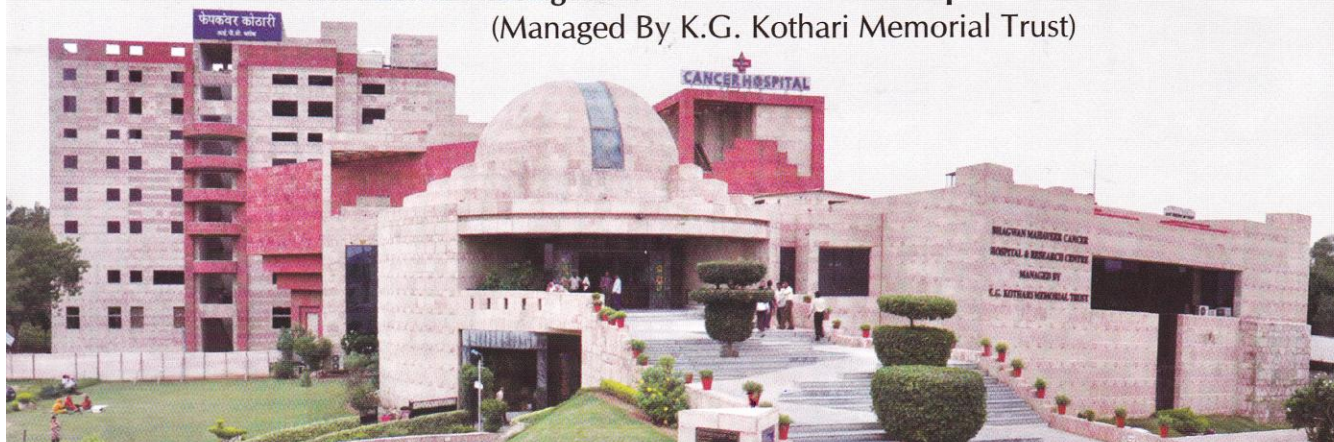




DARPA

एक संवाद बेहतर ~~X~~ कैंसर रहित जीवन के लिए

News Letter of **Bhagwan Mahaveer Cancer Hospital & Research Centre**
(Managed By K.G. Kothari Memorial Trust)



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Editorial

Greetings from BMCHRC family!

Over the last few decades, we have been witnessing lot of breakthrough in cancer treatment and care. These advances have been duly accepted and implemented in clinical practice. With advancing accessibility to modern technology and ease of availability of best treatment modalities including surgical equipments and techniques, newer radiotherapy methods, nuclear medicine (PET imaging, diagnostics and therapeutic), modern chemotherapy (including targeted therapies), we are not only treating patients but also provide them much needed comfort, support and guidance.

With our cancer awareness activities and continuous support from government, cancer care team and public, we have proved that cancer is a treatable disease. Your support and inputs are essential for continuous improvement in care and support of cancer patients. The news bulletin has been revised with efforts to give you a glance of BMCHRC Activities.

Dr. Lalit Mohan Sharma

Inside Pages :

- Acute Myeloid Leukemia
- Radio Iodine Therapy
- Research Paper On Head & Neck Cancer
- Psychooncology Support
- Prophylactic Cranial Irradiation (pci) In Non-small Cell Lung Carcinoma
- Happenings
- Appeal from Executive Director



Inauguration of Phep Kanwar Kothari IPD Block by Shri Ashok Gehlot, Hon' CM of Rajasthan

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Successful Treatment of Acute Myeloid Leukemia in child with Down's syndrome

