THIRD PILLAR: MANAGEMENT OF INVASIVE CERVICAL CANCER

Dr Elena Fidarova

Towards Elimination of Cervical Cancer in the Americas, 1-2 August 2019, Washington DC, USA
Valentine Gode-Darel
Why cervical cancer management?

CERVICAL CANCER IS CURABLE
Why cervical cancer management?

CERVICAL CANCER IS CURABLE

Why cervical cancer management?

- Treatment of early stage cervical cancer is cost-effective

<table>
<thead>
<tr>
<th>Manage Cancer</th>
<th>'Best buys' and other recommended interventions</th>
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<tbody>
<tr>
<td>'Best buys': effective interventions with cost effectiveness analysis (CEA) ≤ $100 per DALY averted in LMICs</td>
<td>Vaccination against human papillomavirus (2 doses) of 9–13 year old girls</td>
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<td>Prevention of cervical cancer by screening women aged 30–49, either through:</td>
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| | - Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions
| | - Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions
| | - Human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions
| Effective interventions with CEA >$100 per DALY averted in LMICs | Screening with mammography (once every 2 years for women aged 50–69 years) linked with timely diagnosis and treatment of breast cancer
| | - Treatment of colorectal cancer stages I and II with surgery +/- chemotherapy and radiotherapy
| | - Treatment of cervical cancer stages I and II with either surgery or radiotherapy +/- chemotherapy
| | - Treatment of breast cancer stages I and II with surgery +/- systemic therapy.
| | - Basic palliative care for cancer: home-based and hospital care with multi-disciplinary team and access to opiates and essential supportive medicine
Why cervical cancer management?

100 000 women screened

10 000 screen (+)

3-5% with cancer

300-500 women with cancer

Whose responsibility is to provide care?
Comprehensive approach to cervical cancer control?
Comprehensive approach to cervical cancer control?
Putting into perspective

Health System

NCDs

Cancer Control

- Prevention
- Early detection
- Diagnosis and Treatment
- Palliative Care
- Survivorship Care

CERVICAL CANCER

Broad Social Context
Care pathway for screening and early diagnosis

**EARLY DETECTION**
- Woman with symptom visits primary health care
- Woman goes to routine screening
  - Suspicious lesion and/or persistent symptom
  - Suspicious of cancer
    - Biopsy
    - Precancerous lesion
      - Treatment
      - Thermal ablation
      - Cryotherapy
      - LEEP
    - Benign lesion
      - Treatment

**DIAGNOSIS**
- Refer to a facility with diagnostic capacity
- Suspicious of cancer
  - Pathology
    - Positive for malignancy
      - Treatment if needed
    - Negative for malignancy

**STAGING & TREATMENT**
- Refer to a cancer center
- Clinical, pathological radiological staging
  - Treatment planning
  - Treatment
    - Early stage (Stage IA-IB2): Mainly surgery
    - Advanced stage (Stage IB3-IVA): Mainly radiotherapy + chemotherapy
    - Metastasized (Stage IVB): Palliative treatment/care

**SURVIVORSHIP CARE**
- Refer back to primary health care
- Follow up, rehabilitation
  - Long-term survival
  - Relapse
  - End of life care

**EARLY PALLIATIVE CARE**
- Symptom management and physical, psychosocial and spiritual support
Understanding barriers to care

- Health System approach
- Linking different levels of care

Presentation in late stages
- No or misdiagnosis
- Progression of disease due to delays

Curative treatment is not possible

Poor survival

Step 1: Awareness and accessing care
- Awareness of symptoms, seeking and accessing care

Step 2: Clinical evaluation, diagnosis and staging
- Accurate clinical diagnosis
- Diagnostic testing and staging
- Referral for treatment

Step 3: Access to treatment
- Accessible, high-quality treatment

Barriers:
- Poor health literacy
- Cancer stigma
- Limited access to primary care
- Inaccurate clinical assessment and delays in clinical diagnosis
- Inaccessible diagnostic testing, pathology and staging
- Poor coordination of services and lack of follow-up
- Financial, geographic and logistical barriers
- Sociocultural barriers

