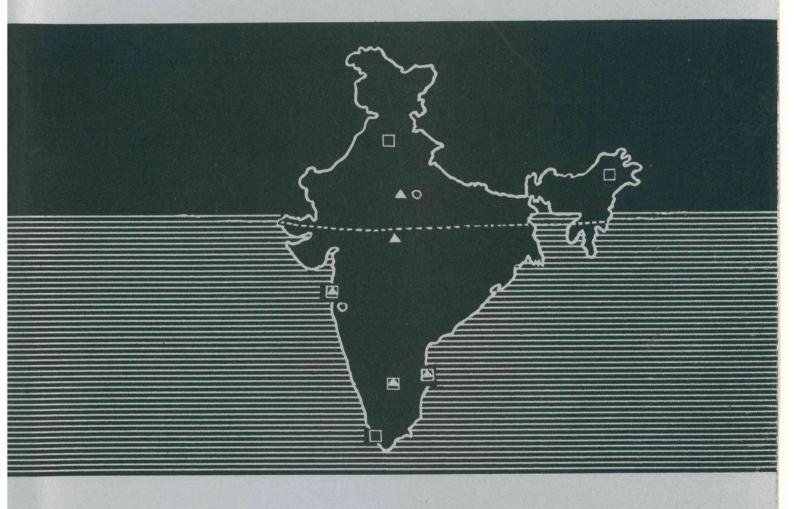


ANNUAL REPORT 1986



NATIONAL CANCER REGISTRY

A PROJECT OF INDIAN COUNCIL OF MEDICAL RESEARCH ANSARI NAGAR, NEW DELHI-110 029

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NATIONAL CANCER REGISTRY

A PROJECT OF THE INDIAN COUNCIL OF MEDICAL RESEARCH ANSARI NAGAR, NEW DELHI - 110029

JANUARY, 1989

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ANNUAL REPORT 1986

The Consolidated Report was prepared by the Technical Wing of the Coordinating Unit, National Cancer Registry Project, Bombay.

Cancer registries provided individual core data.

Technical Wing, Tata Memorial Hospital, Bombay, prepared the tables and analyses in this report except for Ch. 6 prepared in Delhi.

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(A project of the Indian Council of Medical Research)

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PREFACE

I am delighted to introduce the fifth Annual Report of the National Cancer Registry Project (NCRP) which presents the 1986 data. The NCRP was initiated by the Indian Council of Medical Research in 1981-82 by augmenting/establishing three Population-Based Cancer Registries (PBCR) one each at Bombay, Bangalore and Madras, three Hospital Cancer Registries (HCR) at Chandigarh, Dibrugarh and Trivandrum and a Co-ordinating Unit with an Operational and a Technical Wing. The overall objectives of the NCRP are:

- 1. to generate reliable data on the magnitude of the cancer problem, from the population-based registries;
- to generate authenic data on cancer patient care parameters including diagnosis and extent of disease, treatment and outcome, follow-up and survival for clinical epidemiology studies and other relative frequency data, - from the hospital cancer registries;
- 3. to undertake other epidemiological investigations and to evaluate cancer control measures; and
- 4. to develop human resources in cancer epidemiology.

The National Cancer Registry Project has expanded over the years. It now consists of twelve registries collecting data on cancer. There are six hospital cancer registries and six are population-based. Locations of the six hospital cancer registries are Chandigarh, Dibrugarh, Trivandrum, Bangalore, Bombay, Madras - the first three collecting data in general hospitals from 1982, the last three in cancer centres from 1984. Five of the six PBCRs are urban-based; - in Bombay since 1964, Bangalore and Madras since 1982; and Bhopal and Delhi from 1986. The sixth is rural based in Barsi, in Solapur District of Maharashtra State.

The Steering Committee has both national and international experts, (WHO consultants) who review and monitor the functioning of the entire project. This year saw the induction of two new members of the Steering Committee - Dr. N.C. Mishra, Prof. of Surgery, K.G. Medical College, Lucknow, and Prof. P.S.S. Sundar Rao, Prof. of Biostatistics, Christian Medical College, Vellore. We look forward to their ideas and contribution in the working of NCRP. Many thanks to Dr. I.K. Dhawan who served the Steering Committee from 1985.

