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Primary HPV DNA Screening

Turkish Program : Challenges and Solutions

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Part-1 Turkish Program

Since 2014

- Gynecol Oncol 2020 Jul;158(1):105-111.
- Br J Cancer 2020 Jun 8
- Papillomavirus Res. 2019 Jun;7:118-122
- Int J Cancer. 2018 May;142(9):1952-1958
- Lancet Infect Dis. 2017 Apr;17(4):368.
- J Gyn Oncol. 2017 Nov;28(6):e85.
- Int J Gyn Cancer. 2017 Oct;27(8):51-59.
- MEGA HPV Lab
<https://www.youtube.com/watch?v=8mAPRj10>
- GP Training
<https://www.youtube.com/watch?v=y4uGvYz7Q>
- E-HPV Applications
<https://hpvarama.saglik.gov.tr/duyurular/sonucgorule>
- Apple and Google Stores

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Previous Turkish Screening Program

- ✓ Low Cervical Cancer Incidence 4-5 / 100.000 with higher mortality per case compared to EU
- ✓ Pap-Smear since 1985, Population Based Since 2004
 - KETEM + GP + Gynecologists
 - However, coverage rates could not exceed
 - 2% for population, 40% for opportunistic plus population based

Reason: Organisational Problems

- Large target population (15 Million)
- Lack of manpower (technician, expert)
- Frequent positional changes in manpower
- Lack of awareness (medical staff and population)
- Geographical limitations (large surface area, seasonal difficulties, transport difficulties)
- Quality control

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New Screening Program-2014

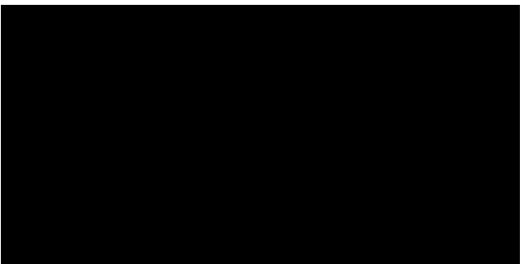
- ✓ HPV + Conventional Smear in each five years, for women aged 30-65 years old
- ✓ GP & Nurses
 - 500 / GP or nurse for 5 Years, 10 /month
- ✓ Cargo to Ankara and Istanbul HPV Lab
- ✓ Results are on internet in 10 days maximal
- ✓ HPV Negative, nothing more
- ✓ HPV Positive, Genotyping Plus Double Blind Smear Evaluation
- ✓ Samples are stored for **five years**, smear pictures are also digitally stored
- ✓ Colposcopy Referral
 - HPV 16/ 18/ Other HPV with Cytological Abnormalities
 - Other HPV with NILM : 1 year later re-screen

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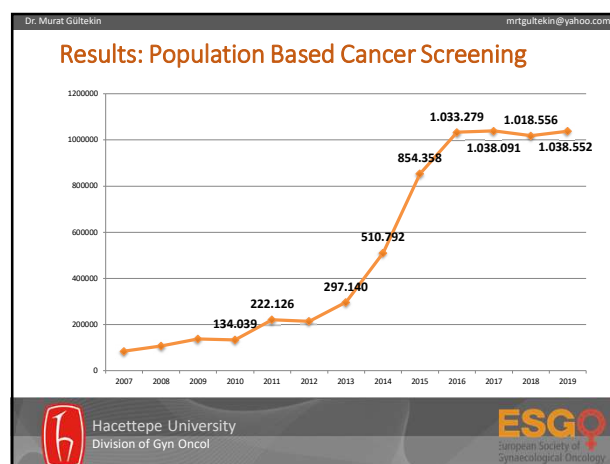
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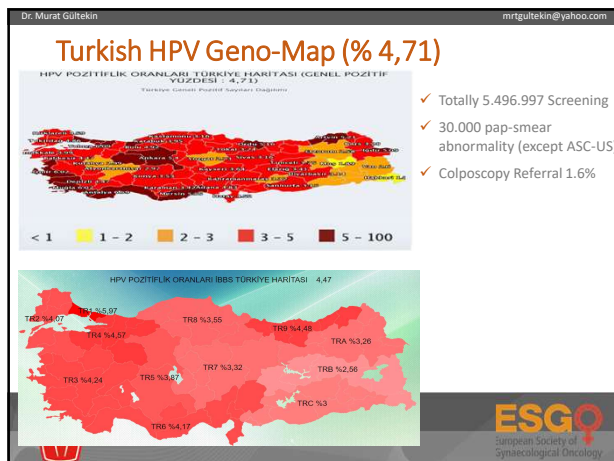
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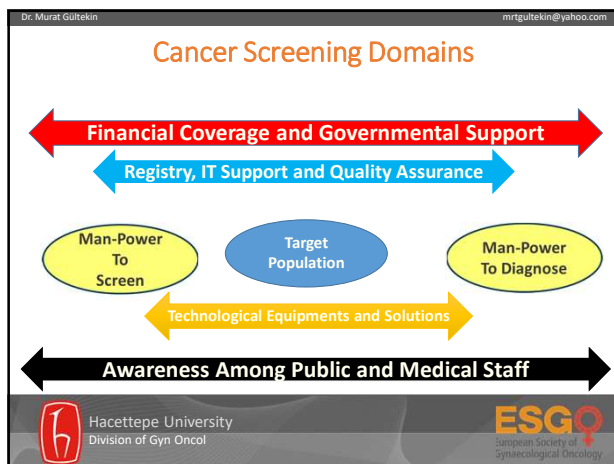
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Part-2 Challenges and Solutions

