May I request the panelist to come on the dice please. Dr. Anantra Maaswami.
Dr. Anam Prem, Dr. Rajiv Rajendranath, Dr. Akhil Kapoor, Dr. Agnisha Sharma, Dr. Tarachand Gupta,
Dr. Karthik Mital, Dr. Babita Kateria, Dr. Ani Shrikanth Rajamundri.
Dr. Anantra Maaswami, Dr. Chirachand
So Akhil, you are required here.
So I think the first question which may come, how do you perceive, because all of you,
I do know that you practice geriatric oncology, that I am aware.
Unless someone wants to say that, I don't.
I think so Akhil, told us, how do you want to be seated there?
Yeah, light are you up, chair I pray.
So what benefit you perceive when you do this, you perceive the benefit is there or not.
I think so you perceive that's why all of you practice, but you can say that you perceive or not.
And if you perceive, what kind of benefit you think you provide to the patient if it is practiced, each of you.
So what can be started to hear about the ability that you learn from you and the determine what they understand.
It makes significant differences in the quality of life, the oxy cities, and when these are different,
the outcomes are also going to be different because the continuation of the treatment,
compliance of the treatment depends on these factors.
So it is not just adding number to the life, it is about adding the quality of the life for the patients.
And that is why when we started at Varansi with the support, we have gone a long way from just one patient per week to now,
close to ten patients per week, and we are going to expand to daily geriatric oncology clinic very shortly.
So Karthik.
So thank you sir for inviting me here.
Karthik is a geriatrician and he works together with oncologist Hyderabad.
When my medical oncologist, when I met my medical oncologist in the private sector for the first time,
he knew about this concept of geriatric assessment and its interventions based on what Dr. Ganyita has propagated all over India.
So he was like, okay, let's do it, but let's be a little bit more skeptical because this is private practice.
Let's, we are new to it. There is no data in private, much out there, so let's be a little bit skeptical.
So he just, when all of his investigations and everything is done, he sends me the patient by saying him,
this is a specialist in old age, and he'll counsel you and he'll treat your comorbidities,
and he'll counsel you regarding your further treatment, if anything extra, he needs to act.
He just gives us small statement and the screening is simple.
The patient that my medical oncologist decides, only that patient I get.
So there is no screening or there's no nothing else.
The patient he thinks is appropriate for an assessment, he sends that to me.
So what I have seen in my practice currently is,
okay, when these patients come to me, they are totally clueless.
They don't know what a geriatric oncology assessment is, how I'm adding to that.
But that 30 minute assessment is like a two way communication in that way.
And these patients who have, like now I have a data from 35, 40 patients in the last six months,
these patients just don't want to leave me now as a primary care physician.

So the oncological aspect, they will definitely be going back to their oncologist, but their follow-ups regarding from head to toe any symptom related to their, you know,
either mild ones like what you call grade one or grade two related, oncology related issues,
or maybe some other issues, whether there are inappropriate drugs or whether any drug interaction is there,
or whether he had a fall, or whether he had a new event, or is it regarding nutrition?
They will definitely follow up very regularly.
And since the setup I work in is almost like Tata, and I think most major cancer centers,
I like that where most patients that they get are from outside their, the city of residence.
So I think what I've seen is for follow-ups, telemedicine is extremely good to follow up them regularly.
So I think so, we'll come to the care model, but I understood what one is that domain related things you pick up,
and where you intervene.
Second, do your oncologist change oncology related treatment based on your evaluation.
So as as Servo saying, I think we should not focus on the changes that the oncologist may be asking.
No, not as of now.
Not as of now.
He will wait for the assessment to be there, but I have seen what they're screening.
No, no, no, no, no.
And eyeballing assessment, is there it almost correlates with the ability.
No, no, no, no, no, no, no, no, no.
So that's eyeballing.
Yeah.
Because we'll come to Anant, what we people do, and Dr. Vanita can say.
