PUNYASHLOK AHILYADEVI HOLKAR
HEAD & NECK CANCER INSTITUTE
OF INDIA

Issue No.7

May 2026

A collection of insights, stories, and updates
from the Departments of Surgery, Anaesthesia and Infection Control

HEAD & NECK CANCER INSTITUTE OF INDIA
Issue 07 · May 2026

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AT A GLANCE

82K+
OPD VISITS

10K+
SURGERIES

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SURGERY

In Search of Excellence

Dr. Sultan Pradhan, Department of Surgery

The Elements: What We Have Built

Surgery remains the mainstay of treatment for cancers of the head and neck, which include tumours of the oral cavity, nasal and paranasal sinuses, larynx, thyroid, parathyroid, and parotid glands. Yet for many years, these surgeries were being performed not by specialists but by general surgical oncologists, often relying on guidelines from Western textbooks and journals.

In Mumbai this changed when two institutes — the Tata Memorial Hospital and the Prince Aly Khan Hospital — started offering specialised training in head and neck surgical oncology through fellowships for general surgical and ENT postgraduates. Both these fellowship programmes were made possible through the **Narotam Sekhsaria Foundation,** which has supported them for 28 long years. Many of the surgeons who trained through these fellowships now occupy leadership positions in head and neck surgical oncology in hospitals across the country.

There was a clear need for a dedicated National Institute of Head & Neck Cancer — a Centre of Excellence that could integrate service, education, research, prevention, and palliative care. In response to that need, the Head & Neck Cancer Institute of India (HNCII) was established.
At the core of HNCII is the hospital, which — with a 100-bed capacity and a calm ambience — provides comprehensive treatment for head and neck cancers (surgery, chemotherapy, and radiotherapy) at genuinely affordable charges.

Experienced full-time faculty provide expert surgical care, resident training, and academic research. This year, the National Board of Examinations recognised two faculty members as postgraduate training units. This specialised head and neck residency program further enhances our service quality and academic culture. In two and a half years since commissioning, we have seen over *82,000* visits in the surgical oncology OPD and performed more than *10,000* surgeries, including *2,800* day surgeries and over *7,000* major resections.

Teaching residents and fellows is an ongoing process during surgery

Two formal academic meetings are held every week, attended by the staff of all departments for case discussions, journal reviews, and updates on ongoing projects. Surgical audit and morbidity/mortality meetings are held monthly, during which complications and measures to avoid them are reviewed. This continuous cycle of reflection and learning strengthens individual and team performance. Multidisciplinary tumour-board meetings are held on alternate days, ensuring evidence-based treatment decisions that also comply with NABH standards.

HNCII has excellent leadership in nursing management. With high volumes of head and neck cancer, the nursing staff has developed specialised expertise in postoperative care. This includes meticulous oral hygiene with power sprays, declotting of drains, tube-feeding, monitoring flap viability, early recognition of collections under flaps, and careful management of the airway and tracheostomies. Rehabilitation service is another visible marker of excellence. Our speech and swallowing department helps patients regain communication and the ability to eat safely after major surgery. Our physiotherapy team works hard to prevent trismus, shoulder stiffness, and neck stiffness. Our dental rehabilitation services support complex prosthetic and functional restoration after major resections.

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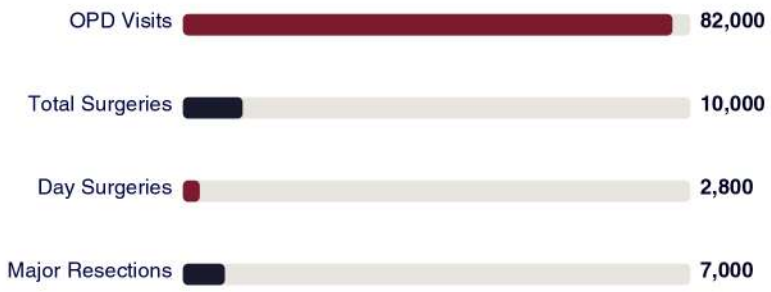
The Hospital Infection Control Committee directs key prevention strategies and antibiotic-use policies. Its contribution to patient safety and continuous quality improvement is commendable. HNCII is adding a neuro-oncology unit to complete the 'Head and Neck' dimension. Besides routine management of brain tumours, neurosurgeons will lend a useful hand to our skull-base surgeries and will also manage cases where urgent neurosurgical intervention is needed, such as decompression in a metastatic setting.

Surgery 01

Surgery 02

Surgery 03

ACTIVITY AT A GLANCE



The Quest for Change

Excellence is not only about the systems we have built: strong infrastructure, structured training, robust multidisciplinary care, and a clear commitment to affordability are all very important. But true excellence means more than this. It means a culture that is constantly asking: What needs to change? What is most appropriate for our people, our nation, and for the science of Head & Neck oncology? We can only claim to excel when our work not only delivers high-quality care, but also contributes to scientific progress and to the evolution of the specialty itself.

Our high volume of cases is an opportunity: if we ask the right questions, we can steer that volume towards meaningful research. In early oral cancer, 70–75% of neck dissections can be avoided if we can identify the small subset of patients with occult nodal disease. Advances in molecular biology may yield biomarkers that help spare many patients this surgery without compromising oncologic safety.

In advanced but oral cancers with no bony involvement, we should explore organ-preservation strategies using effective combinations of chemotherapy and targeted drugs, to avoid the devastating full-thickness lip and cheek resections and total glossectomies whose functional and cosmetic impact even the best reconstructions cannot fully overcome.

In patients with oral cancer and associated submucous fibrosis, who often tolerate adjuvant radiotherapy poorly, we must seek safer, more tolerable drug-based adjuvant options.

The choice of reconstructive flaps — microvascular and pedicle, including the submental and pectoralis-major flaps — should be guided by carefully conducted quality-of-life studies so that pedicle flaps are seen not as compromises but as cost-effective, high-value choices in appropriate patients.

