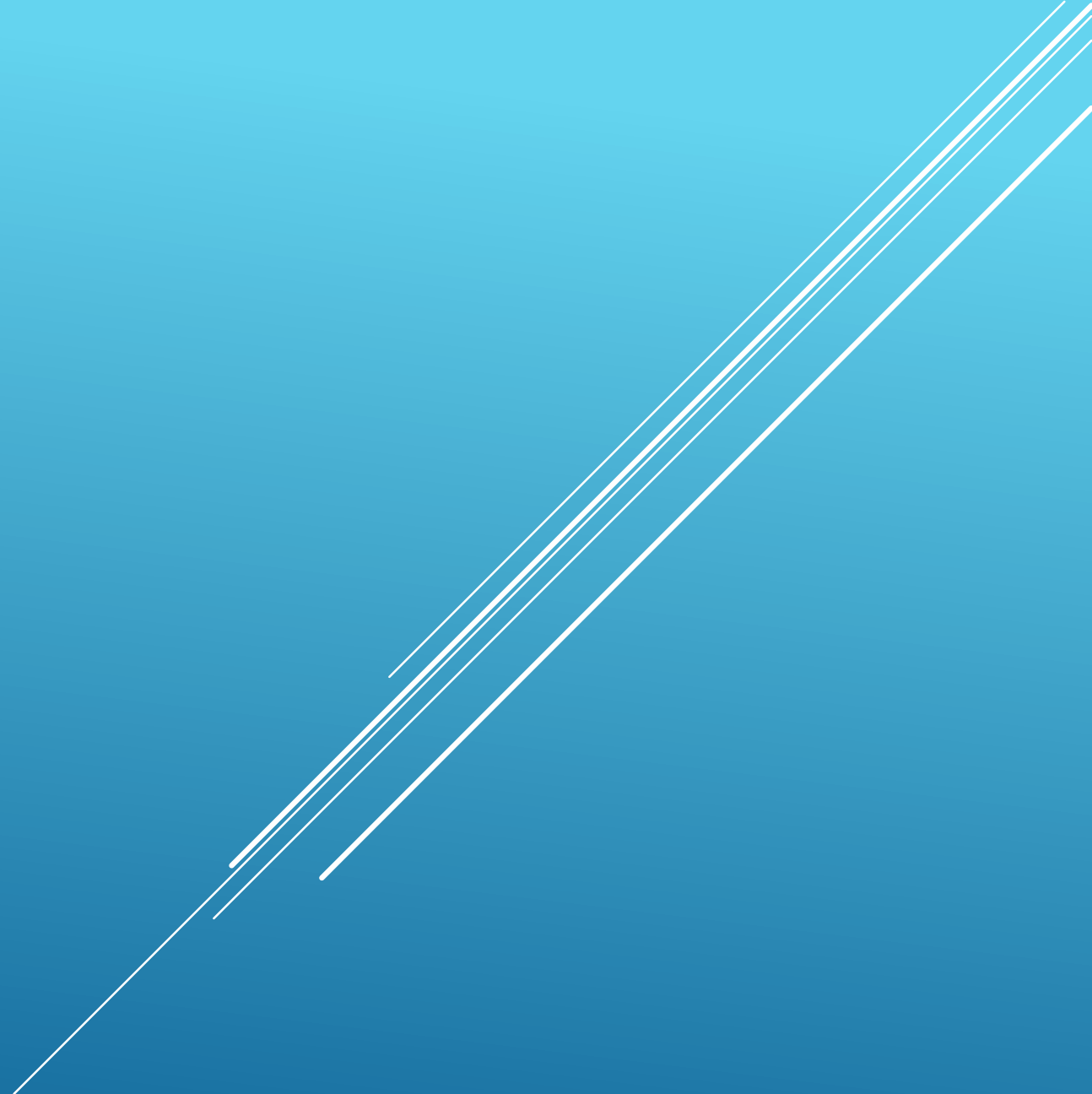


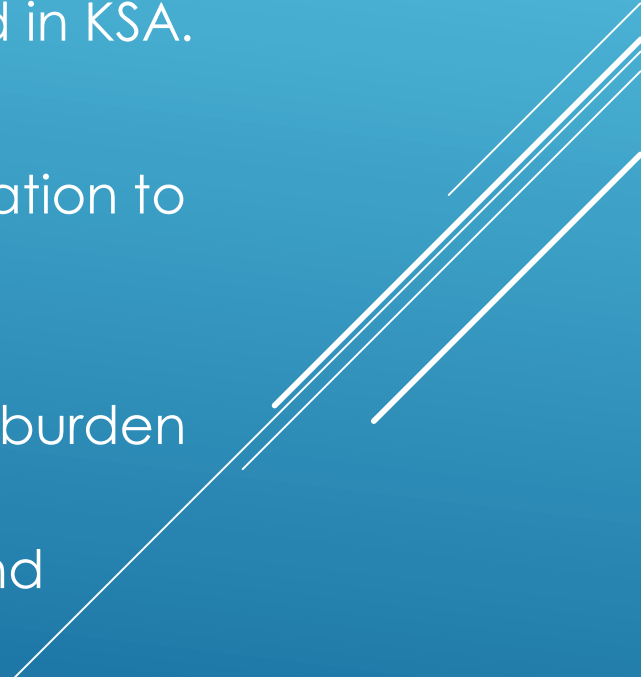
CANCER

By Dr. Haytham AlSaif

MBBS, MPH, SBFM, ABFM



OBJECTIVES

1. Appreciate the Global impact of cancer.
 2. Identify the most prevalent cancers worldwide, in the region and in KSA.
 3. Identify the leading causes of cancer deaths.
 4. Understand the cancer control continuum and explain its implication to public health.
 5. Screening for cancer.
 6. Understand and reflect the Kingdoms efforts to control the rising burden of Cancers in KSA.
 7. Explain important factors and trends affecting cancer control and directions for future research.
- 

Brain storming questions....

The image features a solid blue background with a gradient from light to dark. In the bottom right corner, there are several white, parallel diagonal lines of varying lengths, creating a sense of motion or a stylized graphic element.



True or False?

Large percentage of cancers
are preventable



True or False?

Preventing cancer is easier
than treating cancer



True or False?

Screening tests are
recommended for most
cancers

1-THE GLOBAL IMPACT OF CANCER

- ▶ the 2nd leading cause of death globally.
- ▶ In 2018, 18.1 million new cases and 9.6 million deaths.
- ▶ One in 5 men and one in 6 women develop cancer during their lifetime.
- ▶ One in 8 men and one in 11 women die from the cancer.

1-THE GLOBAL IMPACT OF CANCER

- ▶ The total annual economic cost of cancer in 2010 was estimated at approximately US\$ **1.16 trillion**.
- ▶ Late-stage presentation and inaccessible diagnosis and treatment are common.
- ▶ In 2017, only 26% of low-income countries reported having pathology services generally available in the public sector.
- ▶ More than 90% of high-income countries reported treatment services are available compared to less than 30% of low-income countries.

