Mar - Apr 2025 | Issue 6

The Delhi North DOCTOR

THE BULLETIN OF INDIAN MEDICAL ASSOCIATION

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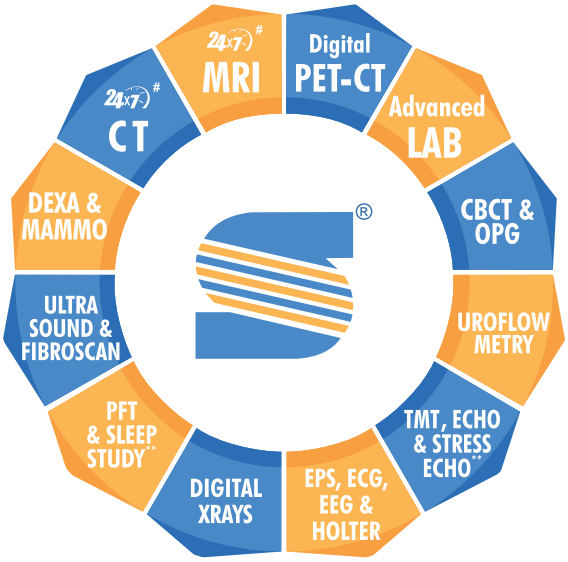

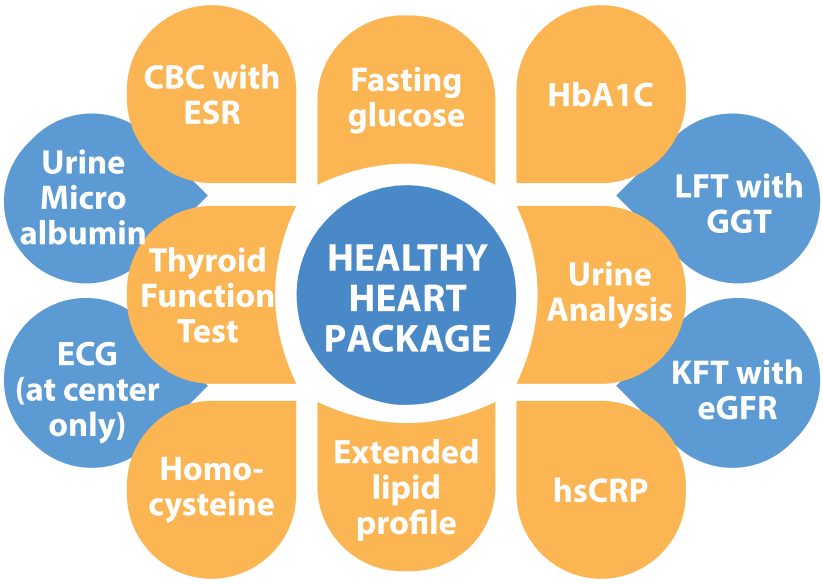

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From the Secretary's Desk

Dr. Shakuntla Kumar
Secretary

Dear Friends

As the year has passed by : the constant that stays back is : Change.And Change brings with it Growth. Learning from past makes us experienced and moving forward with gratitude and generosity towards all fellow colleagues brings about cohesiveness and cooperation. Dear friends, it's time to say goodbye with the change of guards. Sincerely Wishing the oncoming team for a successful tenure carrying forward the mission and vision of IMA DNZ.

With Regards
Dr. Shakuntla Kumar

OBITUARY

Our deepest condolences to the families who lost their near and dear ones.

1. Dr Suresh Munjal left for his heavenly abode on 1.03.2025.
2. Dr V. S. Gupta father of Dr. Richie Gupta passed away on 6.03.2025.
3. Smt.Chandrawati mother of Dr. Dinesh Singh departed from us on 6.04.2025.

OUR PRINTER OF THIS BULLETIN

MR. GAJENDER BATRA departed to his permanent home in heaven on 11.03.2025.

Our heartfelt condolences to the bereaved family.

From the President's Desk

Dr. Jyoti Chugh

Senior Consultant OBG
Satyam Medical Centre
Fortis Hospital Shalimar Bagh

Dear Friends,

As I pen down the last message as President for our sixth and final bulletin there are mixed emotions.
An extremely busy, eventful and hectic year, culminated with the Annual conference which was a huge success. The euphoria and joy is still lingering and now the sudden lull.

Life is slowly returning to its old routine and I am beginning to enjoy it .

I am glad ,I could encourage at least two to three from the young brigade to come forward and work actively to take IMA-Delhi North Zone to greater heights.