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Palliative care must also evolve beyond compassion and morphine, with evidence-based options such as acupuncture, acupressure, and targeted nerve-block protocols explored in selected patients to improve pain control, swallowing, and quality of life.

Some of these ideas will need multi-institutional collaboration. HNCII must build bridges with other credible centres and encourage young Head & Neck oncologists to ask questions. The "question" is the beginning of scientific progress. Excelling in service delivery is essential — but not enough. Science must progress, and HNCII must be part of that progress.

It has been a privilege to lead this effort, together with a full-time faculty team that is committed to making HNCII a Centre of Excellence. We have not written a formal manifesto for what constitutes a Centre of Excellence; its elements have been time-tested by leading institutions around the world. We have followed them with rigour. And in the India in which we practise, we have gone a step further: we have pursued a mission of affordability. There is hardly a patient whose first question is not, "Kharcha kitna hoga?" (How much will it cost?)

Whether it is a glossectomy or laryngectomy, mandibulectomy or maxillectomy, thyroidectomy or parotidectomy, the total bill at HNCII is half or even one-third of what it will be at many other well-known hospitals in the city, with quality and ambience at least as good, if not better. Affordability is as important as excellence.

HNCII still has a long journey ahead, but the direction is clear: we are building a Centre of Excellence in Head & Neck oncology in the context of the India in which we practise, where affordability is as important as excellence. That is the reality we cannot ignore.

HNCII will strive to be a leader in Head & Neck oncology because it is the right thing to do for our patients, our country and for the future of this profession.

> ***"Affordability is as important as excellence. That is the reality we cannot ignore."***

Oncology Team

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SURGERY

Head & Neck Cancer: A Citizen's Freedom Movement for Prevention & Early Detection

Dr. Sultan Pradhan, Department of Surgery

Head and neck cancers are India's most common group of malignancies, and yet the majority of patients still present with advanced disease. This is not destiny; it is mostly preventable, if we turn prevention and early-detection into a true national movement.

The common reasons for delay are clear:

- Denial: "This cannot happen to me."
- Fear: of cancer, its treatments, and the perceived mutilation and loss of speech and swallowing.
- Poverty and lack of savings or health insurance, so even early-diagnosed patients abandon or delay treatment.
- Ignorance and misconceptions, such as the belief that biopsy or surgery will "spread" the cancer.
- Blind faith in Ayurveda and Homeopathy, which often leads to long delays in evidence-based care.

Health professionals, the government, and NGOs can do their best, but none of this will ever be enough unless citizens take ownership. We need a "Citizen's Freedom Movement" against Head & Neck cancer: a movement that frees India not only from the disease but also from the fear, stigma, and delay that define so many lives.

Three core messages must drive this movement:

- The danger of delay: as the disease advances, treatment becomes more extensive, more costly, and less successful.
- The benefits of early detection: early-stage Head & Neck cancers can be cured with less morbid, less mutilating, and less expensive treatment.
- The importance of saving for treatment: health insurance and financial planning are not luxuries; they are essential tools of prevention.

Organisations such as Rotary, Lions, and other civic and corporate bodies should adopt this cause and help spread the message of self-inspection, early screening, and prompt treatment.

School and college level education, in collaboration with Oral Medicine departments and NGOs, can embed these ideas in the next generation.

In the spirit of India's great freedom fighters, we need modern-day civic leaders who can mobilise the public, sustain the movement, and help reverse the high ratio of advanced-to-early-stage H&N cancers.

HNCII is ready to play its part through community outreach and early-detection programs. But the real power lies in the people. For this movement to succeed, every citizen must become its messanger.

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"Early-stage Head & Neck cancers can be cured with less morbid, less mutilating, and less expensive treatment."

COMMON REASONS FOR DELAYED PRESENTATION

01	Denial — 'This cannot happen to me'
02	Fear of cancer and its treatments
03	Poverty and lack of health insurance
04	Ignorance and misconceptions about treatment
05	Delayed presentation due to alternative medicine

SURGERY

The OT of HNCII: A Vibrant World Within a Hospital

Dr. Kanav Kumar, Department of Surgery

In the eyes of the public and patients, the operation theatre is frequently regarded as the exclusive domain of the surgeon. This is a space where skilled hands and decisive minds save lives. However, this perspective often overlooks a silent, dedicated team that works quietly and efficiently in the background. Their contributions are essential to every successful procedure.

Step inside the operation theatre of our hospital, and you enter a world where teamwork, experience, and supervision come together like magnets drawn to one another. It is a place steeped in quiet concentration, where every individual has a defined role to play, even as the anaesthetised patient sleeps on in blissful unconsciousness.

For the patient, the operation theatre is a formidable place that evokes anxiety. Some patients are anxious, others stoic, some are tearful, but every patient ultimately must rely on the OT team. Their spirits are lifted by calming words and the silent reassurance of care from everyone involved, particularly by the anaesthetists.

The Surgeon: Clad in sterile gowns and masks, patients look to surgeons with a mixture of fear and hope in their eyes. Every action of the operating team is chosen carefully to perform intricate procedures that can transform or save lives.

The Anaesthetist: While the surgeon operates, the anaesthetist remains ever vigilant by the patient's side. Their responsibilities are immense: managing pain, monitoring vital signs, and ensuring the patient remains safe, unconscious, and comfortable throughout the procedure.

The Nurses: The role of nurses in the OT is all-encompassing. They are vital to the functioning of the theatre and play a part before, during, and after surgery. During surgery they remain sharply focused, anticipating the needs of the team even before they are expressed.

The Technicians: They work diligently to ensure that every monitor and machine functions flawlessly. Operation theatre attendants maintain the sterility and safety of the operating room, ensuring a smooth workflow.