So one is that domain related issues, we do miss it.
And what he's trying to say, domain related people sitting going through is domain and picking up that this domain requires intervention.
We are not able to pick it with our eyeballing and people do work on it.
As far as the treatment of change of treatment is concerned, that is, you know, we'll come back to about it.
So.
Hello, sir.
So I primarily, I'm coming from the clinical pharmacology background.
Yes.
And so one of the things that we notice or I notice here is PIMs and the drug drug interactions.
So these are the primary focus from my end and, yes, sir.
So, so when you, you know, pick up those PIM, do you change drugs and do the treating physician, they change drugs?
We, I mean, I recommend it to the physician then.
What do they do?
That depends on the intensity of the problem.
So what is the chance they change it?
It is.
10%, 50%, 80%.
It's quite low.
It's quite low.
Anant, adhag.
That is, so all fault of anant, I'm telling you.
Not exactly.

Not exactly.
No, totally okay.
So I think, so again, ideas that, so, you know, we, you know, on colleges.
Many times, I think, so Vikram, left, so Vikram was right in saying, you know, we are usually, we, generally it is a human tendency.
We are comfortable in a situation and we don't want to change because we have written something,
Japthak side effect, Honeerai patient, Kothak, Thakthak, Thi Khaa, you know, Vikram, Jobe, Likai,
Oh, what's the best approach?
But, you know, that happens.
So I think so we need to, you know, you need to work more on it, maybe threaten them.
No, not that.
We more like a collaborative approach.
So Anant, how does it benefit?
What do you feel, because now you have been there for, you know, quite some time, working in this area.
What you see perceptible difference when you evaluate and see that patient, what happens to them?
So, whatever Akil said, exactly the same thing.
And as a clinician, it adds on to your assessment, even when you are not assessing geriatric patients.
That is the biggest takeaway for me.
That eyeballing is out.
Eyeballing is of limited use, good deeper.
Exactly what he said.
That, another one thing that I'd like to add, and I think you have also seen in a lot of geriatric conferences,
people complain about the lack of hard endpoints when doing comprehensive assessment.
I think that's the wrong way to look at it.
If you're improving quality of life, if you're escalating or de-escalating, based on a rational assessment,
I think those should be the endpoints.
And that is what we can clearly see in our patients.
We'll come to that hard end point also.
But this is important, that more you do, you know, these assessments, and more you start seeing them as Anant suggests,
you start seeing that, you know, you start managing them.
And it happens very passively.
It doesn't happen initially, but passively you start seeing that, you start changing the way you manage them.
Tarachan, Tarachan has also been doing for geriatric oncology for quite some time.
Sir, as for the perception, yes, I'm concur with Akhil, that patient's quality of life is much better.
And after reducing doses and calculating according to their geriatric models, and of course,
there is second part is also there, they are getting less admissions, that is getting their finances better.
So complete that treatment and from our aspect, patients are coming for like 200 kilometres, like Jyotpur and etc.
And so that they need to come less time, and that's why they are saving their finances also.
And after the geriatric, I'm looking at another point also like polypharicy, and one more important thing,
I'm having a check to rise.
Because just I look at my eyes that one and a half year back, I was having frequent giddiness,

but I have to miss the meetings or on plan meetings, because just my morning get up and I was having severe giddiness,
but I am not able to even sit there.
Then I was taking treatment of vascular, migraine and etc.
When I meet my ophthalmologist friend, I told just for my daughter, I can see she's not able to see this,
I will please check your eyes for the near vision.
And then I saw that it was 0.75 and this is a specs care on my eyes and now there is no episode of giddiness.
That's why he told me that after the age of 40, it comes to nearby everyone.
So I ask every one of my patients of geriatric, please go for the refractory or check in.
Yesterday only one patient was there, that patient is on TDXD on breast cancer.
And he just complained to me that patient is having drowsiness and giddiness,
not able to move limbs and weakness and anything was there.
