AOGIN India

ISSUE 26• MAY 2022

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WHAT'S INSIDE

From the Secretary's desk

Dear AOGIN India Members,

Its good to see life getting back to normal and screening services limping back to normal. Its wonderful to see that UP has started HPV vaccination and cervical cancer screening in earnest! For any screening and vaccination programmes to be sustainable we do need governmental support and perhaps AOGIN India can play a pivotal role in bringing this about.

We have uploaded resources that you may find useful- short videos on awareness in english and hindi. In due course of time, the AOGIN-India website will have all the latest information and recommendations on HPV vaccination and screening. We hope it will become the one stop for all relevant and updated information on screening and vaccination.

The theme of the 11th national AOGIN India conference is "Taking health to the last mile". This will be held in Coimbatore from 18th - 20th November. Please block your dates and we hope to see all of you in Coimbatore for not just academics but fun and fellowship which we have sorely missed the last couple of years.

Warmest Regards,

Latha Balasubramani

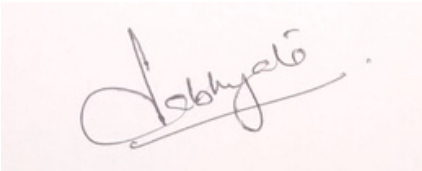
MESSAGE FROM THE PRESIDENT

Dear Friends,

It is heartening to see that everyone is putting their best foot forward to contribute to the elimination of cervical cancer. A lot of work is being done to spread awareness amongst the general masses and update knowledge amongst the doctor community. We also have a robust ongoing Colposcopy MDT programme. There are new SAGE recommendations for vaccination and hopefully, we will soon find its incorporation in WHO position paper and national guidelines leading to increased immunization.

We have the 11th national conference of AOGIN India coming up in November 2022 to be held at Coimbatore. I look forward to active participation by all the members and I am sure that your contribution will make it an intellectually stimulating and memorable conference.

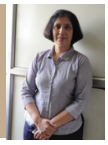
Best regards,



Dr Sabhyata Gupta
President, AOGIN (India).
Chairperson, Department of Gynaecology&Gynaec Oncology,
Medanta - The Medicity, Gurugram (Delhi NCR), India.

Secondary prevention of cervical cancer among women living with HIV

Dr Smita Joshi
MBBS, PGDEPI, PhD
Department of Preventive Oncology, Prayas, Pune
Programme Director, JCDC and Project Consultant,
Grant Medical Foundation Ruby Hall Clinic, Pune



Although preventable, cervical cancer is a major public health problem in the low- and middle-income countries including India. India contributes to about a fifth of the global burden of cervical cancer. Cervical cancer disproportionately affects women living with human immunodeficiency virus (WHIV)[1]. The risk factors for HIV and HPV often overlap and WLHIV have a significantly higher risk of acquiring HPV infection, having persistent HPV infection, they are more susceptible to develop cervical precancer and cervical cancer[2] [3] [4]. WLHIV have a 6-fold increased risk of cervical cancer as compared to the women in the general population[4]. Improved access to antiretroviral therapy (ART) has increased the life expectancy in HIV-infected individuals[5]. Early ART initiation and ART adherence are two main components of HIV disease management which lower the risk of incidence of cervical precancer and cancer provided cervical cancer screening and management of precancer is integrated into the ART program[6]. Even then, compared to the general population, WLHIV require more intensive screening and long-term follow-up, if they are HPV positive and/or treated for high-grade CIN[7], [8].

Screening should be initiated for WHIV at 25 years of age and HPV primary screening should be the test of choice for screening women for cervical cancer as suggested by the WHO in the 2021 guidelines[9]. If the HPV test is not available or affordable, VIA is a better screening option than cytology considering the advantages of VIA screening such as its higher sensitivity than cytology in detecting cervical abnormalities and VIA is a point-of-care test providing an opportunity to treat screen positive women preferably during the same sitting. The visual screening tests seem to perform better in WHIV than in the general population due to the increased prevalence of high-grade lesions and the possibility of large lesions among them [10], [11]. If the HPV test is negative in WHIV, repeat screening is advised after 3 to 5 years (as compared to 5 to 10 years for women in the general population).

