The Journey of the Cancer Patient: Cervical Cancer

Venus Dadirai Mushininga

ICCP ECHO, 26 July 2023
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
Primary contact point: screening and treatment of precancerous lesions Primary Health Care Service Point

General population
Screening with HPV test

- HPV DNA test
  - CxCa screening clinic
  - VIA
    - +ve
      - Post-treatment follow up 1 year with VIA
    - -ve
      - Rescreen after 5 years
  - +ve
    - Thermal ablation
    - Excise (LEEP/LLETZ)
      - Rescreen after 1 year
      - Refer to appropriate diagnosis & treatment
      - Suspicious for cancer
Primary contact point: screening and treatment of precancerous lesions Primary Health Care Service Point

HIV positive
Screening with HPV test

- CxCa screening clinic
- HPV DNA Test
  - +ve VIA to determine tx option
  - -ve Rescreen after 3 years
    - Thermal ablation
    - Excise (LEEP)
    - Post-treatment follow up 1 year with VIA
    - Refer to appropriate diagnosis & treatment
    - Suspicious for cancer

Key
- Entry points
- Triage screening
- Primary screening
- Treatment
- Follow-up

Based on WHO guidelines for screening & treatment of precancerous lesions for cervical cancer prevention (2013)
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)
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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Surgery</th>
<th>Radiotherapy</th>
<th>Chemotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A_1</td>
<td>Excisional conisation or simple hysterectomy</td>
<td>If childbearing not desirable</td>
<td>Not recommended</td>
</tr>
<tr>
<td>1A_2</td>
<td>Bilateral pelvic lymphadenectomy + modified (type II) radical hysterectomy</td>
<td>Consider radiotherapy for the following:  - LVSI.  - Deep stromal invasion  - Adenosquamous, clear cell, small cell and undifferentiated histology.</td>
<td>Concurrent chemotherapy indicated for:  - Positive surgical margin  - Positive lymph node  - Parametrial involvement</td>
</tr>
<tr>
<td>1B1, 1B2 &amp; IIA1</td>
<td>Radical hysterectomy + pelvic lymph node dissection</td>
<td>Definitive pelvic radiotherapy plus brachytherapy boost +/- concurrent chemotherapy.</td>
<td>Concurrent chemotherapy</td>
</tr>
<tr>
<td>1B3-IIC1</td>
<td>Not recommended</td>
<td>Pelvic radiotherapy plus brachytherapy boost +/- concurrent chemotherapy.</td>
<td>Concurrent chemotherapy</td>
</tr>
<tr>
<td>IIC2</td>
<td>Not recommended</td>
<td>Extended field radiotherapy plus brachytherapy boost +/- concurrent chemotherapy</td>
<td>Concurrent chemotherapy</td>
</tr>
<tr>
<td>1VA</td>
<td>Not recommended</td>
<td>Pelvic radiotherapy plus brachytherapy boost +/- concurrent chemotherapy</td>
<td>Concurrent chemotherapy</td>
</tr>
<tr>
<td>IVB</td>
<td>Not recommended</td>
<td>Palliative radiotherapy if needed</td>
<td>Palliative chemotherapy</td>
</tr>
</tbody>
</table>
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
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.
Thank you

Venus Dadirai Mushininga
vmushininga@gmail.com