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REPORT ON

THE SECOND MEETING OF THE REGIONAL ADVISORY PANEL ON CANCER

Tunis, 18 November 1976

The views expressed in this report do not necessarily reflect the official policy of the World Health Organization.

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INTRODUCTION

The Second Meeting of the Regional Advisory Panel on Cancer was convened at the Salah Azaiz Cancer Institute in Tunis on 18 November 1976. The list of Participants is attached as Annex I.

On behalf of Dr A.H. Taba, Director for the Eastern Mediterranean Region of the World Health Organization, Dr N.T. Racoveanu, Regional Adviser on Radiation Health and Cancer, opened the Meeting. Two members of the Panel, Dr Kh. Al Qassab and Dr S.H.M. Zaid were welcomed (see message from Dr A.H. Taba - Annex II).

Dr N. Mourali was elected Chairman and Dr A.H.M. Zaidi, Rapporteur.

The Draft Agenda and the Provisional Programme (Annex III) were approved by the members of the Panel.

I REPORTS OF WHO REGIONAL OFFICE ACTIVITIES DURING 1976 AND REGIONAL REFERENCE CENTRES' ACTIVITIES ON VARIOUS CANCER SITES DURING 1975/1976

1. Regional Office

During 1976, the Regional Office concentrated its efforts on implementation of the Regional Cancer Programme outlined by the Regional Advisory Panel at its first meeting in February 1975.

Most of the cancer projects were reoriented and the importance of developing cancer registries, improving the use of the International Histological Classification of Tumours and gathering more data about the cancer infrastructure and activities in countries was emphasized. One national and one regional meeting were organized in order to define better the diagnosis, treatment and prevention of bone tumours and cancer of the cervix uteri. The activities of the WHO Regional Office during 1976 are summarized in Annex IV.

2. Regional Reference Centres

2.1 WHO Regional Reference Centre on Bladder and Head and Neck Cancer, Medical Research Institute (MRI), Alexandria (Egypt)

This Centre was concerned during 1975-1976 with evaluation of different methods for early detection and diagnosis of bladder cancer such as:

(i) urine cytology

(ii) urine enzymes (α - esterase, β - glucuronidase)

(iii) cystoscopy.

In a pilot study on seventy-five consecutive patients with past or present history of schistosomiasis, the following tests were applied: serum and urine enzymes (α - esterase and β - glucuronidase) and urine cytology. Neither serum α - esterase nor serum or urine β - glucuronidase were found to have a correlation with bladder cancer. Urine α - esterase has shown highly significant increased values in bladder cancer, with zero negative, but 42.5 per cent false positive results.

Urine cytology, performed only once, has shown 28 per cent false positive and 21.7 per cent false negative results.

The same study will be expanded in the future to a larger number of subjects in the rural area of the Nile Delta. For this reason, a Bladder Cancer Committee was established at MRI, a unified clinical investigation sheet prepared and a special clinic opened.

2.2 WHO Regional Reference Centre on Bladder and Head and Neck Cancer, Cancer Institute, Cairo (CCI), Egypt

A short comment was made about the organization of cancer activities in Egypt. The Cancer Committee of the Ministry of Public Health was established. CCI was charged with the supervision of five general hospitals in order to improve cancer detection, diagnosis and treatment. Alexandria University was requested to supervise one centre. Due to the referral system, CCI sees annually more than 700 cases of bladder cancer, therefore a remarkable experience has been accumulated and CCI has proposed to share the experience with WHO during post-graduate courses.

Approximately 98 per cent of bladder cancers are found in patients with schistosomiasis. The histological type is usually a well-differentiated squamous cell carcinoma. Surgery is the best treatment, with 27 per cent five-year survival, increasing to 35 per cent when lymphnodes are not involved, and decreasing to 18 per cent in cases with lymphnode involvement. Radiotherapy and chemotherapy have not been found very successful; new therapeutic methods are now under trial.

Studies are going on in relation to aetiopathogenic mechanisms of bladder cancer induction, with the collaboration of the International Agency for Research on Cancer (IARC), Lyons and the Middlesex Hospital, United Kingdom, to investigate the presence of nitrosamine in the urine of patients with bladder cancer as well as in schistosomiasis patients.

2.3 Regional Reference Centre on Oesophageal Cancer and Lymphoma, Taj Pahlavi Cancer Institute (TPCI), Teheran (Iran)

TPCI is now preparing to become a focal point for lymphomas in the Region. An adapted protocol of immunoproliferative small intestine disease (IPSID) has been prepared and circulated in the Eastern Mediterranean countries for comments. Of the twenty-two IPSID cases collected so far, α - heavy chain was present in only 25 per cent.

To provide the clinical infrastructure, two new wards, with twenty beds each, for oesophageal cancer and lymphomas, will be opened in the near future at TPCI.

Arrangements have been made to store all information on lymphomas on a computer memory for rapid retrieval and processing of data.

With regard to oesophageal cancer, three projects are now considered:

(i) early detection using cytology and other methods;

(ii) chemotherapy;

(iii) investigation of mutagens and carcinogens in the environment in areas with high incidence. This project has been going on with IARC support for some years, but no important facts have been found till now.

Improvement of cancer services offered to the population in high risk areas by better detection and treatment are considered a major need on which TPCI will concentrate.

2.4 Regional Reference Centre on Cancer of the Breast and Uterus, Salah Azaiz Cancer Institute (SACI), Tunis (Tunisia)

This Centre has directed its attention to "inflammatory breast cancer", a rapidly growing form with very restricted prognosis. This particular form, called by French specialists "poupée évolutive" (PEV), has its own staging: PEV I; PEV II and PEV III, not well delineated as regards PEV I. The main features are the co-existence of signs of inflammation with breast tumour. Breast cancer with PEV can be found in approximately 60 per cent of female breast cancers in Tunisia. The five-year survival rate is zero, while for the usual breast cancer the seven-year survival is now 50 per cent.

Attempts were made to find more objective tests for PEV staging. Thermography was considered suitable as the hot spots in PEV cases show higher differences as compared with the usual type of breast cancer.

Another direction of study is therapy for breast cancer with PEV. Radiotherapy and hormonotherapy are the only treatments applied in this case, as surgery has been proven dangerous. The new approach, to be started soon with NCI co-operation, will be multiple drug chemotherapy.

The immunology of breast cancer with PEV is being studied, including electrophoretic patterns of proteins from PEV oedema fluid and other immunological tests.

The hormonal patterns of Tunisian females are being investigated as an attempt to explain the high frequency of PEV forms.

A standardized protocol is applied for diagnosis, staging and treatment of cervix uteri cancer (CCU) in order to obtain data comparable with that of other countries. As seen during the Group Meeting on CCU at SACI, the survival of CCU stages I and II proximal, with no lymphnode involvement, has reached 86 per cent at five years and, with lymphnode involvement, 40 per cent. The four-year survival in Stages II distal and III is 49 per cent.

2.5 Situation in participants'countries

Commenting on the Regional Office and RRC reports, the members of the Panel outlined the situation in their own countries.

