Commentary - Cancer and palliative care by Prof. E Molyneux

'The rise of cancer in less affluent countries is an impending disaster'

Dr. Margaret Chan WHO Director-General 2008

Sixty high level policy makers, leaders and health experts met this year in August, in Geneva, at the World Cancer Summit organized by the International Union Against Cancer (UICC), to adopt ambitious targets for cancer care. In a World Cancer Declaration 11 targets (see box) are set for 2020. The Declaration outlines steps that need to be taken to achieve success.[1,2]

About 25 million people in the world live with cancer; it is the second leading cause of death in the world (accounting for 14% of all deaths), and by 2010, it is predicted to become the leading cause. WHO forecasts that by 2030, over 11 million people will die every year of cancer;[1] 72% of these deaths will occur in developing countries. In 2005, for the first time, WHO declared the fight against cancer a priority and global awareness has gradually been increasing.[3] But it has still not become part of the political agenda even though cancer kills more people than tuberculosis, AIDS and malaria combined.[4] Collingridge writes in frustration in the Lancet Oncology that this message has fallen on deaf ears for too long, especially as many deaths are needless and preventable.[5] Vaccination against such infections as hepatitis B, and human papilloma virus could prevent half a million deaths from liver and cervical cancer. Screening programmes are improving and becoming affordable but need to be freely available and accessible at primary health level.

11 points of the World Cancer Declaration 2008

- Availability of cancer- control plans in all countries
- Substantial improvement in measurement of global cancer burden
- Substantial decrease in tobacco consumption, obesity and alcohol intake
- Universal vaccination in areas affected by human papilloma virus and hepatitis B
- Misconceptions about cancer dispelled
- Substantial improvements in early detected programmes
- Diagnosis and access to cancer treatment, including palliative care improved worldwide
- Effective pain control universally available
- Greatly improved training opportunities in oncology
- Substantial decrease in migration of health workers
- Major improvement in cancer survival in all countries

Paediatric oncologists met in Ponte di Legno in 2004 and stated that *'all children in the world have a right to full access to essential treatment for acute lymphoblastic leukaemia and other cancers and called upon all authorities to recognise and support all measures that promote this chance of cure'*[6]. The principle of 'distributive justice' has been used to explain that because an illness affects relatively few people in a population this does not make it unimportant or unnecessary to provide essential treatment for them.[7] WHO has now included cancer drugs on the 'essential medicines' list.

It is important for cancer care to be adapted to local circumstances, culture, understanding and medical facilities. Howard et al emphasise the importance of local adaptation of protocols, training of staff in the administration of drugs, a supportive infrastructure and an unbroken supply of essential chemotherapy. Treatments are often long (3 years for ALL) and in high income countries non-compliance is cited as being the most common difficulty. In low income countries financial worries are foremost.[8]

One of the targets for 2020 is to provide proper pain control for cancer patients and it is heartening to see how palliative care teams in Malawi are expanding in number and greatly improving pain control. The availability of oral morphine has made a huge difference to patients. Families and health carers, previously demoralized by the inability to help have been empowered by the ability to control discomfort and pain.

In this issue of the MMJ, Mlombe writes about different drug regimens for treating Kaposi Sarcoma (KS). It is now, with the AIDS epidemic, the first or second most common cancer in Malawi in adults and children. HIV related KS is not curable but symptoms can be alleviated with chemotherapy and the progress of the disease may be slowed. Antiretroviral drugs are the most important (and most easily available) treatment option but then there are several combination therapies that have been tried and found useful on a case by case basis. There is no good comparative study to guide us as to the best therapy to offer, bearing in mind that this is palliative care, and that chemotherapy can have debilitating side effects. It can also be a great finance burden to the family.

Cancer, and other illnesses such as HIV, remind us that as health providers we look after those who will get better and those who die. We must be advocates for prevention, supporters of all efforts to provide care and cure the curable. We need to be alert to the patient's real needs and wishes and in those that will not be cured there should be a gradual transition from active to supportive treatment. This requires the united efforts and commitment of the family, the patient and carers.

Mary Robinson, former UN commissioner for human rights and chairman of the World Cancer summit said. *'Ultimately it is a question of human rights and above all it is a question of human dignity'.*

There is, always something we can do.

References

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