EDITORIAL
About this issue…

Patient-centred guidelines for brachytherapy for cervical cancer[1]

This multi-disciplinary and multi-institutional South African group developed a document that is additional to existing more technical guidelines and which is based on their research into patient experiences and comments. It is hoped that all South African facilities will take note of and implement these guidelines.

In an invited editorial, Kotzen congratulates the group and points out that local research from our service-overloaded radiation facilities is scarce and that we fail to utilise our unique position in the world to help improve techniques and outcomes in cost-effective ways.[2] He points out correctly that the use of affordable ultrasound in gynaecologic oncology deserves much more attention.

Standardised colposcopic evaluation using the R-way evaluation system[3]

Women were referred to Peking University First Hospital for colposcopy as triage test after a first screening test with either HPV16/18, cytology or visual inspection. This study was undertaken to develop a method to improve the objectivity and standardisation of colposcopic evaluation and to shorten the learning curve for colposcopy without compromising the detection of HSIL or CIN2+.

This new standardised method to report colposcopy and to guide biopsy describes the parameters of "Red" for bleeding or red areas on first evaluation, "white" after 2 minutes of 5% acetic acid, "abnormal" for the classical abnormal vessel patterns and "yellow" for mustard yellow areas after Lugol's iodine. Interestingly, emphasis is placed on biopsy of any bleeding or ulcerative area. The system was found to be superior to subjective assessment and is thus recommended as part of cervical "screening".

Despite obvious similarities in socio-economic conditions between China and South Africa, this method must be tested locally after training to confirm its performance as triage test among our population with a different epidemiology. Colposcopy is a possible but not the only triage method after primary screening tests, and alternatives should be vigorously investigated due to serious resource constraints and limited access to colposcopic services.

Experiences of women receiving brachytherapy for cervical cancer[4]

Similar to the first project from Bloemfontein, this study performed in Johannesburg interviewed women who received brachytherapy to enquire about their experiences of the procedure. These two similar projects were probably proposed by female staff members observing brachytherapy and suspected that the patient perception would not be very positive. One strength of the latter report is its non-structured approach allowing the patient to 'speak' directly to the reader.

Somewhat predictably, patients reported that pain and humiliation of the lithotomy position (especially without privacy) and poor information made the procedure difficult. Much can be done to improve the patient's experience and it is hoped that units around our country will take note of both these papers to lessen pain, fear and humiliation.

Acute toxicity in cervical cancer patients treated by chemo-radiation in Zambia[5]

This study found low and similar rates of treatment toxicity in a prospective trial which recruited equal numbers of HIV positive and negative patients. The finding must be read together with the inclusion criteria and disease characteristics, and the authors correctly state that this treatment could be considered 'suitable for similar patients', i.e. carefully selected patients. Importantly patients were excluded from chemotherapy if they had any hydronephrosis, anaemia, CD4 < 200, AIDS-defining disease, and deranged creatinine clearance. Most participants had stage IIB disease and, similar to many other reports, mean age of HIV positive patients was 15 years younger than HIV negative.

Diagnosis of high-grade serous carcinoma metastasized to the breast[6]

Among South African women where inherited BRCA mutations are perceived as common, second primary cancer of the ovary after breast cancer is relatively common. Breast cancer after ovarian cancer is much less common due to higher average age at presentation and poorer survival of ovarian cancer. This case report describes a large metastasis to the breast in a relatively young ovarian cancer patient four years after first diagnosis. It was elegantly confirmed with immunohisto-staining. Although multiple other systemic disease foci were present, these responded well to platinum and second line therapy, but the breast mass did not. In the absence of guidelines, clinical decision making should prevail. It is thus difficult to understand why third line chemotherapy was chosen above simple surgical excision of the breast lesion when second line treatment failed locally.

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References:

1. Brachytherapy for cervical cancer: guidelines to facilitate patient-centres care in a multidisciplinary environment. South Afr J Gynaecol Oncol. 2016;8(2):6-12
2. Guest editorial: South African guidelines for cervical brachytherapy. South Afr J Gynaecol Oncol. 2016;8(2):4-5
3. Performance of the R-way colposcopic evaluation system in cervical cancer screening. South Afr J Gynaecol Oncol. 2016;8(2):13-18
4. Experiences of women receiving high dose rate brachytherapy for cervical cancer at an academic hospital. South Afr J Gynaecol Oncol. 2016;8(2):20-23
5. Acute toxicity in HIV-positive vs. HIV-negative cervical cancer patients treated by radical chemo-radiation in Zambia. South Afr J Gynaecol Oncol. 2016;8(2):24-28
6. Immunohistochemistry markers in diagnosing high-grade serous carcinoma of ovary with breast metastasis: a rare case report. South Afr J Gynaecol Oncol. 2016;8(2):29-31