

The quarterly newsletter of Asia Oceania research organization on Genital Infections and Neoplasia - India



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From the editor's desk

Dear friends,

It is my pleasure and great privilege to present to you this issue of AOGIN newsletter. Our goal is to create a forum for exchange of information on all aspects of preventive oncology.

We hope that our readers will find it useful.

A major health care goal currently is to develop an approach to fight against cervical cancer. With great pride we are delighted to share the new venture of AOGIN India "Kalyanmayee-AAIWWA" camps. Dr Srabani has very nicely shared the brief summary of this new venture. Dr. Neerja Bhatla in this issue has presented an expert well-constructed and educational review on Primary HPV screening. Management of pre cancerous lesions is an integral part of any screening programme. In Clinical Pearls "Management of CIN" is explored by Dr Shalini Rajaram and Dr Bindiya Gupta with the help of case based Discussion. Journal Scan contributed by Dr Puneet Chandna and Dr Jyoti Meena highlights an important novel association between IUCD usage and cervical cancer.

The first HPV international awareness day was inaugurated on March 4, 2018. A special delight for our readers is a set of resources given by Dr Neerja Bhatla. For more details visit our website and see the "HPV Flash" by Path cervical cancer prevention team where you will also find a brief summary of What is new in literature in the field.

I extend my warmest thanks to all the authors for their contribution. The entire AOGIN India team and I request you to submit novel and enlightening manuscripts to educate and support the growing field of gynecologic oncology. I will be looking forward to your valuable feedback and suggestions.

Happy reading!!!

Dr Seema Singhal



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Message From the President

Dr Abraham Peedicayil, Professor and Head Department of Gynae Oncology, CMC Vellore



Dear Colleagues,

Several of you are involved in the AOGIN.India-Kalyanmayee Cancer Screening project. We get regular updates with photographs and statistics on the whatsapp group. Congratulations on your sustained interest and commitment to the project. Keep up the good work. I look forward to the consolidated results of screening and treatment. I am sure together we can make a real difference in the health of women in India.

Some of us are also involved in HPV vaccination. The main argument against introduction of the HPV vaccine in to the national UIP is its cost-effectiveness. India needs a cheaper vaccine and hopefully there will one be available in the near future. Those of us who are associated with Ministry of Health & Family Welfare as well as the state health system should push for introduction of the vaccine at primary health centres.

Recently there have been articles in newspapers and magazines regarding the HPV vaccine. Some of us should write articles about the importance of primary and secondary prevention. If anyone has contacts in the television media please try and arrange for some air time. We can make use of both the English and vernacular channels. At the various screening camps and community outreach programmes please do have some health education sessions about vaccination and warning signs of cancer.

Since we decided to have our annual conference only every alternate year, our next one will be in 2019. It's imperative we continue efforts that not only promote greater access, to health care, but also promote research to look for cure and effective treatment.

Best wishes,

Abraham Peedicayil

Dear AOGIN India member

The 32nd International Papillomavirus conference in conjunction with AOGIN 2018 is being organized at Sydney, Australia October 2nd - 6th, 2018.

AOGIN India is pleased to announce two travel grants for young AOGIN India members who are less than 40 years age. The selected outstanding abstracts will be paid Rs. 20,000.

Please submit your abstract at info@aoginindia.com after acceptance from the conference committee at the earliest.

Best wishes,

AOGIN India Team

HPV Primary Screening : A new paradigm in the fight against cervical cancer

Prof. Neerja Bhatla, Dr. Seema Singhal, AIIMS, Delhi

Screening for cervical cancer with repeated rounds of cytology has been very effective in reducing cervical cancer incidence in several countries. Interest in the use of HPV testing as a screening test emerged based on the discovery that high risk HPV types are the necessary cause of cervical cancers. The test is objective, easy to perform and highly sensitive. The role of the HPV test has changed over the years as data has accrued. In 2000, the US FDA approved the use of the digene Hybrid Capture II test (Qiagen) in women aged over 30 years to determine the need for colposcopy in women with ASCUS cytology. The use was further expanded when HPV testing was included with cytology. The combination of the two tests, called co-testing, was approved by FDA in 2003. Co-testing in women over 30 years led to an increase in the screening interval: from 3 years with cytology-based screening to 5 years with co testing. In 2008 the 3 year prospective ATHENA (Addressing the need for advanced HPV diagnostics) study was initiated in USA, to evaluate the performance of primary screening with the Cobas HPV test in women aged >25 years. The sensitivity of cytology, co testing and Primary HPV testing for detecting CIN 3+ lesions was 47.8%, 61.7% and 76.1% respectively. The specificity for detecting CIN3 + lesions with cytology, co testing and Primary HPV testing was 97.1%, 94.6% and 93.5% respectively. (1) In 2014, the Cobas HPV test (Roche) was approved by FDA for primary HPV screening, i.e., a stand-alone screening test in women over 25 years of age. This was a major paradigm shift. Several HPV tests that have received approval include the following:

