

Trainer Manual on Cancer Prevention and Control

For Primary Health Care Staff



National Cancer Control Programme
Ministry of Health
2021



Trainer Manual on Cancer Prevention and Control for Primary Health Care Staff

**National Cancer Control
Programme Ministry of Health
SriLanka 2021**

Trainer Manual on Cancer Prevention and Control for Primary Health Care Staff

First Edition -
2021

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Forewor



Cancer has become one of the leading public health concerns in Sri Lanka. Annually more than 31,000 new cancer patients are diagnosed with cancer in the country. As the national level focal point, National Cancer Control Programme (NCCP) is currently operating under several strategic directions identified in a five-year strategic plan to minimize the cancer burden in Sri Lanka. Capacity building of the healthcare staff is one of the main strategic directions stated in the 5-year plan.

NCCP took several initiatives to build the capacities of the preventive and curative healthcare staff. Primary care health staff plays a vital role in providing preventive, diagnostic, treatment, and palliative care services related to cancer care in Sri Lanka as first contact health care professionals. NCCP developed guidelines and conducted several training programmes to improve the up-to-date knowledge and skills among primary care physicians in Sri Lanka and currently in the process of developing a distant training programme for them. Similarly, there was a high demand for a structured and uniform training programme to build capacities among other members of primary healthcare staff including nurses, Public Health Midwives and Public health Inspectors. NCCP, with the partnership of other stakeholders developed a trainer manual to train regional level staff as trainers. It is expected to provide the required training to primary care health care staff through the trained regional level staff. This training programme consists of six modules and each module consists of PowerPoint presentations and video clips. These resources were developed and pre-tested through several stakeholder meetings.

This programme has been designed to provide a comprehensive training on cancer prevention and control covering all key aspects. Special attention has been paid to present the content in a simple and comprehensible way. All resources have been provided in Sinhala, Tamil, and English languages.

The development of these guidelines and resources became a reality due to the hard work of the team of contributors. We hope primary care health staff will get the maximum out of it and contribute their best to reduce the burden of cancer in Sri Lanka.

National Cancer Control Programme appreciates the commitment provided by the contributors of this project. National Cancer Control Programme greatly acknowledge World Health Organization, Sri Lanka for the given partnership.

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NCCP acknowledges the valuable contribution given by the different stakeholders who participated for the workshops to develop this manual.



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Introduction to the trainer

manual

Why this training programme is required

Recent disease trends in Sri Lanka show that there is an increasing trend in non-communicable diseases. Cancers play a major role among non-communicable diseases. Out of all cancers in Sri Lanka, breast cancer is the commonest cancer among females while oral cancer is the commonest cancer among males. Cervical cancer accounts for third commonest cancer among females. In Sri Lanka facilities are available to cure breast cancer completely if detected in early stages, but treatment is difficult if it is detected late. Cervical and oral cancers can be identified and managed at pre- cancerous stage hence development of invasive cancer can be prevented.

Well Woman Clinics (WWC) throughout the country provided facilities to screen cervical cancers and clinical breast examination for clients attending the clinics. At WWCs women are getting many services including screening for other non-communicable diseases such as Diabetes Mellitus and Hypertension in addition to cancer screening. Though, well woman clinic programme was in-cooperated into the Maternal and Child Health programme in year 1996, the coverage of it remains sub optimal in certain districts. Healthy lifestyle clinic is providing services for both men and women for controlling non- communicable diseases including cancer. Addressing “common modifiable risk factors is a major step in cancer prevention. The male participation for cancer screening and early diagnosis need more attention as the current figures remaining very low.

Therefore, it is a timely need that primary health care workers to be trained on cancer prevention, early detection, and provision of palliative care. Furthermore, Primary health care worker has more opportunities to communicate and create awareness of the community on cancer prevention, early detection and control. In order to carry out these responsibilities, it is imperative for the primary health care worker to have a proper knowledge, skills and confidence in carrying out these activities. Main objective of this training programme is to fulfill this requirement which will ultimately create a healthy community.

General guideline for all sessions

- Sufficient practical exposure may be provided to all trainees on cancer prevention, early detection and palliation
- The main focus should be on common cancers such as that of oral cavity, breast and uterine cervix
- At the end of training it is expected that all trainees will have a clear understanding of principles of prevention, early detection, management and palliation of cancer and information on the services available in their settings

Suggestions to conduct sessions.

Introduction to the course and participants

The idea is to make the trainees comfortable to work together. Introduce yourself and make the trainees introduce themselves. Make them familiarize with the objectives of the training course and the course structure.

Pre-test

The idea of conducting the pretest is to assess the current knowledge and practice of trainees. According to the scores obtained, can be categorized as follows.

<50 – poor knowledge

50– 74 – fair knowledge regarding cancer

>75 – good knowledge on cancer

Similar scoring may be used for the post test to assess whether any changes in knowledge after the training.

At the end of each module give adequate time to ask questions to clarify the unclear areas. The aim of this training is to build capacities among primary health care staff on cancer prevention and control. However there may be barriers to carryout given recommendations in a given area due to many reasons. You have keep in mind that there may be wide range of disparities in distribution of health care facilities, human resources and other social determinants of health. Therefore it is advisable to take some time at the end of each module to discuss and make a customized plan to implement these recommendations and activities in the local area.



Module 1– Introduction to Cancer Prevention and Control

Learning objectives

Know the impact of cancer on a population – describe the cancer burden globally and locally

Risk factors for cancer - Differentiate between non-modifiable and modifiable cancer risk factors, List the primary non-modifiable cancer risk factors, List the primary modifiable cancer risk factors

Common cancers in Sri Lanka - Identify the most common shared risk factors among priority cancers in

Strategies for cancer prevention, screening and treatments - Differentiate between primary, secondary, and tertiary cancer prevention strategies, Discuss the purpose of a comprehensive cancer control program

This module provides an overview of the cancer situation in Sri Lanka. It provides cancer incidence rates and their trends over the time for the participants. Module one also focuses on the common risk factors of cancer. At the latter part of the module it discuss about the cancer care services available in Sri Lanka which will be very useful for the participants. NCCP recommends conducting pre and posttests to assess the effectiveness of the programme. Sample test questions have been provided with the other resources or can be downloaded from the NCCP website.

Slide
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Module 1
Introduction to Cancer Prevention & Control

NATIONAL CANCER CONTROL PROGRAMME
SRI LANKA

National Cancer Control Programme
Ministry of Health

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Introduction to Cancer Prevention & Control

Welcome to the course cancer prevention and control. Introduce yourself as the speaker. This is the 1st Module of the course “introduction to cancer prevention and control”. Explain objectives of the module listed above at the beginning of the module 1.

Slide
2

What is a tumor?

Tumor
an abnormal lump or growth.

Benign

- not cancerous
- Do not spread to other parts of the body

Eg: Fibro adenoma of breast

Malignant

- Cancer
- Spread to other parts of the body

Eg: Breast cancer

Benign Tumor: Cells are not cancerous and won't spread.

Malignant Tumor: Cells are cancerous and can spread to other tissues and organs.

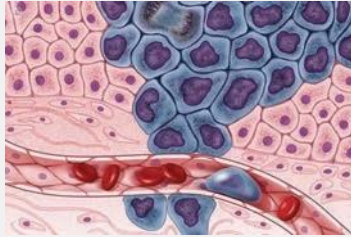
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What is a tumor?

Explain that a lump or a growth can be called as a tumor. It can be benign or malignant. Malignant tumors can spread. But benign tumors do not spread to other parts of the body

Slide 3

What is cancer?



Cancer is a disease in which some abnormal cell of the body grow uncontrollably and spread to other parts of the body.

Cancer can start almost anywhere in the human body

What is cancer?

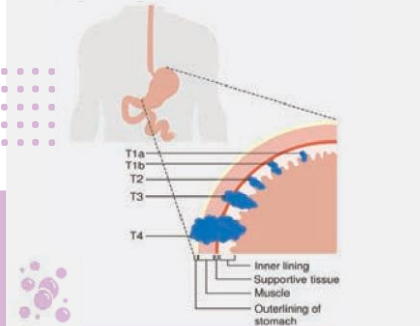
Give a simple definition for cancer.

Body is made up of cells. Most of them divide and grow in a controllable manner.

- When some of the abnormal body cells grow/divide uncontrollably and spread to other parts of the body it can be called as a cancer.
- Cancer can be caused in any living tissue in the body

Slide 4

What is the cancer staging?



This is an assessment of the spread of the cancer

A lower stage (such as a stage 1 or 2): Spread is less

A higher stage (such as a stage 3 or 4): spread is more.

The stage of the cancer is very important in choosing the best treatment for a person.


What is the cancer staging?

Health staff should have a basic knowledge about the staging of cancers which gives an impression about the spread of the cancer. Lower stages (such as a stage 1 or 2) indicate less spread and usually good prognosis. Higher stages (such as a stage 3 or 4) indicate that the spread is more and usually prognosis is poor. The stage of the cancer is very important in choosing the best treatment for a person.

Slide 5

Global burden of cancer

- NCDs are the leading cause of death in the world
- The four main NCDs
 - Cardiovascular disease,
 - **Cancer**
 - Chronic lung diseases
 - Diabetes
- “Effective action will save millions of lives and avoid suffering.”
-WHO, NCD Global Monitoring Framework



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Global burden of cancer

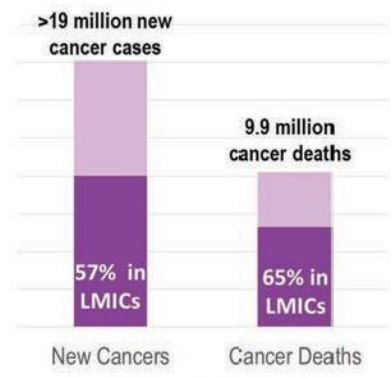
Cancer makes a significant contribution to NCD burden both globally and locally. Major risk factors for cancer and other common NCDs are shared.

Ask the participants whether they are agreed to categorize cancer as an NCD. There may be participants who are not completely agree due to the HPV & cervical cancer, Hepatitis B & Liver cancer are communicable.

Even in the absence of such participants you must explain that even though those risk factors are communicable cancers themselves are not communicable.


Slide 6

Global Burden of Cancer, 2020



Category	Total	LMICs (%)
New Cancers	>19 million	57%
Cancer Deaths	9.9 million	65%

GLOBOCAN 2020 (IARC)



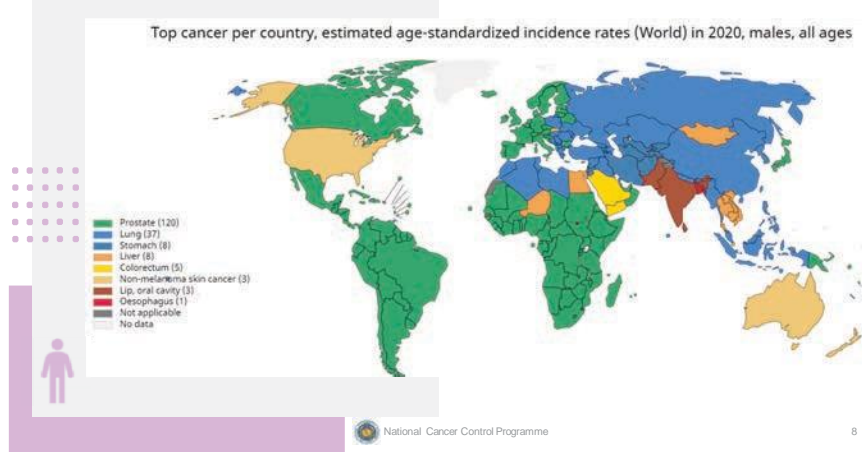
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Global Burden of Cancer, 2020

There were 19.3 million new cancer cases and 10 million cancer deaths in 2020 around the world. Out of them more than 50% of cases and deaths are occurred in low middle-income countries

Slide 7

Most Common Cancer Sites in Males, 2020



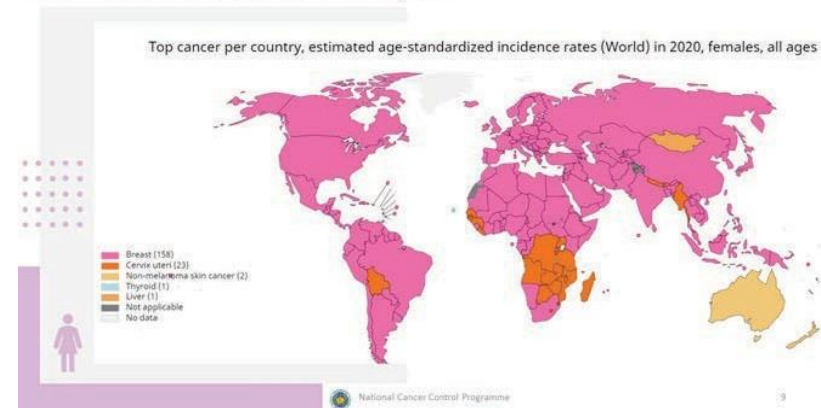
Most Common Cancer Sites in Males, 2020

This map shows the commonest male cancer by country. Prostate cancer is the most common cancer among males in many developed countries and in many of the African countries.

Cancers of the lip and oral cavity is the commonest male cancer in South Asian countries including Sri Lanka.

Slide 8

Most Common Cancer Sites in Females, 2020



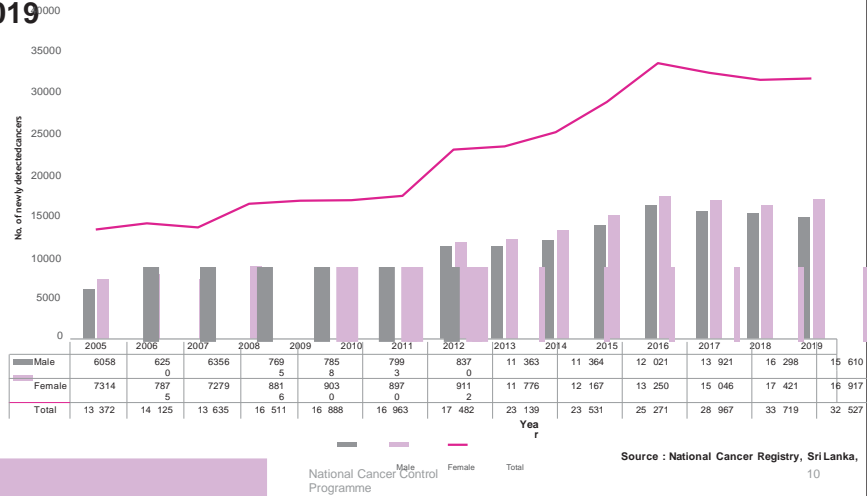
Most Common Cancer Sites in Females, 2020

This map shows the most common female cancer diagnosed in many countries of the world. It clearly shows breast cancer is the commonest female cancer in many countries including Sri Lanka.

Cervical cancer is the commonly diagnosed female cancer in less developed regions including eastern, middle and western Africa.

Slide 9

Trend of ASR of all cancers among males and females 2005 - 2019



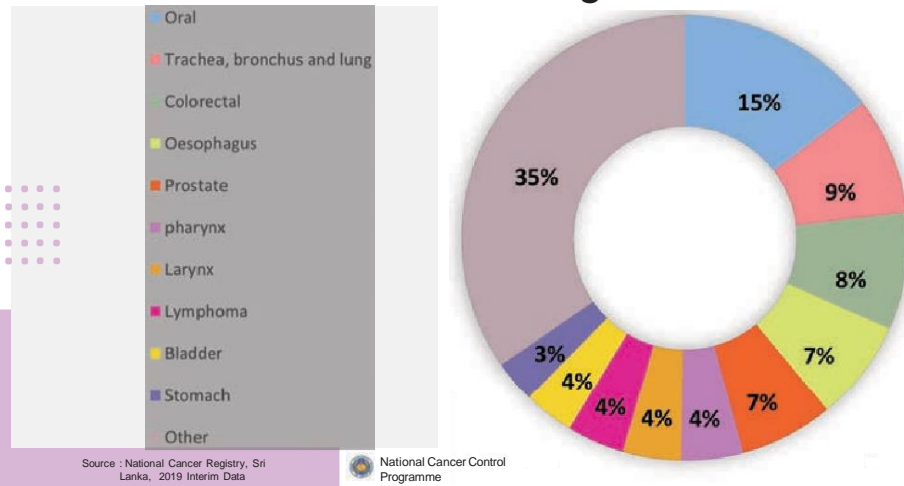
Trend of ASR of all cancers among males and females 2005-2019

The incidence of cancer in Sri Lanka is increasing over the years. Discuss the possible reason for this trend.

