BREAST CANCER IN LATIN AMERICA.

DIFFERENCES IN MEDICAL CARE.

DR. CARLOS GARBINO.

SOCIETE INTERNATIONALE DE SENOLOGIE.

S.I.S.

EXECUTIVE DIRECTOR.

PRESENTATION BASED IN OUR PREVIOUS SURVEY.

1) **Breast Cancer in Latin America. Results of the Latin American and Caribbean Society of Medical Oncology –SLACOM- and the Breast Cancer Research Foundation –BCRF- expert survey.**

   Cazap E, Buzaid A, Garbino C, de la Garza J, Orlandi F, Schwartsmann G et al.

   Cancer 2008; 113 (S8): 2359-65.

2) **Breast Cancer in Latin America. Expert perceptions compared with medical care standards.**

   E Cazap, A Buzaid, C Garbino, J de la Garza, F Orlandi, G Schwartsmann, C Vallejos, A Gercovich, G Breitbart.

   The Breast 19 (2010): 50-54.

EPIDEMIOLOGICAL ASPECTS 1.-

. Latin America and the Caribbean: have 10% of developing countries population.

. Cancer Incidence: 10% of the new cancers that occur in the world.

. Breast Cancer incidence: in general is lower that in developed countries.

. The highest incidence occurs in URUGUAYand ARGENTINA, with crude rates of 110.9 and 88.1 per 100.000 inhabitants respectively.

. 2050 estimates suggest that incidence and mortality would have a bigger increase in developing that in developed countries.

. This increase is related to: population increase, aging, life style modifications, migration to urban communities, difficulties in preventive measures aplication and in early diagnosis in poorer countries, and to the requirement of more and best medical care facilities.

EPIDEMIOLOGIC ASPECTS 2

- **In 2025: estimate medical care increase in Latin America and Caribbean would be, approximately, 47 % !!!!!. *Critical data for the region.***

- **Great differences in Medical Care Budget exists between developed and developing countries.**
- **GDP in developed countries in Health Care: > 10%.**
- **GDP in developing countries in Health Care: < 5%.**

- **Stage differences at initial diagnosis and different treatment facilities could have an important impact in health care costs and patient pronostic.**

- **Socioeconomic conditions of countries populations would be related to incidence, mortality and survival rates in Breast Cancer.**

- **In developed countries, incidence is higher and mortality is lower. Causes: differencs in screening programs and oncologic specific treatments.**

OBJECTIVES.

- **Perform a Leaders of Opinion survey in Latin America and the Caribbean, in order to obtain an exploratory analysis of the actual Breast Cancer Treatment in these regions.**

- **Create a Data Base for correlative studies in order to provide recomendations or minimal treatment rules, propose projects based in better information, that could benefit from available resources regarding achievable goals.**

SURVEYED EXPERTS PER COUNTRY.

- **ARGENTINA 19**
- **BOLIVIA 3**
- **BRAZIL 11**
- **COLOMBIA 7**
- **CHILE 7**
- **HONDURAS 4**
- **MEXICO 14**
- **PANAMA 3**
- **PARAGUAY 5**
- **PERU 6**
- **URUGUAY 6**
- **VENEZUELA 7**

MATERIAL AND METHODS. 1.

- **Study driven by a SLACOM expert Committee.**
- **5 Medical Oncologists prepared 65 questions that were accepted by the different country representatives on: Epidemiology, Screening, Diagnosis, Treatment, Research, Paliative Treatment and Medical Education.**
- **92/100 experts of 12 countries answered an expert medical telephone survey.**
- **Country expert participants were assigned according to Breast Cancer incidence and Country size.**

MATERIAL AND METHODS. 2.

- **Distribution of experts surveyed:**
  - **Medical Oncologists: 30 – 60 %.**
  - **Ginecologists or Breast Surgeons: 20 – 35 %.**
  - **Radiationtherapists: 10 – 15 %.**

. **Telephonic pool was conducted by a centralized medical expert in epidemiologic surveys.**

. **Experts had to valorate Breast Cancer treatment in its Centre and in its Country, in general.**

. **Answers were evaluated by simple descriptive statistics.**

POOL QUESTIONS AND ANSWER OPTIONS.