Though each role is distinct, every member of the team is equally vital to ensure the success of the operation.

A Powerful Example of Teamwork: A high-risk cardiac patient with advanced lower-jaw cancer underwent surgery, experienced cardiac arrest during anaesthesia reversal.

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The surgical team quickly transitioned from surgery to resuscitation, showcasing efficiency and trust. Thanks to their collective effort, the patient was revived, stabilized, and discharged. This case emphasizes that while surgeons may receive recognition, it is the entire team's collaboration that ultimately saves lives. In the operating theatre, every role is crucial, and success is a shared victory.

> *"While surgeons often take the spotlight, it is the collective effort of the entire team that saves lives."*

ANAESTHESIA

History of Anaesthesia

Dr. Roshan Chinoy

Anaesthesia, the art and science of rendering patients insensible to pain during medical procedures, is a vital science of modern medicine. Yet its journey from rudimentary methods to sophisticated technology has been marked by remarkable discoveries, amusing mishaps, and ingenious improvisations.

The history of anaesthesia is an incredible journey of innovation, perseverance, trial and error, inadvertent cruelty, and, yes, a fair bit of unintentional comedy. From herbal concoctions and attempts at mesmerisation with swinging shiny watches, to computerised drug delivery and robotic surgery, anaesthesia has come a very long way.

Ancient civilisations were earnest, and often desperate, to find ways to dull the pain of illnesses and of surgery. A Roman surgeon might try to dull the pain of his gladiator patient with a cup of wine and a prayer, though there was always the risk that the operation would outlast the effects of the wine. The Sushruta Samhita, an Indian medical text dating back to 600 BCE, described the use of wine and cannabis to render patients more comfortable during operations.

In China, acupuncture was employed as a method of pain relief

Mental illnesses were treated by making burr holes in the skulls of screaming patients, and pregnant women unable to deliver normally were made to lie in the path of mad bulls and enraged animals. In a lighter vein, a particularly humorous episode occurred in 1846, when dentist Horace Wells attempted to demonstrate the use of nitrous oxide ('laughing gas') for painless tooth extraction in Boston. Unfortunately, the patient groaned loudly during the procedure, causing the audience to jeer and shout, *'Humbug!'* The demonstration was considered a failure, but ironically, nitrous oxide would later become a mainstay of dental anaesthesia.

The Birth of Modern Anaesthesia: The breakthrough came in the same year, 1846, when an American publicly demonstrated the use of ether at Massachusetts General Hospital. The patient was rendered insensible for the removal of a neck tumour, the crowd was stunned at the absence of pain or struggle. *'Gentlemen, this is no humbug,'* declared the surgeon, Dr. John Collins Warren.

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Chloroform soon followed, championed by James Young Simpson in Edinburgh. It became famous when Queen Victoria used it during childbirth in 1853, giving it a royal seal of approval. With the discovery of safer agents such as halothane and the development of muscle relaxants, anaesthesia entered its scientific age.

The following decades saw a host of innovations in anaesthetic techniques and drugs. Ether and chloroform, though effective, carried risks —leading to the search for safer alternatives.

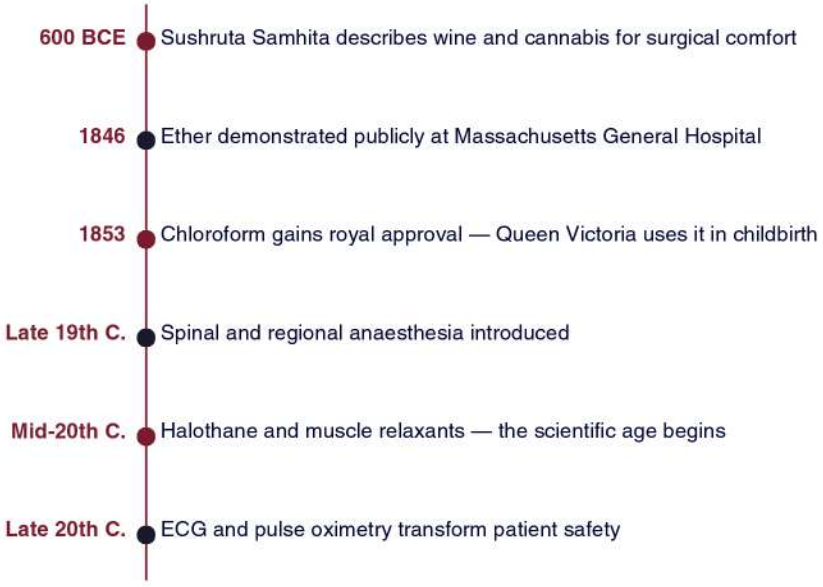
> *"Anaesthesia has come a very long way — a testament to human imagination and the strong desire to alleviate pain."*

The introduction of spinal and regional anaesthesia in the late 19th and early 20th centuries allowed surgeons greater precision. Local anaesthetics like cocaine (first used in eye surgery) brought their own set of mishaps—most notably, excitable doctors accidentally numbing their own fingers or, in one famous incident, an entire surgical team accidentally inhaling enough anaesthetic to become giggly and unsteady.

With the discovery of safer agents such as halothane and the development of muscle relaxants, anaesthesia entered its scientific age. An amusing yet telling episode occurred in the 1950s when a new anaesthetic agent was tested on a volunteer. The patient, upon awakening, described vivid dreams of riding elephants through a colourful jungle—proving that anaesthesia could be both effective and, at times, entertaining.

The advent of monitoring equipment — ECG, pulse oximetry — in the late 20th century greatly reduced the risks, transforming anaesthetists from 'ether pushers' into highly skilled perioperative physicians. This period also saw the rise of anaesthesia as a respected medical specialty in India and worldwide.