Dr. Lalit Mohan Sharma

Senior Consultant, Dept of medical Oncology

Introduction

Down's syndrome is the most common postnatally viable chromosomal anomaly having an incidence of about 1:700 live births. It is caused by a trisomy in the chromosome 21. One of the several disturbances seen in these patients is a bone marrow dysfunction. Among the diverse hematological abnormalities, leukemia development is the most serious one. In general, children and adolescents with Down's syndrome have a 10 to 30-fold increased incidence of leukemia. Every 150th such child will eventually develop leukemia. The increased risk extends into adulthood and is also probable among siblings. About 2% of pediatric leukemia patients have Down's syndrome. The reason remains unknown. Although most of the patients have ALL (acute lymphoblastic Leukemia), a great majority of smaller children have AML (Acute Myeloblastic Leukemia). ALL of Down's syndrome is characterized by increased frequency of favourable prognostic signs. With modern treatment regimens its prognosis is similar to that in other patients. AML is diagnosed at younger age, has a large over presentation of acute megakaryoblastic subtype, different cytogenetic abnormalities, and a better prognosis than in general pediatric population. The challenge is to design specific antileukemic treatments that are less toxic but as effective as the best standard regimens.

We share our experience of successful treatment of an 18 month old female child of AML with Down's syndrome who is disease free for more than 6 years.

Hematologic problems in children with Down's syndrome

Although the association between Down's syndrome and leukemia has been known for nearly 70 years, the etiologic and underlying mechanisms remain poorly understood. Several considerations have been presented, including developmental error with disruption of hemostasis, ineffective regulation of granulopoiesis, immune deficiency leading to decreased immune surveillance, abnormal cell kinetics, susceptibility to viral transformation, genetic predisposition to nondisjunction, increased chromosomal fragility, impaired DNA repair mechanisms or oncogene activation.

The most promising areas of research are those relating to the cytogenetics and molecular genetics. Chromosome 21 contains approximately 750 genes that are present in a triple dose in each cell of most patients with Down's syndrome. This extra material may result in generalized disruption of genetic balance and consequently lead to an altered response to normal genetic and environmental factors.

Leukemic Cells In Down's Syndrome

Leukemia in children with Down's syndrome is usually ALL, more common than AML. AML usually presents before the age of 4 years.

Most AML cases of Down's syndrome have acute megakaryoblastic leukemia, a very rare type of leukemia. This malignancy is often preceded by a preleukemic phase of a few months. If a patient with Down's syndrome has myelodysplasia, the condition will ultimately proceed to megakaryoblastic leukemia.

Leukemia Treatment In Down's Syndrome

In the past, leukemia of patients with Down's syndrome was often treated suboptimally, and many patients did not receive cytoreductive treatments at all. Their several physical abnormalities, including potentially life-threatening cardiac and intestinal malformations along with mental retardation and associated psychosocial issues, high susceptibility to infections as well as increased toxicity of chemotherapy are the main fear amongst the physicians for the use of standard chemotherapy and led families to accept less aggressive therapeutic programmes.

The poor tolerance of cytoreductive regimens in patients with Down's syndrome is well documented. Their fibroblasts and lymphocytes have increased chromosomal sensitivity to mutagenic agents and abnormal DNA repair. The patients therefore are predisposed to more severe toxicity of irradiation or alkylating agents. Despite these obstacles, modern intensive schedules have recently been used to treat patients with Down's syndrome. With improved supportive care, these regimens have been acceptably tolerated. In patients with AML, preexisting congenital heart disease did not appear to predispose the patients to anthracycline cardiac toxicity. Major neurotoxicity after high dose ARA-C was not seen. Several patients have even had allogeneic bone marrow transplantations.

Prognosis

The life expectancy of children with Down's syndrome has improved with more effective treatment of congenital heart disease and respiratory infections. Thus, more children with Down's syndrome are now surviving to develop leukemia. Three decades ago, most of such leukemia patients usually died early after diagnosis. While treatment results of acute leukemia in the general pediatric population improved, these children are treated with special protocols with good outcome.

Our experience

Baby PJ had Down's syndrome with classical phenotype. She had pallor, petechie and was diagnosed with AML at 18 months age. Cyogenetic studies revealed trisomy 21. Immunophenotype was suggestive of leukemic cells positive for CD13 and 33, while lymphoid markers were negative.

