AOGIN INDIA NEWS LETTER

www.AOGININDIA.IN

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EVENTS, NEWS AND ACADEMICS

This news letter brings you a new set of information, about the happenings since you our last news letter.

Let us share our contributions, our concerns, our ideas about women's health.

In this news letter we have an intersting article written by a young writer, who has shared his vaccine experience in his own words.

Proudly Indian

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Letter from the President and the Secretary

Dear AOGIN-India members,

We had a wonderful annual conference organized in Rishikesh by Dr. Shalini Rajaram and her team. It was a wonderful venue with the Ganga flowing close by.

Stalwarts working in the field of HPV related diseases addressed us giving us important take home messages that we can apply to clinical practice. The AOGIN India Oration has been renamed

'AOGIN India Dr.R Sankaranarayanan Oration'

in tribute to the tremendous work Dr. Rengaswamy Sankaranarayanan has done in the field of cervical cancer screening.

The best paper award has been renamed

'Dr Srabani Mittal Best Paper Award' in memoriam of our AOGIN India Secretary who we sadly lost a few years ago.

On the 13th October, our founder Dr. Neerja Bhatla received

'the Women in Cancer Research Award'

presented by IARC. Such a proud moment for all of us at AOGIN India!!

The link to the recording will be available on the AOGIN India website shortly. We are revamping our website and will have an educational hub that will have publications from our own members, important guidelines and policy documents in the members section for easy access. AOGIN India also awards community screening grants and research grants to help researchers travel to present their work. More information on this can be found on the website. We encourage you to make use of these grants. Apart from the well-attended monthly colposcopy MDT's, we will be having a series of talks next year culminating in the next annual conference that will be held at JIPMER, Pondicherry.

till we meet again,

Dr Rupinder Sekhon *Dr Latha Balasubramani*

MADE-IN-INDIA HPV DNA DETECTION ASSAYS

NEW TESTS

Following the COVID-19 pandemic, molecular diagnostics have become part and parcel of the traditional microbiology laboratory.

Dr. Priya Abraham
Senior Professor,
Department of Virology,
CMC Vellore.
Former Director,
ICMR-National Institute of Virology, Pune

Further, WHO currently recommends using HPV DNA detection as the primary screening test over VIA or cytology in cervical cancer screening.

Therefore, In the last two years, a handful of Made-in-India HPV real time PCR assays (requiring prior nucleic acid extraction) have been developed. Many of them are being developed for point-of-care (POC) testing.

TRUNAT® HPV HR (MOLBIO DIAGNOSTICS PVT.LTD)

The Truelab workstation comprises a sample processing (DNA Extraction) device (Trueprep AUTO) and a real-time quantitative micro polymerase chain reaction (PCR) analyzer (Truelab® Uno Dx: for 1 sample; Truelab® Duo: for 2 sample and Truelab® Quattro: for 4 samples along with accessories such as a cartridge and microtip holding stand. Both the devices are portable, powered by a rechargeable battery, developed for POC application, and can run continuously for ≥ 8 hours on a single charge. DNA extraction is done in 20 minutes while DNA amplification takes 40 mins.

One channel is used to detect amplification of HPV 16 and 31, a second channel for HPV 18 and 45, and a third channel for an internal positive control (IPC). Truenat® HPV

6/18 & 31/33/35/45/52/58 is also available, and this panel is going to be expanded to detection of 14 high risk (HR) genotypes. This Chip-Based, Point-of-Care, Portable, Real-Time Micro PCR assay had been evaluated in ICMR-NICPR, Noida against Hybrid Capture -2 and individual genotypes identified using the 14 Real-TM Quant Kit. This assay has been approved by CDCSO.

Truenat® HPV (testing 8 genotypes) costs INR 750.

PATHODETECT HPV (MYLAB DISCOVERY SOLUTIONS, PVT. LTD.)

This has 3 platforms to run same configuration of cartridge tests as per the throughput requirements. A. Compact XL+Compact Q - For High throughput testing of 1 to 32 samples simultaneously. Results of first run will be available in 2 hours, after which every hour we can get 32 results; B. Compact DX- For Simultaneous testing of 1 to 8 samples every 2 hour; C. Compact Mini – For Testing of One sample every 2 hours. No manual handling/processing/pipetting/interpretation is required. The automated platforms provide an advantage of being operated by minimally skilled staff without expertise. There are three 3 formats of HPV Kits: HPV 16 & 18 genotype detection and differentiation; HPV 7 Genotypes detection with 16/18/31/45/52/33/58 detection along with 16 &/or 18 genotype differentiation and HPV 15 thigh risk genotypes 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68 detections with 16 &/or 18 genotype differentiation. This product has got CDSCO approval. The assay has been compared with limited number of 4 samples tested in other commercial laboratories. Cost per test is INR 550-1200, based on configuration of the kits as detailed above.

