

The Journey of the Cancer Patient: Cervical Cancer

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Outline

- *Community*
- *Point of contact*
- *In the system*
- *Gaps*



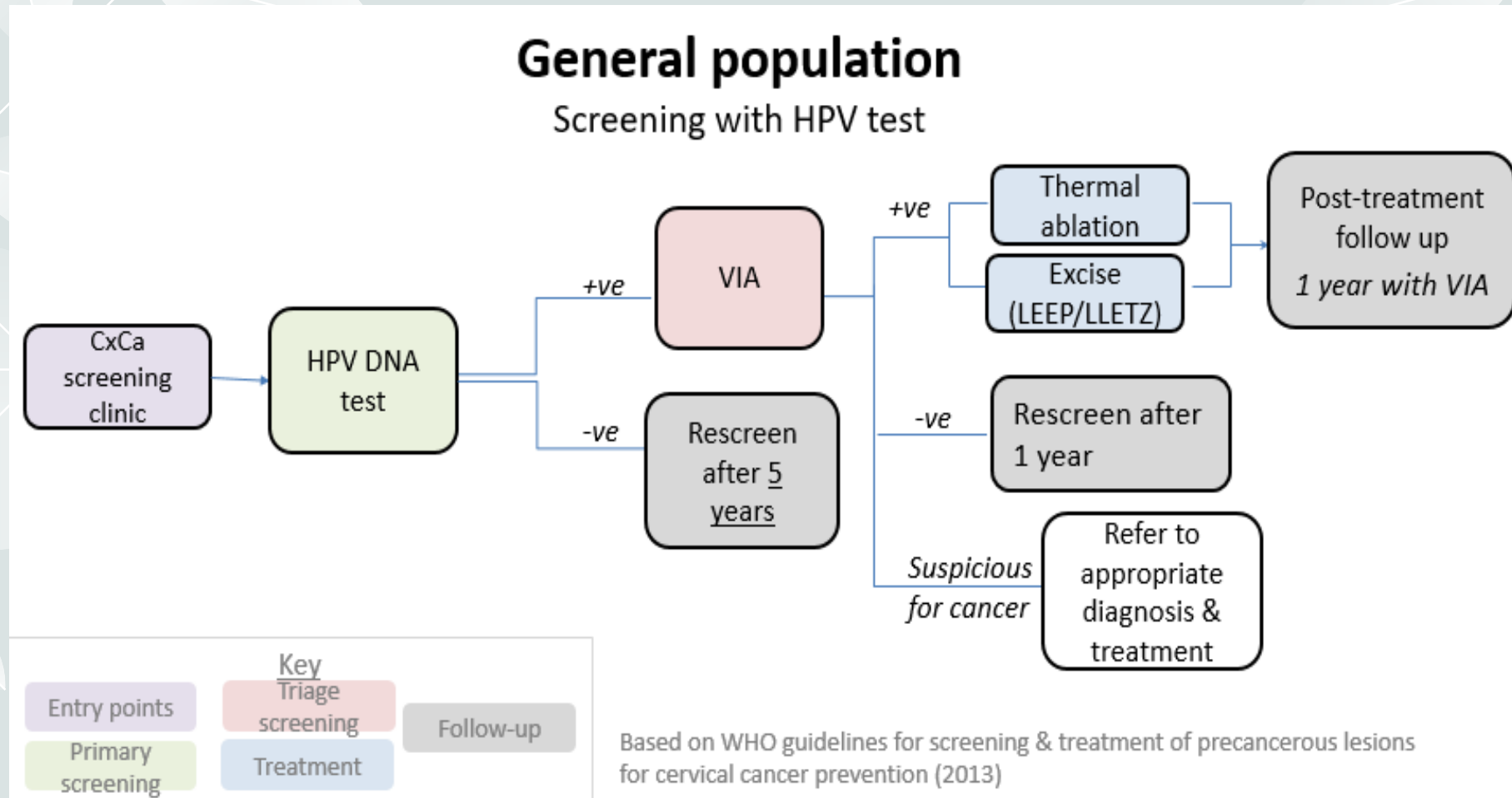


Community awareness activities drives patient to seek care

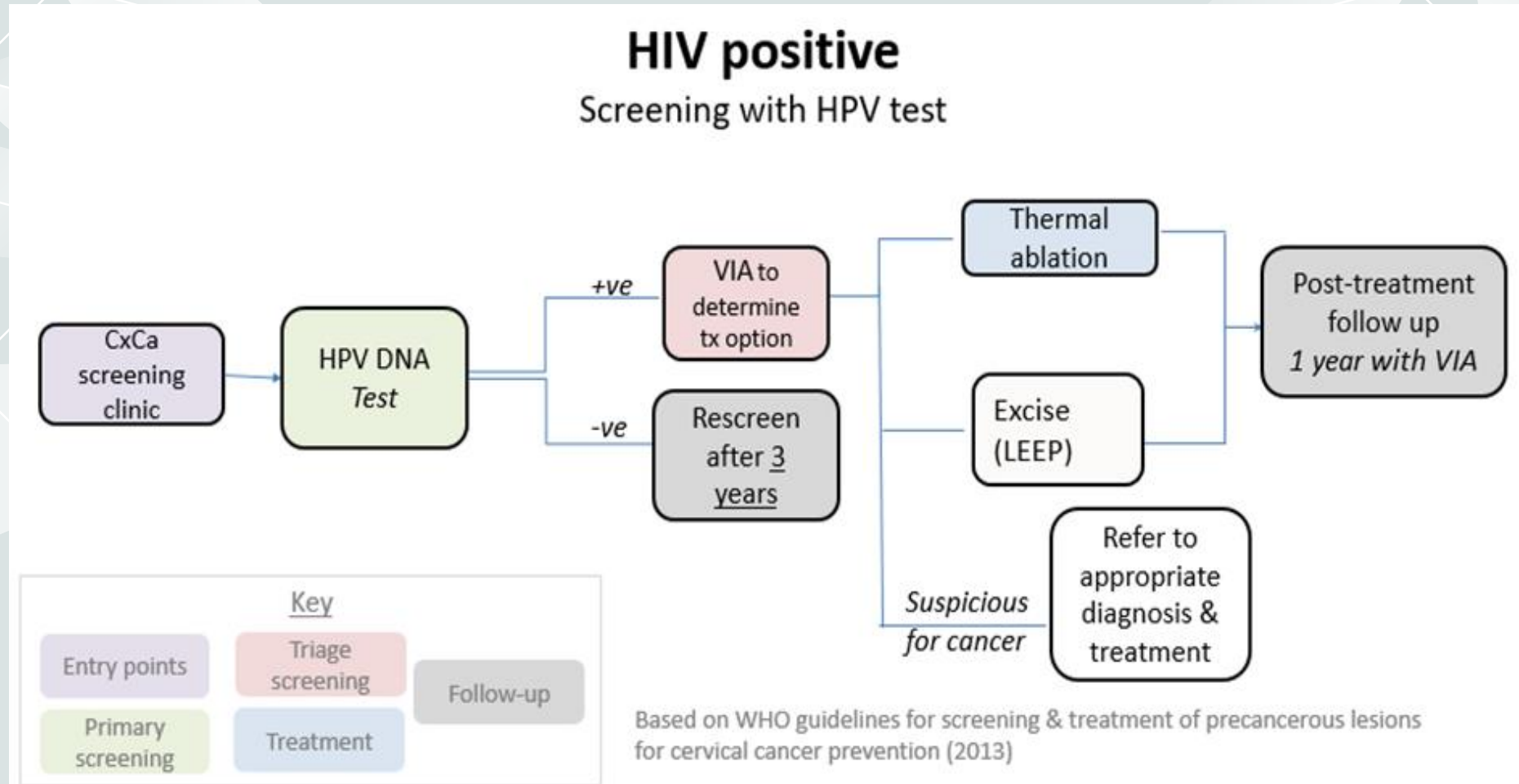
- Cancer awareness activities conducted by various stakeholders in the community
