## Conference Report

# First Regional Symposium on Management of Cancer in Countries with Limited Resources, held at SKICC, Srinagar, Kashmir, J & K, India ($10^{th}$ –$12^{th}$ May 2006)

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***"If we are to preserve civilization, we must make certain its benefits are available to the many, not reserved for the few."***

A regional Symposium on Management of Cancer in Countries with Limited Resources was conducted at SK International Convention Centre, Srinagar, Kashmir, from $10^{th}$ to $12^{th}$ May, 2006. Hakim Sanaullah Specialist Hospital & Cancer Centre, Sopore, Kashmir, Rajiv Gandhi Cancer Institute New Delhi, SK Institute of Medical Sciences Srinagar, Kashmir and Government Medical College Srinagar, Kashmir jointly organized the symposium. More than 150 delegates including the distinguished faculty from many major cancer care institutions of India as well as leading cancer experts from the state participated.

First day of the symposium consisted of an intensive continuing medical education program, for practicing physicians and junior doctors which proved to be a very exciting experience both for the faculty and participants. During the subsequent two days, gynaecological, breast, haematological and paediatric malignancies were discussed with an emphasis on diagnosis and management in limited resources set up. A special session on communication skills and palliative care concluded the symposium.

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**General observations and recommendations:**

After multiple interactive session and panel discussions the participants were able to identify some of the major problems effecting cancer care in general in this part of the world:

1. **Advanced stage of disease at presentation**: It was reiterated that irrespective of site of disease, the majority of our patients present late and in an advanced stage of disease. The following factors were considered to contribute to this trend:

- Lack or deficiency of public and physician awareness programmes.
- Lack of organised population based screening programmes.

2. **Lack of resources**: This was recognised as the other important factor effecting cancer care. Mainly the budget allocated for health care in general and cancer treatment in particular, is inadequate to meet the growing costs of cancer care.

   A range of barriers were identified which prevent proper utilization of available resources. Based on the data presented the participants made the following recommendations to improve cancer care in our setting.

1. There is a need to improve cancer awareness and education among health care providers as well as the general population, particularly about cancer prevention and early detection. The following may be of help to achieve this goal:

   a. Conducting such symposia at frequent intervals.

   b. Frequent interactions between oncologists and physicians practicing in different fields of medicine/surgery.

c. Utilizing the press and media to spread the message to all sections of society.

2. Chronic diseases, like diabetes, cardiovascular disease and cancer should not compete for attention, time and resources of patients and health care providers. As has already been done in many developed countries, a partnership must be created between various organizations and doctors working for chronic non communicable diseases, to reduce their impact on mortality and morbidity.[1]
3. Depending on the prevalence of different cancers in a particular region, cost effective screening programs should be implemented as widely as possible.
4. In order to improve doctor patient relationship and patient satisfaction and eventually the quality of care, communication skills of the physicians need to be improved. This may be achieved by the following interventions.

   a. Communication skills training should be incorporated in undergraduate curriculum.

   b. During postgraduate training stress should be laid on these skills.

   c. Training programs for physicians should be conducted to teach these skills.

5. Doctor patient contact time can be increased by making the following:

   a. More doctors should be employed.

   b. Minimum time for doctor patient encounter should be specified and the number of patients per clinic should be accordingly limited.

6. Since other super-specialties are by and large more lucrative, incentives should be provided to encourage physicians to receive training in various fields of oncology.
7. An atmosphere of team work needs to be created in all cancer care facilities. It should be made a prerequisite for making important therapeutic decisions.
8. The treatment of an individual patient should be tailored to the available resources.
9. As the data indicate a relationship between outcome and the expertise of surgical staff, cancer surgery should be performed by a team led by a trained surgical oncologist or a general surgeon trained in this field.
10. Non Governmental Organizations (NGO) must be involved in all aspects of cancer care, particularly for creating cancer support groups, cancer awareness and control programs as well as palliative care.
11. Financial support to such NGOs should be liberalized specifically to promote development of cancer care and control programs in rural areas.
12. Evidence based protocols, guidelines and recommendations should be generated locally according to available resources and implementation should be ensured through quality management interventions.

**SITE SPECIFIC RECOMMENDATIONS:**

As a part of the deliberations of this symposium, site specific brief recommendations were also made. These, however, were general suggestions and not detailed treatment guidelines:

**BREAST CANCER:**

It was acknowledged that breast cancer is the commonest cancer among females and the incidence is rising. We need to improve awareness of the physicians and public about this disease. All females with a breast mass must undergo triple assessment consisting of clinical breast examination, mammography (where available) ± breast ultrasound and FNAC. These interventions need very little resources. On the other hand costly staging investigations like bone scan may not be easily available and may be low yielding in early stages of disease. Due to lack of trained manpower, non availability of radiotherapy & mammography facilities and difficulties in follow up, breast conservative surgery may not be appropriate for a large number of our patients. It was noted that compared to more than 9000 radiotherapy machines in USA, there are only 335 in India. It is interesting to note that while as there was one radiotherapy machine for every 6 million people in 70's, today after 4 decades there is 1 for just more than 4 million, not a real impressive change in ratio, in Pakistan the situation is not much different.[2] Receptor assays have a major role to play in making a treatment decision. It is important that these should be made cheap and easily available. Receptor status must be used (where available) for making therapeutic recommendations.

