



NEWS LETTER

ISSUE: JANUARY 2024 | VOLUME: 28 | No. 1 | PRICE: 50 PAISA

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CAN WE ELIMINATE CERVICAL CANCER?

Cervical cancer is one of the most preventable cancers. However, in 2020, an estimated 341,800 women died from cervical cancer globally. Most of these deaths occurred in low- and lower-middle income countries (LMICs) due to inadequate access to cervical cancer prevention, screening and treatment.

In November 2020, the World Health Organization launched a Global Strategy to accelerate the elimination of cervical cancer as a public health problem. The Strategy proposed an elimination threshold of 4 cases per 100,000 women, achieved by implementing the triple intervention targets by 2030:

- 90% of girls should be fully vaccinated with the HPV vaccine by age 15.
- 70% of women should be screened with a high-performance test (such as the HPV test) by 35, and again by 45 years.
- 90% of women identified with cervical precancer or invasive cancer should receive adequate treatment and care.

In India, cervical cancer is the second most common cancer in women, with 96,922 new cases (14.7 per 100,000 women) and 60,078 deaths (9.2 per 100,000 women) in 2018. Although cervical cancer screening guidelines have been developed for India. Screening coverage across the country is low. Pilot projects for HPV vaccination started in 2009 but were paused due to apparent adverse events, which were later found to be unrelated to HPV vaccination. Efforts are being made to introduce the HPV vaccine into the immunization programmes in some states. However, to reach the elimination targets, organized national programmes for HPV vaccination, screening and treatment need to be implemented across the whole country.

In 2016, Government of India (GOI) launched the operational framework for prevention and control of oral, breast, and cervical cancers. The guidelines included screening women aged 30 - 65 years through visual inspection of the uterine cervix after application of 3% - 5% acetic acid (VIA), a cost-effective cervical cancer screening method in low-resource settings. The National Health Policy (2017) has mandated population-based cancer screening at all health and wellness centres under universal health care coverage.

WHO has proposed a triple pillar intervention strategy for eliminating cervical cancer?

Pillar 1: HPV Vaccination

The introduction of HPV vaccines into the national immunization programme is a crucial first step. Scale-up of HPV vaccination coverage could be facilitated by considering multisectoral delivery platforms, including a school-based strategy targeting adolescent females aged 9-14 years, or innovative community-based strategies.

Pillar 2: Cervical Cancer Screening

70% of women should be screened (HPV Test) by 35 years age. But the coverage of screening for cervical cancer in India remains strikingly low. The National Family Health Survey, India (2019–2021) indicated that only 1.9% of women (aged 30 - 49 years) have ever undergone cervical cancer screening (2.2% in urban areas and 1.7% in rural areas) Cervical cancer is the second most common cancer in Indian women. In India, nearly 80% of women with cervical cancer are diagnosed in advanced stages, with a relative survival rate of less than 50%. Screening programmes should be integrated with existing services such as primary care services, for instance by offering HPV testing at health clinics, PHCs, ante-natal care consultations, family planning consultations or women's health clinics. Additionally, it is essential to provide information and education for women on the importance of cervical cancer screening, and potentially offering self-collection for HPV testing, or point-of-care HPV testing in rural areas, so that women who need pre- cancer treatment can be given in the same visit. Implementing surveillance and monitoring systems are also critical for ensuring women are not lost to follow-up.

Pillar 3: Cervical Cancer Treatment

The establishment of strong referral networks between all aspects of the cancer care spectrum is needed to ensure the timely management of patients. Diagnosis, treatment, and monitoring of invasive cervical cancer will require high-quality pathology services and oncology services. Safe, effective, and timely surgery accompanied by supportive services such as anaesthetic services and intensive care units are important for the treatment of early stage cancers. Furthermore, expanding access to radiotherapy units and access to chemotherapy services, as well as palliative care services, is important. **(Continue on last page)**

HPV VACCINATION IN INDIA: NEW PROGRESS AND THE WAY FORWARD

In a promising advance in its fight against cervical cancer, India recently launched its first locally produced version of the human papillomavirus (HPV) vaccine “Cervavac”. Currently, India lacks a national immunization program for carcinoma cervix eradication. Inclusion of Cervavac into the national immunization schedule will undoubtedly boost the fight against cervical cancer.