 - Targeted mobilization for cervical cancer screening
 - Cancer commemoration day activities
 - Initiatives to introduce community based self sampling for HPV testing
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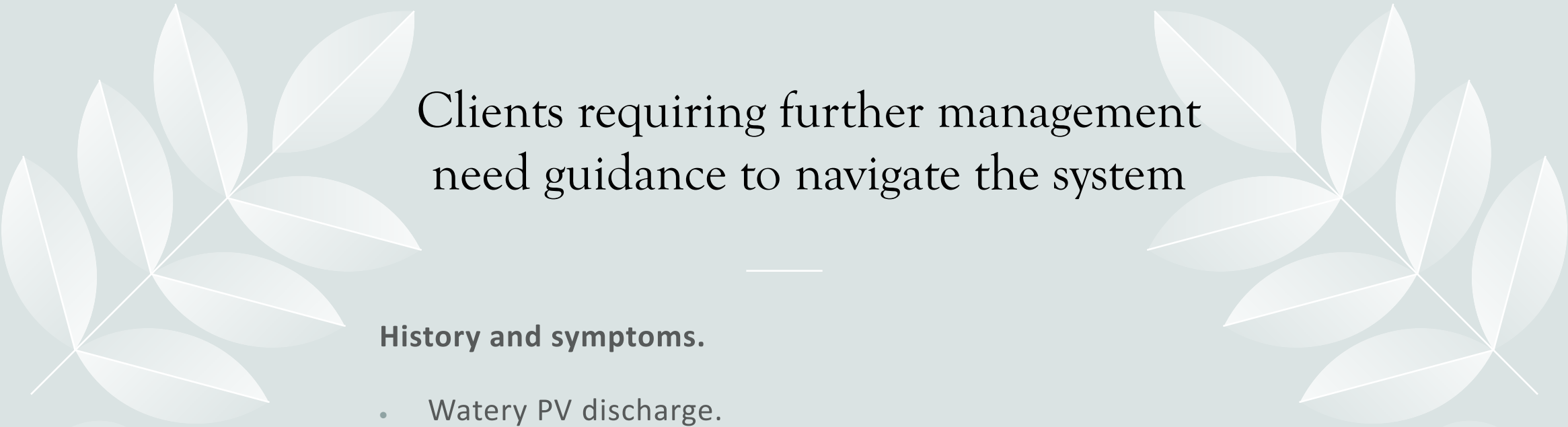
Primary contact point: screening and treatment of precancerous lesions