TATA MD CHECK HPV HR (TATA MD HEALTHCARE LTD.)

This is a qualitative real time PCR for detection of HPV from cervical / vaginal samples. It involves a separate DNA extraction step with subsequent DNA amplification Can detect 15 individual HPV genotypes: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66,68 and 73. The instrumentation used for DNA extraction and other real-time PCRs, can be used for this assay. For a cost-effective testing strategy, samples need to be batch tested. It is available in a 20, 50 and 100 test kit formats. This assay has been evaluated at Tata Medical Hospital, Mumbai. The manufacturers also market a self-collection swab (dry swab) which can be added to the proprietary re-constitution buffer, stable at room temperature for 7 days. A single test costs INR 500 excluding GST.

HPV-Q POC AND COMPREHENSIVE RT (GENES2ME PVT. LTD.)

This HPV DNA diagnostic kit detects 14 high risk HPV genotypes: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68 and can individually differentiate HPV 16 and 18 in the clinical specimens. HPV-Q POC can process between up to 8 samples in less than 60 minutes and does not require pipetting. The comprehensive real time PCR kit is compatible with commonly available instruments for real time PCR and can process 512 samples over an 8-hour shift. It can be used to testing cervical and vaginal fluids. The overall run time is approximately <90 minutes.

Cost of the Genes2Me POC test (Rapi-Q) is INR 650 (PCR Kit and DNA Extraction kit) and can be battery operated.

TRUPCR® (3B BLACKBIO BIOTECH INDIA LTD.)

This a qualitative real time PCR capable of detecting 14 high risk HPV genotypes i.e., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68 using five tube format or just HPV16/18 in a single tube. The kit is compatible with any 48-well MIC (magnetic induction cycler format) RTPCR machine which can be battery operated and used in a field setting. These reagents are also compatible with commonly available instruments for laboratory based real time PCR. This assay has been used in Indian studies pre- and post-treatment for cervical neoplasia. A single test costs INR 700.

From among the five made-in-India HPV assays, Trunat® HPV HR, PathoDetect HPV, HPV Rapi-Q POC and TRUPCR® are assays that will lend themselves to point-of-care and near point-of-care testing because they can be run is small batches with compact equipment and may be battery operated. The future will see more such Made-in-India kits reaching the commercial market. Broadly, costs of individual assays will depend on volume of testing.

However, to know their individual performance in primary cervical cancer screening, a well-designed evaluation protocol to compare virological (analytical detection threshold, genotype concordance) and clinical test performance (sensitivity and specificity for high grade cervical intraepithelial neoplasia or worse [CIN2+]), using large numbers of samples needs to be carried out. Such systematic validations are still not available.
Compatibility with vaginal samples and urine samples are also being currently studied.

JOURNAL SCAN

Evaluation of cervical cancer screening during pregnancy in India: Human papillomavirus testing can change the paradigm.

Dr Priyanka Mathe,
Assistant Professor,
Department of Obstetrics & Gynaecology,
University College of Medical Sciences & Guru Teg Bahadur Hospital,
Delhi

Background

The World Health Organization's call for elimination of cervical cancer envisages 70% screening coverage of women aged 35 and 45 years by an effective test. In India, this target seems unrealistic as awareness and access to cancer prevention services are poor. However, the institutional delivery rate is now >80%. We evaluated the acceptability and feasibility of human papillomavirus (HPV) testing and its role in screening during pregnancy.

Methods

This observational study recruited 275 pregnant women women aged >25 years between 12 and 34 weeks of gestation for screening by cytology and HPV testing. Colposcopy was advised if either test was positive. Acceptability and feasibility were assessed by a questionnaire.

Results

Cytology and HPV reports were available for 269 subjects. The median age was 28 years and median parity was two. Only 98 (36.4%) had heardabout carcinoma cervix. Awareness improved with education ($p<0.001$). On cytology, only 4 (1.5%) were abnormal (atypical squamous cells of undetermined significance 3; low-grade squamous intraepithelial lesion 1). The prevalence of high-risk HPV infection was 8.2% (22/269). On colposcopy, all had the Swede score <5. No high-grade cervical

intraepithelial neoplasia or carcinoma was detected. Pre-procedure, 183 (68.0%) subjects expressed apprehension, post procedure 114 (42.4%) of them had realized that their apprehensions were unfounded.

