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Newsletter

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From the Editor's Pen

Dear Friends,

Wishing you all a very happy and prosperous 2016 from the Editorial team of ISCCP

For a grand beginning to the year, we bring to you a new edition of the newsletter. We had wonderful year where we have initiated new ideas, motivated more gynecologists and created a vision for the society to move forward. We are resolute in our aim of making the newsletter a forum for assimilation and dissipation of knowledge in cervical cancer.

We hope to bring the recent updates and trends in the field of cancer cervix and colposcopy from all places in India. True to that intention, this edition includes an epidemiological study from Patna and a successful exenterative surgery from Mumbai. We thank the respective authors for sharing their experiences with us. In addition, closer to home, training camp for ASHA workers was organized at Safdarjung Hospital under the aegis of ISCCP.

As members of this society, the onus is upon all of us to make a mark in the coming editions of the news letter. We are sure your dedication and skills have benefited a lot of women in the country. It is our request that you share your experiences, brain storm newer techniques and bring to the table interesting topics for discussion. The perspectives from the 'India view point' would immensely help to create awareness among the younger lot, thereby ensuring an academically motivated pipeline of gynecologists. Please refer to the guidance for authors section of the newsletter to learn more about how you can contribute to the newsletter.

This year's annual conference is slated to be held at Jodhpur in April. It is a great opportunity for the members to deliberate on the latest developments in the field. We request that you attend in large numbers and make the event a 'royal' success!

Dr Pakhee Aggarwal
Dr Roopa Hariprasad
Editorial Team
ISCCP

Announcement

All life members of ISCCP are requested to pay Rs 1,575/-to retain their membership of International Federation of Colposcopy for 5 years. Cheques in favor ISCCP may be sent to:

ISCCP
G-367 (Ground Floor)
Preet Vihar, New Delhi 110092, India.

Forthcoming Event

ISCCP 2016 at Jodhpur, Rajasthan on 2-3rd April, 2016

Organising Chairperson:
Dr Pratibha Singh
Ph: 08003996941
E-mail: drpratibha69 hotmail.com

Carcinoma Cervix: Where do we stand? Epidemiological data from a Hospital Based study

Dr Vibha Gahlot
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Cancer cervix is the second most common cancer among women worldwide. About 86% of the cases occur in developing countries and is responsible for 88% of deaths. It constitutes about 11-30% of all cancer in women in India. The current estimates indicate that approximately 1,32000 new case are diagnosed each year with this disease in India and is responsible for 74,000 deaths annually, which accounts for the 1/3rd of the global deaths from cervical cancer. This is a huge burden on any country and society. We conducted a study to look at the epidemiological distribution of the carcinoma of cervix in patients' population of Mahavir cancer Sansthan in Patna, the capital city of Bihar.

Mahavir Cancer Sansthan is a renowned cancer hospital and research institute in state of Bihar, established in December 1998. In this institute cancer patients come from all over the state however most patients are from Patna and from the villages near the Gangetic belt. Following map shows cancer cervix distribution amongst the patients registered so far in Mahavir cancer Sansthan (MCS) (Figure-1).

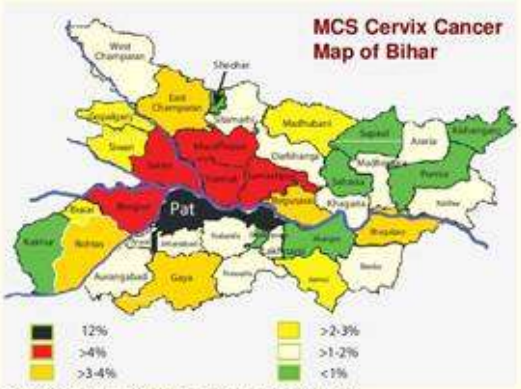

Figure 1. MCS Cervix Cancer Map of Bihar

The cervical cancer is the second most common cancer in the hospital population of Mahavir Cancer Sansthan. According to cancer patients registry data of our hospital from 2006 to 2013, total number of patients seen in this institute were 1, 33,656 out of which 20,000 patients were of cancer cervix. Our study period is 2013-2014 at 12 months period. The patient registry data showed that the total number of patients visited from all cancer were 20746. The cervical cancer constituted 14% of the patients.