Primary Health Care Service Point



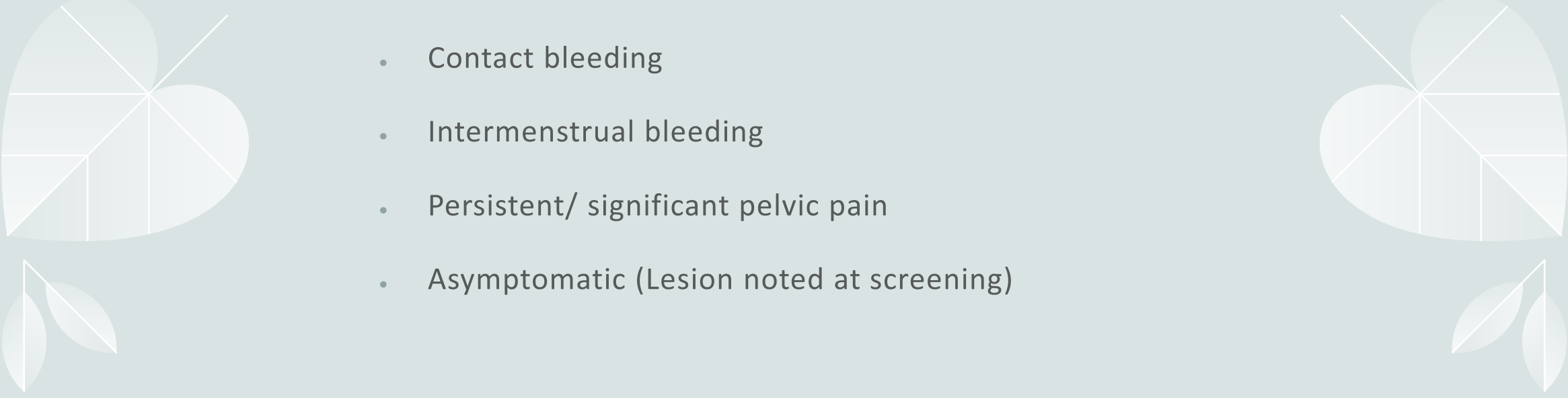
Primary contact point: screening and treatment of precancerous lesions Primary Health Care Service Point