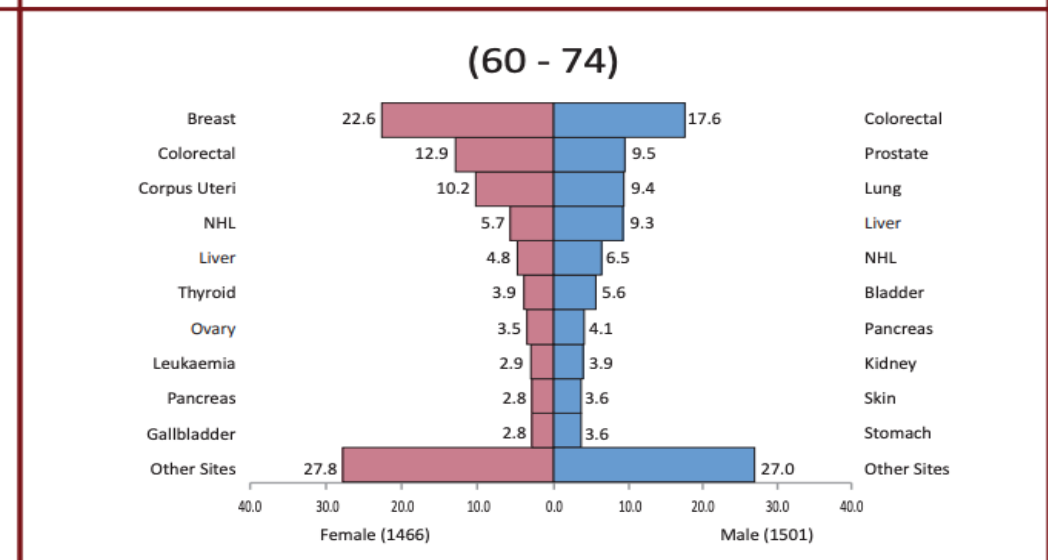
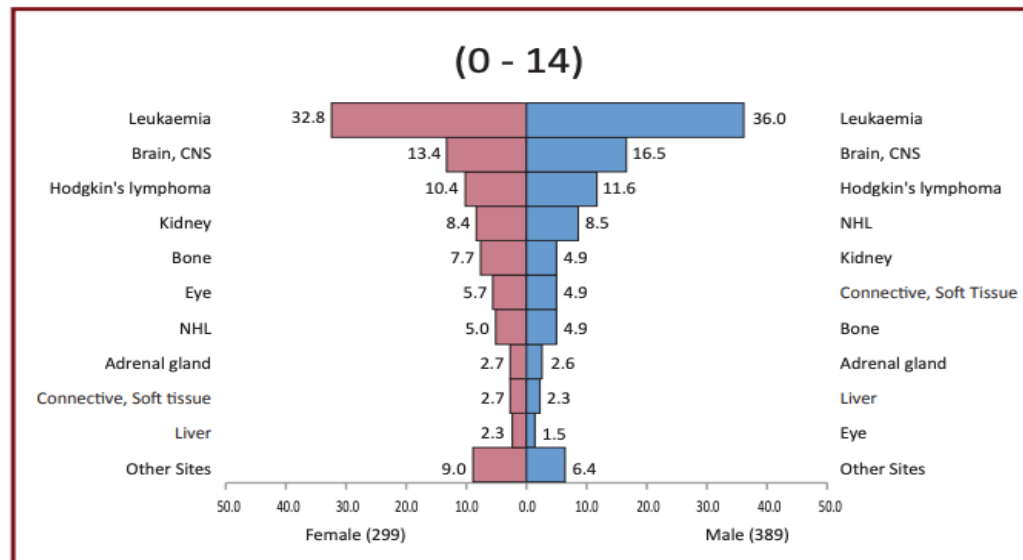
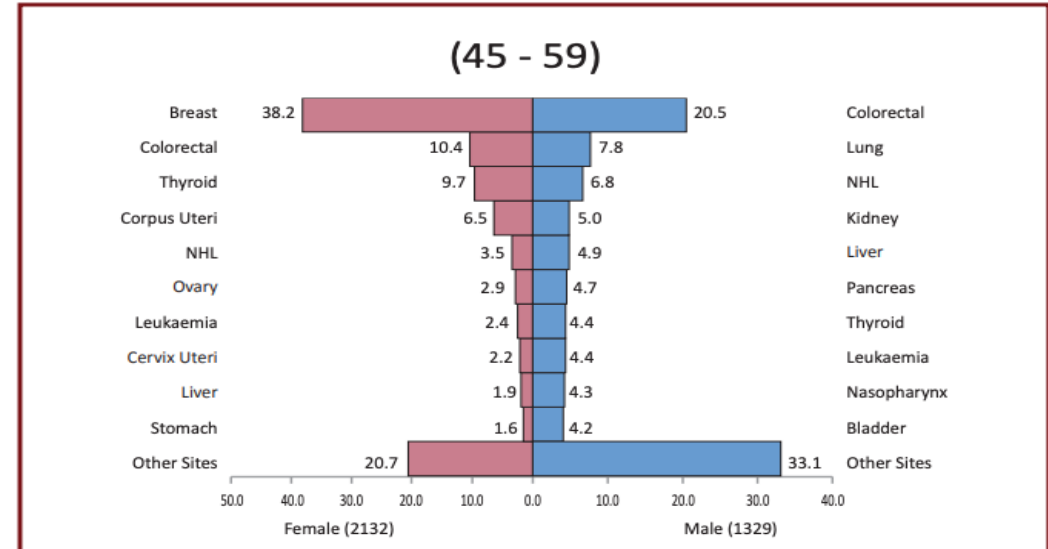