PROGRESSION OF ANAESTHESIA: FROM ANCIENT TO SCIENTIFIC



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ANAESTHESIA

Guardians of Comfort: Behind the Mask

Dr. Rafique Khimani, Department of Anaesthesia

Message from the Head of Department

It gives me great pleasure to contribute to this edition of our newsletter, dedicated partly to the Department of Anaesthesia. Our department continues to grow in strength through teamwork, dedication, and commitment to patient safety. I thank each member for their hard work and contributions towards excellence in perioperative care. Let us continue striving for innovation, learning, and compassionate care.

The Anaesthesia Department at the HNCII is proud to have a dedicated team of highly trained **Head and Neck Onco-Anaesthetists** who specialize in managing the most challenging airways. We care for patients who require advanced techniques such as awake fibre-optic intubation and those who come with airway obstruction, ensuring safety even in the most complex situations.

We are recognized as a **Centre of Excellence**, providing specialized services that are not widely available elsewhere. Our team supports a wide range of advanced and life-saving surgical procedures, including major head and neck cancer surgeries, complex laryngeal operations, reconstructive surgery of the mouth and jaws, skull base surgery, functional endoscopic sinus surgery, and laser surgery of the larynx and trachea. We also manage high-risk situations such as shared airway procedures, acute massive hemorrhage, and massive blood transfusions, as well as providing safe anaesthesia for emergency surgeries. Beyond the operation theatre, our department extends its care to **Non-Operating Room Anaesthesia (NORA)** services, including CT scan, PET scan and Radiotherapy procedures, ensuring patient comfort and safety during important diagnostic tests.

With skill, experience and compassion, our department stands committed to delivering safe anaesthesia and trusted care in even the most critical moments.

The Anaesthesia Team at HNCII

> *"We care for you before you sleep… and stay with you until you wake up safely."*

TEAM ANAESTHESIA

Dr. Rafique Khimani
Over 42 years of experience. Specialises in difficult airway surgery. Previously a long-term consultant at Prince Aly Khan Hospital.

Dr. Meher Elavia
An impressive 50-year career. Expertise in difficult airway surgery, having served at Tata Memorial Hospital, Breach Candy Hospital, Parsee General Hospital, and Prince Aly Khan Hospital.

Dr. Janardan Talla
22 years of experience in monitored anaesthesia care. Known for a calm presence in difficult environments with unwavering commitment to patient safety.

Dr. Shital Rajput
Senior consultant and dedicated onco-anaesthesiologist with over a decade of experience, practising since 2013. Highly skilled in managing complex airway surgeries and anaesthesia for advanced robotic surgeries.

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Dr. Farheen Shaikh
Holds an MD and DNB in Anaesthesia, with over 8 years of experience as a junior consultant at Wockhardt Hospital, Mumbai Central.

Dr. Mahrzeba Quazi
Clinical Associate in Anaesthesia with 4 years of experience. Has worked at Fortis Hospital, Cooper Hospital, and Jaslok Hospital. Skilled in perioperative anaesthesia care, patient monitoring, and OT/ICU management.

Dr. Ruchira Vinekar
Clinical Assistant with special interest in difficult airway management and critical care. Formerly associated with SR Mehta and Kikabhai Cardiac Institute as Intensivist.

Our Mission

At our Anaesthesia Department, patient safety and comfort are at the heart of everything we do. Our team of highly specialized and experienced doctors is available round the clock to care for patient before, during and after surgery. We are dedicated for providing safe and smooth anaesthesia, complete peri-operative care, with special attention to pain relief, ensuring that every patient feels secure and well-supported.

Use of the latest technology such as Video Laryngoscope, Fibre-optic Bronchoscope and High-Flow Oxygen Systems provides the highest level of safety. Advanced monitoring systems help to carefully measure the depth of anaesthesia, so that the patient remains comfortable and protected throughout the procedure.

After surgery, every patient is closely observed in a specialized Post-Operative Care Unit, under the constant supervision of our expert team, until full stability and comfort are achieved.

Our mission is simple: to provide safe anaesthesia, empathetic care and a peaceful recovery for every patient who trusts us with their life.

A note to our Patients & their Family:

We recognize that surgery can be intimidating due to fears of pain and the unknown. At HNCII's Department of Anaesthesia, we provide compassionate care and support throughout your surgical experience. A dedicated anaesthesia doctor monitors your comfort and vitals during the procedure.

Our commitment includes:

- Safe, modern anaesthesia for all surgeries
- Pre-surgery check-ups and counseling
- Pain-free recovery support
- Emergency and critical care anaesthesia
- Specialized care for children, elderly, and high-risk patients.

Patient Comfort & Safety First:

Before surgery, the anaesthesiologist will:

- Review your medical history
- Explain the type of anaesthesia
- Answer all your questions
- Help reduce fear and anxiety

After surgery, we ensure:

- Proper pain management
- Continuous monitoring
- Smooth and safe recovery

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Patient Voice:

"I was very nervous before my surgery, but the anaesthesia doctor explained everything so clearly and made me feel safe. Thank you for taking such good care of me."

— A Happy Patient

Our Heartfelt Commitment:

At HNCII hospital, your safety is our responsibility and your comfort is our Commitment. We care for you before you sleep… and stay with you until you wake up safely.

ETHICS

Ethical Dilemmas in the Practice of Surgery

Dr. Kartik Krishnan, Department of Surgery

THE FOUR PILLARS OF MEDICAL ETHICS

AUTONOMY	BENEFICENCE	NON-MALEFICENCE	JUSTICE
Patient's right to decide	Patient's best interest	First, do no harm	Fair distribution

Inside the operation theatre, a surgeon's hand moves deftly and confidently, guided by training, experience and an innate sense of anatomy. Operated wounds from the surgery, can be reconstructed flawlessly by the trained plastic surgeon, or the onco-surgeon.