If the HPV test is positive, the WHO has recommended 'screen, triage and treat' option for WHIV over 'screen and treat' strategy. When the first screening test is positive, another test called as a 'triage test' is interposed between screening and diagnosis to further stratify individuals[12]. We have several options for triaging when primary HPV test is positive and they are VIA, cytology (or liquid based cytology), HPV genotyping or colposcopy. The most feasible and pragmatic option for triaging is VIA in resource constrained settings.

The management options for any CIN among WHIV are the same as that of women in the general population namely ablative treatment when eligible (cryotherapy or thermal ablation) and lower loop excision of the transformation zone (LLETZ). Some studies have shown that excisional treatment of CIN 2-3 disease provides better cure rates compared to ablation in WLHIV[13]. But despite treatment of CIN, WHIV have an increased risk of failure compared to non- HIV infected women[14].

At Prayas, Pune, we followed a large cohort of WHIV (after obtaining necessary ethical approvals) and some of the results have been published [11], [15], [16]. At baseline, 26.4% were HPV positive by the Hybrid Capture 2 test (HC2) and about 5% of the women had high-grade cervical lesions (CIN 2/3 lesions) [11]. We have reported that sequential testing with VIA and VILI is the most feasible screening approach for cervical cancer screening in WHIV in low-resource countries until HPV testing becomes feasible and affordable[11]. Sequential testing implies screen positivity only when both the tests are positive (i.e. a negative result by either test is considered as a negative screening result). We also reported use of

thermal ablation for the first time among WHIV. HPV genotyping showed a very high frequency of high-risk HPV and multiple infections in WHIV. Any HPV was detected in 44.8% and high-risk ones in 41.0% WHIV [15]. At baseline HPV 16 was the most common genotype and contributed to the most high-grade CIN disease. The cohort was longitudinally followed and subsequently we reported HPV type-specific incidence of cervical intraepithelial neoplasia (CIN) among WHIV who did not have any colposcopic or histopathological evidence of CIN at baseline[13]. In our cohort, the incidence rate of any CIN was 1.9 per 100 PYO and that of CIN 2/3 was 0.7 per 100 PYO. The median time for follow-up for women with any CIN was 3.0 (IQR 1.6–3.7) years[13]. HIV- infected women with human papillomavirus infection at baseline had a 57 times increased risk of developing cervical intraepithelial neoplasia during follow-up, underscoring the urgent need for regular cervical cancer screening in HIV treatment platforms.

The WHO's 2021 guidelines for screening and management of cervical pre-cancer have a major focus on WHIV[9]. Studies in the developed countries have shown that early initiation of ART and sustained adherence to ART is likely to reduce the incidence of cervical cancer in WHIV provided cervical cancer screening and management of precancer is integrated into the ART program[6]. However cervical cancer prevention services are not offered at the ART centres in India (as well as majority of the other countries with high HIV burden). WHIV are referred to the Gynaecology OPD for screening which is often not in the vicinity of the ART centre and women get lost, there are long waiting hours and stigma and discrimination still prevails[17], [18] even after 40 years of the epidemic. Most of the Gynaecology OPDs are still offering cytology screening which is often not quality assured in a real sense. And there is a dire need for the authorities of the Gynaecology OPD and ART centres to think of solutions so that the lifesaving intervention for WHIV can be offered and the opportunity to prevent cervical cancers among WHIV is not missed[19].

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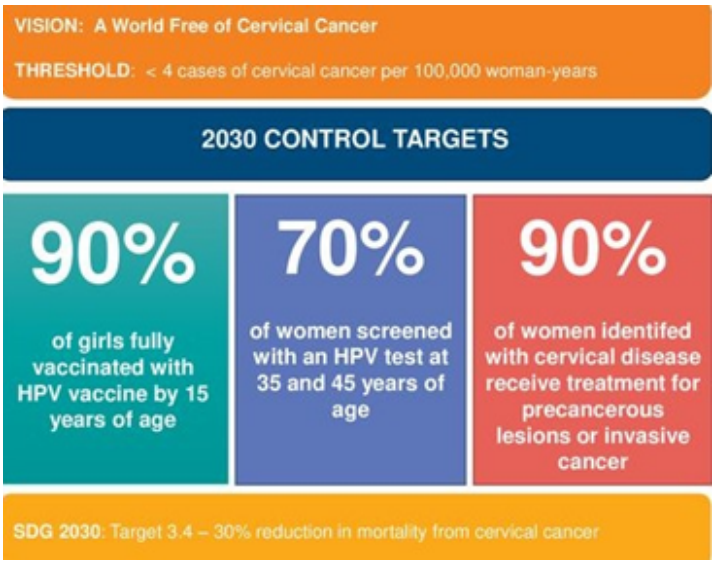
HUMAN PAPILLOMA VIRUS NUCLEIC ACID AMPLIFICATION TESTS TO SCREEN FOR PRECANCEROUS LESION AND PREVENT CERVICAL CANCER