As the registry project has grown, so have the material to be presented at its Annual Meetings and in the consolidated report. It was felt therefore that in alternate years, the focus of the meeting and the report should be on the hospital or on the population registries. This year's report focuses therefore on hospital cancer registry data from the six HCRs with a brief chapter on the PBCRs. Tables in Part II are from the HCRs only.

The Hospital Cancer Registries show that patients registered in the six HCRs in 1986 were 30,871, which was an increase from 29,619 in 1985 and 27,057 in 1984. Of these around 23,000 cases in 1986 were from the three cancer centre HCRs and nearly 8,000 from the general hospital HCRs. This year, analysis of head and neck tobacco-related cancers by the 4th digit of the ICD9 for the first time has revealed that pharyngeal cancers have the highest relative frequency in males except in Trivandrum where oral cavity leads. Cervix remains the feading cancer in women. It is followed by breast in Bombay, Chandigarh, Madras and Trivandrum, but by cancers of oral cavity in Bangalore and pharynx in Dibrugarh. The large majority of cancers are regionally spread at first diagnosis. Analysis of treatment data has shown that, while localised cancers are mostly treated, large proportions of regionally spread cancers go untreated. Reasons for this need elucidating.

Population-based cancer registry data in this report shows that the age-adjusted incidence rates for 1986 were respectively, 107, 118.9, and 116 for males in Bangalore, Bombay and Madras. For females they were 129.4 in Bangalore, 115.2 in Bombay, and 144.3 in Madras. Data for Bhopal and Delhi are as yet provisional. Rural cancer registry data are not yet available for publication.

The Inter registry Panel of Pathologists has recently begun to study a single year's data from the NCRP for a specific cancer. This year's report includes information on histologic types of cervical cancer in India from the registry centres for the first time.

Automation and expansion in the registries has been a recurring topic for discussion. While most registries are automated, a clear need to convert from the existing CPM to the more widely accepted MS-DOS system has been indicated. This will be done in a phased manner.

Information from the NCRP has provided support to the National Cancer Control Programme and the various State Cancer Control Programmes. Annual Review Meetings including the various WHO experts - Profs. M. Hakama and T. Hirayama, the Steering Committee members, the various Project Chiefs and registry staff, Technical Wing and Operational Wing staff contribute to better communication and functioning among all. I thank them all, and Dr. L.D. Sanghvi, Project Consultant, for their cooperation and support in making the NCRP possible.

USHA K. LUTHRA ADDL. DIRECTOR-GENERAL ICMR

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PART I CONSOLIDATED REPORT

Chapter 1 Introduction

2-5 Hospital Data

6 Population Data

PART I

The fundamental objective in science is maximum economy in the accurate description of nature.

- E.A. MURPHY. 1976

1. INTRODUCTION

The National Cancer Registry, a Project of the Indian Council of Medical Research (ICMR), was initiated in February 1980 when the ICMR formulated its expanded programme in cancer research. From 1982, ICMR supported the existing Bombay Cancer Registry founded in 1963 by the Indian Cancer Society, and established two new population-based cancer registries at Bangalore and Madras. Criteria for selecting the latter two centres were their ability to coordinate a population-based cancer registry system around a hospital medical records department in operation for several years. Simultaneously three hospital registries were organised in places of special epidemiological interest. These were the PostGraduate Institute of Medical Education & Research, Chandigarh; Assam Medical College, Dibrugarh; and Regional Cancer Centre/Medical College, Trivandrum. A Coordinating Unit with Operational Wing in Delhi and Technical Wing in Bombay was also set up to liaise the various activities of these registries. A Steering Committee was constituted to monitor the progress of the registry programme. WHO consultants were invited to advise the Coordinating Unit and the ICMR by visiting the registries and participating in the annual review meeting and in other ways. Necessary staff to run the registries efficiently was sanctioned by the ICMR. Ongoing programmes for their training and continuing education were developed. Registry Chiefs with senior staff members of the coordinating unit, steering committee and WHO consultants meet annually to review the project and its progress.