I Must thank all members my enthusiastic pink team who actively participated in all activities of the branch.

I take this opportunity to thank our main sponsors for the bulletin ,ACTION MEICAL INSTITUTE& ACTION CANCER HOSPITAL, RAJIV GANDHI CANCER INSTITUTE AND RESEARCH CENTRE,SARAL DIAGNOSTICS & GUPTA DIAGNOSTIC CENTRE.

I wish Dr. Praveen Bhatia our incoming President along with the enthusiastic new team all the very best for the coming year . We did a good job and I am certain they will do even better.

The loss of Dear Mr Gajender Batra our chief Printer for the bulletin after a prolonged illness left a huge void.

I once again thank each and every one of you who encouraged, appreciated us and actively participated in all our events.

I apologise for the many mistakes I made and yet each of you were magnanimous enough to pardon.

GOD BLESS EACH ONE OF US!
LONG LIVE IMA-DNZ!
JAI HIND!

DR Jyoti Chugh
Senior Consultant & Director
Satyam Medical Centre
Fortis Hospital Shalimar Bagh

From the Editor's Desk

Dr. Madhu Varma
Editor

Dear DNZians,

Change of gaurd done and new team has taken over, but our commitment of six bulletins remain. So with this last bulletin, our promise is full filled.

It was lovely working with the last team, led by Dr Jyoti Chugh and my sincere best wishes to the new team being led by Dr. Praveen Bhatia.

Meanwhile the loss of our printer, friend, advisor and a beautiful person at heart, was shocking. His sincere soft words endeared him to everyone. Some loses lead to a void inside you, he was one such human being.

All my best wishes to the new team

God bless

Dr Madhu Varma

Real Journeys, Real Victories

Action Cancer Hospital

FERTILITY SPARING TREATMENT IN OVARIAN CANCER

Dr. Shruti Bhatia
(Principal Consultant),

Dr. Shubhi Yadav
(Consultant)

Dept. of Gynae-oncology, Action Cancer Hospital

Ovarian cancer, though commonly associated with postmenopausal women, is increasingly being diagnosed in younger patients, emphasizing the need for heightened awareness. This case of a 27-year-old unmarried female with a complaint of persistent abdominal pain highlights the need for early diagnosis and treatment. Despite her general examination revealed no abnormalities, and she had a history of regular menstrual cycles with no significant past medical or family history, her imaging studies, including ultrasonography and MRI, revealed a multiloculated cystic lesion of 6 x 5cm in the right adnexa with a solid echogenic focus, while PET-CT suggested malignancy with increased FDG uptake in the solid component. Tumor marker investigations showed elevated CA-125 (163 U/ml) and CA 19.9 (70 U/ml), raising suspicion for ovarian malignancy. Given the patient's age and fertility concerns, she was counselled for fertility-sparing surgery. She underwent right adnexal mass excision and frozen section, which indicated malignancy. In the same sitting, staging laparotomy was done, which included infracolic omentectomy, peritoneal biopsies, and lymphadenectomy. Final histopathology confirmed Grade 1 Endometrioid Carcinoma of the right ovary (pT1a N0 Mx). Patient did not require any adjuvant chemotherapy and was asked to follow up 3-monthly. This case highlights the importance of early detection and intervention in ovarian cancer, even in young women. We should remain vigilant in such cases as timely diagnosis and referral can significantly impact prognosis and fertility preservation. Secondly, frozen section of ovarian masses can help in making accurate diagnosis, and can avoid second staging surgeries.

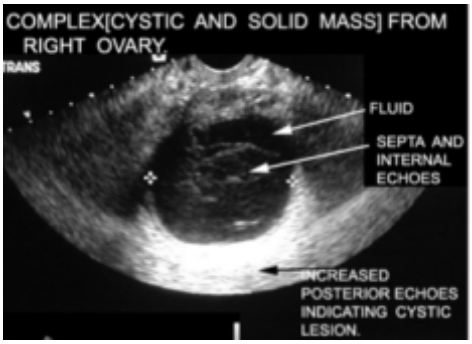
Fertility-Sparing Surgery in Ovarian Cancer:

Ovarian cancer is a significant concern for women of reproductive age. However, with advances in medical research, fertility-sparing surgery (FSS) has emerged as an option for select patients, preserving reproductive potential while ensuring oncologic safety. FSS involves the preservation of at least one ovary and the uterus, allowing the possibility of future conception. The primary goal is to balance cancer control with fertility preservation.