Pakistan has a high incidence of oral and oropharyngeal cancer, which has been studied during the last six years in order to find the correct early detection and prevention methods and to define the magnitude of the problem. Cytology was not found to be a satisfactory method for early detection. Suggestions have been made to start collaborative studies throughout the Region, using a standardized approach. Oesophageal cancer, which has also quite a high frequency in some areas in Pakistan, could be a good starting point for such collaborative studies.

Iraq has now established a cancer registry for Baghdad City where during 1975 more than 100 cases x 105 inhabitants were recorded. The most important sites are:

(1)	In Males	Percentage
(i)	Bladder	15.1
(ii)	Larynx	12.1
(iii)	Malignant lymphoma	9.8
(iv)	Bronchus	9.4
(v)	Skin	6.6
(vi)	Stomach	4.1
(vii)	Bone	3.1
(viii)	Lymphatic leukaemia	2.5
(ix)	Lymphnodes secondaries	2.2
(x)	Nasopharynx	2.1

(2) In Females		Percentage
(i)	Breast	20
(ii)	Malignant lymphoma	6.1
(iii)	Skin	5.6
(iv)	Bladder	5.4
(v)	Larynx	4.4
(vi)	Cervix	4.3
(vii)	Uterus	3.4
(viii)	Stomach	3
(ix)	Lymphnodes secondaries	2.3
(x)	Thyroid	2.2

The type of breast cancer defined as PEV is very seldom found, being approximately 5 per cent of all cases, but 15.2 per cent of breast cancers are rapidly metastasizing, although no inflammatory signs are observed.

II PROGRAMME OF THE REGIONAL REFERENCE CENTRES DURING 1977 AND 1978

RRC directors envisage the following programmes for their respective RRCs:

1. RRC for cancer of the breast and uterus

1.1 Breast cancer

(i) Investigations in order to have a much more objective delineation of PEV staging will be continued and the staging will be defined as appropriately as possible. In order to have a systematic approach to breast cancer with PEV, registration and follow-up of cases will be improved.

(ii) Clinical trials of chemotherapy protocols (two protocols with CEMF and CFP) will be started in co-operation with NCI.

(iii) The immonological study of breast cancer with PEV will be continued, using *in vivo* and *in vitro* tests.

(iv) A study of hormonal patterns of Tunisian females is envisaged in co-operation with Harvard University.

1.2 Cancer of the cervix uteri

The study decided on during the Group Meeting (Tunis, 15 - 17 November 1976) will be carried on; support and co-ordination on a regional basis will be provided.

2. RRC for oesophageal cancer and lymphomas

2.1 Oesophageal cancer

(i) An early detection project will be implemented in the high risk area, together with improved treatment and follow-up procedures, by increasing the services offered to the population from these areas.

(ii) Immunological studies will be applied to the high risk area population.

(iii) Studies on the presence of mutagens and carcinogens in the environment of high risk areas will continue.

2.2 Lymphomas

(i) The registration of lymphoma cases in Iran and gradually in all countries of the Region will be improved.

(ii) Treatment of IPSID will be subject to a more scientific trial once the disease patterns have been better outlined.

(iii) A survey and recommendations for more adequate therapeutic methods for lymphomas to be used in countries of the Region will be initiated and followed.

(iv) A meeting on lymphomas with pathologists from countries of the Region will be convened in Teheran in order to establish better diagnostic guidelines for IPSID.

(At this point the participants discussed the proposed simplified protocol for IPSID which was considered still too complicated for application on a large scale. Mainly the idea of exploratory laparotomy was strongly opposed due to the risks such a procedure entails. It was decided that RRC in Teheran should review and simplify this protocol.)

3. RRC on bladder, head and neck cancer in Cairo

(i) Studies on relationship between nitrosamines and schistosomal bladder cancer will continue.

(ii) A Symposium on Bladder Cancer was proposed but the timing, aim and agenda were not defined.

4. RRC on bladder, head and neck cancer in Alexandria

4.1 Bladder cancer

(i) The project, using α-esterase, cytology and cystoscopy for early detection, will be expanded in a field trial in the Nile Delta.

(ii) Investigations concerning the role of Schistosoma haematobium and mansoni in bladder cancer will be carried out, because of severe urinary symptoms described in patients with mansoni type.

(iii) Another area of investigation will be an attempt to assess the role played by antimonium salts and other antischistosomal drugs in bladder cancer aetiology.

4.2 Cancer registration in Alexandria will be reviewed and improved in order to be able to gather minimal incidence rates.

During the discussion of this item the members of the Panel suggested that:

(a) RRCs should act as collaborative centres where material for diagnosis of difficult cases would be available and eventually patients could be referred for treatment;

(b) RRCs should be involved with countries of the Region in seeking and gathering specific information about cancer activities (data on cancer, methods of detection, diagnosis, staging, treatment, etc., survival of patients, incidence of specific cancers, etc.) and offering services and information needed by the countries;

(c) in order to maintain contact between all cancer specialists from the Region, RRC will have to produce periodic newsletters (at least once per quarter) which will be distributed through the WHO Regional Office to all cancer specialists in the Region. Each RRC will provide the WHO Regional Office every three months with material for the newsletter; all editorial activity and distribution will be the Regional Office's task.

III CANCER PRIORITIES IN THE EASTERN MEDITERRANEAN REGION

1. Cancer registration and improvement of actual cancer data

Despite the fact that in some areas of the Region (Cairo, Alexandria), cancer registration started a long time ago, very little is known about the cancer incidence, except in Israel, and for oesophageal cancer in Northern Iran and oral cancer in Karachi (Pakistan). During 1975, cancer registration in Baghdad, Iraq, was quite successful, but still no true incidence figures could be produced.

In order to direct all cancer control efforts properly and to measure the impact of cancer on health, as well as the efficacy of cancer programmes, better cancer data are needed and the members of the Panel concentrated their discussion on the ways to produce such data.

The main difficulties encountered in obtaining reliable cancer data are:

(a) lack of interest of medical specialists treating cancer patients in completing the forms for registration of these cases;

(b) improper organization of medical records in hospitals and other medical institutions in most countries of the Region.

(c) passive attitude to cancer registries where these exist in collecting cancer cases from the places where they could be found;

(d) diagnosis is very often based only on clinical data, without pathological examination of the tumour;

(e) the patient is referred from one place to another before diagnosis is made and treatment started, complicating the possibility of keeping trace of his records.

Recognizing such limitations, which are the main causes of under-registration of cancer, the Panel analyzed the modalities to overcome these limitations. The following suggestions were agreed upon:

(i) Hospital-based cancer registries (HBCR) have to be considered as the first step in cancer registration. The system of HBCR recommended by WHO, although found a little too complex by a few members of the Panel, was accepted as the most suitable for this Region. Using a standardized approach, countries will have the opportunity to compare their data within the Region, as well as with other countries outside the Region.

