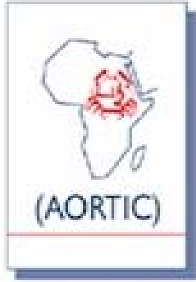

AFRICAN ORGANISATION FOR RESEARCH AND TRAINING IN CANCER

AORTIC NEWS

The Pulse of Africa

Volume 2, Issue 2

February 2005

Special points of Interest:

- 5th International Conference
- World Cancer Stats
- National Cancer Control Programme

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FROM THE EDITOR

Almost half a million new cases of cervical cancer are identified each year around the world. Approximately 80% of those cases occur in developing countries such as South Africa. However, there is hope in the battle against cervical cancer. (Refer to article titled "Khayelitsha Cervical Screening Project" on page 6 for this story). Clearly, Africa has a lot to offer to the research and development of successful treatments for cervical as well as other cancers prevalent in Africa.

AORTIC's 5th International Conference is coming up in November this year. Those who want to partake are requested to submit abstracts. The first announcement of the conference is posted on our Website and more details are outlined on page 7.

Thank you to those that contributed to the first issue of "AORTIC News" in terms of articles as well as positive feedback. Please feel free to contribute on a regular basis, your contributions are much valued. I hope you will find this edition as informative and useful as the first newsletter.

BRodrigues

Belmira Rodrigues

E-mail: aortic@telkomsa.net

ACTING PRESIDENT'S MESSAGE

Dr Paul Ndom

Dear Readers

Our Organisation's mission is to provide research, training and expertise towards the fight against cancer in Africa. Statistics show that in most African countries the cancer incidence is on the increase. Many patients presenting with cancer in Africa present at an advanced stage of the disease, making treatment very difficult and often unsuccessful. It is therefore essential that we focus on prevention of cancer as well as treatment. Further, we have a lack of trained health care personnel to meet the demand for cancer care, support and treatment. I would like to make an appeal to all willing supporters to join our Organisation to assist us in our cause.

- Consult our website: www.aortic.org
- Complete and submit our registration form
- Read and encourage people to read this newsletter
- Your suggestions are appreciated
- Ask questions
- Financial contributions are welcome

Thank you for your support and interest in AORTIC.

Paul Ndom
Acting President: AORTIC

ST LUKE'S HOSPICE

St Luke's Hospice is celebrating its silver jubilee in 2005 – acknowledging that their care has been given freely to more than 18 000 patients and their families during the past 25 years, a service that has moved with the times and met the escalating demands of the community without ever compromising their quality of care.

Hospice is not a place of death where patients go to die. It focuses on quality of life, making every moment count. St Luke's Hospice is committed to providing palliative care for patients with incurable illnesses at an advanced stage and supporting their families, in the greater Cape Town area.

Palliative care is the active, total care of patients whose disease is no longer responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. South African hospice programmes provide palliative care particularly for patients with advanced, progressive diseases, mainly cancer and HIV/AIDS. The focus is on home-based care and extends into the bereavement period.

St Luke's Hospice services are made available to people of all religions and race groups, regardless of ability to pay. On any given day they care for more than 750 patients. Their work is carried out in different settings – mostly in patients' homes, the day hospices and the wards in Kenilworth and at Lentegeur Hospital in Mitchell's Plain. Patients are admitted for pain and symptom control, or to give their families a break and then return home. There are 16 home-care sisters visiting patients in their homes on a regular basis. Their approach is a team effort responding to patients' physical, spiritual, emotional and social needs – the team consists of a doctor, sister, social worker and spiritual counselor.

"Palliative care is the active, total care of patients whose disease is no longer responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount."

Over 800 trained volunteers help with hands-on care of patients and a myriad of behind- the-scene tasks such as fundraising, transporting patients, administration, catering, gardening, reception, crafts and working in the charity shops.

Each of the 12 community hospices has its own voluntary committee, led by a dedicated chairperson. Eddie Cyster is chairperson of the board of St Luke's Hospice, and was for six years been chairperson of the Wynberg branch. The organization is headed by CEO Fiona Grant.

The only way to cope with the ever-escalating demand on the services in the AIDS pandemic in Africa is to care for patients in their own homes. Nowadays there is the added challenge of planning future care for orphans and empowering grandparents and carers with knowledge and skills. St Luke's Hospice works in partnership with other NGO's to ensure that these needs are met.

St Luke's Hospice provides all its services free of charge, and is reliant on the generosity of the donor public and corporates, and their team of fundraisers.

For more information visit St Luke's Hospice website, www.stlukes.co.za or telephone (021) 797 5335.