But what happens when the most cruel and irreparable damage comes not from the scalpel, but from the surgeon's inability to grasp, understand or act by ethical principles that may get violated in the course of treatment? Ethics, even in today's modern medicine, is deeply rooted in the principles of the Hippocratic Oath with the highpoint being *Primum Non Nocere* (First do no harm).

The 19th and 20th centuries uncovered a blatant ignorance and abuse of ethics in medicine, for e.g. the inhuman Nazi experiments by doctors and researchers. Decisions made by the judges following the doctors Trials in Nuremberg gave rise to the Nuremberg Code at the end of the Second World War, which underlined the principle of 'informed consent'. This was followed by the Geneva declaration (1948) and the Helsinki declaration (1964), with the later forming the cornerstone of ethical guidance in clinical research. The infamous Tuskegee trials resulted in the Belmont Report (1979) which laid down the principles of ethics as we know them today.

As onco-surgeons, it's vital for the medical profession to be aware of the history of ethics but also realize that medicine is constantly evolving. New frontiers reached in medicine and changing times come with their own set of ethical dilemmas. It's also equally critical to understand and apply ethical principles in the Indian context, which could be radically different from Western scenarios. Let us examine some case scenarios in our field which present ethical conundrums.

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- **The Burden of Truth (Autonomy and Beneficence)**

Take the example of Mr. Sharma *(name changed)*, a 55-year-old teacher who has advanced laryngeal cancer (cancer of the voice box). A total laryngectomy was the obvious course of treatment. He would live, but he would lose his natural voice and have to breathe through a permanent opening in the neck. As we prepared to explain this life-altering surgery to our patient, his son intercepted us secretly in the corridor, eyes wide with panic. *"Doctor,"* he pleaded, *"please don't tell Papa it is cancer. And don't tell him he will lose his voice. He is a proud man. If he knows, he will give up. Just tell him it is a small procedure to clean the throat."*

We could not possibly remove a man's voice box without his explicit, informed agreement - both legally and ethically, it would be a breach of trust at an emotional and legal level, if we operated without Mr. Sharma's consent. We could relate to the son's concerns and anxiety. Protecting our elders from emotional turmoil and harm is a sign of affection in our culture. If we insisted on "Autonomy" and bluntly told Mr. Sharma the cold facts, we might destroy the family's trust—the very support system he needs to survive. But if we agreed to the son's "Beneficence," we would be operating on a man who didn't know what he was losing.

We went with the Indian way, which is the middle route. The family was seated first near us. While acknowledging their anxiety, we clarified that Mr. Sharma would awaken speechless and that the shock could be greater than the prognosis if he wasn't ready. Together, we decided to gently inform him, focusing on healing rather than loss. Rather than "Informed Consent," as defined in the textbook, it became "Compassionate Consent."

- **Palliative vs Curative Intent (Non- maleficence and Beneficence)**

Rohan (name changed), a 22-year-old engineering student, arrived with a significant, fungating recurrence of sarcomatoid carcinoma in his left neck. He had previously undergone surgery and received the maximum dose of radiation. The tumour was breaking through the skin, emitting a foul odour, and actively oozing. More alarmingly, scans revealed that it was encasing the Common Carotid Artery (CCA), rendering it inoperable. The likelihood of a curative resection (R0) stood at 0%, with the risk of a catastrophic bleed leading to death during surgery nearly 100%.

We met with his parents in the counselling room. They were educated, weary, and filled with despair, fully aware that the cancer was terminal. However, they had a different request.

"Doctor," the father said, his voice shaking, *"We cannot bear to watch him bleed to death at home. The smell... the panic... it's too much for us. Please, take him to the operating theatre. Attempt to remove it. If he dies on the table under anaesthesia, at least he will pass peacefully. At least we will know we did everything we could."* They weren't seeking a cure; they were asking for a surgical death — a dignified ending in the sterile environment of the operating room, rather than a chaotic and traumatic conclusion in their living room.

The Ethical Dilemma

- **Logic (Non-Maleficence)**

As a surgeon, our primary oath is *Primum Non Nocere* (First, do no harm).

Operating on a patient who has no chance of survival is, by definition, physical harm. It is *"futile care."* It wastes scarce OT resources, blood products, and staff time that could save a salvageable patient. It essentially turns the OT into a graveyard.

- **Emotion (Beneficence)**

Refusing surgery meant sentencing this young man (and his parents) to a horrific final few days of profuse bleeding and terror. By operating, we could perhaps "debulk" the misery, or at worst, allow him to pass away without pain, surrounded by medical professionals.

This raises complex questions: Does it serve Rohan or alleviates his parents' guilt. Family caregivers face significant challenges; surgery may be seen as a means for survivors to cope with loss.

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There are many questions to answer: Should we perform that surgery for Rohan? Or should we perform it for his parents, to absolve them of the guilt of "giving up"? We often say "surgery is for the living." But in India, where the family caregivers invariably carry the weight of the illness, sometimes surgery is the only way to help the survivors live with the loss.

- **Distributive Justice**

It was the turbulent days of the Covid-19 pandemic. A critically ill young man desperately needed a ventilator. In the adjacent bed, an older but physically robust gentleman awaited the same lifeline. With only one ventilator available, the surgeon was forced to make a heart-wrenching choice—a decision that weighed on him heavily, filled with compassion for both lives and deep regret for the impossibility of saving them both, the clinician made his choice with a very heavy heart. This was a dilemma with no just solution, one that would haunt him, long after the crisis had passed.

