

Opportunistic Screening for Ca PVU in Primary Health Care

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ABSTRACT Majority of countries don't have an organized screening program. It is not conducted or is in form of opportunistic screening. An organized screening for cervical cancer in developed countries is resulted in significant decrease of incidence and mortality. In our country there is no an organized screening program. Even it is carried out, it is in form of opportunistic screening. Consequently, the number of cervical carcinoma (Ca PVU) is the largest in Europe. The goal of this research is accomplishing possibilities and limits of opportunistic screening in Velika Plana

KEY WORDS *screening, oportunistc, cervix, carcinoma*

Introduction

Text Introduction

Invasive cervical cancer, one of the most common malignant tumor of women [1] is usually the second or third. place, behind breast cancer and colorectal cancer (colon cancer) [2]. According to the International Union for the Fight against Cancer (IUC) cervical cancer goes up to 12% of all malignant diseases of women [3]. It is believed that these diseases cause 3 to 5% of deaths because of cancer [4]. According to latest estimates 466,000 new cases of cervical cancer occur annually among women worldwide [5]. Almost 80% of that number are diagnosed in developing countries (Melanesia, Africa, Central and South America), where screening programs are not implemented or poorly organized.

In most countries the incidence of invasive cancer is very low for women under 25 years. Incidence grows about 35 to 40 years and reaches a maximum in the fifties and sixties [6]. Average time required for the development of cervical cancer is 10 years, and it usually occurs from 48 to 52 years, in recent times is evident that the incidence of, and mortality from cervical cancer, especially among young women, rises. Infection by human papilloma virus (HPV) is the biggest risk factor for disease emergence. HPV is a sexually transmitted disease. Although HPV infection is an important element for the development of cervical cancer, it is not sufficient for the development of the malignant transformation. Other cofactors participate in the process: the early entry into sexual relations, a higher number of sexual partners, multiple pregnancies, sexually transmitted infections, low socio-economic standard of living, stressful events, the situation of hopelessness and depression, smoking, use of oral contraceptives

for a long time, alcohol, chemotherapeutics, immunosuppression, factors related for male partners (number of sexual partners, visiting prostitutes, male age at the time of the first relationship, infection of genital organs, the existence of condyloma or penile cancer [7]).

Today it is known that the disease develops from precancerous changes (dysplasia known as the General), advancing from low, through moderate and severe dysplasia. Next stage is cancer in situ, and the next one is the invasive cancer. The time required for the progression from dysplasia to invasive cancer is variable, but it is estimated that is 10-15 years. Programs for the Prevention of cervical cancer are based on this fact. Prevention of invasive cancer is effective when it is diagnosed and treated early. Precancerous changes are asymptomatic. The majority of cases have no clinical signs that a woman could notice. Therefore, women who are regularly controlled will not develop cervical cancer. (8).

For the diagnosis of premalignant and malignant changes today, there are a few methods. In addition to cytology (pap-PAP test), which after more than half a century since the introduction of the practice remains sovereign screening methods for detection of cervical cancer, the most important place in the early diagnosis of cervical changes take colposcopy (examination of cervix, under conditions of good lighting and magnification) and target biopsy (snippet) (8).

Screening aims to detect disease in apparently healthy people and such a serious illness and death could be prevented. Screening for Ca PVU can be organized or opportunistic (disorganized, spontaneous, individual)..

Objective

To evaluate the importance of opportunistic screening for Ca PVU in primary health care.

Methods

This science work included all women who came between 1.1 - 31.12.2005. was reported in the gynecological examination in the Home Health Velika Plana. Each of the respondents, regardless of the reason for reporting gynecologist, in addition to the basic gynecological examination was done colposcopically and PAP test review and, if necessary, cervical biopsy. From patients were collected data on age, qualifications, social origin, place of residence, marital status, deliberate and involuntary abortions, pregnancies and childbirth. It has been taken a detailed gynecological history, especially the part related to the review of cervix (the time of the last review, the frequency of examinations for early detection of cancer, pre-located). The data were statistically processed.

Results and discussion

1028 women came to review to Home Health in Velika Plana, and 606 women fulfilled the conditions for opportunistic screening. Other women did not meet the requirements because they were from other municipalities, have never had a sexual relationship or they had their uterus removed. A number of women could not be carried out screening on the same day because of their strong secretion, bleeding, severe pain or because they came only to rewrite them or to cure breast examination and did not want gynecological examination. These women have Pap smears and colposcopy scheduled the next day. From this group of 341 patients, which is scheduled to review, 122 patients did not respond to the scheduled examination (35.7% of the scheduled review). In 1028 the first examination was 192 pregnant women. Screening is done to a small number of pregnant women because among pregnant women in the area there are prejudice that gynecological examination may jeopardize the pregnancy. In addition, they are mostly young women that this is the first contact with gynecologist and one very difficult to agree on the common view, and any additional examinations required by the screening program does not want to accept. From this passage we can clearly see two major limitations in the performance of spontaneous (opportunistic) screening. The first problem is that there is no legal provision which obligate women to respond to the invitation for

screening, and the other is lack of information and poor education of patients, which leaves room for prejudices that can be eradicated only be painstaking many years of work.

