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Keeping Their World Together – Network-Focused Nursing in Teenager and Young Adult Cancer Care

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Teenagers and young adults with cancer face a dual crisis. Their health and lives are threatened and they are thrown back into dependant roles with their parents, just as they have begun to establish their independence. Moreover, disconnection to their normal lives as young people is likely to happen during treatment and beyond. Thus, they face numerous developmental challenges and their needs are special, broader in scope and more intense than those at any other time in life, which will be exemplified in the presentation.

A nursing programme in a Danish youth unit was developed with the aim of assisting the young patients and their parents to cope with their new situation.

The programme is based on the notion that cooperation and coordination between the patient's multidisciplinary health professional network and involvement of the young person's private social network is crucial.

A grounded theory study has shown that this network-focused nursing programme entails nurses' ability to bridge differences between their personal and professional values and norms and the values and norms of the young person and the families, and nurses' ability to facilitate social support from the young persons' social network.

The programme helps teenagers and young adults with cancer to stay connected to their friends and their ordinary lives and to assist them and their significant others in keeping their world together.

The network-focused nursing programme in the youth unit includes four domains and several components that will be outlined in the presentation, which will be based on the grounded theory study, the nursing practice involved and a current study of network meetings and their influences on relationships.

Special Session (Sat, 24 Sep, 14:15–15:15) Preventing Cervical Cancer

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Prospects for Rapid Worldwide Reduction of Cervical Cancer

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Most HPV 16/18 vaccination programmes target adolescent girls who have not yet been infected. However, restricting HPV vaccination to young women will have little effect on overall cancer rates for several decades, as most of the 10 million women who are expected to develop cervical cancer over the next 20 years have already been infected with HPV. The majority of HPV infections disappear within a year or two, and these confer little risk of progression to cancer. A screen-and-treat policy based on a single HPV test therefore entails substantial overtreatment, and does not protect against later reinfection.

Polyvalent HPV vaccines that prevent the large majority of new infections with high-risk HPV types (notably HPV L2 vaccines) and rapid HPV testing may soon be generally available at affordable cost, and this will have important implications for vaccination and screening policy, particularly in older women. Polyvalent HPV vaccination, followed 3 or more years later by a HPV test and immediate ablative treatment of any high-risk HPV infection (irrespective of cytology or colposcopy), would greatly reduce cervical cancer incidence in women at all ages. This once in a lifetime intervention might be a cost-effective alternative to regular screening in developed countries, and in developing countries where regular cervical screening is impractical it may be the only way to produce a large and rapid reduction in cervical cancer incidence and mortality. In developing countries this might be achieved more easily by a programme of mass vaccination followed a few years later by mass HPV testing than by attempting to follow up individual women after vaccination. (EUROGIN 2010 roadmap on cervical cancer prevention, Int J Cancer (2011) 128: 2765–74.)

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Cervix Cancer Vaccination

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Vaccination against the Human Papillomavirus offers a great opportunity to further reduce the disease burden associated with cervix cancer. When given before exposure to the virus, the two commercially available vaccines

both offer almost complete protection against precursor lesions associated with HPV types 16 & 18 which are the cancer associated types found in the vaccines. However current programmes mostly focus on girls ages 11–13 y, so it will be many years before the benefits of vaccination are seen on cancer rates. Projections of the impact for women aged 20–29 y, where the first effects will be seen, will be given based on data from the UK.

Several questions about the long term efficacy and best use of the vaccine remain however. Of greatest interest is the extent and duration of cross protection against related viral types, notably types 45 and 31. Duration of protection is also a major issue as data are only available out to 9 years, and there is no data on the impact of vaccination on cancer and durability of cross protection. Recent data also suggest that receipt of two doses or even only one in comparison to the recommended three dose schedule may also be highly efficacious. The current knowledge on these issues will be reviewed.

Extension of the primary target population to older women and boys is also an important issue, and will become more attractive as the price of the vaccine comes down. In addition multivalent vaccines are currently under test in large clinical trials, and they offer the prospect of substantially higher efficacy. This possibility will need to be built into plans for future vaccine programmes. Higher protection will be particularly important if programmes are to be extended to older women.

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Cervix Cancer Screening – European Guidelines and Programme Implementation

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Introduction: EU health policy recommends population-based screening for breast, cervical and colorectal cancer according to European quality assurance guidelines.

Aim and Methods: A standard approach to implementation of population-based cervical screening programmes has been developed based on the EU Guidelines for cervical screening and the experience in implementation of over 50 population-based programmes for breast, cervical and colorectal cancer in the EU.

Results: The decision to establish a screening programme should be made in the framework of an overall cancer control plan. The subsequent generic elements of the implementation process are as follows:

1. Comprehensive planning of screening process: feasibility of screening models, professional performance, organisation and financing, quality assurance. The decision to establish a screening programme should be made in the framework of an overall cancer control plan. The subsequent generic elements of the implementation process are as follows: Comprehensive of screening process: feasibility of screening models, professional performance, organisation and financing, quality assurance
2. Preparation of all components of screening process to perform at requisite high level including **feasibility testing**
3. Expert verification of adequacy of preparations
4. Piloting in routine settings and modification, if necessary, of all screening systems and components, including quality assurance
5. Expert verification of adequacy of pilot performance
6. Transition of pilot to service screening and geographically phased programme rollout in other regions of the country. Intensive monitoring of programme rollout for early detection and correction of quality problems
7. Continuous quality improvement of routine programme.

Specific actions are required to implement this generic process in the context of any country:

1. Establish governance
2. Appoint coordinator to prepare work plans
3. Test feasibility in small-scale studies
4. Initiate staff training (continuous process adapted to scale of programme activities)
5. Piloting (large scale, "routine" setting)
6. Establish Management and Evaluation (M&E) unit for national programme in pilot phase
7. Geographically phased programme rollout.
8. Continuous quality improvement of programme based on performance monitoring, impact evaluation and international collaboration in quality assurance.

Discussion and Conclusions: EU experience demonstrates that the translational process by which a cancer screening programme is established can be effectively controlled. This permits verification that requisite changes in current practice will minimize risks and maximize benefits of screening before large numbers of people are exposed to screening and before substantial resources are consumed.