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MEDIA GUIDE on

CERVICAL CANCER IN LATVIA

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Cervical cancer is preventable and curable. So why do around 155 women in Latvia die from this disease every year?

This media guide won't tell you the answer

But it could help you ask the right questions

Too many deaths

Every year around 155 women die of a cancer that could have been prevented. Cervical cancer is one of the most common cancers in women, and if it is left to grow undetected and untreated, it is fatal.

It is possible to prevent women developing cervical cancer, because ‘early warning signs’ can be detected in the cervical cells long before they become cancerous. And even after a cancer has developed, a cure is possible so long as it is caught at an early stage.

Many of the women who die of cervical cancer are in their forties and fifties, or even younger. Their death can deprive young children of a mother, families of a breadwinner, and parents of daughter’s care.

So why are these unnecessary deaths still happening? This media guide is designed to help journalists like you find out.

What causes cervical cancer?

Cervical cancer grows in the tissue of the narrow passage between the top of the vagina and the uterus or womb, sometimes known as the neck of the womb.

Almost all cervical cancers are caused by becoming infected with certain variants of the human papillomavirus (HPV). As with most viruses, in most cases HPV infection lasts for no more than a few weeks or months before it is cleared from the body – it produces no symptoms, and no is harm done. When infections do not clear, however, the HPV-infected cells may become ‘precancerous’. This usually takes many years, or even decades. While some precancerous cells can heal by themselves, there is a risk that they may turn into an invasive cancer if they are not detected and treated early.

The HPV virus is caught by having sex with someone who is already infected. While having many sexual partners does increase the risk, all it takes to catch the virus is one partner.

How is cervical cancer prevented?

Checking for warning signs

It takes a long time for the cellular changes resulting from HPV infection to lead to the beginnings of a cancer.

During this period, precancerous changes in the cells can be clearly seen under a microscope, so long as the sampling and analysis is done according to validated methods, and regular checks are made for quality control, as defined by the *European Guidelines for Quality Assurance of Cervical Cancer Screening and Diagnosis*, and other international standards

The conventional test for cervical cancer and precancerous abnormalities is called the Pap test (named after its developer, George Papanikolau), which is the methodology used according to the European quality assurance guidelines. Latvia is unusual in using an alternative method, the Leishman test, which has been taught and used throughout the country's long history of cervical cancer screening.

All tests involve taking a cervical smear – scraping some cells off the cervix wall. This procedure can be done by almost any properly trained health worker in almost any setting. The cell samples are sent off to a laboratory for examination by experienced cytopathologists.

If the cells show possible warning signs of cervical cancer, the woman is referred for tests to confirm the diagnosis, and is referred for treatment if the test shows positive. The tissue at risk is removed before any cancer has had time to develop, and the woman should be referred for careful follow-up for up to five years.

The evidence shows that undergoing a Pap test once every three to five years will pick up 80% of potential cervical cancers before the cells have turned cancerous. So long as the treatment and follow-up is done according to the guidelines, it is possible to prevent precancerous cells developing into cancer in more than 99% of cases. Not all cancers can be diagnosed in the precancerous phase, but even if the cells have turned cancerous (or malignant), it is still possible to cure the disease so long as it is picked up early.

Vaccines

Vaccination against the HPV virus also helps to prevent cervical cancer. Two vaccines are now available that have been shown to be effective in preventing HPV 16 and HPV 18 infections, the two strains of HPV virus that are responsible for around 70% of cases of cervical cancer. However, they are not effective against all cancer-causing HPV strains, and they cannot prevent cervical cancer developing in women who have already become infected with the HPV virus. For this reason, the European recommendation is that HPV vaccination can be used in addition to Pap tests but should not replace regular screening.

Both vaccines are administered in three doses given over six months. Like all vaccination programmes, the effect is greatest when coverage is high. Many European countries are now introducing HPV vaccination programmes successfully; in some countries, controversy about vaccinating children or young teenagers against a sexually transmitted disease has affected uptake. Many countries have decided not to introduce a programme of HPV vaccination, possibly on the grounds of affordability.

Gardasil is manufactured by the US pharmaceutical company Merck & co and is effective against HPV 6, 11, 16 and 18. Cervarix is manufactured by GlaxoSmithKline and is effective against HPV 16 and 18.

How can Latvia reduce the death toll from cervical cancer?

There is a very strong consensus based on evidence from decades of experience in many European countries that the best way to cut the number of cases of cervical cancer, and the number of deaths is through a national cervical cancer screening programme.