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Basic Universal Principles

- Target affordable projects and grow it step by step
 - Pilot Studies
 - Quality Assurance
 - Registry Steps
- There is always money
 - Amount and priorities change
 - Depends on your capacity to change the minds
- If the people do not attend to screening
 - Check your system and quality assurance
 - Do not directly accuse the people
- Become a leader in the press, not a follower
 - Continuous press releases about the program progress
 - Always follow the scientific evidence
- Work together with national and international stakeholders
 - Patient NGOs, Governmental people, Population leaders
 - IARC, NCI, IARC, WHO

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TARGET POPULATION

- Registry is a must
 - National ID Number
 - Ministerial software to follow up screening
- You can select different target populations and different screening intervals depending on your capacity, infra-structure and culture
- Avoid unnecessary waste of time in screening process for these healthy people
 - Make screening easily accessible, free of charge and results given online-
 - E-HPV Smart Phone Application
 - Make referral centers ready after a positive screening
 - 1.5 additional case per day per each device
- Continuous Education and Awareness
 - Remember, it may take several years to engage the target population in to the screening
 - Prevent cancer dogmas by making early diagnosed people visible on media
 - Always first check the quality and comfort of your screening system

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MAN-POWER

To Screen and To Diagnose

- Primary Level
 - GP or Family Physician
 - Preferred man-power, but priorities should be given among all tasks
 - Longer Screening Interval
 - Motivation
 - Negative Performance
 - Positive Performance
 - Annual awards and Weekly Calls and Statistical Competitions
- Secondary to Tertiary Level
 - Not preferred, depends on your health system
 - Usually in opportunistic screenings and adds on population based screening
 - Avoid the ego-centric reactions , continous educations with NGOs, prevent re-screenings
- Nurses
 - Especially important in conservative populations
- Pharmacists
 - Especially for colorectal cancer screenings

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MAN-POWER

To Screen and To Diagnose

- Post-Screening Diagnostic Centers at Secondary to Tertiary Level
 - Triage is important
- Minimal Criteria to Follow Up and Perform Continous Trainings
 - Colposcopy

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TECHNOLOGICAL EQUIPMENTS and SOLUTIONS

- Cervical Cancer
 - HPV DNA, Self-HPV, Urine HPV, Fast HPV
 - 3. Generation Colposcopies

REGISTRY, IT SUPPORT and QUALITY ASSURANCE

- Registry
 - Power of Data for Changing the Minds of Populations and Policy Makers
 - Cancer Registry linkage with Cancer Screening
 - Cancer Screening Registry : CAN-SCREEN Project by IARC-WHO
 - Should include the data coming from post-screening diagnostic screening centers
- IT Support
 - Prevent repeat screenings
 - Linkage between primary level and secondary-tertiary levels
 - National Maps per each physicians, each province
- Quality Assurance
 - Start again with minimal essential and affordable ones

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AWARENESS AMONG PUBLIC and MEDICAL STAFF

- Should include public, patients and advocacy groups, popular people in the public, academicians and political leaders
- Should sometimes include international bodies
- Should be sensational and different
- Should be sustainable
- Should be country wide as possible