But I saw that I am treating since last one year, TDXD, but I have never seen these things.
Then I just saw the medicines which was being given by neurophysics surgeon for the back pain.
That was gavapentin anti-adventor, that means mementamine and prednisolone and etc.
So I just looked into the medicines and found that gavapentin is causing 20% of patients giddiness and drowsiness
and not reptile and causing dryness of mouth and etc.
So he was scared that he will not meet neurosargany otherwise he will be called.
Okay, I call him.
Then I call boss, please look into the matter of the patient is responding well to your medicines.
Patient is having better pain relief, but the patient is experiencing the least side effect you mentioned in your medicines.
But he is having biologically something different, that's why he is having these side effects.
Please look into the matter if you can do it.
So he removed that gavapentin anti, now I will take the call what will happen to on the Monday.
These things are happening and I am sending all the patients to the dietitian and you send me one time a formula LCEF
for a hand acumen when I was in Sangrull and I am giving to all my patients to make it with the LCEF
and I have tested that formula also with soya milk and this is tasty.
Please you can take it.
So that's why I am getting improved nutrition and protein.
One patient got 3 kg weight within 2 weeks.
I am adding these formulas, I will see if you are not having patent right.
No patent right.
I don't have anything on any patent right.
Sir, you are saying and I am asking them to please grind these.
I am asking please grind all these molecules and you can buy from my shop also if you want these raw materials
and take a soya milk and mix it.
Yes, yes matter you are saying something.
Yes.
Yes.
Sir, LCEF has done my ass and I have done the study with your patients.
So it was a low cost and it is normally mum and myself.
So it is a population of serials and bilits which are taken as a high rate.
It is a low cost rather than the nutrition supplements.
Okay, yes.
Had any cancer patients yes.
Yes, yes.

That's very good.
I have changed a little bit.
You are giving skimmed milk and sugar.
I am giving soya milk of their flavor like quesar pesto, vanilla, whatever they want.
This is coming in 200 and I have used, that's why I know.
I just tried what is the taste so I am giving to the patients and this is really fantastic.
So I will tell you about Dr. Dharachan.
So it is always so wonderful to interact with him.
So he is one of the many private practitioners.
I interact with many people.
That's a good thing about being an academic setup.
So many private people and then you realize that individual patients related, detailing,
which we miss unless others can say that they are able to do it.
I miss that part.
And that I get from so many, every time I will get some wonderful information from him
and what you heard, absolutely something like this.
This I gave, this happened, then I changed and say, okay, with that,
then you say, whoa, long a chandel, what happened to the patient detailing will be there.
Absolutely wonderful, Tharachan always nice interacting with you.
Rajiv, I know that you are working apart from Adir.
Now you are working in a center where there is a good geriatric support.
So what do you feel that, how the patient benefits with what you are doing for geriatric patients?
I think I look at it from a different perspective, like, you know,
geriatricians are usually a rarity.
So I have been fortunate to work in a center where there are 12 geriatricians.
So it's mainly a geriatrician centered hospital.
So that has made all the difference.
Actually the geriatricians bring in lot of care and support for the patients
who are the primary caregivers.
And that has made my job as a medical oncologist much easier after we, you know, compared to Anant and Vanita, we are very junior in the geriatric oncology, this thing.
But what I saw was, you know, the patient preference is given lot of importance because that comes with the geriatricians on close contact with the patient as well as the family.
And then the clinical pharmacologist, which we have, we do listen to them, we change,
and that has made a difference.
My job is easier.
I don't have to look at the rest very multiple times.
And then the more importantly, the psychoncologists.
So they get into the subtle, you know, the family background and, you know,
there has been death in the family or out traffic action.
So we are given all these background inputs before we see the patient.
And that has made the job much easier compared to,
I work in a non- geriatric oncology hospital where everything is in my head to go ahead and, you know,
from the consenting to the patient preference.