The registries started uniform collection of minimum date using a pre-designed proforma from 1st January, 1982. Separate proformas for population-based and hospital registries were adopted from January 1, 1984. Three more hospital registries in the base hospitals of the population registries at Kidwai Memorial Institute of Oncology, Bangalore; Tata Memorial Hospital, Bombay; and Cancer Institute, Madras - were supported and started uniform data collection from January 1, 1984. Two new population-based cancer registries were established to collect data from January 1, 1986; - at Institute Rotary Cancer Hospital, New Delhi and at Gandhi Medical College, Bhopal. The registry at Bhopal is a special cancer registry set up in the aftermath of the MIC gas tragedy in December, 1984. A rural population-based cancer registry at Barsi in Sholapur District of Maharashtra State started collecting data from July, 1987 to study the incidence of cancer in a rural population of the country. The present report does not include the data of this registry. The map on page - shows the location of these 12 registries and the Coordinating Unit.

Cancer Registration and Cancer Control

The broad purpose of cancer registration is to assess the load of malignancies in the community. Hospital and population-based cancer registries complement each other and consequently have common areas with differing emphasis in organisation, operation & areas of possible research. In the short-term, this Project aims to provide reliable data on incidence and mortality rates of cancers according to sex, age, ethnicity, language, cultural subgroups etc; on the types of cancer diagnosed in a hospital; stage of the disease when patients are diagnosed, treatment patterns, and outcome. The long-term objective, however, is to provide a research base for a National Cancer Control Programme, viz. (i) primary prevention, (ii) early detection, (iii) effective treatment (iv) survival rates (v) health care infrastructure and to monitor and evaluate such a programme. These registries are active so that registry staff regularly go to original sources and interview cancer patients whenever necessary to elicit desired information. The information from both population & hospital registries is collected on a standard proforma.

All registries are required to report all malignant neoplasms as defined in the ICD-O and ICD-9. Each registry is required to consolidate all data concerning an individual cancer case, with the exception of duplicate information, into one abstract. The abstracted data on all the cancer patients are sent to the Technical Wings by the PBCRs and HCRs. The data so received are scrutinised for internal consistency, legitimate data codes, subjected to strict quality control checks, processed and tabulated, using a microcomputer.

Population-based registries mainly assess the magnitude of cancer in the community and some aspects of epidemiology by providing both denominators and numerators although numerators are of poorer quality than in hospital registries. Patients are registered from the main cancer hospital, other general hospitals, and private nursing homes. Death certificates are also scrutinised. Each registry is required to register all cancer patients resident in the area, and record all death certificates wherein cancer is mentioned of residents dying within or outside the area. "Resident" is defined as a person continuously living in the defined geographic area for one year or more.

Hospital registries primarily assess cancer patient care in hospitals, and help evaluate treatment. Their data has high quality numerators but unknown denominators, and are valuable from a clinical epidemiology perspective. The data are limited by selection bias of patients who attend a certain hospital, and the relative frequencies that result do not represent all the cancer in a geographical region. Data focus on diagnostic procedures, extent of disease, treatment modalities, follow-up, and patient outcome in addition to demographic information.

Cost of Registration

The Indian Council of Medical Research provides a basic budget to the registries for staff, contingencies, and equipment. Infrastructural facilities and services are provided by the institutions where the registries are located. The grants vary from registry to registry.

The cost of registering each PBCR case currently is about Rs 120 in Bangalore, Rs.70 in Bombay and Rs.90 in Madras. The cost per HCR case is about Rs. 92 in Chandigarh, Rs. 184 in Dibrugarh and Rs. 62 in Trivandrum, and only about Rs.11 in Bangalore, Rs. 7 in Bombay and Rs. 14 in Madras.

Present Report

This is the fifth Annual Consolidated Report of the National Cancer Registry Project. The data to be organized and presented has increased as the registry has grown. Therefore, it was decided to have an alternating focus for each year's report - hospital registries one year and population registries, the next. Accordingly the focus of this year's report is the hospital registry data, which Dr. S. Krishnamurthy describes in chapters 2 to 5 of Part I with criticisms & comments from Dr. L. D. Sanghvi. The chapter on the population data is prepared by Mr. D.K. Jain. Part II presents detailed tabulations of the HCR data of all the registries.