1. **Hybrid Capture 2 High Risk HPV DNA test** (Digene)
2. **Cervista HPV and Genfind DNA Extraction** (Hologic)- Identifies DNA from 14 high risk HPV types
3. **Cervista™ HPV 16/18** (Hologic) : Identifies HPV types 16 and 18 DNA
4. **Cobas HPV Test** (Roche Molecular Systems) : Identifies DNA from 14 high risk genital HPV types commonly associated with cervical cancer . Specific for 16,18 but also identifies other high risk types.
5. **APTIMA HPV assay**(Gen Probe): Used with the Tigris DTS system to identify RNA from 14 high-risk genital HPV types. Detects messenger RNA from two HPV viral oncogenes, E6 and E7.

The higher sensitivity of the HPV test offers several advantages, including better reassurance, reduced cancer rates in women who test negative and longer screening intervals, but whether the increased sensitivity of human papillomavirus (HPV) testing was a result of over-detection of abnormalities that would have regressed with time, or

whether it represented a lead-time gain has been a matter of debate. (2) A meta analysis that supported cervical cancer prevention via primary screening with HPV testing starting at age 30 or later years observed higher colposcopy rates with HPV testing at baseline screening and among younger women. However when HPV positive women were triaged with cytology, referral rates reduced to 1.1% from 13% for women aged 25 to 34 who were directly referred to colposcopy after a positive HPV test (referral threshold of 1pg/mL). (3) Hence it is recommended that HPV positive women need to be triaged with either cytology or genotyping before taking them for colposcopy and subsequent management.(4)

The superior clinical performance of HPV-based screening in preventing cervical cancer as evident by a meta- analysis of the four European randomized controlled trials with 1,76,464 women aged 20–64 years randomly assigned to HPV-based (experimental arm) or cytology-based (control arm) screening. The pooled rate ratio for invasive cervical carcinoma among all women from recruitment to end of follow-up was 0.60 (95% CI 0.40–0.89). A significantly lower rate of invasive cervical cancer was observed in the primary HPV screening cohort than the cytology arm with cumulative incidence of invasive carcinoma in women with negative entry tests 4.6 per 105 (1.1–12.1) and 8.7 per 105 (3.3–18.6) at 3.5 and 5.5 years, respectively, in the primary HPV screening cohort and 15.4 per 105 (7.9–27.0) and 36.0 per 105 (23.2–53.5), respectively, in the cytology-based screening arm. This reduction was more for adenocarcinoma than for squamous cell carcinoma with rate ratio: 0.31 versus 0.78, respectively. (5) This highlights the fact that primary HPV screening could be more useful to reduce cervical cancer mortality by increasing the detection of cervical adenocarcinoma. A larger proportion of AC than SCC cases are attributable to HPV 16 and 18 (85% versus 70%, respectively), which also has important implications for vaccination in the primary prevention of cervical cancer. (5) The risk of high-grade precancer or cancer (CIN3+) was compared for HPV, cytology and co testing by Gage et al in 2014. Three-year risks following an HPV-negative result were lower than 3-year risks following a Pap-negative result (CIN3+ = 0.069% vs 0.19%, $P < 0.0001$; Cancer = 0.011% vs 0.020%, $P < 0.0001$) and 5-year risks following an HPV-negative/Pap-negative co-test were almost equal (CIN3+ = 0.069% vs 0.11%, $P < 0.0001$; Cancer = 0.011% vs 0.014%, $P = 0.21$). (6) Although these risks are not identical, both are lower than the risk of high-grade precancer/cancer associated with cytology screening every three years therefore this very small decrease in cancer risk associated with co-testing (versus

Expert Opinion

HPV testing alone) may not be considered affordable in most low and middle income countries (LMICs) with important competing health priorities.