Dr. M. Karthiga
DGO, DNB Trainee,
Department of Obstetrics and Gynaecology,
Sri Ramakrishna hospital, Coimbatore

INTRODUCTION

Cervical cancer is the leading cause of mortality. In 2020, 6,04,000 women were diagnosed to have cervical cancer and about 3,42,000 women died from cancer. In 2018 WHO issued call to action for elimination of cervical cancer. In November 2020, WHO launched global strategy to accelerate the elimination cervical cancer with targets for 2030.

2030 TARGETS :



WHO RECOMMENDATIONS:

WHO has formulated new and updated recommendations for general population women and for women living with HIV. This new guidelines recommends NAAT for primary screening for cervical cancer.

NUCLEIC ACID AMPLIFICATION TESTS:

- HPV DNA NAAT- detects the presence of virus by detecting the viral DNA
- m RNA NAAT- detects the transcripts of viral E6 &E7 oncoproteins responsible for HPV mediated oncogenic transformation

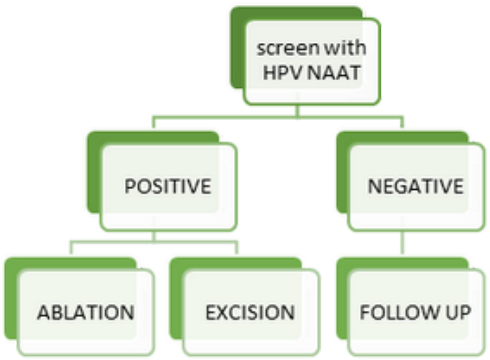
HPV DNA NAAT	HPV m RNA NAAT
General population starting at age 30 years as primary screening test in both" screen and treat "and " screen triage and treat"	General population starting at age 30 years as alternate primary screening test in both "screen and treat" and "screen, triage and treat"
Women living with HIV - the preferred primary screening test is "screen, triage and treat" starting at age 25 years	No recommendation
Screening interval : General population 5 to 10 years. Women living with HIV 3 to 5 years .	Screening interval : General population- 5 years
Samples taken by health care provider or self collected	Samples taken by health care provider only

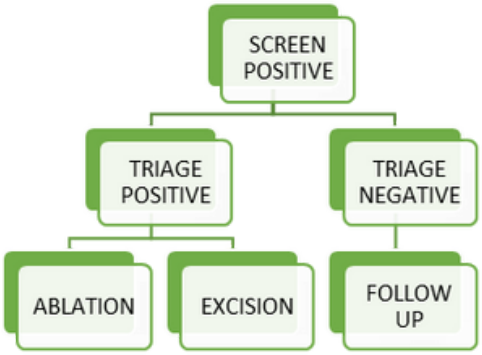
PUBLIC HEALTH IMPACT HPV DNA NAAT results in 8 to 12 % lower incidence of cervical cancer and 6 to 8% lower incidence of cervical cancer mortality.

RESOURCE REQUIREMENTS Costs are expected to be similar

AVAILABILITY HPV DNA NAAT tests are available, whereas m RNA NAAT tests is limited

SCREEN AND TREAT APPROACH





SCREEN, TRIAGE AND TREAT APPROACH

Triage with HPV 16/18 genotyping, VIA, cytology and or colposcopy

CHOOSING APPROACH FOR PRIMARY SCREENING:

- Incidence and mortality are similar for both approaches
- The addition of triage will result in increased need of resources
- When triage is used, treatments are reduced to half

CHOICES BETWEEN TWO APPROACHES CONSIDERED BY FOLLOWING CONTEXTUAL FACTORS:

- Capacity of the health system
- Accessibility to equipments
- HIV prevalence

TRANSITION TO HPV NAAT BASED SCREENING PROGRAMMES:

- Program should reach all women
- Continuing screening is crucial
- Transition to use HPV NAAT should be done rapidly
- Priority should be given to screening women in general population aged 30 to 49 years and HIV positive women aged 25 to 49 years
- Screening twice in lifetime is beneficial
- Screening without treatment does not prevent cervical cancer

Ovarian cancer population screening and mortality after long term followup in the UK collaborative trial of ovarian cancer screening (UKCTOCS)

Dr. Mirudhulaa
MS, Department of Obstetrics and Gynaecology,
Coimbatore Medical College Hospital

INTRODUCTION

Ovarian cancer remains the most deadly of all gynaecological cancers. Most patients are diagnosed at an advanced stage with poor survival.The aim of the study is to determine if population screening can reduce death due to the disease.

METHODOLOGY

A randomised control trial of postmenopausal women aged 50 to 74 years who were recruited from 13 centres was done. Exclusion criteria were bilateral oophorectomy, previous ovarian or active non ovarian malignancy, increased familial ovarian cancer risk. The participants were randomly allocated in blocks of 32 using computer generated random numbers to annual multimodal screening [MMS], annual transvaginal ultrasound screening [USS] or no screening in 1:1:2 Investigators and participants were aware of group allocation but members of the outcome committee were masked to randomization group.

PROCEDURE

Annual screening in the MMS group used serum CA125 measurements . On the basis of risk women were triaged to normal [annual screening], intermediate [repeat CA125 , ROCA test in 3 months] and elevated [repeat CA125 ROCA test and transvaginal USS as second line test in 6 weeks]. Annual screening in the USS group used TVS as the primary test which was classified as normal[annual screening], unsatisfactory [repeat in 3 months] and abnormal [scan with ultrasonographer within 6 weeks]. In both groups women with persistent abnormality were assessed by a trial clinician and referred to NHS where they underwent further investigation of surgery. We deemed women who has surgery or biopsy for suspected ovarian cancer after clinical assessment as screen positive.

OUTCOMES

The primary outcome was death due to ovarian cancer [ICD 10 C56] or tubal cancer [ICD 10 C57]. Ovarian cancer includes primary non epithelial, borderline epithelial and invasive epithelial ovarian cancers. Secondary outcomes were incidence and staging of ovarian and tubal cancer.

STATISTICAL ANALYSIS

Compared with the no screening group, the mean estimated relative mortality reduction rate in MMS group was 11% and in USS group was 9%. Mean mortality reduction was only apparent 7 years after randomization.

RESULTS

12,43,282 women invited for the study of which 2,02,638 were recruited and randomly assigned and 2,02,562 were included in the analysis. 25% in MMS group, 25% in the USS group and 50% in the no screening group. At a median follow up of 16.3 years, 2055 women were diagnosed with ovarian and tubal cancer. 1% of the MMS group and 1% of the USS group and 1% of non screening group were diagnosed with ovarian or tubal cancer.

Compared with no screening, there was a 47.2% increase in stage 1 and 2 disease, 4.5% decrease in stage 4 incidence in the MMS group. Overall , the incidence of stage 1 or 2 was 39.2% higher in the MMS group than in the no screening group, whereas the incidence of stage 3 and 4 was 10.2% lower .

0.6% of the MMS group, 0.6% of the USS group and 0.6% of the no screening group died of the disease. No significant reduction in ovarian or tubal cancer death was observed in the MMS or USS groups compared with the no screening group.

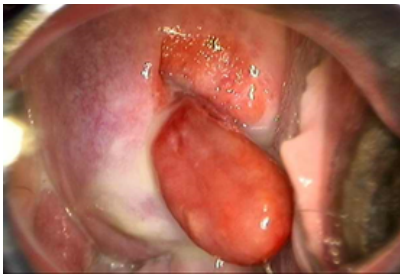
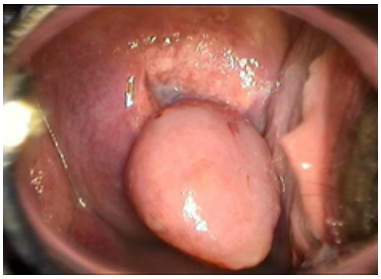
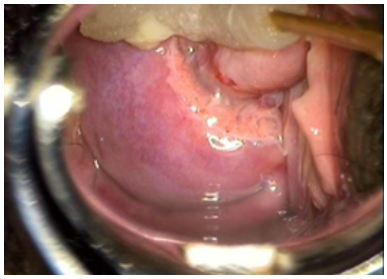
INTERPRETATION

The reduction in stage 3 or 4 disease incidence in the MMS group was not sufficient to translate into lives saved, illustrating the importance of specifying cancer mortality as the primary outcome in screening trials. Given that screening did not significantly reduce ovarian and tubal cancer deaths, general population screening cannot be recommended.