There is greater awareness, today, of the predominance of tobacco-related head and neck cancers in our country and the need to understand their epidemiology better for prevention and control. It has become clear therefore, that the existing classification of these cancers by the ICD9 3-digit code, as done so far, is not satisfactory, since the 3-digit code does not permit classification with anatomic and biologic accuracy as defined by the UICC. This year, for the first time, detailed tabulation by the ICD9 4-digit rubric of cleaned data on head & neck cancers have been provided, and clinical epidemiologic parameters of these cancer patients analysed according to 4th digit classification.

Another first this year is the presentation of data on histologic types of a cancer. This is the second year that the InterRegistry Panel of Pathologists affiliated with each registry have studied slides of representative cases of a particular cancer from the entire registry. Data of histologic types of cancer cervix in the 1985 data is presented in this report in the chapter on Breast & Cervical Cancers.

This year saw several changes in the Technical Wing. The statistician Mr. D.K. Jain responsible for data cleaning and tabulation until May-June, 1988 moved to New Delhi on 22 June 1988, and the statistical assistant Ms. Joshi left in July 1988 for training in the U.S. New computer programmes to clean and organize the data had to be developed afresh as of June 1988. Much of the committment, dedication and hard work required for this major task was put in by Ms. C. Stewart, Ms. V Krishnan and Dr. S. Krishnamurthy who guided and directed them. Further, the typing and artwork needed to make this report a reality was done by Mss. Krishnan, Stewart, and by Messrs. Gujarathi & Chavan under Dr. Krishnamurthy's direction. The chapters on the HCR data in Part I and tabulations in Part II of this report are therefore truly the result of team work at the Technical Wing in Tata Memorial Hospital, Bombay.

L.D. Sanghvi Consultant, NCRP

2. THE HOSPITAL CANCER REGISTRY PATIENTS

This chapter provides a profile of the number of patients in the HCRs over the years, their age, gender, and a ranking of the most frequent cancers in each registry. Its objective is to provide the context for the analyses in the subsequent three chapters, of diagnosis, cancer extent, treatment and condition at discharge of all cancer patients, and the leading cancers in each gender group.

2.1 NUMBER OF CASES REGISTERED

The number of cases registered in each hospital cancer registry from 1984 to 1986 are show in Table 2.1. In general, more cancer cases-about 4,500 to 12,500 - are registered

Table - 2.1 Number of Patients Registered - All Cancers
HCRs, 1984 to 1986

Registry Type & Place		1984	1985	1986	Cumulative 1984 to 1986
GENERAL HOSPITAL F	REGISTRIES				
Chandigarh	Male	1206	1143	1090	3439
	Female	1220	1285	1325	3830
	Sub Total	2426	2428	2415	7269
Dibrugarh	Male	863	856	928	2647
3	Female	335	355	385	1075
	Sub Total	1198	1211	1313	3722
Trivandrum	Male	2097	2067	2297	6461
	Female	1755	1790	1935	5480
	Sub Total	3852	3857	4232	11941
CANCER CENTRE REC	GISTRIES				
Bangalore	Male	2260	2757	2874	7891
	Female	2733	3020	3152	8905
	Sub Total	4993	5777	6026	16796
Bombay	Male	5744	6537	6939	19220
	Female	4871	5465	5508	15844
	Sub Total	10615	12002	12447	35064
Madras	Male	1807	1985	2046	5838
	Female	2166	2359	2408	6933
	Sub Total	3973	4344	4454	12771

at cancer-centre registries (Bangalore, Bombay, Madras) than in the largely general hospital registries (Chandigarh, Dibrugarh, Trivandrum) where around 1200 to 4500 cases are included. These two groups of registries show differences in number of cancer patients registered, in treatment patterns and in outcome at discharge. Trivandrum alone shows a tendency towards the cancer-centre-based registries as expected by its location in the

Regional Cancer Centre (although its case material is derived from the Medical College Hospital and other Hospitals under its aegis, as well). Generally, there is a continuous increase in the number of cancer cases registered from 1984 to 1986 in all the registries except Chandigarh where there is a slight decline in male registrations.