Jenny Handley Promotions
St Luke's Hospice

WORLD CANCER STATS

In 2003, more than 7 million people died from cancer.
More than 10 million new cancer cases are diagnosed each year.
Cancer claimed twice as many lives as AIDS in 2004.
12.6% of all deaths each year are caused by cancer.
43% of cancer deaths are due to tobacco, diet and infection.
The number of new cases annually is estimated to rise from 10.8 million in 2002 to more than 16.5 million by 2020.
In developing countries, 80% to 90% of cancer patients suffer from advanced and incurable cancers at time of diagnosis.
Lung cancer kills more people than any other cancer.
By 2020, 60% of all new cancer cases will occur in the developing world.
There will be more than 10 million cancer deaths per year by 2020, if current trends continue.
At least 30% of the estimated 10 million cancer cases diagnosed each year can be prevented.
30% of all cancer cases can be cured if diagnosed early.

Between 25% and 30% of all cancer deaths are attributed to tobacco use. Halving tobacco consumption now would avert 150 million premature deaths by 2050.

The opportunity to save lives and to contribute to well-being has never been greater.

World Health Organisation (WHO)

UICC CONFERENCE FOR WORLD CANCER ORGANISATIONS

This report will dwell exclusively on the poster presentation and the contacts made at the meeting on behalf of AORTIC.

Thirty-six (4.9%) of the 734 registered participants were from Africa. The African registrants came from different backgrounds, including cancer survivors, specialist nurses and doctors, social workers, cancer control advocates and journalists.

Several African participants brought with them educational materials that they use in promoting cancer control in their respective countries. Most of the African participants had not heard of AORTIC before and were eager to join our organization.

The poster on AORTIC was displayed with handouts, including 50 copies of the poster and 50 copies of the AORTIC Newsletter.

Mr. Nathan Grey, who is a Vice President of the American Cancer Society, proposed that I meet with him early in the New Year for a "face-to-face" discussion of AORTIC's needs.

I held several discussions with Joe Harford, mainly on the topic of the 5th International Conference on Cancer in Africa (Dakar, Senegal 2005) as well as the Multidisciplinary Cancer Management Course proposed by ASCO. He suggested that it would be easier for NCI to help if both events could be held conjointly. He would however like to see the type of management course that AORTIC would like to have, and I have indicated that this would be subject to the desire of the AORTIC membership, which would be gathered through a questionnaire survey. The process of doing so will hopefully be completed by the end of January 2005.

Paula Rieger, the Director of the International Affairs Department of ASCO expressed a strong interest in the prospects of providing funds for the Multidisciplinary Cancer Management Course. This will depend on ASCO's assessment of AORTIC's proposal for the course.

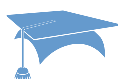
European Organisations:
Brief discussions were held with Ian Magrath, President of the International Network for Cancer Treatment and Research (INCTR). He is keen to work with AORTIC, especially towards a successful Dakar 2005.

UICC:
I attended a workshop in which recent effort to "rebrand UICC" was extensively discussed. The organization has realized that after 70 years of its existence (it was founded in 1930), it needs to change its image to reflect a new focus and to become a resource for action and a voice of change.

Ms Sepulveda (World Health Organization):
The bottom line of my brief discussion with Ms Sepulveda of the WHO was that the organization has no money for sponsoring conferences at this time. However, a global cancer control program is to be ready for signature by May 2005.

African participants:
As I said earlier, I had a great deal of opportunities to interact with African participants of varying backgrounds. Most of them were enthusiastic about AORTIC and expressed the hope to attend AORTIC 2005 in Dakar. Several of them will be able to encourage more people to Dakar, regardless of availability of sponsorship from AORTIC.

Dr Chris Williams
AORTIC Council Member



ICRETT Fellowships

Under its well known International Cancer Technology Transfer fellowship scheme *ICRETT* , we are pleased to announce the launch of a Fellowship scheme that supports the travel and living costs for 1 week for up to 3 faculty members who have agreed to teach specific cancer research and clinical training courses at a hosting organisation abroad. For full details, please visit http://www.uicc.org*Faculty Reverse ICRETT* website.

City of Cape Town Cancer Registry

The Cancer Association of South Africa (CANSA) is piloting a population based cancer registry (PBCR) in selected suburbs of Cape Town in the Western Cape in collaboration with the Medical Research Council (MRC), University of Cape Town (UCT) and the International Agency for Research on Cancer (IARC). This registry is the first urban registry in South Africa. The primary function of the PBCR will be to keep register of all cancer cases occurring in the city of Cape Town. All personal particulars of cancer patients, clinical and pathological characteristics of the cancers will be collected continuously and systematically from various cancer data sources and documented using a specialized computer programme developed by IARC.