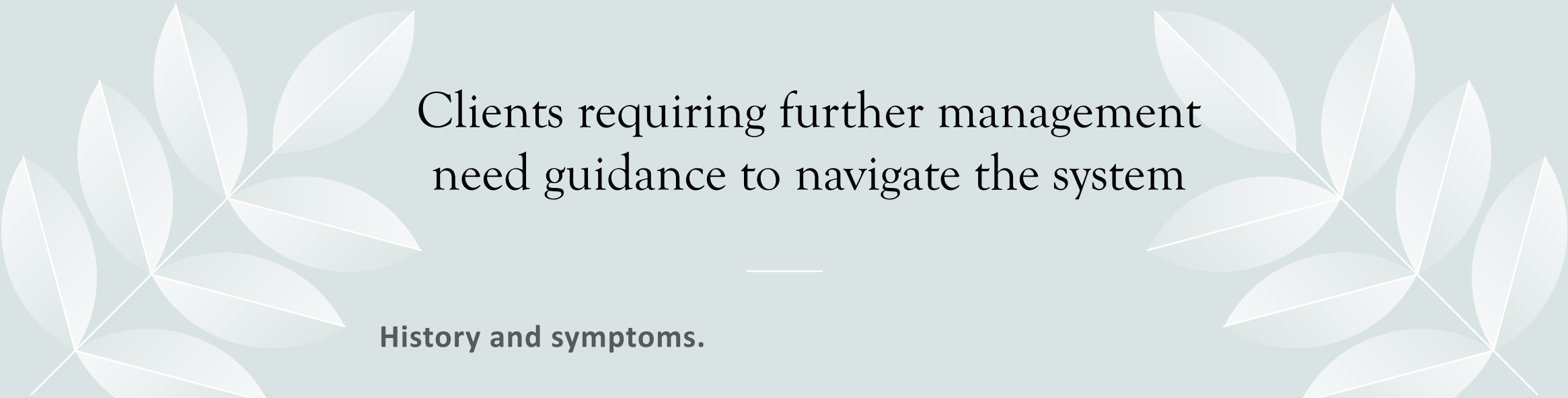




Clients requiring further management need guidance to navigate the system

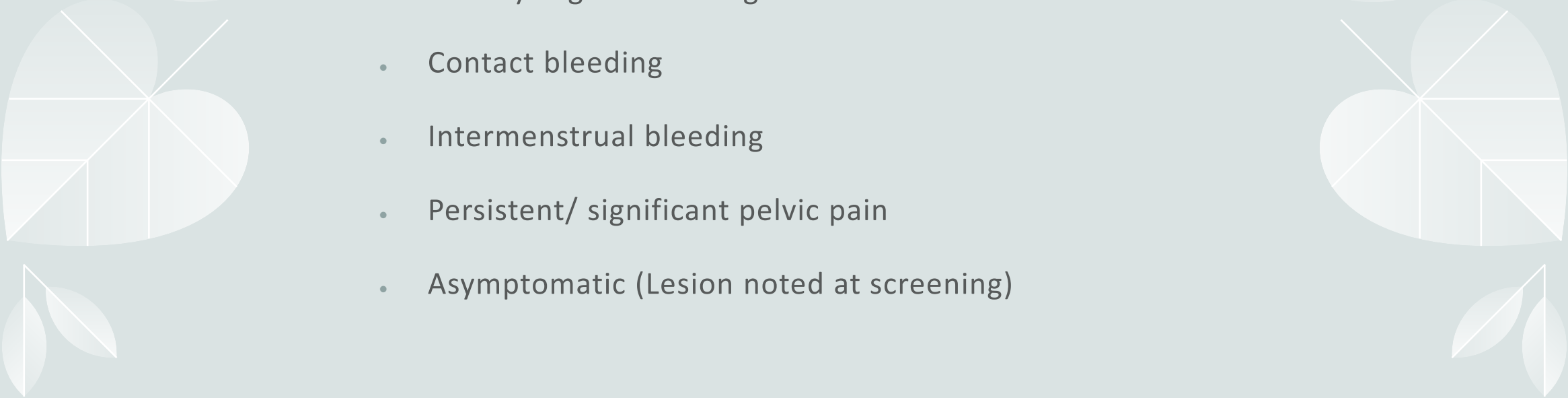
History and symptoms.

- Watery PV discharge.
 - Contact bleeding
 - Intermenstrual bleeding
 - Persistent/ significant pelvic pain
 - Asymptomatic (Lesion noted at screening)
- 



Clients requiring further management need guidance to navigate the system

History and symptoms.

- Watery vaginal discharge.
 - Contact bleeding
 - Intermenstrual bleeding
 - Persistent/ significant pelvic pain
 - Asymptomatic (Lesion noted at screening)
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All women with above signs and symptoms should be referred to the next level centre of care with a specialist.

Physical examination

Cervical lesion which can be a mass or ulcer

- General examination- includes signs of anaemia and lymph nodes
- Abdominal exam.
- Pelvic Exam (Mandatory)
 - *speculum exam to visualise the cervix*
 - *Digital vaginal and rectal exam, to determine size of , involvement of vagina, parametrium, pelvic side wall, rectum and bladder*

Further investigations are required to confirm the type of cancer and stage

Diagnostic Workup

- Cervical biopsy

Staging Workup.