- Aging population
- Improving diagnostic facilities
- Unhealthy lifestyle

Slide 10

Most common cancers among males -2019



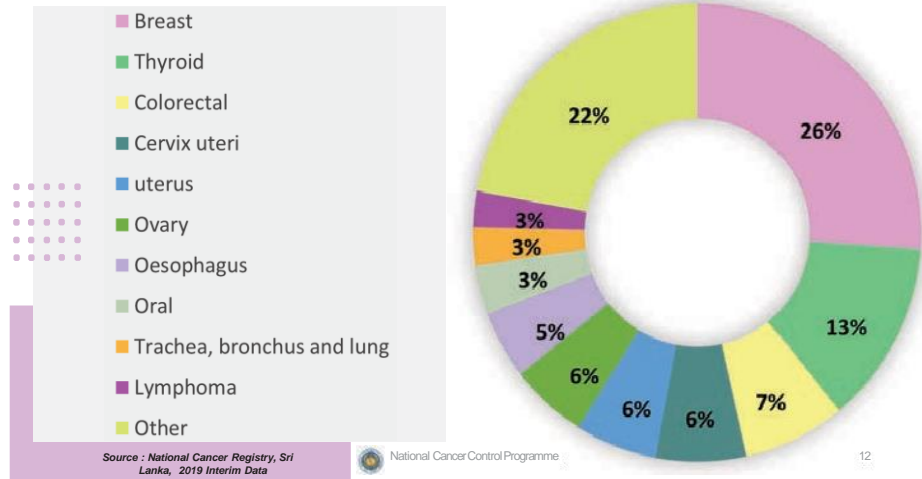
Most common cancers among males-2019

Before displaying the slide ask the audience to list the most common cancers among males in Sri Lanka. Oral is the most common cancer among males. Cancers in trachea, bronchus and lung is the next.

Highlight that these common cancers among males have direct relationship with unhealthy behaviors like tobacco and alcohol consumption.

Slide 11

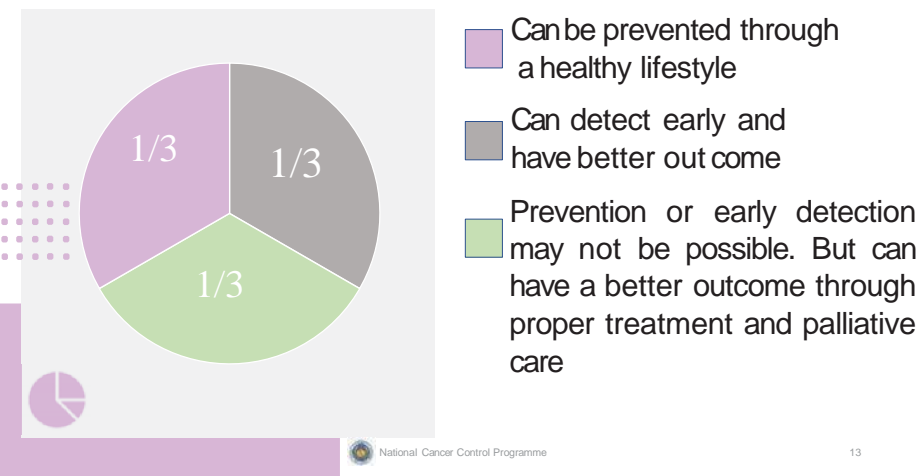
Most common cancers among females-2019



Most common cancers among females-2019

Before displaying the slide ask the audience to list the most common cancers among females in Sri Lanka. Breast cancer is the most common cancer among females in Sri Lanka which is similar to global cancer pattern. Thyroid cancer has become the second commonest which is a new trend in Sri Lanka.

Slide 12



The burden of many cancers can be decreased through effective primary prevention, early detection, treatment, and palliative care.


- WHO estimates that 1/3 of cancers could be prevented by preventive strategies.
- Another 1/3 of cancers can be detected early and treated effectively.
- The remaining 1/3 of cancer may not be able to prevent or detect. But can have a better outcome through proper treatment and palliative care.

Slide
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Non-modifiable risk factors for cancer



- Risk factors that cannot be changed:
 - Age
 - Sex
 - Race and ethnicity
 - Family history / genetics
- Can be used to identify high risk groups and screening.

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Non-modifiable risk factors for cancer

Discuss the modifiable and non-modifiable risk factors in detail. First, explain what are the non - modifiable risk factors. Non-modifiable risk factors are the risk factors that cannot be changed, which include age, sex, race ethnicity and family history (genetic factors). Risk of developing cancers are increases with age and some cancers are restricted to one sex due to anatomical differences. Although many cancers affect both sexes, the risk of some cancers are higher in one sex, for eg: Oral cancer among males and thyroid cancer among females. For the development of certain cancers family history is an important factor eg: Breast, Ovarian and Colorectal cancers. Particularly if the cancer occurred at a younger age family history may be important. Though these risk factors cannot be changed, they are important in determining the age for screening etc.

Slide 14

Modifiable risk factors for cancer



Can be modified at the individual or population level through targeted interventions:

- Tobacco use (Active or passive)
- Cancer causing (Oncogenic) infections
- Physical inactivity and unhealthy diet
- Use of alcohol
- Environmental and occupational exposures
- Low immunity

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Modifiable risk factors for cancer


Next explain what the modifiable risk factors are and ask audience to list them. These factors can be altered and risk reduction of cancer can be done through health interventions.

Slide
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Tobacco & areca nut use



- > 20% of all cancer deaths worldwide
- Risk factor for > 16 types of cancers
Lung, Oral cavity, Oesophageal cancers
- ~~9~~¹:1 billion people worldwide use tobacco (>80% are in LMIC)
- Male smokers > female smokers
- Users of smokeless tobacco > 300 million people (89% in Southeast Asia)

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Tobacco & areca nut use

Tobacco use is most important modifiable risk factor for cancer responsible for > 20% of cancer deaths globally each year.

Among Asian communities' betel quid with smokeless tobacco and areca nut chewing are highly prevalent. Global reports estimate 600 million users, making areca nut chewing the fourth most common habit after tobacco consumption, alcohol intake and caffeine containing beverages.

Prevalence of smoking and other tobacco use is significantly higher among males compared to females.

Slide
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Excessive use of alcohol



- Causes 4% of all cancer deaths
- Alcohol is a risk factor for cancers in
 - Oral cavity,
 - Pharynx & Larynx
 - Oesophagus
 - Liver
 - Breast

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Excessive use of alcohol

Excessive use of alcohol is estimated to cause 4% of cancer deaths globally and 5% of cancer deaths in LMIC. Following cancers are associated with alcohol consumption oral cavity, pharynx, larynx, oesophagus, liver and breast.

Slide 17

Unhealthy diet, excess body weight & physical inactivity



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- Unhealthy diets:
Related to approximate 15% of all cancer deaths
- Excess body weight:
3% of all cancer deaths in LMIC
6% of all cancer deaths in high income countries
- Physical inactivity:
3.2% of all cancer deaths in LMIC
5.5% of all cancer deaths in high income countries

Unhealthy diet, excess body weight & physical inactivity

Unhealthy diet: High intake of red meat, processed meat and low intake of fruits and vegetables are associated with development of cancers

Overweight and obesity: emerging evidences indicate that in addition to contribute causation of cancers overweight obesity is associated with increased risk of cancer recurrence and poor survival.

Physical inactivity can increase occurrence of certain cancers including breast and colon caners.

Slide 18

Environmental pollution



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- 1-4% of all cancers globally :
Exposure to carcinogens in air, water and soil
- Widespread exposures (e.g. diesel exhaust)
- Specific environmental exposures
Carcinogenic compounds in the environment
 - Arsenic – bladder cancer
 - Asbestos – mesothelioma, lung cancer
 - Aflatoxin – liver cancer
 - Radon/Uranium
 - Indoor air pollution – lung cancer
 - Ionizing radiation – lung cancer

Environmental pollution


The International Agency for Research on Cancer has classified more than 120 naturally occurring and man-made agents as human carcinogens

- Arsenic – can cause bladder cancer, found naturally and contaminated water sources.
- Radon/Uranium – (radioactive) damage lung tissue and cause lung cancer. Miners are at higher risk
- Aflatoxin – is a toxin produced by *Aspergillus flavus* a fungus that grows on maize, ground nuts and grains especially in high moisture & high temperature environment. Accumulation of small amount over long period of time can result in hepatocellular carcinoma.
- Indoor air pollution – exposure fires & cook stoves burning solid fuels can cause lung cancer

Slide
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Oncogenic infections

- Oncogenic infections cause two million new cancers (16.1% of all cancers) / Year
- **90% caused by**
 - Human papillomavirus (HPV)
 - Hepatitis B & C viruses (HBV/HCV)
 - *Helicobacter pylori*
- **Other oncogenic infectious agents:**
 - Epstein Barr Virus (EBV)
 - Human Herpes Virus type 8 (HHV8)

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Slide 20

Immune status and cancer

- Immune system is important in protecting from cancer
- Factors which suppress immune function
 - Some medicines
 - Infection (HIV)

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Oncogenic infections

Oncogenic infections are another cause for certain cancers worldwide. About 16.1% or two million new cancer cases globally are due to the persistence of infections with bacteria, viruses or parasites.

About 90% of all infection associated cancers are caused by

- HPV (Human Papilloma Virus) – cervical cancer
- Hepatitis B & C viruses – Hepatocellular carcinoma
- Helicobacter pylori – stomach cancer

The remaining 10% of infection associated cancers are due to Epstein Barr virus - Hodgkin's lymphoma, Burkitt's lymphoma, and nasopharyngeal carcinoma

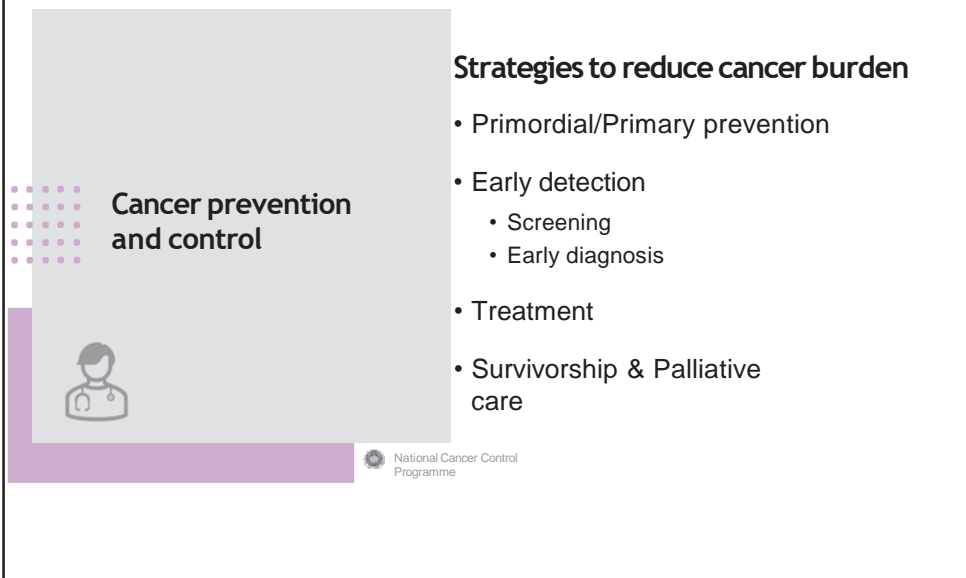
- Human Herpes Virus type 8 - Kaposi's sarcoma
- Human T-cell Lymphotropic virus - T-cell leukemia/lymphoma
- Schistosoma hemotobium - squamous cell cancer of the

Immune status and cancer

Immune system can identify and destroy abnormal cells before converting them to cancer cells.

Some medicine and certain infections can suppress immune system, these include corticosteroids, HIV infection etc

Slide
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Cancer prevention and control

Strategies to reduce cancer burden

- Primordial/Primary prevention
- Early detection
 - Screening
 - Early diagnosis
- Treatment
- Survivorship & Palliative care

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Cancer prevention and control

Explain that a cancer control programme of a country should cover several key components.

Primary prevention: Preventing exposure to agents & conditions that increase risk for cancer

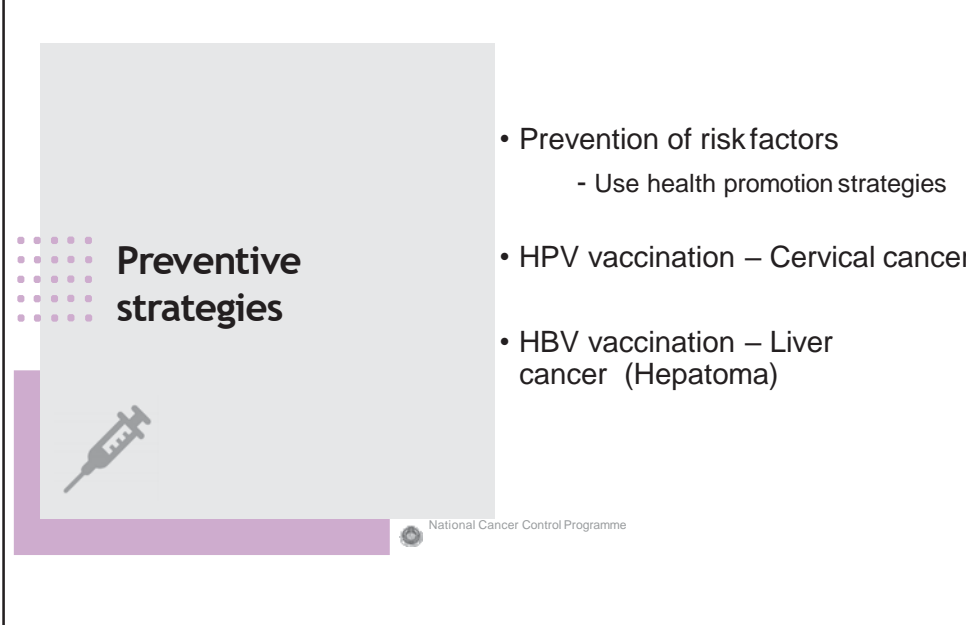
Early detection: Early detection has two main components.

1. Screening
2. Early diagnosis

Treatment: Includes surgery, radiotherapy, and chemotherapy

Palliative care and survivorship: This includes the services help to improve the quality of life cancer patients and survivors. This will be covered in a separate module

Slide 22



Preventive strategies

- Prevention of risk factors
 - Use health promotion strategies
- HPV vaccination – Cervical cancer
- HBV vaccination – Liver cancer (Hepatoma)

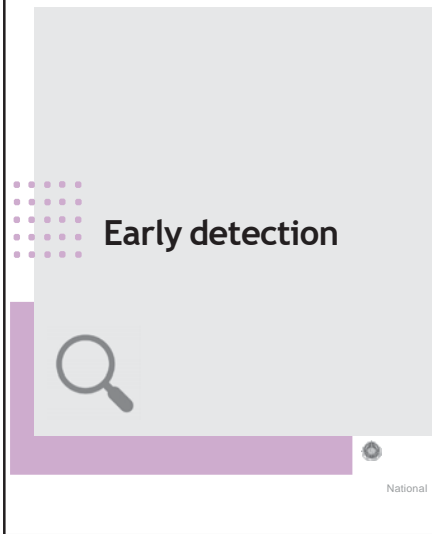
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Preventive strategies

Highlight the importance of identification the risk factors and taking necessary steps to minimize them. Health programmes should be conducted at each level targeting to avoid modifiable risk factors. This can be done at different settings including village settings, School settings, occupational settings.

Emphasize the importance of HPV and HBV vaccinations. Remember to ask whether the health care staff participated in the programme has taken the HBV vaccine.

Slide 23



Early detection

- Detecting cancer at an early stage
- Two strategies
 - 1. Screening**

Use a test to detect the likely presence of a specific pre-cancer or cancer before illness or symptoms develop
 - 2. Early diagnosis**

Diagnosing cancer soon after symptoms develop when the chance of a cure is more likely

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Early detection

Early detection is a strategy based on detecting cancers in the population at an earlier stage of the disease.

The two primary strategies are

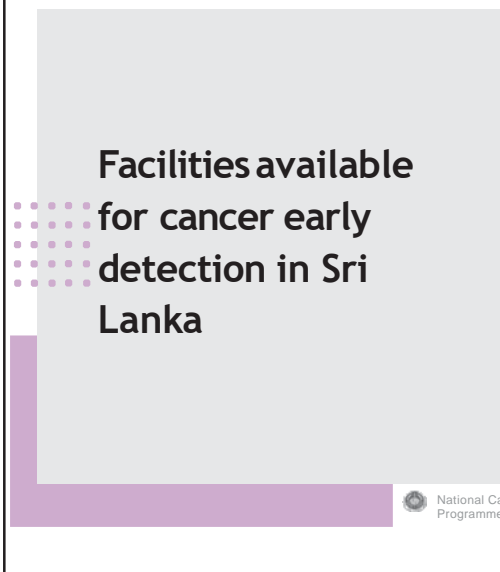
1. Early diagnosis

2. Screening

Early diagnosis aims to diagnose cancers soon after symptoms develop when the chance of cure is more likely. This could be done at population level by raising awareness of early cancer signs & symptoms and the advantages of seeking cure early.

Screening aims at detecting the likely presence of specific type of pre- cancer or cancer before symptoms appeared. This can be done by improving awareness among target population.

Slide 24



Facilities available for cancer early detection in Sri Lanka

- Cancer early detection centers
- Well Women Clinic
- Breast clinics
- Healthy Lifestyle Centers
- Dental clinics
- Mammography centers
- Colposcopy centers
- Surgical clinics

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Facilities available for cancer early detection in Sri Lanka

Discuss the services available for cancer early detection in Sri Lanka and discuss how these facilities are distributed in the regional setting. Outline a plan how the primary care staff can refer the suspected patients to the respective services.

Cancer Early Detection Centers in Sri Lanka

Currently functioning centers

- Narahenpita
- Jaffna
- Matara

Upcoming centers

- Ratnapura
- Kurunagala

- Cancer Early Detection Center is a dedicated clinic for cancer early detection
- Clients can visit with or without referral
- Facilities available
 - Clinical examination
 - Clinical breast examination
 - Oral examination
 - Mammography
 - Pap smear / HPV DNA test
 - Counseling and health education
 - Early referral

Cancer Early Detection Centers in Sri Lanka

Highlight that there are dedicated centers for cancer early detection. Explain how these centers are functioning.