To evaluate the effectiveness of a single round of HPV testing, cytologic testing or VIA in reducing the incidence of cervical cancer a cluster randomized study was conducted by Sankaranarayanan et al. The hazard ratio for detection of advanced cancer was lowest in HPV testing group (0.47; 95% confidence interval [CI], 0.32 to 0.69) followed by cytology (0.75, CI 0.51-1.10) and VIA (1.04, CI 0.72-1.49). Similarly, deaths due to disease were highest in the VIA and cytology groups and least in the HPV screening group with hazard ratios 0.86 (0.60-1.25) vs 0.89 (0.62-1.27) vs 0.52 (0.33-0.83) in VIA, cytology and HPV screening groups respectively. The age-standardized rate of invasive cancer among women who had negative results on cytology or VIA was more than four times the rate among HPV negative women, indicating a high negative predictive value associated with a negative HPV test. (7) The performance of various screening tests in the Indian population was reviewed by Bobdey et al in 2016. (8) The pooled sensitivity and specificity of HPV testing was found to be the highest i.e 77.81% and 91.54% respectively. VIA was more sensitive than cytology (67.65% vs 62.11%) with somewhat lower specificity (84.32% vs 93.51%). (8)

In conclusion, HPV testing may safely be introduced as a stand-alone primary screening method to maximize efficiency associated with extended screening intervals resulting in substantial cost saving and reduced burden. However it is important to recognize that all HPV tests are not the same. Many laboratories in India use their own non-validated HPV tests and PCR primers so data on the performance of these tests needs evaluation before we can confidently use these for primary HPV testing alone. In the future, this will be the best choice as cytology or VIA will not be adequate to screen HPV vaccinated populations. Presently the main hesitation to introduce the test comes from costs, lack availability of HPV test in many cities and the misconception that screening must first be organized before technological changes can be made. The superior NPV, high throughputs, need for lesser infrastructure, trained staff and provision of self-sampling make it ideal for inclusion in screening programmes.(2,4) Primary HPV screening is an important scientific and clinical advance in cervical cancer screening. The use of available low cost tests in primary HPV screening needs to be further validated.

References

1. Wright TC, Stoler MH, Behrens CM et al. primary cervical cancer screening with human papilloma virus: End of study results from the ATHENA study using HPV as the first line screening test. *Gynecol Oncol* 2015;136(2):189-97.
2. Tota JE, Bentley J, Blake J, et al. Introduction of molecular HPV testing as the primary technology in cervical cancer screening: acting on evidence to change the current paradigm. *Prev Med.* 2017;98:5-14.
3. Murphy J, Kennedy EB, Dunn S, et al. HPV testing in primary screening : A systematic review and meta analysis. *J Obstet Gynaecol Can.* 2012;34(5):443-452.
4. Huh WK, Ault KA, Chelmow D, et al. Use of primary high-risk human papillomavirus testing for cervical cancer screening: interim clinical guidance. *Gynecol Oncol.* 2015;136(2):178-82.
5. Ronco G, Dillner J, Elfstrom KM, et al. Efficacy of HPV-based screening for prevention of invasive cervical cancer: follow-up of four European randomised controlled trials. *Lancet* 2014;383:524–32.
6. Gage JC, Schiffman M, Katki HA, et al. Reassurance against future risk of precancer and cancer conferred by a negative human papillomavirus test. *JNCI.* 2014;106(8).
7. SankaranarayananR, NeneBM, ShastriSS, et al. HPV screening for cervical cancer in rural India. *NEnglJ Med* 2009;360:1385-1394
8. Bobdey S, Sathwara J, Jain A, et al. Burden of cervical cancer and role of screening in India. *Indian J Med Paediatr Oncol.* 2016;37(4):278–285.