The information that would be collected in this registry would help us at CANSA to track trends in the incidence of cancers specific to this locality as a strategy for cancer surveillance. Our surveillance would include the links between cancer trends lifestyle, environmental and other causative factors that may arise. This would provide significant input to our planning of programmes and interventions, identification of partners and monitoring and evaluation of outcomes. It will also form the platform for epidemiology studies, treatment trends and cancer control programmes.
With the data we are currently receiving from the NCR it is not possible to undertake such a surveillance, although this approach has been international best practice for many years. This is because the system of data collection and reporting by the NCR is limited and in fact compromised. The population based registry system of data collection is most appropriate for South Africa, with our varied population groups and their lifestyles that present different disease incidence and trends.

We are in the inception stages of implementing this PBCR as a pilot in the Western Cape and we have received approval from the Ethics Committee of the MRC.

The project would be implemented fully on the WHO guidelines on confidentiality (PBCR). These guidelines are strict and thorough. They cover all persons employed by or connected with the registry. They include areas such as collection of data, the storage of data and issuing of information etc.
The information that is collated as reports from the registry is anonymous. However the collection of data is done with a Notification Form designed by IARC, which include individual information updated over time.
The confidentiality requirements are the same for any medical practitioner or facility that provides a service for the client at any given time.

In order for this PBCR to be effective, we must have the participation of every source of data in our catchment area including clinics, hospitals, laboratories, mortuaries, etc. The National Cancer Registry (NCR) is also a stakeholder in this registry. Other stakeholders include the department of health, national and provincial including local government, the tertiary hospitals eg. Groote Schuur hospital, Tygerberg hospital and the Red Cross Children hospital, private hospitals, UCT and MRC.

We therefore consider this pilot as most significant for South Africa as it would herald a new level in our practice of public health. We would then be able to do the work the public expects of us.

Patsy de Lora
Registrar

Letters to the Editor

Belmira,
Good day to you and the other members of the editorial board of our esteemed newsletter.
Thank you for your messages and for publishing our work on ovarian cancer in the last issue. Please keep up the excellent work.
I have noticed an increased awareness of the activities of AORTIC amongst practitioners here in Nigeria. One prays that it translates to better research, care and training concerning cancers.
I was awarded an International Traveling Fellowship (**observer status**) by the Helene Harris Memorial Trust for their biennial forum on ovarian cancer taking place in Washington DC, USA in April 2005. Their website is www.hhmt.org and email address is info@hhmt.org.
With warmest regards.
Akin-Tunde Ademola Odukogbe

NATIONAL CANCER CONTROL PROGRAMME

The World Health Organisation (WHO) produced a guideline for National Cancer Control Progammes (NCCPs) in 1995.

A NCCP is established by the Health Department in collaboration with stakeholders in the health sector, as well as relevant partners in the sectors of education, agriculture, industry and commerce. To develop a NCCP, the following aspects need to be determined:

- An assessment of the cancer impact on the population of a country;
- Setting measurable objectives for control;
- Evaluating possible control strategies, and
- Prioritising control strategies.

It is important that policy development should take into account the resources that can be devoted to the particular activity against evidence based criteria acceptable for the recipient target community and financial feasibility.

"Prevention programmes are far more effective and much less costly than efforts to treat the disease. Policies should therefore make provision for

- Controlling tobacco use by various means, including mass education, tax increases and restrictions on sales and places of use;
- Evaluation of dietary intake of fats, fruits and vegetables and promoting the adoption and maintenance of healthy diets;
- Alerting the public to the cancer risks of certain communicable and sexually transmitted diseases and promoting appropriate measures such as vaccination against viral hepatitis B infection, and
- Identification of carcinogens to which people are exposed and legislation for their control.

An effective NCCP is based on four principles, namely
- Prevention
- Early detection
- Treatment, and
- Palliative care

Once the foundation for a NCCP has been laid, it is vitally important that political commitment for the adoption and implementation of policies is obtained. Furthermore, systems need to be put in place to monitor and evaluate the effectiveness of policies implemented for each of the four principles at national, regional and district levels.

Successful NCCPs are interdependent on collaboration between government, non-governmental organisations, private sector coupled with a strong political commitment to effectively reduce the impact of cancer on the peoples of its country.

South Africa established a NCCP in 1999 and was one of the first African countries to introduce anti-tobacco laws. This NCCP will be reviewed in 2005 to broaden the scope of particularly the primary prevention and early detection sections. The Cancer Association of South Africa (CANSA) has formed a valuable partnership with the government's Health Department to actively ensure that this important task is completed in this year. Once a NCCP is established, such a document, together with political commitment, can be placed on the agenda of the African Union (AU). It is time that Africans join hands to prevent the onset of this terrible disease and that we make a concerted effort to combat the effects of cancer on the patients, families and communities.

