Oral Cancer: Rationale for inclusion in SEA Regional NCD Strategy

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This presentation

1. Oral Cancer in SEAR
2. Coherence with major strategies
3. Available Public Health Strategies
4. Achievability
5. Data availability & baselines
6. Possible target and indicators

Key references listed in supporting background document
<table>
<thead>
<tr>
<th>ICD10 Code</th>
<th>Cancer localisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>C00</td>
<td>Lip</td>
</tr>
<tr>
<td>C01-02</td>
<td>Tongue</td>
</tr>
<tr>
<td>C03-06</td>
<td>Mouth</td>
</tr>
<tr>
<td>C07-08</td>
<td>Salivary glands</td>
</tr>
<tr>
<td>C09-14</td>
<td>Pharynx</td>
</tr>
</tbody>
</table>
Oral Cancer
Schools are key determinants of health.
Estimated age-standardised incidence for lip/oral cavity cancer, males
<table>
<thead>
<tr>
<th>WHO Region</th>
<th>Most common cancer Male</th>
<th>Female</th>
</tr>
</thead>
</table>

- **Highest incidence:**
  - Male: Maldives, Female: Bangladesh

- **High incidence:**
  - Male: Maldives, Bangladesh, India, Nepal
  - Female: Bangladesh, India, Maldives

- **Moderate incidence:**
  - Male: Bhutan, Thailand
  - Female: Sri Lanka, Thailand

- **Low incidence:**
  - Male: Korea, Indonesia, Timor, Myanmar
  - Female: Korea, Indonesia, Bhutan, Myanmar, Timor
### Ranking of SEAR countries (overall incidence ASR)

1. Maldives   (16.5)  
2. Sri Lanka   (10.3)  
3. Bangladesh  (9.7)   
4. India       (7.5)   
5. Nepal       (6.7)   
6. Thailand    (5.9)   
7. Bhutan      (5.7)   
8. Myanmar     (4.5)   
9. Timor Leste (2.6)   
10. Indonesia  (2.4)  
11. DP Korea   (0.9)   

(GLOBOCAN 2008)
Coherence with major strategies

- Global NCD Action Plan 2013
- Political Declaration on NCDs 2011
- WHA Resolution on Cancer Prevention and Control 2005

All policies mention oral cancer explicitly or implicitly, often in the context of screening for prevention (similar to cervical cancer)
Available Public Health Strategies

1. **Primary Prevention**
   Reducing exposure to risk factors

2. **Secondary Prevention**
   Screening for malignant and premalignant lesions

3. **Tertiary Prevention**
   Clinical care and rehabilitation
Primary prevention of oral cancer

Key risk factors:
- Tobacco, alcohol, HPV infection, consumption of carcinogens (areca nut, betel, etc), nutritional deficiencies, oral/dental neglect, other factors

Common risk factor concept

Shared broader determinants

Similar socio-economic gradients and inequalities
Highly endemic risk factors in SEAR
Secondary prevention of oral cancer

- Visual screening
  Simple visual examination, no adjunctive tests, minimal training required, quick & simple
- Can be performed by non-dental professionals
- Good evidence for screening of high-risk populations
- Clear referral process and subsequent treatment must be ensured - otherwise screening is not appropriate
- Importance of self-examination and awareness
Tertiary prevention of oral cancer

- Surgery, radiotherapy, chemotherapy
  Usually complex interventions, survival rate depends on tumor stage and facility/surgeon competence

- Persistently low survival rates and highest impacts on quality of life

- High costs of care, lack of trained surgeons and specialised facilities make it difficult for low- and middle-income countries to offer appropriate services
"Treatment will never represent the route to reduced incidence."

Achievability at country level

- Primary prevention
  Good evidence for risk factor reduction
- Secondary prevention
  Examples of successful screening programmes in a number of SEA countries
- Tertiary prevention/care
  Weak, patchy, complex & expensive
Reduction of common risk factors and visual screening of populations at risk should be the public health priorities to address oral cancer.
Data availability & baselines

- Functioning cancer registration is vital (no difference to other cancers)
- Oral cancer must be integrated in such systems, if possible with staging info
- Capacity in the region varies from good to non-existent
- Minimum baselines available from GLOBOCAN 2008 or better based on newer national data
Conclusion: Oral Cancer...

1. Is a significant public health problem
2. Is in line with major strategies
3. Public health strategies are available
4. They are potentially achievable
5. Data & baselines are available
Decisions required:

1. Include oral cancer as a voluntary indicator?

2. If yes - upgrade to target(s)? Which targets?

3. If no - how to address and recognise the issue otherwise?
Additional voluntary target

25% reduction of premature mortality from oral cancer (lip/oral cavity) by 2025

- In line with wording and approach of the Global NCD Action Plan - value to be discussed
- Positive: Reflects risk reduction and health system performance (tracer), contributes to overall reduction of cancer/NCD mortality, relevant for male and female
- Negative: Rather ambitious
Options for indicators related to oral cancer*

**Option 1**
35% relative reduction of age-standardised overall oral cancer incidence

**Option 2**
At least 50% of individuals at risk for oral cancer screened once in 2 years

**Option 3**
50% of health care providers competent for visual screening and rapid referral

**Option 4**
30% increase of early detection of oral cancer

* Indicator options adapted from WHO/FDI/IADR Global Goals for Oral Health by 2020
"Oral diseases are a neglected area of international health. We have the tools and best practices to address them but we need to ensure that they are applied and implemented."

January 2007 Resolution WHA60/R17
Thank you