- Inappropriate treatment
- High toxicity
- Treatment refusal/abandonment
- High relapse rate
- No supportive and palliative care
Treatment outcome

Stage at diagnosis

Accuracy of diagnosis

Access to diagnosis and treatment

Quality
Pathology

- Pathology services are essential for diagnosis, differential diagnosis and treatment choice

- Differential diagnosis: cancer or not?
- Diagnosis: what type of cancer?
- Treatment choice:
  - Suitable for surgery?
  - Need for adjuvant treatment (high risk for recurrence?)
  - What radiotherapy?
  - What chemotherapy?
Why Staging?

- Prognostic factor
- Selection of treatment (stage-appropriate)

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<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Primary Treatment</th>
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<tr>
<td>Stage I</td>
<td><strong>A</strong> Tumour confined to cervix</td>
<td>Surgery</td>
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<td><strong>B</strong></td>
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<td>Stage II</td>
<td><strong>A</strong> Tumour invades adjacent tissues</td>
<td>Radiotherapy+ concurrent chemo</td>
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<td>Stage III</td>
<td><strong>A</strong> Dissemination to lymph nodes, spread to the pelvic wall and/or lower 1/3 of vagina</td>
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<td><strong>C</strong></td>
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<tr>
<td>Stage IV</td>
<td><strong>A</strong> Tumour invades adjacent organs (bladder, rectum) and/or spread to distant organs</td>
<td>Palliative treatment</td>
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Cancer Surgery

- Complex surgery
- Requires special training
- Quality of surgery influences outcomes

Wu et al. OncoTargets and Therapy, 2016
Radiotherapy

- Population 5-year overall survival benefit 18%
- Additional 3% OS benefit for chemoradiation
- Quality of radiotherapy has impact on outcomes

Hanna et al, Radiother Oncol 2018
Chemotherapy

- Off patent cancer medicines
- WHO EML recently updated to extend indications

### Cytotoxic and adjuvant medicines
- cisplatin
- carboplatin
- paclitaxel
- fluorouracil
- gemcitabine
- docetaxel
- ifosfamide
- filgrastim
Palliative care

- Symptom management is complex
- Pain is not the only symptom
- Palliative care is not only end-of-life care
- Early integration of palliative care is essential

Common Symptoms:

- Pain
- Ureteric obstruction +/- renal failure
- Bleeding
- Malodorous vaginal discharge
- Lymphoedema
- Fistulae
Multidisciplinary care

• Improves patients’ assessment and management practice
• Impact on quality of care
• MDTs also within individual disciplines

MDT:

• Pathologist
• Radiologist
• Gyn Oncologist
• Radiation Oncologist
• Medical Oncologist
• Palliative Care Specialist
• Oncology Nurse
Health System Lens

**Service Delivery**
- Analyzing and removing barriers to care
- Integrated service delivery models
- Guidelines adapted to local context
- Quality of care and patient safety

**Health Workforce**
- Optimizing performance and quality of cancer health workforce
- Aligning investments in human resources with current and future needs and investments in infrastructure
- Policies to improve retention and regulate the private sector

**Registries and Information Systems**
- Strengthening of population-based cancer registries: survival and stage distribution
- Monitoring and evaluation of clinically relevant facility level data (e.g. quality of care indicators)

**Access to Technology and Medicines**
- Selection, procurement, supply, storage and distribution chain management
- National lists of priority medical devices and essential medicines

**Financing**
- Efficient use of domestic funding
- Financial protection: inclusion in UHC benefit package
- Innovative solutions for sustainable financing of cancer programme

**Governance**
- Integrated national cervical cancer control programme
- Strengthening of regulatory framework
“It is time to consign cervical cancer to the history books”

THANK YOU!

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