New Learning resources

Learning Resource	Learning Resource
Guidelines for organizing a quality assurance program for introduction and routine use of <i>careHPV</i> in low-resource settings	Based on PATH's experience implementing the <i>careHPV</i> TM test in Central America, this manual provides guidance for organizing a quality assurance program for screening programs adopting the test.
Training resources for cervical cancer screening and management of cervical pre-cancers	World Health Organization, South-East Asia Regional Office (WHO SEARO) with contributions from colleagues at International Agency for Research on Cancer (IARC), has released new training resources . They include information on thermo-coagulation.
Secondary Prevention of Cervical Cancer Resource-Stratified Guideline	The American Society of Clinical Oncology has released a new set of guidelines for secondary prevention , including adjustments for various on-the-ground situations.
Videos for providers on making effective recommendations to increase HPV vaccination rates	The United States Centers for Disease Control and Prevention have produced a set of short online videos explaining how experienced providers recommend the vaccine and address different issues.
Q&As on HPV vaccine	The WHO Regional Office for Europe has produced a set of Q&As that provide answers to the most frequently asked questions posed by parents, health care professionals, young people eligible to receive HPV vaccine and the media.
New colposcopy resources	IARC has produced two new publications: Colposcopy and Treatment of Cervical Precancer: IARC Technical Publication No. 45 Atlas of colposcopy – Principles & Practice

Intrauterine Device Use and Cervical Cancer Risk

A Systematic Review and Meta-analysis

Dr Puneet Chandna, Dr Jyoti Meena

Victoria K. Cortessis, Malcolm Barrett, Niquelle Brown Wade, Temuulen Enebish, Judith L. Perrigo, Jessica Tobin et al. *Obstet Gynecol* 2017;130:1226–36

BACKGROUND: Intrauterine devices are the most commonly used reversible contraceptive method worldwide. Heavy menstrual bleeding and associated anaemia can be controlled by levonorgestrel-containing IUDs, and women who have used non hormonal IUDs experience lower endometrial cancer incidence. It has been hypothesised that intrauterine device use may alter the natural history of human papilloma virus infections, preempting development of precancerous lesions of the cervix and cervical cancer, but the effect of intrauterine devices on the natural history of human papilloma virus infection and subsequent development of cervical cancer is poorly understood. After publication of a series of studies sponsored by the International Agency for Research on Cancer, the body of epidemiological data relating IUD use to occurrence of cervical cancer needs further investigations.

OBJECTIVE: To estimate the association between use of an intrauterine device (IUD) and risk of cervical cancer by subjecting existing data to critical review, quantitative synthesis, and interpretation.

METHODS OF STUDY SELECTION: Abstracts from 225 reports, identified 34 studies with individual-level measures of use of an IUD and incident cervical cancer. By critically assessing the full text of these reports, independent reviewers identified 17 studies conducted without recognised sources of systematic error, of which data from 16 of these studies reporting on 4,945 incident cases of cervical cancer and 7,537 women who remained free from this malignancy could be harmonised for inclusion in the meta-analysis.

RESULTS: The estimated summary OR associated between any (compared with no) use of an IUD and cervical cancer was 0.64%(95%CI0.53-0.77) as estimated from 16 high quality studies. Stratum-specific summary OR estimates did not differ appreciably between sub- sets of studies of like

design, results from studies of the common design and did not materially change by omitting data from any of the 16 studies. These findings reveal a robust inverse association that is unlikely to have arisen spuriously from either random error or participation bias. The natural logarithm of the OR values from individual studies were inversely correlated with both HPV prevalence and proxy for lower access to screening, age-adjusted incidence rate of cervical cancer , and only the age-adjusted incidence rate coefficient achieved statistical significance (P5.005). These results accord with the possibility that protective effects of IUDs may be somewhat greater in populations that experience higher cervical cancer risk.

DISCUSSION: Results of influence, sensitivity, and cumulative meta-analyses indicate that the observed association is unlikely to be explained by study design, residual confounding by recognised cervical cancer risk and protective factors, or publication bias. The possible mechanisms whereby placement of an IUD might mediate malignant potential focus on proximity of the cervical canal to the transformation zone, where pre neoplastic lesions arise. The transformation zone is both targeted by HPV and a major effector and inductive site for cell-mediated immune responses. Tissue underlying the transformation zone is manipulated during IUD placement, and the possibility that this procedure may elicit an immune response that might finally clear persistent HPV infections and pre invasive lesions. Moreover pre invasive cervical lesions might be removed mechanically during IUD insertion or removal.

