

ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

The lifetime risk of developing cancer in Sri Lanka is 1/13. There were 13,635 new cases of cancer in Sri Lanka in 2007. Of these, 6356 were males (increase from 6205 in 2006) and 7279 were female (decreased from 7875 in 2006). The age standardised rate was 71.6 (63.8 among males, and 72.2 for females). In the UK, there were 331,487 new cases of cancer in 2011 of which a third were in patients over 75 years. The most common cancer affecting females in Sri Lanka is breast cancer, which is also the most common cancer affecting females in the UK. In males, the most common in the UK is prostate cancer, whereas in Sri Lanka it is oromaxillofacial cancer. The reason for the high incidence of OMF cancer is due to cultural and habitual chewing (followed by spitting out) of the areca nut, which is wrapped in betel leaf. It is offered to priests and guests before ceremonies, but is also chewed for leisure. The National Cancer Control Programme has recently created an alternative, wrapping various spices in betel leaf to avoid exposure to carcinogens. Although accepted by high ranking buddhist priests as a suitable alternative, uptake has been slow in the population. As in the UK, the most common paediatric cancer in Sri Lanka was Acute Lymphoblastic Leukaemia for both genders.

Health provision in Sri Lanka is not too dissimilar to that in the UK. Healthcare is free, and prescribed medications are free. One significant difference is that there are no general practitioners. Patients present to local hospital clinics (akin to A&E) and are assessed there. If scans or blood tests are needed, patients often choose to have these done privately. There is no centralised electronic database and patients notes are written on paper and kept by the patient. X-rays, CT scans and MRI scans are printed off onto film and kept by the patient. If a patient is diagnosed with cancer based on their results, they present to a ward (based on gender) at one of the few cancer units for assessment and admission. There are 26 districts in Sri Lanka, with a regional cancer centre (usually small) in each. Most of the patients present to the large, national cancer hospital in Maharagama. The services available there are almost exactly the same as in the UK - X-ray, CT, ultrasound and gamma camera facilities are available, along with pathology and histology laboratories. The treatment modalities available are again akin to the UK - radiotherapy, chemotherapy, surgical and hormonal treatment is available.

The National Cancer Control Programme has put into place a strategic framework for primary prevention and early detection of cancers. Despite free healthcare, patients present late in Sri Lanka and as a result mortality rates are high (especially in rural areas). Screening services available for women include breast cancer screening (clinical, mammogram and ultrasound examination), and cervical cancer screening (PAP test, colposcopy and transvaginal ultrasound examination) - both of which are part of a national programme and drive for early detection. For both men and women, screening for oral cancers and thyroid cancer are available but these are walk-in services, rather than a screening programme. By focussing on primary prevention and early detection, the rate of cancers detected has risen - but the severity and late-stage presentation has dropped. There is some controversy as many of the doctors I spoke to believe that breast cancer screening is unnecessary for women who are not in the "high risk group", as it falsely diagnoses lesions that would not become cancerous as tumours.

The opportunity to shadow oncologists in Sri Lanka was a fantastic experience. As there is no formal oncology placement at medical school, what I learnt about cancer management and the daily life of an oncologist will help shape my decision on pursuing it as a career. Obviously practicing oncology in the UK will not be the exact same as what I saw and learnt in Sri Lanka, but the basic principles/challenges are likely to be similar. The Maharagama national cancer hospital caters to a staggering amount of patients daily. The wards are always full, and at times there are even two patients per bed and some on plastic chairs that line the corridors. While there, I didn't notice there being a lack of any chemotherapeutic drugs or other medication - the doctors were prescribing current known regimens to treat cancer sparing no expense. There were usually large queues of patients outside the radiotherapy department, but I was notified that turn-over is quick. The doctors did point out that the cost of some treatments are almost extortionate and significantly deplete the department of health budget, and that attempts to standardise treatment regimens is often met with difficulty as pharmaceutical companies hold great influence over some of the doctors.

I saw that breaking bad news to the patients wasn't a simple, one-size fits all thing. Some patients came in knowing the prognosis and others didn't have a clue. These patients were approached differently and I learnt that it is vital to adapt to the situation and speak to the patients with honesty and empathy. The patients were grateful just to be seen and admitted. They spoke about their doctors with reverence. English is the working language spoken during ward rounds and clinics, but some patients couldn't speak any English at all. They were spoken to in Sinhala and management plans made at the bedside were in English. The doctors made every effort to explain the treatment and the rationale to the patients.

The most important thing I took from this experience is that oncology is not a "depressing job", where you're constantly fighting a losing battle. Patients improve and you gain a real sense of satisfaction knowing that you're making a difference in someone's life. There is a fine balance that needs to be maintained between when to use these strong treatment modalities and when to suggest that palliation is the best option. With new technology changing the face of oncology, the demands of the oncologist are likely to change but the motivation of treating a feared and unpredictable disease drives these doctors to do their best for all their patients. After this placement, I am certain that I am capable of dealing with difficult conversations, very sick patients and how to work effectively in a team of specialists.