

CANCER IN DEVELOPING COUNTRIES - CONCERNS

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The mention of cancer still send chills down the spine of most people. This happens because it is deemed to be a death sentence. Globally, there were an estimated 14.1million new cases and 8.2 million deaths from cancer in 2012 and as a single entity, the biggest cause of mortality(1). Cancer cases worldwide are forecast to rise by 75% and reach close to 25 million over the next two decades(2). World cancer report 2014 urges countries to adopt National programmes aimed at early detection and life style modifications(3). Unfortunately, in India, around 35%-50% of all cancer patients succumb to the disease(4). This is much better than what was happening a decade or two ago; but we need to improve our results to achieve at least 70% - 80% cure rates. The results can be improved by focusing on Prevention, Early detection and Proper Management.

Most are aware of the importance of prevention and early detection but proper management is never brought out as an issue probably because it is difficult to monitor and is presumed to be done properly- which is seldom the case. The focus is always on the health education of the public – and never on educating the health providers. The knowledge of doctors is taken for granted. Unless the health educators provide correct information to the public – the present scenario would not change. In the early detection of breast cancer, the importance of investigations like mammograms is mostly over emphasized – while clinical examination by trained volunteers/experts is never mentioned. It would be good

to note that there is up to 15% chance to miss clinically palpable lesions on mammograms, and most of these lesions would be invasive cancers; whereas there is up to 25% chance to miss mammographically detected lesions on clinical breast examinations – the difference being that only 5% of these lesions would be invasive cancers. In the USA, of 100 mammograms done, 11% undergo surgery for suspected lesions – of which only 0.3% turns out to have cancer (80% of these are insitu cancers)(5).It is known that only 20-30% of all insitu cancers go onto become invasive cancer in the person's life time(6). The need for legislations to prevent the use of tobacco, which is the cause of 40% of cancers, still seems to evade the imagination of our legislators. Life style modifications needed to decrease the incidence of cancers are now considered by most people(6).

The knowledge that proper surgery is the primary treatment, without which most solid tumours cannot be cured, is alien to most doctors. Hence the emphasis of treatment is mostly on hasty treatment –and hastily performed surgery by an untrained surgeon which could seal the fate of the patient – and subsequent adjuvant therapy (chaemotherapy/radiotherapy/targeted therapy) which can provide only 2%-12% absolute benefit in most cases, is not going to come to the rescue of the patient, however costly it may be. People should be advised to obtain proper advice from trained surgeons in the case of solid tumours like cancers of breast, gastrointestinal tract (esophagus,stomach,colon,rectum), soft tissue sarcomas,

oral cancers and gynecological tumours. A medical oncologist should be approached in case of lymphomas and leukemias.

We should be able to train at least one health worker from every panchayath to provide health education and conduct health check up on a specified population at a specified interval. They should provide insight about the early signs and symptoms of cancers, take history of any such clinical symptoms and clinically examine the population to detect early cancer. The focus should be only on the four common cancers – namely oral cavity, breast, uterine cervix and colorectal. They should be trained to conduct an examination of the oral cavity, clinical breast examination, pap smear and per rectal examination. These should be done on every target person at least once a year. Per rectal examination can be reserved for individuals above 50yrs and the rest for all above 30 yrs. A single trained health worker may not be able to cater to the entire population of a panchayth and hence more volunteers should be trained from the area – our aim being to have trained personnel in every locality – like a residential colony or apartment complex(7). This would not happen overnight, but can certainly be achieved by people's participation which could be encouraged by certain incentives for the volunteers. Any suspicious lesion identified should be referred only to a certified doctor who is part of a team of doctors identified for cancer care in the state. This team of doctors should be formed by the state administration from willing participants from the public and private sector. They should be properly trained by a select team of experts who would continuously monitor their work.

“Governments must show political commitment to progressively step up the implementation of high-quality

screening and early detection programmes, which are an investment rather than a cost,” says Dr Bernard W. Stewart, co-editor of World Cancer Report 2014(8).Lack of money is not the main issue in providing adequate and appropriate treatment for cancer – proper knowledge and attitude to utilize existing facilities and personnel – rather than rely on modalities which give little and promise much – is very important. A well structured health education programme, screening programme and treatment guidelines should be brought out in consultation with experts in the field.

References

1. WHO | NCD mortality and morbidity [Internet]. WHO. [cited 2014 Feb 27]. Available from: http://www.who.int/gho/ncd/mortality_morbidity/en/
2. Press Release WCD 2014 [Internet]. [cited 2014 Feb 27]. Available from: <http://www.worldcancerday.org/press-release-wcd-2014>
3. World Cancer Report 2014 | ESMO [Internet]. [cited 2014 Feb 14]. Available from: <http://www.esmo.org/Oncology-News/World-Cancer-Report-2014>
4. Dikshit R, Gupta PC, Ramasundarahettige C, Gajalakshmi V, Aleksandrowicz L, Badwe R, et al. Cancer mortality in India: a nationally representative survey. *Lancet*. 2012 May 12;379(9828):1807–16.
5. Albert U-S, Schulz K-D. Clinical breast examination: what can be recommended for its use to detect breast cancer in countries with limited resources? *Breast J*. 2003 Jun;9 Suppl 2:S90–93.
6. Augustine P, Jose R, Peter A, Lal AA, Prabhakar J, Sreedharan J, et al. Risk Factors of Breast Cancer in Kerala, India - A Case Control Study. *Acad Med J India* [Internet]. 2014 Feb 25 [cited 2014 Mar 1];2(1). Available from: <http://medicaljournal.in/volume2-issue1-feb-2014-59-original-research-risk-factors-breast-cancer-kerala-india-case-control-study/>
7. Zonderman AB, Ejiogu N, Norbeck J, Evans MK. The influence of health disparities on targeting cancer prevention efforts. *Am J Prev Med*. 2014 Mar;46(3 Suppl 1):S87–97.
8. Bernard W. Stewart Christopher P. Wild. World Cancer Report [Internet]. [cited 2014 Feb 14]. Available from: <http://www.iarc.fr/en/publications/books/wcr/index.php>