Reference:
World Health Organisation. National Cancer Control Programmes : Policies and Managerial Guidelines, 1995 (ISBN 92 4 154474 0)

Salomé Meyer
Development Consultant for CANSA

AORTIC'S 5th International Conference
14—16th November 2005
Dakar, Senegal

AORTIC invites all oncologists, health care professionals, scientists, and post-graduate students to submit an abstract for the conference. Information on abstract submission and deadlines is posted on the AORTIC website, www.aortic.org or will be sent upon request, aorticdakar2005@yahoo.com

Main Topics

- Cancer epidemiology and clinical research
- Clinical management and Cancer Research
- Treatment of cancers
- Training

Additional Topics

- AIDS-Related Malignancies
- Gynaecologic and breast cancers
- Prostate cancer
- Tobacco related cancer
- Nursing - Palliative care

Scientific Committee:

C Gombe(Congo)
C Hunter (USA)
S Mohammed (Sudan/USA)
F Olopade(Nigeria/USA)
A Elzawawy (Egypt)
J Holland (USA)
L Denny (South Africa)
S.Ayettey (Ghana)
P Ndom (Cameroon)
S Bayo (Mali)
Hwabinga (Uganda)
P Fordelmann (South Africa)
C Williams (Nigeria/Canada)

International Union Against Cancer Issues Lung Cancer Alert
Calls on governments to back tobacco treaty

Geneva, Switzerland (27 February 2005) – Action against tobacco must be a priority for governments if they are to tackle cancer, says the International Union Against Cancer (UICC), the global cancer control organization (1). Warning that deaths from tobacco use are set to soar, they are calling on governments worldwide to back a new international treaty on tobacco, which will become law in 40 countries on 27th February (2).

The Framework Convention on Tobacco Control (FCTC), the world's first-ever public health treaty, commits governments to enacting public policies that will cut tobacco consumption, including: increasing tobacco taxes; placing large health warning on packs; banning all tobacco promotion; and making public places smoke-free (3).

UICC warned that around one in five of all cancers worldwide are caused by tobacco. Each year, tobacco kills around 5 million people, of whom 1.2 million die of lung cancer. Tobacco is also a cause of other cancers, including cancers of the mouth, head and neck; kidney; pancreas; bladder; and uterine cervix.

Speaking from the UICC Secretariat in Geneva, Isabel Mortara, UICC Executive Director said, "Lung cancer will

Speaking from the UICC Secretariat in Geneva, Isabel Mortara, UICC Executive Director said, "Lung cancer will kill 1.2 million people this year – many of whom will be in the developing world. And as tobacco consumption continues to climb in much of the developing world, lung cancer rates are set to soar."

Dr Yussuf Saloojee, UICC Strategic Leader on Tobacco Control, highlighted the importance of rapid action, saying, "Sadly, the prognosis for lung cancer is often poor. But prevention is possible. The Framework Convention on Tobacco Control sets out effective measures that can curb tobacco consumption and save lives. We call on all governments to ratify and implement the treaty without delay.

"We know that when it comes to cancer, swift action can save lives. We congratulate the 57 ratifying countries at the forefront of the global movement to tackle tobacco - and call on leaders in other countries to ratify the treaty immediately. The future health of millions is in your hands."
For further information, please contact:

Dr Sinéad Jones
Head, Tobacco Control
Telephone + 44 77 8986 1870

Khayelitsha Cervical Cancer Screening Project

The KCCSP was initiated in 1995 as a collaborative project between the University of Cape Town, Columbia University, New York and Engender Health. The initial aim was to find an alternative test to the Pap smear as a primary screening test, particularly with the intention of finding a test that could be performed at a primary health care level and would give a rapid result without requiring the infrastructure required by a laboratory based test.

Between 1996 and 1999 we screened just under 6000 women recruited from a peri-urban settlement 20 kilometres outside Cape Town, an impoverished area known as Khayelitsha where two-thirds of the residents live in informal housing. We recruited previously unscreened women aged 35 – 65 years. We compared conventional Pap smears to three other tests:

> **"Our initial aim was to find an alternative test to the Pap smear as a primary screening test ..."**

- Direct Visual Inspection or DVI
- Testing for Human Papillomavirus (HPV)
- Cervicography

While DVI and HPV testing proved to be equivalent and/or superior to Pap smears for identifying lesions, both tests had a very low specificity – that is, there were many false positive cases, compared to Pap smears. This meant, that if we were to link screening with immediate treatment of women with positive tests we would end up doing the following:

- Treating 1 in 5 screened women
- And more importantly, over-treating large numbers of women who had a positive test but did not have a true cervical cancer precursor.

We designed a randomised control trial of screening and treating women based on DVI and HPV testing. 7200 women were recruited between 2000 and 2003 and randomly assigned to one of three groups: Treatment performed by a nursing sister at a primary care level using cryotherapy if DVI positive, treatment with cryotherapy if HPV positive or to no treatment regardless of the result of the DVI or HPV test.