There were social issues (downs syndrome, acute leukemia and female child) about treatment decisions. She was treated with A2971 chemotherapy protocol. We completed the treatment in january 2007. Now child is well for last more than 6 years.

The idea of sharing our experience is that children with downs syndrome can be treated successfully with chemotherapy.



Before Treatment
Age : 18 Months



After Treatment
Age : 6.5 yrs.

Radio Iodine Therapy is non neoplastic thyroid disease and Differentiated Thyroid Carcinoma (DTC)

Dr. J.K. Bhagat

Senior Consultant & Head Nuclear Medicine and PET imaging

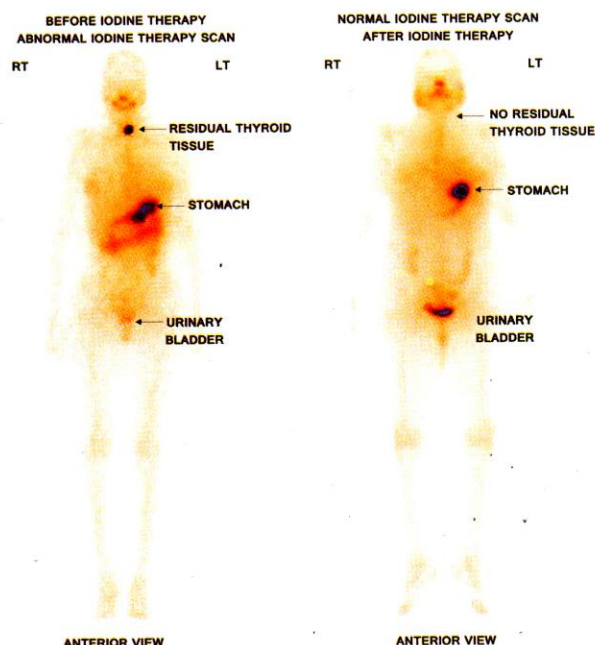
Radio Iodine 131 (I-131) is used for the treatment of non neoplastic thyroid disease and differentiated thyroid carcinoma (DTC). This isotope emits beta particles with energy of 0.61 MEV, which has range in body tissues of about 0.8mm which is found most suitable for destroying the functioning thyroid tissues.

Following non neoplastic diseases have been successfully treated with I-131

- (a) Grave's disease
- (b) Autonomous functioning thyroid nodule
- (c) Multi nodular goiter (Plummer's Disease)
- (d) Non toxic nodular goiter.

Though there is no age bar for treating patients with I-131 but typically patients with age of 30 years and above, those who have completed family and few selected cases of pediatric age group can also be treated. The dose of I-131 is so titrated that the patient can be rendered euthyroid in reasonable period of 06 months. The amount varies from 100-200 micro curies per gram of thyroid tissue.

The appropriate dose is determined by considering the factors like gland size, radio kinetics and age of the patient. Before treating with I-131 these patients have to stop anti thyroid drugs like (propyl thiouresil or neomercazone) for approximately 07 days, these drugs can be restarted after 03-05 days post iodine administration. 80 to 90 percent patients are successfully treated with first dose of I-131, remaining patients may require a second dose of I-131 which can be safely administered after 03 to 04 months of first therapy.



Results of the therapy starts 02 to 06 weeks later and maximum effect of therapy should occur between 03 to 4 months but final results are best known at about 06 months.

Pregnancy is an absolute contra indication of I-131 therapy. Pediatric age group and breast feeding woman is a relative contra indication in which I-131 can be administered case to case basis.

Generally there are no side effects, but some cases may show transient exacerbation of hyper thyroid symptoms, thyroid storm, due to sudden release of thyroid hormone from the gland. It is also advised that the cases with severe thyrotoxicosis or thyro-cardiac disease and elderly patients should be given a "cool down period" by pre treatment with anti thyroid medications. This form of therapy has become a standard of care for treating thyroid disorder and is giving very good results.