Aim of this epidemiological study is to understand the underlying extent and spread of the disease and what level of prevention can be applied to reduce the number of patients with this disease and to reduce the morbidity, mortality and improvement in the quality of life. We reviewed 700 case notes of patients from carcinoma cervix for various epidemiological parameters. We looked at known risk factors like early age of sexual activity, high parity, tobacco smoking, low socioeconomic status and low educational background and on the other hand clinical parameters like mean age at presentation, clinical staging at the time of presentation, pre and post-menopausal status of women have been noted.

Our data showed mean age at marriage in this population was 15 years which correlates with the exposure to first physical contact. The Average parity was 4.92. 7% of women were addicted to either tobacco chewing or bidi smoking. Only 1.8% had family history of cancer and 5% belong to the ethnic minority. About 95% of the patients belong to the low socioeconomic status and 54% patients have never been to school. As regards to clinical parameters, mean age of cervical cancer is 49.5 years and 80% of the patients in our studied group were between the ages of 30-60 years. (Figure 2).

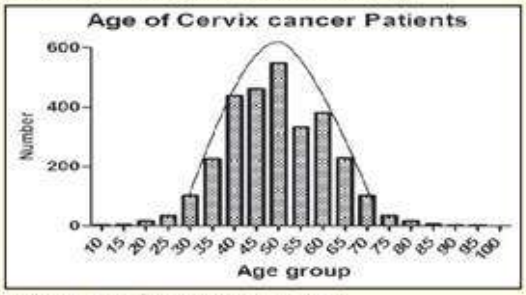

Figure 2. Age of Cervix Cancer Patients

Menopausal Status: 55% patients were premenopausal and 45% postmenopausal

Clinical Staging: Figures for clinical staging at the time of presentation were astonishing as 71% of the patients were in stage 2b at the time of clinical presentation; 24% at stage 3, 4% at stage 4 and only 1% of patients were in stage[1].

50% of the patients belong to the 6 district which fall

in Gangetic belt. It is concluded from our study that 99% of patients had reported at stage 2b and beyond. (Figure 3).

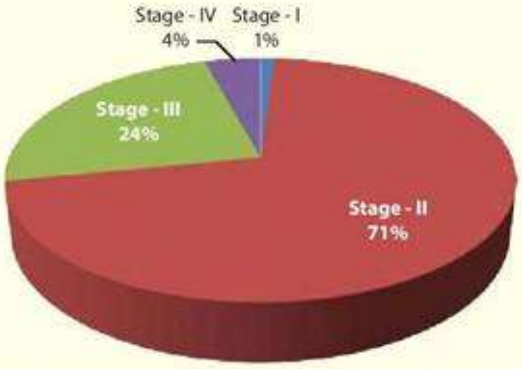

Figure 3: Cervix Cancer patient's clinical stage wise distribution

Poverty and illiteracy were the two key factors identified for high incidence of cervical cancer. Most cases belong to Gangetic belt of Bihar.

Discussion: Cervical cancer accounts for the 26% of cancer death in women according to GLOBOCAN 2002 and IARC 2009. IARC also estimates that mortality from cervical cancer is expected to see a 79% increase from 74,118 deaths in 2002 to 132,745 deaths by 2025 (National Cancer Registry Programme 2009). In India the age adjusted incidence of cervical cancer is 30.7 per 100000 women and is higher than average for the South Central Asia Region shown by GLOBOCAN 2002 databased. The age standardised death rate of 9.5 per 100,000 populations is representative of global rates but in India mortality is considerably higher relative to the world and to the South Asia Region[1,2].