- **CANCER REGISTRIES :** Is a CANCER REGISTRY available in your country with poblational data of the last 5 years?.

- **ACCESS TO MAMMOGRAPHY:** are legal regulations that determine the performance of a periodic MX Screening and that cover the whole country?.

- **ORIGIN OF THE INITIAL DIAGNOSIS:** in your Center/Country whom determines the suspition of initial diagnosis of BR. CA.: Patient; Which Pshycian; Screening; Other?

- **1st. CONSULTATION TO AN SPECIALIST FOR BR. CA. SUSPICION:** in your Center / Country which is the specialist most frequently counsulted in front of a suspicious diagnosis: Physician; Surgeon; Breast Surgeon; Gynaecologist?

- **DELAY WITHIN MX OR CLINICAL SUSPICION AND HISTOPATHOLOGY DIAGNOSIS: Estimated delay:** < 1 month; 1 – 3 months; > 3 months; unknown?.

- **HORMONE RECEPTOR AVAILABILITY:** in your Center/Country is determination of HR available: Yes; No; in < 25%; 25 - 50%; 50 – 75%; in >75% ?.

- **BIOLOGIC MARKERS: Ki 67 – HER 2:** in your Center/Country is possible to perform these molecular determinations or others? Yes; No; another.

- **DELAY BETWEEN HISTOPATHOLOGIC DIAGNOSIS AND SURGERY OR 1st. SISTEMIC TREATMENT: in your Center/Country which is the estimated delay? < 1 month; 1 - 3 months; > 3 months.**

- **DELAY BETWEEN SURGERY AND 1st. TREATMENT: HT, CT, RT: in your Center/Country the estimated time between Surgery and CT - HT, and CT or RT is: < 1 month, 1 to 3 months, > 3 months.**

- **FIRST SURGICAL TREATMENT: I, II, IIIA -: in your Center/Country is Surgery the 1st. treatment for each of those Stages? Which of the Specialists perform the Surgery? Gynaecology, Breast Surgeon or Surgeon? Establish its percentaje: < 25%, 25 - 50 %, 50 - 75 %, > 75 %.**

- **SENTINEL NODE: in your Center/Country is this technique performed? Yes, No, send to other institution or not.**

- **CT PREVIOUS TO SURGERY: in your Center/Country, to most of the operable patients is Pre-Operative CT proposed and whom proposes it ? In Stage I - II? In Stage IIIA? It is not proposed.**

  The Medical Oncologist, the Gynaecologist, the Surgeon, the Breast Surgeon?

- **CT – HT COSTS: in your Center/Country whom covers > 80% of the cost? Health System; the patient; other?**

- **CT – ANTHRACYCLINS: in your Center/Country are the majority of CT based in Anthracyclins? Yes, No, other?.**

- **TAMOXIFEN: in your Center/Country which percentaje of patients receive Tx?: > 95 %; 80 - 95 %; < 80 %; other?.**

. **PALLIATIVE CARE: in your Center/Country which is the availability of opiods for terminal patients? None; Available with or without use or usually not used?.**

. **MEDICAL AUTONOMY: in your Center/Country the election of > than 80% of Adjuvant or Palliative Treatments is not limited for a physician or it is pre-established for a medical care system (drugs bank, oncologic vademecum)? For Adjuvant HT – CT? Is it pre-established; not restricted; other?.**

. **FOLLOW – UP: in your Center/Country whom carry on the follow – up of most patients? Breast Surgeon; Gynaecology; Surgeon; Oncologist; Both; None?.**

- **RESEARCH LEVEL: in your Country, how could you qualify de clinical, epidemiologic and basic research development in BR.CA.? Insufficient; Sufficient; Other?.**

- **RESEARCH REASONS: in your country, which reasons you consider for Insufficiency? Absence of institutional support; specialists without adequate time; specialists without motivation; specialists without training; inadequate salary; inadequate infraestructure; obstacles in regularory mechanisms; other reasons; unknown?.**

- **RESEARCH SUPPORT: in your Country, where the majority of clinical – epidemiological research in BR. CA is performed? Public Centers; Private Centers; National Oncologic Groups; Regional Oncologic Group; Universities.**

RESULTS
EPIDEMIOLOGY: CANCER REGISTRIES.