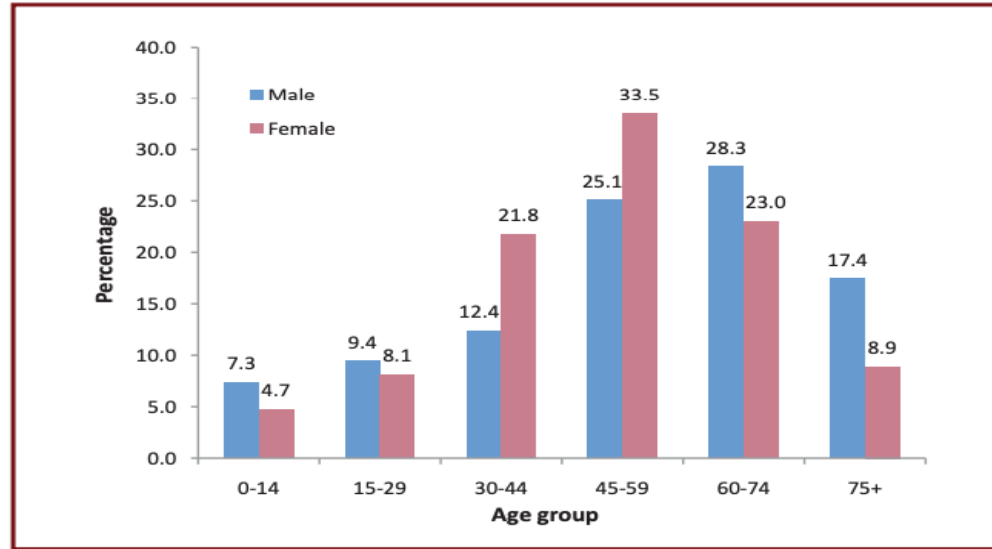
2-Identify the most prevalent cancers worldwide, in the region and in KSA.