Natural History of cervical cancer: It is established now beyond doubt that the cervical cancer begins with the development of pre- cancerous, benign lesions at squamo-columnar junction of cervix. The first stage of development is mild dysplasia which progresses to moderate and severe dysplasia and then carcinoma in situ (CIS) and then to micro invasive and invasive. Mild dysplasia regresses by itself and needs no treatment but in few percent of women can progresses to severe forms. It may take as long as 10 years.

The situation is very different for moderate and severe dysplasia. They are at a high risk of developing in to invasive cancer. The time period before it happens could be several years but can be as short as 2 years therefore all moderate to severe lesions need treatment. Until this point all lesions are asymptomatic and can only be recognised by some types of screening test may it be Pap's smear, VIA, VILI, Colposcopy etc.

Most developed countries follow a screening programme and colposcopy services have seen reduction in incidence of cervical cancer. According to Trent cancer registry 2012, profile of cervical cancer document the downward trend in mortality rates reflect the success of the screening programme. They estimated that cervical screening saves around 5000 lives each in UK. Earlier detection of invasive disease through screening has also impacted on mortality rates with more women diagnosed at a treatable stage[3].

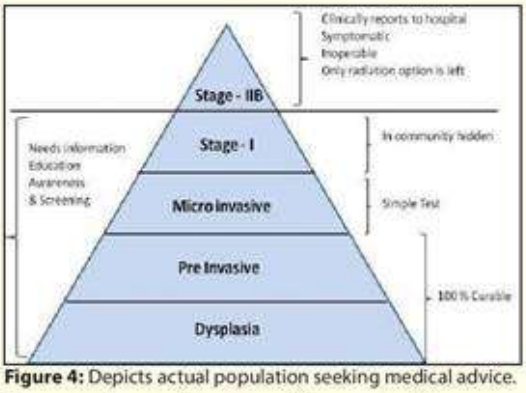

Figure 4: Depicts actual population seeking medical advice.

Presentation at a late stage: Is it poverty, illiteracy, or something more than that? Poverty, Illiteracy and lack of awareness have been proven in many studies as a cause of increase in cervical cancer incidence in developing countries however a questionnaire survey conducted amongst 403 female teachers from 40 public secondary schools in Malaysia by cluster random sampling between Jan – March 2010 revealed that 62% never had Pap smear. This means that regardless of educational level, employment status they also perceived Pap smear screening negatively[4]. Many studies have cited factor such as shyness, embarrassment, reluctance and time consuming for not having Pap smear.

The WHO 2004, revealed that low socio economic conditions increase the risk of development of cervical cancer due to restricted access to the health care services, poor nutrition and a low level of awareness**5**. It is also suggested by Katherine et al 2006 in their study that socio economic status, race and ethnicity were independently associated with the poorer cervical cancer survival[6].

On the other hand it is difficult to find any robust study to understand that cervical cancer is such a symptomatic disease yet women they don't report it earlier. Excessive vaginal discharge, irregular bleeding, bleeding after intercourse, chronic backache, fowl smelling discharge are the few symptoms. Each one of

them in their own right interferes with the routine life. This generates another whole lot of work and debate to understand that is it only the health care services, poverty, unawareness or it is negligence on the part of the women, family or society, or fear of being left alone or fear of unknown yet need to be answered.

This study although conducted in a cancer hospital clearly showed that 99% of patients were in stage 2b and beyond that. Figure 5, Tip of the Iceberg gives a diagrammatic representation that for each patient coming to the hospital with stage 2b, many more patients are awaiting to reach there before they will approach to be seen.

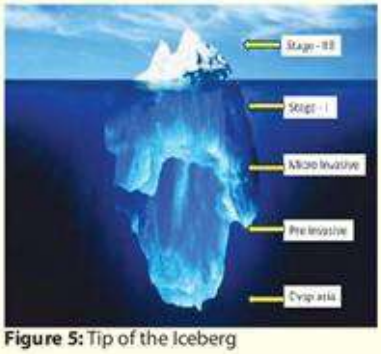

Figure 5: Tip of the Iceberg

Conclusion

With this hospital based study we conclude that 99% of our patients seek medical advice only at a later stage when primary and secondary level of preventions cannot be applied. Like other studies my study also has concluded that early age of marriage and high parity, low socioeconomic status and illiteracy are the key factors responsible for high incidence of this disease**7**. We strongly believe that due to the diverse society and inequity in health services, different educational and economical background a strategic approach which is suitable for a particular society with high acceptance and economically viable is needed to address this disease which is 100% curable in its preinvasive stage.