(ii) As a second step, a few HBCR could be unified, or the population covered by the HBCR could be well defined and incidence rates of cancer for a defined area obtained. It was not found advisable to have national cancer registries, except for very small countries both in terms of area and population, but to encourage population-based cancer registries (PBCR) for areas with a population not more than 0.5 - 2 million with adequate medical coverage. Such PBCR could be the only adequate source of cancer incidence rates.

(iii) HBCR or PBCR have to be active in searching for all possible cancer cases from all places where these cases can be found (hospitals, - surgeries, radiology and radiotherapy, pathology units, etc. - all medical institutions, governmental or private, plus private practitioners). Also, the cancer registries must

offer services to medical specialists, such as: lists for follow-up, data for studies on cancer distribution by site, age, sex, etc.; survival in relation to stage, treatment applied; home care, day care, social care,medicines,transportation to attend the follow-up clinic or during treatment rehabilitation, etc. By using such a method, the cancer registries will be considered useful by both physicians and patients and, therefore, cancer patients will be referred for registration.

Other suggestions made during the discussion of the ways to improve cancer registration were:

(iv) Cancer registries might be provided with a budget in order to pay a small fee to all physicians referring cases for registration. This system has the disadvantage that very busy physicians will not be attracted by the fee and, in addition, the same patient could be reported many times by various physicians (or the same physician) during his illness.

(v) A strategic entry point could be created for diagnosis and treatment of a cancer patient from which all patients would have to be reported to the cancer registry. For example: radiotherapy might not be given to the patient if this had not been registered with the cancer registry, or chemotherapic drugs might be delivered only if the patient had been registered. This method has the disadvantage of increasing administrative difficulties for the patient and still cannot assure that 100 per cent of cases are recorded by the cancer registry;

(vi) Cancer might be made a notifiable disease (this was also considered to have disadvantages)

(vii)All medical practitioners should be informed about the aims and usefulness of a cancer registry in order to obtain their cooperation.

All the above suggestions were stressed by the members of the Panel as methods which should be applied in countries of the Region in order to obtain better data on cancer.

Major recommendation

The Panel considered the following as a major recommendation.

(a) National health authorities, as well as cancer institutes and cancer associations, in Eastern Mediterranean countries will have to consider the need to organize hospital-based cancer registries (HBCR) in all major hospitals where cancer patients are diagnosed and treated.

(b) These HBCR will have to be organized according to the recommendations published by WHO - see publication WHO Handbook for standardized cancer registries, WHO offset publ. No.25, Geneva 1976, 194 p.

(c) As a further step, the HBCRs could be transformed into PBCRs if the area and population covered can be well defined, so that real cancer incidence rates will be produced thereby.

(d) Every cancer registry will have to search actively for cases and offer services to both patients and medical specialists.

(e) Special attention will have to be given to informing all medical practitioners on the aim and usefulness of cancer registries.

2. Cancer prevention in Eastern Mediterranean countries

Analyzing what has been done for cancer prevention since the first meeting of the Panel in February 1975, the members of the Panel found that very little effort has been made. Keeping in mind the important role played by primary and secondary prevention in a comprehensive cancer programme, the following peculiarities of the Region, which have to be considered in order to establish realistic approaches to cancer prevention, were underlined:

(i) Countries of the Region have still a high incidence of bacterial, viral and parasitic diseases, as well as of nutritional and maternal and child health problems, which are the major health priorities for national health authorities.

Most of these diseases have an influence on specific patterns of cancer - bladder cancer related to schistosomiasis, intestinal lymphoma, nasopharyngeal carcinoma and other malignancies where viral infections, immunological and nutritional deficiencies seem to play a role, are among the common malignant tumours in the Region.

(ii) The increase in life expectancy, resulting from the gradual successful control of communicable disease and improvement of social, economic and sanitary environmental conditions, has caused a change in the pathology towards chronic and degenerative diseases - cancer occupying an important place.

(iii) Natural environmental factors are constantly altering due to urbanization, industrialization in areas with limited agricultural land, restricted water resources, waste desert areas and heavy solar exposure, and little or no efforts are made to prevent environmental pollution and population explosion.

(iv) Rapid industrialization and pollution of the environment by artificial factors (chemical, biological, physical), without proper legislative and effective countermeasures, will lead to a rapid increase in population exposure to unnecessarily high concentrations of pollutants, some of which are carcinogenic. Special mention was made of the development of petrochemistry and of the great increase in the number of cars in large cities.

(v) Insufficiency of locally made food products obliges importation of such products from the world market. These products are imported without any, or very limited quality control, usually at low prices, and are often those which cannot be sold in countries with proper food control regulations because of their content in substances considered harmful (conservants, additives, pesticides, etc.).

(vi) The continuous increase in smoking is not controlled by any measures to discourage young adults from starting to smoke, to reduce or stop cigarettes advertisements, to increase taxation, etc.

(vii) There are difficulties in reaching the population by health education methods due to poverty, the high percentage of illiteracy, poor communications through mass media, cultural, social and religious taboos, which all interfere with the usual ways of promoting health education of a population.

Recognizing the above-mentioned factors as objective conditions which should be met by cancer preventive measures, the Panel has underlined the following recommendations:

2.1 Primary prevention

In formulating their National Cancer Programmes, countries will have to define adequate legislative and technical measures to decrease the human exposure to environmental carcinogens (physical, chemical and biological) as a part of their health legislation and their health services. Special attention should be directed to the following:

(a) solar exposure of the skin;

(b) unnecessary medical exposure to ionizing radiations and drugs with carcinogenic potentialities;

(c) exposure to infestation with parasites such as schistosomes and infection with viruses;

(d) exposure to environmental pollutants such as: pesticides, industrial and communal wastes, pollution generated by motor vehicles;

(e) exposure to food contaminants (aflatoxine, nitrosamines, etc.) and additives (conservants, sweeteners, etc.) with carcinogenic potentialities;

(f) exposure to carcinogens related to individual habits, such as smoking tobacco or other substances, chewing tobacco, betel nuts and other vegetal substances.

Adequate technical, legislative and educational measures will have to be included in the National Cancer Programme and national health legislation in order to protect the population and keep its exposure as low as possible.

2.2 Secondary prevention

Due to the constraints in terms of health manpower and health expenditure, National Cancer Programmes in the Region will only envisage limited early cancer detection. To obtain the maximum health benefit from the investment made, activities should be directed.

(a) towards the high risk groups defined by adequate epidemiological investigations of the local population;

(b) using the most simple and reliable methods in terms of specificity, sensitivity and practicability;

(c) integrating the early detection programmes in existing health facilities and making better use of their personnel and equipment;

(d) taking into consideration the capacity of the local diagnostic and treatment facilities to cope with suspect cases detected.

With the above prerequisites, it is recommended that the following cancer sites be considered for early detection, as relevant in individual countries: oral cancer, oesophageal cancer, hypopharyngeal cancer, breast cancer, cervix uteri cancer, urinary bladder cancer and skin cancer.