National cervical cancer screening programmes:

- Invite healthy women for regular screening visits using the Pap test,
- Are organised at a regional or national level and involve all women in a certain age range (usually at least 30 to 60), who are invited for screening at regular intervals (every three to five years is the recommended interval),
- Systematically recall women for further examination and, if necessary, treatment when cells appear abnormal or suspect,
- Have quality assurance built in to ensure that all aspects of the programme are working to a high standard – the attendance is high, the smear test is properly done, the lab analysis is accurate, the results are reported in a timely fashion, the woman is recalled for further investigations and referred for treatment, where appropriate, and treatment is carried out to a high level,
- Promote a high level of attendance through public awareness campaigns, effective communication, and ensuring screening is accessible. Women will be more likely to respond to invitations if they are addressed to them in person, if they contain clear and credible information (see box), and if the screening test is free or very cheap, and can be done in a convenient place at a convenient time.

These sorts of organised, systematic national programmes have been shown to be far more effective than relying on ‘opportunistic screening’, where Pap tests may be available, even free of charge, but rely on the patient or the doctor to take the initiative. Tests done opportunistically lack the quality control of the sampling, analysis, treatment and follow up that is built into well-organised screening programmes. Opportunistic screening is also a very inefficient way to use health resources, as it results in large numbers of women never being screened for cervical cancer, while others may be screened far more frequently than is necessary.

<illustrated box>

Convincing women to attend cervical screening is one of the big challenges particularly in the early stages of a national screening programme.

Women will be more likely to attend screening if the invitation:

- Is addressed to them in person and makes clear that cervical screening is a health check-up for women like them
- Clearly explains what level of risk they face of developing cervical cancer and how effective screening is at protecting against that risk
- Tells them how the Pap test is performed: how long does it take, does it hurt, who will do it, what will be required of them
- Tells them what will happen to their sample, when can they expect their results, who will have access to their results
- Explains that they may be recalled for further tests, and what this could mean (usually this happens when tests are unreadable or inconclusive; even where abnormalities are found, they may not pose a danger of cancer)
- Tells them where to go for further information

The evidence from Finland

The experience of countries like Finland, which was the first country to establish a cervical cancer screening programme, shows how effective these national screening programmes can be. Finland pioneered cervical cancer screening in 1962. In 1976, 14 years later, it was able to show that women who had been regularly screened were five times less likely to develop cervical cancer than the rest of the population. Figures from 2008 (globocan.iarc.fr) show that women in Latvia are more than six times more likely to die of cervical cancer than women in Finland, and the mortality rate is almost two and a half times the EU average.

Cervical cancer screening in Latvia

Latvia has a long history of cervical cancer screening. It was widely used from the 1960s to the end of the 1980s in the laboratories of the Latvian healthcare institutions. In 1984 cervical screening was recommended as a compulsory part of the system for prevention and treatment of diseases. But in 1989, preventive gynaecological examinations were stopped as the country went through major political and economic changes.

It was more than 15 years later, in 2005, that a new Programme of Preventive Checkups reintroduced some form of opportunistic screening policy. However, while women could now go to their GPs to be tested free of charge, there was no centralised system for sending out invitations, no way to track attendance, results and follow-up, and no quality control. The programme relied on GPs making a serious effort to ensure their patients were regularly tested, and this did not happen. A survey of GPs showed that they did not feel competent to carry out the tests and felt it should not be their responsibility.

In 2009 a full screening programme was started, with a national authority responsible for overseeing all cancer screening programmes, which has a formal commitment to comply with the European Guidelines for Quality Assurance in Cervical Cancer. Personal invitations are issued every three years to all women between the ages of 25 and 70 years. This invitation acts as a formal referral document for the woman's GP or gynaecologist to do the test. There are now rules about how to proceed if a test comes back as unclear or abnormal and GPs have financial incentives to give check-ups to at least 65% of patients in their practice annually, though this is not tied specifically to cancer-related examinations. If women prefers to have the screening test done by their gynaecologist, this can now be reimbursed by the Health Compulsory Insurance State Agency.

However, there are still a number of issues that will need to be addressed. There is a lack of defined standards and inadequate quality control of many aspects of the programme, including the taking of the cervical smear, the laboratory analysis, the follow-up of unclear or abnormal smears, and treatment. A needs assessment has also revealed a shortage of trained specialist staff, particularly for conducting further diagnostic tests in the case of suspicious smears and carrying out treatment, as well as a shortage of gynaecological services, especially in rural areas. The use of the Leishman test in place of the standard Pap test for analysing cervical smears, is also controversial. European guidelines recommend the Pap test because its accuracy in detecting warning signs of cervical cancer has been scientifically validated.