And the patient preference, I think that was sort of unlearning.
For people who are used to treating young patients, we make the decisions mostly in our mind
before we see.
And the patient denies something, then we are sort of frustrated and we sort of,

you know,
unwillingly agree.
But here, more and more, we learn that, you know, that makes a better choice when we have a patient preference
who absolutely don't want hair loss, no chemo.
And then when we have options and we see the results, I think, you know,
these are learning opportunities for us.
And my job has been easier to work in a geriatric oncology unit.
Thank you. Thank you.
Ani?
Sir, it keeps people motivated and they get, like,
if I know about geriatric medicine, if I'm starting at my center,
the other consultants will be aware about it.
That's the most important thing that happens.
Then when a kid comes to any clinic, they specially refer them to pediatrics,
unsaid rule.
Like, yes, the badshai, the pediatrics capacitor.
Yes.
When an adult comes, that's okay.
But when a geriatric patient comes, it's not like that.
It's not like that.
Everyone takes care of that patient and they don't have a border line that he's a geriatric patient.
He has to be specially seen because I have two of my elderly patients, parents at home.
So I know how special they are and how different and difficult to manage them.
So it's mainly the sensitization of whole department and whole hospital that they need
in special care.
That is most important.
And once we do geriatric assessment, we talk to them for longer time.
Then we establish a connect and bond with them.
So that even gets better from time to time.
And obviously, it will improve the comfort and quality of life of patient mostly.
So thank you.
So, Prem is the iteration.
So this is what he has done.
How you feel like, how the patient, you say they come referred to you because you are
able to see other side also.
Oncologists, we are not able to see because we have got so ingrained into sink it tumor,
shrink work in it.
Other part, you know, the problem with that we have forgotten our hypertension and diabetes
management also a lot of time which when we got trained.
So how do you see this part gets missed and this is where you contribute?
I think of course, first of all, it's extremely gratifying and satisfying because you actually,
from both perspectives, because the patients know that you have given that time.
And at the same time, we know that we have been able to make a difference purely because
the quality of life is one of the most important things.
If not the only important thing for the particular person.
And we can say we as different specialties try to achieve that.
So for example, you are trying to battle the tumor so that the person improves and has
a better quality of life.
But the thought process is for the tumor because you are oncologists because you,

if the tumor is there and you are trying to take care of everything else, then that is not,
that is not going to make you sleep in the night.
But as a geriatrician helping you out, making your life easy, we are obviously trying to
help you to say maybe when you want to let go because a lot of times we are battling the tumor and we are not understanding that we have to stop battling the patient.
I think shared decision making is something which is very important.
Of course, again, very well talked about in almost every conference and we always say
in the Indian setting, it is always tough because sometimes it's the relative saying,
I have not shared with the patient, how can you share?
So then it obviously becomes more challenging.
But I feel ultimately it's, if like he was saying, I mean, there is different settings,
so the, I mean, we will come to the model so that models have to be different.
You have to be flexible in your thought process, how you will intertwine the joint sort of approach,
wherein you want to make sure that yes, the cancer is taken care of, but you want to make
sure that the non-oncological vulnerabilities are important because ultimately, if a patient
comes to you, you want to offer the highest level of care.
And in this setting, if you have a specialist who takes care of above 60 and you are taking
the organ, whether it's cardiology, nephrology, neurology or oncology, you will ultimately
give the highest level of care and that is what matters to the patient.
Thank you. Thank you so much.
Dr. Babita.
Hello, I'm a medical oncologist working currently at NCI Ames-Jurjur.
So ours has a relatively new center started in 2009, December and it actually took only
after COVID.
So we still don't have a lot of departments like clinical pharmacology or geriatrics at NCI.
At Ames-New Delhi, it is there.
So we have a real challenge to administer comprehensive geriatric assessment.