- Currently functioning centers
- How people can access to these centers
- Available facilities

Cancer Early Detection Center is a dedicated clinic for cancer early detection. Clients can visit with or without referral

Facilities available

- Clinical examination
- Clinical breast examination
- Oral examination
- Mammography
- Pap smear / HPV DNA test
- Counseling and health education
- Early referral

Currently functioning Breast clinics

- NHSL - Colombo
- Apeksha Hospital
- NH - Kandy
- TH Karapitiya
- PGH Kurunegala
- TH Ratnapura
- TH Ragama
- TH Anuradhapura
- TH Trincomalee
- DGH Polonnaruwa



Currently functioning Breast clinics

Breast clinic is dedicated clinic for breast care conducted by an surgeon/ onco-surgeon and trained staff. Primary health care staff can directly send patients to these clinics.

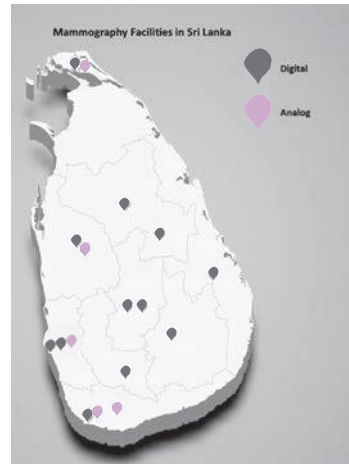
Identify the nearest breast clinic in your area and discuss the following

- Venue
- Clinic dates
- Indications to send patients to breast clinics.

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Mammography facility

- Apeksha Hospital
- TH Peradeniya
- TH Kurunegala
- TH Kolubowila
- TH Batticaloa
- BH Kamburupitiya
- TH Karapitiya
- NH Kandy
- PGH Badulla
- NHSL
- Breast Health Center - Colombo
- GH Sri Jayawardanapura
- TH Ragama
- FGH Polonnaruwa
- GH Kaluthara
- TH Anuradhapura
- TH Jaffna
- TH Ratnapura
- BH Kalmunai (North)
- CEDC Narahenpita
- BH Homagama
- Army Hospital



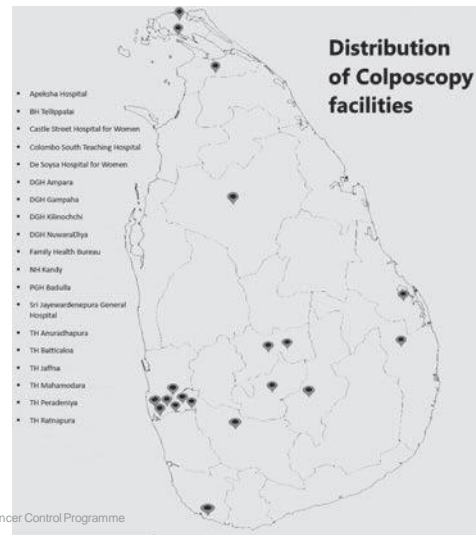
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Mammography facility

Explain that mammography is used for the screening and diagnosis of breast cancer. Highlight that there is no population level mammographic screening programme for Sri Lanka. Identify the nearest mammography facilities in your area. This topic will be discussed in detail in module 2

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Distribution of Colposcopy facility in Sri Lanka



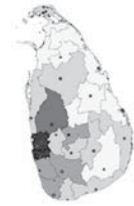
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Colposcopy facility

Colposcopy is an essential facility for diagnosis and treatment of cervical cancer. Identify the nearest colposcopy facilities in your area

Slide
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Cancer treatment centers in Sri Lanka



Western

province

Apeksha Hospital

CNTH

DGH

Gampaha

DGH Kalutara

BH Awissawella

Southern Province

Hospital

DGH

Hambanthota

DGH Matara

Northern Province

BH

Thellipallei

DGH

Vavuniya

North western province

TH

Kurunegala

DGH Chillaw

North central

Province

Central

Province

NH Kandy

DGH Nuwaraeliya

Province Sabaragamuwa Province TH

Anuradhapura

TH Rathnapura

Province DGH Kegalle

PGH Badulla

DGH

Province

TH Batticaloa

DGH Amapara

DGH

Trincomalee

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Cancer treatment centers in Sri Lanka

The cancer treatment facilities are currently expanding in the country. Primary care staff should be aware about these facilities
Identify the nearest cancer treatment facility in your area



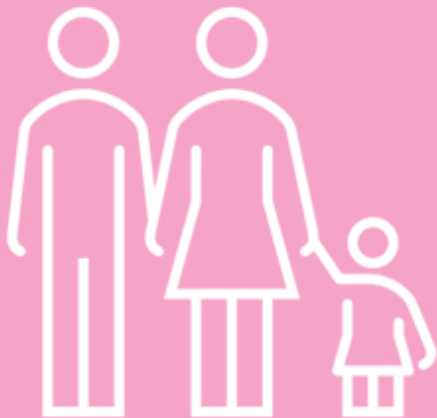
Module 2: Breast cancer

Learning objectives

Understand the concepts of screening and early diagnosis methods for breast cancer.

Apply the knowledge gained on risk factors, signs and symptoms of breast cancer for early identification of patients with breast lumps

Conduct the Clinical Breast Examination to identify any suspected breast cancer lesions





Breast cancer is the leading cancer among females. This module covers all important aspects of breast cancer including information on incidence, risk factors, clinical features, and preventive and early detection strategies. Most importantly at the end of this module required guidelines have been provided to train the participants on self and clinical breast examination. NCCP recommends conducting pre and posttests to assess the effectiveness of the programme. Sample test questions have been provided with the other resources or can be downloaded from the NCCP website.

Slide
01

Breast cancer



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Breast cancer

The second module is on prevention and control of breast cancer.

Slide 02

Breast cancer burden

- Most common cancer among women in the world.
- One in every four cancers among women
- Leading cause of death from cancer in women
- 2.2 million new cases and 684,996 deaths from breast cancer (2020)
- Most common cancer among women in Sri Lanka.
- 4651 new cases in 2019
- Prognosis – Good if diagnosed in early stages

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Breast cancer burden

Breast cancer is the most common cancer globally and is the commonest cause of cancer related deaths among women. Breast cancer accounts for 6.6% of all cancer deaths in the world. The incidence of breast cancer is increasing rapidly in the less developed world due to increase in life expectancy, urbanization, and the adoption of fast-paced lifestyles.

Slide 03

Breast cancer trend in Sri Lanka (2005-2019)



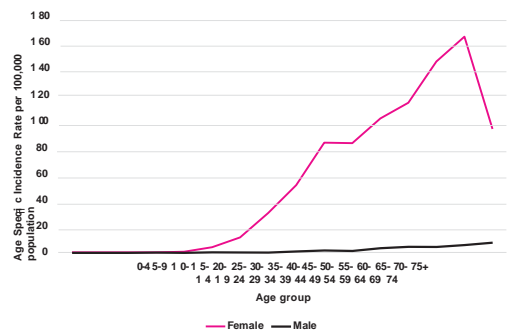
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Breast cancer trend in Sri Lanka (2005-2019)

Breast cancer incidence is increasing in Sri Lanka. There were 4651 breast cancer patients in Sri Lanka

Slide 04

Age specific incidence rates of Breast cancer 2019



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Age specific incidence rates of Breast cancer 2019

The incidence of breast cancer increases with age and comes to a peak around 70 years of age.

Different types of breast cancers



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- **Carcinoma in situ**
- **Invasive breast cancer:** Breast cancers that have spread in to surrounding breast tissue
 - **Two most common types**
 - invasive ductal carcinoma – Most common type*
 - Invasive lobular carcinoma

Different types of breast cancer

Carcinoma in situ: In this stage of cancer, cancer cells are confined to the place where it has originated. Sometimes these in situ carcinomas never become an invasive cancer during one's lifetime but some progress to invasive cancer.

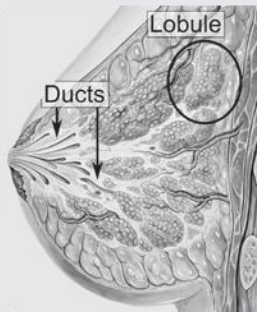
Invasive breast cancer: Breast cancers that have spread in to surrounding breast tissue is called invasive breast cancer

Two most common types
invasive ductal carcinoma – Most common type
Invasive lobular carcinoma

Invasive ductal carcinoma



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- About 8 in 10 invasive breast cancers are invasive (or infiltrating) ductal carcinoma
- which starts from cells in the wall of the duct

Invasive (infiltrating) ductal carcinoma

This is the most common type of breast cancer which starts in the cells of the ducts and break through the wall of the duct to spread to the adjacent tissues of the breast. It can spread to other areas of the body through blood and lymphatics.

Slide 07



- 10% of all breast cancers
- Starts in the milk producing glands (lobules)
- Sometimes harder to detect on physical examination and imaging

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Invasive (infiltrating) lobular carcinoma

This cancer starts in the cells of the lobules and similar to invasive lobular carcinoma this also will invade the adjacent tissues and it will spread to distant organs as well

Slide 08



Factors that increase the chance of getting cancer

- Non-modifiable risk factors
- Modifiable risk factors

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Risk factors for breast cancer

There is no definite cause for development of breast cancer. However, there are some modifiable and non-modifiable risk factors which may increase the risk of developing breast cancers. Therefore, while minor risk reduction may be achieved with prevention, early diagnosis is the cornerstone for improving breast cancer outcomes and survival.

Slide 09

Non-modifiable risk factors of breast cancer

- Increasing age
- Female sex
- Genetic factors
- Family history of breast cancer
- Personal history of breast cancer
- Lifetime exposure to estrogen and progesterone hormones
 - * Early menarche (<11yrs)
 - * Late menopause (>55 years)
- Never having children



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Non-modifiable risk factors of breast cancer

The factors which cannot be changed with interventions are called non modifiable risk factors. Ask audience to list the known modifiable risk factors. Increasing age, Female sex, Genetic factors, Family history of breast cancer, Personal history of breast cancer, Lifetime exposure to estrogen and progesterone hormones, Early menarche (<11yrs), Late menopause (>55 years), Never having children.

Slide 10

Risk factors

Aging

- Over 80% of all cancer occur among women aged 50+ years
- The chance of getting breast cancer increases with the age



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Aging

Risk of developing breast cancer increases with age. In Sri Lanka, many breast cancer patients are more than 50 years of age at the time of diagnosis.

Slide
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Risk factors Being a female

Females have a 100 times
higher risk than males



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Slide
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Risk factors Genetic Risk Factors

- Contribute to 5% -10% of
all breast cancers

- Most common mutations



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Being a female

Sex - Being a woman is the main risk factor for developing breast cancer. On the other hand, breast cancer can also occur in men. However, breast cancer is about 100 times more common among women than men. Women have more female hormones namely estrogen and progesterone, which can promote breast cancer cell growth.

Genetic Risk Factors

About 5% to 10% of breast cancer cases are thought to be hereditary, resulting directly from gene defects (called mutations) inherited from a parent.

Most common inherited gene mutations are BRCA1 and BRCA2 mutations. In normal cells, these genes help to prevent cancer by making proteins that keep the cells from growing abnormally. For families with BRCA mutation the risk may be as high as 80%. These cancers tend to occur in younger women and affect both breasts. They also have higher risk of developing ovarian cancer


Slide
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Risk factors

Family history



- Maternal side and paternal side have equal risk
- Breast cancer of 1st and 2nd degree relatives has higher risk
 - Having a first degree relative has two-fold risk
 - Having two first degree relatives has three-fold risk
- 85% of women with breast cancer **do not** have family history

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Family history

Risk of developing breast cancer is higher in women whose close relatives have breast or ovarian cancers. A woman with more than one first degree relative (mother or sister) affected with breast cancer has higher risk compared to having one relative affected. The exact risk is not known, but women with a family history of breast cancer either maternal or paternal side have an increased risk of breast cancer.

Personal history of breast cancer

A woman with cancer in one breast has increased risk of developing a new cancer in the other breast or in another part of the same breast. This is different from a recurrence of the first cancer.


Slide
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Risk factors

Early menarche & late menopause



- Women who had more menstrual cycles have a higher risk of breast cancer
- May be due to prolonged exposure to estrogen and progesterone

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Early menarche & late menopause

Lifetime exposure to estrogen, progesterone hormones


- More menstrual periods
- Early menarche (before age 12) and/or late menopause (after age 55) have a slightly higher risk.

Slide
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Risk factors Parity

- Women who do not have children
- or
- Who have first child after the age of 30 years has higher risk




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Slide
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Modifiable risk factors

- Overweight and obesity
- Inadequate physical activity
- Unhealthy diet
- Tobacco and alcohol
- Hormone replacement therapy

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Parity

Women who never had children or had their first childbirth after the age of 30 years have a slightly higher risk of developing breast cancer. Women who had many pregnancies and had first childbirth at young age reduces the breast cancer risk. This is probably due to reduction of total lifetime menstrual cycles due to pregnancy

Modifiable risk factors

Ask the audience to list the modifiable risk factors

- Overweight and obesity
- Inadequate physical activity
- Unhealthy diet
- Tobacco and alcohol
- Hormone replacement therapy

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Risk factors

Overweight & Obesity



Being overweight and obese increases the risk



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Risk factors Overweight & Obesity

Overweight and obesity - post-menopausal obesity and overweight increases breast cancer risk

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Risk factors

Inadequate physical activity



- Inadequate physical activity increases the risk of breast cancer
- Brisk walking for 30 min per day 5day per day week reduces breast cancer risk by 18%

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Inadequate physical activity

Physical inactivity - Physical inactivity is associated with increase breast cancer risk.


Slide
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Risk factors

Smoking and Alcohol consumption

- Smoking and alcohol consumption increase the risk of breast cancer
- Second-hand smoking is also a risk factor



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Slide 20

Risk factors

Hormone replacement therapy

Hormone therapy with estrogen increases the risk of breast cancer.



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Smoking and Alcohol consumption

Excessive alcohol consumption - Consumption of excess amount of alcohol is related to development of many cancers including the breast cancer

Tobacco - Smoking can cause many cancers including breast cancer

Hormone replacement therapy


Hormone replacement therapy (HRT) - Use of HRT for long period will increase the risk of breast cancer in women.

Slide
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Protective factor Breastfeeding

- Reduces the risk of breast cancer
- Should be continued at least for one year



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Breastfeeding

Women who breast fed their children are having slightly lower risk of breast cancer compared to women who never breast fed. This protective effect is increases with increasing the duration of breast feeding. This could be partly because breast feeding reduces total number of menstrual cycles.

Slide
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Clinical features

Breast lump



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Breast lump

The signs and symptoms of breast cancer may vary from patient to patient. However, any patient presenting with following clinical features need to be suspicious of having breast cancer until proven otherwise. Breast lump is one of the commonest presentations. If it is hard, fixed, or irregular more favor for breast cancer. Sometimes it may appear as a thickening in the breast or axilla

Slide
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Clinical features

Changes in breast size, skin texture or colour



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Changes in breast size, skin texture or colour

Change in the size and/or shape of the breast – Many women may be having slight asymmetry of their breast (eg: Right breast may be larger than left breast etc) this feature is normal unless it is a recent change

Slide
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Clinical features

Nipple changes



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24

Nipple changes

Nipple discharge is a frequent complaint. It can be due to benign or physiological condition. But if the discharge is blood stained or unilateral and form a single duct that should not be neglected.

Slide
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Clinical features
**Late stages of
inflammatory
breast cancer**



Peau d' orange
appearance

Late stages of inflammatory breast cancer

Changes of the texture of the skin - this could be either changes in the colour, skin texture or dimpling of the skin of the breast. In inflammatory breast cancer at the later stages skin of the breast is similar to a skin of an orange which is known as Peau d' orange appearance.

Slide
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Clinical features
Lump in axilla



Lump in axilla

Axillary changes – swelling or lumps in the axillae

Slide
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Prevention & early detection of breast cancer


Prevention

Can be done through controlling the modifiable risk factors

Early Detection

Screening
Early diagnosis



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Slide 28

Early detection of breast cancer

Self breast examination

- Includes visual inspection and careful feeling of the breasts and armpits
- Look for lumps or other abnormalities
- Frequency: A Ger 20 years monthly

**for the correct procedure refer the video clip

Clinical breast examination

- Done by a trained healthcare provider
- Frequency
 - Age 20 to 40 : every 3 years
 - A Ger 40 years: Annually

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Prevention of breast cancer

Control and prevention of modifiable risk factors and healthy lifestyle may eventually have an impact in reducing the incidence of breast cancer in the long run.

Screening – is the systematic application of a screening test in presumably asymptomatic population.

Early diagnosis

Aim of early diagnosis is to provide timely access to diagnosis and effective treatment. The goal is to identify patients at early stages of cancer and reduce the risk of death from breast cancer.

