુનોથેરાપી આજે પણ શરૂ છે. તેમણે ઓગસ્ટ ૨૦૨૦માં કરાવેલા પી.ઈ.ટી. સિટી સ્કેનમાં રોગ જોવા મળ્યો નથી.



ચિત્ર-૩ : પેરોટિડ જખમ:
નિવોલુમેનના એક વર્ષ
પહેલાં અને પછી

ખભાના જખમ: નિવોલુમેનના
એક વર્ષ પહેલાં અને પછી

ચર્ચા: કેન્સરની અદ્યતન સારવારને કારણે એ અસાધ્ય રોગ ધરાવતા દર્દીઓ તેમના રોગ સાથે રહેવું અને ઉત્તમ રીતે જીવવું સંભવ બનાવી દીધું છે. પહેલું દર્દી ઓરલ હોર્મોન થેરાપી અને ટાર્ગેટિડ થેરાપી પર બીમારી સાથે જીવી રહ્યો હોય છે, બીજું, દર્દી કીમોથેરાપી અને ટાર્ગેટિડ થેરાપી અને ત્રીજું દર્દી ઈમ્યુનોથેરાપી સાથે, આ બધી અદ્યતન સારવાર દર્દી સારી રીતે સહન કરી શકે છે અને એમનું જીવન વ્યવસ્થિત રીતે જીવી શકે છે. આ ઉપચારો તમને ધીરજ રાખતા શીખવે છે અને જે જીવનને વધુ ઉત્તમ ગુણવત્તા અને અસ્તિત્વ પ્રદાન કરે છે.

તે સમજવું અગત્યનું છે કે દરેક દર્દી અલગ હોય છે, દરેક કેન્સરનું અલગ ચુક્ર છે, આથી હિંમત હારતા પહેલાં હંમેશા પ્રયત્ન કરવો યોગ્ય છે કેમ કે તમે ક્યારેય નથી જાણતા કે તમે ત્રણ દર્દીઓમાંથી એક છો કે નહીં ?



ડૉ. આશિષ કૌશલ

કન્સલ્ટન્ટ - મેડિકલ ઓન્કોલોજિસ્ટ
એયસીજી કેન્સર સેન્ટર, અમદાવાદ



ડૉ. વિરાજ લવિંગિયા

કન્સલ્ટન્ટ - મેડિકલ ઓન્કોલોજિસ્ટ
એયસીજી કેન્સર સેન્ટર, અમદાવાદ



ડૉ. માનસી શાહ

કન્સલ્ટન્ટ - મેડિકલ ઓન્કોલોજિસ્ટ
એયસીજી કેન્સર સેન્ટર, અમદાવાદ



ડૉ. પ્રિયંકા પટેલ

કન્સલ્ટન્ટ - મેડિકલ ઓન્કોલોજિસ્ટ
એયસીજી કેન્સર સેન્ટર, અમદાવાદ

CASE STUDY

CASE - 1

A 53 years old male patient, working as Engineer at under construction site and suddenly fall down from height. So patient was brought to HCG Emergency by 108 ambulances. Patient was conscious. He was shouting due to severe pain. He was unable to move his legs and left upper limb. He had profuse bleeding from huge wound over left leg, bones are visible. Patient had severe hypotension due to Hypovolemic/ Haemorrhagic shock. Immediately wound management and fluid resuscitation done. Tight bandage was applied to stop the bleeding and Inj. Tranexamix was given. After stabilisation of ABC, patient was taken for X ray and CT scan & Orthopaedic surgeon was informed. X ray Suggestive of fracture left humerus, Lower end ulna & radius, Fracture of pelvis, Fracture of left Tibia & fibula, fracture of bilateral calcaneum bones & fracture of left sided multiple ribs. CT scan spine showed fracture in dorso-lumbar spine & sacrum. POP application was done. Patient was admitted in ICU and later on he was operated for fractures. After 15 days of hospitalization he got discharged. He recovered gradually and started walking with walker and stick support. After 4-5 months he was started walking without any support and came to hospital for thanking us.

HR- 60/min, BP- 100/70 mm of hg, SPO2- 96 % at room air. Immediate ECG was taken which showed hyper acute inferior wall myocardial infarction (ST elevation in II , III and avf leads) Pt and pt's relatives were explained about the disease and its complications. They have been explained about treatment options and they opted for urgent PCI. So immediately Tab.Ticagrelor 180 mg, Aspirin 300 mg & Atrovastatin 80 mg were given and cardiologist was informed. After 5 minutes pt had sudden ventricular tachycardia and patient become unconscious and unresponsive. There was no pulse and patient had gasping breathing. Immediately CPR was started & DC shock of 360 Joules was given. Inj.Adrenaline 1 ml was given still patient had ventricular tachycardia so again DC shock of 360 was given & CPR was continued. After resuscitation for 5 minutes , patient was revived, she became conscious and ECG was showing Inferior wall MI. HR-90 / Minutes, BP- 90/60, Spo2 – 95 % with O2 3 litre/minutes. Patient was shifted to cathlab and urgent PCI was performed by cardiologist. After 3 days patient was discharged from hospital in stable condition.

