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## Physiology, Healthcare Integration and Cancer Consciousness are Vital for Early Diagnosis and Prognosis of Leukemia

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Most medical curricula do not make a physician cancer conscious. Even with the slogan of integrated curricula at medical schools and integrated care at hospitals, the real integration of interdisciplinary grand rounds is missing. Residents, house-officers as well as medical undergraduates must present all cases admitted at hospital, followed by feedback by consultants across disciplines as diseases never read textbooks.

An adult male patient may complain of abdominal pain, which may remain a disputed territory between a surgeon and a gastroenterologist, even after an abdominal CT scan. There should be a system of case discussion and involvement of an oncologist in case of any complaint of fever and pain caused by inflammation anywhere in the body. Unfortunately, cancer is considered the last option after ruling out all diseases caused by micro-organisms. The dilemma is prescription of antibiotics for hit and error treatment resulting in alteration of flora, instead of sending blood, swab and stool etc., for culture and sensitivity. Skipping these basic laboratory investigations to start with, end up into unnecessary and costly tests with the consequence of making the culture false negative, further running away from diagnosis which requires relevant basic investigations including complete blood count (CBC). Sadly, if leukocyte count falls outside physiological range, peripheral morphology is not essentially searched, resulting in failure to put a finger on leukemia. There is paucity of hemato-oncologists in South-Asia, so a collaborative platform needs to be developed for global case-discussion with the help of experts who are willing to bridge the

gap. Especially, problem-based learning (PBL) curricula should include leukemia in the list due to rapid deterioration by virtue of blast cells in blood with excess to all body systems and tissues.

Furthermore, it should be included in hematology module starting from first year of medical undergraduate curriculum that siblings should not be used as donors for blood transfusion, to avoid graft versus host disease (GVHD) as they may be required later in life for bone-marrow transplantation. Lifestyle medicine should not only be taught, but also adopted in the medical curricula with sleep hygiene, stress management, smoking/vaping awareness as leading causes of all cancers. Also, three monthly routine CBC, liver and renal function tests as parameters of well-being should be adopted. Simultaneously, self-medication at home and over-the-counter sale of antibiotics and analgesics can be controlled to encourage timely hospital visit. Clinicians should be fined for advising medicine without completing all three limbs of diagnosis including history, clinical examination and relevant investigation.

There must be a common registry in each country for blood group and bone-marrow so that appropriate donor can be approached. Also, social groups should exist for each disease carrier, especially for rapid cancers like acute leukemia, led by at least one relevant expert to avoid misinformation and promote health education so that patients feel supported. Support by biological family members, friends and workplace family can significantly shape the outcome. Inter-patient support at place of admission to cater for the needs by mutual moral support of attendants is another avenue.

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