The Conclusion

As surgeons, we often wish for the clear answers in the OT for our ethical questions. We want a clear legally correct decision. But in India, our practice is messy. It is entangled with heavy emotions, tight finances, and deep family bonds. Is compassionate and ethical care more important than dogged precision? These are difficult decisions, and answers are never entirely right or absolutely wrong. We rest our case, in the minds of our readers.
Hippocrates understood these challenging situations and his concluding message stands:

- *Cure Sometimes*
- *Treat Often*
- *Comfort Always*

CLINICAL

Stones, Bones, Groans, and Moans

Kasturi Jawalgikar and Dr. Roshan Chinoy, Department of Histopathology

A Story of a Mysterious Illness

A retired 72-year-old school teacher named Sonali (name changed) was being treated for the past two years for periodic episodes of projectile vomiting. She was also experiencing depression and constantly complained of bone pain, general irritability, and lower back pain. She had been facing variable persistent and distressing health issues for more than two years.

Exhausted, sick and tired of being shunted to several labs for tests, this patient had been worked up repeatedly for every possible ailment that could produce vomiting, but the only thing wrong with her blood parameters was her high blood calcium levels. Her GP, himself was a gentle old timer, and he kept plying her with anti-emetics and pain relievers. He was at his wits end for a diagnosis and some appropriate treatment. Nothing seemed to be working to relieve the increasingly irritable old lady.

Finally, she was referred to our "Head and Neck Centre" for a diagnosis and further management. Our alert radiologist had incidentally detected a grape sized midline nodule in the neck, near the thyroid gland. He also remembered an old mnemonic about a disease classically remembered as **"stones, bones, groans, and moans".**

Bingo!

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A breakthrough diagnosis of parathyroid dysfunction emerged after blood work revealed high parathyroid and calcium levels alongside low serum phosphate. Additionally, a lower back X-ray confirmed the presence of kidney calculi (stones), consistent with the condition.

- **Diagnosis**

Further blood tests revealed that her parathyroid hormone levels were rapidly rising to abnormally high levels: her blood calcium remained elevated, and in contrast her serum phosphate level was low. Collectively, these findings pointed decisively to a diagnosis of a hormonal problem.

A breakthrough diagnosis

- **Course and diagnosis**

Following the discovery of marked hypercalcemia (13.2 mg/dL) and supportive symptoms, Sonali underwent further evaluation. Her PTH level remained markedly elevated, confirming primary hyperparathyroidism. Asestamibi scan localized a single hyperfunctioning parathyroid gland on the left inferior pole of the thyroid.
Given her symptomatic hypercalcemia and end - organ involvement, she was scheduled for focused parathyroidectomy.

- **Surgery**

Sonali underwent a minimally invasive parathyroidectomy. On the operating table, our surgeons identified a single enlarged, grape-sized parathyroid growth. It was substantially enlarged as compared to normal parathyroid tissue (which is usually the size of a tiny lentil).

Figure 1: Large parathyroid adenoma (benign). Normal size = lentil. Enlarged size = grape.

The 2.5 cm sized parathyroid was excised without complication. PTH monitoring showed a sharp drop of more than 50%, consistent with successful removal of the functional gland.
Immediate Postoperative Period : In the first 24–48 hours :

1. Her calcium levels began to fall gradually
2. She experienced mild tingling and hand cramps, consistant with transient postoperative fall in the blood calcium level (a common “hungry bone” phenomenon)
3. Our patient improved gradually and went home on the 3rd post operative day

- **So, what is a ‘Normal Parathyroid’?**

The normal parathyroid glands are four in number and are lodged in the neck, in proximity with the thyroid. They play a crucial role in regulating the body’s calcium levels. They secrete parathyroid hormone (PTH), which increases blood calcium, by stimulating bone resorption, enhancing calcium absorption from the intestines, and promoting calcium reabsorption in the kidneys. This delicate balance is essential for proper muscle function, nerve transmission, and overall metabolic stability.

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- **Parathyroid Adenomas (Benign Growths)**

Parathyroid adenomas are abnormal growths that develop in one or more of the parathyroid glands. These benign tumours can cause the affected gland to become significantly enlarged, as was observed during Sonali's surgery, where a single large, grape-sized adenoma was identified. In comparison to normal parathyroid tissue, which is typically the size of a tiny lentil, Sonali's gland was huge.

The presence of an adenoma disrupts the gland's function, often leading to excessive secretion of parathyroid hormone (PTH) and subsequent imbalances in calcium levels within the body.

> *"These are rare tumours, often misdiagnosed or missed entirely. At HNCII, we have seen more than 19 such cases in just two years."*

The surgical removal of the adenoma is effective and a curative treatment, usually confirmed intraoperatively by a sharp decrease in the otherwise raised PTH levels, as seen in Sonali's case.

These are rare tumours, often misdiagnosed or missed totally. At our centre in HNCII we have seen more than 19 cases of parathyroid growths over a period of two years. It is a very gratifying surgery as the patient returns to normal, cured, within a short period of time.

INFECTION CONTROL

What If? The threat of Antibiotic Resistance

Dr. Prapti Gilada and Dr. Trupti Gilada, Department of Infection Control

What if we were living, once more, in an era where there were no antibiotics? How can anyone overlook the horrors of the past — the suffering, death, and devastation that once swept through humanity before these life-saving drugs were discovered? Will the loss of antibiotics become mankind's next great tragedy unfolding before our very eyes?

Before Alexander Fleming's remarkable discovery of penicillin in 1928, hospitals were sites of high risk. Soldiers on battlefields often died, not from their wounds, but from the infections that followed. Mothers succumbed to childbirth fever, and children perished from pneumonia, diphtheria and bacterial infections — diseases that today are readily curable with a short course of pills. Without antibiotics, surgery would again become a gamble. Humanity would return to that era, when unchecked microbes ruled the world. Are we actually heading towards the very disaster in the near future?

- **The Advent of Antibiotic Resistance**

Even as antibiotics once rescued humankind from the brink of microbial tyranny, their overuse and misuse now threaten to undo that triumph. Antibiotic resistance, spawned from decades of careless prescriptions, self-medication, unnecessary usage, and agricultural abuse, has allowed bacteria to evolve into formidable, drug-defying adversaries. Diseases which were once curable like tuberculosis, gonorrhoea, pneumonia — are re-emerging in deadly, resistant forms. Hospitals now battle "superbugs" that no longer respond to the most powerful antibiotics.

