EDITORIAL

Progress of cancer research in developing countries

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Cancer is the second leading cause of death globally, and was responsible for 8.8 million deaths in 2015[1]. Today, developing countries bear an increasing proportion of the burden; in 1970, 15% of newly reported cancers were in developing countries, compared with 56% in 2008[2]. Approximately 70% of deaths from cancer occur in low- and middle-income countries. Late-stage presentation and inaccessible diagnosis and treatment are common, and cancer causing infections, such as hepatitis and human papilloma virus (HPV), are responsible for up to 25% of cancer cases in developing countries[3].

A diagnosis of cancer does not only mean physical suffering for the patient, but also a financial burden for the household. ASEAN Costs In Oncology (ACTION) study, a prospective longitudinal study of 9,513 newly diagnosed cancer patients from 47 sites in eight Association of Southeast Asian Nations (ASEAN) countries, found that at one year after diagnosis, 29% of patients had died, 48% experienced financial catastrophe, and a mere 23% were alive with no financial catastrophe[4]. Cancer is a major cause of poverty for the patients and their families.

Early diagnosis and screening, combined with adequate treatment, has contributed to a modest, but constant, decline in cancer mortality rates in high-income country[5]. This is not the case, however, in many developing countries. In China, a marked increase in the numbers of cancers diagnosed was seen between 2000 and 2011, with the largest increase in the incidence of prostate cancers for men, and cervix and thyroid cancers for women[6]. Cancer accounted for 23.82% of overall deaths in China in 2010, and most cases were diagnosed at intermediate or late stage[7]. In order to tackle the rising incidence of cancer and its health and socio-economic burden, a functioning national cancer control plan is needed, yet only one in five low-income and middle-income countries have the necessary data to drive cancer policy[1]. With cancer becoming such a socio-economic and health burden, more research in this part of the world is sorely needed.

This special issue of Advances in Modern Oncology Research brings together research in three aspects of oncology care: body, mind and the community. Yip et al. reported the outcome of breast cancer patients who presented with very large tumour and who were treated with neoadjuvant chemotherapy at a single centre in Malaysia. These patients achieved similar breast conservation rate as those presented with early stage disease[8]. 40%–50% of breast cancer patients presented as stage 3 or 4 disease at many parts of developing world; therefore, apart from assessing the clinical and pathological predictors of response to treatment, the health systems performance as a whole should also be assessed in order to achieve better outcome. A survey conducted at eight major cancer hospitals in Malaysia in 2011, encompassing 20% of annual new breast cancer patients, revealed that only 75% to 80% of patients received treatment in a timely fashion. Access to the more expensive treatment, trastuzumab, was even lower, with only 19% of those eligible receiving the treatment[9]. Strides in medical advances cannot produce
results without improvements to the effectiveness and equity of health services, and health resources and services should be available to all.

A second aspect of improving cancer care is the engagement of the community. A large majority (around 83%) of the global burden of cervical cancers occurs in developing countries, where it accounts for almost 12% of all female cancers\[19\]. A single round of HPV screening project has been shown to bring significant decline in the rate of advanced cervical cancers and associated deaths, as compared with the unscreened control group\[13\]. Asthana et al. reports in this issue a consensus-planning workshop aimed at identifying factors which affect the success of HPV screening project. Despite the low rate of awareness of association of HPV infection and cervical cancer, rural Indian women are mostly comfortable with self-collection of care HPV samples. Husbands emerged as the most influential component for the success of screening project as they are the decision makers especially for further investigations and treatment after screening round\[12\]. Special efforts are also needed to educate the elderly women and peers of the rural community as their views significantly influence the community participation.

Third, whilst focusing on treating the body, health care providers frequently forget to treat the patient as a whole person, who also has psychological need, spiritual demand, as well as social responsibilities. Clinical depression is a prevalent and often neglected illness among cancer patients, with rates ranging between 13% and 40%\[13\]. Many patients also experience subthreshold or subsyndromal symptoms without meeting the criteria for a depression diagnosis. Depression has been shown to confer risk for all-cause mortality\[14\]. An assessment of 467 consecutive adult cancer patients attending the oncology clinic at University of Malaya Medical Centre revealed a range of psychiatric disturbances: minor depression (17.6%), major depressive disorder (15.8%) and adjustment disorder (15.8%). Cancer patients with psychiatric morbidity had a survival disadvantage of 2.2 months (20.9 vs. 23.1 months median survival)\[15\]. It is therefore essential to have psychological screening as part of oncological care. To this end, Tan et al. contributed in this issue of AMOR a timely and important schematic analysis on the art of caring for terminally ill patients: (1) Attitude, (2) Behaviour, (3) Communication, (4) Duty and (5) Environment — ABCDE\[16\]. The study explored the perception of good care from the point of view of terminally ill patients and their caregiving family members, and gave useful insight into the art of caring for cancer patients. Everyone treating cancer patients should be equipped with the basic skills of palliative care, which is not just about the relief of pain, but about the prevention and relief of suffering, via treatment of physical, psychosocial and spiritual problems.

It is timely that this issue of AMOR follows on immediately after the recently concluded Tzu Chi International Medical Association (TIMA) Conference in Kuala Lumpur, which promoted humanistic values as the core ethos of health care\[17\]. Research and effort on delivering equitable and humanistic care should be at the centre of medicine, and be the main feature of all medical curriculum and post-graduate training, in order to benefit cancer patients in the developing, as well as the developed world.

Conflict of interest

The author declares no potential conflict of interest with respect to the research, authorship, and/or publication of this article.

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role of neoadjuvant chemotherapy in the surgical management of women with breast cancer in a middle-income country. 


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