

Retrospective (One Year) Study of Cases of Ca Cervix

INDER DHIR GILL, PARMJIT KAUR, SURINDER K. BHUPAL, RUBY BHATIA, AMAN DEV SINGH, KARANVEER SINGH

ABSTRACT

Introduction: Cervical cancer is the most common cause of cancer in India. It is considered a preventable disease by WHO because it can be diagnosed in its precancerous stage. But in India women come too late when the cancer is incurable and no treatment is available. However mass screening is not feasible in resource poor settings as it is expensive. But opportunistic screening and downstaging can go a long way in controlling the disease.

Objective: To evaluate causative factors and stage of cancer so as to assess strategies to control the disease.

Materials and Methods: One year retrospective analysis of cases of carcinoma cervix was done to evaluate incidence, parity, rural/urban, sexual and reproductive factors, socio-economic factors, contraceptive usage, and disease stage.

Results: Total number of gynae admissions was 175 out of which 39(22.28%) cases were of Ca cervix. Most cases

(25.64 %) were in 60-64 years age group, followed by 35-39 years (20.51%). Majority (51.28%) were para four and above. Maximum cases (84.61%) belonged to rural background. Discharge per vaginum with pain lower abdomen was commonest presenting symptom (58.97%) followed by post-coital bleeding and irregular bleeding (41.03%). Median age at first sexual contact was 18.9 years. No history of contraceptive usage in 53.84%. Three cases were HIV positive. No patient had screening for cervical cancer. 18(46.15%) cases were of advanced stage, 15(38.46%) stage II and 6(15.38%) to stage I.

Conclusion: Main factors responsible were early onset of coitus, absence of contraceptive use, multiparity, poor socio-economic status, rural background and no cervical cancer screening. In India, women come too late when the cancer is incurable. As mass screening is not feasible in poor resource settings, opportunistic screening and downstaging can go a long way in controlling the disease.

Keywords: Downstaging, Incidence, Screening

INTRODUCTION

Worldwide, cervical cancer is the third most common cancer among women with an estimated 493,000 new cases occurring annually and 274,000 deaths occurring each year. In India, 132,000 new cases are reported annually with 74,000 deaths occurring each year hence, every 7th minute a woman dies due to cervical cancer. The relative five years survival is reported to be on an average 48.7%. It is predicted that figures are expected to double by 2020 if no action is taken [1].

The magnitude of the problem in India can be judged from the fact that cervical cancer is the most common cancer in women in our country. The highest age specific incidence of 98.2 per 100,000 has been seen in the 60-64 years age group [2]. Among the estimated new cancer cervix cases per year 79% occur in the developing countries. The cervical cancer burden in India is estimated at 100,000 in the year 2001. The Truncated Rate (TR) in the age group 35-64 years in Chennai, India, is even higher (99.1/100,000; 1982-95) than rate reported from Cali, Columbia (77.4/100,000, 1987-91) [3].

Based on the data of the Population Based Cancer Registries (PBCRs) under the National Cancer Registry Programme (NCRP), the estimated number of new cases during 2007 was 90,708 [4]. Projected number of new cervical cancer cases in 2025 is estimated to be 203,757 and projected number of cervical cancer deaths in 2025 is estimated to be 115,171 [5]. So there is an urgent need to assess the strategies for control of the disease.

But challenges and failure do exist in implementing cervical cytology screening in resource poor settings. This has resulted into exploring alternative methods for downstaging of the cervical cancer during last decade [6]. Some of these methods are:

- 1) Creating awareness by education and counselling,
- 2) Camp approach for screening,
- 3) Visual Inspection of Cervix with Acetic Acid (VIA),
- 4) Visual Inspection of Cervix with Lugol's Iodine (VILI),
- 5) Single visit approach,

- 6) Treatment with cryosurgery for VIA positive women,
- 7) Low cost HPV tests and
- 8) HPV vaccines.

MATERIAL AND METHODS

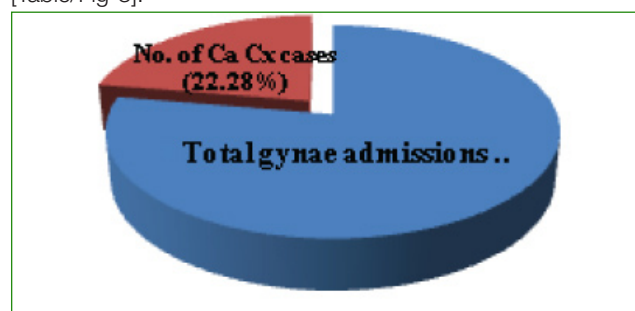
A one year retrospective analysis of cases of Ca cervix admitted to the Gynae ward unit III of Rajindra Hospital, Patiala was undertaken between Jan 2011- Dec 2011. Total number of Gynae admissions was 175 out of which 39 i.e. 22.28% cases were of Ca cervix. Age specific incidence, age, parity, rural/urban background, causative factors and stage at the time of admission were evaluated. The different factors were tabulated and analysed. A detailed clinical history, Gynaecological examination and other investigatory findings were recorded. The clinical and histo pathological findings were analysed.