Women found screening to be more uncomfortable after 28 weeks of gestation (n=26/68; 38.2%; p<0.001). Physicians found the cervix more difficult to visualize after 20 weeks of gestation (p<0.001).

Conclusion

HPV screening at 16–20 weeks of pregnancy is acceptable, feasible, and can greatly improve screening coverage in resource-limited settings. Pregnancy is a good opportunity to improve awareness of the screening programmes.

Discussion

Cervical cancer is the fourth most common cancer in the world and the second most common among women in India. In low-income group countries like India, there is poor access to healthcare services and utilising the time of antenatal period for cervical cancer screening when women is likely to visit the healthcare facility plays a crucial role in screening cervical cancer. In this study antenatal women between 12-34 weeks pregnancy were screened for cervical cancer through PAP and HPV testing during their antenatal visits and colposcopy was offered to those indicated. Also, this study found increased awareness regarding cervical cancer screening after educating these females during the antenatal period itself. Thus, incorporating HPV testing or PAP testing during antenatal period which is rather a golden opportunity for obstetrician for cervical cancer screening and raising awareness along with antenatal care should be encouraged.

Journal access: Sudhakaran S, Bhatla N, Mathur SR, Mahey R, Vashist S, Natarajan J, et al. Evaluation of cervical cancer screening during pregnancy in India: Human papillomavirus testing can change the paradigm. Natl Med J India 2023;36:17–21.
DOI:10.25259/NMJI_768_20

JOURNAL SCAN

Towards elimination of cervical cancer - human papillomavirus (HPV) vaccination and cervical cancer screening in Asian National Cancer Centers Alliance (ANCCA) member countries

Dr Priyanka Mathe,
Assistant Professor,
Department of Obstetrics & Gynaecology,
University College of Medical Sciences & Guru Teg Bahadur Hospital,
Delhi

Background

About 95% of cervical cancers worldwide are caused by human papillomavirus (HPV). Cervical cancer is preventable and curable if it is detected and treated early. Ensuring health service accessibility and affordability for women, addressing sociocultural barriers, and strengthening the healthcare system and continuum of care are essential to increase HPV vaccination and cervical cancer screening coverage.

Methods

This study was conducted from January to March 2023 among the ANCCA members from Bangladesh, Bhutan, Brunei, Cambodia, China, India, Indonesia, Iran, Japan, Laos, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Thailand and Vietnam. The latest national cervical cancer indicators, and barriers to HPV vaccination and cervical cancer screening in 21 Asian National Cancer Centers Alliance (ANCCA) member countries were reviewed. The barriers against HPV vaccination and cervical cancer screening along with the impact of COVID-19 pandemic on HPV vaccination and cervical cancer screening were assessed in this study.

Results

Half (n = 11, 52%) of the countries have introduced HPV vaccination

for girls as part of their national vaccination

programme, three countries reported coverage of over 90%. Most ANCCA member countries have cervical cancer screening programmes, only five countries reported screening uptake of over 50%. It was noted that the coverage of the first dose of HPV vaccination was even lower in the Asia region which was found about 6% in the Western Pacific Region and only 3% in the South East Asia Region. Only three out of 21 (14%) ANCCA member countries (Bhutan, Brunei and Singapore) have reported first dose national vaccination coverage of above 90% for girls by 15 years of age which is vey less. Among ANCCA members, about a third (38%) of countries utilise VIA as the primary screening test for cervical cancer screening while the rest of the countries use cytology alone or in combination with VIA or HPV test, and only 4 countries have rolled out HPV test in the national screening programme.

Conclusion

A comprehensive approach is required to overcome the barriers to HPV vaccination and cervical cancer screening among ANCCA member countries. In low income countries, a concerted approach is required to increase the awareness. Cultural and social barriers need to be addressed to strengthen the healthcare facilities to overcome the high burden of cervical cancer in Asian region.

Journal access: Ong SK, Abe SK, Thilagaratnam S, et al. Towards elimination of cervical cancer - human papillomavirus (HPV) vaccination and cervical cancer screening in Asian National Cancer Centers Alliance (ANCCA) member countries. Lancet Reg Health West Pac. 2023;39:1.