A further concern is that the impact of the national screening programme is far less than it could be, because too few women are responding to invitations to attend a cervical smear test. In 2009, the first year of the national programme, the take-up rate was only 25%. By 2011 the response rate had risen to almost 40%, thanks largely to greater public awareness. However, the majority of women in the target age group are still not getting screened within the national screening programme.

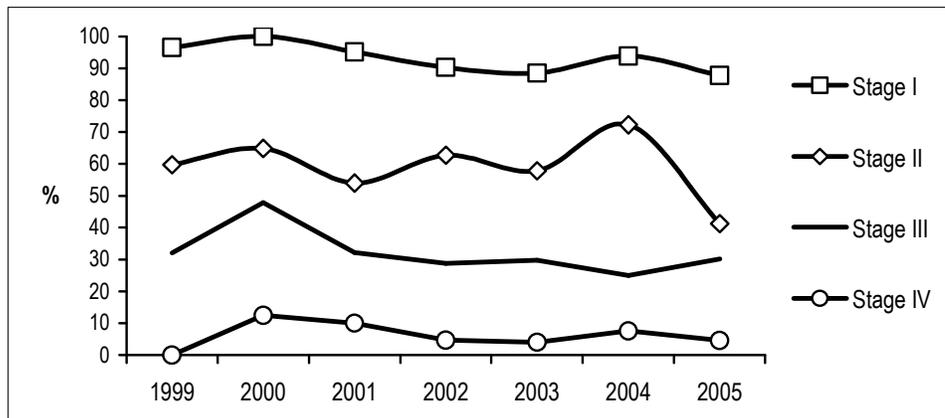
There is some evidence to show that unresolved issues remain around who is responsible for carrying out the smear test. To carry out the number of tests required in the national screening programme it is necessary for GPs to be involved. However, an unpublished survey carried out in 2011 indicated that three-quarters of girls and women aged 15–49 do not trust their GPs to provide gynaecological care, and some GPs have expressed the view that the test should be carried out by specialist gynaecologists, even though taking a cervical smear can be done by anyone with basic training. Specialist gynaecologists, on the other hand, work largely in private practice. Though they can claim reimbursement from public health insurance for screening tests, only a minority do so.

Unnecessary Deaths from Cervical Cancer – Covering the Story

Almost one in three cases of cervical cancer are currently diagnosed when the cancer has had so much time to grow that it is almost impossible to cure. This would not be happening if the cervical cancer screening programme was functioning effectively.

<graph>

Five-year survival rate of cervical cancer patients in different stages of the disease in Latvia, 1999–2005



When a cervical cancer is detected very early (stage 1), it is highly treatable and the vast majority of women will be cured. But almost one in three cervical cancers are being detected when it is too late (stages III and IV)

Source: Latvian Cancer Registry

If Latvia does not improve its record in preventing cervical cancer, women will continue to die unnecessarily. As a journalist you have a vital role to play in telling the story of these unnecessary deaths, and in raising awareness about the risks of cervical cancer and how women can protect themselves. Journalists also have a responsibility to take a critical look at the way current policies and programmes for preventing cervical cancer are functioning, and to investigate how they might be improved.

- Why are so few women responding to invitations to be screened? Is there a lack of trust in the system? If so, how can this be resolved?
- Latvia is the only country in Europe to use the Leishman test to screen for cervical cancer. Should cytologists be trained in the use of the Pap technique for preparing and analysing cervical smears?
- Are GPs still not taking responsibility for ensuring their patients attend screening tests? If so, why is this? Are there problems with workload? Do they need training to feel more competent in this role?
- Should midwives, nurses and paramedics be trained in taking cytological smears, to ensure smears can be taken, particularly in the rural areas where gynaecological services are not available.
- Should the laboratory specialists and assistants who analyse the cervical smears be required to have specific training and qualifications in cytology?

If Latvia could replicate the success in Finland, the number of women dying from cervical cancer each year would drop, over time, from around 155 to around 25. Latvia can also look at its own history to see how effective cervical cancer screening programmes can be at cutting the annual number of new cases. The urgent question now is how to make such a programme work under the current model of healthcare delivery. Good media coverage that highlights the problem and explores solutions can make all the difference.

This media guide was produced by Anna Wagstaff and Peter McIntyre on behalf of the European School of Oncology (www.eso.net) as part of EUROCHIP-3 project funded by the European Commission Directorate for Health and Consumer Protection (DG SANCO) and conducted by the Fondazione IRCCS “Istituto Nazionale dei Tumori” in Milan in collaboration with the European School of Oncology

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Good communication is important to the success of a screening programme