All women were seen at one month post treatment to assess for complications of treatment, including untreated women so we had a comparison group, and again 6 monthly for 36 months for a colposcopic assessment, histological sampling and treatment, if necessary. All colposcopies were performed by myself and trained medical officers on-site working out of adapted second hand shipping containers located at two primary health care clinics in Khayelitsha. This study is still ongoing but our first analysis of the data has shown that women screened with DVI and treated with cryotherapy had a 40% reduction of cervical cancer precursors at 6 and 12 months post treatment compared to untreated women. Women in the HPV arm of the study had an 80% reduction compared to untreated women. We performed just under a 1000 cryotherapies and had only one serious complication in a woman suffering from advanced HIV who had a bleed post cryotherapy and required admission to hospital for a blood transfusion. She subsequently recovered.

These data proved to us that screening and treating women, albeit in the confines of a stringently controlled and monitored research study, is safe, feasible and effective. We also found that the women experienced the process as being highly acceptable. Another indicator of acceptability is that our follow up rates have been extremely high, with 98% of women returning for their one month interview, over 86% for the 6 month examination and around 80% for the 12 month examination. These high return rates are exceptional for large clinical studies and have been made possible partly by having a dedicated team of community health workers visiting patients in their homes to remind them to return for their visits. In addition, we have provided a very patient centred service, which we acknowledge may not always be possible in the 'real world', although certainly we should be aspiring to provide this quality of service to our patients.

Professor Lynette Denny
Secretary/Treasurer: AORTIC

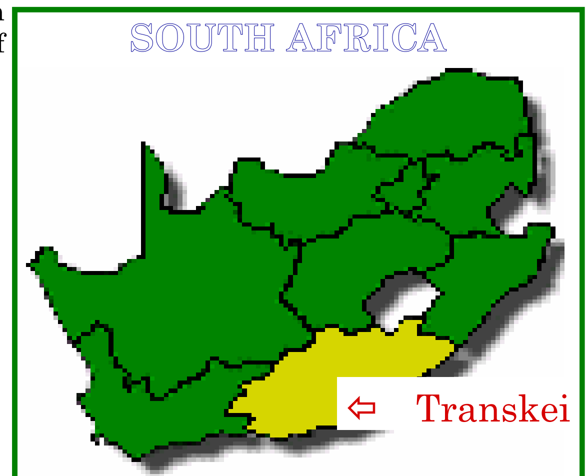
Mo re information about this project will be available in our next issue. - AORTIC News

KCCSP STAFF

CANCER REGISTRATION IN THE RURAL TRANSKEI REGION

Reliable incidence rates and detailed information of cancer cases are rare in South Africa because of lack of well-established population-based cancer registries (PBCRs). However, the PROMEC Unit of the Medical Research Council of South Africa conducts a limited PBCR in the rural Transkei region of the Eastern Cape Province. The registry provides valuable information on the cancer incidence and prevalence in this region where the oesophageal cancer (OC) rate is amongst the highest in the world. The registry collects cancer data from ten selected magisterial areas extending from the Amatole District to the OR Tambo including Alfred Nzo with a population of 1.2 million according to 2001 Census. These magisterial areas include Centane (Kentani), Butterworth, Nqamakwe, Idutywa and Willowvale in the south, and Bizana, Flagstaff, Port St Johns, Lusikisiki and Umzimkulu in the north. The objectives of the registry is to:

- Monitor the burden of cancer in ten selected magisterial areas.
- Analyze and interpret cancer data periodically.
- Provide information on the incidence and characteristics of specific cancers in various segments of the resident population. This information is the primary source not only for epidemiological research on cancer but also for planning and evaluating health services for prevention, diagnosis and treatment of cancer.



Case finding

More than 60% of the cases are reported by hospitals and clinics in the registration area and the rest by referral hospitals including the regional pathology laboratory.

Case finding is based upon notification by a designated nurse in each of the major hospitals in the ten selected magisterial areas. This is supplemented by active case finding by the project leader. The project leader undertakes visits to eleven hospitals located in ten magisterial areas, and in certain neighbouring areas including the regional pathology laboratory. During these visits, ward registers in each hospital are scrutinized to check completeness of notification, and missing or incomplete records are updated. Case finding also extends to hospitals outside the registration area, to which cases may have been referred or presented themselves for better treatment facilities. These include the regional radiotherapy referral centre in Frere Hospital and Cecilia Makiwane Thoracic Surgery Clinic in East London, three referral hospitals (Inkosi Albert Luthuli, King George V and Addington) for thoracic surgery, gynaecology, oncology and radiotherapy in Durban, KwaZulu-Natal Province.