Colposcopy MDT

A BRIEF SUMMARY OF DISCUSSUION OF MONTHLY MDT

Colposcopy MDT discussion:

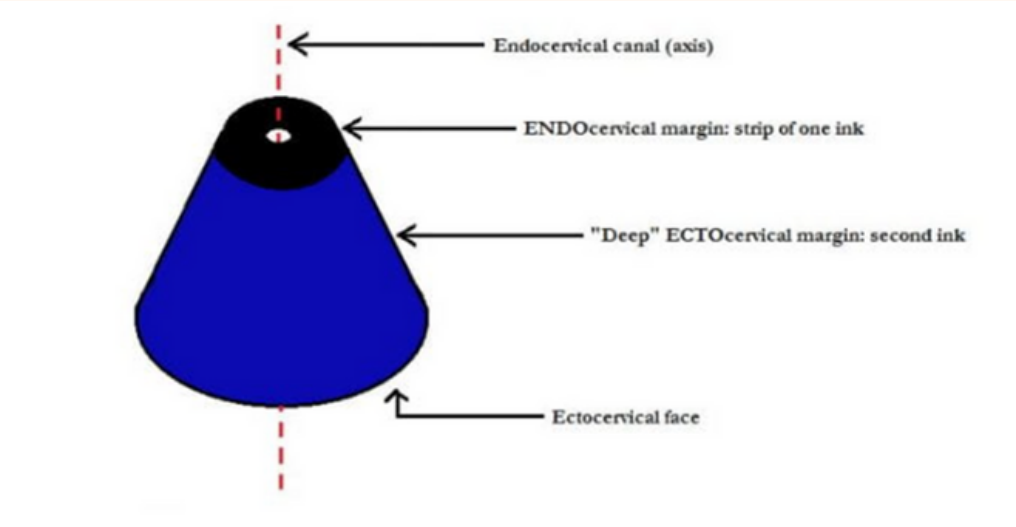
CANCER INSTITUTE
(WIA)
ADYAR, CHENNAI

Case 1

29 years old female married since 8 years. She is under treatment for infertility and asymptomatic . Routine pap smear screening has detected HSIL. She underwent colposcopy.

***What is the role of cone biopsy? How do we get an 'Ideal cone biopsy specimen' and what are the pre-op evaluation and considerations in deciding the cone size and shape.**

Cone biopsy may be diagnostic or therapeutic. Cone biopsy helps to identify malignancy if exist in cervix diagnosed with preinvasive lesions and offer the appropriate management.



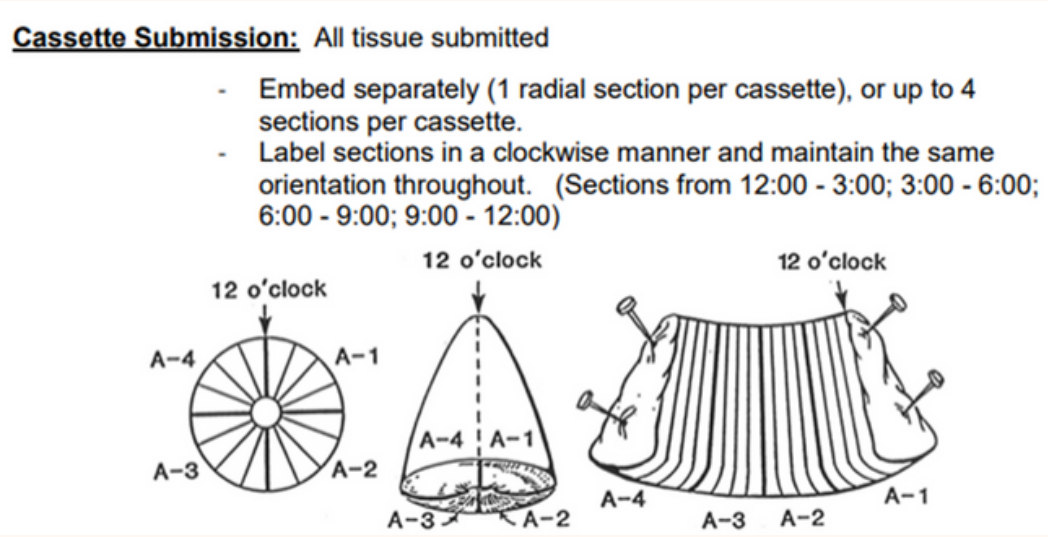
Ideal cone should include the entire transformation zone and lesion over the cervix, should include adequate length of endocervical canal. While proceeding with cone biopsy it is good practice to measure the endocervical canal length with uterine sound and see the extent of lesion over ectocervix by using acetic acid or lugol's iodine.