2.3 Education

Education is another important preventive measure which should have an important place in a National Cancer Programme. The following categories should be covered by education programmes:

(i) Physicians - in undergraduate and all types of post-graduate studies the following should be emphasized: known carcinogenic agents and their role in human carcinogenesis, high-risk factors in common sites and types of cancer (oral, lung, gastric, liver, intestine, breast, uterus, prostate, skin, etc.), early signs for diagnosis, staging procedures, treatment efficacy by stage of most common cancers, methods to motivate the public to use early detection programmes and reduce their exposure to carcinogens; curability rates, long-term survival, long-term palliation must be emphasized by figures and demonstrations.

(ii) Middle level medical personnel - all specialities should be taught about carcinogens in the human environment and early signs of the most common cancers in the area where they will work, as well as health education methods related to anti-cancer campaigns;

(iii) Other types of health personnel - will have to be made aware of the carcinogens in the human environment, the role of early detection and methods to motivate the public in relation to anticancer campaign;

(iv) Teachers at all levels (primary, secondary schools, colleges) will have to be given clear ideas about carcinogens in the human environment, and cancer as a curable disease when early detection and treatment are applied.

(v) General public education will include raising the population's understanding about carcinogens and ways to reduce their exposure, while specific education will relate to anti-smoking campaigns, special early detection programmes when applied in an area, etc.

2.4 Active role of cancer specialists and scientists

In order to guide the health authorities in the Region towards cancer prevention, it is recommended that all cancer specialists and scientists in this field, starting with the members of the Panel, should begin an active campaign to persuade the national health authorities of the importance of prevention for human and economic reasons.

ANNEX I

LIST OF PARTICIPANTS

MEMBERS

Dr M.E. El Kharadly, Director and Dean, Medical Research Institute, Alexandria, Egypt

Dr El Sheikh Abdel Rahman, Director, Radiation and Isotope Centre, Khartoum, Sudan

Dr I. El Sebai, Dean, Cancer Institute, Cairo, Egypt

Dr A. Mojtabai, Director, Taj Pahlavi Cancer Institute, Teheran, Iran

Dr N. Mourali, Director, Salah Azaiz Cancer Institute, Tunis, Tunisia

Dr Kh. Qassab, Professor of Surgery, College of Medicine, University of Baghdad and President, Iraqi Cancer Society, Baghdad, Iraq

Dr M. Zaidi, Professor and Head of the Radiotherapy Department, Jinnah Post-graduate Medical Centre, Karachi, Pakistan

SECRETARIAT

Dr N. Racoveanu, Regional Adviser on Radiation Health and Cancer and Secretary to the Meeting, WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt

Dr A. Linsell, Liaison Co-ordinator, International Agency for Research on Cancer, Lyon, France

Mrs R. Lunt, Scientist, Cancer Unit, WHO Headquarters, Geneva, Switzerland (unable to attend)

Mrs L. Wissa, Secretary, WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt

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ALSO PARTICIPATED

Dr G. Riotton, Director, Centre de Cytologie et de dépistage du cancer, Geneva, Switzerland

Dr B. MacMahon, Professor of Epidemiology, Harvard University, School of Public Health, Boston, USA.

ANNEX II

MESSAGE FROM DR A.H. TABA

DIRECTOR

WHO EASTERN MEDITERRANEAN REGION

The second meeting of the WHO Eastern Mediterranean Regional Advisory Panel on Cancer is convened today in the premises of one of our Regional Reference Centres on Cancer.

We have pleasure in welcoming to this Panel: Professor Al Qassab from Baghdad, Iraq, and Professor M. Zaidi from Karachi, Pakistan, both newly appointed members. It is believed that their experience and competence will add to the soundness of recommendations this Panel has to make.

As you are aware, since February 1975 when the First Meeting of this Panel was held in Alexandria, some notable developments have happened in the field of cancer in the Eastern Mediterranean Region. The Group Meeting on Cancer of the Cervix Uteri in which you have participated during the previous two days is a good example of such development.

This Second Meeting of the Regional Advisory Panel on Cancer is aimed at reviewing the implementation of the Regional Cancer Programme and at discussing the reports of our Regional Reference Centres on various sites of cancer for 1975-1976 and their planned activity for 1977-1978.

Being aware of the actual lack of correct data in the field of cancer, data which are essential in an adequate orientation of cancer control measures, this Meeting has to concentrate its attention on methods to improve the availability and collection of such data.

Prevention is always one of the most desirable public health actions and true prevention of cancer is becoming more realistic with modern scientific knowledge.

Here in the Eastern Mediterranean Region, we are confronted with complex preventive measures related to the actual economic, social and public health aspects. It is our main concern to find and recommend adequate methods for cancer prevention, to be implemented in the context of larger preventive measures which should be applied as part of countries' development programmes.

It should be a major task of the members of this Panel, who are all prominent specialists in their countries, to continue the work started here during this Meeting after their return home.

We are entirely relying for the implementation of our recommendations on the persuasion and insistence you yourselves and WHO will be able to offer to our colleagues from the National Health Authorities, the medical profession at large, as well as the general public.

Before ending, I wish to express my thanks to Professor Mourali and the Tunisian Authorities who so kindly have offered their hospitality for this Meeting.

I wish you all success!

ANNEX III

AGENDA AND PROGRAMMME

A. AGENDA

1. Opening of the Meeting.

2. Review of the activities of the Regional Reference Centres during 1975/1976.

3. Programmes of activity of the Regional Reference Centres for the biennium 1977/1978.

4. Cancer priorities in countries of the Region.

   (i) How to improve the actual data on cancer incidence and prevalence in countries of the Region.

   (ii) How to improve the actual cancer prevention and detection in countries of the Region.

5. Discussions and Conclusions.

B. PROGRAMME

08.30 - 09.00	Message from Dr A.H. Taba, WHO Regional Director, Eastern Mediterranean Region
	Election of Chairman and Rapporteur
	Programme of Work by Dr N.T. Racoveanu, Regional Adviser on Radiation Health and Cancer, WHO Eastern Mediterranean Region
09.00 - 10.30	REPORTS ON CANCER ACTIVITIES DURING 1975-76
	I Cancer activities in WHO Eastern Mediterranean Region during 1976 by Dr N.T. Racoveanu, WHO
	II Report of activity of WHO Regional Reference Centre on Bladder and Head and Neck Cancers in Alexandria during 1975-76 by Professor M.E.A. El Kharadly, WHO Temporary Adviser
	III Report on activity of WHO Regional Reference Centre on Bladder and Head and Neck Cancers in Cairo during 1975-1976 by Dr I. El Sebai, WHO Temporary Adviser
	IV Report of activity on WHO Regional Reference Centre on Lymphomas and Oesophageal Cancer in Teheran during 1975-76 by Dr A. Modjtabai, WHO Temporary Adviser
	V Report of activity of WHO Regional Reference Centre on Cancer of the Breast and Uterus during 1975-76 by Professor N. Mourali, WHO Temporary Adviser
	DISCUSSIONS
10.30 - 11.00	COFFEE BREAK