- FBC, LFT, U&E, HIV test.
- Chest x-ray and USS abdomen & pelvis.
- CT scan Abd/pelvis (if affordable in place of USS)

MRI recommended in early stage disease to determine extent of parametrial involvement when contemplating primary surgery (if available)

Treatment will depend on the type and stage of cervical cancer

Stage	Surgery	Radiotherapy	Chemotherapy
1A ₁	Excisional conisation or simple hysterectomy	If childbearing not desirable	Not recommended
1A ₂	Bilateral pelvic lymphadenectomy + modified (type II) radical hysterectomy	<p>Consider radiotherapy for the following:</p> <ul style="list-style-type: none"> • LVSI. • Deep stromal invasion • Adenosquamous, clear cell, small cell and undifferentiated histology. <p>Consider chemoradiation for the following:</p> <ul style="list-style-type: none"> • Positive surgical margin • Positive lymph node • Parametrial involvement 	<p>Concurrent chemotherapy indicated for:</p> <ul style="list-style-type: none"> • Positive surgical margin • Positive lymph node • Parametrial involvement
1B1, 1B2 & IIA1	Radical hysterectomy + pelvic lymph node dissection	Definitive pelvic radiotherapy plus brachytherapy boost +/- concurrent chemotherapy.	Concurrent chemotherapy
1B3- IIC1	Not recommended	Pelvic radiotherapy plus brachytherapy boost +/- concurrent chemotherapy.	Concurrent chemotherapy
IIC2	Not recommended	Extended field radiotherapy plus brachytherapy boost +/- concurrent chemotherapy	Concurrent chemotherapy
1VA	Not recommended	Pelvic radiotherapy plus brachytherapy boost +/- concurrent chemotherapy	Concurrent chemotherapy
IVB	Not recommended	Palliative radiotherapy if needed	Palliative chemotherapy

Client should be followed up throughout provision of treatment

Follow up.

- Should be done at the treatment facility.
- History and examination 6 weeks post chemoradiation or surgery.
- CT scan chest, abdomen & pelvis (if available) or USS abdomen & pelvis and Chest X-ray within 3-6 months of completion of therapy.
- Review clinically every 3 months for 2 years then every 6 months till 5 years then annually.
- Vault/Pap smear screening maybe considered a year post treatment.

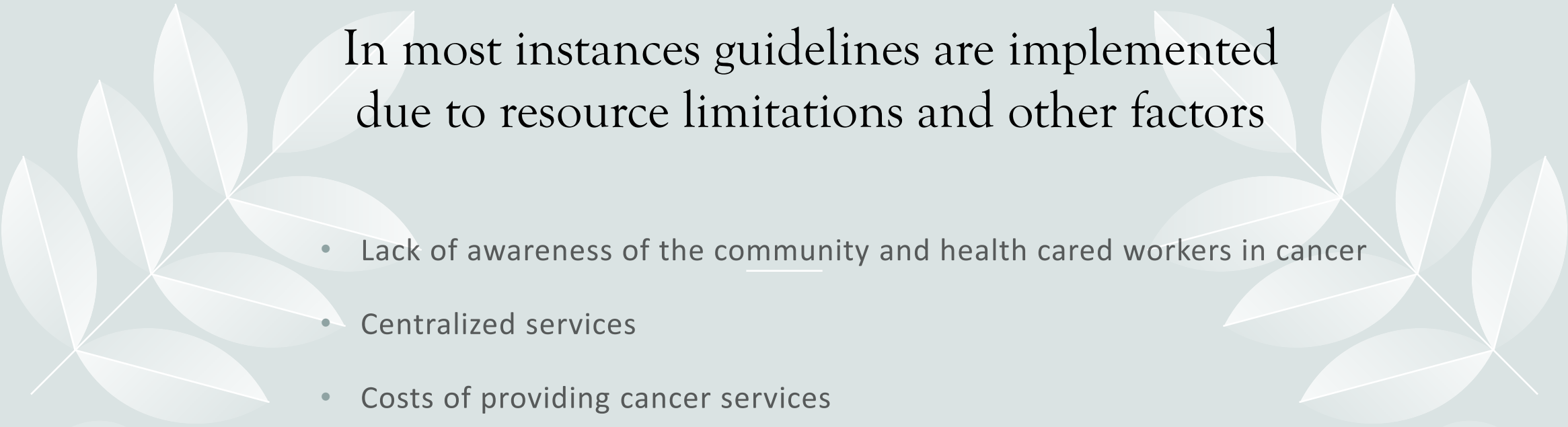
Cervical cancer can recur and the client will require management