Early detection of breast cancer

Self-breast examination

This is to empower the women taking responsibility for their own health. Therefore, breast awareness is recommended to improve the early diagnosis of breast cancer

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Early detection of breast cancer

Clinical breast examination

- Done by a trained healthcare provider
- Frequency
 - Age 20 to 40 : every 3 years
 - Ager 40 years: Annually



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Early detection of breast cancer

Clinical breast examination
Done by a trained healthcare
provider Frequency

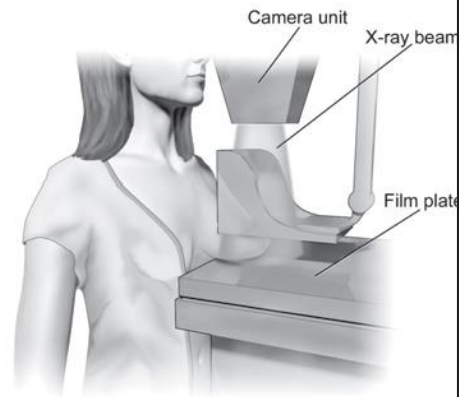
- Age 20 to 40 : every 3 years
- After 40 years: Annually

Both these procedures will be covered during the practical session

Slide 30

Mammogram

- A mammogram is an Xray of the breast
- For a mammogram the breast is pressed between 2 plates to flatten and spread the tissue
- It produce a picture of the breast tissue



Mammogram

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Mammogram

Mammographic screening

Population based mammogram screening is carried out in developed countries having high incidence of breast cancers. Sri Lanka being a developing country and having comparatively low incidence of breast cancers is not having population-based screening programme. Mammograms are mainly carried out for diagnostic purposes except for screening mammograms for high risk women. Clinical breast examination is recommended for women on regular basis to identify breast cancers early.

Slide
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Protocol for assessment & referral



Women presenting with signs & symptoms
of breast cancer




History, intensity, duration, progression
(identify relevant breast cancer risk
factors)



Clinical examination of both
breasts, axillae, neck



Refer immediately to a next level
health facility for further
investigations

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Protocol for assessment & referral

If you come across a woman with signs and symptoms of breast cancer it is mandatory to take a detailed clinical history and carry out thorough examination before referring her for further investigations. If a woman complains that she is having a lump, she needs further investigation even though you are unable to detect any abnormality

Practical session

- Play the videos provided by NCCP on self-breast examination and clinical breast examination.
- Discuss the important steps with the audience according to the **“National Guidelines for Self-breast Examination and Clinical Breast Examination”**
- Ask the participants to practice the steps using breast mannequins

National Guidelines for Self-breast Examination and Clinical Breast Examination

The screening protocol

- Breast self-examination should be conducted once a month by all women starting from 20 years of age.
- Clinical Breast Examination (CBE) is recommended every 3 years for all women from the age of 20 to 40 years. Women aged 40 or over, CBE is recommended annually.
- In women whose relatives had breast or ovarian cancer under the age of 40 years, annual clinical breast examination should be started 5 years before the index case.
- Breast self-examination should be taught and reinforced at every consultation.
- Screening mammography is offered once in 2-3 years for women aged 50 – 69 years. (Can be adopted only when adequate mammography facilities are available throughout the country)

Self-breast examination

Self-breast examination (SBE) is the inspection and palpation of the breast by the woman herself. The role of the primary health care physician/ staff is to provide necessary information to women and to make them competent in self-breast examination.

Information that should be provided to the woman:

Importance of SBE

If breast cancer is detected early, it gives a better outcome. A practice of self-breast examination on a monthly basis is very important for early detection of breast cancers.

Best time to conduct the SBE

It is better to conduct SBE one week after the beginning of menstruation (During menstruation, some women feel their breasts painful and lumpy). If she is not menstruating, a convenient fixed date should be selected.

Frequency of carrying out the SBE

This should be carried out once a month by all women over the age of 20 years.

Required setting to carry out the SBE

This procedure takes little time and can be incorporated into the routine life activity, in any place that is comfortable and would secure the privacy of the woman.

Steps of self-breast examination:

Two components:

1. Inspection (Preferably in standing position)
2. Palpation (Either lying down, sitting, standing)

Inspection

Stand in front of the mirror exposing the chest up to the waist, look at the breasts through the mirror, while keeping the arms in positions.



1. Arms hanging by the side head
2. Hands pressed on the hips
3. Arms raised over the head

Figure 1: Positions of Breast inspection

Note the changes mentioned below:

- Skin changes of the breasts
- Color changes of the breasts

- Change in shape of the breasts
- Orange peel / Peau d'orange appearance of the breast
- Ulceration on the breast
- Late occurrence of breast asymmetry (most women may have asymmetry in normal circumstances. Therefore, a long- standing breast asymmetry is not a sign of a cancer)
- Nipple changes, discharges other than breast milk/ inverted nipple (having inverted nipples from birth is not a sign of a cancer)
- Breast lump, change in the texture, thickening of the breast skin.
- Lumps in the arm pit or around the neck

Palpation of the breasts while standing

Palpate the breast using middle three fingers to identify thickened areas and or lumps. Use the palmar surfaces of the fingers (flat surface of the three middle fingers). Palpation of breast can be done in sitting or lying down positions.

On examining right breast, raise the right arm over the head and palpate the right breast using the left hand. While examining the left breast raise the left arm and palpate the left breast using the right hand



Figure II: Palpation of the breast

Continue palpating the breast in a clockwise direction from outer circle of the breast towards the nipple using three pressure levels.

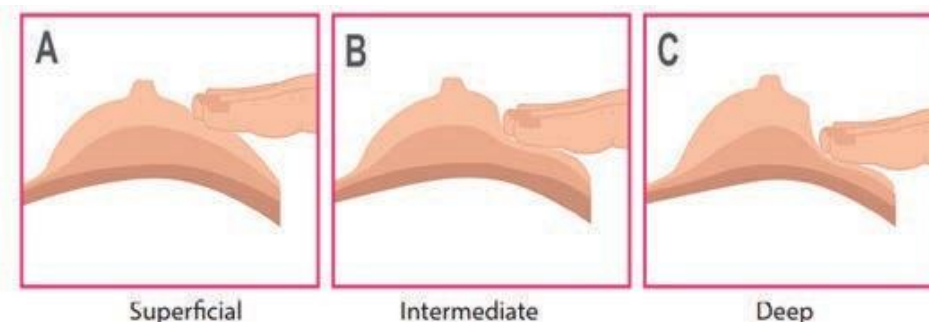


Figure III: Palpation of the breasts in superficial, intermediate and deep pressure levels

Start with applying 'minimal' pressure as indicted (to feel the area just beneath the skin) and then gradually increase the pressure (to feel the tissue deeper within).

At the end of the breast palpation, find out whether there is a nipple discharge by squeezing the areola using thumb and middle finger.

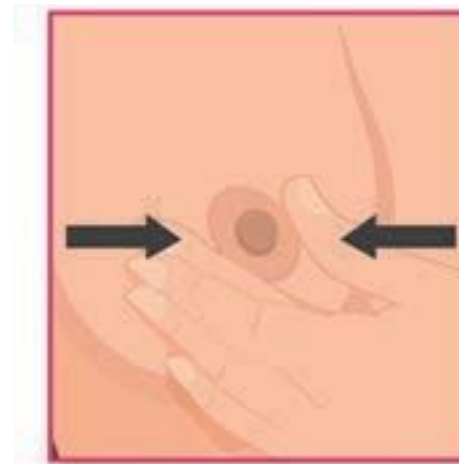


Figure IV: Look for nipple discharge.

Then examine the armpit and look for lumps. Use the same technique to examine the other breast.

Palpation of breast in lying down position.

To palpate the right breast, keep the right palm beneath the head and palpate the breast using the left hand. For the palpation of left breast, keep the left palm under the head and palpate with the right hand.

If any abnormality is detected during self-breast examination, it is necessary to consult a doctor even though all the changes may not be due to breast cancer.

Clinical breast examination

Clinical breast examination serves two purposes. It can be used as a screening method for women without any signs and symptoms of breast cancer and as a component of triple assessment in women with signs and symptoms when diagnosing breast cancer. A detailed history and thorough clinical examination provide important information on which, further investigations would be based.

Clinical history

History should be taken from women presenting to the clinic, either with signs and symptoms or without signs and symptoms before doing clinical breast examination. Following are the possible signs and symptoms and information need to be collected.

Possible signs and symptoms and information to be collected:

Breast Lump	<ul style="list-style-type: none"> • Site - Constant and changing • Duration- when and how it was noticed. • Any new changes since first notice (e.g., getting bigger) • Relationship to menstrual cycles or exogenous hormones • Associated symptoms
Breast Pain	<ul style="list-style-type: none"> • Site- Constant or changing/ unilateral or bilateral. • Cyclical or noncyclical • Duration - how long and characteristics of pain • Any recent change such as intensity, frequency, site of pain • Relationship to menstrual cycles or exogenous hormones • Associated symptoms
Nipple discharge or any other nipple changes	<ul style="list-style-type: none"> • Duration - when and how first noted (Spontaneous or not) • Any changes since first notice • Bilateral or unilateral • From single duct or multi duct

Steps of Clinical Breast Examination (CBE)

CBE should be done in a covered room with good light. A female chaperon should be there if the examiner is a male. Before starting the examination, it is necessary to explain the procedure to the client.

Inspection

Breasts should be inspected in each of the following positions:

1. Arms relaxed at her sides
2. Hands placed on the hips and pushing inward (contraction of the Pectoralis Major muscle)
3. Arms raised over her head

The breasts should be inspected from the front and from each side. Pay particular attention to:

- Breast size, contour, shape, symmetry
- Skin changes such as erythema, dimpling, tethering or puckering, Peau d' orange, eczematous skin changes, visible lumps.
- Nipple – position, inversion, retraction, erythema, eczema, nodules

Palpation

The ability to identify breast lumps by palpation is influenced by the characteristics of the tumour, the surrounding breast tissue, the position of the lesion in the breast, proper positioning of the client and thoroughness of the search, the area covered and use of a consistent pattern of search. During the process of palpation, the client should feel comfortable and need to ask about it.

• Positioning the woman for palpation

For the palpation of the breasts, the woman should be placed in the supine position, placing both arms under her head, which will facilitate palpation of the outer quadrant of a large breast. Use the examiner's other hand to stabilize breast in position.

Perimeter of the breast should be noted during clinical breast examination.

Anatomically, breast tissue extends superiorly from the second rib or clavicle, medially to the lateral border of the sternum, inferiorly to the sixth rib and laterally to the Latissimus Dorsi muscle.

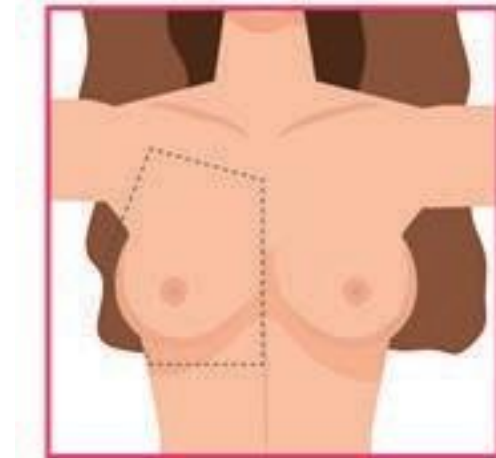


Figure V: Perimeter of the breast

Palpation technique

The examiner should use the distal phalanges of the middle three fingers to palpate the breast. The entire breast should be palpated using overlapping dime-sized circles. Use three different levels of pressure (superficial, intermediate and deep) at each point to palpate different layers of the breast.

(See Figure III)

There are three typical patterns used to palpate the breast:

- Circular technique
- Radial spoke technique (wedges)
- Vertical strip technique (lines)

Whichever pattern is used for palpation of the breasts, it is important to make sure that the entire perimeter of the breasts are being covered.

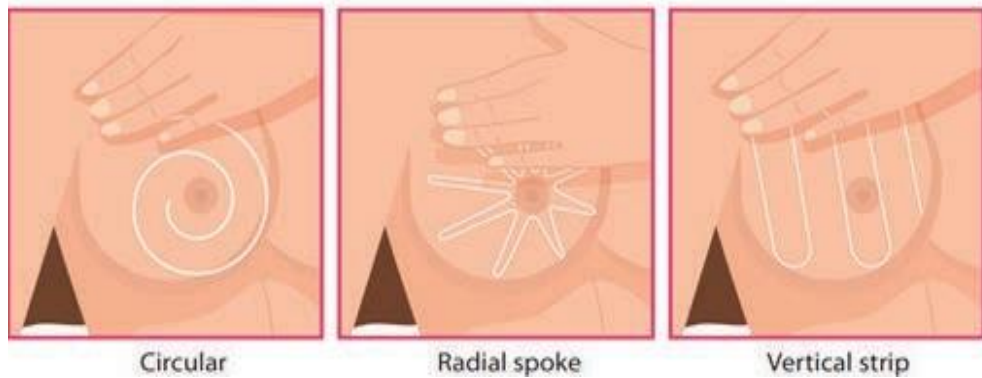


Figure VI: Three patterns of breast palpation

The woman should be asked to squeeze areolar region of the nipple to see whether there is any nipple discharge. (Nipple discharge that occurs only with nipple or breast stimulation is a normal physiological function.)

(See Figure IV)

Palpation of Regional Lymph Nodes

The regional lymph nodes (Supra-clavicular, Infra-clavicular and axillary nodes) should be palpated while woman is in the sitting position.



Module 3: Cervical Cancer

Learning objectives

Understand the concepts of prevention, screening and early diagnosis methods for cervical cancer

Apply the knowledge gained on risk factors, signs and symptoms of cervical cancer for early identification of patients at risk of developing cervical cancer.


Cervical cancer is a preventable cancer. It can also be detected easily at early stages. The third module covers the important aspects of prevention and control of cervical cancer. NCCP recommends conducting pre and posttests to assess the effectiveness of the programme. Sample test questions have been provided with the other resources or can be downloaded from the NCCP website.

Slide
01

Cervical Cancer



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Cervical Cancer


Third module is the prevention and control of cervical cancer

Slide 02

Global Situation



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Incidence

- 4th leading cancer among women worldwide
- 604,127 cases worldwide (2020)
- 85% in less developed countries

Mortality

- 4th leading cancer related deaths in women
- 341,831 cervical cancer deaths in 2020
- 87% in less developed countries

Global Situation

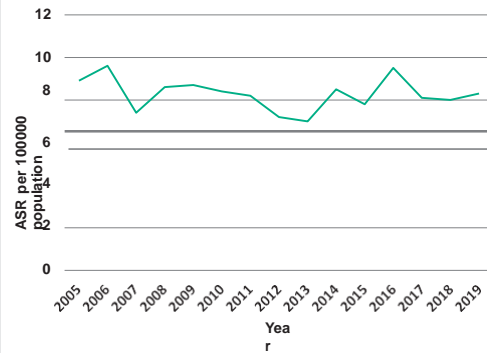
Cervical cancer is the fourth commonest cancer and cancer deaths among women globally.

There were 604,127 cervical cancer patients in the world in 2020. In Sri Lanka cervical cancer is the 4th commonest cancer among women with more than 1000 new patients with invasive cancers seeking treatment annually from government hospitals.

Slide 03

Cervical cancer incidence 2005 to 2019: Sri Lanka

1114 new cervical cancer patients in 2019



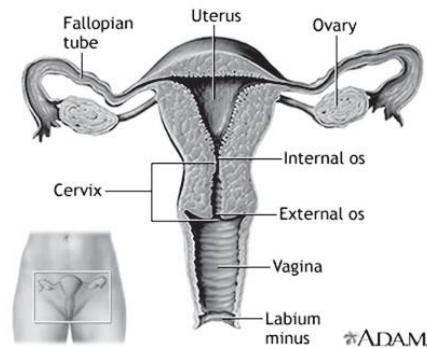
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Cervical cancer incidence 2005 to 2019: Sri Lanka

Cervical cancer incidence increases with the age and comes to a peak around the age of 70 years. Cervical cancer is a most preventable cancer as well as curable if detected at early stages.

Slide 04

Anatomy of the Uterine Cervix



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Anatomy of the Uterine Cervix

Cervix is 3-4 cm in length and 2.5 cm in diameter. Varies with age, parity, menstrual and hormonal status.

Ectocervix is covered by pink multilayered squamous epithelium and endocervix is lined by single layered columnar epithelium and is red in appearance.

Squamo – columnar junction (SCJ) is the area where 2 epithelia meet.

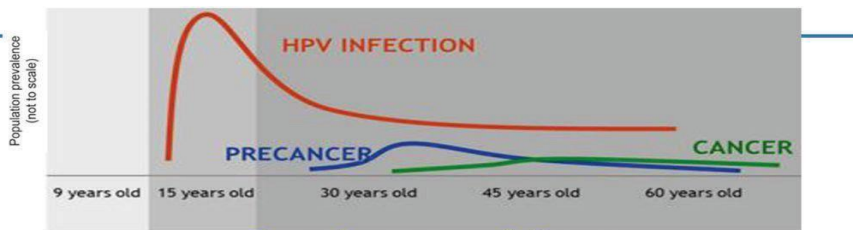
Cervical cancer Caused by HPV infection

- Sexually transmitted
 - Usually no symptoms
 - No treatment for HPV infection before symptoms
 - Immune system clears most cases; some persist
- HPV present in >99% of cervical cancers
 - High risk types (16, 18) associated with cancer
 - Low risk types are associated with genital warts
 - All can cause abnormal Pap tests

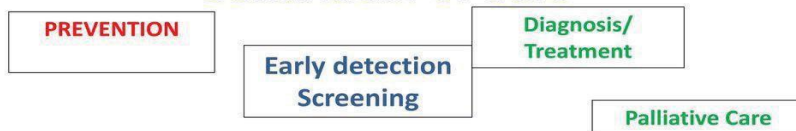
Cervical cancer

Human Papilloma virus (HPV) is a sexually transmitted infection. High risk types (16, 18) of HPV associated are the main cause for cervical cancer.

Natural History of Cervical Cancer



Continuum of Care



Natural History of Cervical cancer

In most women the infection clears by the immune system. But in some women specially when there are factors like other STIs, immunosuppression the HPV virus will persist.