CONCLUSION: The meta-analysis revealed a robust inverse association between any use of an IUD and incident cervical cancer with overall incidence approximately 30% lower in women who reported ever using a device. This possible non-contraceptive benefit could be most beneficial in populations with severely limited access to screening and concomitantly high cervical cancer incidence.

Management of CIN: Clinical Situations

Bindiya Gupta, Shalini Rajaram
UCMS and GTB Hospital, New Delhi

Case 1

Mrs S, 33 years old female, P3L3 presented to GOPD with complaints of :

- Discharge per vaginum x 1 year

Menstrual cycles regular,

Past History and Family History: Not significant

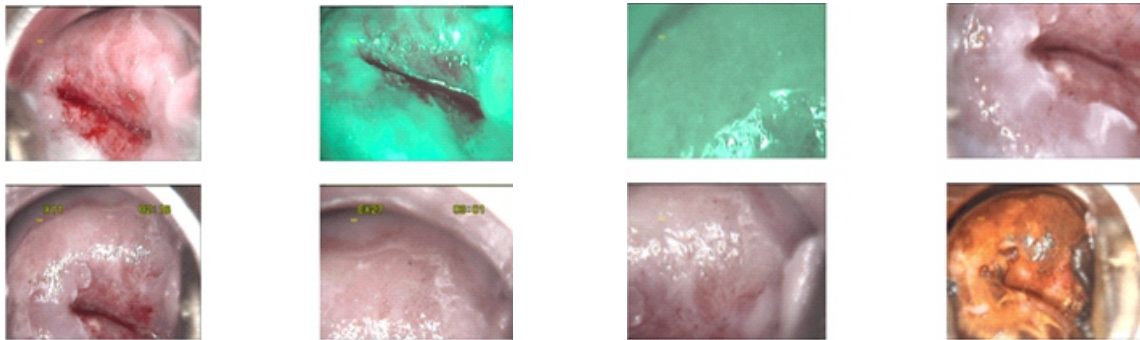
On Per speculum examination cervix looked unhealthy, Bimanual examination revealed a normal size uterus, bilateral fornices were free and non tender.

After application of acetic acid a dull acetowhite area was seen on posterior lip of cervix

She was advised to undergo colposcopy

Following are the Colposcopy images (Fig 1)

Her Swede Score was 7. A biopsy was taken from posterior lip of cervix. The biopsy report showed Mild Mild dysplasia (CIN-1) with koilocytic changes



Q1a. What is the further management?

Q1b. What is the risk of progression of CIN -1?

Case 2

Mrs S, 33 years female P3, L3 presented with complaints of

- Persistent vaginal discharge and Post coital bleeding x 6 months

Menstrual cycles regular, Past History and Family History: Not significant

On Examination

Cervix showed an irregular area on cervix that bleeds to touch.

After application of acetic acid a large distinct opaque acetowhite area was seen on posterior lip of cervix abutting the squamo columnar junction which is fully visible.

She was advised to undergo colposcopy

Colposcopy and biopsy done (Figure 2); Swede score: 8; HPE: CIN 2



Q2a. What is the further management?

Q2b. What is the follow up after treatment?

Q2c. What are the factors associated with increased risk of recurrence or persistence?

Case 3

Mrs Z, 33 year female P3L3 with HIV +
C/o

- Foul smelling vaginal discharge x 2 years
- No intermenstrual or post coital bleeding