The study group of patients belong to the age of 15 to 80 years, and most of them belong to the ages of 30 to 59 years. Given that the goal of screening for cervical cancer detection of premalignant lesions, screening should be targeted to the group of women who probably could have premalignant lesions, which is between 25 and 35 years. In the study population is well covered by the age of 30-35 years. Women from 25 to 30 years are somewhat less common in this group and this indicates the need for greater attention be paid to the motivation of these women for gynecological examinations and screening(Fig.1).

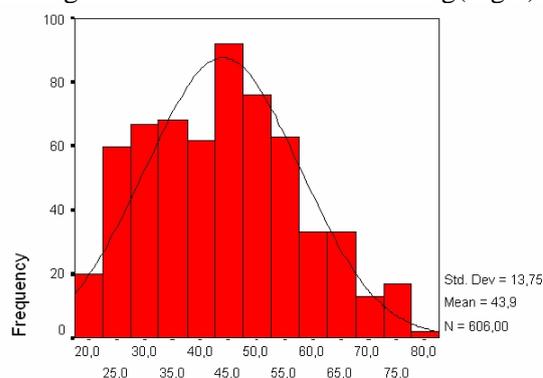


Fig.1

In the study group, 274 (45.2%) patients were from the city, and 332 (54.8%) patients were from the village, which shows that a slightly greater representation of patients from rural areas, and this is in contradiction with the assumption that because of better access to health care of patients from the city should be higher(Fig.2).

By comparing the marital status of patients with marital status of women in the general population census in 2002. was found that the number of married women in the study group, 91.1% to 58.9% in the general population, and the number of unmarried in the study group 8.9% to 41.1% in the general population. So, the percentage of married women is far higher in the examined sample, and the percentage of unmarried women is far smaller in the study group compared to the general population. This relationship and examined the general population can be explained by a variety of reasons that married women leading gynecologist: pregnancy, contraception, abortion, any absence of menstruation, the condition after birth, problems related to lactation, infertility, menstrual disorders

and a host of other problems that are inherent primarily married women(fig.3).

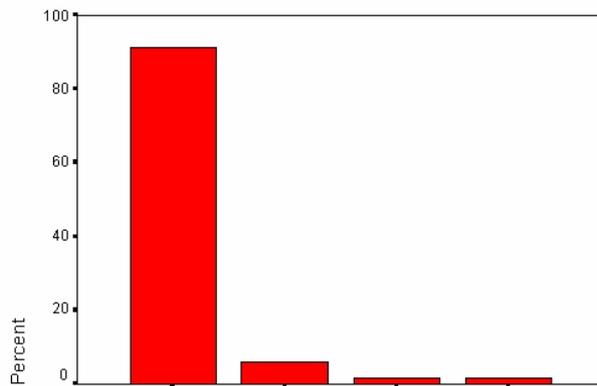


Fig.3

Among the tested women 56.1%. have completed high school (hs). Their representation in the general population census in 2002. was 28.6%. The patient completed faculty and university students is 12.8%, and in the general population, their percentage was 4.5. Women with incomplete primary school (ps) education in the study group 6.1% to 36.1% in the general population. From these data it is clear that educated women are better motivated to gynecological examination and screening test of uneducated. It can be connected with better and bigger opportunities informations communications educated women, which contributes to raising their awareness of the importance of this type of examination for early detection of cervical cancer(Fig.4).

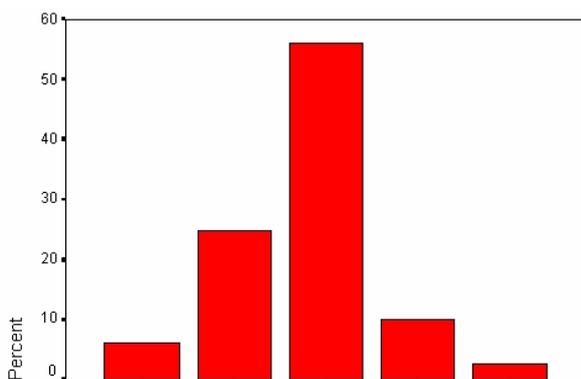


Fig.4

According to the history of menstruation, most patients have regular menstruation (62.4%). This is the logical representation of women because the majority of gynecological problems (and problems that these women bring to the review) tied just generative period for women. Most women assessed their material status as moderate (52.5%) and good (25.1%), and at least as very poor (4.5%) or very good (6.4%)(fig.5).