When HPV infection persists, it can progress on to CIN (cervical intraepithelial neoplasia) and if not treated to cancer later. At this point discuss the possible strategies for prevention and control of cervical cancer as shown in the diagram.

Slide 07

Risk factors - HPV infection is the necessary cause of cervical cancer

Factors Favoring Infection

- Early commencement of sexual activity
- Multiple sexual partners
- Partner's high risk sexual activities
- Poor socio-economic status
- Poor hygiene
- Immunosuppression – primary acquire



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Risk factors

There are risk factors which increases the risk of acquiring HPV infection while some other risk factors favor persistence of HPV infection. However, there are risk factors which are common to both acquiring and persistence of infection. Such as

- Immunosuppression
- Poor socio- economic status and poor nutrition

Slide 08

Clinical features

- Pre-cancerous lesions - Usually asymptomatic
- Symptoms begin when pre-cancer becomes true invasive cancer

Common Symptoms

- Intermenstrual bleeding / Post menopausal bleeding
- Post coital bleeding
- Abnormal vaginal bleeding
- An unusual vaginal discharge
- Excessive sero-purulent discharge



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Clinical features

Usually there are no signs or symptoms while women having HPV infection, pre- cancerous lesions and sometimes during the early invasive cancer. At the time patient presenting with symptoms and signs cancer may have spread. However, it is worth referring patients with symptoms and signs as early as possible.

Clinical features of advanced cancer

- Anaemia (due to abnormal vaginal bleeding)
- Pelvic, leg or back pain
- Urinary problems or renal failure
- Leakage of urine or stools into vagina (Fistula between vagina and bladder or rectum)
- Weight loss
- Loss of appetite



Clinical features of advanced cancer

Late stage cervical cancer can have clinical features such as Anaemia (due to abnormal vaginal bleeding) Pelvic, leg or back pain, Urinary problems or renal failure Leakage of urine or stools into vagina (Fistula between vagina and bladder or rectum) ,weight loss, loss of appetite.

Control Strategies

- Prevention
 - Vaccination against HPV
 - Safe sexual practices
 - Avoid sex at young age
 - Avoid smoking
 - Healthy lifestyle
- Early detection by screening
- Early diagnosis of symptomatic patients
- Treatment

Control Strategies

Prevention: Cervical cancer can be prevented by several ways. Primary prevention of Cervical cancer

Essentially on healthy lifestyles

- Safe sexual practices – avoid sex at young age.
- Avoid smoking – smokers have 3 times higher risk of cervical cancer than non-smokers.
- Healthy lifestyle – enhances the immune system.
- Vaccination against HPV


Early detection by screening: Through well women clinics Early diagnosis of symptomatic patients

Treatment; Initiating early and required treatment and follow up is very important

Slide
11

HPV Vaccination

- Highly efficacious in preventing
 - Infection & precancerous cervical lesions caused by HPV 16 and 18
 - Anogenital warts – caused by HPV 6 and 11
- School based immunization programme for girls aged 10 – 11 years in Sri Lanka
- 2-dose schedule (0, 6-15 months)

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Slide
12

Cervical cancer screening in Sri Lanka

- Well Women Clinic Programme
 - Pap smear screening
- Married females at 35 years and 45 years of age & follow up
- Around 1000 Well Women Clinics through MOH & Primary Care setting
- Coordinated by Family Health Bureau
- HPV DNA testing – More precise

 National Cancer Control Programme

HPV vaccination

School based immunization programme for girls aged 10 – 11 years. Quadrivalent vaccine is given to protect against viral types 16, 18, 6 & 11. 2 doses are given at 0 and 6 months.

Cervical cancer screening in Sri Lanka

Screening - Cytology screening (Pap test) is the oldest and most widespread cancer screening technique. Organized cytology screening programs have led to effective reduction in the incidence and mortality from cervical cancer in many developed countries.

HPV DNA tests to detect the presence of viral markers for the high- risk HPV types.

- It tests for HPV infection instead of cancer, which means that a negative HPV test indicates a low probability for the patient to develop cervical cancer within 5-10 years

Slide
13

HPV DNA test HPV DNA test

- More Precise test
- Recently introduced and currently expanding in Sri Lanka
- If the HR-HPV DNA is negative, the patient can be referred for the routine review in 5 years in the presence of risk factors .
- If HPV DNA positive needs to do Pap smear.
- Positive HPV DNA and abnormal Pap smear needs colposcopic examination

13

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HPV DNA test

HPV DNA has higher sensitivity and specificity and it was recently introduced to Sri Lanka. Currently expanding throughout the country. If the HR-HPV DNA is negative, the patient can be referred for the routine review in 5 years in the presence of risk factors .If HPV DNA positive needs to do Pap smear. Positive HPV DNA and abnormal Pap smear needs colposcopic examination.

Slide
14

Responsibility of primary care staff

1. Coverage: Try to reach 100%
2. Make sure every client get the report on time,
3. Need to refer if required and records should be maintained (eg: Colposcopy)
4. Make sure everyone get the required treatment and records should be updated

Follow up is very important.

Any women can contact area PHM to know that how to visit Well women clinic regarding date & time

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Responsibility of primary care staff

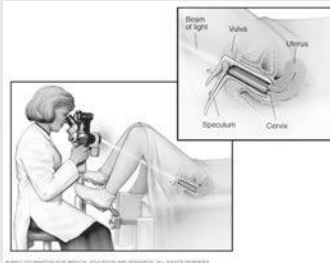
Discuss the responsibilities of primary care staff for prevention and control of cervical cancer

- Coverage: Try to reach 100% WWC coverage 35 and 45 year age cohorts.
- Make sure every client gets the report on time,
- Need to refer if required and records should be maintained (eg: Colposcopy)
- Make sure everyone gets the required treatment and records should be updated
- Follow up is very important to achieve a better outcome.

Stress that any women can contact area PHM to know that how to visit Well women clinic regarding date & time Explain that WHO has declared targets to achieve cervical cancer elimination target.

Slide
15

Colposcopy



- Depending on PAP smear report some need to be referred for colposcopy
- Colposcopy is done by consultant gynecologists in Sri Lanka
- Colposcopy is performed to
 - Further investigate the cervical lesions
 - Treat some minor conditions

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Colposcopy

Provide a brief description on colposcopy.

Depending on PAP smear report some need to be referred for colposcopy. Colposcopy is done by consultant gynecologists in Sri Lanka. Colposcopy is performed to investigate the cervical lesions further and to treat some minor conditions.

Slide
16



Cervical cancer elimination strategy

WHO launched the Global Strategy to Accelerate the Elimination of Cervical Cancer

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Cervical cancer elimination strategy-2020

First time ever, the world has committed to eliminate a cancer. That is cervical cancer. This is a long process which includes several land marks. First one is the 90-70-90 interim targets in 2030.

Slide
17

Interim targets of cervical cancer elimination to achieved by 2030

- 90% of girls fully vaccinated with the HPV vaccine by the age of 15
- 70% of women screened* by the age of 35, and again by the age of 45 (* Should be a quality test)
- 90% of women identified with cervical disease receive treatment

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Interim targets of cervical cancer elimination to achieved by 2030

We have to work together to achieve its interitem targets by 2030. This will be the first step.

- 90% of girls fully vaccinated with the HPV vaccine by the age of 15
- 70% of women screened by the age of 35, and again by the age of 45
- 90% of women identified with cervical disease receive treatment

Slide
18

National Strategic Plan to Reach the Interim Targets of Cervical Cancer Elimination in Sri Lanka 2021 - 2030



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Ministry of Health Sri Lanka National Cancer Control Programme

- NCCP launched the National Strategic Plan to Reach the Interim targets of Cervical Cancer Elimination in Sri Lanka 2021 -2030
- As public health staff we must work as a team to achieve targets in Sri Lanka

National Cancer Control Programme

18

NCCP launched the National Strategic Plan to Reach the Interim targets of Cervical Cancer Elimination in Sri Lanka 2021 -2030. This will be the road map to achieve the targets of global initiative. You can find it in NCCP official web site (www.nccp.gov.lk). As public health staff we must work as a team to achieve targets in Sri Lanka

Sri Lankan guideline of classification for cervical cytology was adapted from the Bethesda system (8)

Categories included in Modified Bethesda classification adapted for Sri Lanka

1. Negative for Intraepithelial Lesion or Malignancy (NILM)
2. Low grade Squamous Intraepithelial Lesion (LSIL)
3. High grade Squamous Intraepithelial Lesion (HSIL)
4. Atypical Squamous Cells of Undetermined Significance (ASCUS)
 - Atypical Squamous Cells of Undetermined Significance – Low grade (ASCUS - Low grade)
 - Atypical Squamous Cells of Undetermined Significance – High grade (ASCUS - High grade)
5. Glandular cell atypia
6. Benign endometrial cells in a woman > 40 years
7. Squamous or Glandular malignancy

**Although the this calcification is not included in the presentation the trainer should have a clear understanding about this.

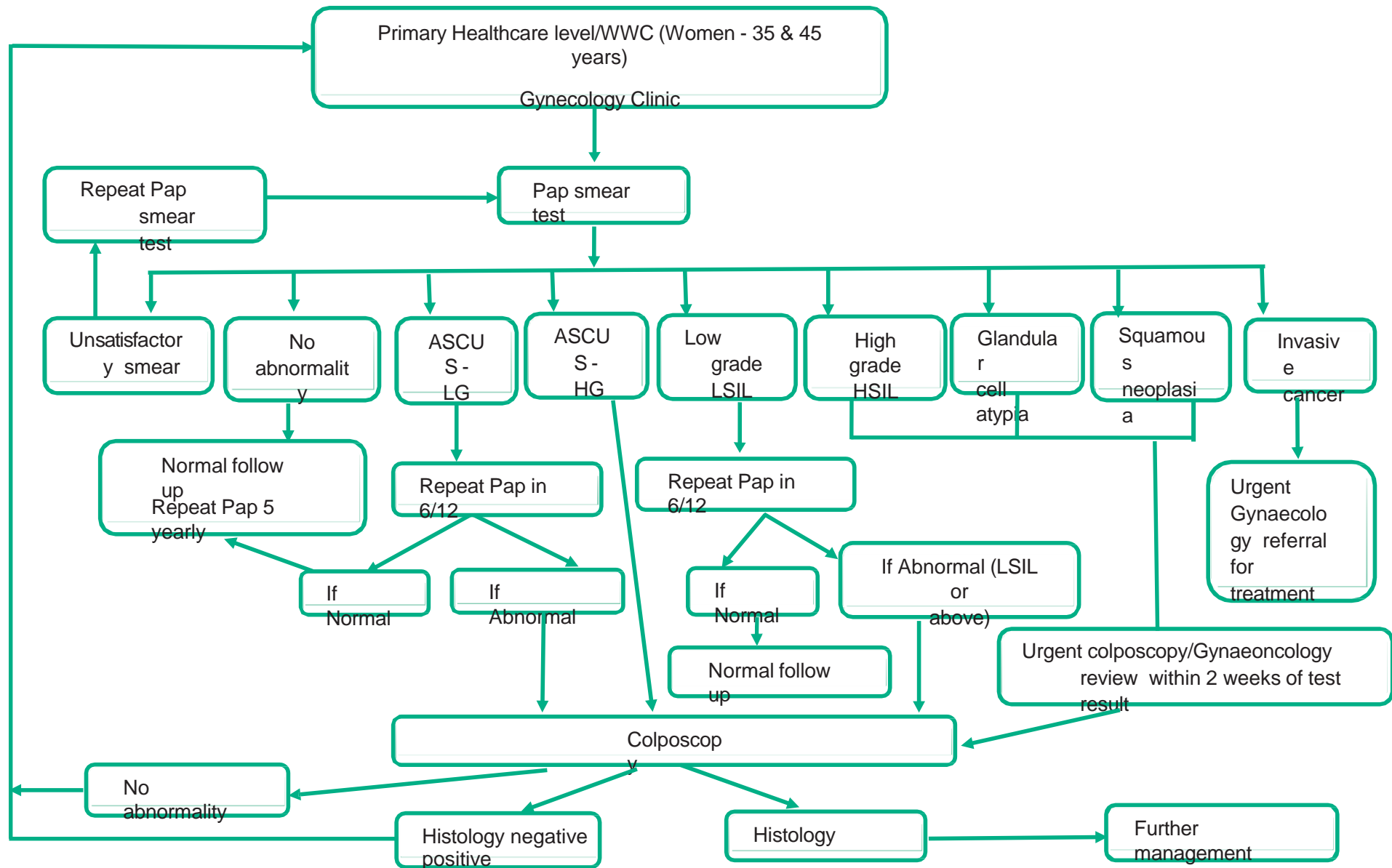
Sri Lankan guideline of classification for cervical cytology was adapted from the Bethesda system (8)

Cytological classification (Modified Bethesda System adapted to Sri Lanka)	Histological classification (used for diagnosis)	Recommendation
Normal	Normal	Routine re-screening (5 yearly) If inflammatory – treat and follow up
ASCUS – Low grade	Atypia	Medical officer at primary health care level to follow up and repeat smear in 6 months
ASCUS – High grade		Refer for colposcopy If colposcopy biopsy is positive, treat as for HSIL
LSIL	CIN 1 (including flat condylomata)	If HPV DNA is not available, repeat smear in 6 months → If second smear also LSIL or above refer to a gynaecologist for → colposcopy → If HPV DNA is available, triage If HPV DNA positive + LSIL refer for colposcopy
HSIL Glandular cell atypia	CIN 2 / CIN 3	Refer for colposcopy Refer for colposcopy
Invasive carcinoma	Invasive a (Squamous or Glandular malignancy)	Urgent referral to a Tertiary Cancer Center (For gynaecologist opinion)

**Although this classification is not included in the presentation the trainer should have a clear understanding about this.

Algorithm for Pap smear test

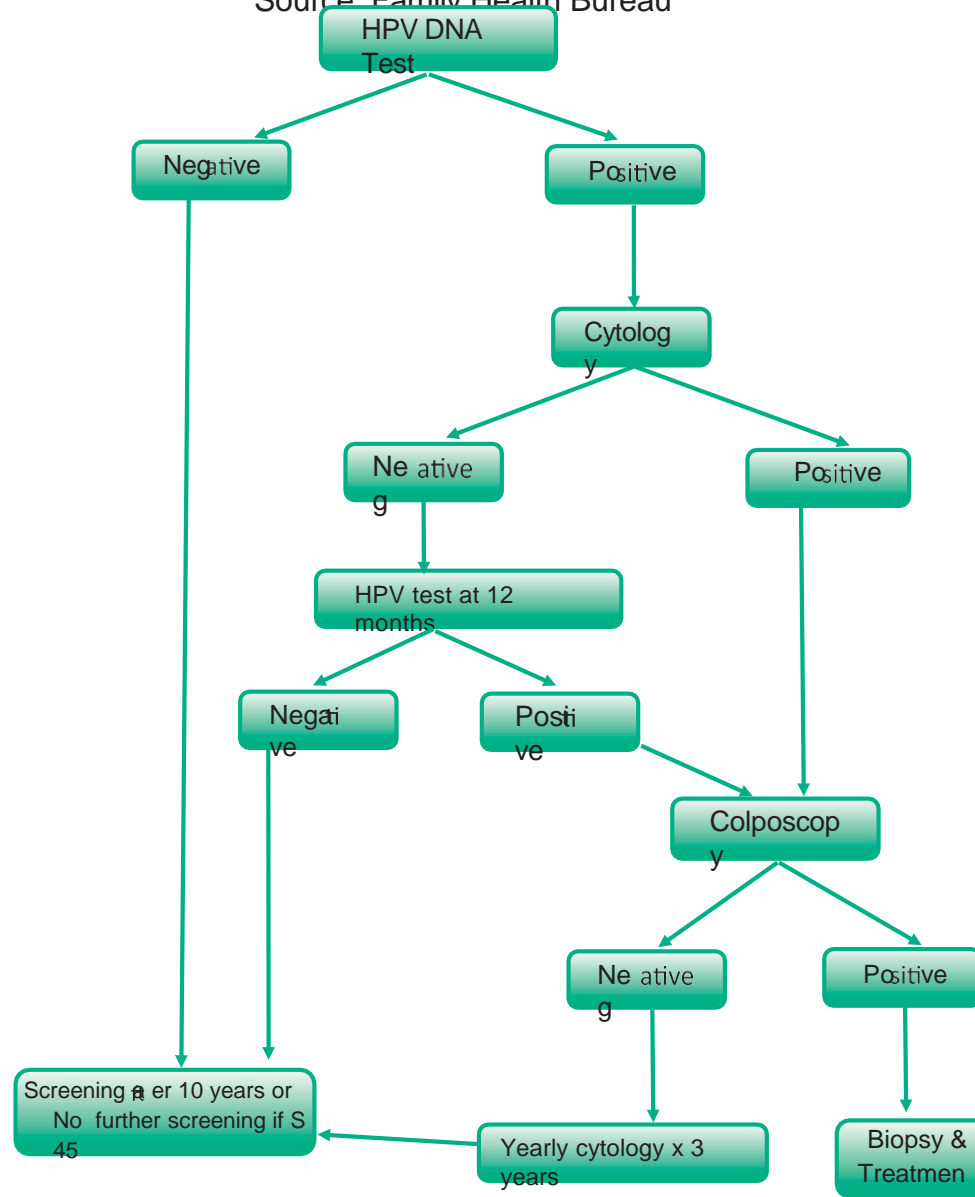
Source: National Cancer Control Programme



**Although the this calcification is not included in the presentation the trainer should have a clear understanding about this.

