Cancer Control in India-The Cancer Institute (WIA) Chennai, Experience

Selvalucksmi G, Shantha.V, R. Swaminathan, R. Rama

Cancer Institute (W.I.A), India

Shantha. V

Introduction

The magnitude of the problem of cancer in India is a matter of concern. The annual burden of new cancers has shown a 4.4% increase annually. The annual burden which was 4, 93,140 in 1985 is today 8, 21,000 and projected to be 13, 50,000 by 2020.

The prevalence of cancer today is 25, 00, 000 which will be 43, 00,000 in 2020. The annual mortality due to cancer today is approximately 4, 49,000.

Purpose

Cancer control in a sizable uneducated population, poor socio economic condition and in an environment of limited resources is certainly a daunting challenge. Given the current trend, with control of communicable disease, increased life expectancy, trend in smoking and changing life style, cancer incidence and burden is bound to increase.

Other major compounding factors are changing pattern of common cancers and late stage presentation.

The first major effort for cancer control was the setting up of Demographic and hospital registries. Today we have a total of 23 demographic registries and 5 hospital cancer registries at present under NCRP. Out of which only 2 are rural registries.

In 1982 the commonest cancer in women was cervix, today breast has become the commonest cancer in women in the urban areas. The top ranking in the rural area continues to be cervix.

Among men oral cancers were the commonest but today it has been pushed to the 4th place, commonest being stomach and lung followed by esophagus.

Background

Evolution in concepts for cervical cancer control at the Cancer Institute started as early as 1961 – 1962 when the first hospital based rural survey of cancer conducted in Chingleput demonstrated that routine clinical screening of all women attending the rural hospitals could detect cancers in the early stages (70% as against 5.7% in the hospital registry). This finding laid the foundation of the first ever WHO pilot Cancer Control Programme in Kancheepuram established in 1969.

On the basis of this background a feasibility study to train VHNs (Village Health Nurses) in the visual and digital detection of an abnormal cervix was undertaken in 91-92. The project concluded that the VHNs were competent in detection of an abnormal cervix with a concordance rate of over 90% and that a rural cervical screening programme was worthwhile (985 abnormal cervix detected in 6450 women screened). The IARC study in collaboration with

Nargis Dutt Trust documented significantly earlier stage disease in the study area as against non-interventional areas.

In the evaluation of different methods of cervical cancer screening by IARC- conventional cytology, VIA, and HPV, the most useful and affordable method appears to be VIA - visual inspection of cervix with 3-5% acetic acid with a sensitivity of 56-77% and specificity of 64-86% in high grade CIN I.

Methods

At the cancer Institute (WIA) population based screening for cancers of cervix, breast, and oral cavity is a continuing programme.

In a large country with limited resources population screening is not practicable and screening of high risk group only should be undertaken.

Primary preventions were aggressive anti tobacco activity by public education, mass communication and implementation of ban on tobacco advertisement, sale of tobacco in the immediate vicinity of schools and Colleges, stringent action for use of any form of tobacco in public places.

Based on MMTR data, the women most at risk for cervical cancers are married women over the age of 35 years, in the low socio economic strata, with little or no education. Since over 80% of the population of India is rural, the focus has to be the rural women.

Accepted methods for early cervical cancer detection and control for a developing environment would be education and access to health care, Unaided visual inspection and clinical down staging, aided Visual Inspection (VIA).

The first IARC sponsored case control study on HPV and cervical cancer carried out at the Cancer Institute documented that 99% of cervical cancers were HPV positive compared to only 22% in the controls.

Another major activity today was creating awareness about HPV vaccination as a potential preventive for cervical cancers. A programme for HPV vaccination of girls between the age group of 13 – 20 in the rural area is being studied by Cancer Institute.

Palliative care is a specialty and major component in cancer control. High priority is given by cancer centers and the government to ensure improved quality of living. There are about 80 palliative care centres, hospices, hospital based centers and domiciliary services.

Conclusions

Cancer control is not an easy task and cannot be achieved overnight, needs concerted effort, adequate finance, infrastructure, training and logistics.

In any screening for women, in traditional south Indian, it must be by women only. Population screening is not realistic and practicable. We should target only high risk groups. High priority and focus should be on education and awareness. Serious effort should be made to integrate screening in the routine health delivery system although we have found it difficult to implement.