FSS is most suitable for women of childbearing age who wish to become pregnant. The conditions under which FSS may be considered include epithelial ovarian cancer (EOC) at Stage IA and selected Stage IC cases, germ cell tumors, sex cord-stromal tumors such as granulosa cell tumors, and borderline ovarian tumors, which have an excellent prognosis.

Patients and their families must be thoroughly informed about the potential oncological and obstetrical outcomes. The procedure should only be considered in early-stage disease with adequate surgical staging. A histopathological review by an expert pathologist is crucial to confirming eligibility. Furthermore, patients must be compliant with follow-up, as regular monitoring is essential for long-term success. Genetic risk assessment and counselling should also be implemented to identify carriers of the BRCA mutation or other hereditary cancer genes related to EOC.

Adjuvant chemotherapy may be necessary for some patients. Regular surveillance is crucial Patients should undergo regular physical examination and serum tumor marker assessments, such as CA-125 , every three months for the first two years and then every six months until five years post-surgery. Additionally, every young patient diagnosed with ovarian cancer should be evaluated for hereditary high-risk genes related to ovarian cancer, including BRCA1 and BRCA2.



Conclusion

Fertility-sparing surgery offers hope for young women with early-stage ovarian cancer, allowing them to retain reproductive potential without compromising their survival. As medical advancements continue, we must stay informed about the latest criteria for FSS, surgical approaches, and follow-up care. By facilitating early referrals, educating patients, and supporting multidisciplinary collaboration, we can ensure optimal outcomes for these patients.

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BEYOND AESTHETIC CONCERNS
Understanding and Addressing Breast Hypertrophy

Dr. Seema Patni
M.S. (Gen.Surgery)
Senior Consultant Surgeon
Fortis Hospital Shalimar Bagh

When we hear the word "breast," our minds often jump to breast cancer-an understandably well-publicized and feared disease. However, what many do not realize is that only 10-12% of breast-related issues are cancerous. The remaining 88-90% fall under benign conditions, some of which, though not life-threatening, severely impact a woman's quality of life.

Introduction

One such condition, often overlooked and underestimated is breast hypertrophy or macromastia -an excessive enlargement of breast tissue or large voluminous brest. It can lead to significant physical, emotional, and social challenges. Health is defined + as a state of complete physical, mental, and social well being by WHO. Unlike the common perception that large breasts are merely a cosmetic concern, breast hypertrophy is a debilitating condition affecting posture, mobility, and mental health. Unfortunately the stigma surrounding this issue means that many women suffer its effects in silence

Breast hypertrophy is characterized by an excessive and disproportionate increase in breast size relative to body frame. It can occur at different life stages and is classified into the following types:

1. Pubertal Hypertrophy (Virginal Hypertrophy) – Begins with puberty and continues for 2-3 years post-menarche, leading to distressing breast enlargement in young girls.
   the following types:
2. Gravid Macromastia (Gestational Hypertrophy) Develops during pregnancy and persists even after lactation. -
3. Adult Hypertrophy – Can occur in adult women due to increased serum prolactin levels or without any obvious cause.
4. Drug-Induced Hypertrophy – Rarely, certain medications like penicillamine can trigger excessive breast growth

Characteristic &Symptoms:

Throughout a woman's life, breasts undergo continuous changes due to hormones-from puberty, menstruation, pregnancy, and lactation to menopause. Post menopause till end of life.

Adolescents and Young Wobreast hypertrophy is often dismissed as a cosmetic issue rather than a medical concern. sudden breast enlargement disproportionate to their body. They become self-conscious, face social bullying, and, in severe cases, abandon social activities, sports even education due to peer ridicule.

Pregnant and Postpartum

Women: Breast enlargement can make sleeping in lying position become uncomfortable, interfere with breastfeeding and cause distress due to persistent heaviness. Menopausal Women: lack of hormons lead to breast ptosis or sagging, some extreme cases where the breasts hang below the umbilical region, further exacerbating physical discomfort and self-esteem issues.

Physical Challenges and Health Risks

Women with macromastia often struggle with:

Chronic Pain: Persistent musculoskeletal pain in the neck, back, and shoulders due to the added weight. Many seek treatment from orthopedic specialists but receive only temporary relief. Lack of physical activity invites obesity & this vicious cycle add more miseries.

Postural Deformities: Long-term forward bending leads to postural kyphosis (hunchback) and, in severe cases, ulnar + neuropathy due to compensatory posture changes. Skin Problems: Deep bra strap grooves on the shoulder abrade the skin. painful intertrigo (rashes under the breast folds), and recurrent skin infections in mammary folds& breast cleft.