Data handling

Data are coded according to the International Classification of Diseases for Oncology (ICD-O 2). Sociodemographic data are coded according to a system developed by the registry. CANREG, which is a cancer registration computer software developed by the Unit of Descriptive Epidemiology of the International Agency for Research on Cancer (IARC) is used for data processing. This is a reliable system that currently adequately meets the data processing requirements of the registry. Only valid cancer notifications, after thorough scrutiny from the hospitals and laboratories are processed. Quality checks are run periodically to all data already entered. This is the other best way of maintaining the quality of data in the database. Confidentiality is strictly observed and the data remain the property of the project leader. Specific file numbers are allocated to each patient to ensure that he/she remains anonymous during further analyses.

Most common cancers reported in this region

The following are the top ten cancers and they include oesophageal, cervical, breast, lung, prostrate, liver, larynx, stomach, mouth and tongue.

Data presentation methods

Results of the data analyzed from time to time are presented during workshops, seminars, and conferences locally and internationally and published in peer-reviewed journals. Technical reports are also prepared and distributed to stakeholders.

Cancer Registration In The rural Transkei region (Cont.)

Data users include

Research Institutions, Health Department in the Eastern Cape Province, Cancer Association of South Africa (CANSA) and communities in the rural Transkei region.

Conclusion

Cancer registries are the main sources of cancer data. Rational planning is not possible without a means of identifying health problems, determining priorities for preventive and curative programmes, evaluating whether goals are reached and comparing resource input and outcomes. Cancer control programmes as advocated by the World Health Organization (WHO) without cancer registries therefore are impossible.

"There is need for massive education about cancer in Africa in order to promote the awareness of the disease and highlight its preventability". This is the statement made by the AORTIC Past President, Professor Seth Ayettey as well as The Cancer Association of South Africa (CANSA) (AORTIC News, Vol.1, p 7-8). But, unfortunately the magnitude of cancer in Africa is under-estimated. The establishment of more registries therefore will be an important tool to raise awareness especially in the political agenda about the magnitude of cancer in the African Continent.

There are very few cancer registries in Africa that are able to produce good quality data because of numerous problems and challenges that they have to face. These are: Structural problems that include:

- Lack of finance because of perception of cancer as not a problem by the government, which results into inability to recruit, train and retain dedicated staff for cancer registries.
- Lack of dedicated, qualified personnel to run cancer registries.
- Lack of commitment in collaborators including medical professionals.

Technical problems that include:

- Difficult in case finding because of quality and inaccessibility of hospital records.
- Lack of co-operation in data sources such as private hospitals and pathology laboratories.
- Problems in defining a resident, etc.

There is an urgent call for AORTIC to look into these problems and devise means to solve them. The few words below are encouraging those who have already established cancer registries in Africa or are still working hard to establish them. With imagination, patience, perseverance and dedication, the good work of cancer surveillance shall continue, G.W.F. Hegel confirms this by saying " Nothing great in the world has ever been accomplished without passion".

Ntuthu IM Somdyala, MDS, BCur, RM, RN., Medical Research Council of South Africa, Cape Town

WELCOME TO OUR NEW MEMBERS!

We extend our sincere welcome to the following new members of AORTIC:

Dr Dan Jones, South Africa
Dr Manivasan Moodley, South Africa
Dr Olufemi Akinsanya, Nigeria
Dr Olayinka Olaniyan, Nigeria

If you would like to become a member contact the secretariat at: aortic@telkomsa.net or see our website: www.aortic.org

BREAST CANCER CLINIC AT GROOTE SCHUUR HOSPITAL

South Africa has aspects of a developed and a developing country. To many our resources – such as the lack of a simulator in a radiotherapy department until 2005– will seem appalling, to some in Africa where no radiotherapy or chemotherapy is available, it will seem that we are very wealthy. I have been asked to describe the work done in our clinic.

History

The Combined Breast Clinic (interdisciplinary breast cancer panel) at Groote Schuur Hospital and the University of Cape Town began as discussions about patients in a clinic passage. These were between the well-known surgeon, Samuel Helman and the radiotherapist, Betty Bennet. Professor David Dent subsequently spent time in Edinburgh and when he returned he developed the clinic further along the lines of the British model.

Aims

The Clinic is truly interdisciplinary. We aim to provide the best treatment possible with the resources available to us while continuing registrar and specialist teaching and research, and whilst also providing appropriate staff support and care. We do not aim at levels of sophistication beyond our present resources as these are costly with small gain.

Resources

In spite of our hospital being a tertiary academic one, theatre time is very limited so patients may wait 2-3 months for breast cancer operations. We use outlying secondary hospitals as much as possible for breast cancer operations. Recently our local government has given us money to try and cut back on waiting lists. Plastic surgeons form part of our panel but again patients have to be carefully selected for reconstruction because of limited theatre time. As far as radiotherapy is concerned, we are soon to receive our first simulator in the department. We have major shortages of technicians as well as money, but a history of managing with limited resources by making our own devices to a high standard. Basic chemotherapy regimens such as CMF and CAF are available, but not more expensive regimens such as those containing taxanes. Tamoxifen is freely available at a cost of approximately $3USD per patient per month. We have recently obtained Arimidex on hospital code but at a cost of approximately $115USD per patient per month, this will only be available as a second-line and to selected patients.