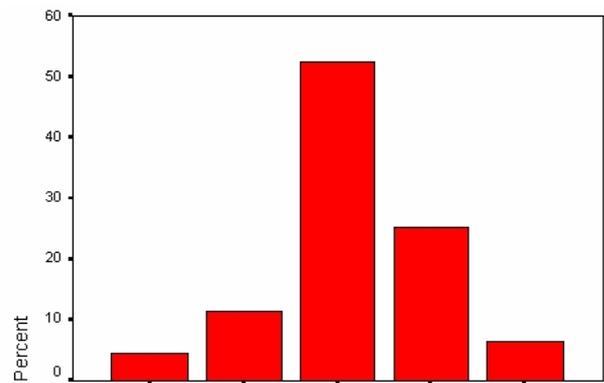


Fig.5

When it comes to the number of spontaneous and induced abortions obtained the result that 89.1% had no spontaneous miscarriages, and 43.6% of them had no deliberate miscarriages. Most patients had two deliveries, and 9.4% of women did not gave birth.

The results show that there are multiple reasons why women came to the gynecological examination, but they are very evenly represented. Only the control, without any problems, there was 15.2% of women. The percentage of such visits is low because patients generally think that if you do not feel any symptoms do not need to see a gynecologist and do not know how important it is to review when they come and not have problems because precancerous changes in the cervix generally do not have any symptoms.

The analysis of data relating to the date of last visit I found that regular gynecological examinations occurs 37.8% of women. I also found that 45.7% of women surveyed had never had a PAP test, and 88.4% of them never had colposcopy, only 4.1% of women for the first time in their life came the gynecological examination.

Table 1

| year | 1997. | 1998. | 1999. | 2000. | 2001. | 2002. | 2003. | total |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L-SIL | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 9 |
| H-SIL | 1 | 0 | 0 | 0 | 1 | 1 | 2 | 5 |
| CaPVU | 1 | 1 | 3 | 5 | 3 | 3 | 7 | 23 |

Table 2

| year | 2004 | 2005 | total |
|--------|------|------|-------|
| L-SIL | 7 | 10 | 17 |
| H-SIL | 8 | 7 | 15 |
| Ca PVU | 3 | 3 | 6 |

Also, for seven years (1997th to 2003rd, a period when opportunistic screening is not implemented) diagnosed a total of 14 precancerous changes in the cervix(table1), and for only two years of implementing the screening (2004th and 2005th) diagnosed a total of 32 such

changes, that with simple intervention can be removed and thus save the patient's life(table2).

Since 2004. in the Dispensary for women in Velika Plana was introduced opportunistic screening for cervical cancer. Protocol analysis colposcopy and Pap smears for women dispensaries I came to the fact that for seven years (from the 1997th to 2003rd) 772 colposcopies had been done, and for the two years since the introduction of opportunistic screening was done in 2933 colposcopic examination.

From these data it can be concluded that the increase in the number of preventive examinations for cervical cancer resulted in increasing the number of diagnosed precancerous lesion which is the goal of screening. The number of cervical cancer in 2004. and 2005. year remained unchanged, as expected given that the result of screening, in the form of reducing the number of malignant changes in the cervix, can be seen only in a few years.

Conclusion

Based on the results of the work I came to the following conclusions about the limitations and possibilities of opportunistic screening:

Limitations of opportunistic screening:

1) lack of information the patient about the importance of preventive screenings for cervical cancer is a major obstacle for opportunistic screening

2) In our country there is no legal provision that would oblige the patient to respond to the invitation for screening.

3) Most women come on irregular review so that it is not possible for them to do screening

4) Women for review come mainly if they have problems, very few women occurs only in control without any gynecological problems.

5) uneducated women rarely come to the view

6) Women who are not married rarely come to the view

7) Poor service organized Women's Health (services that are not carried out screening) is largely responsible for the high incidence and mortality of cervical cancer.

Possibilities of opportunistic screening

1) At the gynecological examination more often come married women.

2) Women more often come from the countryside.

3) educated women more regularl come to the gynecologist of the uneducated.

4) Women in their reproductive stage of life more often come to the gynecologist.

5) The introduction of opportunistic screening significantly increased the number of Pap smears and colposcopy.

6) For two years the implementation of screening of precancerous lesions diagnosed almost 3 times larger than the sum of these changes are diagnosed in the last seven years when screening was not implemented.

Proposal of measures

1) It is necessary to inform and educate women about the importance of screening for cervical cancer prevention. This can be conducted through individual interviews with patients in practice, through lectures and through the mass media.

2) Special attention to the uneducated, young (from 25-35 years.and younger) and unmarried women

3) Talks and lectures to put emphasis on the necessity of regular visits to the gynecologist when there are no gynecological problems.

4) Organize a system to call patients for review which may provide adequate coverage of the population

5) Regulate the legal obligation of responding to the call for screening

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