International Journal of Computer Science Engineering & Technology
IJCSET
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COUNCIL OF SCIENTIFIC AND INDUSTRIAL RESEARCH (CSIR)– NEW DELHI INDIA .
ISSN :2455-9091

SURVEY ON CERVICAL CANCER

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ABSTRACT

Cervical cancer is the most common cancer in women in sub-Saharan Africa and is a leading cause of death in women in Southern Africa. The disease is a prime example of global inequality in health. Mortality from cervical cancer in developed countries is substantially lower than in developing nations because of the availability of prevention, early detection, and treatment. In this paper, we see about Cervical Cancer Control and their preventions.

Keywords: [Cervical Cancer, Barriers, Prevention]

1. INTRODUCTION

Cancer fatalism has continued to increase among especially young women, this is the belief that women have had that diagnosis of cancer directly translates to inevitable death therefore they find it better to avoid going for screening and are with no knowledge whatsoever on their health status. Education and Knowledge on both breast cancer and cervical cancer has continued to decrease as the cancer fatalism increases not because there is no available information but because the women have been ignorant to enlighten themselves.

Cervical cancer is, potentially, one of the most preventable cancers. Unlike many other cancers there is an easily detectable and normally prolonged premalignant phase. The incidence and mortality rates for cervical cancer have levelled off during the past 40 years. With early detection through Papanicolaou (Pap) test screening, cervical cancer can be prevented. Minority populations and persons of low socioeconomic status, however, still have high incidence and

mortality rates. The world-wide occurrence of the cancer cervix cases show that only 20% of these cases occur in the developed nations while 80% of the cases are found in the developing countries. The mortality rate of this cancer can be affected by the alteration of earlier diagnosis and improved treatment in the natural history of the disease, and recent clinical research has identified that HPV is one of the main triggers for cervical cancer. The patterns discovered when mining cervical cancer screening data may support these observations, or suggest additional triggers. One of the emerging issues in medical research is data mining. The widespread use of computers makes it easy to gather and manage large amounts of data from many different sources. A well-organized system can make available clinical, biological, genetic data, and all other information collected about patients. This data is often complex, meaning

that it contains many elements related in non-obvious ways or characterized by explicit or implicit relationships and structures. Such integration is increasingly considered necessary in order to produce more accurate diagnoses. Cervical cancer remains one of the leading causes of cancer-related death among women globally.

2. LITERATURE SURVEY

Jacobs and coworkers did a randomized, prospective study to determine if psychological and social functioning could be enhanced in patients with Hodgkin's disease either through education or by participation in a peer support group. 105 patients who were currently receiving or within 2 years of completed chemotherapy for Hodgkin's disease were randomized to one of four groups: an education group versus an education control group and a peer support group versus a peer support control group. In the education group, knowledge regarding Hodgkin's disease improved significantly compared with the control group. They also showed significant improvement in anxiety and treatment problems and improvement trends in depression and life disruption. Neither group showed significant changes in interpersonal problems, personal habits, activities, life satisfaction or self competency. Surprisingly, the education group showed a significant decrease in social competency. This intervention was able to decrease anxiety and treatment problems, but may have also decreased denial resulting in patients becoming more self-conscious in social situations. In the peer support arm of the study, no significant changes were found between groups on any scale. However, both groups did improve in depression, interpersonal problems, anxiety, personal habits and treatment problems. Interestingly, they also showed decreases in life satisfaction, self competency, and social competency. These mixed results indicate that time will serve to resolve some issues but that other issues may become long-term problems if left alone. Peer support in certain cases may not be enough. Just talking about problems may not be helpful. Patients may need professional guidance to help them deal with the issues raised.

Maguire and colleagues studied the effect of counseling by a specialist nurse on the psychiatric morbidity associated with mastectomy. 75 patients were individually counseled before surgery and 1 week after surgery with follow- up visits at both clinic and at home. The aim of the counseling was to provide information, advice, and practical and emotional support to each patient from the time of admission to 12 months after surgery. 77 control patients received only routine medical care. Followup occurred at 12-18 months after surgery. Contrary to expectations, the counseling failed to prevent morbidity in the first year. However, the nurse's regular monitoring of patients' progress resulted in her recognizing and referring 76% of those who needed psychiatric help. This is in marked contrast to only 15% of the control group whose condition warranted being recognized and referred appropriately. As a result, there was less morbidity in the counseling group (12%) than among controls (39%) 12-18 months after mastectomy.

The Fawzy study may have exerted its positive influence through a combination of enhanced psychological mechanisms, improved compliance, and positive effects on certain immunological parameters. This study showed an enhancement of coping and reduction of emotional distress. The increased utilization of active-behavioral and active cognitive coping might have positively affected compliance with healthcare maintenance (for example reduced sun exposure). Reduction of distress could have positively enhanced the natural killer cell subsystem. Enhancement of immune functions might have played a role in tumor surveillance, thereby affecting recurrence and survival.

3. CERVICAL CANCER IN DEVELOPED AND DEVELOPING COUNTRIES

Experience in developed countries has shown that well planned, organized screening programs with high coverage can significantly reduce the incidence of cervical cancer and its associated mortality. Evidence also suggests that general awareness about cervical cancer, effective screening programs, and the improvement of existing health care services can reduce the burden of cervical cancer, both for the women and for the health care system.

Important reasons for the higher incidence and mortality in developing countries are:

1. Lack of awareness of cervical cancer among the population, health care providers and policy-makers.
2. Absence or poor quality of screening programs for precursor lesions and earlystage cancer. In women who have never been screened, cancer tends to be diagnosed in advanced stages making it incurable and difficult to treat.
3. Limited access to health care services.
4. Lack of functional referral systems.

