WHY IS THERE NO PROGRESS AGAINST CERVICAL CANCER?

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Abstract • Résumé

The author reflects on the disheartening report given by Dr. E. Jean Parboosingh and associates on Canadian screening programs for cervical cancer (see pages 1847 to 1853 of this issue). Although cancer of the cervix is one of the few preventable forms of cancer, little progress has been made toward the establishment of programs to control this disease. Barriers to progress include a lack of priority given to women's health issues, insufficient public awareness of cervical cancer, the absence of vocal lobby groups, poor understanding of the limitations of secondary prevention, uncertainty about professional jurisdiction and the financial commitment of government, a tendency for minutiae to deflect attention from essential aims and the sheer complexity of the task of prevention and control. Unless these barriers are overcome it is unlikely that there will be much progress toward the eradication of cervical cancer in Canada.

L'auteur trouve décourageant le rapport du Dr E. Jean Parboosingh et de ses collègues au sujet des programmes canadiens de dépistage du cancer du col (voir pages 1847 à 1853 de ce numéro). Même si le cancer du col est une des rares formes de cancer qu'il est possible de prévenir, l'établissement de programmes de lutte contre cette maladie n'a pas beaucoup progressé. Les obstacles au progrès comprennent la priorité insuffisante accordée aux enjeux de la santé des femmes, une population mal sensibilisée au cancer du col, l'absence de groupes d'intervention visibles, une mauvaise compréhension des limites de la prévention secondaire, l'incertitude au sujet de la sphère de compétance des professionnels et de l'engagement financier du gouvernement, une tendance à laisser les détails détourner l'attention des buts essentiels et, enfin, la complexité même de la tâche que constituent la prévention et le contrôle. Si l'on ne surmonte pas ces obstacles, il est peu probable que le Canada fasse de grands progrès vers l'éradication du cancer du col.

In this issue (see pages 1847 to 1853) Dr. E. Jean Parboosingh and associates give a disheartening report on screening programs for cervical cancer in Canada. Although it is good to be optimistic about the eventual success of such programs, it is important to be realistic about their relative failure to date. From the first gathering of experts leading to the Walton report of 1976[1] to the update provided at the Interchange '95 workshop in Ottawa early in 1995, progress in the adoption of the recommendations of various task forces, working groups and advisory bodies has been made at a snail's pace. Participants at the National Workshop on Screening for Cancer of the Cervix, held in Ottawa in November 1989, made 27 recommendations, but few of these have been implemented.[2] British Columbia, Nova Scotia and, more recently, Prince Edward Island have led the way by establishing provincial registries, but the other provinces and territories are still far behind. Why has there not been more progress in the control of cervical cancer?

PRIORITIES

Legislative bodies have generally not given high priority to issues with particular importance to women, such as day care, employment equity and women's health. This is beginning to change as more women enter the higher echelons of government and of nongovernment agencies; however, much progress remains

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to be made. The current focus in government on budgetary deficits will likely result in slippage in the progress toward equal priority for women's issues.

Public awareness

Despite the large number of women who obtain abnormal Papanicolaou test results, the Canadian public is generally unaware of cervical cancer as an important health issue. Although newspapers and magazines are replete with articles about lifestyle changes to reduce the risk of cardiovascular disease and certain cancers, little attention is given to cancer of the cervix.

Although cervical cancer is an important cause of death in developing countries, the number of deaths from this disease in the western world is relatively low. The National Cancer Institute of Canada estimates that there were 1300 new cases of cervical cancer and 370 deaths from the disease in this country in 1995.[3] Cancers of the lung, breast and colon are much more prevalent; in the same year there were 16 800 deaths from lung cancer, 5400 from breast cancer and 6300 from cancer of the colon in Canada.[3] As a result, cancer of the cervix may be perceived as having been "tackled" in western countries. None the less, it demands our attention by virtue of the fact that it is one of the few essentially preventable forms of malignant disease.

Members of the public tend to be unaware of the fact that cervical cancer is a sexually transmitted disease (STD) associated with human papilloma virus. Little research has been done on the prevention of cervical cancer by the use of barrier contraceptives. Primary prevention of STDs is a delicate subject that requires a careful approach so as not to offend public sensibilities. None the less, more public education and interventions to change understanding, attitudes and behaviour with respect to STD prevention should also reduce the incidence rate of cervical cancer.

There is a general lack of understanding of what the Papanicolaou test is and why it is important. Many women (and unfortunately many physicians) fail to appreciate that a Papanicolaou test is a screen and therefore subject to limitations such as false-positive results leading to unnecessary treatment, false-negative results leading to false reassurance, and the cost of overscreening. Screening is not a treatment: women who obtain a positive test result must return for follow-up and medical care. Unfortunately, there is often no formal mechanism to ensure that women who obtain a positive result come back for treatment and that the treatment they do receive is appropriate.

Women with cervical cancer are often from low-income, native or immigrant communities.[4] In contrast, breast cancer is more likely to strike upper-income, well-educated women.[5] Women with cervical cancer have no public voice: there is no active lobby group for cervical cancer as there is for AIDS and breast cancer. Cancer of the cervix does not provoke the same emotional response as, say, cancer of the breast; the cervix is not perceived as a symbol of femininity in the same way as the breast is. There is no "ribbon campaign" for cancer of the cervix, and no national society to raise funds for research and patient education and advocacy. Within the Canadian Cancer Society, cancer of the cervix must compete against all other cancers for funding and resources.