So for now, what we are doing is like patients above 60 years of age where we intend to
give curative intent treatment and where we intend not to compromise doses, there we are
administering card and card B.C.
But the geriatric assessment is still not being done.
We are hopefully as in the next phase, like we get more human resources and maybe we will
be able to start it properly.
I just, just take, today came to know there was an interview yesterday at Ames and hopefully
we have some geriatrician, more geriatrician there to handle it.
So go ahead, please.
Go ahead.
Okay.
But sometimes it has helped us in escalating the treatment.
I agree.
Yes.
You feel eyeballing is different?

Correct.
Correct.
A 74 year gentleman, EJFI exone 19 del positive, P53 was also there.
Initial thought was to give Jefitini below, patient was not feasible for oceumetinum.
But we did geriatric assessment, patient was fit, we started chemo plus Jefitini, which
has been developed by our institute.
So that is why it is not only to the skeleton, it is also a skeleton.
I agree.
We don't talk much about it.
Scalations are because de-escalation at this moment is people look up.
But I totally agree.
Many times you have, because many times our patients are those 40, 50 kg weight and then
you realize when you evaluate, they are absolutely very fit and they do all kind of things and
you realize you can do a good job.
So, actually, one was which was pointed by Dr. Anand at the hard end points.
Now we started getting those kind of data and that is something which people like to have
it and we should try to have it.
And that is I think our fault or also the limitation of working in geriatric domain and geriatric
oncology that we need to put those kind of research work and trial which have those kind
of end points to show it.
But that doesn't mean something is not visible which is so apparent.
This I learned from one of my patients.
She was again on Osumatnev, exon 19 patients, elderly lady, you know, and then she died.
She survived for six years.
Post-COVID, she made a specific point and she had lots of weight loss and muscle loss after
that because COVID time she didn't move around much.
And she said, Dr. you should have anticipated this.
I said, I agree, I didn't because she was restricted at home.
But it should have come from you that I need to do exercise and she could, you know, afford
anything.
I could have got someone at home or online I could have done.
But, you know, because of not anticipating and not evaluating because I had not evaluated
that part.
If it was evaluated by a geriatrician, I am sure that would have been reflected and then we
could have integrated a service for her.
So learning was there, you know, you require those evaluations.
There was another lady, had a cough, lung cancer, cough, middle masses.
Now, as much I knew and I thought I know cough management fairly well, then I realized
that he couldn't keep up to somebody.
I said, I have cough, cough, syrup, death, if you're coding syrup, death, and that lady
used to read everything and then I realized, plain coding is not available in India.
Then Drexto Mithorphan, not available in India in the dose which is recommended.
And I didn't know, she found out from Amadapath somewhere, the lunges are available.

And then she offered, if you make a service supportive care service and lung cancer,
I will support it.
I will provide fun, but you guys are oncologist, you don't look after other part of the things,
you miss it.
So, have a group of people only looking after it.
And that was the telling thing, you know, as much I take a pride that I had managed well,
but having said that, this is a good thing about patients, they keep showing you mirrors.
So, absolutely agree, no doubt that evaluation.
And now I see evaluation, you know, TMH, you have to have a look and then you get a hang
of it where the patient is.
So, where the patient stands and what needs to be done.
So, this was how it benefits.
And you hear from different people, different things because they will have a different experience
how their patients benefited.
Coming back to care models, so we can go back to care models, okay, this doesn't look good.
Okay, but anyway, so when we laptop, it's all agratha.
Or someone can switch off the light on that side, hopefully it will make a look better.
So, what do you practice and what do you think will be ideal.
So, you know, care model is either you have a geriatrician, inbuilt into it, you have
geriatrician who you refer to, you know, aid or you have screening tool and then the
patient goes for geriatric clinic.
Anyone, maybe we can start from, so that because you will be establishing.
So, you have a chance to see which care model you will prefer.
Definitely, it has to be multi-disciplinary with the like all the stakeholders to be part of
the team.