HPV is a group of more than 200 related viruses, sexually transmitted HPV types fall into two groups, low risk and high risk. High-risk HPVs can cause several types of cancer. **HPV infection is common.** Nearly all sexually active people are infected with HPV within months to a few years of becoming sexually active. **Most HPV infections don't cause cancer.** Our immune system usually clears most of HPV infections. **Only about 1% of High-risk HPV infections that persist can cause cancer.** Human papillomavirus (HPV) infection is a well-established cause of cervical cancer and there is growing evidence of HPV being an important factor in other anogenital cancers (anus, vulva, vagina, and penis) as well as head and neck cancers.

India has a population of 511.4 million women ages 15 years and older who are at risk of developing cervical cancer. Almost all cervical cancers are caused by persistent infection with one of the 14 high-risk types of human papillomavirus (HPV), with HPV types 16 and 18 accounting for 73% of cervical cancers globally and **80 - 85% of cervical cancers in India.** Cervical cancer is the second most common cancer in India, with an estimated 1, 23,907 new cases and 77, 348 deaths annually (Globocan2020) which is close to one-fifth of the global burden of this cancer. With more than three-quarters of cases diagnosed at a locally advanced clinical stage with poor prospects of survival.

Types of vaccines available in India

GARDASIL 9:

- HPV STRAINS COVERED - **6, 11, 16, 18, 31, 33, 45, 52, 58**
- Above strains are responsible for **98.4%** cases of **Cervical Cancer.**

GARDASIL / CERVAVAC:

- HPV STRAINS COVERED - **6, 11, 16, 18**
- Above strains are responsible for **83.2%** cases of **Cervical Cancer.**

Primary and secondary target groups

- Primary target group: HPV vaccination in girls aged 9-14 years before they become sexually active
- Vaccination of secondary target population e.g. females aged ≥ 15 years, boys, older males (MSM) is recommended only if this is feasible and affordable.

The most favourable time to take the vaccine is "Before the Sexual Debut".

HPV vaccines should be administered intramuscularly in the deltoid region of the upper arm. HPV vaccines do not protect against all HPV types that can cause cancer. Women who have been vaccinated are advised to follow the same screening recommendations as unvaccinated women.

WHO position paper with SAGE recommendation.

- A one or two-dose schedule for girls aged **9-14 years**
- A one or two-dose schedule for girls and women aged **15-20 years**
- Two doses with a 6-month interval for women older than 21 years

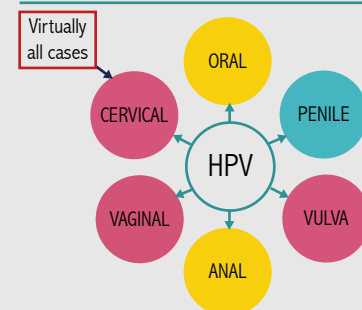
But one dose efficacy with Cervavac not yet established.

Special Situations

- HIV positive or immunocompromised girls - Three doses
- Interrupted doses - Continue with the remaining doses as per age-based recommendation, vaccination series need not be restarted
- Pregnancy - Not recommended in pregnancy (if advertently given, no need for MTP)
- Lactation - Can be given during lactation

HPV vaccines are based on virus-like particles (VLPs) that are formed by HPV surface components. VLPs are not infectious because they lack the virus's DNA. However, they closely resemble the natural virus, and antibodies against the VLPs also have activity against the natural virus.

HUMAN PAPILLOMAVIRUS CAN CAUSE SEVERAL TYPES OF CANCER



cancer.gov/hpv

Over 15 years of monitoring has shown that HPV vaccine is very safe

Like any vaccine or medicine, HPV vaccines can have minor side effects. The most common side effects Pain, redness, or swelling in the arm where the shot is given, Dizziness or fainting (fainting after any vaccination, including HPV vaccine, is more common among adolescents), Nausea / Headache etc. The benefits of HPV vaccination far outweigh the risk of potential side effects. To prevent fainting and injuries from fainting, adolescents should be seated or lying down during vaccination and for 15 minutes after getting the shot.

Cervical cancer is one cancer that we can actually eliminate: it's time to do it.

Eliminating any cancer would have once seemed an impossible dream, but we now have the evidence-based tools to make that dream a reality, they just need to be made accessible and acceptable. In 2020, World Health Organization approved a strategy aimed at eliminating Cervical Cancer worldwide. To eliminate cervical cancer, all countries must reach and maintain an incidence rate of below 4 per 100 000 women.