While treating metastatic breast cancer one should consider the cost factor of the therapy as cure is not the goal. Investigations in these patients should be used judiciously and only when these will effect treatment decision. Results of investigations should not dictate change in therapy in the absence of a contraindication or deterioration in patient's condition. In the absence of life threatening disease in a post menopausal lady with receptor positive or receptor unknown disease endocrine therapy should be tried first.

No doubt recent data confirms the superiority of aromatase inhibitors, but due to their high cost and impact on bone mineral density, tamoxifen may still be considered the drug of choice for our patients, until such time that the aromatase inhibitors and bisphosphonates become affordable by the majority of our patients.

**Ovarian cancer:**

It is the third commonest cancer among females and has a high mortality rate and a high index of suspicion needs to be maintained, as there are no diagnostic signs and symptoms. Ultrasound (especially transvaginal) can be a useful and easily affordable investigational tool while as CA 125 may be useful for screening in suspicious cases. A very important variable in the outcome of ovarian cancer is the skill of operating surgeon; therefore, a surgeon trained in this field should perform ovarian cancer surgery.

**Haematological malignancies:**

Immunophenotyping and cytogenetic markers are essential for confirming the diagnosis, recommending therapy, as well as prognostication of most of the haematological malignancies. These must be made available in all centers treating such patients. The lack of financial support directly affects the availability of blood component therapy, antibiotics and chemotherapy agents hence the outcome. We need to create some form of financial support which may overcome financial constrain making the continuation and completion of therapy impossible for these patients. Bone marrow transplantation should be restricted to specialized centres with adequate supportive care facilities for treating such patients. We also need to address the shortage of trained manpower in these specialities. Particularly in patients of lymphoma in addition to a thorough history and physical examination essential staging investigations should be performed to identify internationally recognized prognostic factors. In most of the developing countries, radiologists need to be oriented to the proper use of CT scanning for staging of lymphoma. For prognosticating and risk stratification, internationally accepted prognostic indices should be used for non-Hodgkin's lymphoma (NHL) as well as Hodgkin's disease (HD), these need no additional resources. For NHL, CHOP should be considered standard therapy and rituximab should be added only when financial constrains permit, however, a cost effective

analysis needs to be conducted in our setup. Early NHL should be treated with a combination of chemotherapy and radiotherapy whenever available. ABVD should be considered standard therapy for HD and in early HD, 2 months of chemotherapy with local radiotherapy (*if available*) may be adequate in our setting.

**Paediatric Cancer:**

Large proportion of childhood cancers are curable but in our setup for multiple reasons, only one in 10 childhood cancer patients gets adequate therapy. Obviously this adversely affects the chances of cure. In some parts of the world, collaboration between a centre in limited resource area and a large cancer centre in a developed country has shown improved survival of paediatric patients probably by ensuring adequate therapy and follow up.[3] The delay in diagnosis, the other adverse factors, may be avoided by improving physician and public awareness. It is important that while recommending therapy for childhood cancer we must consider, short and long term sequelae, and mutilating surgery should be avoided.

**Palliative Care:**

**Pain:**

Palliative care is probably one of the most neglected aspects of cancer care in developing countries. Particularly pain which is a major symptom of advanced cancer is greatly underestimated in our part of the world. It is essential to remember that more than 3/4$^{th}$ of cancer patients have cancer related pain in advanced stage of disease and more than 70% desire to commit suicide as a result of severe pain. Routine pain screening at each encounter must be encouraged. The major barriers to adequate pain management in countries with limited resources include; inadequate priority, lack of education, inappropriate attitude of the health care providers, health care systems, patients, families and the general population. Opiates especially morphine, which at present is only available in a few hospitals, need to be made freely available to this group of patients. Pain control medication should be titrated according to the severity of pain following the recent international guidelines.

**Bowel obstruction:**

In addition to the tumour, opiate use may be an important etiological factor and use of proper bowel regimes with opiates will prevent this complication.

In tumour induced obstruction metal stents, wherever available, may be more cost effective than non metallic stents in the long run due to lesser number of procedures required for maintaining such stents. However, in the majority of our cases surgery whenever possible remains the mainstay of therapy.

**Nausea and vomiting:**

The commonest side effects of cancer treatment which must be controlled with adequate therapy as these affect the adherence to treatment. Simple and affordable drug regimens may be more cost effective especially for preventing emesis due to moderately emetogenic chemotherapeutic agents.

**Communication skills:**

This is an important aspect of patient care which has a direct impact on the patient satisfaction. It is indeed a major lacuna in our medical training as many medical curricula do not have a specific training and testing program for these skills. Most of our physicians do not possess adequate skills of interviewing, conveying the diagnosis, discussing inclusion in a trial, breaking bad news and so on and so forth. It is vital that with the gradually changing scenario of information technology, public awareness and stringent supervision by various organizations, physicians should be taught these skills and these should be added to the undergraduates and postgraduates curricula.

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