2.2 GENDER & AGE (See Tables 2.1, 2.2a and b, and Fig. 2.2)

Females slightly outnumber males in Bangalore, Chandigarh and Madras, and males exceed females marginally, in Bombay and Trivandrum. Males markedly exceed females in Dibrugarh. Thus, in the HCR dataset as a whole, (see Table 2.2b) there is a small excess of males over females, with male:female ratios of 1:1 from 1984 to 1986. Female preponderance of registered patients is due to high frequencies of cervical cancer in Bangalore, Chandigarh and Madras.

Figure 2.2 MALE: FEMALE RATIO OF ALL CANCER PATIENTS
Hospital Cancer Registries, 1984-86

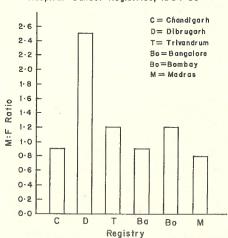


Table - 2.2a Male:Female Ratios - HCRs, 1984 to 1986

Registry	1984	1985	1986	Cumulative 1984 to 1986
Chandigarh	1.0	0.9	0.8	0.9
Dibrugarh	2.6	2.4	2.4	2.5
Trivandrum	1.2	1.1	1.2	1.2
Bangalore	0.8	0.9	0.9	0.9
Bombay	1.2	1,2	1.3	1.2
Madras	0.8	0.8	0.9	0.8

Table - 2.2 b Total Number Patients & Male:Female Ratios HCRs, Cumulative 1984 to 1986

	General Hospital Registries	Cancer Centre Registries	Overall
Male	12,547	32,949	45,653
Female	10,385	31,682	42,229
Total	22,932	64,631	87,882
Male:Female	1.2	1.0	1.1

Median ages of registered patients have uniformly been around 50-54 or 55-59 years in men and about five years earlier, in women.

Sources of Registration as documented by the registries are of value only in the general hospital registries where patients with many other diseases besides cancer are admitted so that identifying cancer patient sources is important. In contrast cancer centres by definition largely admit patients suspected to have cancer and identifying sources of patients may be of less value. Within each registry, sources of male/female registrations do not vary much. Neither are annual variations marked over the years from 1984. As expected radiotherapy departments provide the bulk of registrations, followed by surgical departments. Interestingly, pathology departments are not apparently a major source of case material.

2.3 LEADING CANCERS IN THE HOSPITAL REGISTRY PATIENTS

The 1986 data has been tabulated in Part II of this report, both according to the ICD9 three-digit rubric and for the upper aerodigestive tract cancer sites according to the 4th digit of the ICD9 code. Studies since many years in this part of the world have shown* that upper aerodigestive tract cancers are the most common in frequency and in incidence in men, and among the major cancers in women. The UICC definition for these tobacco-related cancer sites of the head and neck are as follows: Oral Cavity includes all structures in the mouth, the mucosa of the lip, anterior two-thirds of the tongue, but excludes the base (posterior two-thirds) tongue, soft palate and uvula which are biologically related to the oropharynx (see Fig 5.1).

The base tongue, soft palate and uvula are coded only to 4th digit subcodes of the main ICD9 3-digit codes. Since base tongue belongs biologically to the oropharynx, to assess the true frequency of oral vs pharyngeal vs other cancers, 4th digit subclassification is necessary. Although done in a limited way for the first NCRP report, for practical purposes it has not been available till now. In assessing the relative frequency of oral cavity and pharyngeal cancers, in this report, they are therefore defined according to the 4th digit rubric of ICD9 codes for the anatomic locations contributing to the oral cavity and the oropharynx.