3-Identify the leading causes of cancer deaths.

2-IDENTIFY THE MOST PREVALENT CANCERS WORLDWIDE, IN THE REGION AND IN KSA.

Region		World				Middle East and North Africa				Saudi Arabia			
Cause		Men		Women		Men		Women		Men		Women	
	Incidence	Mortality	Incidence	Mortality	Incidence	Mortality	Incidence	Mortality	Incidence	Mortality	Incidence	Mortality	
1st	Lung		Breast		Lung		Breast		Colorectal		Breast		
2nd	Prostate	Liver	Colorectal	lung	Prostate	Liver	Colorectal		Lymphomas, multiple myeloma		Colorectal		
3rd	Colorectal	Stomach	lung	Colorectal	Bladder	Prostate	Thyroid	Lung	Prostate	Lung	Thyroid	Lymphomas , multiple myeloma	
4th	Stomach	Colorectal	Cervical		Colorectal		Non-Hodgkins	Stomach	Lung	Liver	Lymphomas , multiple myeloma	Leukemia	
5th	Liver	Prostate	Stomach		Liver	Bladder	Ovarian	Liver	Leukemia		Uterine	Liver	

Figure 2.3: Distribution of Cancer Cases Among Saudi Nationals by Gender and Age Groups, 2014



CANCER CAUSES

- ▶ Cancer is the result of the interaction between a **person's** factors and 3 categories of **external** agents, including:
 - ▶ **Personal** factors:
 - ▶ 1-Genetic.
 - ▶ 2-Age:
 - ▶ A-accumulation of external risk factors.
 - ▶ B-the tendency for cellular repair mechanisms to be less effective as a person grows older.
 - ▶ **External** factors:
 - ▶ **physical** carcinogens, such as ultraviolet and ionizing radiation;
 - ▶ **chemical** carcinogens, such as asbestos, components of tobacco smoke, aflatoxin (a food contaminant), and arsenic (a drinking water contaminant).
 - ▶ **biological** carcinogens, such as infections from certain viruses, bacteria, or parasites.

Table 4

Cancer-causing Pathogens

Bacteria

Infectious Agent	Cancer	% of global cancer cases attributable to infection*
<i>Helicobacter pylori</i>	Stomach cancers	32.5

Parasites

Infectious Agent	Cancer	% of global cancer cases attributable to infection*
<i>Clonorchis sinensis</i>	Biliary, gallbladder, and pancreatic cancers	0.1
<i>Opisthorchis viverrini</i>	Biliary, gallbladder, and pancreatic cancers	
<i>Schistosoma haematobium</i>	Bladder cancer	0.3

