Cancer Disease Burden

As a result of demographic, economic and epidemiological transitions, Non Communicable Diseases including cancers are in a rising trend. According to the latest estimates by “Globocan”, a project by the International Organization on Research on Cancer which provides global estimates on cancer incidence, mortality and prevalence, 14.1 million new cancer cases and 8.2 million cancer deaths have occurred in the world in year 2012. Out of this 57% of new cancer cases and 65% of cancer deaths were reported from less developed regions of the world.

According to the Sri Lanka Cancer Registry, the number of incident cancer cases has increased from 5,012 in 1985 to 16,963 in year 2010 in Sri Lanka. Cancer is the second commonest reported cause of hospital deaths in Sri Lanka. Crude annual cancer death rate has increased from 27.9 per 100,000 population in 1985 to 55.2 per 100,000 population in 2009.

Cancer survivors

Earlier the cancer survivor was defined as someone who has been diagnosed with cancer and free of any signs of the disease for at least 5 years. Those who are with signs or symptoms of the disease were referred as “cancer victims”. Later this definition of cancer survivor has been changed by the National Coalition for Cancer Survivorship as “any person who has been diagnosed with cancer, from the time of diagnosis through the balance of his or her life”. The new definition gained more acceptance as it empowers the newly diagnosed cancer patients and is now accepted by most of the leading organizations including the Center for Disease Control and Prevention and American Society for Clinical Oncology. Discussions are now going on whether to further expand the definition to include other categories such as family members, friends, and care givers affected by cancer.

As a result of the rising trend of cancer incidence combined with improved survival due to several reasons including early and accurate detection, effective treatment, and better follow up, ever increasing numbers of cancer survivors could be observed in almost all the countries of the world. It has become a major challenge to the health system.

Five year prevalence, a term used in cancer epidemiology refers to the number of patients who have been diagnosed within prior 5 years and living by the end of the given 5-year period per 100,000 adult (above 15 years) population. According to the estimates by Globocan, 5 year prevalence of all cancers was 625/100,000 adult population globally in the year 2012. Five year prevalence of all cancers except non-melanoma skin cancer was 321.9 per 100,000 adult population in Sri Lanka in year 2012.
Supportive care

Most, if not all patients, have needs beyond early cure, averting death and preventing recurrences. Cancer being a disease with a high case fatality rate and a chronic disease with the risk of inheritance, this aspect of care is much more important, though highly neglected. Even with the most sophisticated technology for screening and early detection, it is inevitable to prevent having a proportion of cancer patients, for whom the only available option is palliation. Even for those who the cure is a possibility, cancer is a destructing experience that deserves a lot of ‘supportive care’ to cope with it.

National Institute for Clinical Excellence (NICE) states that “supportive care, helps the patient and their family to cope with their condition and treatment of it, from pre-diagnosis, through the process of diagnosis and treatment, to cure, continuing illness or death and into bereavement”. It helps the patient to maximize the benefits of treatment and to live as well as possible with the effects of the disease.

According to the European Association of Medical Oncology (ESMO) ‘supportive care’ is the care that aims to optimize the comfort, function, and social support of the patients and their families at all stages of illness.

Even though many such view points on ‘supportive care’ are available a consensus definition is available for “cancer supportive care”. The most recent and most comprehensive definition derived after a systematic review says that “supportive care” is “the provision of the necessary services for those living with or affected by cancer to meet their informational, emotional, spiritual, social, or physical needs during their diagnostic, treatment, or follow-up phases encompassing issues of health promotion and prevention, survivorship, palliation, and bereavement’ (Hui et al 2013). It includes care by both hospital sector and society and includes the care for caregivers as well.

This definition spells out that ‘Supportive care’ consisted of several domains;


Other than the above, needs related to health system and financial needs as well have been identified as important aspects of supportive care.

Supportive care versus Palliative care

The revised definition by the World Health Organization states that palliative care is ‘an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual’ (World Health Organization, 2016).

This revised WHO definition does not limit the “palliative care” to the incurable patients, but it includes all the patients who had encountered a life threatening illness. Thus, the term “supportive care” and “palliative care” could be considered as synonyms, in relation to cancer, as cancer is considered a “life threatening illness”.

However, as the term “palliative care” has been used to refer to the care given for incurable patients since history, it has been shown that the patients prefer the term “supportive care” more than “palliative care” and the service utilization was more when the term “supportive care” is used instead of “palliative care”.

The association between quality of life, patient satisfaction, and supportive care

“Supportive care”, “Quality of life” and “Patient satisfaction” are related constructs, however their relationship is complex. Fulfillment of certain supportive care needs directly improves the quality of life, while others indirectly. Further, fulfillment of certain supportive care needs improve the quality of life to a major extent while others improve the quality of life only marginally (Richardson, Sitzia, Brown, & Medina, 2005). Similar complex relationship exists between supportive care needs and patient satisfaction as well.

Eg:

Quality of life

Need 1

Need 2

Satisfaction with care

Complied by:
Dr. P.J.Arunapperuma
Senior Registrar in Community Medicine
Epidemiology Unit
Ministry of Health

Page 2 to be continued…..
<table>
<thead>
<tr>
<th>RDHS Division</th>
<th>Dengue Fever</th>
<th>Enteric Fever</th>
<th>Encephalitis</th>
<th>Dysentery</th>
<th>Lymphatic Filariasis</th>
<th>Typhus Fever</th>
<th>Leptospirosis</th>
<th>Leprosy</th>
<th>Human Rabies</th>
<th>Menigitis</th>
<th>Cholera</th>
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<th>Hepatitis A</th>
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</table>

Source: Weekly Return of Communicable Disease (WRCO)

N.B.: Figures refer to returns received before or on date. 2017 Total number of reporting units 337. Number of reporting units provided for the current week: 314. **C.** = Completeness
Table 2: Vaccine-Preventable Diseases & AFP

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Cases by Province</th>
<th>Number of cases during current week in 2017</th>
<th>Number of cases during same week in 2016</th>
<th>Total number of cases to date in 2017</th>
<th>Total number of cases to date in 2016</th>
<th>Difference between the number of cases to date in 2017 &amp; 2016</th>
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<td>AFP*</td>
<td>W 02 C 01 S 00 N 00 E 00 NW 00 NC 00 U 00</td>
<td>03</td>
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<td>21</td>
<td>11</td>
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<td>00</td>
<td>00</td>
<td>00</td>
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<td>Mumps</td>
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<td>04</td>
<td>07</td>
<td>53</td>
<td>78</td>
<td>-32.1%</td>
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<td>Measles</td>
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<td>02</td>
<td>06</td>
<td>62</td>
<td>129</td>
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<td>Rubella</td>
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<td>00</td>
<td>01</td>
<td>02</td>
<td>05</td>
<td>-60%</td>
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<tr>
<td>CRS**</td>
<td>W 00 C 00 S 00 N 00 E 00 NW 00 NC 00 U 00</td>
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<td>00</td>
<td>00</td>
<td>00</td>
<td>0%</td>
</tr>
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<td>00</td>
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<td>Neonatal Tetanus</td>
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<td>00</td>
<td>00</td>
<td>00</td>
<td>0%</td>
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<td>00</td>
<td>20</td>
<td>00</td>
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<td>00</td>
<td>04</td>
<td>18</td>
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<td>61</td>
<td>67</td>
<td>1369</td>
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<td>-17.1%</td>
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</tbody>
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Key to Table 1 & 2


Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps, Rubella, CRS.

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS** = Congenital Rubella Syndrome

Number of Malaria Cases Up to End of February 2017,

12

All are Imported!!!