I-131 ABLATION OF DIFFERENTIATED THYROID CARCINOMA

I-131 is primarily concentrated by functioning thyroid cells and its beta energy destroyed thyroid cancer cells making patient free of cancer.

After near total or total thyroidectomy, the remaining thyroid tissue in the neck is successfully ablated by high dose of I-131. A dose of 7000 rads per gram of remnant thyroid tissue is delivered.

The dose of I-131 will vary with the mass of remaining thyroid tissue in the neck, association of lymph node metastasis, bone metastasis, lung metastasis and brain metastasis.

Post surgery diagnostic iodine whole body scan will give a clear idea about the spread of disease in the body and helps to decide the dose of I-131 to be given. Generally a fixed amount of radiation is delivered as recommended by Bushnell et.al. in 1992, he has recommended following

- (a) Residual thyroid bed activity only 50-100mci.
- (b) Regional metastasis (cervical nodes) 100-175mci.
- (c) Lung metastasis 175-200mci.
- (d) Skeletal (bone) metastasis 200mci.

The above mentioned doses schedules are practiced world over and has given successful ablation rates from 80-90% in first dose. Lung metastasis and bone metastasis generally require multiple doses of I-131.

There is a limit of 1 curie (1000mci) of radio active iodine administration in life time of patient, more than this dose has not been administered.

In children doses of I-131 are suitably adjusted : These patients are kept in separately designed wards as per Atomic Energy Regulatory Board (AERB) recommendations, to avoid radiations to relatives, hospital staff and other patients. Facility of such ward is available in Bhagwan Mahaveer Cancer Hospital & Research Centre, Jaipur one and only of its kind in Rajasthan.

Proper care is taken so that maximum given radiation dose goes to the remnants of thyroid and blood dose/bone marrow doses are kept minimum. The retained whole body dose is also less to avoid complications of radiation to other tissues of the body.

As per the existing AERB guidelines at this point of time 15mci of

I-131 can be administered as OPD basis any patient requiring doses more than 15mci needs hospitalization in special wards.

Once treated with high dose of I-131 patients continues to get benefit of the drug for at least 3-4 months

Such patients are assessed after 06 months with, USG Neck, T-3-T-4 TSH and thyroglobulin (Tg) if Tg levels are high than a diagnostic whole body scan is required to be done. Depending on the results of whole body I-131 Scan second dose of I-131 is administered.

Following benefits are noted with I-131 therapy

- Decrease in local recurrence.
- Improves survival in patients following local recurrence.
- Prolongs survival in patients with lung or bone metastasis.
- Eliminates the thyroid gland as source of thyroglobulin.

Few complications are reported such as sialoadenitis, xerostomia and mucositis, radiation parotitis, change of taste, nausea, vomiting, minimal bone marrow suppression, radiation pneumonitis, radiation cystitis and thyroid storm, but all these complications can be effectively prevented and controlled.

After ablation therapy thyroxin replacement is given in slightly higher doses so that TSH remains suppressed. Calcium supplements are also given.

Post ablation screening can also be done with thallium-201, Technetium sestamibi, Technetium tetrofosmin and FDG PET imaging is also performed in few cases specially in patients who do not show I-131 uptake and show rising values of thyroglobulin.

Dr. Naresh Somani's Research Paper on Head & Neck Cancer In ASCO, USA

Dr. Naresh Somani

Senior Cancer Specialist, Coordinator of Department of Medical Oncology

Dr. Naresh Somani presented his research paper on Head & Neck Cancer at the Annual American Society of Clinical Oncology meeting at Chicago, USA. This was Dr. Somani's second presentation at the world's most prestigious cancer conference.

Dr. Naresh Somani who is also in charge of Clinical Trials and Research at Bhagwan Mahaveer Cancer Hospital and Research Center, Jaipur, Dr. Somani's research work on Head & Neck Cancer was presented on 1st June 2013. According to Dr. Somani "The main cause of head and neck cancer is largely due to smoking and use of tobacco."