11.00 - 12.00	PROGRAMMES OF ACTIVITY OF THE WHO REGIONAL REFERENCE CENTRES FOR 1977-1978
	I Programme of activity of WHO RRC on Cancer of the Breast and Uterus by Professor N. Mourali, WHO Temporary Adviser
	II Programme of activity of WHO RRC on Lymphoma and Oesophagus Cancer by Dr A. Modjtabai, WHO Temporary Adviser
	III Programme of activity of WHO RRC on Cancer of the Bladder and Head and Neck Cancers in Cairo by Professor I. El Sebai, WHO Temporary Adviser
	IV Programme of activity of WHO RRC on Cancer of the Bladder and Head and Neck Cancers in Alexandria by Professor M.E.A. El Kharadly, WHO Temporary Adviser
	DISCUSSIONS
12.00 - 13.30	Cancer priorities in Eastern Mediterranean countries:
	(i) How to improve the actual data on cancer in countries of the Region
	I- Introductory remarks by Professor M.E.A. El Kharadly II- Round table discussions III- Summarized conclusions by Rapporteur
13.30 - 16.00	RECESS
16.00 - 17.30	Cancer priorities in countries of the Region:
	(i) How to improve the actual cancer prevention and detection in countries of the Region:
	I- Introductory remarks by Dr El Sheikh Abdel Rahman, WHO Temporary Adviser II- Round table discussions III- Summarized conclusions by Rapporteur
17.30 - 17.45	TEA BREAK
17.45 - 18.30	General Discussions and Conclusions.

ANNEX IV

CANCER ACTIVITIES IN WHO EASTERN MEDITERRANEAN REGION DURING 1976

by

Dr N.T. Racoveanu

Regional Adviser, Radiation Health and Cancer
WHO Regional Office for the Eastern Mediterranean

Cancer activities in the WHO Eastern Mediterranean Regional Office have continued during 1976 to become more and more involved in technical implementation of a Regional Cancer Programme. The following activities were undertaken in this respect:

1. Collection of information regarding cancer infrastructure and research in Eastern Mediterranean countries based on HQ's Questionnaire. Although this questionnaire is not precisely suitable for gathering information from developing countries, being too research-oriented, it was circulated to twenty-three out of twenty-four Eastern Mediterranean countries and answers were received from eighteen countries up to 16 August 1976. A synopsis of this information is given in Table 1. Comments on the information obtained, and on the questionnaire, will be made in a special Annex to the present paper.

2. Participation in the ICD-O Field Trial. The following Eastern Mediterranean countries are participating: Egypt, Iran and Israel. Mrs Constance Percy of the National Cancer Institute (USA) has visited these countries and has been received at the Regional Office in relation to her interest in this Field Trial.

The Regional Office has onforwarded to the National Cancer Institute, Bethesda, USA,the cards filled by the Alexandria Cancer Registry and has distributed the ICD-O Field Trial Volume to many cancer institutes throughout the Region.

3. Second Meeting of the Regional Panel on Cancer, organized in Tunis, 18 November 1976. All members participated as well as representatives from WHO/HQ, IARC and UICC. The Regional Panel has received a new member from Pakistan: Dr M. Zaidi, Professor of Radiotherapy, Jinnah Post-graduate Medical Centre and President Elect of the Cancer Association of Pakistan. The Iraqi participant has been replaced by Dr I. Al Qassab, Professor of Surgery, University of Baghdad and President of the Iraqi Cancer Association.

The Second Meeting analyzed the implementation of the Regional Cancer Programme, discussed the programme of activity of the three Regional Reference Centres: 1) Cancer of the Oesophagus and Lymphoma, Teheran; 2) Cancer of Urinary Bladder and Head and Neck, Alexandria and Cairo; 3) Cancer of the Breast and Uterus, Tunis. Programmes of these RRCs for 1977 and 1979 were approved during this meeting and a decision was reached to start a periodic information bulletin of RRCs.

Another subject discussed by the Second Meeting of the Regional Panel was the ways to improve cancer data obtained in countries of the Region. The conclusion reached was to give any possible help to cancer registry activities in all countries of the Region and to convince health authorities of the need to train personnel for such activities and to provide the financial resources required.

The last point on which the attention of the Regional Panel was focussed was the improvement of the actual measures on cancer prevention and detection in countries of the Region.

It was felt that until now very little attention, on the whole, is paid by health authorities and, in general, by governments in countries of the Region, to cancer prevention and detection. Although some countries have taken action towards cancer prevention,the United Arab Emirates have banned the advertisement of cigarettes; Iran,and Saudi Arabia have taken some measures to restrict use of reserpine in females - no comprehensive legislation to reduce population exposure to known carcinogens is envisaged in any of the countries of the Region and no real cancer programme at the national level has been defined until now. In Egypt, advertisement of cigarettes is largely practised and smoking is not forbidden, even in public places like cinemas, where it is not only a health nuisance but also a fire danger and is creating an unhygienic environment.

The members of the Regional Advisory Panel who are prominent persons in their countries in the field of cancer have not been fully successful, despite great efforts, in convincing their governments to devote some resources to the national cancer programmes, in order to start such activity with the adequate support and involvement of authorities and public.

4. Group Meeting on Cancer of the Cervix Uteri, Tunis, 15-17 November 1976. Participants from the Region, with the help of WHO Temporary Advisers and specialists from WHO/HQ, Regional Office, IARC and UICC have reviewed the epidemiological aspects, the problems of early detection, staging and treatment of cancer of the cervix uteri (CCU). The participants have presented data on CCU from the unit they are working with during the last five years which has allowed the members of the group to assess the actual situation in countries of the Region, resumed as follows:

- the majority of cases diagnosed are Stage III and IV (45 per cent from the total of cases seen in countries of the Region from 1971 to 1975) demonstrating that no active detection is practised in countries of the Region and the female population is not aware of the symptoms of CCU in order to seek medical care before the tumour has invaded the pelvic area;

- staging is not uniform nor properly done; some of the data show a quite high percentage of undefined stages (average 11 per cent reaching 41 per cent in some areas);

- a very small percentage of cases is properly followed after treatment and practically no data on survival were available to assess the adequacy of the treatment;

- the treatment methods were variable from place to place, depending not so much on available facilities, but also on training and local traditions.

The Group Meeting has managed to make the recommendations presented in Appendix II which should now be followed in all places where CCU could be detected, diagnosed and treated throughout countries in the Region.

It was decided to commence a periodic survey on CCU with the participants at the Group Meeting in order to assess the impact the recommendations will have on CCU in countries of the Region.

5. Seminar on the International Histological Classification of Tumours, Baghdad, 28 November - 2 December 1976. During 1975, a similar seminar was held in Karachi for Pakistani pathologists, with the help of Dr Sobin, HQ and two consultants. On this occasion it was found that the WHO histological classification of tumours is not properly understood and used in Pakistan. This is one of the main reasons that cancer registries started in 1973 by the Pakistan Medical Research Council in different places throughout the country were not able to collect relevant data because of non-homogenous classification of the tumours by various pathologists, in addition to mistakes in diagnosis, reporting, etc.