Table 2.3.1 : Comparison of Ranking When Sites Classified by ICD9-3 - Digit or 4 - Digit Code

3 - Digit	Registry	ible - 2.2a Mala	4 - Digit
1. Lung 2. Tongue 3. Esophagus	CHANDIGARH		Pharynx Lung Esophagus
 Esophagus Hypopharynx Oropharynx 	DIBRUGARH		Pharynx Esophagus Primary Unknown
 Lung Other Mouth Tongue 	TRIVANDRUM		Oral Cavity & Lip Lung Pharynx
 Esophagus Hypopharynx Lung 	BANGALORE		 Pharynx Esophagus Lung
 Tongue Hypopharynx Esophagus 	BOMBAY	12,547	Pharynx Oral Cavity & Lip Esophagus
 Esophagus Hypopharynx Mouth NOS 	MADRAS		Pharynx Oral Cavity & Lip Esophagus

^{*} Sanghvi LD: J Cancer Res Clin Oncol, 99: 1-14; 1981

2.3.1 Ranking According to ICD9 three digit code and ICD9 four digit code

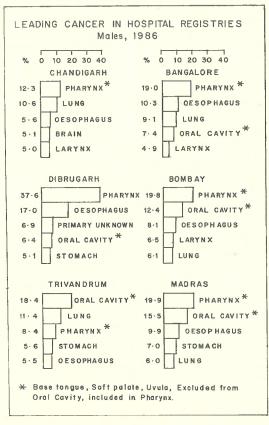
Changes in rank of leading cancers in males by using the 4-digit ICD9 code instead of the 3-digit code are shown in Table 2.3.1 The leading, and sometimes the second, cancer in frequency, changes in all registries, when the more anatomically accurate 4th digit ICD9 code is used to define the oral cavity and the pharynx. One note of caution; cases coded to "lip", are included with "oral cavity" for two reasons. One, their numbers are very small and unlikely to have any impact on the relative frequencies. Second, lip cancers in this country are most often of the angle of the mouth or the labial commissure, often involved by a buccal mucosal cancer which would belong to the oral cavity anyway.

A similar comparison for cancer in females shows that the only major change occurs in the second most frequent cancer in Bangalore which becomes oral cavity, instead of breast when only the 3-digit code is used.

2.3.2 a Leading Cancers in Males in 1986

Pharyngeal cancer leads in all registries except Trivandrum where it is third. Dibrugarh registrations include nearly 40% pharyngeal cancer, - one of the highest frequencies worldwide, of these cancers. Cancers of the oral cavity are number one in Trivandrum, and are among the first five in the remaining registries except Chandigarh. Lung cancer is second in Trivandrum and Chandigarh but is also within the first five cancers everywhere except Dibrugarh. Overall, assuming oral, pharyngeal, laryngeal, esophageal, and lung cancers are related causally to tobacco use in one form or another (chew, smoke bidi, cigarette, apply mishri, etc.) anywhere from around 28% cancers in males in Chandigarh to over 50% in Dibrugarh and Bombay are tobacco-related. (See Fig. 2.3.2a)

Management of these patients poses immense problems, and obviously, control of tobacco use is the single most important need in any aspect of cancer control.



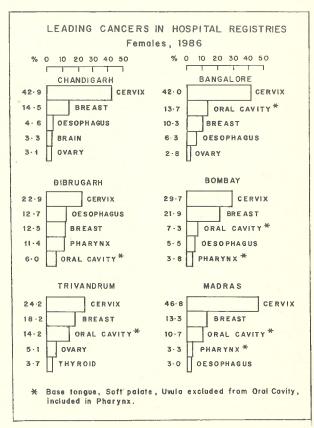


Figure 2.3.2a

Figure 2.3.2b

2.3.2b Leading Cancers in Females in 1986 (See Fig. 2.3.2b)

Classifying the head & neck aerodigestive cancers into their accurate categories by the 4th digit ICD9 rubric yields as much of interest in females as in males. In all the registries, cervix leads. Breast cancer is second in all the registries except in Bangalore and Dibrugarh where it is third. The second most frequent cancer in Bangalore is oral cavity as mentioned above and esophagus in Dibrugarh. Points to note are the narrow gap in frequency between cervix at number one and breast at number two, in Trivandrum (6%) and Bombay - Tata Hospital (8%). This may relate to the decline in the incidence of cervical cancer and a slight increase in cancer of the breast as has been shown in the Bombay PBCR reports. In Bombay this may also relate to the fact that the Tata Hospital's patients come not only from Bombay city but from much of Maharashtra and from the rest of India where cervical cancer exceeds breast in incidence. In Trivandrum, it may reflect a truly higher incidence of breast cancer. Kerala which contributes most of the Trivandrum registry patients, has the highest female literacy rate, socioeconomic status and lowest brith rate in the nation. It may well be that reproductive risk factors associated with breast cancer are more prevalent in these women than risk factors of cervical cancer. Other points of interest are the inclusion of thyroid cancer in the first five cancers in Trivandrum, and the first ten in the other registries except Chandigarh. The high frequency of tobacco-related upper aerodigestive tract cancers even in registries like Trivandrum, Bombay, Madras, where reproductive system cancers lead in frequency suggests control of tobacco use will affect not only the management and occurence of cancers in males but also in females, although to a lesser degree.