Algorithm for HPV DNA Test

Source: Family Health Bureau



**Although the this calcification is not included in the presentation the trainer should have a clear understanding about this.



Module 4: Colorectal, Oesophageal, Thyroid, Prostate and lung cancers

Learning objectives

Know the burden of Colorectal, Oesophageal, Thyroid, Prostate and Lung cancers

List the risk factors and clinical features of each cancer

Know the prevention and control strategies of each cancer

This module will focus on colorectal, oesophageal, thyroid, prostate, and lung cancers. At the end of this module, the audience should be aware about the disease burden, risk factors and control strategies of these cancers. NCCP recommends conducting pre and posttests to assess the effectiveness of the programme.

Sample test questions have been provided with the other resources or can be downloaded from the NCCP website.

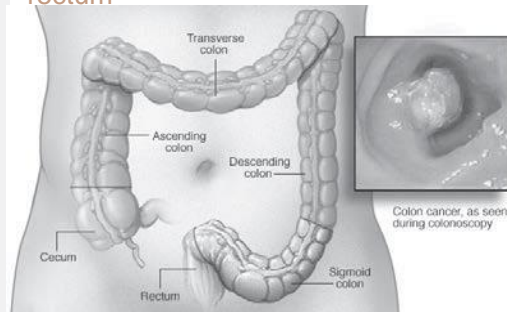
Slide
01

Colorectal Cancer



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Health

Cancer of the colon or rectum



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1

Colorectal Cancer

Colorectal cancer includes the cancers in large intestine and rectum.

Slide 02

Colorectal Cancer

- 1260 males and 1248 females with colo-rectal cancer were diagnosed in 2019
- Third commonest cancer among males and females in Sri Lanka (2019).
- Survival is good if diagnosed early

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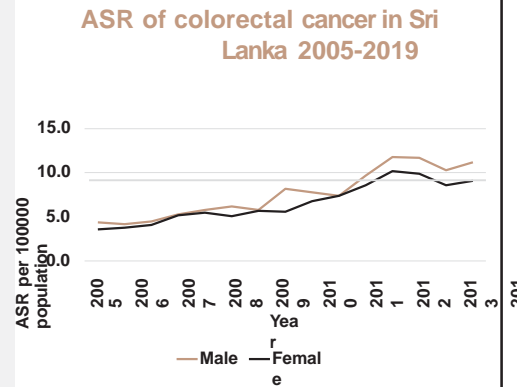
2

Colorectal Cancer

Among males it is the 3rd commonest cancer while among women it is the 3rd commonest cancer. In 2019, there were 1257 males and 1248 females with Colo-rectal cancer in Sri Lanka

Slide 03

Colo-rectal cancer trend in Sri Lanka



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3

Colo-rectal cancer trend in Sri Lanka

Colo-rectal cancer incidence is increasing gradually among both males and females in Sri Lanka

Slide 04

Non modifiable Risk factors

- Personal history of colorectal cancer or polyp
- Inflammatory intestinal conditions
- Inherited syndromes
- Family history of colorectal cancer
- Old age

Modifiable Risk factors

- Alcohol consumption
- Tobacco smoking
- Red meat
- Consumption of processed meat
- Overweight / Obesity
- sedentary lifestyle
- Radiation
- Diabetes

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4

Risk factors for colorectal cancer

Ask the audience to list the known risk factors

Non modifiable

Personal history of colorectal cancer or polyp, Inflammatory intestinal conditions, Inherited syndromes, Family history of colon cancer, old age

Modifiable

Low fiber diet, processed meat, sedentary lifestyle, diabetes, obesity, smoking, alcohol, radiation.

Protective factors

- Physical activity
- Fruits and vegetables
- Dietary fiber
- Dairy products
- Dietary folate
- Vitamin D



Protective factors

There are some factors which reduces the risk of colorectal cancer. Ask the audience to list the known protective factors

- Physical activity
- Fruits and vegetables
- Dietary fiber
- Dairy products
- Dietary folate
- Vitamin D

Clinic presentation

- Early stages - No symptoms / signs
- Blood in stools
- Altered bowel habits (diarrhea / constipation)
- Feeling of incomplete bowel evacuation
- Stools narrower than usual (pencil stools)
- General abdominal discomfort
- Unintentional weight loss
- Feeling tired, vomiting, loss of appetite



Clinical presentation


Explain that patients can be asymptomatic during the early stages of cancer. However, it is very important to be aware about the signs and symptoms to diagnose early.

Blood in stools/ Altered bowel habits (diarrhea / constipation) / Feeling that the bowel doesn't empty completely / change in consistency of stools/ Persistent abdominal discomfort/ cramps/ pain vomiting/ loss of appetite/ Unexplained weight loss/ Weakness /fatigue

Slide 07

Diagnosis

- History & physical examination
- Digital examination of rectum (DER) (compulsory)
- Other tests – fecal occult blood
- Sigmoidoscopy/colonoscopy
- Biopsy – if there is a lesion

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7

Diagnosis

Give a simple description on methods available for diagnosis

- History & physical examination
- Digital examination of rectum (DER) (compulsory)
- Other tests – fecal occult blood
- Sigmoidoscopy/colonoscopy
- Biopsy – if there is a lesion

Slide 08

What can primary health care staff do?

- Identify individual with
 - Risk factors
 - Clinical features
- Refer them early to
 - Surgical clinics
 - Cancer early detection centers

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What can primary health care staff do?

Discuss with the audience

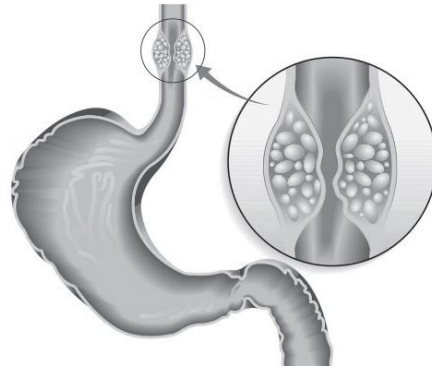
1. How to identify high risk individuals based on risk factors and clinical features,
2. Identify the clinics/centers in local setting to refer this type of people

Slide 09

Oesophageal Cancer



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Oesophageal Cancer

Oesophageal cancer is the 4th commonest cancer in males and 7th commonest cancer in females in Sri Lanka.

Slide
10

Oesophageal Cancer

- 1100 males and 816 females with Oesophageal cancer were diagnosed in 2019
- Survival
 - Usually, poor
 - Varies by stage at diagnosis

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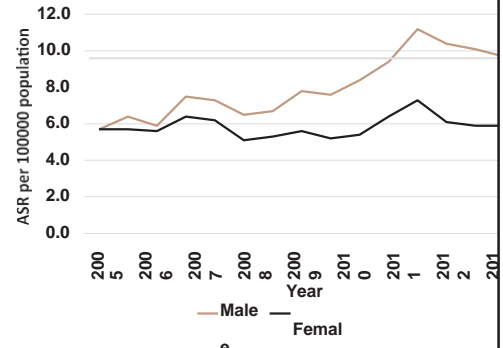
Oesophageal Cancer

1100 males and 816 females with Oesophageal cancer were diagnosed in 2019. Usually, the prognosis is poor even in developed countries. Prognosis is highly dependent on the stage of the cancer.

Slide 11

Current trend

ASR of oesophageal cancers in Sri Lanka 2005-2019



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Current trend

Oesophageal cancer is gradually increasing in Sri Lanka. Discuss the possible reasons

- Ageing population
- Improving diagnostic facilities

• Changes in risk factors pattern- next slide

Slide 12

Risk Factors

- Personal habits
 - Excessive alcohol consumption
 - Tobacco smoking
 - Betel quid chewing
 - Overweight/Obesity
- Long standing strictures and achalasia cardia
- Radiation

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Risk Factors

Ask audience to list the known risk factors

- Personal habits
 - Excessive alcohol consumption
 - Tobacco smoking
 - Betel quid chewing
 - Overweight/Obesity
- Long standing strictures and achalasia cardia
- Radiation

Slide
13

Clinical features

- Early stage - No symptoms / signs
- Painful or difficult swallowing
- Weight loss
- Pain behind the sternum
- Hoarseness and cough
- Indigestion and heart burn



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Clinical features

Explain that the early stage of the cancer does not have signs and symptoms. This is one of the reasons to have poor prognosis.

Highlight the importance to detect dysphagia as early as possible. Discuss other factors

- Weight loss
- Pain behind the sternum
- Hoarseness and cough
- Indigestion and heart burn

Slide
14

Diagnosis

- History & physical examination
- Chest X-ray
- Barium swallow
- Upper GI endoscopy



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Diagnosis

Give a simple description about the methods available for diagnosis

- History & physical examination
- Chest X-ray
- Barium swallow
- Upper GI endoscopy

Slide
15

What can primary health care staff do?

- Identify individual with
 - Risk factors
 - Clinical features
- Refer them early to
 - Surgical clinics
 - Cancer early detection centers



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What can primary health care staff do?

Discuss with the audience

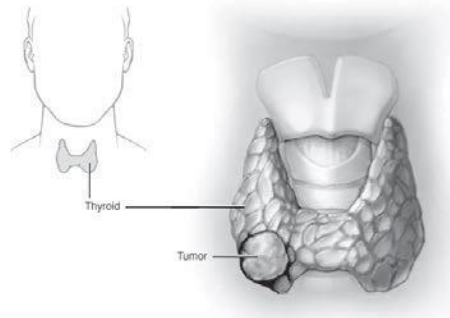
1. How to identify high risk individuals based on risk factors and clinical features.
2. Identify the clinics/centers in local setting to refer this type of people

Slide
16

Thyroid Cancer



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Thyroid Cancer

Thyroid cancer is the second most leading cancer among females in Sri Lanka.

Slide
17

Thyroid cancer

- 2201 females and 441 males with thyroid cancer were diagnosed in 2019
- 2nd most common cancer among females in Sri Lanka
- Prognosis is usually good

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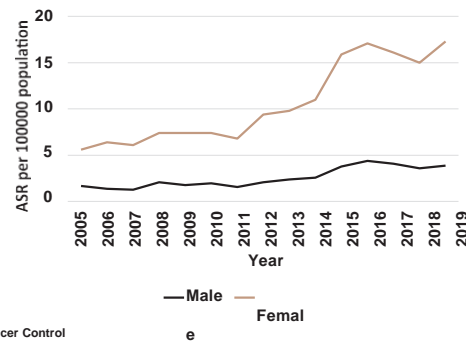
Thyroid cancer

In 2109, there were 2201 females and 441 males was diagnosed with Thyroid cancer. Usually the prognosis is good in most thyroid cancers.

Slide
18

Current trend

ASR of Thyroid cancers in Sri Lanka, 2005 -2019



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Current trend

Incidence of thyroid cancer is increasing in Sri Lanka

Slide
19

Risk factors

- Female sex: Three to four times common
- Having a first-degree relative diagnosed of thyroid cancer
- Long term Multinodular Goiter
- Thyroiditis
- Radiation
- Some hereditary conditions

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Slide 20

Clinical Features

- Solitary nodule in the neck
(Recent onset progressively enlarging nodule)
- Other local symptoms such as
 - o Hoarseness of voice
 - o Dysphagia
- Evidence of metastasis
 - o Dyspnea
 - o Bone pain
 - o Bony lumps

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Risk factors

Discuss about the possible risk factors

- Female sex: Three to four times common
- Having a first-degree relative diagnosed of thyroid cancer
- Long term Multinodular Goiter
- Thyroiditis
- Radiation
- Some hereditary conditions

Clinical Features

Give a basic description about the signs and symptoms of thyroid cancer


- Solitary nodule in the neck (Recent onset progressively enlarging nodule)
- Other local symptoms such as
 - o Hoarseness of voice
 - o Dyspnea
 - o Dysphagia
- Evidence of metastasis
 - o Dyspnea
 - o Bone pain

Slide
21

D iagnosis



- History & physical examination
- Serum T4, TSH
- US Scan of thyroid & neck
- FNAC of the nodule

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Diagnosis

Give a simple description about the methods available

- History & physical examination
- Serum T4, TSH
- US Scan of thyroid & neck
- FNAC of the nodule

Slide
22

What can primary health care staff do?



- Identify individual with
 - Risk factors
 - Clinical features
- Refer them early to
 - Surgical clinics
 - ENT clinics
 - Cancer early detection centers

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What can primary health care staff do?

Discuss with the audience

1. How to identify high risk individuals based on risk factors and clinical features.
2. Identify the clinics/centers in local setting to refer this type of people


Slide
23

Prostate Cancer



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Prostate Cancer


Prostate cancer is a cancer affects only men and develop within the prostate gland.

Slide
24

Prostate cancer



- 1008 prostate cancer patients were diagnosed in 2019
- Survival is good if diagnosed early

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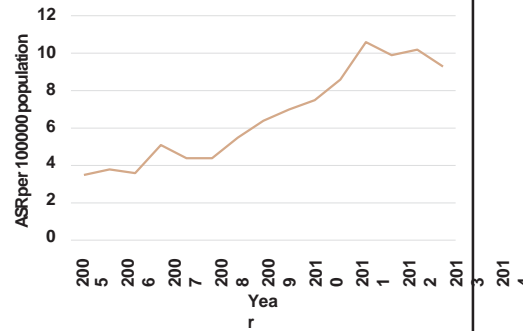
Prostate cancer

There were 1008 prostate cancer patients in 2019. Usually, the diagnosis is good if diagnosed early.

Slide
25

Current trend

ASR of prostate cancers in Sri Lanka, 2005-2019



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Current trend

Prostate cancer incidence trend is increasing in Sri Lanka.

Slide
26

Risk Factors

- Age – Increases with age
- Family history (25%)
- Race/ethnicity
- Genetic factors

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Risk Factors

While there is no single cause for development of prostate cancer, several risk factors have been identified. List the risk factors of prostate cancer


- Age – Increases with age
- Family history (25%)
- Race/ethnicity
- Genetic factors

Slide
27

Clinic presentation



- Early stage – No signs and symptoms
 - Weak / interrupted flow of urine
 - Sudden urge to urinate
 - Increase frequency
 - Hesitancy (difficulty in starting urination)
 - Inadequate emptying of the bladder
 - Pain or burning during urination
 - Blood in the urine
- * common conditions like benign prostatic hyperplasia shows similar signs and symptoms

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Slide 28

Diagnosis



No recommended screening programme in Sri Lanka

- History / Physical Examination
- Prostate specific antigens (PSA)
- Digital examination of rectum (DER)
- Transrectal ultrasound scan
- Prostate biopsy

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Clinical presentation

Discuss the clinical features of prostate cancer

Early stage – No signs and symptoms

- Weak / interrupted flow of urine
 - Sudden urge to urinate
 - Increase frequency
 - Hesitancy (difficulty in starting urination)
 - Inadequate emptying of the bladder
 - Pain or burning during urination
 - Blood in the urine
- * common conditions like benign prostatic hyperplasia shows similar signs and symptoms

Diagnosis

Give a simple description about the available methods for diagnosis

- History / Physical Examination
- Prostate specific antigens (PSA)
- Digital examination of rectum (DER)
- Transrectal ultrasound scan
- Prostate biopsy

Slide
29

What can primary health care staff do?

- Identify individual with
 - Risk factors
 - Clinical features
- Refer them early to
 - Surgical clinics
 - GU clinics
 - Cancer early detection centers



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What can primary health care staff do?

Discuss with the audience

1. How to identify high risk individuals based on risk factors and clinical features.
2. Identify the clinics/centers in local setting to refer this type of people

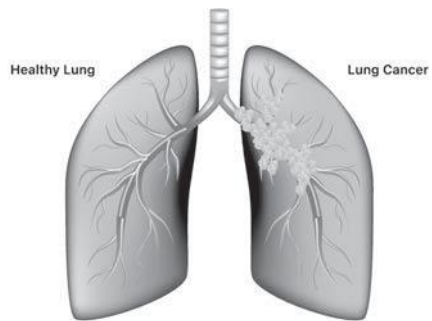
Slide 30

Lung Cancer



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Lung Cancer

Lung cancer is one of the deadliest cancers in the world.

Slide
31

Lung Cancer



- Most common cause of cancer related death in the world
 - In 2020, 2.2 million deaths
 - 60% were in less developed regions
- 1264 male and 464 female lung cancer patients were diagnosed in 2019
- Usually, the prognosis is poor

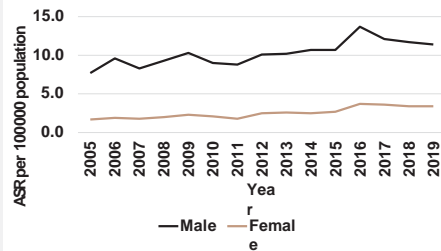
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Slide
32

Current trend



ASR of trachea, lung and bronchus cancers in Sri Lanka -2005-2019



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Lung Cancer

In Sri Lanka, lung cancer is the 2nd commonest cancer among males. In 2019, 1264 male and 464 female lung cancer patients were diagnosed. Usually, the prognosis is poor

Current trend

The incidence trend is increasing in Sri Lanka

Slide
33

Risk Factors

- Tobacco smoking - major cause

**80% of lung cancer deaths are due to smoking/second hand smoking

- Indoor air pollution
- Occupational exposures
- Dust and fibers
- Radiation

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Risk Factors

Factors associated with an increased risk of lung cancer can be categorized as personal habits, some occupational exposures, exposure to dust, fibers, radiation and some metals etc..