Clinical pearls

Dr Dipanwita Banerjee
MS,DPM, MCh SR (Div of Gynaecologic Oncology)
Dept of Obstetrics and Gynaecology,
All India Institute of Medical Sciences, Delhi

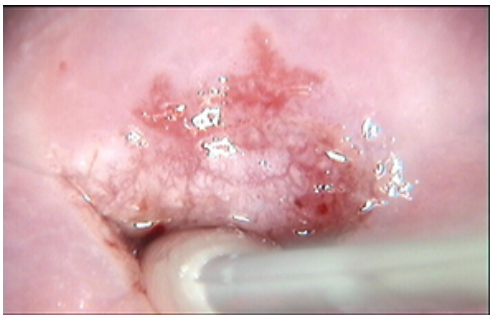
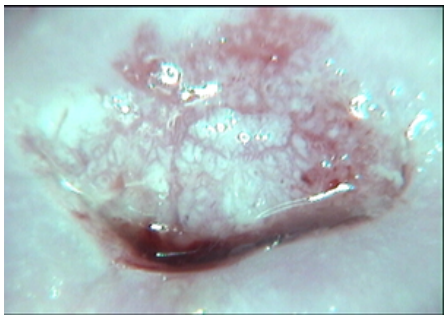
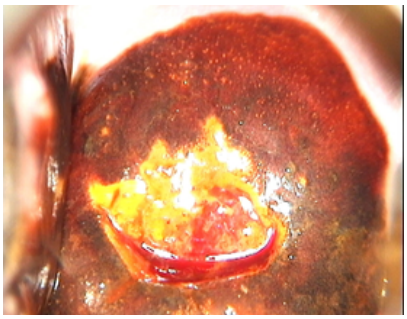
1. A 38 year old P3L3 presented with persistent vaginal discharge, Pap test inflammatory smear, HPV DNA positive (RLU/CO 38.6)


a.Describe the colposcopy findings.

b.Management for the above case?

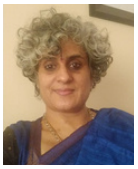
2. A 46 year P2L2 on opportunistic screening HPV DNA test: positive (RLU/CO -1.5)

a.Describe the colposcoy findings. What will be the swede score?

b.Management for the case?

How a poem writes itself for a working mom



A verb gets in the way
of an overflowing laundry basket,
sending lines to hang out dry.
Words sputter along with the tadka
in a hastily put-together dinner.

Pencil tucked in the knot at the nape of the neck,
the one word that this poem was waiting
for disappears
in a quagmire of grey peeking
from a month-overdue burgundy, tone, 3.
Finally, when the cat has gone to bed,
the dog fed,
family, all tucked in,
the poem begins
anew.

The adjectives seem a tad too pretentious,
the noun, not enough.
The punctuation is a half-way cross
between the Kingdom and America
forever wondering
whether one must go for the right
or the easy.
Finally, after a few attempts,
the poem slips
into quiet sleep.

It arrives faithfully,
the next day,
amidst a 3000-word deadline.

Oops, sorry.
Perhaps another time, dear.

A note on the poem

As working mothers, all of us know that all this talk about the work-life balance, is a complete myth. The more appropriate picture would be of a juggler with numerous balls mid-air and having more being chucked at her from random directions. In this hullabaloo that life is for most of us, we still manage to complete work, prepare for the next day, factor in known uncertainties (like organising that birthday gift for a sudden invitation from your teenager's classmate), and still make time to instil all that we want our children to imbue. No matter which area of work women take on, I think we will all universally agree that we would trade anything for a few hours of undisturbed sleep. And one also grows with this firm belief that things will get better when the children get older (our mothers of course, wouldn't agree). It takes us the middle-age to discover that that too is a myth.

This poem arrived when I was trying to finish a book deadline, and it took me several months to edit and prune. It got me wondering how easily all the things that we innately want to do, are automatically pushed into that space behind the backseat, if there is one.