Respiratory Restrictions: lying supine becomes challenging, Affective sleep quality

Despite these challenges, breast hypertrophy is not widely recognized as a legitimate medical issue, leaving many women without proper guidance or support

Management and Treatment Options

Non-Surgical Approaches

For mild to moderate cases, certain lifestyle modifications can help manage symptoms:

Proper Support: Well-fitted bras, customized to the patient's needs, help distribute the weight of the breasts evenly and reduce discomfort.

Physical Therapy & Posture Training: Strengthening back and shoulder muscles can alleviate pain and prevent posture-related issues. Weight

Management & Exercise: Although obesity can worsen symptoms, but break on cycle of inactivity is encouraged.

Topical Treatments & Hygiene Measures: Medicated powders and barrier creams can help prevent infections and skin irritation in the breast folds.

Surgical Treatment: Breast Reduction Mammoplasty

Normally breast reduction mammoplasty is the best treatment for these patients. This surgery preferably done in female's who have completed their families because this surgery jeopardize breast feeding. The cost of surgery, hospitalization. operative & post operative anaesthesia & surgery

related problems must be weighed against the profound benefits of pain reduction. This can be done by various techniques. Aim is to reduce the volume of breast with aesthetics. All techniques depend upon breast size shape & nipple position etc. Unlike breast augmentation where no breast tissue handling no interferance with breast feeding no scars while in reduction mammoplasty breast tissue is handled & cut, nipple is repositioned & produce visible scar. Post surgery patient can not feed. These female require meticulous preoperative counseling. This surgery has some post op complications too like other surgeries. Wound infection altered nipple sensation scarring are most common.

Our Breast Clinic we found the patients after reduction mammoplasty were very satisfied. All of them felt free of excessive burden on their chest. It boost their self esteem even they felt more comfortable with their outfits. One lady who had little altered nipple sensation happily accepted it as she could lie down in supine position after long time.

Sometimes virginal hypertrophy breast girls undergo reduction mammoplasty as the excessive volume of breast hamper their routine life adversely.Respiratory restrictions in lying position become very challenging. In these female normally amputation of breast with repositioning nipples remains the only option.

Challenges & Conclusion :

Ignorance remains our greatest challenge. Our society is still not mature enough to discuss females body issues. Even among physicians these topics are uncommon.

Barriers to Proper Care:

Lack of Awareness: Many women do not recognize breast hypertrophy as a medical condition and hesitate to seek help. Limited Access to Medical Support: In rural areas, specialized care is often unavailable, and women may be dismissed when they approach doctors with their concerns.

Financial Constraints:

This surgery requires proper hospitalization & long surgical procedures. It is a costly affair.

Surgical intervention is often categorized as a cosmetic procedure rather than a medical necessity. Most health insurance policies refuse coverage for breast reduction surgery, leaving many women without options for relief.

Steps Toward Change

✓ Medical Community Awareness: General practitioners, orthopedic specialists, and dermatologists need training to recognize breast hypertrophy as a medical issue rather than merely treating symptoms like back pain or rashes.

✓ Inclusion in Healthcare Policies: Government and private health insurers should recognize breast reduction surgery as a necessary medical intervention and provide financial coverage.

✓ Public Education & Destigmatization: Just as breast cancer and cervical cancer awareness have increased, conversations around breast hypertrophy must become normalized in public discourse.

✓ Comprehensive Patient Care: Women experiencing physical and emotional distress due to macromastia require multidisciplinary support, including mental health counseling, physiotherapy, and surgical options.

Final Thoughts

Breast hypertrophy is not just about aesthetics; it is a complex condition that affects physical health, self-esteem, and overall quality of life. The burden of this condition extends far beyond appearance, yet it remains underrecognized in both the medical community and society. It is time to shift the narrative. Breast hypertrophy is a legitimate medical condition that deserves attention, early intervention, and comprehensive care. By fostering greater awareness, encouraging empathetic medical support, and advocating for policy changes in healthcare coverage, we can ensure that no woman has to suffer in silence.

Let us break the silence and bring this conversation to the forefront-because every woman deserves to feel comfortable and confident in her own body

MINIMAL INVASIVE SPINE SURGERY (MISS) FOR SPINAL METASTATIC TUMOURS

Dr. (Prof.) Ishwar Chandra Premsagar
Chief of Neuro & Spine, Oncology Services
RGCIRC, DelhiMinimal invasive surgery has revolutionised almost every surgical field including spine surgery. But its application in spine- oncology is still very limited. Only a handful of centres are practicing minimal invasive approaches in spine - oncology.