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Journal Scan

J Clin Virol. 2015 Nov 18. pii: S1386-6532(15)00754-4.

Cervical cancer screening of HPV vaccinated populations: Cytology, molecular testing, both or none.

El-Zein M, Richardson L, Franco EL.

Cervical cancer control includes primary prevention through vaccination to prevent human papillomavirus (HPV) infection and secondary prevention through screening to detect and treat cervical precancerous lesions. This review summarizes the evidence for the population impact of vaccines against oncogenic HPV types in reducing the prevalence of cervical precancerous lesions. We examine the gradual shift in screening technology from cervical cytology alone to cytology and HPV co-testing, and finally to the recognition that HPV testing can serve alone as the new screening paradigm, particularly in the initial post-vaccination era. We should expect an impact on screening performance and practices, as cohorts of HPV-vaccinated girls and adolescents reach cervical cancer screening age. In preparation for changes in the screening paradigm for the vaccination era, we propose that policymaking on cervical cancer screening should mirror current practices with other cancers as benchmarks. Cervical precancerous lesions will become a very rare condition following the widespread implementation of HPV vaccines with broader coverage in the number of preventable oncogenic types. Irrespective of screening technology, the false positive results will far outnumber the true positive ones, a tipping point that will herald a new period

when the harms from cervical cancer screening will outweigh its benefits. This article presents a conceptual framework to guide decision making when this point is reached within 25-30 years.

J Int AIDS Soc. 2015 Dec 1;18(6 Suppl 5):20282.

The time has come to make cervical cancer prevention an essential part of comprehensive sexual and reproductive health services for HIV-positive women in low-income countries.

Huchko MJ, Maloba M, Nakalembe M, Cohen CR.

Introduction: HIV and cervical cancer are intersecting epidemics that disproportionately affect one of the most vulnerable populations in the world: women in low- and middle-income countries (LMICs). Historically, the disparity in cervical cancer risk for women in LMICs has been due to the lack of organized screening and prevention programmes. In recent years, this risk has been augmented by the severity of the HIV epidemic in LMICs. HIV-positive women are at increased risk for developing cervical pre-cancer and cancer, and while the introduction of antiretroviral therapy has dramatically improved life expectancies among HIV-positive women it has not been shown to improve cancer-related outcomes. Therefore, an increasing number of HIV-positive women are living in LMICs with limited or no access to cervical cancer screening programmes. In this commentary, authors have described the gaps in cervical cancer prevention, the state of evidence for integrating cervical cancer prevention into HIV programmes and future directions for programme implementation and research.

Discussion: Despite the biologic, behavioral and demographic overlap between HIV and cervical cancer, cervical cancer prevention has for the most part been left out of sexual and reproductive health (SRH) services for HIV-positive women. Lower cost primary and secondary prevention strategies for cervical cancer are becoming more widely available in LMICs, with increasing evidence for their efficacy and cost-effectiveness. Going forward, cervical cancer prevention must be considered a part of the essential package of SRH services for HIV-positive women. Effective cervical cancer prevention programmes will require a coordinated response from international policymakers and funders, national governments and community leaders. Leveraging the improvements in healthcare infrastructure created by the response to the global HIV epidemic through integration of services may be an effective way to make an impact to prevent cervical cancer among HIV-positive women, but more work remains to determine optimal approaches.

Conclusions: Cervical cancer prevention is an essential part of comprehensive HIV care. In order to ensure maximal impact and cost-effectiveness, implementation strategies for screening programmes must be adapted and rigorously evaluated through a framework that includes equal participation with policymakers, programme planners and key stakeholders in the target communities.

