

## Cancer in Malaysia - There is Light at the End of the Tunnel

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The truth often hurts, but only by knowing the truth can proper solutions be found. It has long been recognised that adequate epidemiological data is crucial for the planning and development of cancer programmes. In the First Report of the National Cancer Registry, 26,089 cases were registered among the population in Peninsular Malaysia. Taking into account the estimated 10,656 unregistered cases and the 3750 cases registered in Sabah and Sarawak, the total number of new cancer patients in Malaysia in 2002 would be approximately 40 500<sup>1</sup>. This means that the cumulative life-time risk of getting cancer was 1 in 4 in Malaysia, a fact which hit the headlines in many of the daily newspapers of the country<sup>2,3</sup>. Cancer is indeed a serious national health problem. Correlating these registry findings with existing findings from studies on lifestyles, presentation of disease, diagnostic tests, interventions in cancer prevention, treatment, palliation and rehabilitation will be the way to go in defining and refining the strategy against cancer in this country.

Strategy should be aimed at primary prevention (i.e. avoidance of risk factors), secondary prevention (i.e. screening and early detection), treatment, rehabilitation and palliative care.

Lung cancer is the most preventable of diseases and an impact would easily be seen once smoking is stopped in the community. Cancer of the lung was the most common malignancy amongst males, constituting 13.9% of all male cancers, with a cumulative life-time risk of 1 in 29. This result underscores the urgency of the anti-tobacco campaigns. A review of patients with carcinoma of the lung seen in Kelantan<sup>4</sup> demonstrated that 75% of the patients were smokers. The prevalence of those who reported to have smoked at least once in his or her lifetime was 30.6% in Malaysia, with males outnumbering females (59.7% and 5.1% respectively)<sup>7</sup>. Children should be specially targeted in awareness campaigns which should start with lower secondary school children and reinforced in school leavers, while laws pertaining to the minimum age for buying tobacco

products must be reviewed<sup>7</sup>. Underlying economic and agricultural factors pertaining to tobacco growing and trade must be addressed comprehensively at the national level to develop alternative economically viable activities in place of cigarette-related industries.

Cancers of the breast (cumulative life-time risk of 1 in 19) was the most common cancer among females. This finding has major implications on the role of wellness programmes which include breast self-examination, screening and public awareness of the symptoms of disease. The Second National Health and Morbidity Survey (NHMS II)<sup>8</sup> data showed that overall prevalence for breast screening was 46.8%. Breast Self Examination was reported by 34.1%, followed by Health Worker Examination (31.1%), while mammography was carried out in 3.8% of women. Women who were less likely to undergo breast examination and are therefore at higher risk of late detection of breast cancer include those from rural areas, those who had no formal education, those from the agricultural sector and low income families<sup>9</sup>. As breast cancer can be detected early, and has a better cure rate with early treatment, public education regarding early detection must be stepped up not only by the government but also by professional bodies and non-governmental organizations.

The malignancy with the second highest incidence in women in Malaysia was cancer of the cervix (cumulative life-time risk of 1 in 43)<sup>1</sup>. In the list of the most common cancers in women of other Asian countries, cancer of the cervix occupied fourth place or lower, while it was even less common in Western countries. Correlation of this finding with existing data on prevalence of healthy lifestyles could suggest directions to take for the prevention and treatment of cancer of the cervix in Malaysia. The prevalence of having had Pap smear examinations has been shown to be 26% among women in the NHMS II<sup>8</sup> study, 27.7% among Universiti Kebangsaan Malaysia female support and academic staff<sup>10</sup> and 6.4% among electronics women workers in one Industrial Zone<sup>11</sup>. As in breast cancer, screening examinations for

cancer of the cervix can be expected to achieve an impact on lowering mortality due to disease only if the screening examination covers at least 60% to 80% of the target population<sup>8</sup>. Among the efforts of high priority would be improvement in health education programmes that target the population subgroups who would benefit from screening for cancer. The involvement and participation from non-government sectors in service to the community is welcomed, for instance the joint initiative by the Malaysian Medical Association, women's organizations and other bodies in 2002 to create national awareness and provide free screening in rural areas<sup>12</sup>.

The age specific incidence rate of nasopharyngeal cancer in Malaysian males was second highest in the world next to Hong Kong (23.3 per 100,00 and 24.3 per 100,00 respectively), while the age specific incidence rate of nasopharyngeal cancer in Malaysian Chinese females was greater than that of Hong Kong females (10.3 per 100,00 and 9.5 per 100,00 respectively)<sup>1</sup>. More needs to be done to create awareness of early symptoms and the availability of effective treatment for this disease.

Although prostate cancer ranked sixth among male cancers in Malaysia<sup>1</sup>, it is expected to move up in position with an increasingly ageing population. As the country undergoes further development and there is a greater awareness of the disease leading to increasing diagnosis, our incidence pattern will approach that of developed countries. Interestingly, the age specific incidence rate in Chinese (15.7 per 100,000) and Indians (11.5 per 100,000) in Malaysia were already higher than those in China (2.3 per 100,000) and India (7.9 per 100,000) respectively<sup>1</sup>. Analyses of prostate biopsies such as that by N Dublin,<sup>13</sup> in this issue, could contribute towards optimizing the various tests used in the diagnosis and screening of cancer in our local setting. Better strategies in overcoming delays in diagnosis are needed, while the implications of early diagnosis on availability of timely treatment must be addressed.

