

Public cancer awareness with lectures and diagnostic camps; the key to improve cancer survival in rural area

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Oral cancer is a major problem in the Indian subcontinent as it ranks amongst the top three cancers. It accounts for over 30% of all cancer reported in the country [1]. It is one of the common cancers and is an important public health problem. About 30,000 new cases have been estimated to occur each year, which will lead to more than 100,000 individuals suffering from the disease in the population in any given year [2-5].

Many Indians are habituated to tobacco in various forms and even to alcohol. The vast majority of malignant neoplasm's in the mouth are squamous cell carcinomas. The disease is largely preventable [6]. Early diagnosis greatly increases a patient's chance of survival, as the mouth is very accessible for clinical or even self examination. However, there is poor public awareness about the signs and symptoms of oral malignancies and premalignant lesions.

A poor compliance to attend for oral cancer screening following invitation (25.7%) has been linked to probable lack of public awareness of this disease [7]. Cancer awareness is essential to prevent and to get cancer patients to seek early treatment. It is essential to teach about cancer knowledge to each and every person in society.

For this cancer awareness lectures are organized and slide and video cassette films are shown in local languages. Medical social workers visit various places repeatedly with the cancer awareness knowledge. For this the pillars of the society, mainly Medical Associations, Rotary clubs, Lions Clubs, Mahila mandals, teachers and political people are made aware about cancer, and they are also expected to create awareness of cancer. Use of advertisement media, local

organizations and peripheral physicians can create good awareness of cancer in society in the area. So we repeatedly organize cancer awareness lectures and diagnostic camps in rural population in 100 KMs of radius of Krishna hospital in three districts of Maharashtra. Due to this there was good awareness in local physicians and villagers.

We came across 101 well documented cases of oral malignancies during period of Oct 1997 to Dec. 2003 with age ranging from 24 to 85 years. They were treated by surgery – wide excision, supraomohyoid neck dissection, radical neck dissection and primary reconstruction with split thickness skin graft, forehead flap, deltopectoral pedicle flap and local labial flap. Post operative radiotherapy (n=74) and chemotherapy (n=20), were carried out. After clinicopathological evaluation patients regularly followed up for every two months in first year, every three months for next year and subsequently after completion of treatment.

In the analysis we found survival in tobacco chewer as 74.4% and that of non tobacco chewer as 54.4% at the end of first year while five year survival in tobacco chewer as 72.3% and non tobacco chewer as 75%. Five year survival in tobacco chewers with alcohol was less than as 57.1% that of tobacco chewing without alcohol as 78.8%. Anatomical site commonly involved was anterior part of mouth mainly buccal mucosa and buccal gingival sulcus with the patients having buccal gingival sulcus lesion showed higher five year survival 100% while lower lip showed less survival 50%, alveolus 75%,

buccal mucosa 57.1 % Tongue 91.7 % . Clinically node negative patients having good survival were 81.3 % and that of node positive were 68.8 % Histopathologically 98% patients were having squamous cell carcinoma among these well differentiated squamous cell carcinoma showed good (83.3 %) five year survival.

With this we observed interesting five year survival results 88.9 % for T1, 87 % for T2, 43 .8 % for T3 and 66.7 % for T4. Five year duration of survival in T1+T2 is 87.5% and T3+T4 is 47.4%. Surgical margin free patients having more five year survival rate (76%) than that of 40 % in surgical margin positive patients and also stage wise five year survival is stage I 90%, stage II 84.2 % stage III 53 % and stage IV 60 %. With combine survival of stage I and stage II is 86.2 % and stage III and IV 54.5 %.

Cancer survival information is available in only few populations in developing countries. In India

Bombay population based cancer registry showed five years survival 59.1% for localized cancer (Stage I and II) 15.7%, for cancer with regional extension and 1.6% for those with distant metastasis and also showed that detecting oral cancer in early stages ,when these are amenable to single modality therapies , offers the best chances of long term survival [8].

The present study reveals that, treatment in early stage of the disease, offers excellent prognosis in cases of oral cavity malignancy. But in our area there exist a significant gap in public knowledge, attitudes and behaviors Efforts must be made to bridge gap between research, development, and public awareness .With prevention through action against risk factors tobacco alcohol and modification in life style will be key to reducing morbidity with improvement in survival.

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