J Clin Virol. 2015 Nov 28. pii: S1386-6532(15)00749-0.

Triage of HPV positive women in cervical cancer screening.

Wentzensen N, Schiffman M, Palmer T, Arbyn M.

Despite HPV vaccines, screening will remain central for decades to control cervical cancer. Recently, HPV testing alone or with cytology was introduced as an alternative to cytology screening. However, most HPV infections are harmless and additional tests are required to identify women with progressing infections or precancer. With three options for primary screening, and without clear strategies for triage of screen-positive women, there is great confusion about the best approach. Also, increasing HPV vaccination coverage will lead to lower disease prevalence, and force new screening approaches. Currently recommended triage strategies for primary HPV screening include HPV genotyping for HPV16 and HPV18 and cytology. Other alternatives that are currently evaluated include p16/Ki-67 dual stain cytology, host methylation, and viral methylation testing. Clinical management of women with cervical cancer screening results is moving to use risk thresholds rather than individual test results. Specific risk thresholds have been defined for return to primary screening, repeat testing, referral to colposcopy, and immediate treatment. Choice of test algorithms is based on comparison of absolute risk estimates from triage tests with established clinical thresholds. Importantly, triage tests need to be evaluated together with the primary screening test and the downstream clinical management. An optimal integrated screening and triage strategy should reassure the vast majority of women that they are at very low risk of cervical cancer, send the women at highest risk to colposcopy at the right time, when disease can be colposcopically detected, and minimize the intermediate risk group that requires continued surveillance.

Anterior exenteration in a patient of unstaged cancer cervix who received complete dose of radiation, with residual disease involving urinary bladder: a case report

Dr Nikhil S. Parwate
Consultant Colposcopist & Gynaeoncosurgeon, Brahmakumaris Global Hospital and Research Hospital, Andheri, SRV Multispeciality Hospital, Goregaon and Currae Speciality Hospital, Thane, Mumbai

Background: Mrs XYZ, a 42 yrs old lady underwent total abdominal hysterectomy for cervical fibroid which turned out to be squamous cell carcinoma of cervix on histopathology. There was lymphovascular emboli, with poor differentiation. Tumor size on specimen was reported to be around 3.5 cm.

Patient was then referred to a private hospital and was given full dose of concurrent external beam radio and chemo therapy including 2 doses of intracavitary brachytherapy.

During the second course of intracavitary brachytherapy, she complained of pain in abdomen. On evaluation, a pelvic mass around 12 by 10 cm was found with solid components. Presence of residual disease was confirmed by biopsy from the mass and a PET-CT scan. EUA and cystoscopy revealed the mass to be involving the bladder.

A joint decision (by the team of surgical oncosurgeon, gynaecologic oncosurgeon and urosurgeon) was made for exploratory laparotomy and removal of mass including anterior exenteration.

After a detailed consent regarding risks, complications, permanent urinary diversion with a stoma, morbidity and mortality of surgery, required pre operative fitness was obtained and 4 units blood was reserved. Preop ureteric stenting was done.

On opening the abdomen a very hard mass arising from pelvis, stuck to the lateral abdominal wall and pubic symphysis, with bladder completely adherent to the mass (inseparable from the mass) and obliterating the entire POD was seen.

The rectus muscles were cut laterally to gain access to the lateral border of mass. As the mass was completely stuck to the pubic bone, an orthopaedic surgeon was called in to remove the pubic bone. Despite extensive dissection the mass was not movable and bladder could not be separated from the mass at that point. After removing the symphysis pubis, and all its muscle attachments, the mass became mobile and was slowly separated from all its attachments in the POD taking care to prevent injury to vital structures.

After nearly 7 hours of surgery the mass, urinary bladder, symphysis pubis with all its muscle attachments and distal end of ureter were removed sent for histopathological examination (Figure 1). Thereafter, an ileal conduit with permanent ureterostomy was created.