Early detection and prompt treatment improves the chances of cure in cancer. Unfortunately, delays in presentation are commonly found among our cancer patients. The Penang Cancer Registry reported that stage I disease in breast cancer and cervical cancer was 8% and 31% respectively<sup>14</sup>. Patients with colorectal cancer in the Department of Radiotherapy and Oncology whose disease was confined to the mucosa or the bowel wall constituted only 28.5% of all patients<sup>15</sup>. A pilot study on cancer registration<sup>16</sup> demonstrated that patients with stage 1 or stage 2 disease comprised 16.3% of all patients.\* Also in this issue the hospital-based study on prostate cancer in the United Arab Emirates<sup>18</sup> reported that 77.7% of their

patients with prostate cancer presented at an advanced stage. While our stage distribution is similar to developing countries, a smaller proportion of patients present at advanced stages of disease in Western nations. There should be concerted efforts towards down-staging of cancer in Malaysia in order to achieve better results in tumour control and survival. Our Malaysian public must be empowered with the awareness that cancer is not something to be feared as being untreatable but that cancer can be cured if attended to early.

Along with early detection and treatment, there must be adequate facilities and skilled manpower. The priorities for Malaysia include training of more oncologists and allied health staff, upgrading and replacement of aging machines in the various government cancer centres, strengthening of programmes for palliation and consolidation of existing cancer treatment programmes. While overseas training for clinical oncology is being continued, it is heartening that the Master in Clinical Oncology has started in University of Malaya since 2002.

Treatment of cancer is a multidisciplinary effort. Close networking between oncologists, surgeons, radiologists, pathologists and other relevant disciplines optimizes cancer treatment as well as facilitates the development of management policies that improves the outcome in patients. This is highlighted in two articles in this issue. Reconstruction of aggressive bone tumours in Sarawak described by KL Pan et al<sup>19</sup> also discussed various aspects of rehabilitation in their patients. Joint management has been shown to be beneficial in many ways, as demonstrated in the case report by BH Gooi et al on pulmonary resection for metastatic breast cancer<sup>20</sup>.

As cancer is a common disease in Malaysia, it is very important that basic principles of cancer and its management must be more widely taught to future generations of medical practitioners. The study by B M Biswal et al<sup>21</sup> has elegantly demonstrated that there are alarming deficiencies in knowledge in cancer related subjects and hence uncovered the need to re-examine our existing curriculum with regards to cancer education. In the light of these findings, appropriate and swift action must be taken by the medical schools in the review of the basic curriculum used in our medical schools in order to address the gaps in knowledge and attitude-building of our future health care professionals in a disease of tremendous public health significance. It cannot be overemphasized that the action taken today for the medical students will have a great impact on the doctors and opinion leaders of tomorrow.

Apart from reducing the incidence and mortality due to cancer, programmes for the control of cancer must also

\* and a study of gastric cancer in Ipoh in this issue found that 82% of patients presented with stage IV disease<sup>17</sup>

improve the quality of life of cancer patients. There must be optimum utilization of available resources, appropriate use of technology while at the same time encouraging active participation by the community and consumers. Issues about accessibility to reliable data on cancer, appropriate dissemination of cancer information to the public, measures for prevention, screening and early diagnosis of cancer, treatment of cancer, rehabilitation, palliative care, inter-agency cooperation, training programmes, research in cancer and legislative changes must all be addressed effectively.

Appropriate palliative care must be given to the large proportion of patients currently presenting at stages of the disease in which cure is no longer a possibility. The initiatives in palliative care pioneered in Kota Kinabalu, Kuching, Penang and Kedah must be complemented by further efforts in making Palliative care available throughout the country. In East Malaysia, Palliative Care Programmes have been started with close cooperation between the hospitals, health staff and non-governmental organizations. With the setting up of the Palliative Care Unit at Selayang Hospital in 2002, it is hoped that further developments in Palliative Care will be facilitated and consolidated in terms of career structure, formal training and networking between the various agencies involved with patients with advanced cancer.

Another area that has to be highlighted in the light of the findings of the National Cancer Registry is the importance of

research in cancer. The Ministry of Health together with the universities, professional bodies, private sector and non-governmental organizations are looking into the various issues and priorities in cancer research. A conference on cancer research in 2004 is being organized to streamline and coordinate cancer research so that returns for the effort and resources invested in this area can be maximised. It is hoped that there will be an enthusiastic and fruitful participation from all those working in cancer in this country.

The first report of the National Cancer Registry has received commendations locally and from overseas for the quality of content and transparency in analysis. The information generated from the National Cancer Registry results would be very useful to health planners, health practitioners and others involved in cancer work. Public education, promotion of healthy lifestyles and wellness programmes can thus be further refined. The revelation of the enormous national burden of cancer highlights the need for treatment facilities to be further developed to a capacity that will be able to cater adequately for the needs of all cancer patients. Collaboration between agencies must be optimized whilst unhealthy competition and duplication of efforts must be avoided. In doing so, cancer services which are comprehensive, patient-centred, accessible, equitable, effective, timely and technologically-appropriate can be achieved despite the limitation of resources.

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