Cervical Cancer Control

There are four basic components of cervical cancer control under the National Cancer Control Program-

- Primary prevention
- Early detection, through increased awareness and organized screening programs
- Diagnosis and treatment
- Palliative care for advanced disease

The differences between developed and developing countries reflect the bitter inequalities in the social and economic status, health status and represent a challenge for healthcare delivery services.

Primary Prevention

It means prevention of development of the causative factor. For cervical cancer, HPV infection is the primary causative factor and development of HPV infection and co-factors is known to increase the risk of cervical cancer. Methods of primary prevention includes

- Education and awareness- to reduce high-risk sexual behavior.
- Implementation of locally appropriate strategies to change behavior.
- Development and introduction of an effective and affordable HPV vaccine.
- Efforts to discourage tobacco use, including smoking (which is a known risk factor for cervical and other cancers).

Early detection

It includes

- Organized screening programs, targeting the appropriate age group and with effective links between all levels of care.
- Education for health care providers and women in the target group with stress on the benefits of screening, the most commonly affected age group and its signs and symptoms.

Diagnosis and treatment

It includes

- Treatment of precancerous lesions using relatively simple procedures, to prevent the development of cancer .
- Treatment of invasive cancer, including surgery, radiotherapy and chemotherapy.
- Follow-up of patients who are have been treated for cancer or precancerous lesions.

Palliative care

Palliative care is the care provided to untreatable and incurable disease when the disease enters its end-stage. It includes

- Symptomatic relief for bleeding, pain and other symptoms of advanced cancer and for the side-effects caused by some treatments.
- Compassionate general care for women whose cancer cannot be cured.
- Involvement of the family and the community in caring for cancer patients.

4. BARRIERS TO CONTROL OF CERVICAL CANCER

A number of countries have implemented cervical cancer control programs in recent decades. Some of these have produced significant decrease in incidence and mortality, while others have not. The reasons for failure may be described as,

- **Political barriers**
  - ✓ Lack of priority for women's sexual and reproductive health.
  - ✓ Lack of national policies and appropriate guidelines.
- **Community and individual barriers**
  - ✓ Lack of awareness of cervical cancer as a health problem.
  - ✓ Attitudes, misconceptions and believes that inhibit people for discussing diseases of the genital tract
- **Economic barriers (lack of resources)**
- **Technical and organizational barriers that are caused by poorly organized health systems and weak infrastructure.**
- **Lack of evidence-based national guidelines**

National guidelines for cervical cancer control may not exist or may not reflect the recent evidences and local epidemiological data. Generic guidelines, available in the literature, are often not used or not adapted to local needs. In many programs, scarce resources are wasted in screening young women attending family planning and antenatal clinics, and in screening more frequently than necessary. Resources should be better used to reach older women, who are at greater risk and who generally do not attend health services.

- **Poorly organized health systems and infrastructure**

A well maintained health system, with the necessary equipments and trained healthcare delivery providers, is essential for prevention activities, screening and diagnosis, linkages for follow-up and treatment, and palliative care.

- **Lack of awareness**

In many places, cervical cancer has been ignored by policy makers, health care service providers and the population at large. Policy makers may not be aware of the tremendous burden of disease and magnitude of the public health problem caused by this cancer. Health care service providers may lack accurate information on its natural history, detection and treatment. Most of the population has not heard of cervical cancer and does not recognize early signs and symptoms of the disease. Women at risk may not be aware of the need to be tested, even when they do not have any symptoms.

- **Attitudes, misconceptions and believes**

Attitudes and beliefs about cervical cancer among the general population and health care providers can also present barriers to its control. Cancer is often thought to be an untreatable illness, leading inevitably to death. In addition, the female genital tract is often considered private and women are shy in discussing the problems related with it. This is especially true in settings where the health care provider is a man, or is from a different culture. Destigmatizing discussion of the female genital tract may be an important strategy to encourage women to get screened and seek medical attention if they have symptoms suggestive of cervical cancer.

- **Lack of resources**

In the vast majority of settings where competition for limited funds is fierce, cervical cancer has remained low on the agenda. In these settings, cervical cancer is often not considered a problem or a funding priority.

- **Lack of priority for women's health**

The lack of priority given to women's health needs, particularly those not related to maternity and family planning, was a focus of the International Conference on Population and Development, held at Cairo in 1994. At this Conference, countries made strong commitments to reframe women's health in terms of human rights and to promote an integrated vision of reproductive health care.

Significant advances have occurred in some areas, but cervical cancer still has not received sufficient attention in most countries, despite its high incidence, morbidity and mortality.

- **Financial issues for cervical cancer prevention and screening**

Financial issues can play an important role in whether or not women are screened for cervical cancer. Women with lower incomes and those without health insurance are less likely to be screened. Many states ensure that private insurance companies and public employee health plans provide coverage and reimbursement for Pap test screening. The American Cancer Society supports such coverage assurances, because they remove financial barriers for women who have health insurance, but whose insurance plans previously did not cover Pap tests. Other programs are also available to help provide financial assistance for women with lower incomes and those without insurance.

5. CONCLUSION

A summary of the types of interventions that have been proved helpful for patients with cancer is provided. The first of these is education. Education about the disease needs to be tailored to the type and phase of cancer. Information about nutrition should be included. Coping skills should form a large part of any psychosocial intervention for cancer patients. This includes behavioral training, stress management and cognitive therapy.

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