So, ideally the geriatrician should be on board.
So, and each and every patient who is a potential candidate for comprehensive geriatric assessment like maybe more than 60 or more than 65 as per institutional policy
should be assessed by the team comprehensively.
So, ideas that screened and then, you know, do comprehensive geriatric assessment for all
elderly cancer patients, am I right, okay.
I think.
But with the disclaimer, at this moment you do kargan, correct, at this moment.
But that should be ideally what she thinks that if that model is adopted, that will be most
useful.
So, prim, what do you do today and what do you think that should be.
Yes, I think I mean having a geriatrician in the system would be very helpful.
But again, a lot of times we keep thinking that no everybody above 60 ideally should
get it.
Everybody.
I mean every cancer patient above 60.
But a lot of times I think we have to pick and choose purely because the cancer patient
has the thought process that I want the tumor to be treated.

So, do I need to see another person for it?
So, I mean it's a natural sort of thing which happens.
So, the oncologist role I think is very important.
So, like in the setting that I work in, I actually work in a daycare setting and also
in a hospital setting.
So, hospital setting is purely like how it's some referral model.
Whereas daycare setting in a lot of times it is chemo is going on anyway.
So, we already know that the person I have been referred to.
And then the oncologist has breathed that this is like how would Karthik was saying that
this is a specialist for older person who will help us in knowing your non-oncological
part so that we are able to treat you better.
And people are obviously sort of convinced.
Now, the most important part I feel is which has been brought about already is also sensitization.
You cannot just tell the patient, chemotherapy, nutrition, hair, Janae Pradega.
What is the cause?
What is the need?
What exactly they will do?
Because all those things I think matter a lot.
And ultimately I mean multiple is important.
Assessing is one thing.
I mean it's happening in Tata it happens in a lot of other settings.
The intervention is very important.
There is no use of doing any assessment and not intervening.
So, if the cognition is problematic involved your therapist, if the physio therapy is needed.
Everything has to go on simultaneously.
So, what you are saying at this moment depending upon setup in daycare you have one kind of
setup, hospital you have different kind of setup.
Ideally you would have preferred that every 60 year old should get evaluation done.
Anyone has a different opinion?
Rajiv, same or from your center?
No, I think.
All evaluation done or you do select it?
No, no, in the place I work for geriatric concology everybody.
Everybody gets.
Absolutely, I heard, you know.
One move.
And I think I will go one step ahead saying that only the screening and one time visit
may not help.
The geriatrician should be part of the journey throughout.
And more importantly I think Gagan made a very important point.
He was the only surgeon in the room and he has also left.
So it's not only the medical oncologist who is part of geriatric oncology.
It should be absolutely that, you know, we should have a geriatric oncology MDT to start
with with our own peers attending the surgical oncologist and radiation oncologist.
And we are not able to do in one center.
I think TMS can take a lead and we can like we have enough molecular MDTs now.
Why not we have a national geriatric oncology MDT and you know, on board online geriatrician
set least, you know, to decide on some cases will be of very useful.
Anyone any other thing in mind?
So it will be at this moment ideally looks like everyone will like it should be

like
pideatrix the way Arnie was saying if it the way you have less than 15, it needs to go
to pediatrician or pediatric oncologist to see above 60 or above 65.
What do you choose?
We choose above 60.
Let all of them go to geriatric, you know, geriatrician, which is not there at this moment.
Now you choose model based on where you are unless anyone has any other ideas in mind.
I think one more point is we are trained for pediatric oncology, but we are not trained
for geriatric oncology at least.
And that's why sensitization is not there and that's why we don't send to geriatrician.
So that is important.
So good sensitization is important to have this working.
Yes.
So apart from oncology, it may also reduce all cause mortality if he is SS by a geriatrician.
So maybe other things pop up that can get treated, then I feel even better.
Okay.
So then actually because a lot of time the person does not necessarily die of the tumor.