Dr. Naresh Somani told that head and neck cancer is most common cancer in India and is largely attributed to tobacco and chewing habits. Patients unfortunately come in locally advanced stage when results of combination of chemotherapy and radiotherapy are not very satisfactory. This study was to evaluate the results of treatments with the help of new target molecule Nimotuzumab.

Dr. Somani was lead investigator of this study held at various Indian centres.

Dr. Somani also stressed that decrease opening, persistent ulcer in mouth or appearance of growth on tongue or oral cavity or hoarseness of voice may be few of signs and symptoms of cancer and one should go for check-up.

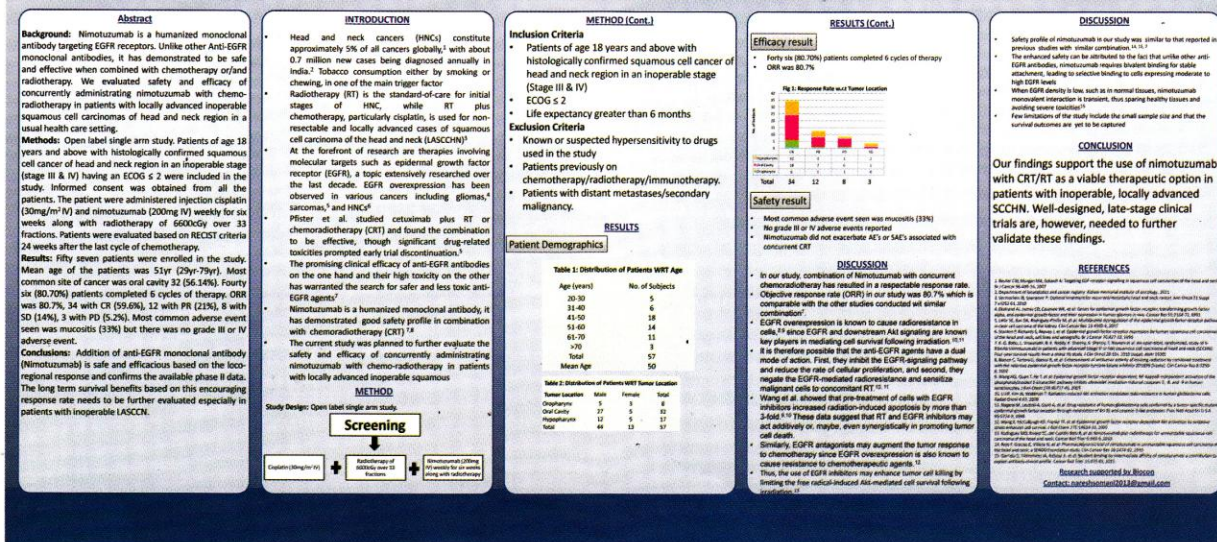
Nimotuzumab with concurrent chemoradiotherapy in patients with locally advanced squamous cell carcinoma of head and neck (LASCCHN).

Naresh Somani¹, Karandikar², Kamlesh Bokil³, Kumar Tapash Bhowmik⁴, Shyam Agarwal⁵

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² Ruby Hall Clinic Pune, India; ³ Grant Medical Foundation Ruby Hall Clinic, Pune, India;

⁴ Safdarjang Hospital and VMMC, New Delhi, India; ⁵ Sir Ganga Ram Hospital, New Delhi, India



Psychooncology Support Is Imperative

Dr. Laxmi Shekhawat
Psycho oncologist

All though its well recognised that the diagnosis of cancer and exhausting treatment are extremely stressful events and emotional burdens for the patient. For the last 20 years psycho-oncology has rapidly developed and has produced a model that integrates psychological domain into oncology. The main purpose of psycho oncology is to investigate psychological factors with in multidimensional understanding of malignant diseases which implies psychiatric diagnostics, therapeutic, educational and research activities in oncological institutions i.e. oncology team .Psycho-oncology 1) Psychological reactions to cancer among patients, members of family and care givers. Quality of relationship between physician and patient significantly effects on patients at

each appointments with physician, at all levels of care, at all stages of cancer and during all methods of treatment. 2) Psychological, behavioural, biological and social factors that affect risk occurrence of cancer, its detection, treatment and survival.