The seminar in Baghdad was organized for pathologists from Egypt, Iran, Iraq, Libya, Saudi Arabia, Sudan, Syria and Tunisia, all working with existing or planned cancer registries. All participants received, five months before the seminar, a set of slides which they were requested to examine, diagnose the lesion and make a classification using their actual system and a coding using the ICD-O Manual. All reports prepared by participants were examined before the seminar by Dr L.H. Sobin and the two WHO consultants and the content of the seminar was decided accordingly. In Appendix III are given the main observations made by the three WHO specialists concerning the way to diagnose, classify and code the slides of the pathologists from countries of the Region.

Being aware of the importance such uniformity in classification and coding will have in the adequacy of data on cancer in the Eastern Mediterranean Region, it is hoped that such seminars could be repeated in the near future for other groups of pathologists from this Region.

6. In addition to the Regional Meetings during 1976 the Regional Office has supported some national activities such as seminars, courses, consultations, etc.

6.1 Seminar on Bone Tumours - This was held in Karachi, Pakistan, from 15 - 18 March 1976 with the participation of forty Pakistani specialists and three WHO consultants. The topics discussed were the diagnosis and treatment of bone tumours and epidemiology of bone cancer in Pakistan. The recommendations have insisted on the need to improve the medical facilities involved in diagnosis and treatment of bone tumours (radio-diagnostic units, pathology, and biochemistry laboratories, etc.) to ameliorate the actual training programme in this particular field, and to further develop the epidemiological study started in 1971.

6.2 Course on Cancer Chemotherapy sponsored by UICC in Tripoli (Libyan Arab Republic), 19-26 March 1976 with the collaboration of the Libyan Government and of the Regional Office of WHO. A faculty of seven members provided by UICC, and one provided by WHO, has presented to approximately sixty to eighty medical specialists practising in Libya actual problems in cancer chemotherapy. The Regional Office has offered to the faculty some basic information about cancer in countries of the Region and particularly in Libya and has presented a lecture emphasizing the role of general practitioners and medical specialists in cancer detection, diagnosis and registration. Some WHO publications in respect to the above-mentioned problem were distributed to participants.

It was felt that this UICC activity could have been more adequately prepared had previous consultation taken place between WHO and UICC to arrange the most suitable subjects appropriate to Libya. More proper utilization of the money and technical capacities which UICC devoted to this activity would have been possible if such a consultation had been organized. A discussion with the UICC representative to the course clearly revealed the above-mentioned points.

6.3 Consultation concerning Breast Cancer activities in Tunisia and the Region was held at the Salah Azaiz Cancer Institute in Tunis, 15-21 May 1976, with the participation of Professor B. MacMahon, Mrs R. Lunt, HQ and Dr N. Racoveanu, EMRO, with the staff of the Institute, led by Professor N. Mourali. Data on inflammatory breast cancer were examined and a decision to investigate a hormonal hypothesis was reached. This investigation will be done in collaboration with Harvard School of Public Health.

On the same occasion, the Group Meeting on Cancer of the Cervix Uteri was planned and attention was also given to a study to define the epidemiological patterns of breast cancer in countries of the Region which will be started from 1977 as part of the programme of the Regional Reference Centre on Breast and Uterine Cancer, Tunis.

6.4 At the request of the Government of Saudi Arabia a list of consultants able to help this country in defining a comprehensive cancer programme was prepared. Professor M.E.A. El Kharadly was selected from our list as WHO Consultant and is under recruitment.

It should be mentioned that neither HQ nor IARC has adequate information on specialists able to advise governments on general problems of cancer management, a field in which more and more requests will come as Member States become aware of cancer as a public health problem. It is advisable to start to identify such specialists and eventually to invite them to attend some of WHO activities related to the subject such as the Annual Meeting of Regional Advisers on Cancer; Meetings of Regional Advisory Panels on Cancer, etc.

6.5 A further National Seminar on Cancer of the Female Genital Tract will be sponsored by the WHO Regional Office in Karachi, Pakistan early in 1977. Two WHO consultants are under recruitment for such a seminar.

6.6 A one-week Course on Cancer Epidemiology to be held early in 1977 for Pakistani specialists is also being planned with the collaboration of IARC and the WHO Regional Office. It is felt that it is much more suitable to develop such an activity on a regional basis, in the future, taking into account the lack of cancer epidemiologists and the need for such specialists in the development and orientation of comprehensive National Cancer Programmes.

6.7 IARC has requested the Regional Office to collaborate in the project established by the Cairo Cancer Institute and Middlesex Hospital, London, concerning the role of nitrosamines in bilharzial bladder cancer. A discussion was organized in Cairo in March 1976 with interested parties and a decision was reached to use the Geneva pouch to send samples of urine to London for measurement of nitrosamines. It was also supposed that the Regional Office will be fully informed about the project in order not to play the role of post office, only. The Regional Office has not been requested to onforward samples of urine and no information about the project has been received, except that related to the meeting mentioned.

6.8 A team from IARC (Drs Griciute and Linsell) has visited the Regional Office and discussed regional cancer activities. On the same occasion the team visited the Alexandria Medical Research Institute to discuss a request for help in developing the cancer registry, and has also met the applicants for Research Fellowships from Alexandria.

6.9 In co-operation with the Regional Reference Centre on Lymphomas, Teheran, a draft Protocol for the study of immunoproliferative disease of the small intestine (IPSID) was circulated to Cyprus, Egypt, Libya, Kuwait, Iraq, Sudan, Syria. Replies and comments favourable to participation in a co-operative study have been received from Egypt, Kuwait, Iraq and the Sudan. The RRC on Lymphomas is now preparing a revised form of the Protocol in order to start the study in 1977.

A few pathological specimens from the Lymphoma Clinic, organized by the Medical School of Alexandria University, were sent through the Regional Office to Professor H. Rappaport, City of Hope Medical Centre, Duarte, California, USA, for diagnosis. None of the suspected cases was confirmed as IPSID.

A Fellowship for one medical specialist from the School of Medicine, Alexandria University, was arranged, and completed, in Paris in relation to the IPSID project and with lymphomas in general.

6.10 The paper "Geographic Distribution of Cancer in countries of the Region", prepared by the Regional Adviser, has been accepted at the Third International Symposium on Detection and Prevention of Cancer (DePCa), New York, 28 April - 1 May 1976. The Regional Adviser also presented a lecture on the subject "Environmentally induced Cancer in countries of the Region" at the International Course on Environmental Toxicology held in Jerusalem on 3 July 1976.

7. The Course on Cytotechnology organized by the Regional Office with the Taj Pahlavi Cancer Institute, Teheran, was terminated in February 1976. All eight participants graduated and returned to their place of assignment with the ability to screen Pap. smears and identify abnormal and malignant cells.

A follow-up of the present activity of course graduates has not yet been possible but is now planned for early 1977.

Attempts to start a small-scale project of screening for cancer of the cervix uteri in Alexandria, Egypt, have not been successful yet despite many discussions and preparations made with local gynaecologists and pathologists.