ELIMINATION STRATEGY SUGGESTS A THREE - PILLAR APPROACH



- **Vaccination:** 90% of girls fully vaccinated with the HPV vaccine by the age of 15
- **Screening:** 70% of women screened using a high-performance test by the age of 35, and again by the age of 45
- **Treatment:** 90% of women with pre-cancer treated and 90% of women with invasive cancer managed

Each country should meet the 90-70-90 targets by 2030 to get on the path to eliminate cervical cancer within the next century. About 125 countries have HPV vaccine in their national immunisation programme for girls, with about 47 countries extending the programme also to boys. However, this corresponds to only around a third of the global target population. Introduction of the vaccine in low-income and middle-income countries (LMICs), where 90% of deaths occur, remains slower. **There is a long way to go to meet the 2030 elimination target of 90% in India as presently less than 1% of our girls are vaccinated and less than 2% of Indian women have ever been screened according to NFHS-5.**

HPV vaccination is our best defence in preventing HPV-related cancers. India has an impressive track record in its childhood immunization program and recently COVID-19 vaccination. Inclusion of HPV Vaccine into the national immunization schedule will undoubtedly boost the fight against cervical cancer. A strong political and bureaucratic will and an effective public awareness campaign with positive messaging are imperative for the success of any such endeavour. By creating awareness, removing misconceptions and myths the cervical cancer menace can be effectively controlled. It takes governments, NGOs, and other concerned organizations to come together to fight against HPV and cervical cancer. Improvements in screening, diagnosis, and treatment are urgently needed, but widespread vaccination against human papillomavirus will have the largest effect towards eliminating the disease.

The HPV vaccine is CANCER PREVENTION

Dr. Indu Aggarwal

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RGCIRC, Rohini

CME - IMA JANAKPURI

CME Programme organized by RGCIRC in association with IMA Janakpuri on Friday, 12th January 2024 at IMA Medico House, D - Block Road, Janakpuri Institutional Area, Janakpuri, New Delhi. Dr. Rajat Saha, Sr. Consultant & Unit Head, Medical Oncology, RGCIRC delivered a lecture on **Early Diagnosis and Management of Cancers** and Dr. Sarika Gupta, Sr. Consultant & Unit Head, Gynae Surgical Oncology, RGCIRC spoke on **Prevention and Management of Gynecologic Cancer**.



FOGSI NORTH ZONE CONFERENCE WITH YUVA 2024

RGCIRC participated in FOGSI North Zone Conference with YUVA 2024 organized by Meerut Obstetrics & Gynecology Society from 19th - 21st January 2024 at Hotel Godwin, Meerut, UP. Dr. Vandana Jain, Sr. Consultant & Chief of Gynae Surgical Oncology, RGCIRC delivered a lecture on **Sentinel Node Mapping in Endometrial Cancer** and Dr. Sarika Gupta, Sr. Consultant & Unit Head, Gynae Surgical Oncology, RGCIRC spoke on **HIPEC in Ovary Cancers**.



EDITORIAL: Continued from page 1

U.S.A is on track to achieve cervical cancer elimination (incidence less than 4 per 100,000 women) by 2038-2046. Current HPV vaccination rates in the U.S have achieved cumulative coverage of ~75% by age 26 years in female and ~ 62% by age 21 years in males. Australia is one of the world leaders in cervical cancer prevention; it was the first country to implement the HPV vaccine into national immunization programs and one of the earliest to change national screening programs to HPV-based testing. It is estimated that Australia will eliminate cervical cancer by 2035.

India is at a crucial stage in its efforts to prevent and treat cervical cancer, and a concerted strategic plan to accelerate the elimination of cervical cancer needs to be developed and implemented. There will be many challenges along the way, including vaccine and screening test supply and delivery challenges, human resource capacity and the infrastructure challenges associated with scale-up of invasive cancer diagnostics, treatment, and supportive and palliative care services. Cervical cancer elimination is within our reach and we urge all stakeholders to support this effort by investing in the comprehensive approach as a national priority.

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Printed and Published by Mr. Pramod Maheshwari on behalf of Indraprastha Cancer Society and Research Centre and printed at R. R. Enterprises, 18 - A, Old Gobind Pura Ext., Street No. 2, Parwana Road, Delhi - 110051, Tel: +91 84474 94107, Published from Rajiv Gandhi Cancer Institute and Research Center, D-18, Sector - 5, Rohini, Delhi - 110085