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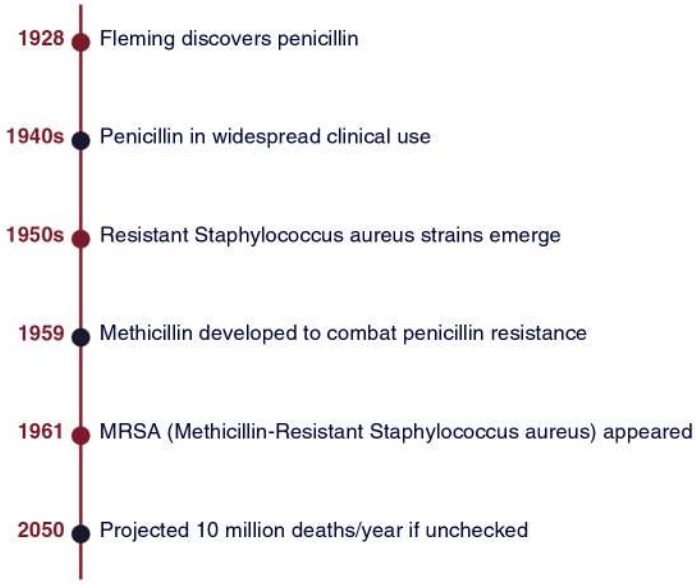
- **How does Antibiotic resistance develop?**

Antibiotic resistance arises through the natural process of genetic mutation and selection within bacterial populations. When antibiotics are used—especially when overused or misused—some bacteria survive because they acquire mutations, or genes that protect them from the drug's effect. These tough surviving bacteria then multiply, passing their resistant traits to future generations of bacteria. Resistance once confined to one bacterial strain can quickly transfer to others, creating multi-drug-resistant ("superbug") organisms.

This process is accelerated by careless and thoughtless human behaviour:

- *Over prescription of antibiotics for viral or mild illnesses*
- *Incomplete courses of treatment, allowing partially resistant bacteria to survive*
- *Use of antibiotics in livestock feed, leading to resistant strains in food chains*
- *Poor infection control in healthcare settings, enabling resistant bacteria to spread*

TIMELINE OF ANTIBIOTIC RESISTANCE



Return of Once-Controlled Diseases, like tuberculosis, pneumonia, and gonorrhoea are re-merging in forms that resist multiple drugs, leading to longer illnesses, higher medical costs, and increased mortality. Similar patterns have occurred with nearly every major antibiotic class since.
This evolutionary race between microbes and medicine continues today, with resistance often outpacing the discovery of new drugs. Developing a new antibiotic can take 10–15 years, while bacteria can evolve resistance in less than a decade, sometimes in mere months of clinical use.

- **The Impact on Humanity and Medicine**

The consequences of antibiotic and drug resistance are far-reaching, affecting not only individual patients but the entire structure of healthcare and society. Resistant infections require longer hospital stays, more expensive drugs, and intensive care, straining public health systems. The World Bank estimates that unchecked antimicrobial resistance could push millions into poverty. Low and middle-income countries face the worst consequences. Resistance spreads rapidly and can cross borders through travel, trade, and migration.

- **A Foreseeable Future?**

The "post-antibiotic era" is not just a distant nightmare — it is an increasingly foreseeable reality. The World Health Organization (WHO) and the Centre for Disease Control and Prevention (CDC) warn that antibiotic resistance is one of the greatest global health threats of the 21st century.

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Already, there are strains of bacteria resistant to every known antibiotic. If this trajectory continues, by 2050, antimicrobial-resistant infections could cause 10 million deaths annually, surpassing cancer as a cause of death.

- **Conclusions:**

Antibiotic and drug resistance represent not just a medical challenge but a moral and social responsibility. They reflect the tug of war between scientific progress and thoughtless human behaviour between innovation and misuse. Resistance develops swiftly, spreads invisibly, and threatens universally.

> *Can this grim future be averted?*
>
> *Yes.*

Through responsible antibiotic use, stricter infection control, investment in new drug development, and public education, mankind can still turn the tide. The race is not yet lost—but it is perilously close.

INFECTION CONTROL

Hospital Infection Control Committee (HICC)

Dr. Prapti Gilada, Department of Infection Control

The Hospital Infection Control Committee (HICC) plays a pivotal role in overseeing infection prevention strategies and guiding key policy decisions at the Head & Neck Cancer Institute of India. The committee convenes regularly to review infection data, set priorities, and approve protocols, while the day-to-day implementation is led by the Hospital Infection Control (HIC) team.

The HIC team is responsible for developing and periodically updating evidence-based infection control policies. They ensure adherence to hand hygiene practices, implement sterilization and disinfection standards, and conduct regular staff training programs. In addition, the team performs systematic audits to identify gaps in infection control practices and ensures strict compliance with biomedical waste segregation and management protocols. Standard and transmission-based precautions, including isolation and cohorting practices, are implemented based on patient risk and clinical diagnosis. Environmental hygiene is further strengthened through structured audits of cleaning practices and high-touch surface disinfection.

The team conducts continuous surveillance of device-associated infections and hospital-acquired infections, with a strong focus on surgical site infections (SSIs). A key initiative is the 30-day post-discharge telephonic follow-up of all surgical patients, enabling comprehensive monitoring of SSI rates beyond the hospital stay and ensuring accurate outcome tracking.

In alignment with antimicrobial stewardship principles, prophylactic antibiotics in clean surgical cases are discontinued within 24 hours, and in selected clean-contaminated cases within 72 hours. These patients continue to be monitored for 30 days for any signs of infection, and we consistently have low SSI rates in this cohort.