Which one is preferred: cold knife or with diathermy? Why?

Cold knife conization or diathermy does not show any difference in patient outcome. In cold knife conization the margins involvement can be commented by pathology than in diathermy as the margins may be charred.

How should the cone biopsy specimens be reported?

The picture below explains how to do grossing for cone biopsy specimen.



Reporting also follows the same labelling pattern and mentions the areas and the results for each. Reporting guidelines are available in CAP protocol.

Case 2

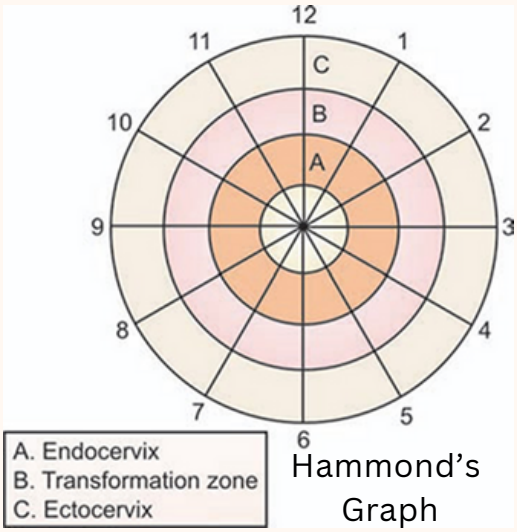
40 years old P3L3 lady, regularly menstruating with nil gynae complaints (on eliciting) complaints of white discharge per vaginum on and off, not of concern to her. She had her cervical cancer screening with VIA detected to have VIA positive lesion, same visit she had colposcopy examination of her cervix which showed high grade lesion with Swede score of 7, biopsy was taken and she underwent thermal ablation of cervix (same sitting). Final HPE of cervical biopsy suggestive of 'CIN III with possible invasion, tissue inadequate to comment'.

How to avoid this situation?

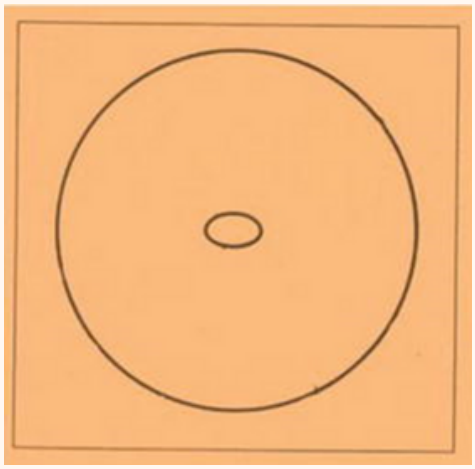
When we are proceeding with screen and treat or screen see and treat approach it is better to go for excision manage high grade lesions and use ablative treatment for low grade lesions.

How to document colposcopy and procedure findings?

Using colposcopy scoring system like Swede's or Reid's scoring system, pictoral representation of lesion with Odell's diagram or Hammond's graph , 2011 IFCPC colposcopy reporting form can be used to document the colposcopy findings which will help in followup and referral.



Hammond's Graph



Odell's Diagram

Link for IFCPC 2011 colposcopy terminology - https://site.ifcpc.org/Nomenclature/

WELCOME TO OUR

WRITER'S CORNER

unleashing the writers passion!

Raindrops and Operation Theatre...

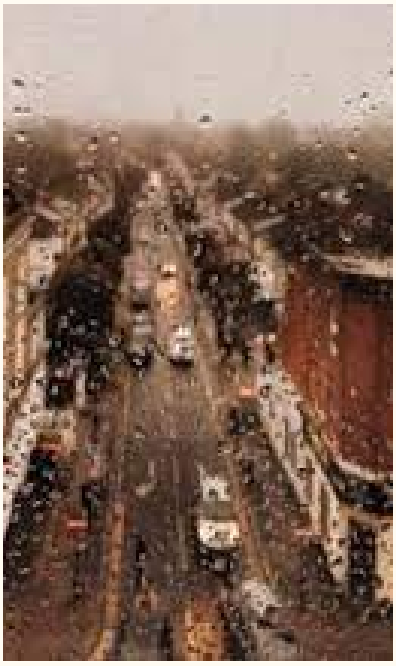
It was a slightly humid afternoon on the 16th day of the first phase of lockdown during the coronavirus pandemic crisis. I was standing in the operation theatre near the fixed glass windowpane overlooking the lush green entrance garden of the hospital. Although the weather outside was cool, sweat was continuously tricking down my back. I was geared up in full 'personal protective equipment' to do an emergency surgery!