Turf wars and medical minutiae

Battles over matters of professional jurisdiction have impeded progress in the control of cervical cancer, and a lack of communication between the various players has contributed to this problem. Health care providers see cancer prevention and treatment as their mandate. Public health officials are hampered by a lack of funding and of research into ways to increase recruitment of women at high risk into screening programs. Small laboratories have relied on income generated from the reading of Papanicoloau smears and have resisted, for financial and administrative reasons, the adoption of a uniform nomenclature.

The training and credentialling of colposcopists is another unresolved issue. Currently any gynecologist or family practitioner can purchase his or her own colposcope, but no specific qualification is required for the practice of colposcopy. There is a wide spectrum of expertise in colposcopy and no mechanism to ensure that practitioners are adequately trained.

At the same time, much effort has gone into the dissection of such issues as the frequency of screening, the appropriate patient age range for screening, and protocols for follow-up. Although these issues are important, they have deflected energy and effort from the implementation of the main recommendations of the task forces, namely the recruitment of women who have never been screened, the formation of provincial registries and information systems and the establishment of quality-control systems in laboratories.[2]

A complex task

There is no simple route to the prevention of cervical cancer. This is not a disease that can be managed by single-action public health efforts such as adding iodine to salt or fluoride to water or legislating the use of seat belts (not that these interventions were easily established). For cancer of the cervix to be eradicated in this country, all 27 recommendations of the 1989 task force[2] would need to be implemented: this requires money, a

coordination of efforts and the dedication of all concerned. One strategy that might help to streamline the task of cervical cancer control would be to integrate some efforts with breast cancer screening programs.

Government funding is needed in the short term to establish registries, information systems and follow-up mechanisms. Studies have shown that these efforts will be cost-effective only in the long term.[6,7] Sadly, cash-strapped provincial governments are unlikely to do much in this area, given today's economic climate. But even during the relative wealthy 1980s, there was little movement toward the establishment of cancer registries in most provinces.

Although the federal government has taken the lead in the formation and funding of a number of task forces on the issue, when it comes to pursuing the implementation of the various recommendations that result it is not clear who will pay. The federal government thinks that the provinces should fund cancer registries, laboratory quality-control programs and the like, while the provinces look to the federal government for financial assistance. In the meantime, little is accomplished.

Given this gloomy picture, will anything ever happen to promote the decline of cervical cancer in Canada? Movement to date has been excruciatingly slow, and the successes we have enjoyed have resulted from the efforts of a few dedicated individuals. Sadly, without a concerted effort to bring cervical cancer into the public's imagination, without backbenchers in the legislatures to take it up as their cause and without an active public lobby group it is likely that little or no progress will be made to eradicate one of the few forms of cancer for which the knowledge and technology exist for its elimination. This is a case in which there has been "too little," but it is not "too late."

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Oct. 9–12, 1996: International Health Evaluation Association 15th International Meeting — Information, Informatics and Health Evaluation: Persons, Providers and Settings
Victoria
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Oct. 9–13, 1996: 4th International Symposium on Childhood Deafness — Serving All Children with Hearing Loss
Kiawah Island, SC
Sheila Lewis, Bill Wilkerson Center, 1114 19th Ave. S, Nashville TN 37212; tel 615 340-8292, fax 615 343-7705

Oct. 11–13, 1996: 4th World Biomedical Conference of the Hellenic Diaspora
Nicosia, Cyprus
Pancyprian Medical Association, PO Box 1348, Nicosia, Cyprus; tel 357 2 367-401, fax 357 2 367-016

Oct. 12–14, 1996: Arab Pharma International Exhibition and Conference for Pharmaceutical Products and Technology
Dubai, United Arab Emirates
Al Fajer Information and Services, PO Box 11183, Dubai, United Arab Emirates; tel 971 4 621-133, fax 971 4 622-802

Oct. 13–16, 1996: Society for Medical Decision Making 18th Annual Scientific Meeting
Toronto
Society for Medical Decision Making, hlt@ices.on.ca, aoconnor@civich.ottawa.on.ca

Oct. 14–17, 1996: MEDNET '96 — European Congress of the Internet in Medicine
Brighton, England
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Clive Baldock, Medical Physics Department, Brighton Health Care National Health Service Trust, Royal Sussex County Hospital, Eastern Rd., Brighton BN2 5BE, England; tel 01273 696-955, ext. 4387, fax 01273 664-503; info@mednet.org.uk; Website: http://www.mednet.org.uk/mednet/mednet.htm

Oct. 17–19, 1996: Atlantic Provinces Radiologists Annual Scientific Meeting
Halifax
Keynote speakers: Drs. Don Kirks and David Li
Dr. Don Cheverie, Dartmouth General Hospital, Dartmouth NS B2Y 4G8; tel 902 465-8321, fax 902 465-8360; 1967istr@fox.nstn.ca

Oct. 18–20, 1996: Canadian Medical Society on Alcohol and Other Drugs 8th Annual Scientific Meeting — the Art of Addiction Medicine
North York, Ont.
Wilcom Services Inc., 59 Horner Dr., Nepean ON K2H 5G1; tel 613 596-6064, fax 613 596-0711

Oct. 24–27, 1996: Medicare Asia '96 — the Asian Medical Exhibition and Conference
Bangkok, Thailand
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