Bony vertebral metastases may be very vascular and thus difficult to achieve haemostasis and a clear operative field during surgical decompression of tumour are the main factors for reluctance of spine onco surgeons to operate through smaller incisions.

Metastatic spine tumours are most common lesions encountered by any spine Oncosurgeon. These patients are usually very frail with post CT/RT status leading to increased immune-compromised status and weaker bones. Thus, traditional open approaches to spine with bigger incisions and extensive dissection leads to more tissue trauma and increased morbidity. Hence Minimal invasive approaches are preferable.

This is an illustrative case of spinal metastasis from extra skeletal Ewing sarcoma who was successfully treated with minimal invasive approach.

This, 21 years young male, a follow up case of Extra skeletal Ewing's Sarcoma of right kidney post nephrectomy with a metachronous metastasis in the right half of L4 vertebra presented with severe mechanical back pain, and right L5 radicular pain which severely restricted all his movements-suggestive of spinal instability and radiculopathy.

His MRI Lumbar spine was showing altered marrow signal intensity in L4 vertebra with visualization of an ill-defined T2 hypointense soft tissue approximately measuring 24 x 21 mm along the right pedicle of L4 vertebra with extension of the soft issue into the right neural foramen at L4-L5 level indenting upon the right exiting nerve root. (Fig 1 & 2).

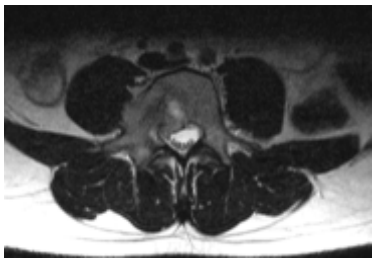

Fig. 1 pre op MRI axial view

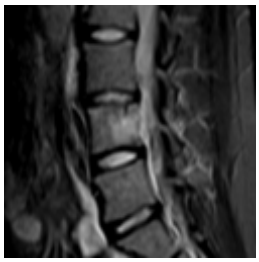

Fig. 2 pre op MRI sag view

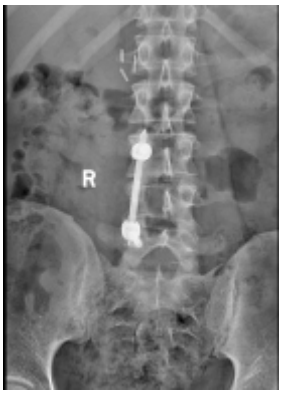

Fig. 3 post op x ray Ap view

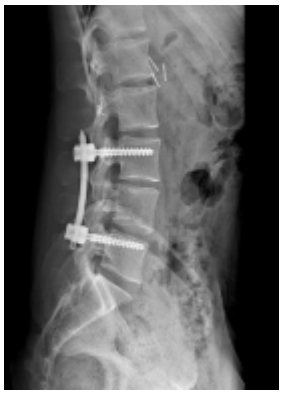

Fig. 4 post op x ray lat view

Patient underwent minimal invasive L3-L5 right sided percutaneous pedicle screw fixation with posterior L4 hemi-laminectomy with intraosseous tumour decompression with ipsilateral L4-5 foraminotomy using tubular retractor system.

Tubular retractor system uses a muscle dilating rather than muscle cutting approach with no disruption of posterior spinal ligaments and muscles. Extensive dissection of paravertebral muscles which leads to their denervation and atrophy in the long term was avoided.

Patient got significant pain relief immediately after recovering from GA and could stand up and start walking the same evening. His radicular symptoms disappeared, and minimal operative site pain required only basic analgesic medicines.

Significant number of patients with malignancies develop vertebral metastases causing instability and neural element compression rendering the patient bedridden for the remainder of his life and severely affecting QOL. With advent of modern facilities like Neuronavigation, O-arm, and drill systems and high-resolution advanced microscopes at RGCIRC minimal invasive surgery is quite safe.

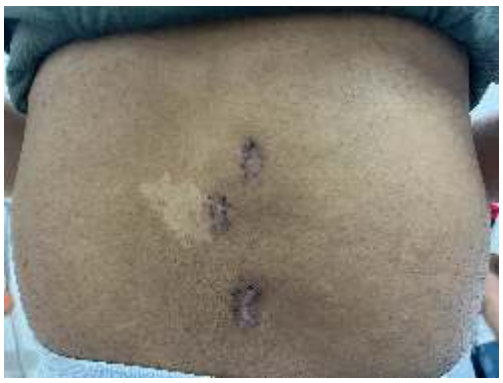

Fig. 5 small scars

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