New Writer in our team Alert

THIS IS DR RANU PATNI, OUR WRITER!

Senior Gynae Onco surgeon,
Sri Ram Cancer Centre,
Mahatma Gandhi University of Medical Sciences,
Jaipur

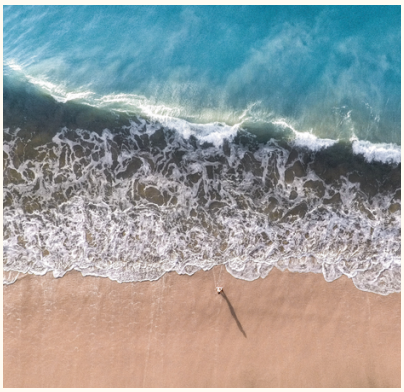
Due to some last-minute preoperative formalities remaining, it would be another half an hourbefore the patient would be wheeled in the theatre, my chief OT assistant told me. To hide my irritation, I abruptly again turned towards the glass pane! At that very moment, it started drizzling outside. The raindrops falling on the windowpane amazingly synchronized their movement on the windowpane and then tuned into a kaleidoscope of colors....



It was a similar afternoon about 25 years back! I was a teenager then, a simple, bubbly, short tempered but well-mannered girl who had dreams in her eyes and determination in her step. That day the result of my premedical test (PMT) was about to be declared. I was not too worried about the result because I had a list of plans for my life, but my parents were! At 3 pm the result was disclosed, and I got selected in PMT. I will never forget the twinkle and pride in my parents' eyes on knowing that I had cleared PMT! That day, the future doctor in me decided to make my parents proud by excelling in the medical field.

Medical profession those days was the most sought-after profession. The society held doctors in high esteem and they in turn lived up to their reputation. Learning came before earning and duty before family. Life for me went into a fast forward mode from there on. After MBBS and MD I did senior residency and specialty trainings. In the meantime, marriage, children and social obligations continued. Finally, I was appointed as a consultant in a reputed corporate hospital. Fifteen long years passed like whirlwind. During those years, a subtle change had started creeping in the society and the medical profession. Corporate culture was gradually seeping in with the medical professionals in corporate hospitals becoming answerable to management consultants. Diagnostics, procedural/surgical techniques and ancillary services were improving fast. Clinical sense was somehow becoming less dependable. Money and politics entered medical profession too. Negligence cases started rising and random instances of physical attacks on doctors began happening.

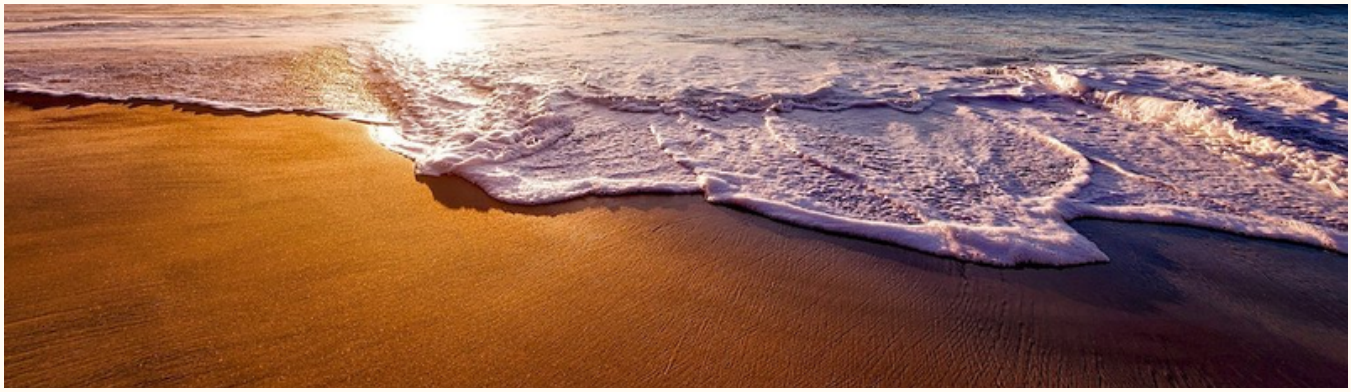
I became a successful superspeciality surgeon. One day, a young couple came to my OPD. The lady, in her mid-thirties, was suffering from advanced epithelial ovarian carcinoma with lung metastasis. She had cachexia, breathlessness and massive ascitis. Her history showed that she had been diagnosed with an Ovarian malignancy about ten months back and had been advised surgery and chemotherapy, but she did not comply. Her present condition made her land in my OPD with the local doctor's referral letter. On confirming her diagnosis as stage IV serous cyst adenocarcinoma of ovary, I advised her admission and thoroughly explained the seriousness of her condition and the expected grave outcome. Her husband was not ready to accept that his wife might not survive long. He expected me to do some magic and cure her. After repeated counseling and a written consent, he got the patient admitted.