Tobacco smoking is a major cause of lung cancers. Approximately, 80% of the lung cancer deaths worldwide are due to smoking. Secondhand smoking also can cause lung cancer

Slide 34

Clinical Presentation

Signs and symptoms differ with stage

- Primary lesion in the lung
 - Cough getting worse
 - Chest pain
 - Shortness of breath
 - Wheezing
 - Hematemesis
- Intrathoracic spread
 - Hoarseness due to nerve compression
 - Horner's syndrome

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Clinical Presentation

Clinical presentation. Signs and symptoms are related to the site:


- Primary lesion in the lung : progressively worsening cough, chest pain, short of breath, wheezing, haemoptysis
- Intra thoracic spread (through the chest area) : hoarseness (due to nerve palsy), Horner syndrome (small pupil, drooping eye lid, lack of sweating)
- Distant metastasis
- Paraneoplastic syndrome

Slide
35

Clinic Presentation ctd



- Distant metastasis
 - Tiredness
 - Weight loss
 - Bone pain
 - Enlarged LN
 - Headache
 - Fits
 - Confusion
 - Paraneoplastic syndrome

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Slide 36

Diagnosis



- History and Physical Examination
- Chest X ray / CT scan
- Bronchoscopy
- Biopsy

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Clinical Presentation ctd

Clinical features of distant metastasis (brain, liver, bone etc..) – tiredness, unintentional weight loss, bone pain, enlarged lymph nodes, headache, seizures, confusion, Paraneoplastic syndrome.

Diagnosis

Give description the available methods for diagnosis of lung cancer

- History and Physical Examination
- Chest X ray / CT scan
- Bronchoscopy
- Biopsy

Slide
37

What can primary health care staff do?

- Identify individual with
 - risk factors
 - Clinical features
- Refer them early to
 - Surgical clinics
 - Cancer early detection centers



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What can primary health care staff do?

Discuss with the audience

1. How to identify high risk individuals based on risk factors and clinical features.
2. Identify the clinics/ Centers in local setting to refer this kind of persons



Module 5: Oral cancer

Learning objectives

Identify people/ population groups who are at risk for oral cancer

Direct them for habit cessation/ necessary counselling sessions

Identify oral cancers and oral potentially malignant lesions through inspection of oral cavity

Use the referral pathway to refer patients with abnormalities to the dental surgeon

Oral cancer is the leading cancer among males. This module covers all important aspects of oral cancer including information on incidence, risk factors, clinical features, and preventive and early detection strategies. Other than the presentation a video clip on self mouth examination has been provided. NCCP recommends conducting pre and posttests to assess the effectiveness of the programme.

Sample test questions have been provided with the other resources or can be downloaded from the NCCP website.

Slide
01

Prevention and early detection of Oral Cancer (Lip, Tongue, mouth) & Oral Potentially Malignant Disorders (OPMD)



National Cancer Control programme
Ministry of Health



National Cancer Control Programme

1

Prevention and early detection of Oral Cancer (Lip, Tongue, mouth) & Oral Potentially Malignant Disorders (OPMD)

Summarize the objectives of this presentation.

Slide 02

Burden of Oral Cancer Global Situation



- Common in South Asian and Pacific region.
- Incidence of OC in Asia > 60%
- Mortality due to OC in Asia > 70%

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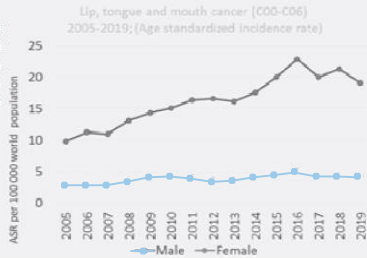
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Burden of Oral Cancer: Global Situation

Oral cancer is common in South Asian and Pacific region. Incidence of oral cancer in Asia is more than 60% Mortality due to oral cancer in Asia is more than 70%

Slide 03

Burden of oral cancer Sri Lankan Situation



- There is a rising trend over the years
- 2700 cases were reported in 2019
- Around 06-07 cases are reported per day
- Around 2-3 deaths occur per day
- Commonest cancer among males
- 8th most common cancer among females
- Male: Female = 4:1
- Approximately 60% of OC are detected at stage III & IV

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Burden of oral cancer: Sri Lankan Situation

There is a rising trend over the years .2700 cases were reported in 2019. Around 06-07 cases are reported per day. Around 2-3 deaths occur per day. Commonest cancer among males. 8th commonest cancer among females. Male to Female ratio is = 4:1. About 60% of OC are detected at stage III & IV.

Slide 04

Oral cancer A preventable cancer

- ★ Most cases are associated with risk habits
- ★ Most cases have a clearly detectable precancerous stage – Oral Potentially malignant disorders (OPMD)



ORAL CANCER FREE

National cancer Control Programme

Oral cancer A preventable cancer

Oral cancer is a preventable cancer. Most cases are associated with risk habits which can be reduced through promoting healthy lifestyle. On the other hand most cases have a clearly detectable precancerous stage namely Oral Potentially Malignant Disorders (OPMD) which can be detected early.

Risk factors for oral cancer and Oral Potentially Malignant Disorders (OPMD)

- Higher the frequency/amount of risk habits, greater the risk of oral cancer
- Combined use of risk factors increases the risk for oral cancer

Major Modifiable risk factors (>90% of OC)

1. Use of Tobacco
 - o Smokeless tobacco
 - o Betel chewing
 - o Tobacco chewing
 - o Tobacco smoking
2. Use of Areca-nut
 - o With betel quid
 - o Commercial areca-nut preparations
3. Alcohol consumption

Risk factors for oral cancer and Oral Potentially Malignant Disorders (OPMD)

Ask the audience to list the common risk factors of oral cancer. Highlight that these risk factors are preventable

Major Modifiable risk factors (>90% of OC)

- Use of Tobacco
 - o Smokeless tobacco
 - Betel chewing
 - Tobacco chewing and other commercially prepared products.
 - o Tobacco smoking
- Use of Areca-nut
 - o With betel quid
 - o Commercial areca-nut preparations
- Alcohol consumption

Risk factors for oral cancer and OPMD

• Other modifiable risk factors

4. Infections (HPV 16 & 18, HIV, some candida species)
5. Poor nutrition (Iron deficiency, Vitamin A, C, high fat diet)
6. Exposure to UV light (not common in SL)
7. Poor oral hygiene
8. Chronic irritation

• Non modifiable risk factors

9. Age
10. Ethnicity

Risk factors for oral cancer and OPMD

Other modifiable risk factors

- Infections (HPV 16 & 18, HIV, some candida species)
- Poor nutrition (Iron deficiency, Vitamin A & C, high fat diet)
- Exposure to UV light (not common in SL)
- Poor oral hygiene
- Chronic irritation

Non modifiable risk factors

- Age
- Ethnicity

Slide 07

Oral Potentially Malignant Disorders (OPMD)

A lesion or condition that has the risk of malignancy being present, either at the time of initial diagnosis or at a future date.

- Prevalence in Sri Lanka: approx. 2%.
- Prevalence is higher in People with risk habits
- Only a certain percentage of OPMD's undergo malignant transformation
- Early identification and proper management can prevent malignant transformation of OPMDs

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Oral Potentially Malignant Disorders (OPMD)

Oral Potentially Malignant Disorders (OPMD) includes a group of conditions which affect the oral cavity. These conditions have an increased risk of transforming into a malignancy compared to healthy mucosa. Malignant transformation of most OPMDs can be prevented by early identification and proper management.

Slide 08

Oral Potentially Malignant Disorders (OPMD)

Usually symptomless, can only be identified through visual examination and palpation

How do they present in the mouth

- Colour variations - White, Red, and Mixed white and red patches
 - Surface changes - Plaques, smooth, corrugated, verrucous, granular, atrophic
 - In variable sizes
 - Can involve any anatomical site in the oral cavity
 - May be uni- or multifocal
- Malignant transformation depend on the type of lesion, site, intensity of risk habits etc.

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Oral Potentially Malignant Disorders

Usually symptomless, can only be identified through visual examination and palpation. They can be presented as White, Red, and Mixed white and red patches. OPMDs can be identified with type of topographic features appear plaques, smooth, corrugated, verrucous, granular or atrophic. They can be in variable sizes and can involve any anatomical site in the oral cavity. There may be single or multiple lesions. Malignant transformation of these lesions depend on the type of lesion, site, intensity of risk habits etc

Slide 09

Types of OPMD Common types

- Leukoplaki
a
- Erythroplakia
- Oral Submucous Fibrosis
- Oral Lichen Planus

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Types of OPMD

There are several types of OPMDs.

- Leukoplakia
- Erythroplakia
- Oral Submucous Fibrosis
- Oral Lichen Planus

Slide 10

Leukoplakia

A white patch or plaque that cannot be wiped off.



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Leukoplakia

Leukoplakia is the most common OPMD compared to other conditions which is a persistent white patch in the buccal mucosa or any other area of the mouth. It occurs usually adjacent to the place where betel quid is kept. It is unable to remove by rubbing. Surface of the lesion could be smooth and homogeneous, fissured, corrugated, verrucoid, nodular or specked

Slide
11

Erythroplakia

A bright red velvety plaque or patch that cannot be characterised by clinically or pathologically as any other condition.

High chance of malignant transformation



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Erythroplakia

Erythroplakia appeared as a red velvety patch or plaque which is not associated with trauma or inflammation. May present with or without leukoplakia which has a higher probability of transforming to a malignancy compared to other types of OPMD

Slide
12

Oral Lichen Planus

A chronic inflammatory condition affecting mucous membranes that have a tendency to undergo malignant transformation.

Types – Reticular, plaque, erosive, atrophic, bullous etc.



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Oral Lichen Planus

A chronic inflammatory condition affecting mucous membranes that have a tendency to undergo malignant transformation.

Types – Reticular, plaque, erosive, atrophic, bullous etc.

Slide
13

Oral Sub-mucous Fibrosis (OSF)



A chronic debilitating disease of the oral cavity characterized by inflammation and progressive fibrosis of the sub-mucosal tissues

- Occurs due to use of areca-nut
- Increasing prevalence over last two decades
- High potential for malignant transformation
- Progression can be prevented by detecting at very early stages
- Late stage detection – cannot be reversed even with treatment

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Oral submucous fibrosis (OSF)

Oral submucous fibrosis (OSF) is characterized by reduce mouth opening, burning sensation, difficulty (Limited) in opening mouth. Whitish appearance due to the presence of non-elastic fibrous bands. May be having dysphagia too and has high potential for malignant transformation. At late stages it can not be reversed even with treatment.

Slide
14

Oral Sub-mucous Fibrosis



Unusual pallor of the mouth

(Early stage)



Restricted opening of the mouth

(Late stage)

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Oral Sub-mucous Fibrosis

Let audience to identify the clinical features.

Slide 15

Symptoms and signs of Oral sub mucous fibrosis

Early stages

- Burning sensation on eating spicy food
- Blanching of the mucosa
- Leathery appearance
- Recurrent ulceration
- Taste disturbances
- Widespread whiteness - particularly vermillion border

****Commonly misdiagnosed as anaemia.**

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Symptoms and signs of Oral sub mucous fibrosis at early stages

- Burning sensation on eating spicy food
- Blanching of the mucosa
- Leathery appearance
- Recurrent ulceration
- Taste disturbances
- Widespread whiteness - particularly vermillion border

This can be commonly misdiagnosed as anaemia.

Slide 16

Symptoms and signs of Oral sub mucous fibrosis

Late stages

- Palpable fibrous bands in lips, cheek.
- De-papillation of the tongue and restricted movements. Difficulty in swallowing
- Tightness of lips with lack of elasticity/ inability to blow or whistle
- **Restricted mouth opening. (less than 3 fingers / < 40mm)**



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Symptoms and signs of Oral sub mucous fibrosis at late stages

- Palpable fibrous bands in lips, cheek.
- De-papillation of the tongue and restricted movements. Difficulty in swallowing
- Tightness of lips with lack of elasticity/ inability to blow or whistle
- Restricted mouth opening. (less than 3 fingers / < 40mm)

Slide

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OPMD/Oral Cancer detection Important things to remember

- Most lesions are small and faintly visible
- Requires:
 - Systematic examination – inspection and palpation
 - Need to retract lips, cheek and tongue to see all parts of the mouth
 - Good illumination
 - Trained examiner



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OPMD/Oral Cancer detection Important things to remember

Important things to remember OPMD detection

Most lesions are small and faintly visible. Therefore following requirements should be available to diagnose OPMD properly (Let participants to observe and identify lesions)

- Systematic examination
- Good illumination
- Trained examiner
- Need to retract lips, cheek and tongue to see all parts of the mouth

Slide

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Oral Cancer



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18

Oral Cancer

Explain that if the above premalignant lesions were missed or ignored they can be transformed into a cancer.

Slide
19

Symptoms of oral cancer

- ❖ Non healing ulcer for more than 2 weeks
- ❖ Unexplained persistent lump/growth in the mouth
- ❖ Unusual mobility of the teeth
- ❖ Difficulty in swallowing, chewing, or moving tongue
- ❖ Persistent feeling that something is caught in the mouth/throat
- ❖ Numbness of the tongue or other areas of the mouth



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Symptoms of oral cancer

Discuss the important clinical features of oral cancer. Highlight that we should not wait till these signs to appear.

- Non healing ulcer for more than 2 weeks
- Unexplained persistent lump/growth in the mouth
- Unusual mobility of the teeth
- Difficulty in swallowing, chewing, or moving tongue
- Persistent feeling that something is caught in the mouth/throat
- Numbness of the tongue or other areas of the mouth

Slide 20

Symptoms of oral cancer cont..

- ❖ Unhealed tooth extraction site for more than a month
- ❖ Chronic swelling of the lymph nodes/lump in the neck
- ❖ Voice changes in recent onset
- ❖ Trismus/difficulty in mouth opening



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Symptoms of oral cancer cont..

Other symptoms

- Unhealed tooth extraction site for more than a month
- Chronic swelling of the lymph nodes/lump in the neck
- Voice changes in recent onset
- Trismus/difficulty in mouth opening

Prevention and control of OPMD and OC

1. Risk factor control

- ★ Enact regulations on risk factors
- ★ Community awareness
- ★ Screening people for risk factors and counselling

2. Early detection of OPMD and oral cancer

- ★ Self-mouth examination
- ★ Opportunistic screening of patients
- ★ Population-based screening
- ★ Targeted screening of high risk groups

3. Treatment of OPMD & oral cancer including palliative care

Prevention and control of OPMD and OC

Prevention and control of OPMD and OC consist of several strategies

- Risk factor control
 - o Enact regulations on risk factors
 - o Community awareness
 - o Screening people for risk factors and counselling
- Early detection of OPMD and oral cancer
 - o Self-mouth examination
 - o Opportunistic screening of patients
 - o Population-based screening
 - o Targeted screening of high risk groups
- Treatment of oral cancer including palliative care

Risk factor control Enact regulations on risk factors (tobacco and alcohol)

tobacco and areca

NATA Act 2006 - tobacco and alcohol regulations

Ban on smokeless tobacco products
(Manufacture, import, sell) Gazette Extraordinary No.1982/33 dated 01/09/2016

Ban on spitting on public roads.
Section 73(3) of the National thoroughfares act of the Road Act (number 40 of 2008)

Ban on the use of betel and

nut products in healthcare facilities.
General Circular No.01-14/2018 dated 20.03.2018 Ministry of Health

Ban on the use of betel, tobacco and areca nut products in State Institutions.
Public Administration circular No. 11/2019 dated 06/05/2019

Enact regulations on risk factors (tobacco and alcohol)

Enactment of regulations on tobacco and alcohol is a one strategy for risk factor control. Primary health care staff should have a clear awareness about these acts and regulations.

- NATA Act 2006 - tobacco and alcohol regulations.
- Ban on smokeless tobacco products (Manufacture, import, sell) Gazette Extraordinary No.1982/33 dated 01/09/2016
- Ban on spitting on public roads. Section 73(3) of the National thoroughfares act of the Road Act (number 40 of 2008)
- Ban on the use of betel and tobacco and areca nut products in healthcare facilities. General Circular No.01-14/2018 dated 20.03.2018 Ministry of Health
- Ban on the use of betel, tobacco and areca nut products in State Institutions. Public Administration circular No. 11/2019 dated 06/05/2019

Slide
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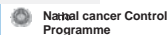
Risk factor control Community awareness

★ Adults: (High risk groups, teachers, parents, etc)

Discourage habits by breaking myths
Risk factor reduction (risk modification)
Warn early signs and symptoms
Encourage oral screening

★ Children

Prevent bad habit formation
Break myths
Be vigilant about children (parents)



Community awareness

Community awareness is the other strategy for risk reduction. Following factors should be considered when planning such interventions

Adults: (High risk groups, teachers, parents, etc)

- Risk factor reduction (risk modification)
- Warn early signs and symptoms
- Encourage oral screening

Children

- Prevent bad habit formation
- Break myths
- Be vigilant about children (parents)

Slide
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Risk factor control Breaking myths on betel chewing

Common misconceptions associated with risk factors:

- Reduced sleepiness
- Energize/improved concentration
- Reduced loneliness
- Maintaining company with others
- Counteract unpleasant smell/taste/cold
- Freshness in mouth

WRONG!



Breaking myths on betel chewing

When addressing smoking and betel chewing following myths should be addressed properly.