Targeted antimicrobial stewardship interventions are actively implemented, including monitoring antimicrobial resistance patterns, conducting prescription audits for higher-end antibiotics, and tracking escalation and de-escalation practices to promote rational antibiotic use.

Compliance with infection prevention practices is reinforced through regular audits and staff engagement initiatives.

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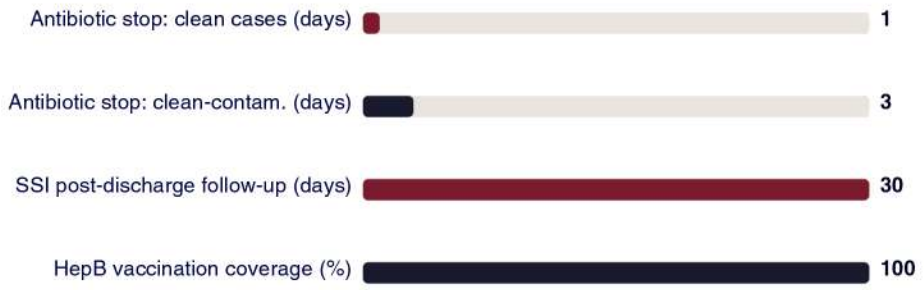
Events such as Hand Hygiene Week and Infection Prevention and Control Week are conducted through innovative activities—including games, quizzes, and an Infection Prevention Carnival—encouraging enthusiastic participation across all staff categories and fostering a strong culture of safety. Protocols are well established for managing occupational exposures, including needle-stick injuries and post-exposure prophylaxis. As part of preventive health measures, the organization has achieved 100% Hepatitis B vaccination coverage among healthcare workers, ensuring protection for both staff and patients.

Patient and caregiver education is also emphasized, with focused guidance on infection prevention practices such as hand hygiene and wound care.

These structured, data-driven interventions, the HICC and HIC team demonstrate a sustained commitment to infection prevention, patient safety, and continuous quality improvement.

> *"A key initiative is the 30-day post-discharge telephonic follow-up of all surgical patients, ensuring accurate outcome tracking."*

ANTIMICROBIAL STEWARDSHIP — KEY METRICS



PATHOLOGY

On Call… All Day…On Frozen Section Duty

Nikita Dasan, Department of Histopathology

Pathologist examining tissue sections

The day begins with a loud shout... *'Frozen!'* bellows the young OT boy, and he unceremoniously places two medium-sized bottles, with a pink form, onto the grossing table.

Even as I rush in and open the bottles, a loud thump from the pneumatic chute warns me that another tiny biopsy has already arrived for a second quick report.

Frozen section cutting—Cryostat

'Our surgeons are in business very early today,' I mutter to my colleague under my breath, '*and there are 12 cases posted for surgery today. Hey Bhagvan!*' Our young consultant, Dr. Netra, hurries in to help. All three fresh tissues are rapidly examined, trimmed, and arranged neatly on metal chucks. At minus 22°C, the fresh pink tissues have no option but to turn icy white and harden like rock-hard stones within 30 seconds.

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Our lab telephone is already ringing relentlessly and loudly, and the impatient surgeon at the other end is demanding answers. *"What is taking you so long?"* booms the voice at the other end. Mind you, it's only 5 minutes since the start of the day's work! *"This surgeon is surely going to get ulcers!"* says my colleague.

In a cancer institute, every Frozen Section specimen carries urgency. Each specimen is linked to a surgeon in the OT, and he, to the patient sleeping peacefully under the watchful eyes of a tolerant anesthetist.

The tissues are frozen, cut, stained and cover slipped. Dr. Netra is peering into her microscope. *"OK"* she calmly says, *" tell the doc, its cancer"* and so it goes on.... .....all day.

The pathologist's report can influence the surgeon's next step in real time – 'extend a margin', 'preserve an organ', or 'conclude the procedure'. **There is little room for blunders and no luxury for hesitation.** And so, this goes on all day, till my colleagues and I are ready to drop with exhaustion and tension.

> *"The pathologist's report can influence the surgeon's next step in real time — 'extend a margin', 'preserve an organ', or 'conclude the procedure'."*

At the end of performing about 18-20 frozen sections, on a daily basis, it's time to go home. Then just as that moment of our departure...in comes another frozen!

"Hai Hai. Do our surgeons never get tired?"

After completing roughly 18 to 20 frozen sections each day, it's finally time to head home.

- **So, What is a Frozen Section Service?**

The frozen section (FS) procedure is a specialized, dynamic diagnostic service requiring a well-equipped pathology laboratory, skilled surgeons and pathologists, and experienced technicians. Frozen section service is a vital rapid procedure performed by pathologists, and technicians, who can help surgeons in the operating theatre, when it is crucial to obtain an immediate quick diagnosis, even as the anesthetized patient sleeps on the operating table.

- **When is a Frozen Section Service needed?**

This service may be needed when the surgeon

- encounters some unexpected growth, or findings that he is puzzled about
- or when he needs a diagnosis of a clinically or radiologically detected mass
- when he needs to stage a cancerous disease,
- or when he wants to know if his surgery is complete with clear resection margins, or in situations as to whether to remove additional tissue or preserve healthy areas.

In all these situations the surgeon requires a diagnosis within 5-10 minutes. This enables him to plan and tailor his surgery, in real time and speed.

- **Why isn't Frozen Section done routinely in all cases?**

Frozen Section are not routinely performed due to

- their high cost, labor intensity, and need for skilled personnel.
- Inbuilt weaknesses: They produce less clear tissue samples than standard glass slides, making them challenging in rare cases or for inexperienced users. The process involves quickly sending fresh tissue to the lab, freezing it at -20°C, and slicing it for rapid examination, primarily benefiting oncology work, but can be difficult with complex cases.