Recurrent Disease

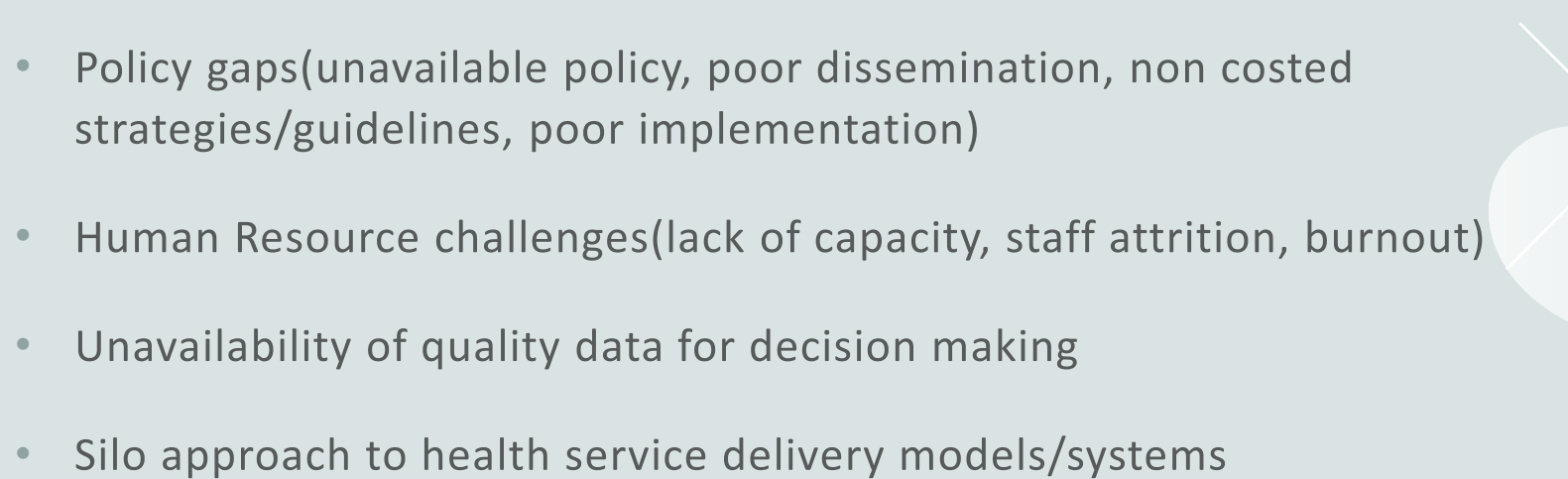
- Management depends on previous treatment modality and performance status of the patient.
- **Local recurrence post treatment can be successfully managed by a modality not previously utilised**
- **Pelvic exenteration:** A pelvic exenteration can be considered for central pelvic recurrent disease after primary RT when spread is confined to the bladder or rectum. Metastatic cancer outside the pelvis and poor medical condition of the patient are contraindications to exenteration.
- **Chemotherapy** for metastatic disease is not curative. Drugs that could be considered following multidisciplinary team consultation include, cisplatin, carboplatin and paclitaxel. Appropriate palliative care should be considered for all the patients.

The client will require support and a multidisciplinary approach is critical

- All cancer patients should be discussed in a multidisciplinary team meeting
- Palliative care services are supposed to be available throughout the continuum of care
- Costs of care and treatment are usually covered out of pocket by the client
- Survivorship follow up is only up to a maximum of 5 years-there is no available guidance for management of long term effects of treatment



In most instances guidelines are implemented due to resource limitations and other factors

- Lack of awareness of the community and health cared workers in cancer
 - Centralized services
 - Costs of providing cancer services
 - Policy gaps(unavailable policy, poor dissemination, non costed strategies/guidelines, poor implementation)
 - Human Resource challenges(lack of capacity, staff attrition, burnout)
 - Unavailability of quality data for decision making
 - Silo approach to health service delivery models/systems
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Last word

Mapping the journey of the cancer patient to identify bottlenecks and addressing these through models of integrated and patient centered care can unlock resources for provision of holistic cancer services-even in resource limited settings.

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Thank you

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