After two days of intensive care, the patient succumbed to her disease. As I was breaking the news to the husband, he suddenly pounced and hit me hard on my head with the paperweight lying on the table! Just before passing out, I pressed the call bell on my table. The last sounds I heard were the scream of the ward lady and an accusation mouthed by the patient's husband that I had killed his wife! When I opened my eyes, I found myself in a private neurosurgery room with my family standing beside my bed. I was feeling a little dizzy. I was told that I had suffered a concussion and was now 'physically out of danger'.

The shock of that sudden attack remained fresh in my mind for long. I often had the feeling that someone was lurking around the corner and would attack me anytime! I decided to take a break from medical practice and research myself. It was an extremely tough decision. I felt as if I was giving up my entire life's earnings. But I knew I had to do it!

Life slowed down quite a bit after that. I spent more quality time with my children, pursued my hobbies and caught up with childhood friends. I missed the intellectual pursuits of my profession and the thrill of surgery but was happy in my own space.



It had been almost six months since I had given up practice. Then came the Corona Virus pandemic and the subsequent lockdown. Everyday thousands of people were dying all over the world. The worth of medical practitioners and health care workers had suddenly gone up and they were being openly applauded. I must admit to feeling proud of the fact that I belonged to the medical fraternity.

One morning around 9 am, I received a call from my old hospital requesting me to come and see a patient in the emergency. They said, their regular surgeon was stuck up somewhere out of the city and the doctor on duty was too junior to handle the situation. They also said that the patient had mild symptoms of suspected Covid-19 infection and samples had been sent for testing. My first instinct was to refuse and say that I had left surgical practice. Then my conscience got the better of me and I said yes. On my way to the hospital, fear suddenly struck me again. The horrifying experience of the patient's attendant attacking me came alive in my mind and I stopped the car in a side lane. My breathing had become labored and mind dizzy. Then, I remembered the twinkle in the eyes of my parents and my determination to make them proud. This was my chance to do that, I told myself. I knew I was taking a big risk operating on a suspected Covid positive patient, but my mind had cleared up now. I switched on the ignition and swerved the car on the main road.

The sound of the stretcher being wheeled into the OT jerked me back to the present. The patient was sedated but I had met her earlier in the preoperative area. She had been diagnosed with post-surgical acute intestinal obstruction. The precautions for Covid infection and the preparation for surgery were already in place. The surgery lasted for about two hours and was successful.

Before leaving the OT, I looked out of the windowpane. The rain had stopped but a few raindrops were still sliding down the glass. The weather had cleared and the kaleidoscope on the windowpane had shifted to the sky in the form of a rainbow! I could not meet my patient
the next day because she had turned out to be Covid positive and the whole OT team involved in her surgery was quarantined. The patient was shifted to the isolation ward, and I got to know that she was fine.

In my quarantine room, alone, I was sitting on the bed and thinking about the events of last six months. Now, my mind was at rest. I laid my head against the backrest of the bed and felt two happy tears trickle out of the corners of my eyes. They felt the same as the raindrops dancing on the windowpane of my operation theatre...

The Day I received my HPV VACCINE!!!

Once, last Tuesday I was taking a nap when the telephone rang, I picked up the phone and my mother called me because I had to get my HPV vaccine. But why did I want the HPV vaccine? Let me explain.

1. saw horrible signs of HPV virus also known as human papilloma virus. They had warts on every part of their body. I was so scared that I told my mother I needed an HPV Vaccine.

2. Vaccine would protect me all my life.

Art and write up by

- Jeremiah John Sudarsan,
- 11 years old.

AOGIN NEWSLETTER

OCTOBER EDITION

WHAT'S HERE?