Due to extensive dissection, it was difficult to close the abdomen by bringing both the rectus together at the end. With the help of a surgical colleague with expertise in difficult abdominal closure primary closure was achieved by mobilising transversus abdominis muscle flaps, taking care to prevent any kink or tension on the ureterostomy. During this extensive surgery, patient was transfused 2 pints blood intraoperatively.

She was later shifted to ICU and kept on ventilator for 12 hours, and then extubated. She was managed in ICU for 2 more days and then shifted to ward. She had an uneventful post operative period and was started on oral feeds and mobilised by day 6. With constant nursing assistance and active physiotherapy, she did well. Contrary to general teaching she did not have a waddling gait due to symphysis pubis removal, and she even got trained for squatting and climbing stairs without any difficulty! She was discharged on day 16 of surgery on full diet and with normal bowel habits.

Highlights of this case were: a twelve hour surgery in a previously irradiated abdomen and pelvis, with only two pint intra op blood required inspite of extensive dissection, meticulous preop and postop care by a team of specialists, patient counselling, continuous guidance and education of patient and her relatives to help cope with such extensive surgery and judicious participation and enthusiasm showed by all team involved in the care of patient.

Discussion

Described by Brunchwings in 1984[1], exenterative surgeries were carried out initially with the intention of palliation. However with modifications[2] and current understanding of gynaecological cancers, exenterative surgeries are now carried out as primary 'curative' intent surgeries, especially in cases of CA cervix stage IV-A, advanced vulval cancer, post- radiation cervical and vulval cancers and in some advanced ovarian cancers[3,6].

A team of dedicated gynaecologic oncosurgeons and those involved in social, emotional and mental support for the patient is a must for conducting these surgeries to give adequate results[3,8]. Continuous guiding of the patient and family members pre op and post op helps them to understand various forms of stoma care and improve quality of life in spite of extensive surgery[4,7]. Although the morbidity and mortality of such surgeries are often 'taught' to be higher[1,5,7], with changing surgical scenarios and well-trained team, there may be an overall reduction of these events[5,6,8].

Figure 1: mass removed at exenteration

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'ASHA training Camp at Safdarjung Hospital'

Cancer training and awareness program for ASHA workers was organized by Department of Obstetrics & Gynaecology, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi on 16th and 23rd December 2015. Around 200 ASHA workers attended the program. It had sessions on Cancer burden in Indian women, methods for prevention, screening and diagnosis of cervical cancer, screening and diagnosis of Breast Cancer and self-examination of breasts followed by an interactive session. There was active and enthusiastic participation by all the ASHA workers.

Colposcopy Workshop at Chattisgarh

A colposcopy workshop was conducted at CCM Medical College, Durg under aegis of ISCCP on 6th December, 2015. Over 80 delegates from all over Chhattisgarh attended the workshop which included a panel discussion, case discussion and an interactive session with medical students and DNB students who also participated in a poster campaign. ISCCP President Dr Gauri Gandhi and Dr Raksha Arora were invited as expert faculty and Dr Meena Naik was the organising secretary.

Guidelines for Authors

All members of ISCCP are requested to send manuscripts pertaining to (but not exclusively limited to) to cervical cancer prevention/treatment for publication in the newsletter. The matter should be original and not published/under consideration for publication elsewhere. This could be in one of following forms:

1. **Original Article**: Articles from original research (including aim, methods, results and discussion), should not exceed 5-6 typed pages, word limit of 1500 words and not more than 10 references. Tables and Figures could be included as per requirement.
2. **Review Article:** The article should not exceed 3-4 typed pages, word limit 1200 words with not more than 8 references.
3. **Case Report**: An interesting case report which has "take home message", word limit 800 words with not more than 3-5 references.
4. **Report of awareness/training camps:** up to 300 words with 2-3 images

References: References should be recent, relevant, indexed and in Vancouver style. References to literature cited should be numbered consecutively and placed at the end of the manuscript. In the text they should be indicated as superscript.

All papers submitted are subject to review process. All accepted papers will be suitably edited before publication.

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