3. ALL CANCER PATIENTS IN THE HOSPITAL REGISTRIES

This chapter presents an overview of diagnosis, extent of spread, treatment, and discharge status of all cancer patients registered in the six hospital cancer registries (HCRs) for 1986.

3.1 DIAGNOSTIC METHODS

Table 3.1 presents the frequencies of microscopic diagnoses which range from 83% to 97% except in Madras where they are around 70%. In general, data on cancer diagnosis is of a high order of reliability. A slightly higher frequency of microscopically diagnosed cancers in females in most registries may be due to the ease of sampling the cervix for a cellular or tissue diagnosis since cervix is the leading cancer in females in all registries (see Ch 2).

Table 3.1 : All Cancer Patients - Microscopic Diagnoses

(ICD 140-208) - HCRs, 1986

	M	ALE	FEM	IALE
Registry	Total Patients T	MV* %	Total Patients T	MV* %
Chandigarh	1090	94	1325	97
Dibrugarh	928	86	385	84
Trivandrum	2297	83	1935	89
Bangalore	2874	90	3152	96
Bombay	6939	93	5508	94
Madras	2046	72	2408	71
Total	16174	89	14713	90

^{*} MV = Microscopically Verified

3.2 METHOD USED IN ANALYSIS OF CANCER EXTENT, TREATMENT, AND CONDITION AT DISCHARGE

Table 3.2 presents an overview of the method used in analysing the patterns of cancer extent, treatment, and condition at discharge of treated patients in the hospital registry data for 1986. The first two columns present Total numbers of patients (T) in each registry and overall, for both gender groups.

From these, patients who cannot be evaluated for extent of disease patterns are identified. These patients are labelled "Other" in terms of Extent of Disease. They consist of six categories of patients. They are those previously treated, or treated elsewhere than in the reporting institution, or with recurrent or impalpable cancers; those with nonsolid eg. hematologic malignancies which do not lend themselves to the AJC classification; and those for whom extent of disease data is not known. The entire group of "Other" Patients (n) is

subtracted from Total patients (T) to yield the Number of patients (N), whose data is analysed for extent of disease or cancer spread at diagnosis. Thus T = n+N.

Table 3.2 : Patient Numbers as analysed for Cancer Extent, Treatment, & Condition at Discharge
All Cancers, HCRs, 1986

Registry	pa	otal tients (T)	Evalu	ents not lated for "Other" (n)	Evalua	ients ated for OD N)	The state of the s			NED & Regressed	
alemmeth saar	М	F	М	" F	M	F	М	F	М	F	
Chandigarh	1090	1325	228	283	862	1042	711	888	578	752	
Dibrugarh	928	385	264	110	664	275	583	248	367	143	
Trivandrum	2297	1935	457	499	1840	1436	1442	1206	786	851	
Subtotal	4315	3645	949	892	3366	2753	2736	2342	1731	1746	
Bangalore	2874	3152	689	564	2185	2588	1280	1413	702	851	
Bombay	6939	5508	2544	2138	4395	3370	2593	2170	1996	1827	
Madras	2046	2408	513	405	1533	2003	849	1166	780	1110	
Subtotal	11859	11068	3746	3107	8113	7961	4722	4749	3478	3788	
Overall Total	16174	14713	4695	3999	11479	10714	7458	7091	5209	5534	

^{*} EOD = Extent of Disease; Other Group = Patients treated prior to registration or treated elsewhere; or with impalpable or hematologic or recurrent cancers; or unknown extent of disease data; NED = No Evidence of Disease

Treatment patterns are examined only among these patients (N) described above. They are classified into three groups of extent of cancer spread, described in the next section. The major patterns are "Treated" and "Not Treated". Since only a proportion of patients are usually treated, the number of patients who receive cancer-directed treatment, i.e. "Treated patients" - for both genders, in each registry, and overall, is presented in the next two columns. "Not Treated" patients include those noncompliant, or nonaccepting of treatment, or patients with "Unknowns" in this data item.