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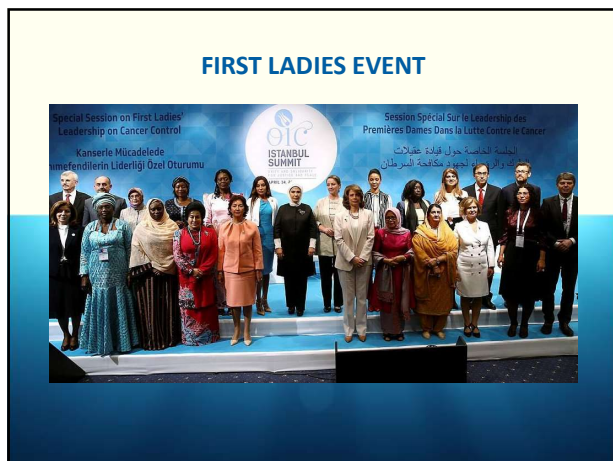
ADVOCACY and AWARENESS Events



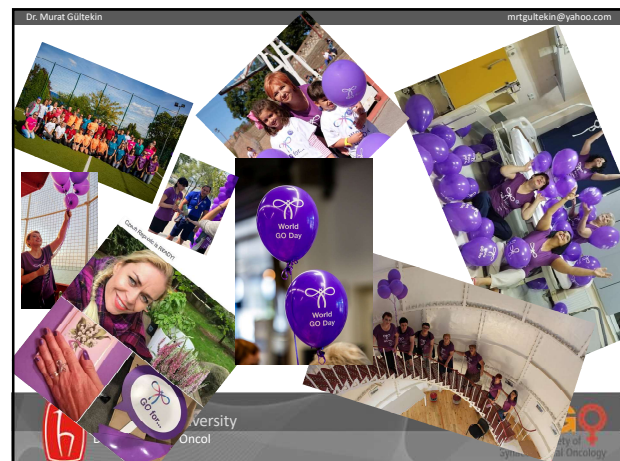
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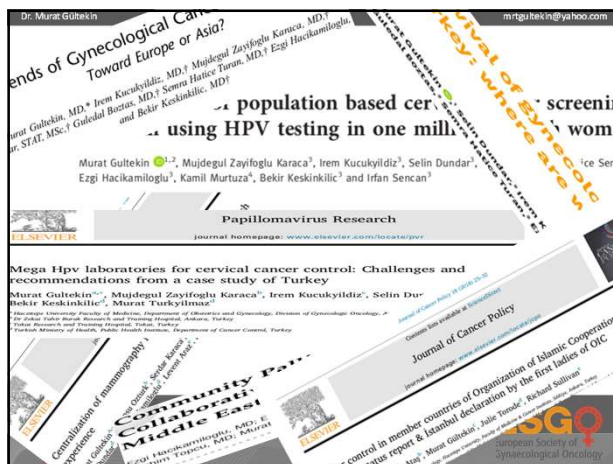
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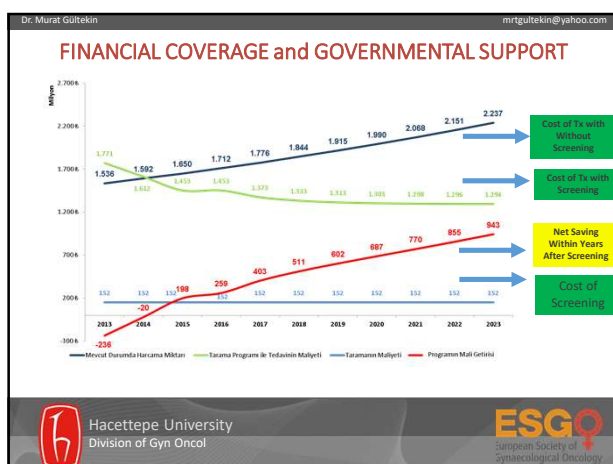
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PPP Model vs. Governmental Models

- Out-Source or PPP Model
 - All inclusive service
 - No transport money
 - No repair cost
 - No IT cost
 - No lab-manpower cost
 - Payment per patient
 - Feasible working hours, female staff and no staff circulation
 - No bureaucracy

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Communication Problems Resolving by CME of the Professional Staff

- ✓ Sexual transmission
- ✓ Preference for Private Centers
- ✓ Questions about Natural HPV Infections
- ✓ Vaccine Questions

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Thank you for your attention

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