Menstrual cycles normal

Examination

P/S: Leukoplakia +

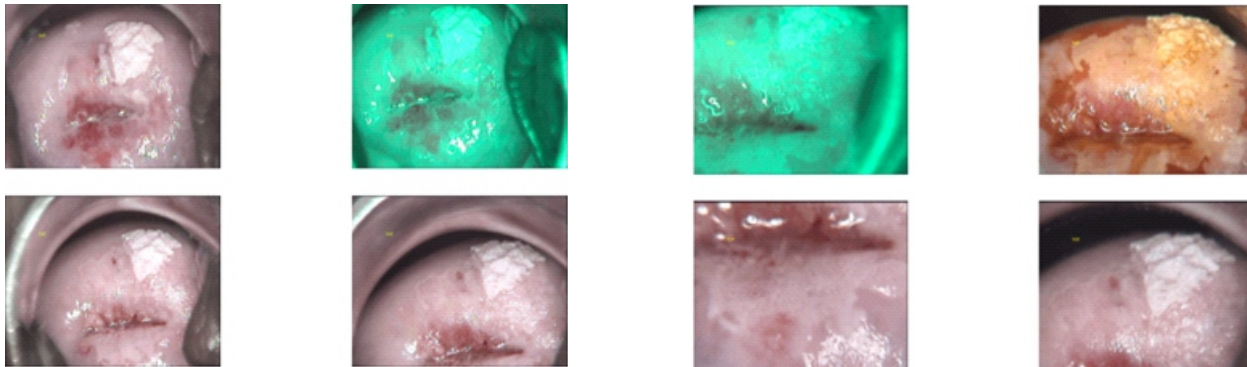
P/V: NAD

Screening test: VIA +ve

Pap smear: Unsatisfactory due to low squamous cellularity

Repeat Pap smear: NILM

Colposcopy and biopsy is suggestive of CIN 3



Q. What is her management and follow up?

Answers

1a. The patient can be counselled that CIN 1 is likely to regress in 57% cases; Persist in 32% cases and Progress in 11% (progress to CIN II / III); <1% progress to invasive cancer and therefore she needs more careful follow up and in case she is unable to follow, treatment for CIN 1 can be advised in form of ablation.

The safety of observation rather than immediate treatment of CIN 1 was illustrated in a randomized trial (n = 415) of women with low grade cytology. The trial found no significant difference in the rate of CIN 2,3 at 18 months following immediate treatment with loop electrosurgical excision procedure (LEEP) compared with observation every six months with cytology, HPV testing, and colposcopy¹.

Therefore depending on the resource and her wish she can be advised either observation/ablation; rescreen with VIA/ cytology after one year, if negative she can return to routine screening.

(Chart 11 FOGSI-GCPR guidelines)²

1b. Risk of progression of CIN -1

In a retrospective study of 680 women with biopsy proven CIN 1³:

1. At six months follow up
 - 49% regressed to negative,
 - 35 percent had persistent CIN 1,
 - and 7 percent had high grade lesions;
2. At 12 months follow up

among the patients with negative results at six months: 80% were negative, 17% had low grade lesions, and 4% had high grade lesions at 12 months, among patients with persistent CIN 1 at six months: 50% were negative, 46% had low grade lesions, and 4% had high grade lesions.

2. a. Excisional procedure (LEEP)

b. Follow up with co-test/ HPV/cytology at 6 months, 1 year & 2 years and if test is negative, return to routine screening. (Chart 14 FOGSI-GCPR guidelines)¹

c. Factors associated with persistent or recurrent disease include age older than 40 years, glandular involvement, large lesions, and positive treatment margins, HIV coinfection⁴.

For CIN 2 lesions: 40 to 58% of lesions will regress if left untreated, while 22% progress to CIN 3, and 5% progress to invasive cancer. (ASC-US/LSIL) Triage Study (ALTS) randomized trial, regression of CIN 2 was less likely in women with human papillomavirus (HPV) 16 subtype than other subtypes⁵. However CIN 2 has lower rates of progression than CIN 3 and this is probably because CIN 2 is more likely to be caused by oncogenic HPV subtypes 31, 33, 35, 39, 45, 51, 52, and 58, which have a weaker association with development of cancer than the more highly oncogenic subtypes HPV 16 and 18, which are commonly found with CIN 3. Therefore for CIN 2/3 lesions treatment is recommended⁶.

3. Excisional procedure (LEEP), ensure patient is on HAART

Follow up at 12 months, 24 months post procedure with HPV and cytology/VIA. If negative return to screening every 2-3 years.

ASCO resource stratified guidelines recommend that HIV positive women should begin screening with HPV testing, every 2 to 3 years, as soon as they receive an HIV diagnosis. The recommended frequency depends on the resource level; in general, it should be twice as many times in a lifetime as in the general population (Type: formal consensus based). Treatment and follow up remain same.