8. The Regional Programme Committee has approved the budget for the Regional Reference Centres on Bladder, and Head and Neck; Lymphoma and Oesophageal Cancer; and Breast and Uterine Cancer, for the biennium 1978-1979. A Regional Training Course on Cancer Registries was also approved for 1979.

In total, the following sums of money were accepted for cancer activities in countries of the Region for the biennium 1976-1977 and 1978-1979,not including expenses incurred at the Regional Office level:

	1976	1977	1978	1979
Cancer	$ 65 500	$ 88 500	$ 140 700	$ 235 100

9. Using the WHO/IAEA TLD Intercomparison Programme, twenty Cobalt-60 units were checked in Eastern Mediterranean Region in April 1976 (XVIIth Batch). Seven of these Cobalt-60 units have shown a deviation greater than $\pm$ 5 per cent, which is considered significant. New sets of dosimeters have been sent to all places where such differences have occurred and a plan was set up to recalibrate the dosimeters used by the medical physicists in these places. Because deviations of -21 or -17 per cent have been noticed, it is felt that action should be taken and the TLD Intercomparison should be introduced on a routine basis for all radiotherapy units, covering not only Cobalt-60 machines, but also X-ray therapy machines, linear accelerators, etc.

APPENDIX 1

REPLIES OF COUNTRIES IN THE REGION TO HQ QUESTIONNAIRE

In the attached Table are presented the replies obtained from twenty-one out of twenty-three countries in the Eastern Mediterranean Region (for obvious reasons no questionnaire was sent to Affars and Issas). No answer to the questionnaire was obtained from Lebanon or the United Arab Emirates (UAE). It is known that Lebanon has quite developed cancer activities, but the actual situation has prevented the authorities from answering the questionnaire. UAE do not have a cancer infrastructure and activity in this field is restricted to a minimum.

Commenting on the replies received from countries of the Region, it is necessary to stress the fact that the HQ questionnaire has not been oriented toward the practical aspects of cancer control activities; ten out of the eighteen questions dealt purely with research in the most sophisticated fields of cancer cells, biology, immunology, biochemistry and molecular biology, research for new anti-cancer drugs. Such questions cannot be answered properly by Health Authorities, being too detailed for their overall interest even in developed countries. The questions dealing with subjects directly related to cancer control were only five (1, 2, 6, 7 and 18); the rest were again more of theoretical importance.

Another comment should be made also - the questions were not clear to persons not having a proper knowledge of the field of cancer. A very clear example is the one concerning cancer registries - we have received in at least four or five cases many answers from the same country - in one case four answers from one country were received. Most of those answers were contradictory with regard to the first two questions about Population-based and Hospital-based Cancer Registries. In some cases the Health Authorities acknowledged the existence of one or both types of Cancer Registry and the Cancer specialists denied their existence.

Similar unclear answers were obtained for the use of ICD at three or four digit level and for question No. 17 concerning Oncology as special discipline - although these questions seem to be very clear.

Apart from these introductory remarks, few comments will be made on the attached Table. Of twenty-one countries of the Region, only twelve have some organized infrastructure where cancer patients could receive real care; those countries are: Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Libya, Pakistan, Sudan, Syria and Tunisia.

Regarding cancer registration, only one country has a National Cancer Registry functioning for more than fifteen years - Israel. Cancer Registries were started long ago in Egypt and the Sudan. In Egypt, one is covering the Cairo metropolitan area and another Alexandria; the number of cancer cases recorded every year in both cases is too small to be considered as a Population-based Cancer Registry. In Cairo, for 6.9 million inhabitants, 3 269 new cancer cases were recorded in 1973 and 2 599 in 1974. This number gives a total cancer incidence of 47.4 per 10^5 in 1973 and 37.7 in 1974, both these figures being 1/4 or 1/3 of what one could expect.

Some new Cancer Registries were started more recently in: Baghdad (Iraq), Isfahan, Shiraz and Teheran (Iran), Kuwait, Tripoli (Libya), Tunis (Tunisia). Most of these registries are based on the Cancer Centre or Pathology Laboratory and do not have a clearly defined population coverage on which to produce cancer incidence. There is at present a clear interest shown by some of the countries of the Region and by the WHO Regional Office to improve cancer registration. Training for Cancer Registry personnel is envisaged to start in 1979 or even earlier, if possible.

Question No.3 concerning the use of ICD is much more related to the actual organization of health statistics departments in the Ministries of Health and, because this situation is being actively improved, will not be discussed here.

Use of WHO International Histological Classification of Tumours has received during 1975 and 1976 very much attention in the countries of the Region, but it will take another three to four years before it will be largely introduced in the main Pathology Laboratories throughout the Region.

Question No.5 is not relevant to countries where cancer registration does not exist. Epidemiological studies are produced in Israel for various aspects of cancer and in Iran mainly on cancer of the oesophagus, because a special cancer registry has been set up in Northern Iran. The rest of the studies done are just attempts based on data collected ad hoc.

Radiation therapy is based mainly on Co-60 machines present in the thirteen countries mentioned before. The tendency to bring in accelerators is manifest; one linear accelerator is working in Baghdad for the last four to five years, two have been installed in Israel and it is expected to see more in countries like Iran, Kuwait, Libya and Saudi Arabia. The main problem with radiotherapy in the countries of the Region is the lack of sufficient trained personnel. Radiotherapists, medical physicists and technicians are insufficient and most of the present more than 40 Co-60 are run only for four to five hours per day, although with two or three shifts of personnel a double or triple number of patients could be treated.

Another major problem is quality of the clinical dosimetry; as mentioned in the main report this problem requires urgent improvement.

Chemotherapy is, with surgery, a large therapeutic means used in countries of the Region. Because of the lack of trained chemotherapists, even in most of those countries having a cancer unit, the resulting problem seems to be more important than is seen at first approach. Countries of the Region have a population with a high incidence of parasitic diseases,tuberculosis, enteric infections, etc. which make the use of chemotherapic agents with severe action on immune defense and bone marrow more dangerous than in populations not having the patterns described above. It is actually not possible to give quantitative estimations for the picture described but it is necessary to start to collect some data in this respect.

A last comment will be made on question No. 18 - screening programmes do not really exist in countries of the Region. Some limited screening is done in a few areas of the Region for cancer of the cervix uteri; in Israel breast screening together with screening of accessible sites is more largely done, but these cannot be considered as proper mass screening programmes.

With the actual cancer incidence, it is not advisable to invest manpower, equipment and efforts in such programmes. If screening should be started, this screening has to be epidemiologically oriented on the main cancer site and type of the area and to the real high risk group. It seems rational to have such programmes in Northern Iran, as well as in some parts of Afghanistan and Pakistan for cancer of the oesophagus, in Egypt, Sudan, Iraq for bladder cancer, in some areas to be determined for skin cancer, etc.