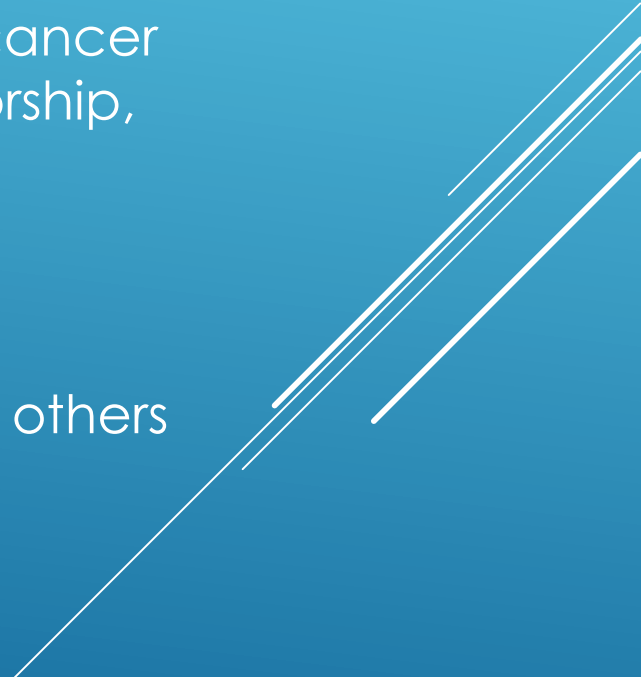
Viruses

Infectious Agent	Cancer	% of global cancer cases attributable to infection*
Epstein-Barr virus (EBV)	Hodgkin and certain non-Hodgkin lymphomas, and stomach and nasopharyngeal cancers	5.4
Hepatitis B/C viruses (HBV and HCV)	Hepatocellular carcinoma	29.5
Human herpes virus type-8 (HHV-8; also known as Kaposi sarcoma herpes virus)	Kaposi sarcoma and certain form of lymphoma	2.1
Human immunodeficiency virus (HIV)	Kaposi sarcoma and non-Hodgkin lymphoma	
Human papillomavirus (HPV)	Anal, cervical, head and neck, oral, penile, vaginal, and vulvar cancers	30
Human T-cell lymphotropic virus, type-1 (HTLV-1)	T-cell leukemia and lymphoma	0.1
Merkel cell polyomavirus (MCV)	Merkel cell carcinoma	

* where known

data from Ref 76

4-UNDERSTAND THE CANCER CONTROL CONTINUUM AND EXPLAIN ITS IMPLICATION TO PUBLIC HEALTH.

- ▶ The cancer control continuum describes the various stages from cancer etiology, prevention, early detection, diagnosis, treatment, survivorship, and end of life.
 - ▶ The cancer control continuum is a useful framework to view plans, progress, and priorities.
 - ▶ It helps us identify research gaps, where we must collaborate with others to have an impact, and where more resources may be needed.
- 

Cancer control continuum

Prevention

Tobacco control
Diet
Physical activity
Sun exposure
Virus exposure
Alcohol use
Chemoprevention

Early detection

Cancer screening
Awareness of cancer signs and symptoms

Diagnosis

Oncology consultations
Tumor staging
Patient counseling and decision making

Treatment

Surgery
Radiation therapy
Chemotherapy
Immunotherapy
Adjuvant therapy
Symptom management
Psychosocial care

Survivorship

Long-term follow-up/surveillance
Late-effects management
Rehabilitation
Coping
Health Promotion

End-of-Life care

Palliation
Spiritual issues
Hospice

Cross-cutting issues

Communication, decision-making, quality of care, health equity, and family/caregiving

5-SCREENING FOR CANCER.



The Wilson-Jungner criteria for screening program

1. The condition being screened for should be an **important health problem**.
2. The **natural history** of the condition should be well understood.
3. There should be a **detectable early stage**.
4. Treatment at an **early stage** should be of **more benefit** than at a later stage.
5. A **suitable test** should be devised for the early stage.
6. The test should be **acceptable**.
7. **Intervals** for repeating the test should be determined.
8. **Adequate health service** provision should be made for the extra clinical workload resulting from screening.
9. The **risks**, both physical and psychological, should be less than the benefits.
10. The **costs** should be balanced against the benefits.

World Health Organisation 1968

USPSTF Recommendation grades

Grade	Recommend / against	Evidence	Benefit
A	Recommend	high	substantial
B	Recommend	high	moderate
		moderate	Moderate to substantial
C	Recommend selectively based on professional judgment + patient preferences.	moderate	small
D	against	Moderate to high	No benefit or harm>benefit
I	Unknown	Lacking, or poor quality, or conflicting	Benefit? Harm?

BREAST CANCER SCREENING

Population	Recommendations	Grade
40 to 49 years	The decision to start screening <u>mammography</u> in women prior to age 50 years should be an individual one. Women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer and thus may benefit more than average-risk women from beginning screening in their 40s.	C
50 to 74 years	The USPSTF recommends biennial screening <u>mammography</u> for women aged 50 to 74 years.	B
75 years or older	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening <u>mammography</u> in women aged 75 years or older.	I

COLORECTAL CANCER SCREENING

Population	Recommendation	Grade (What's This?)
Adults aged 50 to 75 years	<p>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.</p> <p>The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.</p>	A
Adults aged 76 to 85 years	<p>The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.</p> <ul style="list-style-type: none">• Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.• Screening would be most appropriate among adults who 1) are healthy enough to undergo treatment if colorectal cancer is detected and 2) do not have comorbid conditions that would significantly limit their life expectancy.	C

COLORECTAL CANCER MODALITIES AND FREQUENCY

Test	Frequency (years)
Guaiac-based Fecal Occult Blood Test (gFOBT)	1
Fecal immunochemical test (FIT)	1
FIT-DNA	1-3
Colonoscopy	10
CT-colonography	5
Flexible sigmoidoscopy	5
Flexible sigmoidoscopy +FIT	10

Incidence of Cervical Cancer in KSA


Table 3: Cervical cancer incidence in Saudi Arabia (estimates for 2012)

Indicator	Saudi Arabia	Western Asia	World
Annual number of new cancer cases	241	4,455	527,624
Crude incidence rate ^a	1.9	3.8	15.1
Age-standardized incidence rate ^a	2.7	4.4	14.0
Cumulative risk (%) at 75 years old ^b	0.3	0.5	1.4