CASE - 2

A 59 years old female came to our emergency department with complaint of retro sternal chest pain, uneasiness, perspiration and gabharaman,



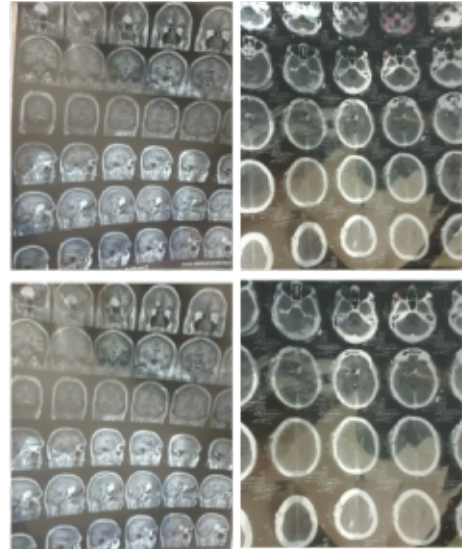
Dr. Malav Shah
Head - Emergency Department
HCG Hospitals, Ahmedabad

SPHENOIDAL MENIMTRIAMA

Admitted with C/o Jayantibhai uibion in eye since Last d-3 months which was gradually deteriorating and was now having RT eye ubinal complaints.pt was examined & investigated s/o skull bone (sphenoidalmenimtriama).

Initially Patient was planned for surgery after explaing risk for vision & limb weakness, there after chest CT was done which was nearly normal. The Patient was admitted and as per the routine protocol of covid-19. We sent patient's K/C/O HBP & DM & physician reference done.

On next day report was positive due to High risk patient was discharged C steroid & anticonvulsant. At home his vision was deteriorating further so, at last after 17 days we decided to operate him even if he was positive COVID, but then luckily report was negative and patient was operated with microscope & Sugita post-ap period uneventful and 3rd post-ap day. Patient was reading a newspaper after around 3-4 months.



Dr. Suvidh Turakhiya
Consultant - Neuro Surgery
HCG Hospitals, Ahmedabad

HCG Hospitals, Mithakhali

Welcome Onboard



Dr. Brajmohan Singh

M.Ch (CVTS)
Director & Consultant - CVTS

- 10 years of experience
- Performed more than 4500+ Surgeries
- Expert in total arterial CABG (LIMA -RIMA Y)
- Minimally Invasive Cardiac Surgery (Key hole surgery)
- Life member of Indian Association of Cardiothoracic Surgery Association
- Was Core member of Heart Transplant and Ventricular assist device team at Fortis Escorts Hospital, Delhi



Dr. Manmohan Singh Chauhan

M.Ch (CVTS)
Consultant - Cardiothoracic and Vascular Surgery

- Experience of more than 2000+ Cardiac and Vascular Surgeries
- Area of Interest: Total arterial CABG, Minimal invasive cardiac surgery
- M.Ch. Cardiothoracic and Vascular Surgery (Gold Medal), PGIMER, Dr. R.M.L. Hospital, New Delhi
- Former Consultant CVTS at Fortis Escorts Heart Institute Delhi 2016-2019

For more information & appointment



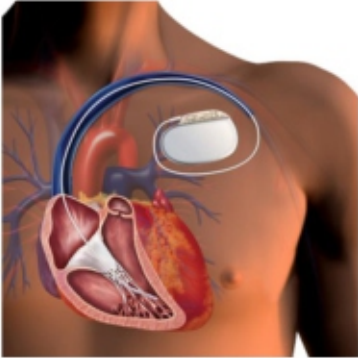
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હાર્ટ એટેક અને સારવાર



હાર્ટ એટેકથી સ્નાયુઓ ડેડ થઈ જાય છે. ત્યાં ઇલેક્ટ્રીક સર્કિટમાં સમસ્યા થવાથી હૃદયના ધબકારા અનિયમિત થવાની શક્યતા હોય છે.