Some have wrong beliefs that these products can

- Reduce Sleepiness
- Energize/improved concentration
- Reduce loneliness
- Maintaining company with others
- Counteract unpleasant smell/taste/cold
- Freshness in mouth

Slide
25

Risk factor control

Screening for risk factors and counselling


To identify risk groups

- Betel chewers
- Smokers tobacco and alcohol consumers
- Smokeless tobacco users & areca-nut products users

Refer identified risk-people for

- Risk-factor counselling
- Oral screening using the referral form

Ensure their referrals and follow-up visits

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Screening for risk factors and counselling

Identification and referring people with risk factors is also important.

Identify risk groups

- Betel chewers
- Smokers tobacco and alcohol consumers
- Smokeless tobacco users & areca-nut products

users Refer identified risk-people for

- Risk-factor counselling
- Oral screening using the referral form

Ensure their referrals and follow-up visits

Slide
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Early detection of OPMD and Oral Cancer

Self-mouth examination

- Main purpose: To identify any lesions in the mouth; not necessarily OPMD
- Need to perform at least once a month
- Need to go for dental check-up if any abnormality detected
- People with risk behaviors- need professional screening once a year

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Self-mouth examination

Self-mouth examination has been identified as an important strategy for early detection of OPMD and Oral Cancer. Use the video clip on self-mouth examination to demonstrate the procedure.

- Main purpose: To identify any lesions in the mouth; not necessarily OPMD
- Need to perform at least once a month
- Need to go for dental check-up if any abnormality detected
- People with risk behaviors- need professional screening once a year

Slide 27

Self-mouth examination – what to look for

Abnormal sensation	→	<ul style="list-style-type: none">• Burning sensation• Inability to take spicy
Patches	→	<ul style="list-style-type: none">• White, red or White/red mixed patch that cannot be wiped away
Change in mucosal texture	→	<ul style="list-style-type: none">• Feel rough or slight elevation on palpation
Restrictions	→	<ul style="list-style-type: none">• Restriction of mouth opening & tongue
Growths	→	<ul style="list-style-type: none">• Abnormal growth, lumps or
Ulcers	→	<ul style="list-style-type: none">• Non healing ulcer for more than 2 weeks
Generalized colour changes	→	<ul style="list-style-type: none">• Unusual whitish appearance of the oral mucosa, tongue or palate

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Self-mouth examination – what to look for

Highlight following factors to look for when performing Self-mouth examination

- Abnormal sensation:
 - o Burning sensation
 - o Inability to take spicy foods
- Patches: White, red or White/red mixed patch that cannot be wiped away
- Change in mucosal texture: Feel rough or slight elevation on palpation
- Restrictions: Restriction of mouth opening & tongue movements
- Growths: Abnormal growth, lumps or nodules
- Ulcers: Non healing ulcer for more than 2 weeks
- Generalized colour changes: Unusual whitish appearance of the oral mucosa, tongue or palate

Slide 28

Self-mouth examination



Practical session will be conducted assisted with a video clip

Separate video is available
Visit: nccp.health.gov.lk

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Self-mouth examination

Use the video clip on self-mouth examination to demonstrate the procedure, at the end of the presentation.

Slide
29

Early detection of OPMD and
Oral Cancer

Screening and appropriate referral

- Services available for screening
 - o Dental clinics
 - o Medical OPD
- Special attention:
 - Recent history of burning sensation/Inability to take spicy foods
 - High-risk groups
- **If any suspected lesion is identified, promptly refer to above mentioned clinical seGng**

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Screening and appropriate referral

Screening for early detection of OPMD and oral cancer is a effective strategy

Services available for screening:-

- HLC (around 1000 distributed island wide)
- Dental clinics
- Medical OPD

Special attention should be paid if the client complains about recent history of burning sensation/Inability to take spicy foods and to high- risk groups

If any suspected lesion is identified, promptly refer to above

Slide 30

Early detection of OPMD
and Oral Cancer

Targeted screening for inaccessible risk groups

- Organize, and support screening programme for inaccessible risk groups through mobiles
- Identified high-risk groups:
 - o Farmers
 - o Drivers (Three wheeler, Bus/Van)
 - o Labourers, plantation workers
 - o Fishermen
- Ensure screening at least once in 3 years
- Ensure OMF/Oncology referrals

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Targeted screening for inaccessible risk groups

Organize, and support screening programme for inaccessible risk groups through mobiles

- Identified high-risk groups:
 - o Farmers
 - o Drivers (Three-wheeler, Bus/Van)
 - o Labourers, plantation workers
 - o Fishermen
- Ensure screening at least once in 3 years
- Ensure OMF/Oncology referrals if required.

Role of public health staff

- Promote OC prevention programmes at PHM and PHI level
- Identify high risk individuals (people with risk factors) for OPMD/OC during field visits and refer them to dental surgeon using the referral form.
- Educate the public on the importance of habit intervention and self mouth examination
- Assist in following up of patients diagnosed with oral cancer
- Follow general circular 54/2018 issued by Ministry of Health for details

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Role of public health staff

Discuss the following to get a clear idea about the Role of Public health staff on oral cancer prevention and control.

- Promote OC prevention programmes at PHM and PHI level
- Identify high risk individuals (people with risk factors) for OPMD/ OC during field visits and refer them to DS using the referral form.
- Priority for oral cancer screening to be given from 10.30 a.m. to 11.30 a.m. on week days at dental clinics
- Educate the public on the importance of habit intervention and self mouth examination
- Assist in following up of patients diagnosed with oral cancer
- Follow general circular 54/2018 issued by Ministry of Health for details

Self-mouth examination

Checking one's own mouth at least once a month for any abnormalities. Upon suspicion, visiting nearest dental surgeon to undergo clinical oral examination.

Areas to check during Self-mouth examination

- Upper and lower lip
- Inside the cheek – left and right
- Palate and throat
- Tongue – surfaces, sides, bottom
- Gum – all sides
- The floor of the mouth

How should self-mouth examination be conducted?

- Wash your hands thoroughly.
- If dentures are worn, remove dentures or any appliance worn
- Rinse and clean your mouth thoroughly.
- Go in front of a mirror
- Let the light fall well into the mouth
- Open the mouth, retract oral tissues and examine every spot

The first step

Turn over the upper and lower lips using your fingers and examine the inside and near gums of the lips



The second step

Open the mouth wide retract cheek mucosa and examine the inside of the cheek, the side walls of the mouth and the proximal gums



The third step

Open your mouth wide and examine palate and throat



The fourth step

Turn the tongue up and examine the underside of the tongue, the bottom of the mouth and proximal gums.



The fifth step

Hold the tip of the tongue with a sterile piece of gauze or cloth and examine each side (surface, sides and bottom) starting from the tip then moving inwards.





Module 6: Palliative Care

Learning objectives

Define palliative care

Explain the principles of palliative care .

Explain the interdisciplinary team approach in palliative care

Palliative care is an approach that improves the quality of life of patients and their families. It prevents and relieves the suffering by Early identification and impeccable assessment and treatment of pain. Palliative care provides physical, psychosocial and spiritual support. Primary care health staff should have a clear understanding about providing palliative care. NCCP recommends conducting pre and posttests to assess the effectiveness of the programme. Sample test questions have been provided with the other resources or can be downloaded from the NCCP website.

Slide
01

Palliative Care in Primary Healthcare



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programme Ministry of
Health



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Palliative Care in Primary Healthcare

In this module it is expected to discuss about the basic concepts of palliative care.

Slide 02

What is palliative care?

Palliative care
An approach that **improves the quality of life of patients and their families**

For patients who are facing the problems associated with **life-threatening illness**
Prevents and relieves the suffering by **Early identification and impeccable assessment and treatment** of pain

Provides physical, psychosocial and spiritual support



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What is palliative care?

Palliative care is caring of patients with life-limiting illnesses, relieving their suffering and supporting them and their families. It provides comfort rather than cure with a multidisciplinary team approach with a aim of not adding days to life but adds a comfortable life to the days.

World Health Organization defines palliative care as “ an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”

Slide 03

Are palliative care and end of life care same?

- There is a misconception that palliative care is only for caring someone in the last few days of his life.
- Palliative care is about relieving suffering and improving quality of life right from the time when a person is diagnosed that he has a life-threatening illness.
- The aim of palliative care is not to lengthen – or shorten – life but to improve quality of life so that the time remaining, be it days, or months, or years, can be as peaceful and fruitful as possible.

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Are palliative care and end of life care same?

There is a misconception that palliative care is only for caring someone in the last few days of his life. Palliative care is about relieving suffering and improving quality of life right from the time when a person is diagnosed that he has a life-threatening illness.

The aim of palliative care is not to lengthen – or shorten – life but to improve quality of life so that the time remaining, be it days, or months, or years, can be as peaceful and fruitful as possible.

Slide 04

End of life care

- End of life care is support for a patient who is in last months of his life.
- End of life care can be provided at home, hospice, hospital according to patient needs and preferences.
- The support should also be provided to family, caregivers etc during this period.

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End of life care

End of life care is support for a patient who is in last months of his life. It should be provided according to patient wishes and preferences and need to plan the care according to those. End of life care can be provided at home, hospice, hospital according to patient needs and preferences. It should help the patient die with dignity- and peacefully. The support should also be provided to family, caregivers etc during this period.

Slide 05

Palliative care is appropriate at any age and at any stage in the illness, and it can be provided along with curative treatment.



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Palliative care is appropriate at any age and at any stage in the illness, and it can be provided along with curative treatment.

Palliative care begins at the point of diagnosis, continuous throughout the rest of patient journey /and extends beyond death into bereavement care.

Slide 06

Why do we need palliative care?



Worldwide

- It is estimated that around 40 million people require palliative care each year. ;
- 78% of them live in low- and middle- income countries.
- only about 14% receive it Sri Lanka

The need for palliative care is increasing due to

- Increasing prevalence of NCD including cancer
- Aging of population

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Why do we need palliative care?

It is estimated that worldwide around 40 million people require palliative care each year. ; 78% of them people live in low- and middle-income countries. Worldwide, only about 14% of people who need palliative care currently receive it.

The need of palliative care in Sri Lanka also continues to grow due to increasing prevalence of non communicable diseases and ageing population. Data shows that about 75% deaths occurred due to chronic non communicable diseases.

Slide 07

Who needs palliative care?

Disease among adults	Diseases among children
Cardiovascular diseases	Congenital anomalies
Cancer	Neonatal conditions
Chronic respiratory diseases	Protein energy malnutrition (severe)
AIDS	Meningitis
Diabetes	HIV/AIDS
Chronic kidney disease	Cardio vascular diseases
Chronic liver disease	Endocrine, blood and immune disorders (5.8%)
Dementia	Cancer (5.6%)
Chronic neurological diseases	Neurological conditions
Congenital anomalies	Kidney diseases
Drug resistant tuberculosis	Cirrhosis of the liver

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Who needs palliative care?

Palliative care can help patients with many different life threatening illnesses: eg: cancer, heart failure, end-stage lung disease, renal failure ,liver failure , progressive neurological illness ,dementia, end stage diabetes ,other life-limiting illnesses

Slide 08

What is holistic approach in palliative care ?

Four domains:

Physical – symptoms (complaints), eg pain, breathlessness, tiredness, vomiting, wounds etc

Psychological – worries, fears, anger, suicidal ideations

Social – needs of the family, needs of children, issues related to work, housing, finance and relationships

Spiritual – questions of the meaning of life and death, the need to be at peace.

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What is holistic approach in palliative care?

Need to address all these issues that we are helping the whole person. This is called holistic care

The holistic approach addresses problems in four domains:

Physical – symptoms (complaints), eg pain, breathlessness, tiredness, vomiting etc

Psychological – worries, fears, sadness, anger ,suicidal ideations

Social – needs of the family, needs of children, issues related to work, housing, finance and relationships

Spiritual – questions of the meaning of life and death, the need to be at peace.

Slide 09

Who provides palliative care?

Multidisciplinary team of palliative care includes many members: health as well as non health.



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Who provides palliative care?

Multidisciplinary team of palliative care includes many members: health as well as non health.

Slide 10

Who provides palliative care in hospitals?

Hospital multidisciplinary team of palliative care includes many members

- Consultants
- Doctors
- Nurses
- Psychologists
- Counselors
- Physiotherapist
- Occupational therapists
- Nutritionists
- Social workers



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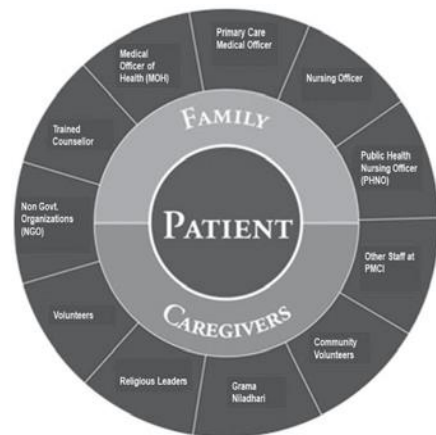
Who provides palliative care in hospitals?

Multidisciplinary team in the hospital includes,

- **Consultants**
- **Doctors**
- **Nurses**
- **Psychologists**
- **Counselors**
- **Physiotherapist**
- **Occupational therapists**
- **Nutritionists**
- **Social workers**

Slide 11

Multi-disciplinary team Palliative care at Primary Care/Community



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Multi-disciplinary team Palliative care at Primary Care/Community

Multidisciplinary team in primary care /community includes

The contribution of community palliative care services in coordination with primary and specialist care service providers is essential as the majority of palliative patients live the balance period of their life at their home. It should be provided with a multidisciplinary approach: e.g. officials attached to divisional secretariat office, community-based organizations, religious leaders etc.

Slide 12

What are the settings palliative care available?

Palliative care services are available in three settings. 3 'H'

Hospital

Hospice

Home

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What are the settings palliative care available?

Palliative care services are available in three settings. 3 'H' –

- (1) Hospital
- (2) Hospice
- (3) Home

Slide
13

Hospital palliative care

Hospital

Specialist palliative care: Tertiary & Secondary care hospitals with consultants (In-patient and outpatient care)

E.g. Palliative Care Consult Service at Apeksha Hospital, Maharagama.
Palliative care centre with inward facilities attached to a state hospital : Teaching Hospital Karapitiya

Primary health care institutions / OPD setting / Family Practice setting

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Hospital palliative care

Availability of Palliative Care

Services Hospital Care-

Specialist care is provided at major hospitals: treating specialist unit or through multidisciplinary approach. E.g. Palliative Care Consult Service at Apeksha Hospital, Maharagama. First palliative care centre with inward facilities attached to a state hospital was established at Teaching Hospital Karapitiya in 2020. At Primary Healthcare level, services are provided by health care teams at primary healthcare hospitals, General Practitioners.

Slide
14

Hospice care

Hospice care provides for people in the last phases of incurable disease so that they may live as fully and comfortably as possible

Organization	Address	Contact No
Sri Lanka Cancer Society	Shakti Seva Path, Colombo 10	2585879
Central Cancer Association	Chandana Senanayake Mawatha, Anuradhapura	2840312
Sri Lanka Cancer Association	Pathiraja Road, Anuradhapura	025 3243077
Sri Lanka Cancer Association	Pathiraja Road, Anuradhapura	04 2226766
Sri Lanka Cancer Association	Satya Seva Path, Colombo 10	036 2254902
Central Cancer Association	Pathiraja Road, Anuradhapura	02 2240258
East Sri Lanka Cancer Association (CANE)	Jaffna	02 2240258
East Coast Cancer Association (CCA)	Pathiraja Road, Anuradhapura	076 0582248
Palliative Care Association	Sahana Seva Path, Abagahapaya, Maharagama	077 3355187

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Hospice care

Hospice is a dedicated institute where supportive care is provided for the patients' emotional, social, and spiritual needs in addition to the care for the remaining physical symptoms following active disease specific treatment by an interdisciplinary team. There are seven hospices in Sri Lanka. These hospice services are provided by Non Governmental Organizations. The services are free of charge

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Community care

It should be provided with
primary health and health
professionals attached to divisional
targeted, community-based
organisations e.g. religious leaders etc.



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Community care

The contribution of community palliative care services in coordination with primary and specialist care service providers is essential as the majority of palliative patients live the balance period of their life at their home. It should be provided with a multidisciplinary approach: e.g. officials attached to divisional secretariat office, community-based organizations, religious leaders etc.

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Home based care

- Home based care is supported by trained community healthcare workers or volunteers.
- Public Health Nursing Officer (PHNO) who is attached to primary health care hospitals, is responsible in home visits and assess palliative care needs at the home setting.

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Home based care

Care at home:

A caregiver is a person who is caring for a palliative patient and helps to improve the patient's wellbeing. Caregiver can be a paid carer, family member or volunteer carer. Caring for a palliative patient is a demanding work, and caregiving without adequate knowledge, skills, support and self-care can cause harm to the patient

Home based care is supported by trained community healthcare workers or volunteers. Public Health Nursing Officer (PHNO) who is attached to primary health care hospitals, is responsible in home visits and assess palliative care needs at the home setting.

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It is a right of every person with a life-threatening illness to receive appropriate palliative care.

A responsibility of every health care professional to practice palliative care according to the need of the patient.


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palliative care

It is a right of every person with life-threatening illness to receive appropriate palliative care

A responsibility of every health care professional to practice palliative care according to the need of the patient.

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Palliative Care Programme
 Ministry of Health

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<https://www.health.gov.lk>
<https://www.facebook.com/CCPSL>

National Cancer Control Programme

Thank you

**Cancer Prevention & Early Detection Unit
The National Cancer Control Programme
Ministry of Health**

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