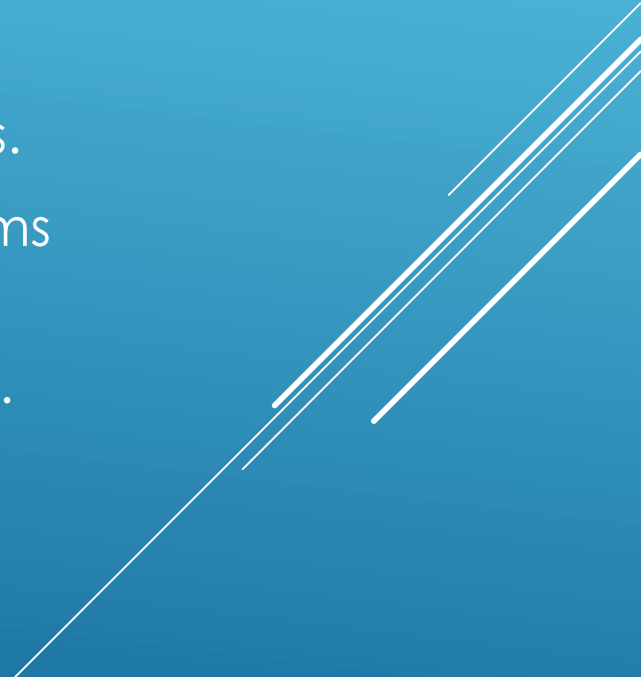
Cervical Cancer SCREENING

Age group	Pap smear (cytology)	HPV testing	Grade
<21 years	Against screening		D
21-30 years		Against	D
	Recommended every 3 years		A
30-65 years	Recommended every 3 years	Recommended every 5 years	A
	Or recommend pap + hpv every 5 years		
>65 years	against screening if have had adequate prior screening and are not otherwise at high risk for cervical cancer.		A
Had Hysterectomy + removal of cervix + no prior high-grade precancerous lesion (CIN grade 2 or 3) or cervical cancer.: Against			D

Define “adequate” Cervical cancer screening?

- ▶ 3 consecutive negative cytology (Pap smear) results.
 - ▶ or 2 consecutive negative HPV results within 10 years before cessation of screening, with the most recent test occurring within 5 years.
 - ▶ Screening may be clinically indicated in > 65 years for whom the adequacy of prior screening cannot be accurately accessed or documented.
- 

Screening FOR hematologic malignancies (lymphoma, leukemia...etc)?

- ▶ There are no routine screening tests for hematologic malignancies.
 - ▶ It is typical for a patient to seek medical treatment when symptoms appear.
 - ▶ Incidental finding when a blood test is ordered for another reason.
- 
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Screening FOR lung cancer

▶ Screening patients for smoking:

1. Ask all your patients systematically if they smoke or not. Make it part of their vital signs.
2. If a smoker is identified, implement smoking cessation guidelines.

Screening FOR lung cancer

- ▶ Age 55–77 years
- ▶ Smoking history >30 Pack Years.
- ▶ Active smoker or quit smoking less than 15 years ago.
- ▶ Did not have chest CT scan the last year.

- ▶ Screening modality:
- ▶ Low dose chest CT scan.

Screening FOR prostate cancer

Population	Recommendation	Grade
Men aged 55 to 69 years	<ul style="list-style-type: none">-the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one.-Screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men.-many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction.-patients and clinicians should consider the balance of benefits and harms on the basis of family history, comorbid medical conditions.-Clinicians should not screen men who do not express a preference for screening.	C
Men 70 years and older	The USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older.	D

Screening FOR thyroid cancer

Population	Recommendation	Grade
Adults	The USPSTF recommends against screening for thyroid cancer in asymptomatic adults.	D

Screening FOR liver cancer

- Patients with cirrhosis of any etiology, but especially cirrhosis caused by hepatitis B or C, are at high risk for the development of HCC and these patients should be the targets for a screening program.
- The best screening modality is ultrasound of the liver.

Screening FOR uterine cancer

- no evidence that screening reduces mortality from uterine (endometrial) cancer.
- Most cases of endometrial cancer (85%) are diagnosed at low stage because of symptoms, and survival rates are high.

Screening FOR ovarian cancer

Population	Recommendation	Grade
Asymptomatic women	<p>The USPSTF recommends against screening for ovarian cancer in asymptomatic women.</p> <p>This recommendation applies to asymptomatic women who are not known to have a high-risk hereditary cancer syndrome.</p>	D

Example of a high-risk hereditary cancer syndrome, women with *BRCA1* or *BRCA2* genetic mutations associated with hereditary breast and ovarian cancer.