૮૦ વર્ષના એક દર્દી ઘરે એકદમ ચક્કર આવીને બેભાન થઈ ગયા અને ૧૦૮માં એમ્બ્યુલન્સ હોસ્પિટલમાં લઈ આવ્યા હતા. ઇમરજન્સીમાં ત્યાં ઇસીજી લઈને તુરંતજ ઇલેક્ટ્રીક શોક આપવામાં આવ્યો હતો. અને તરતજ ધબકારા નિયમિત થઈ ગયા. બ્લડપ્રેશર નોર્મલ થઈ ગયું.



એમને ભુતકાળમાં હાર્ટ એટેક આવ્યો હતો અને હૃદયનું પંપીંગ પણ ઘણું ઓછું હતું. જેથી બે દિવસ પછી એન્જિયોગ્રાફી કરીને AICD મુકવામાં આવેલ જે થી ઘરે, ઓફિસમાં કે બહાર પણ ધબકારા અનિયમિત થાય

તો આ ડિવાઈસ કરંટ આપી દે છે, જેથી ધબકારા ઘરે જ નિયમિત થઈ જાય છે અને જાન બચી જાય છે.

AICD એટલે Defibrillators and Pacemaker બંનેનું કામ કરવાનું મશીન. જે છાતીના ભાગમાં ચામડી-સ્નાયુની નીચે મુકવામાં આવે છે અને હૃદયમાં વાયર નાખીને જોડવામાં આવે છે. દર્દીને બને ત્યાં સુધી બેભાન કરવાની જરૂર પડતી નથી. ખાસ કરીને હૃદયનું પંપીંગ ૩૦-૩૫ ટકાથી ઓછું હોય તેમને આ લાઈફ સેવિંગ ડિવાઈસ મુકવામાં આવે છે અને બે દિવસમાં રજા પણ આપી દેવામાં આવે છે.



ડૉ. ભુપેશ આર. શાહ
કન્સલ્ટન્ટ - કાર્ડિયોલોજી
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એમ્બ્યુલન્સ હોસ્પિટલ, મીઠાખળીમાં
મા યોજના (મુખ્યમંત્રી અમૃતમ યોજના) હેઠળ
નીચેની સારવાર ફ્રીથી કાર્યરત છે.



હૃદય રોગની
સારવાર



મુત્ર રોગની
સારવાર



કીડની રોગની
સારવાર



ઓર્થોપેડીક એન્ડ
જોઈન્ટ રિપ્લેસમેન્ટ સર્જરી

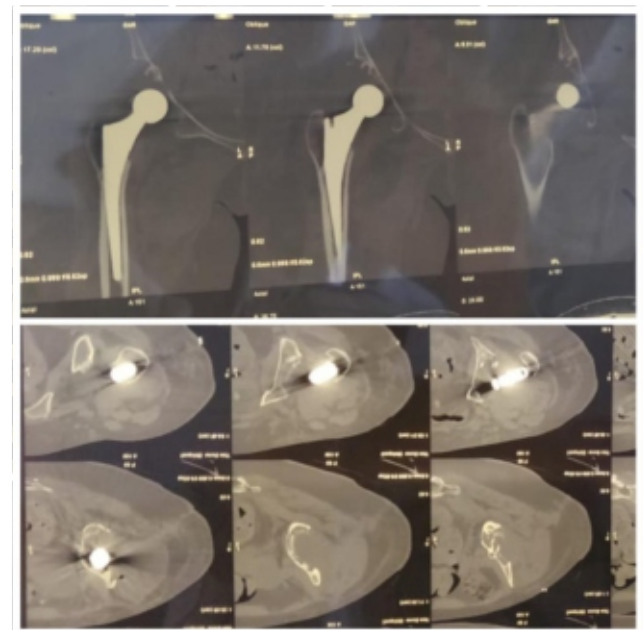
TOTAL HIP REPLACEMENT

50 year old female was operated for total hip replacement 8 years back in mumbai. She started having trouble in hip since one year. On X-ray it appeared that she the poly is wearing out and because of that she had large osteolytic area in retro acetabular area. The surgeon (other hospital) tried to just change the poly but could not do it. When he removed the cup he saw the massive osteolysis in the area. He was not able to reconstruct this and left the case in midway. The patient was then shifted to HCG multi speciality hospital .

Our team took the challenge and planned the surgery well, We made a 3D model of the defect and We did the pre planning and decided the implants and augments to be used in the surgery. We also planned to use allograft .

We reconstructed the acetabulum well with bone graft and metal augments made of gription materials. We used the multihole gription cup with screws in all trajectories.

She was kept immobilized for 6 weeks and then was mobilized with walker. At last follow up of 4 months ,she is independent and follows her daily chores.



Dr. Deepak Dave & Team

Director & Consultant - Orthopaedic,
Trauma & Joint Replacement Surgery
HCG Hospitals, Ahmedabad

કોરોના વાયરસ નિવારણના ઉપાયો

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