The very beginning of psycho-oncology development was closely connected to psychoanalytic concepts. Those conceptions made etiological links between the occurrence of cancer and early family dynamic, traumatic events, unconscious sexual conflicts and personality traits. This approach led to development of two very important fields in psycho-oncology: many studies were conducted on psychobiology of stress and occurrence of liaison psychiatry.

Psychological reactions and adjustment to diagnosis and treatment

When doctor is enclosing information on cancer patient because of existential threat has to use series of adaptive defenses to withhold psychological stability. The very first encounter with a diagnosis of malignant disease arouses more intense emotional reactions than with any other disease. This leads to creating defense mechanisms with which doctors should be familiar and should acknowledge in therapeutic process. Usual accompanying psychological symptoms are fear of body image changes, disabilities, addictions and death. Patients' first reaction is fear of death or fear of separation from others and himself, and psychiatric disorders, communication with family etc. That can lead to developing panic attacks or other disorders. Person confronted with death goes through many different phases and states such as phase of denial, phase of anger, phase of bargaining, phase of depression and finally acceptance. The usual defense mechanisms among oncology patients are regression, denial, projection and suppression. Success of defenses does not only depend on ego-strengths forming during development of patients' personality but also on actual object relationships like family relationships and relations with doctors. Good communication skills are extremely important for suitable care of

oncology patients. Different ways of communicating patients' diagnosis can produce different emotional reactions. For example, absence of empathy can make the moment of finding out the diagnosis the great trauma and get carved in patients' memory for the rest of their life.

Psychological consequences of cancer diagnostics and treatment can be very significant. On the physical level, cancer can cause great changes in body image and in the way patients perceive their body. Oncology patients have various psychological problems such as emotional lability, changes in future perspectives, feelings of solitude, abandonment, marginalisation, stigmatisation, interpersonal problems, an all these problems can occur during different disease stages and during treatment with variety of psychological consequences.

Most common psychiatric disorders among oncology patients

Recent researches and clinical practice indicate that about third to half of oncology patients have different psychiatric/psychological comorbidity disorders. There are many predispose factors for psychiatric disorders among oncology patients such as nature of disease, reduced fertility, different organic factors, prior stress and psychiatric disorders, communication with family etc.

Psychological problems that can usually be seen among oncology patients are primarily depressive disorder, adjustment disorder, posttraumatic stress disorder and others are anxiety disorders, sexuality dysfunctions, delirium and other cognitive disorders provided that the psychiatrist meets with number of other problems (suicidal thoughts, results of lack of family and social support, personality disorders which causes problems in state of extreme stress, question of ability to make decisions, mourning, quality of life, spiritual and religious questions, etc.)

Anxiety associated with cancer amplifies feelings of pain, interferes with sleep habits, causes nausea and vomiting, and negatively affects on patients quality of life. Unless it is treated serious anxiety can affect the length of patients' life. Anxiety symptoms are common at the initial stage of cancer diagnosis, during treatment decisions, as well as with concerns about return of the disease or disease progression but rate of fully developed anxiety disorders is not significantly higher from the one in general population. Contrary to all assumptions patients with advanced cancer have less fear of death but greater from uncontrollable pain,



state of loneliness and dependence on others. The experience of life threatening disease, as cancer, can lead to development of PTSD. Some of the risk factors for PTSD occurrence after cancer include past experience of stress life events, history of psychological disorders, high level of distress prior to cancer diagnosis, coping through avoidance, poor social support and worse physical functioning.

Cancer patients much more frequently have passive suicidal thoughts than real suicidality, although it can be present among uncooperative patients or among those who refuse treatment. The effects of depression on mortality are not definitively confirmed although depression is linked to rapid progression of disease (Prieto et al. 2005). Possible reasons are neuroimmunological changes, reduced compliance with treatment, behavioural changes and effects of depression on social, labour and family functioning.