- **75 % of the interviewee precised that some kind of Cancer Registry, based in poblational data, do exist and with incidence available data for the last 5 years.**

- **National Cancer Registries exist based in Histopathological diagnosis in Mexico, Paraguay, Panama, Uruguay and Venezuela.**

- **Other countries only have Provincial or Town Council Registries, like Argentina 6; Brazil 1; Chile 2; Colombia 1; Honduras 2 and Peru 3.**

SCREENING AND DIAGNOSIS OF BR. CA.
SCREENING PROGRAMS.

- **> 90% of the experts precised that there are no laws or national rules in their own countries, that oblige for a Mammographic Screening.**

- **Access to Mammography was reported as available for 66% of the patients at the Country level.**

- **Access to Mammography was reported as available for 47% of the patients at the Center level.**

SCREENING AND DIAGNOSIS OF BR. CA. BY COUNTRY AND CENTER. INITIAL CANCER SUSPICION.

- **79 % of experts mentioned that the initial suspicion of cancer was done by the patient and 19% mentioned that was made by the physician.**

- **The first consulted specialist was the Gynaecologist – 82%- and the Breast Surgeon – 83%- with similar results at the Center and Country level.**

- **In 62 % of the cases, delay between BR. CA. suspicion and Mammography or Clinical Examination was < 3 months at the Country level, but more patients -91%- were diagnosed, in similar time, at the Center level.**

- **Hormonal Receptors were available in 52 % at the Country level and 100 % at the Center level.**

- **Molecular Markers were available in 5 % at the Country level and 83% at the Center level.**

TREATMENT

- **A delay of only < 1 month for the first treatment – Surgery or Neo Adyuvant CT - occurs in 15% of the patients at the Country level and in 81% at the Center level.**
- **The majority of the patients begun their first treatment in < 3 months, with a rate of 91% at the Country level and of 99% at the Center level.**
- **A delay of < 1 month between Surgery and the begining of CT ocurred in 20% of the patients at the Country level and 76% of the patients at the Center level.**
- **The begining of Adjuvant CT in < 3 months after Surgery ocurred in 89% of the patients at the Country level and of 98% at the Center level.**
- **First treatment for Stage I and II was Surgery, with a rate of 100% both for the Country and the Center level.**
- **First treatment for Stage IIIA was Neo-Adjuvant CT in > 90% of the pooled experts.**

TREATMENT

- **Mastectomy was the most frequent surgical procedure, > 50%, equally performed by surgeons or gynaecologists.**
- **Sentinel Node Technique was employed in 71% of the patients at the Center level.**
- **Adjuvant CT was applied by an Oncologist in 85% of the patients at the Country level and only in 54% of the patients at the Center level.**
- **This fact was attributed to the participation of the Tumour Committees when the decission of treatment recomendation was done in the context of a multidisciplinary team, whose existance was more frecuent in more developed Centers (38% of the Centers).**

COSTS AND ACCEPTED TREATMENTS

SYSTEMIC TREATMENTS.

- **At the Country level, costs of 67% of the patients was covered by the Government.**
- **At the Center level costs of only 28 % of the patients was covered by the Governments.**
- **Shared payments between the patient and the Government were 17% at the Country level and 19% at the Center level.**
- **Insurance Health Companies participated in 13 % of the patients at the Country level and in 53 % of the patients at the Center level.**

COSTS AND ACCEPTED TREATMENTS

- **CT with Anthracyclins: widely accepted at the Country and Center level - 96% - 99% respectively-.**
- **Tamoxifen: widely used at the Country level: > 95% in the countries that answered this question (only 48% of them).**
- **At the Center level > 95% of the patients recieve it, in the Centers that answered this question (only 35% of them).**
- **This different probability could be a consequence, at the Center level, of the use of new Hormonal treatments of last generation, like AI and LHRH-A.**

COSTS AND ACCEPTED TREATMENTS

MEDICAL AUTONOMY IN THE THERAPEUTIC ALTERNATIVES ELECTION.