Patients with any breast problems can be seen on a Friday morning by a member of the surgical team. Tests such as mammograms, fine needle aspiration biopsies and trucut biopsies can be done immediately. The fine needle aspiration specimens are read by a technician and based on the clinical picture and these results, if it appears the patient has cancer she will be seen that morning by a member of the oncology team. Appropriate counselling, according to the level of certainty, takes place and the patient has staging investigations. If the patient is unfit for surgery or the tumour appears inoperable she will be commenced on hormonal treatment or booked for chemo or radiotherapy. If surgery is an option she will be seen again by our interdisciplincary panel the following week. Patients are seen by an experienced counsellor (a social worker) at their first visit and the counsellor is available at the combined clinic. The combined team includes general surgeons, clinical radiation oncologists, plastic surgeons, pathologists, radiologists, nursing staff and secretarial staff as well as the social worker. Post-operatively patients return to the oncology clinic where all further treatment and follow-up takes place. Patients are referred back to the surgeons or the combined clinic if they have further surgical problems such as operable local recurrences. Patients may be referred to their community hospitals for follow-up. We also work closely with hospice organizations for patients with advanced disease.

As clinicians responsible for breast cancer patients we do not wholly agree with the WHO emphasis on prevention and palliation rather than cure. We do not know how to prevent breast cancer in South Africa and many of our patients have curable disease. We do not agree either with the approach mentioned at the Accra AORTIC meeting that in Africa patients should simply be given Tamoxifen. We offer patients the best option available, although many of our black patients do decline surgery and even radiotherapy. They believe that surgery particularly may help to spread the cancer and kill them. Until education is improved this will probably remain a major reason for breast cancer mortality in South Africa.

Continued on next page …

BREAST CANCER CLINIC AT GROOTE SCHUUR HOSPITAL (Cont.)

Although a relatively high number of our black patients have ER+ve tumours (as opposed to those reported from other African countries where there seems to be a high level of ER negativity) we feel that it is imperative that tumours are tested for hormonal receptors before any hormonal treatment takes place. This is in fact a much better use of resources and more cost-effective than simply treating all breast cancer patients with Tamoxifen.

At the last AORTIC meeting the opinion that African centres should be doing their own research rather than collaborating with European or American centres was expressed. However, we find that in spite of being better equipped than centres in many other African countries, we do not have the facilities necessary for running major research projects. We also find collaborative efforts with other centres in South Africa very difficult probably due to lack of resources and staff in all our centres. We believe the most important research we do is that in collaboration with the International Breast Cancer Study Group (IBCSG). As this is an international group, it can be expected to take into account conditions in different countries. Indeed, we have found the IBCSG extremely supportive of the work we do and understanding of what is possible and appropriate in our unit. Many of these international trials touch on issues of tailoring and timing of treatment and these issues may be particularly important where resources are limited. Our work for the IBCSG is partly funded by the CANSA association of South Africa. We are also involved in some pharmaceutical contract research and run some local small trials although we find this difficult.

One of our hopes for the future is that if partial breast radiation, already promising, becomes a proven, accepted technique we will have the facilities to use this in our clinic. This would allow higher rates of breast conservation.

We have been encouraged by registrars trained in our clinic who have gone elsewhere in our country or elsewhere in Africa and started up Combined Breast Clinics. This indicates how staff find work in these clinics worthwhile, enjoyable and morale boosting. We are involved in training registrars from other African countries sponsored for example by the International Atomic Energy Association.

Through AORTIC we hope that our links with Africa will improve as we have found that those with specialists in Europe and America have been very worthwhile and encouraging.

Dr Elizabeth Murray
Senior Specialist
Radiation Oncology
Groote Schuur Hospital

African Guest Researchers' Scholarship Programme 2006

One of the purposes of the Nordic Africa Institute is to establish and maintain relations with African research communities. This is achieved through a Guest Researchers' Programme which provides opportunities for its participants to pursue their own research projects.
This Programme is geared at senior scholars in Africa involved in research on/about the African Continent with a proven track record of extensive postgraduate research. Women especially are encouraged to apply.