Psychological interventions

Psychoanalytic knowledge greatly contributes to understanding of unique personality in the structure of the patient, specific models of stress response, unique defence mechanisms, memory as a result of unique experiences, fantasy, fiction, desire, dreams, thoughts and feelings. Elements necessary for formulating psychotherapeutic approach in work with oncology patients are based on defining personality structure of patients, current problems (reason for psychiatric interventions), patient situations ("life stories"), including experience and meaning of actual disease, identifying life events and crisis that could affect current situation, defences for reducing disease related stress, hospitalization, operative or conservative treatments and behavioural patterns used in the past as possible predictors of reactions to present situations. The aim of psychotherapeutic interventions during treatment of oncology patients is reducing and removing difficulties and bringing psychic stability. The purpose of treatment is not in personality change because they are primarily treated for other difficulties but by the end of treatment some personality changes might occur as a consequence of long term hospitalization and psychotherapeutic interventions.

Psychotherapeutic approach for oncology patients includes following activities: informative-educative meetings with patients (individual and group); individual psychotherapeutic interventions; group psychotherapy; consultations of liaison psychiatrists with oncologists; supporting families.

Disease of one family member can emotionally affect every other family member and family as whole. In the situation of serious disease of one of their member reacts every family reacts with fear and reinforces the interdependence of family. After initial diagnosis cooperation between families members should established on different subjects like dietary regime, medication or possible disabilities or death of patient. Families have difficulties to accept their members' pain and that is the reason why therapeutic interventions are very important for families. They make it possible for patients to reconnect with their families again, to reidentify their parents, partners and children needs and to learn again how to live together with giving and accepting.

Emerging Evidence of Prophylactic Cranial Irradiation (PCI) In Decreasing The Incident of Brain Metastases In Locally Advanced (STAGE III) Non-small Cell Lung Carcinoma.

Dr. Meetu Jain & Dr. Nidhi Patni

Dep. of Radiation Oncology

The aim of prophylactic cranial irradiation (PCI) is to eradicate undetectable cerebral micrometastases before they become clinically significant without manifesting severe side effects. It has been most commonly used in those patients who have achieved complete response with initial treatment at the primary site in small cell carcinoma of lung (SCLC).

A high incident of cerebral failure is observed following radical treatment of locally advanced non-small cell lung carcinoma (NSCLC) also. Cerebral metastases may develop in 13-54% of patients with a median time to relapse between 6-12 months. Brain metastases impair quality of life and are associated with poor prognosis.

Modern therapy regimens are associated with longer patient survival there by increasing the incident of brain metastases. The RTOG 0214 study was a randomized phase III comparison of PCI versus observation in stage III NSCLC (J Clin Oncol 2011 Jan). A dose of 30 Gy in 15 fractions was delivered over 3 weeks. It showed that after one year incident of metastases were significantly different, 7.7 % versus 18.0% for PCI and observation arm respectively. However, there was no statically significant difference in one overall survival (75.6% versus 76.9% for PCI versus observation) or one year disease free survival (56.4% versus 51.2% for PCI versus observation). The study also examined the impact of PCI on neuro-cognitive function & quality of life. At one year there were no statistically significant differences between the two arms in any component of neuro-cognitive function & quality of life. However, at one year, patients in the PCI arm showed a greater decline in immediate recall & delayed recall as measured by the Hopkins Verbal Learning Test.

The updated 5 year analysis of this study was recently presented in ASTRO October 2012. The median follow -up time was 24.2 months for all patients and 58.6 months for who survived. The 5 year OS was 26.1% versus 24.6% for PCI and observation respectively and 5 year DFS was 18.5% was versus 14.9% for PCI vs observation. These were not significantly different. The incident of brain metastases at 5 years were significantly different, 17.3% versus 26.8% for PCI vs observation arm respectively. Brain metastases were diagnosed in 10% and 23% patients in PCI and observation arm respectively. Thus adequate amount of data is available to incorporate PCI in clinical practice in the management of stage III non-small cell lung carcinoma.

