WHAT IS THE OPTIMUM SCREENING METHOD FOR CERVICAL CANCER IN DEVELOPING COUNTRIES?

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Cervical cancer is a major cancer in developing countries, where four fifths of the global burden is experienced due to lack of screening programs. Although Pap smear screening has substantially reduced cervical cancer burden in developed countries, the complex inputs required and the limited success of cytology screening in South America have encouraged evaluation of alternative screening methods such as HPV testing and visual inspection with acetic acid (VIA) as well as new paradigms such as single or twice-in-a-life-time screening and single visit approach to maximize treatment of women with precancerous lesions. In a randomized trial in South Africa, cryotherapy for HPV test-positive women resulted in 77% decline in the prevalence of CIN 2-3 lesions, while VIA followed by cryotherapy resulted in a 37% lower prevalence. A single round of VIA screening resulted in 35% reduction in cervical cancer mortality in a randomized trial in South India. A 50% reduction in cervical cancer mortality following a single round of HPV testing was demonstrated in a randomized trial in Western India. A simple, user-friendly affordable, faster (results within 3 hours) and accurate HPV test (careHPV test), suitable for use in low-resource settings, will be commercially available in the near future. Planned investments for HPV vaccination and screening in developing countries will save many precious lives. Current evidence from studies indicate that VIA screening followed by cryotherapy and LEEP (for large lesions), with or without colposcopy/biopsy inter-phase (if sufficient capacity for colposcopy/histology available), or primary HPV testing with VIA or colposcopy/biopsy triage before treatment, depending on the local resources. In many low-resource sub-Saharan African countries a primary VIA based screening to start with will facilitate the establishment of infrastructure and trained and improved awareness, and in future would permit more effective screening approaches such as rapid HPV testing incorporated in the program. In settings where large scale programs are not feasible now may benefit from organizing small service platforms providing such screening services.

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HPV VACCINATION: WHAT PRACTICAL EXPERIENCE TELLS US TO DATE

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HPV vaccination: What practical experience tells us to date Vivien Tsu, PhD, MPH, PATH/Seattle Vaccines against human papillomavirus (HPV), the primary cause of cervical cancer, have created an important opportunity to prevent a leading cause of cancer death among women in low- and middle-income countries. The screening programs that so dramatically reduced cervical cancer rates in industrial countries have proven very difficult to organize, sustain, or scale up in countries with fewer resources. Several concerns about HPV vaccines were raised when they first became available, dealing primarily with how best to deliver them and ensure that those girls who need them most can receive them. The experience from which we can draw useful lessons includes national immunization programs in at least 19 wealthy countries; nascent programs in a few middle-income countries; PATH demonstration projects with detailed evaluations in India, Peru, Uganda, and Vietnam; and at least 17 programs based on one-time or multi-year vaccine donations. The PATH demonstration projects involved several different vaccination strategies conducted by national immunization programs in selected administrative units, followed by operational research designed to answer questions critical to national decision-making and planning. In the few years since the first HPV vaccine came on the market in 2006, considerable experience has already accumulated to shed light on the concerns that have been raised. These included potential difficulties reaching young adolescent girls with this new service; acceptability of the vaccine to girls, their families, communities, and health workers; the price of the vaccine and how to finance it from global sources; the cost of delivering the vaccine and covering it in national budgets; and the safety of the vaccine once it was in more general and widespread use. Experience to date has demonstrated that there are effective strategies for reaching girls, that acceptability is high if families and communities are appropriately informed, and that the safety profile of the vaccine is excellent. While there is some good news with regard to vaccine prices and delivery expenses, considerable challenges in these areas remain.

Disclosure: The author has declared no conflicts of interest.

CERVICAL CANCER CONTROL: A GLOBAL STRATEGY

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In the past, cancer figures in Peru remain unchanged mainly because neoplastic diseases were managed by the Non-transmissible Diseases Direction of the Peruvian Ministry of Health. Five years ago, being Secretary of Health, Dr Vallejos transferred the responsibility of cancer control to the Peruvian Cancer Institute or INEN, the leader and ruling organism in oncology. Under this approach the process of cancer management deconcentration began, through the creation of Cancer Units in General Hospitals. Also the decentralization process started with the creation of two Regional Cancer Institutes, one in the northern part of the country and the second in the south. Moreover, a multi-institutional organism, the so called “Coalition Peru against Cancer”, was created. It already produced a National Cancer Plan addressing most common malignancies, including cervical cancer. Cervical cancer is the first or second female malignancy in low income settings, representing a real health problem. Taking into consideration disease load and scarcity of resources, special emphasis should be put on primary, secondary prevention and palliation. In places where no effective secondary prevention system exists, HPV vaccination alone constitutes an appealing option. However, since the first HPV vaccine came on the market in 2006, considerable experience has already accumulated to shed light on the concerns that have been raised. These included potential difficulties reaching young adolescent girls with this new service; acceptability of the vaccine to girls, their families, communities, and health workers; the price of the vaccine and how to finance it from global sources; the cost of delivering the vaccine and covering it in national budgets; and the safety of the vaccine once it was in more general and widespread use. Experience to date has demonstrated that there are effective strategies for reaching girls, that acceptability is high if families and communities are appropriately informed, and that the safety profile of the vaccine is excellent. While there is some good news with regard to vaccine prices and delivery expenses, considerable challenges in these areas remain.

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THE HEALTH MINISTER’S RESPONSE TO MANAGING CERVICAL CANCER IN LOW-INCOME COUNTRIES

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