References

1. Elit L, Levine MN, Julian JA, et al. Expectant management versus immediate treatment for low grade cervical intraepithelial neoplasia : a randomized trial in Canada and Brazil. *Cancer* 2011; 117:1438.
2. FOGSI GCPR guidelines 2018. Screening and treatment of preinvasive lesions of cervix.
3. Bansal N, Wright JD, Cohen CJ, Herzog TJ. Natural history of established low grade cervical intraepithelial (CIN 1) lesions. *Anticancer Res* 2008; 28:1763.
4. Jeronimo J, Castle PE, Temin S, et al. Secondary Prevention of Cervical Cancer: ASCO Resource-Stratified Clinical Practice Guideline. *J Glob Oncol*. 2016;3(5):635-657.
5. Castle PE, Schiffman M, Wheeler CM, Solomon D. Evidence for frequent regression of cervical intraepithelial neoplasia grade 2. *Obstet Gynecol* 2009; 113:18.
6. Nucci MR, Crum CP. Redefining early cervical neoplasia: recent progress. *Adv Anat Pathol* 2007; 14:1.

Nationwide cervical cancer awareness and screening initiative by AOGIN India

Dr Srabani Mittal

AOGIN India has initiated cervical cancer awareness and screening camps all over India with the support of Kalyanmayee-AAIWWA (Airports Authority of India Women Welfare Association). Women aged between 30-60 years are being screened through outreach clinics organized in coordination with local non-government organizations (NGOs). The clinics are organized within a radius of approximately 50 kms of the city airports. The community mobilization for the clinics is being done by the local NGOs or by community volunteers, supervised by the AOGIN representatives of the respective cities. All clinics are preceded by awareness sessions focused on breast and cervical cancer risk factors, importance of screening and preventive measures.

The screening tests used are PAP and VIA. In some of the places where screening by PAP is not possible due to local level logistic issues, screening is being done by VIA only. Some of the cities that have HPV screening tests (HC2, Care HPV) available as a part of their ongoing projects are additionally providing these tests free of cost to all women participating in the outreach clinics.

Apart from cervical screening, general medical check-up including measurement of blood pressure, blood sugar tests, distribution of free medicines for treatment of minor ailments and other gynecological problems are being provided to the women as indicated.

From December 2017 to February 2018, more than 1700 women have been screened by AOGIN India through 41 outreach clinics organized in different parts of the country. The list of participating cities is given in Table 1. The city wise distribution of screened women and the number of VIA positive women are given in the Table 2. The overall VIA positivity rate is 7.4%.

The complete PAP and HPV reports are awaited from many cities. All screen positive women are being followed up and recalled for colposcopy &/or biopsy.

Complete data for the current financial year would be presented on availability of all screening test reports and follow up details.

Table 1: Participating cities at a glance

Region	Name of City
NORTH	Delhi
	Lucknow
	Varanasi
WEST	Mumbai
	Ahmedabad
	Pune
CENTRAL	Jabalpur
EAST	Kolkata
	Bhubaneswar
NORTH-EAST	Guwahati
SOUTH	Chennai
	Hyderabad
	Bangalore
	Coimbatore

Table 2: City-wise distribution of women screened

City	No. of women screened	No. of women positive on VIA
Delhi	343	44
Lucknow	103	10
Varansi	87	2
Mumbai	108	5
Ahmedabad	110	3
Kolkata	266	19
Bhubaneswar	192	12
Chennai	105	10
Hyderabad	107	5
Bangalore	58	5
Coimbatore	200	10
Guwahati	42	3
TOTAL	1721	128

Pan India activities at a glance



“A Walk For Life”

Dr Shalini Rajaram

Can support organized “A Walk for Life” on **04th February 2018** at Rajpath, India Gate. 45 doctors participated in this walk under the banner of AOGD, AOGIN & AGOI including office bearers Dr Shalini Rajaram, Dr Neerja Bathla, Dr Abha

Sharma, Dr Mala Srivastava, Dr Nalini Mahajan. It was great experience with the enthusiastic response of doctors. Everybody pledged to organize activities for creating cancer awareness & providing care to cancer patients.



Plan your schedule

Forthcoming Events

1. 4th Annual Conference on Preventive Oncology July 18-19, 2018 Atlanta, USA.
2. 17th Biennial meeting of the International Gynecologic cancer Society September 14-16, 2018 Kyoto Japan.
3. 32nd International papillomavirus conference on October 2018, Sydney Australia.
4. ESGO 2018: new insights in rare gynecological cancers October 4-6, 2018 Lyon France.



The best preparation for tomorrow
is doing your best today.

- H. Jackson Brown Jr.