6-UNDERSTAND AND REFLECT THE KINGDOMS EFFORTS TO CONTROL THE RISING BURDEN OF CANCERS IN KSA.

- ▶ Cancer Control Program Ministry of Health
- ▶ Saudi Cancer society.
- ▶ <http://saudicancer.org/index.php>
- ▶ National program for early detection of breast cancer.
- ▶ <http://www.bc-moh.com/>
- ▶ King Fahad National Centre for Children's Cancer
- ▶ <https://www.kfshrc.edu.sa/en/home/hospitals/riyadh/kfnccc>
- ▶ Sanad Children's Cancer Support Association
- ▶ <http://www.sanad.org.sa/>

- ▶ In Saudi Arabia there is no countrywide policy for colorectal screening despite the increasing incidence of the disease.

وكيل وزارة الصحة يطلق فعاليات الحملة الوطنية للتوعية بسرطان الثدي ويقول: فحصنا 30 ألف سيدة من بينها 171 فقط مصابة بالسرطان

اقرأ أيضاً

- الأمير سعود بن نايف ي دشّن احتفال وزارة التعليم المر
- مجلس الضمان الصحي يعقد ورشة عمل ثانية للربط بالإلكت
- محافظ السليل يرعى احتفال التعليم بيوم الوطن
- الشؤون التعليمية بتعليم المجمعة تعقد اجتماعها
- اعتماد آلية التقاعد المبكر بتعليم عسير



الثلاثاء 13 أكتوبر 2015

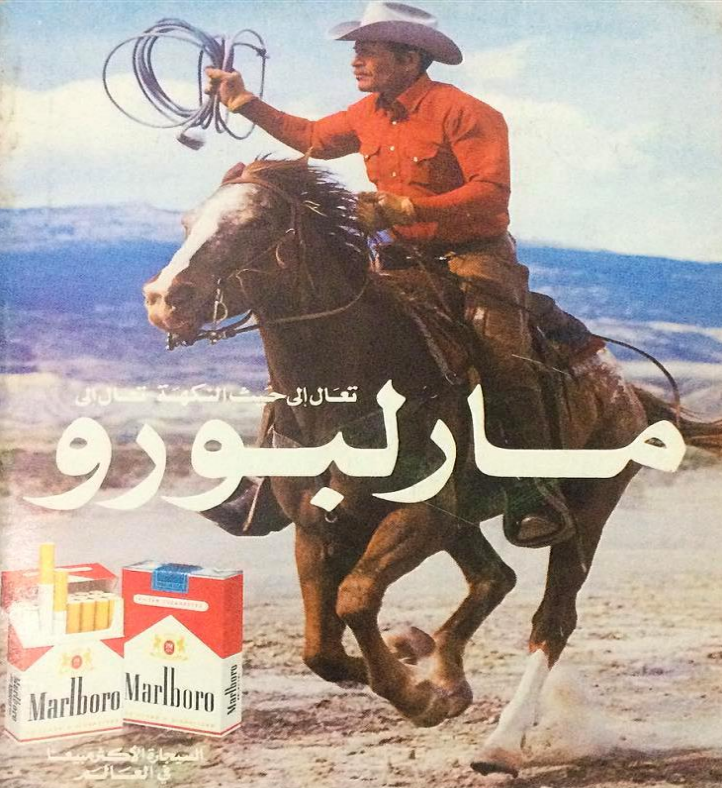
الجزيرة - المحليات:

7-Explain important factors and trends affecting cancer control and directions for future research.

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TOBACCO

- Raise tobacco taxes to keep up with or outpace inflation and income increases to at least prevent tobacco products from becoming affordable.
- Tax all tobacco products to maintain a comparable price to prevent consumers switching from highly taxed products to less taxed ones.
- Require by law and enforce 100% smoke-free environments in all indoor workplaces and public places.
- Ban all advertising, promotion and sponsorship of tobacco products, brands and related trade.
- Put health warnings on all tobacco packaging.
- Establish a national pilot cessation program in health-care facilities.
- <http://www.tcpmoh.gov.sa/> call 937
- Build media awareness of both the addictive nature of tobacco use and treatment options.



He's one of the busiest men in town. While his door may say *Office Hours 2 to 4*, he's actually on call 24 hours a day.

The doctor is a scientist, a diplomat, and a friendly sympathetic human being all in one, no matter how long and hard his schedule.

According to a recent Nationwide survey:
MORE DOCTORS SMOKE CAMELS
THAN ANY OTHER CIGARETTE

DOCTORS in every branch of medicine—113,597 in all—were queried in this nationwide study of cigarette preference. Three leading research organizations made the survey. The gist of the query was—What cigarette do you smoke, Doctor?