About my HPV vaccination

by Jeremiah John Sudarsan

So that is why I needed an HPV vaccine. So after my mother hung up after this. I took a shuttle, and I reached CMC (also known as Christian Medical College). I waited after some time and she came with the vaccine in an ice box. As we entered the hospital I was shivering in my boots.

I took my vaccine, and it was like an Ant bite (I screamed and snorted , not out of pain, though. I just took the liberty to let it out!).

fter that my mother allowed me to have some coffee to drink and sent me on a shuttle. And of course, my sister also demanded the HPV Vaccine for herself, now that I received it.

From AOGM India members who make us proud

Events conducted in the Months May to July 2023 -PHRII

Month of May 2023: Study Abroad Program: Public Health Research Institute of India, Mysore with the collaboration of Study Abroad office USA through the Department of Psychology at Florida International University conducted this program From May 16th for 25 days. This program creates unique experience to undergraduate students with personalized and practice experience in the research field. Twenty one students with five faculties visited to PHRII and had the experience of research knowledge with various resource persons during this program Dr Vijaya Srinivas delivered a talk on Prevention of Cervical Cancer with different screening method with Primary prevention by Awareness programs. PHRII mobile clinic conducted a camp on cervical cancer screening with VIA, VILI and liquid based cytology method was conducted in the rural village known as Halbedu for eligible women in that community. Students were exposed to various lectures which include Primary Health Care system in India. Alternative medicine like YOGA, Nature cure, Unani.

Month of June 2023: Three Awareness programs in the community to recruit women in the community for HPV DNA Self collection methods supported by Karkinos health Care system.

Month of July 2023: Cervical Cancer Screening Program was organized by the Public Health Research Institute of India (PHRII) in collaboration with the Department of Biochemistry, JSS Medical College, JSS AHER as a part of Scientific Social Responsibility (SSR) under the Department of Science and Technology Promotion of University Research and Scientific Excellence (DST-PURSE). PHRII and JSS AHER have been working on several collaborative studies and SSR activity is one example of such collaborative programs between these two institutions.

SSR activities are being conducted to understand a culture

of social commitment among the scientific community and develop an ecosystem to create two-way engagement between science and society. The inaugural function of the screening camp was organized on 13th July 2023 at 11:00am at JSS Medical College, JSS AHER. Dr. Purnima Madhivanan Associate Professor, University of Arizona, USA, and the Founder of PHRII, Dr. Vijaya Srinivas Senior Research Physician, Purnima Jay Administrative Officer PHRII, Dr. H. Basavanagowdappa, Principal JSS Medical College, along with other faculty, research scholars, and M.Sc. Students of the Department of Biochemistry were present at the gathering. Following the inaugural function cervical cancer screening camp with HPV DNA test by self-collection method was conducted. To render few more benefit for the participant's blood tests for HB, HbA1C, and Lipid profile were done. Total 100 participants were screened till the 3rd week of September 2023.

Sincerely,

(Dr. Vijaya Srinivas)
Senior Research Physician

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89/B, 'Ambika' 2nd Main,
2nd Cross, Yadavagiri, MYSORE-20
Ph: 0821-4259555, Fax:4246221
email:phn.mysore@gmail.com


SSR Camp Inauguration at JSS Medical College


Cervical Cancer Awareness by Dr Vijaya


Dr. Karl Krupp, Dr. Lynn Gerald and Dr. Jeffrey Klausner, USA with PHRII Team at Camp


Screening Camp with Study Abroad Team

From AOGN India members who make us proud

Report of activities of Beautiful Tomorrow between May -Sep 2023

18th May 2023

• Cervical Cancer awareness program
at CARTE Medical Centre, Ghaziabad.

1st Jun 2023

• Thermography camp for screening of Breast cancer
- attended by 35 women.

27th Jun 2023

• 35 adolesent girls vaccinated by single dose Gardacil 4
at Nagar Hospital. Cost borne by the Trust.

31st Jul 2023

• Cervical cancer awareness talk at Sopra Steria,
a software company in Noida.

10th Aug 2023

• Screening camp for cervical cancer by
Pap's smear and breast examination
for early detection was done for
wives of Army personnel at Meerut Cantt.
In association with Virina Foundation.

25th Sep 2023

• Addressed a gathering of about 500 students
and faculty of KIET Group of Institutions
on Lifestyle and Cancer prevention
with special focus on Cervical cancer.

From AOGM India members who make us proud

This newsletter was
compiled and edited by
Drs. Vinotha Thomas, Jayashree Natarajan
and
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Please send in your contributions to the next newsletter to
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