TABLE

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	Afghanistan	No	Yes	4 digits	No	No	X-ray superf.	sporadicity	No	No	No	No	No	No	No	No	through fam.plan	No	screening CCU
2	Bahrain		No	cancer registry, no research - unable to fill the questionnaire															
3	Cyprus	No	Yes	3+4 dig.	No	No	2 co.unit 1deepXray	Yes	No	No	No	No	No	No	No	No	only minor	No	No
4	Democratic Yemen	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	none	No	No
5	Egypt	Yes	Yes	3 digits	Yes	Yes	6 co. deepXray	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	clin. field	not yet	not yet
6	Ethiopia	No	No	3 digits	No	No	2 deep X ray	Yes	Yes	No	No	No	Yes	No	Yes	No	none	No	No
7	Iran	No	Yes	4 digits	Yes	Yes	12-14 deepXray	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	clinical aetiology	No	Yes
8	Iraq	Yes	Yes	No	Yes	No	3 Co. 1 accel.	Yes	No	No	No	No	No	No	No	No	none	No	No
9	Israel	Yes	Yes 3hosp.	4digs	Yes	Yes	8Co. 1-2 accel.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	no inf.	Yes	Yes	Yes
10	Jordan	No	No	No	No	No	1Co.unit	No	No	No	No	No	No	No	No	No	none	No	No
11	Kuwait	Yes	No	3 digits	Yes	No	2co.units	Yes	Yes	No	No	No	No	No	No	No	none	No	No
12	Libyan Arab Rep.	No	Yes	3 digits	Yes	Yes	1Co.unit 1deepXray	Yes	Yes	No	No	No	No	No	No	No	Histopath exf.cytol	No	No
13	Oman	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	none	No	No
14	Pakistan	Yes	Yes	4 digits	Yes	Yes	4Co.unit 2caes. 1deepXray	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	many fields	No	No
15	Qatar			Unable to fill the questionnaire															
16	Saudi Arabia			Unable to fill the questionnaire															
17	Somalia			Unable to fill the questionnaire															
18	Sudan	Yes	No	4 digits	No	Yes	2Co.unit 2deepXray	Yes	Yes	No	No	No	No	No	No	No	Geog.dis trib.of cancers	No	Yes
19	Syrian Arab Rep.	Yes	Yes	3 digits	Yes	No	2Co.unit 1deepXray	Yes	No	No	No	No	No	No	No	No	None	No	No
20	Tunisia	No	Yes	4 digits	Yes	Yes	2Co.units 2deepXray	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	clinical inspec.	Yes	Yes
21	Yemen Arab Rep.	No	Yes	3 digits	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

APPENDIX 2

CONCLUSIONS AND RECOMMENDATIONS OF THE GROUP MEETING ON CANCER OF THE CERVIX UTERI (CCU)

During the Group Meeting on CCU held in Tunis from 15 - 17 November 1976, the following conclusions were reached:

I DETECTION

An improvement of early detection of CCU is considered essential for countries of the Region where at present more than 50 per cent of cases seen are in StageIII and IV.

As mass screening programmes cannot be started with the present infrastracture it is recommended to screen the females coming to obstetrics and gynaecology clinics, family planning units, maternal and child health units, etc.

In order to start such screening programmes, all cytotechnologists and cytopathologists already trained have to be identified in all countries of the Region and offered proper laboratory facilities for female genital cytology.

The training of cytotechnologists and cytopathologists should be continued in order to provide countries of the Region with the skilled personnel required for the screening of the high risk group, which has to be defined using the present knowledge of the natural history of CCU and its epidemiological patterns.

II STAGING

The Group has agreed to use a uniform staging system throughout the Eastern Mediterranean Region. Last FIGO staging classification with stages 0 to IV was adopted and minimal as well as optimal diagnostic procedures were recommended.

The minimal diagnostic procedures include examination under anaesthesia; intravenous pyelography, cytology and biopsy are considered obligatory for proper staging. To these procedures cystoscopy, barium enema, exploratory laparotomy, etc, could be added when needed for adequate staging before the decision for treatment is reached.

III TREATMENT

The Group has considered the need to improve and unify the therapeutic approach to CCU in countries of the Region.

The need was stressed for developing adequate brachitherapy (curietherapy) in all countries of the Region where radiotherapy facilities are available, with afterloading techniques (manual or automatic).

Recommended treatment procedures were established according to the CCU stage, with alternatives which take into account the differences existing within countries of the Region in terms of facilities, personnel, etc. Detailed recommendations are included in the report.

IV REGISTRATION - FOLLOW-UP - EPIDEMIOLOGICAL STUDIES

In order to improve the system for registration and follow-up of CCU cases and to obtain uniform data regarding epidemiological characteristics, treatment procedures, follow-up and survival of CCU cases, a uniform CCU form was agreed upon by the Group. This form is recommended for use in all countries of the Region in order to allow future studies on the CCU situation.

V REVIEW OF CCU PROBLEM IN EASTERN MEDITERRANEAN REGION

It was agreed that a further meeting on CCU has to be held in 3-4 years in order to assess the progress realized by countries of the Region in applying the above recommendations.

As part of its field activity, the Regional Office of WHO will co-operate in helping countries of the Region to implement the recommendations made by the Group Meeting on CCU and to assess periodically the progress achieved in this respect.

APPENDIX 3

ANALYSIS OF DIAGNOSES SUBMITTED BY PARTICIPANTS AT THE SEMINAR ON INTERNATIONAL CLASSIFICATION OF TUMOURS, BAGHDAD, NOVEMBER 1976

The tumours of the salivary glands were diagnosed without difficulty. Those presented were characteristic examples.

The polypoid lesions of the colon were not as easily dealt with. Four of the thirteen participants diagnosed two very benign lesions as carcinoma. These will be discussed in detail at the Seminar.

The cases of dysplasia and in situ carcinoma of the uterine cervix showed considerable variation in interpretation, e.g. one case of dysplasia was diagnosed as carcinoma in situ five times, moderate dysplasia twice, mild dysplasia three times, and leukoplakia twice. This subject will be considered in detail at the Seminar and illustrated by material from the WHO publication to try to achieve more uniformity.

The invasive carcinomas of the cervix and vagina were diagnosed correctly but sub-typing showed much variation.

The tumours of the breast were diagnosed quite accurately and there were no major problems. The cases of lung tumours were difficult and did show variations in interpretation. The soft tissue tumours contained several difficult cases but the participants in general were able to reasonably cope with the group. Thyroid tumours posed some problems in interpretation and definition of tumour types. The cases of carcinoma of the urinary bladder were all diagnosed correctly and with considerable uniformity. The ovarian tumours did not pose any difficulty in diagnosis except for sub-typing. The testis tumours were in general without major difficulties. The bone tumours were largely diagnosed correctly.

The coding of diagnoses was done by all but one of the participants. Except for occasional errors in transcription and interpretation, this portion of the exercise was performed accurately.

In general, the participants showed an acceptable degree of diagnostic accuracy with certain ones apparently being rather knowledgeable and several appearing weak. Tumours which the participants are well acquainted with, e.g. bladder and breast, do not appear to pose serious problems whereas some less frequently encountered lesions such as those of the lung and colon, were not as easily dealt with.