Happenings



Dreams Foundation fulfilling wishes of Cancer Children at the hand's of Hon' CM of Raj. Govt.



Shri Ashok Gehlot Hon' CM of Raj. Govt. on a round of the BPL ward at the newly inaugurated IPD Block



World No Tobacco Day Celebrated



Nurses Day celebrated at BMCHRC on 11 May 2013



13th Cancer Survivor's Day celebrated on 28th Feb, 13



Over 40 Kids undergoing Cancer Treatment enjoy "Chota Bheem" Movie



CANCER CARE : A Womens Wing Of Bhagwan Mahveer Cancer Hospital & Research Centre

Cancer Care is a support group established by women with a view to guide and take care of cancer patients. It provides support activities to benefit cancer patients and their attendants. With the active role played by cancer care all the patients under going treatment at this hospital also get motherly love and affection by this dedicated group of ladies working ceaselessly to help cancer patients.

Cancer care arranges for medical funds for needy and helpless patients. Promotes cancer awareness amongst masses for prevention and early detection through talks, slide shows, poster exhibitions, etc.



Save Life | Help Patients | Do Charity | Fulfill Wish

Your support will add to our fervor and will help the underprivileged in successfully overcoming the ailment.

To get associated please call : 7665435579

Contributions made are eligible for income tax exemption under section 80G.

For The Cause of Cancer Patients.....

Dear Doctors (Friends)

Greetings

The monsoon season is a period of greenery and awakening of the inner consciousness with multitude of festivals which cleanse the soul and the earth, I wish to felicitate all who have dedicated their lives and are actively engaged in patients care throughout the year without any tokenism by being engaged in selfless service to mankind "

At Bhagwan Mahaveer Cancer Hospital and Research Centre, Jaipur our emphasis has been on cancer care services which has been our cherished endeavour for the last 16 years. You will be glad to know that our's is one of the best cancer care centre in Northern India in Private Sector. Ever since, its establishment, we have strived and achieved a significant land mark in management and treatment of cancer patient in this part of the country. Apart from treatment, diagnostic updation plays an important role in early and correct treatment of patients and we at BMCHRC Jaipur have shortened the period of reporting time and enhanced the accuracy of tests thereby starting treatment at the earliest possible.

In addition with the functioning of recently added **Radio Iodine Therapy Ward** for treatment of thyroid cancer and other thyroid diseases, installation of PET CT Scanner, Gamma Camera, IMRT, IGRT, **Rapid Arc Linear Accelerator**, accuracy is being ensured. Our next, most reliable service to be started in the



Department of Pathology, the introduction of Flow Cytometry - a Technique to analyze multiple properties of cells in very little time. "In Cancer Hospital, this technique is used to confirm & to differentiate between various types of cancerous conditions."

Dear colleagues surgery is of great eminence in treatment of various tumours, to make this possible world class Operation Theatre Complex has been developed comprising of three (3) Modular, One Integrated and Three (3) Other O.Ts are fully functional and complicated surgeries are well taken care of. Various, Government, Semi Government and other Corporate bodies (about 100) have recognized our services and accorded empanment for treatment of their employees and their dependents.

Since advanced cancer care facilities are may not be available at many places may we request you to kindly refer any cases requiring urgent care and diagnosis to our hospital where we assure the best possible treatment, care, management and of-course treatment with human touch and smile - **"To me, A Home Away From Home"**.

Here, I further, wish to submit that treatment facilities will be provided to all your referred patient at an affordable cost.

" Lets get together and control cancer"

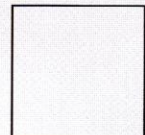
Thanking you.

Yours truly

(Dr. Prem Singh Lodha)

Treasurer Trustee cum Executive Director

To _____



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