Speaker Presentation

Title: DEVELOPMENT OF CONSOLIDATED CANCER SCREENING GUIDELINE IN KENYA, 2018 – EXPERIENCES AND LESSONS

Author(s): Bor JP; Mbau L; Mwenda V, Gathitu E; Nyangasi M, Ng’ang’a A
Introduction/Background

• Cancer is a leading cause of death in Kenya - GLOBOCAN est.

<table>
<thead>
<tr>
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<th>2012</th>
<th>2018</th>
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<tbody>
<tr>
<td>Incidence</td>
<td>37,000</td>
<td>47,887</td>
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<tr>
<td>Mortality</td>
<td>28,500</td>
<td>32,987</td>
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• 45% rise

• Leading cancers
  - Incidence - Breast, cervix uteri, oesophagus, prostate, colorectal
  - Deaths - Oesophageal, cervical, breast

• Late diagnosis – approx 64% cancers diagnosed at stage III/IV
Introduction/Background

PILLAR 1
Prevention, Early Detection & Screening

Develop & implement national guidelines for cancer screening and early diagnosis including a referral and follow up mechanism

Objective:
• Standardize cancer screening
• Provide screening operational protocols
• Stream referral along the levels of care
• Improve treatment outcomes
Methodology

• Guideline development panel constituted by National Cancer Control Program (Ministry of Health)
• Composition – Multidisciplinary teams – including subject-matter experts
  - MOH
  - Academic institutions
  - Health research organizations
  - Civil society organizations
  - Cancer specialists
  - County departments of health representatives
Methodology

• Desktop review done: Aim - to identify available cancer screening guidelines (local and global) - especially in contexts similar to Kenya.
• Preliminary meeting - priority cancers identified & way forward agreed
• Zero drafts developed
• Workshop 1 - development of the first ‘Panoramic’ draft
• External review by relevant experts identified by teams, including various professional associations
Methodology

• Workshop 2 – Second ‘Enashipai’ draft developed –
  ❑ Input from reviewers incorporated & Contentious issues resolved
  ❑ Additional cancers – Oral & oesophageal included - due to high local burden
  ❑ Aligned to a standard agreed format
    (flow of ideas, user-friendliness & clarity)
• Validation – final inputs from the panel
• Endorsement by MOH
• Final step – publication & launch ….Dissemination to follow
Methodology

- Considerations in guideline formulation:
  - Current evidence - Relevant research publications
  - International best practice - Existing international guidelines
  - Guidance statements from cancer care organizations globally
  - Local context
  - Expert opinion/consensus - where there was paucity of evidence

- Guideline specifies:
  - Screening activities at each healthcare level
  - Roles of various healthcare providers
Results/Findings

- Desk review -
  - Africa - Existing guidelines were fragmented – each cancer addressed separately
  - Kenya - available cancer-specific guidelines were incomprehensive and outdated
- Preliminary meeting/workshops - Priority cancers identified for inclusion in the guideline:
  - Breast
  - Cervical
  - Colorectal
  - Prostate
  - Childhood - Retinoblastoma
  - Oral cancers
  - Oesophageal cancer
  - Tumour markers
Results/Findings –

MAIN RECOMMENDATIONS:

BREAST CANCER

• Breast health awareness promotion/education key in early detection
• Mammography - recommended mode of screening
• Magnetic resonance imaging (MRI) - in selected high-risk populations
• Breast Self-Examination (BSE), clinical breast examination (CBE) & ultrasound are NOT screening modalities but aid in early diagnosis
• Age to start screening + frequency - depend on risk stratification
Results/Findings

CERVICAL CANCER

• Target population - women 25 - 49 years
• Human papilloma virus (HPV) test recommended as primary method
• Visual inspection methods - where HPV testing facilities are not yet available;
• Pap smear in some specified circumstances
• Ideal - same day ‘screen & treat’ approach - cryotherapy and/or LEEP
Results/Findings

COLORECTAL CANCER

- Risk-stratified approach recommended
- Average risk – start at 45 years
  - Annual fecal occult blood test (FOBT)
  - OR Colonoscopy every 10 years
- High-risk groups – start earlier
  - Colonoscopy - every 5 or 10 years depending on risk
- Genetic testing for familial colorectal cancer
OESOPHAGEAL CANCER

• Goal - to detect precancerous lesions/early cancer

• Modality of choice - Endoscopy
  - White light endoscopy; Lugol’s chromoendoscopy; Narrow band imaging endoscopy

• Targeted screening for people:
  - With first degree relatives with oes. cancer
  - Living in ‘hot spot’ areas
  - History of head and neck SCC
  - History of caustic acid ingestion
ORAL CANCERS

• Opportunistic screening - All individuals at risk
  - History of tobacco use
  - +/- or exposure to any other risk factor
• Recommended methods – for screening/early diagnosis
  - Visual inspection
  - Imaging
  - Exfoliative cytology
  - Incisional biopsy
Results/Findings

PROSTATE CANCER

• No role for mass screening for prostate cancer.
• Highly-individualized decision between a client and caregiver
• Well-informed client - benefits and harms of screening.
• Targeted screening
  - Men aged ≥40 years of African descent
  - ≥ 55 years Caucasian or Asian origin
  - +ve family history of prostate cancer – start at 40 years
• PSA >4ng/ml – refer to urologist for further management
• Prostate cancer final diagnosis – histological (biopsy)
Results/Findings

CHILDHOOD CANCERS

- Most are not associated with lifestyle
- Mostly not amenable to screening - EXCEPT:
  - Retinoblastoma
  - Rare heritable conditions
- Emphasis on early detection - high potential for cure
- Screening recommended for:
  - Hereditary retinoblastoma
  - Certain genetic syndromes
  - Childhood cancer survivors
Results/Findings

TUMOUR MARKERS

• Most tumor markers have no role in cancer screening in the general population
• Very restricted use in early detection – For screening high risk individuals with strong family history/specific risk factors
  - PSA - prostate
  - CA 125 - ovarian cancers
Conclusions/Recommendations

- Guideline for Kenya developed through multi-stakeholder effort
  - Consolidated
  - Standardized
  - Evidence-based
  - Customized

To be used to streamline cancer screening activities
- Uniformity across the health sector
- Reduce cancer morbidity & mortality
- Reduce cancer treatment costs
- Enhance universal health coverage
Conclusions/Recommendations

• Scope of the guidelines – Early detection, including aspects of early diagnosis where relevant
• An individualized patient-centered approach advocated in implementing
• Patients’ rights – guidelines not a basis to deny services
• Strengthening of the referral systems important to ensure optimal service delivery
• Screening must be part of a comprehensive cancer control plan
• Effective dissemination of the guideline is important for full impact to be realized
Thank you...