I actually end up dying for everything else.
This is like a process cancer.
So you do have competing in, you know, risk is of dying for other things are pretty high.
Maybe what are the challenges?
Tarajan.
So these are the models we say.
What are the challenges in geriatric, you know, evaluation assessment and implementation?
Sir, does your admin support it?
Yes sir.
We have to think about admin supports or not?
Yes sir.
We are having admin support.
Actually we are starting fellowship in geriatric oncology also.
Excellent.
In my unit of geriatric.
And second thing, the first resistance come from patient himself.
What's your patient?
They don't have time.
They want to rush to their home and etc.
If I am evaluating a patient, I am talking to a patient inside or I am giving a time
20 minutes, sometimes just evaluating what is going on at their home, what is the financial
issue.
Sometimes we check that we are around, outside patients are just ready to fight and to beat
me at that time.
What is you are doing?
We have to go home also.
Back.
So please look and second thing, if we are sending them, please go to dietician.
Sir, he will charge another.
And these things are quite, there is, I asked my admin administration that please

make a
package.
For, especially, I presented to Rebecca Haddon, my MDT in my tumor board that I need these
four or five people on a board that dentists, phasor, spistrol and therapist, phasor,
therapist, please make one piece only for these two.
But it will be at least 1,000 rupees, minimum charge they are visiting for.
So sometimes this is my patient, why are you charging 1,000, 1,000, 1,000, or sometimes
patients are selling, we are not started on any treatment and 1,000 rupees already paid.
So these things are going on.
These things are happening in community that are not happening on big centers because
where the patient usually come for any, that I have come here and I will take the treatment
whatever is advised.
I get it.
So I think the admin side, it is not a problem as far as his center is concerned.
Issue is how you implement it because there is a cost involved and who pays for it.
Anant, is the same problem here?
I think we had covered this once before also.
I think if you are offering a service, it has to be monetized and patients will be willing
to pay if you tell them the advantages.
And since this is a 30 to 45 minutes service that is being offered, I see no harm in doing
that because after we are improving quality of life and potential tumor related things.
And I am sure corporate will not have a problem if you explain it in that many words.
That is what I think.
Academic center?
We are doing it, sir.
And we started with only, you know, us doing the assessments.
So I mean, if you speak to a lot of people, if it is monetized and the patients are experiencing
this is part of service which is adding on to you, I don't think it will be a problem.
That's what I feel.
So, yes, okay.
So the situation might be opposite for some patients.
For some patients won't come to the case.
Confident.
Everything to you.
So, I think we have seen 30% patients who were not referred to dietitian or phasal therapist.
Patients asked, please write dietitian.
So that is very common with us.
So I think now our patients demand comprehensive care.
So it should be included.
So looks like speaking up and you know, genetic oncology as a service to the patient.
So there are different challenges, different places.
But concept has picked up.
I was talking to someone, KA, one more thing, I think speech as a finance minister.
This is the time for this idea is there.
And so it will flourish.

You all need to work on it, but it will flourish.
Last one minute.
Collaboration, how one can do in genetic oncology?
Ten, ten seconds by everybody.
One idea.
How you can collaborate, keep people can work together, which is not easy in India.
So geriatrician.
So most centers do not have geriatrician.
So for example, the good thing about image varansis that image varansis just next to
BHU.
BHU is the center of excellence for geriatrics.
It is going to be the center of excellence that is under development.
Both, but it's called cross-institute collaboration, which are in the vicinity is important.
Thank you, Akil.
The way to collaborate with different centers and different group of people.
Jiriyajit.
Jiriyajit, tumor board, sorry.
Jiratic tumor board, excellent.
I think it's pretty well established in TMC here and what I've seen.
More pharmacologists need it to be part of it.
Yes, there are three.
I totally agree.
Most of the DMCs.
Yes.
Anand, how to collaborate more between centers?