- **The possibility of a physician to chose an adequate adjuvant treatment for the patient (not restricted election versus a predetermined treatment by the Health Care System or by the Inssurance System) was of 53% at the Country level, increasing up to 74 % at the Center level.**

COSTS AND ACCEPTED TREATMENTS

FOLLOW UP

- **At the Country level: Follow up is mainly performed by oncologists – 73 % - and only 10 % is performed by surgeons or BR. CA. Specialists.**

- **At the Center level: Follow up is exclusively performed by Oncologists in 24 % of the patients, 14% is done by the Surgeon or BR. CA. specialists and 61% is performed by the Surgeon and the Oncologist.**

COSTS AND ACCEPTED TREATMENTS . PALLIATIVE CARE.

- **The possibility to opiods and narcotics access was evaluated as:**

  + Available for 82 % of the experts at the Country level.

  + Available for 93% of the experts at the Center level.

RESEARCH AND EDUCATION.

- **94% of the experts considered that Clinic – Epidemiologic Research in BR. CA. as insufficient al the Country level.**
- **Principal causes were: insufficient economic support - 79% - and abscense of time - 62% -.**
- **Similar answers for Basic Research: 83% of the experts considered it insufficient.**
- **Most of the Research activities were performed in the Public sector (46%).**
- **In the Private sector (17%) and in Public-Private Centers (22%).**
- **Only 1%, aproximate, were performed in the University or in Cooperative Groups.**

DISCUSSION AND CONCLUSSIONS.

- **Br. Ca. INCIDENCE INCREASE requires a global concerted answer, with the union of national and regional with the international organizations for an adequate advise and global support.**

- **Missing objective and necessary information in Latin America due to lack of CANCER REGISTRIES, minimal scientific information and poor quality of the governmental information with poor political interest on the subject, should be reverted.**

- **This STUDY presents an alternative information source, originated in experts opinions, that could collaborate suppliying the mentioned insufficiencies.**

- **In PREVENTION, the low application of MAMMOGRAPHIC SCREENING is a mayor problem, because increases the detection of BR. CA. done by the patients, generally in more advanced Stages.**
- **79% of the patients detected their own cancer.**

- **In the mayority of Centers, HR, HER 2 and Ki 67 determination is possible, putting in evidence the emphasis in the diagnosis and in the assistencial treatment.**

- **MASTECTOMY was considered a common surgical option, performed, in general, by surgeons or gynaecologists and not by breast surgeons.**

- **A DELAY of < 3 months between cancer suspiction and MX or clinical examination occurred in 92% at the Center level and only in 62% at the Country level, indicating a clear variation in the medical care according to the area where the patient is located.**

- **ADJUVANT CT performed by Oncologist was more frecuent at the Country level than at the Center level. This data could reflect the medical action of the Tumor Committees in the Multidisciplinary management of the patients treatment (38%).**

. **SHORT INTERVAL between diagnosis and treatment could be attributed to the therapeutic interest, medical education and medical care system qualities.**

. **CLINICAL AND EPIDEMIOLOGIC RESEARCH is of fundamental importance for BR. CA. advances, and should be stimulated in Latin American countries.**

This pool evidenced a low governmental support in L.A.

Only 1% was the support from Universities or Cooperative Groups.

- **No great differences were observed between the Centers level and the Country level related to therapeutic recommendations, suggesting that the medical expertise has an adeqauate educational training.**

- **AVAILABILITY of treatment and palliation (HT, CT and Morphine) was evaluated as adequate.**

- **Pool results could present possible bias due to the abscense of procedures for a correct validation of the experts opinions requiring additional data, both clinic or scientific.**

- **THE FUTURE CHALLENGE is to promote an integral BR. CA. global control.**

- **It is considered NECESSARY for L.A. countries the elaboration of adequate programs for the Cancer Centers and the obtention of epidemiologic data with URGENCY, in concordance with the WHO and UICC recommendations.**

  A national and global politic obligation is of essential importance in order that these epidemiologic programs could be installed in all countries.