Bionote

Shobhana Kumar's recent book of haibun, 'A Sky Full of Bucket Lists', published by Red River, India, 2021, is the recipient of an Honourable Mention in the Touchstone Distinguished Books Awards, 2021. She has two volumes of poetry published by Writers Workshop, Kolkata and has authored seven works of non-fiction covering industrial histories, memoirs and biographies. She is co-curator at The Quarantine Train, a writing collective, Associate Editor, Yavanika Press, Haibun Editor, Haikukatha, and Co-editor of Non-fiction at Usawa Literary Review. She works in the spaces of education, social work and advertising. She runs an NGO called Small Differences that works with very vulnerable communities—particularly, the transgender population, women and the elderly, abandoned.

*First published in Madras Courier, 2022.

Quiz Zone

1.The 'Madisaru' style of draping comes from which state?

2.This type of saree draping is from which region of India?

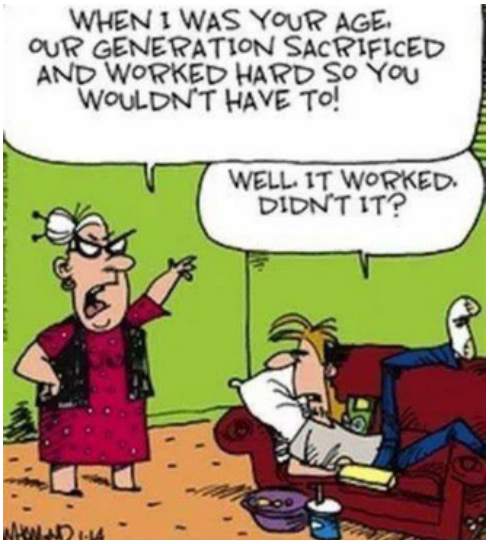
3.The 'Seedha pallu' saree style is a native of which state?

4.This saree draping comes from which part of India?

5.The 'Athpourey' style of draping originates from which state?

6.This style of draping is from which state?

In a lighter vein...



Quiz answers

1. Tamil Nadu
2. Santhal from Jharakhand
3. UP, Gujarat, Rajasthan
4. Maharashtra
5. Bengal
6. Kunbi from Goa

Clinical pearls answers

1.a. Miscellaneous findings; Endocervical polyp

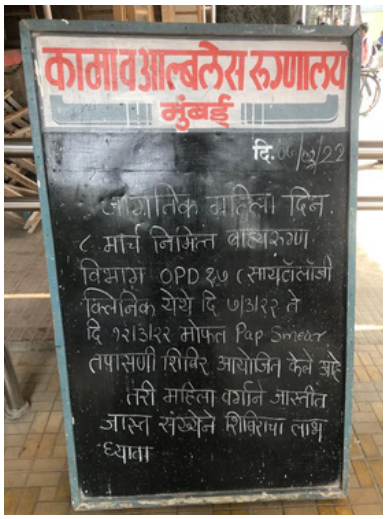
b. cervical polypectomy

2.a. Major grade abnormality, SS 8/10

b. LLETZ

Share your activities

On the occasion of IWD, Cytology Clinic conducted 2 camps. One in Cama OPD which was addressed by Dr. Palve Professor at CAMA and 2nd at Raj Bhavan. Awareness with poster exhibition as always was a success.



Awareness program about HPV vaccine was conducted and 1000 doses of HPV vaccines were administered on 27, 28 and 29 March 2022 in association with CPAA.

Cervical cancer screening camp by HPV DNA self test method was conducted on 07/04/2022 as an event on World Health Day at a rural area in Mysore. Blood test to screen diabetes, lipid profile and hemoglobin along with ECG was done for the group as a supporting measure. This camp was conducted by Public Health Research Institute of India as a routine cervical cancer screening program.




FOGSI Competition for Cervical Cancer Elimination- Nagpur Society received first prize and Bangalore Society of Obstetrics and Gynecology received 2nd prize during AICOG 2022.


Colposcopy MDT- The first colposcopy MDT was successfully held on 11th March, 2022 and monthly henceforth. This will be a forum which brings clinical expertise together for discussion of complex cases. And also a learning platform for students and post graduates.

Upcoming events

ACKNOWLEDGEMENT
My sincere thanks to my research assistant Rithu Pushparaj, who has worked really hard to put this newsletter together.