It's not enough to collaborate only with so-called academic centers.
You need to collaborate with private centers.
That's when it will gain this one.
Otherwise, it will be restricted to one or two rooms and not go further.
Totally agree with it.
That is what we need to do.
Two-odd was so-called academic center.
I totally agree.
Yes.
Yes, sir.
There is a need of collaboration with some NGO and some funding at least initial years
where the people will get like people want pediatricians separately.
When will they realize that they are getting funded from the outside or from NGO for that?
Like something feels like things.
Agree, two-odd.
Agree, two years.
All of the other...
The arbitration has tapped the...
Oh, absolutely wonderful.
At a hospital pediatric group generates almost 65 or 70 crores every year for the patient
management.
I think so, it's a good idea to sensitize the society.
I think I...
How do you collaborate?
I think I...
The academic and private sector...
Absolutely.
...both as to...
...join hands and there may be two, three years down the line we will be in Hall A

and the
lung cancer will be in Hall A.
Hall B, yes.
I agree.
So it has been noted.
Yes.
Sir, we have to persuade most of the people and we have to be persistent over it.
Then only things will come.
And some people have to come together and be persistent.
And like concats, we should get some other thing for us.
Yes.
For the geriatrics.
Shame.
One line, how to collaborate more.
I think the most important thing is to establish a pathway.
You cannot expect people to just come to you because you want to good good care.
So you have to have a proper structure to it.
So I think structure matters.
I'm going to quote you only.
You had quoted something when we actually met in MOC, one of the inauguration.
You strongly believe that whatever is going to happen is going to happen in the private
sector.
But I believe that with that, what has happened in academic of course has happened a lot.
So partnership, yes.
But partnership not only in the way of the academic sector doing the training and the
private sector actually seeing patients, academics also seeing.
The fact that more and more private sectors are also part of education.
I think that's very important because once you get the doctors more learned, I'm very
sure a lot of doctors also are warming up to it.
So when they get the knowledge, I think it would be much better.
Correct.
Yes.
Don't quote that often.
Babita is from AMSA.
She will have a academic center.
They will outcast me.
As much, I believe that.
There's an academic center, especially government academic center.
Academic center doesn't mean any academic center.
Government academic center needs to pull up their socks if they want to make a difference.
And in spite of myself being in a academic center, yes, I totally agree.
So the collaboration has to be one at the institution level itself between the inter-department
collaboration.
So for example, AMSA have an independent department of geriatrics and independent department
of medical oncology.
So maybe if there is a rotation, it has to start from the beginning of the training.
So if there is a rotation, like for example, medical oncology rotation in geriatrics for
six months and vice versa.
So that and more collaborative projects, for example, in terms of thesis, in terms of clinical

trials, et cetera, to generate more data.
Then at the inter-institutional level, especially the centers who don't have the facility, it
can be like a hub and spoke model sort of can be employed where the center that are already leading, they can guide the centers that don't have the facility and help them
develop the facility so that more collaboration can take place in future.
Thank you.
Thank you.
Everybody, unless there is some burning, come in to make our burning question from audience.
I mean, just to highlight the entire thing, to be very frank, when we started having
these talks, I mean, we have been having the end of review and a lot of talks of, I think
that itself shows that more and more people have been involved.
I mean, and more and more geriatricians are available.
So the fact that there is a lack of geriatrician is not there anymore.
But the onus is also on the geriatricians to look for these sort of opportunities because
I think that is also very important.
And if I, now I think so, we were talking with Dr. Vanita.
Now, most of the conference now has a geriatric workshop or a session, which is to be not there,
if you take some time back and so looks like it is picked up.
So look towards that this is one of those modality which needs to be integrated in the,
you know, patient care.
So sorry, sir.
Oh, lunch is served.
So that's a usual cliche that, you know, I am between your lunch and you guys.
So I'm not going to be now.
Thank you.
Thank you so much.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
Thank you.
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