RESULTS

It was observed that out of the total number of 175 gynae admissions, 39 i.e. 22.28% cases were of Ca cervix [Table/Fig-1].

Most cases (25.64%) were in 60-64 years age group, followed by 35-39 years (20.51%) [Table/Fig-2].

Highest incidence of Ca cervix was found among multipara [Table/Fig-3].



[Table/Fig-1]: Pie diagram showing incidence of cervical cancer among gynae admissions

Age groups (yrs)	No. of cases	%age of cases
<35	Nil	-
35-39	8	20.51
40-44	3	7.69
45-49	2	5.12
50-54	6	15.38
55-59	4	10.25
60-64	10	25.64
65-69	4	10.25
70-74	1	2.56
75-79	Nil	-
>80	1	2.56

[Table/Fig-2]: Age group wise incidence of Ca cervix

Parity	No. of cases	%
Nulliparous	1	2.56
2	5	12.82
3	13	33.33
4	10	25.64
5	6	15.38
6	4	10.25

[Table/Fig-3]: Cases of Ca cx depending upon parity

15.38% cases belonged to urban background and majority i.e. 84.61% belonged to rural background. Discharge per vaginam with pain lower abdomen was the commonest type of presenting symptom seen in 58.97% of cases followed by post coital bleeding and irregular bleeding per vaginam which was seen in 41.03% of cases.

Staging was done and it was observed that at the time of presentation, 6 (15.38%) patients belonged to stage I, 15(38.46%) to stage II, 13(33.33%) to stage III and 5(12.82%) were in stage IV. 21 patients i.e. 53.84% were illiterate, 11 (28.2%) patients had studied up to fifth standard and 7 (17.94%) up to tenth standard and majority belonged to lower socioeconomic status. No patient had ever undergone screening for cancer cervix.

Majority i.e. 84.61% belonged to rural background and only 15.38% belonged to urban background. Total fertility rate was 3.66. One case was HCV positive and three were HIV positive. HIV prevalence in the 15-49 years age group was 0.3%. Median age at first sexual intercourse was 18.9 years. There was no history of contraceptive usage in 53.84%. 12.82% used oral contraceptives, 10.25% used IUCD and only 7.69% gave history of barrier contraception. Rest 15.38% had undergone permanent sterilization.

Eight cases got themselves discharged against medical advice without getting biopsied. Four cases left against medical advice before commencement of treatment. Two cases refused radiotherapy.

DISCUSSION

Factors contributing to cervical cancer in our study were early onset of coitus, absence of contraceptive use, multiparity, poor socioeconomic status, rural background, non-availability of screening facilities, multiparity and sexual behaviour.

As per WHO/ICO Information Centre on HPV and Cervical Cancer in India, total fertility rate (live births per women) is reported to be 2.8%, oral contraceptive use 3.1%, HIV prevalence 0.3% (15-49 years), median age at first sexual intercourse among women (25-49 years) 17.6 years, cervical cancer screening coverage only 2.6% and prevalence of condom was only 5.2% in the year 2005/06 [5]. As per WHO comprehensive guide to cervical cancer control, in our country the peak age for cervical cancer incidence is 45-54 years, which is similar to the rest of South Asia. The age-adjusted

incidence of cervical cancer (30.7 per 100,000 women, 132,082 incident cases) in India is the highest relative to that of all other types of cancer, and is higher than the average for the South Central Asia region (GLOBACAN 2002 database, IARC 2005) [1]. In our study, the highest age specific incidence was seen in the 60-64 years age group (25.64%), followed by 35-39 years (20.51%). Majority i.e. 84.61% belonged to rural background and total fertility rate was 3.66. HIV prevalence in the 15-49 years age group in our observation was 0.3% and no patient had ever undergone screening for cancer cervix. Median age at first sexual intercourse was 18.9 years. There was no history of contraceptive usage in 53.84%, about 13% used oral contraceptives, about 10 % used IUCD and only 7.69% gave history of condom usage.

According to ICMR guidelines, for management of cervical cancer, 2010, over 80% of cervical cancer present at a fairly advanced stage with a dismal five-year survival rates less than 40% and around 80,000 deaths are reported due to cervical cancer in India [7]. In our study at time of presentation, 5 (12.82%) patients belonged to stage IV, 13(33.33%) to stage III, 15(38.46%) stage II and 6 (15.38%) to stage I.

International Agency of Research on Cancer (IARC) reported 93% reduction in cervical cancer incidence when women aged 35 to 64 years were screened at 1 to 3 yearly, 84% reduction when screened 5 yearly and 64% reduction when screened 10 yearly [8].

CONCLUSION

The risk factors responsible for Ca Cervix found in our study were low socio-economic factors – illiteracy, low income and rural background, lack of screening facilities, high parity and early age of commencement of sexual activity, STD's especially HIV and PID. Unfortunately in India, women come much

too late when the disease is already in an advanced state. As mass screening is not feasible in resource poor settings, opportunistic screening and downstaging can go a long way in controlling the disease. Educating women regarding awareness, prevention and early warning symptoms of cervical cancer and PAP smear screening can go a long way in downstaging carcinoma cervix in resource poor settings.

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