Preference is given to those involved in research in the following areas:

1) Cultural images in and of Africa
2) Liberation and Democracy in Southern Africa
3) Sexuality, Gender and Society in Africa
4) Gender and Age in African Cities
5) State Recuperation, Resource Mobilisation and Conflict
6) Post-Conflict Transition, the State and Civil Society in Africa

For more information please contact Nina Klinge-Nygård per e-mail: klinge-nygård@nai.uu.se.or or their website at: http://www.nai.uu.se

Letter of appeal from Professor Ahmed Elzawawy

Dear Colleagues

The fight against cancer in countries with limited resources is a complex one.
One of the main problems in many developing countries is that we work in isolation from one another. One way to alleviate this dilemma is to open up channels of communication amongst health-care professionals in Africa.

I believe that it is my duty to serve my fellow scientists with what limited capabilities I possess and to act as a liaison for new initiatives.

During the upcoming UICC Meeting that will be held in March 2005, in Cairo, there will also be a satellite meeting with the purpose of calling upon cancer activists in North Africa and the Middle East.
Dr Joe Harford, Director of International Affairs, NCI, USA will also be present at this meeting. The outcome of this meeting will be reported in the next issue of "AORTIC News".

I would like to take this opportunity to make an appeal to all my colleagues in North Africa to please send me the e-mail addresses of any oncologists in North Africa. I will also be deeply grateful if you would e-mail me the details of any training opportunities, courses and events offered at your institutions, hospitals or training centres in your area.

Thank you to all those who have supported AORTIC's cause and continuously do so.

Professor Ahmed Elzawawy
Vice President of AORTIC, North Africa

This letter has been edited due to space constraints .—AORTIC News

EDUCATIONAL GRANTS AVAILABLE

Educational Grants are available from Johnson & Johnson for upgrading skills of doctors/nurses/ other specialties involved in care of women with cancer in Africa.

Applicants must have at least 3 years experience in their specialty, and must have the permission of the host institution as well as a commitment to return to the host institution post training. All specialties related to cancer care of women will be considered eligible for the grant. The grant will range from US$2000 to US$10 000 depending on the nature of the training.

Interested applicants should apply to Professor Lynette Denny at:
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P O Box 186
Rondebosch 7701
South Africa
E-mail: aortic@telkomsa.net
OR
Erica Bard Riley
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The African Organisation for Research and Training in Cancer is a bilingual (English/French) non-governmental and not-for-profit Organisation that was founded in Lome, Republic of Togo, West Africa in 1983. It is dedicated to the promotion of cancer control in Africa. AORTIC International, founded by expatriate African cancer care workers, scientists and their friends, is committed to the development of AORTIC in Africa.

BOOKS

Patient Education Guide to Oncology Drugs, 2nd Edition
Gail M Wilkes & Terri B. Ades
Published by the American Cancer Society
ISBN: 0-7637-2254-5 480 pages
To order, consult their website: www.cancer.org/bookstore

Oncogenomics, Molecular Approaches to Cancer
Charles Brenner & David Duggan
Published by John Wiley & Sons, Ltd.
ISBN : 0-471-22592-4 384 pages
Price: US$79.95
To order, e-mail: cs-books@wiley.co.uk

When cells die II
Richard A. Lockshin & Zahra Zakeri
Published by John Wiley & Sons, Ltd
ISBN: 0-471-21947-9
Price: US$99.95
To order, e-mail: cs-books@wiley.co.uk

A Cancer Source Book for Nurses, 8th Edition
Claudette G. Varricchio, et al.
Published by the American Cancer Society
To order, consult their website: www.cancer.org/bookstore

UPCOMING CONFERENCES 2005

3rd International Symposium on Targeted Anti-cancer Therapies
March 3 – 5, 2005
Amsterdam, Netherlands
E-mail: congress@nddo.org

58th Annual Cancer Symposium of the Society of Surgical Oncology
March 3 – 6, 2005
Atlanta, Georgia, USA
E-mail: diannekubis@acaai.org

Functional Genomics and Animal Tumour Models
March 7 – 9, 2005
Madrid, Spain
E-mail: ccc@cnio.es

7th Shaukat Khanum Memorial Cancer Symposium
March 11 – 13, 2005
Lahore, Pakistan
E-mail: trainingmanager@skm.org.pk

13th International AEK-AIO Cancer Congress
March 13 – 16, 2005
Würzburg, Germany
E-mail: ssk@biomedtec-franken.de

ASCO Annual Meeting
May 14—15, 2005
Orlando, Florida
E-mail: asco@asco.org

What's happening in Central Africa

06- 15 March 2005: Research Campaign of cancers of the collar and breast in Yaounde and Douala organised by the National Committee of Fight Against Cancer in Cameroon (CNLC).
15 March 2005: Scientific conference on cancer in N'djamena, Tchad, by the leaders of AORTIC Central Africa
05 April 2005: Cancer Research Day in Cameroon.
04- 07 April 2005: Working visit in Yaounde with Director of the INCTR (Dr Ian Magrath)
4- 5 March 2005: Congress of Libreville (3éme Euro - African congress of cancer research). This has been postponed to March 2006.