Prevention of cervical cancer in Portugal

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Summary

- Epidemiology of Cervical Cancer
- Cervical Cancer Screening
- HPV Vaccination Strategies
- Activities at the National Health Institute
- Final Comments
Epidemiology of Cervical Cancer

- Age-standardised incidence and mortality rates are 12.2 and 3.6 (per 100,000 woman) *WHO/ICO 2010*
- 2\textsuperscript{nd} most frequent cancer among women 15-44 years old
- Annually, 949 women are diagnosed with cervical cancer and 346 die from the disease
- Cancer registries show an asymmetrical distribution of disease incidence (Oporto – 12.5, Algarve – 10.1 ASR) due to different screening strategies
- Higher rates among southern European countries – higher HPV infection prevalence (14.2 % 18-64 y)
Figure 4: Age-standardized incidence rates of cervical cancer in Europe

ASR, age-standardized incidence rates; Rates per 100,000 women per year.

Data sources:
IARC, Globocan 2008. Age-specific data from GLOBOCAN 2008 were obtained from IARC, personal communication. For specific estimation methodology refer to http://globocan.iarc.fr/DataSource_and_methods.asp.
Cervical Cancer Screening

- European guidelines are followed (Gynecologists professional association): cervical cytology, followed by HPV testing in ASC-US for women between 25-64 years, every 3 years

- Population-based screening programmes only exist in two Health Regions (Centre – only cytology, Alentejo – cytology + HPV testing)

- Estimated coverage: 49.5% 2001-2002  (WHO/ICO 2010)

- Opportunistic screening – in the majority of areas
Figure 2. Estimated coverage of cervical cancer screening, by age and study

WHS Portugal
- All women screened every 3 yrs in 2001–2002–

Estimated cervical cancer screening coverage (%)

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Estimated coverage</th>
</tr>
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<tbody>
<tr>
<td>18-29</td>
<td>33.0</td>
</tr>
<tr>
<td>30-39</td>
<td>64.2</td>
</tr>
<tr>
<td>40-49</td>
<td>62.5</td>
</tr>
<tr>
<td>50-59</td>
<td>54.6</td>
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<tr>
<td>60-69</td>
<td>31.7</td>
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Notes and sources:
HPV Vaccination Strategies

• HPV vaccine is included in the National Immunization Program since 2007 (quadrivalent: HPV6,11,16,18 genotypes)

• Aiming at vaccinating girls before starting sexual activity -13y with a catch up at 17y (until 2011)

• Ensuring equity of vaccine access – free of charge at Health Centers. Costs 500 € (for 3 doses) outside the NHS – co-insurance of 37% until now

• Vaccination coverage rate: 89% (first dose)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance mechanism$^1$</td>
<td>2008</td>
<td>As of September 2008, vaccine will be available for free to all age groups for which it is recommended</td>
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<tr>
<td>Delivery strategy$^1$</td>
<td>2008</td>
<td>Vaccination is provided on demand through regional health centres across the country. Invitation letters sent by the regional health centre to registered families with females aged 13 or 17.</td>
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<td>Integration of vaccination and cervical cancer screening program$^1$</td>
<td>2008</td>
<td>Cervical screening programmes should continue</td>
</tr>
<tr>
<td>Announcement date and type; and recommendation committee$^2$</td>
<td>2008</td>
<td>12 October 2007, GACR; Technical comission on Vaccinations</td>
</tr>
<tr>
<td>Recommendation for primary target population$^2$</td>
<td>2008</td>
<td>Girls, age 13</td>
</tr>
<tr>
<td>Recommendation for catch-up population$^2$</td>
<td>2008</td>
<td>Females, ages 14-17 between 2009 and 2011</td>
</tr>
<tr>
<td>Recommendation for vaccinating males$^2$</td>
<td>2008</td>
<td>No statement</td>
</tr>
<tr>
<td>Comments$^2$</td>
<td>2008</td>
<td>-</td>
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</table>
Activities at NHI Portugal

• Reference laboratory for HPV in Portugal (genotyping, international quality control – WHO HPV LabNet, molecular markers, R&D)

• Technical support to the National Public Health Authority in planning

• National and international collaboration and networking: differential diagnosis, virological research, epidemiological studies & surveillance (CLEOPATRE, vaccination effectiveness)
Final Comments

• Despite good coverage of HPV vaccination, population-based screening programmes must continue and should encompass all the country - there are women already exposed to vaccinal HPV genotypes, and to other oncogenic genotypes (even if vaccinated)

• Our NPHI is working on immunological diagnosis (effectiveness of vaccination) and virological molecular markers for cervical cancer development – for future implementation of epidemiological surveillance

• We are aware of HPV infection in other anatomical sites, and in man, that might have PH consequences