The brand named most was Camel!

The rich, full flavor and cool mildness of Camel's superb blend of costlier tobaccos seem to have the same appeal to the smoking tastes of doctors as to millions of other smokers. If you are a Camel smoker, this preference among doctors will hardly surprise you. If you're not—well, try Camels now.



Your "T-Zone" Will Tell You...



T for Taste . . .
T for Throat . . .

that's your proving ground for any cigarette. See if Camels don't suit your "T-Zone" to a "T."

CAMELS *Costlier Tobaccos*

H. J. Reynolds
 Tobacco Company
 Winston-Salem, N. C.



UNHEALTHY DIET, PHYSICAL INACTIVITY, OVERWEIGHT AND OBESITY

- Develop and implement national dietary guidelines and nutrition policies. For eg restaurants should put calories.
- Promote educational and information campaigns about reducing salt, sugar and fat consumption.
- Develop and implement national guidelines on physical activity.
- Implement community-wide campaigns to promote the benefits of physical activity.
- Promote physical activity in workplaces.

ALCOHOL

- Raise public awareness, especially among young people, about alcohol-related health risks, including cancer.

HEPATITIS B VIRUS (HBV)

- Implement universal infant immunization using one of the recommended immunization schedules.

جدول التطعيمات الوطني	
التطعيم Vaccine	الزيارة Visit
• BCG • Hepatitis B	• درن • التهاب كبدي (ب) • عند الولادة At Birth
• IPV • DTaP • Hepatitis B • Hib • Pneumococcal Conjugate (PCV)* • Rota**	• شلل أطفال معطل • الثلاثي البكتيري • الالتهاب الكبدي (ب) • المستدمية النزلية • البكتيريا العقدية الرئوية* • فيروس الروتا** • عمر شهرين 2 months
• IPV • DTaP • Hepatitis B • Hib • Pneumococcal Conjugate (PCV)* • Rota**	• شلل أطفال معطل • الثلاثي البكتيري • الالتهاب الكبدي (ب) • المستدمية النزلية • البكتيريا العقدية الرئوية* • فيروس الروتا** • عمر 4 شهور 4 months
• OPV • IPV • DTaP • Hepatitis B • Hib • Pneumococcal Conjugate (PCV)*	• شلل الأطفال الفموي • شلل أطفال معطل • الثلاثي البكتيري • الالتهاب الكبدي (ب) • المستدمية النزلية • البكتيريا العقدية الرئوية* • عمر 6 شهور 6 months

ENVIRONMENTAL EXPOSURE TO CARCINOGENS

- Stop using all forms of asbestos.
- Provide safe drinking water.
- Reduce the use of biomass and coal for heating and cooking at home, and promote use of clean burning and efficient stoves.
- Implement food safety systems (i.e. legislation and monitoring) focusing on key contaminants. For eg. SFDA.

OCCUPATIONAL EXPOSURE TO CARCINOGENS

- Develop regulatory standards and enforce control of the use of known carcinogens in the workplace.
- Include occupational cancer in the national list of occupational diseases.
- Identify workers, workplaces and worksites with exposure to carcinogens.

RADIATION

- Provide information about sources and effects of all types of radiation. Include occupational cancer in the national list of occupational diseases.
- Establish national radiation protection standards (using internationally available guidelines).
- Ensure regular safety training of radiation workers.
- Promote UV risk awareness and UV protection action.
- For example Dose limits for Ionizing radiation are:
 - for the public, 1 mSv/year.
 - for occupationally exposed persons, 20 mSv/year.



Display of background radiation in a hotel at Naraha, Japan, showing dose rate in microsieverts per hour, five years after the Fukushima disaster.

Personal radiation badge



Radiation protection clothes



防护围领



HOW ARE PEOPLE EXPOSED TO UV RADIATION?

- **Sunlight:** the main source of UV radiation.
- **Sunlamps and sunbeds** (tanning beds and booths).
- **Phototherapy** (UV therapy):
 - UVA (320 to 400 nm) OR UVB, UVB is divided into:
 - Broadband (280 to 320 nm)
 - Narrowband (311-313 nm)
 - the carcinogenic potential of narrow band UVB is less established.
- **Other** (Black-light lamps, Mercury-vapor lamps, High-pressure xenon and xenon-mercury arc lamps, plasma torches, and welding arcs).

THANK YOU



APPENDIX

How to use home fecal occult blood screening test:

<https://youtu.be/Wl8zaZiQXDg>

How to use home Fecal immunochemical (FITs) screening test:

<https://youtu.be/UWr7lJpm9do>

How to do pap smear and hpv test

<https://www.youtube.com/watch?v=7AWbs-OUV6Y>