The patients' Condition at Discharge after the first planned cancer-directed treatment is the only available measure of therapeutic effectiveness at the present time in the registry data. This is examined only for Treated Patients who are analysed for Extent of Disease. Obviously, discharge data has relevance only if treatment has been given and in any case, is of limited value in assessing longterm therapeutic effectiveness. The last column describes patients whose condition shows NED (No Evidence of Disease) and Regressed cancer, at discharge.

The data in this and the final table 3.6 are discussed at the end of this chapter.

3.3 CANCER EXTENT PATTERNS

This information, patterned on the AJCC (American Joint Committee on Cancer staging) classification of cancers as localised, regionally spread and distantly spread or disseminated or advanced, is meant for solid cancers, and does not address the unique staging features of hemopoietic malignancies. Data from the UICC devised Tumour, Node, Metastasis - TNM - system is not uniformly entered in the six registries. Further, the 3-digit code that exists for TNM in the presently used HCR form does not easily permit for alphanumeric data entry which is needed. TNM data is not, therefore, studied for this report.

3.3.1 Patients Not Evaluated for Extent of Disease - "Other Group"

Data which cannot be used to accurately assess the extent of cancer at first diagnosis are described in Section 3.2. Care has been taken to exclude previously treated patients as coded in item 17 and in item 24(a) of the current HCR proforma. Table 3.3.1 and and Fig. 3.3.1 show patients categorised as "Other" under Extent of Disease. Inter-registry variation in the percentages of these patients is another reason to exclude them from extent of disease assessments.

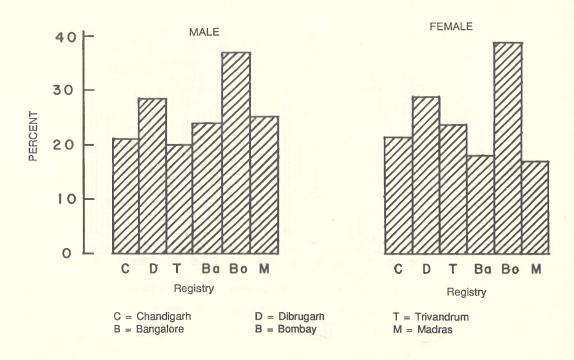
From 20-37% males and 17-39% females in different registries in 1986 are in this group. In Bombay, 37% males and 39% females in this group probably reflect the large referral patient population, many with recurrent cancers.

Table 3.3.1 : Patients Not Evaluated for Extent of Disease-"Other" Group* - All Cancers HCRs, 1986

Registry Total		Ma	ale	Total	Female	
	Patients	Other (Group	Patients	Other C	aroup
	*	n	%		n	%
Chandigarh	1090	228	20.9	1325	283	21,4
Dibrugarh	928	264	28.4	385	110	28.6
Trivandrum	2297	457	19.9	1935	499	25.8
Bangalore	2874	689	24.0	3152	564	17.9
Bombay	6939	2544	36.7	5508	2138	38.8
Madras	2046	513	25.1	2408	405	16.8

^{*} Patients treated prior to registration or treated elsewhere; or with impalpable or hematologic or recurrent cancers; or unknown extent of disease data

Figure 3.3.1: PATIENTS NOT EVALUATED FOR EXTENT OF DISEASE
- OTHER GROUP - IN ALL CANCER PATIENTS
HCRs, 1986



3.3.2 Extent of Disease of Cancer patients after Excluding "Other" Group:

Patients categorised to have Localised, Regionally Spread, or Advanced (syn. Disseminated) cancer are thus determined after excluding patients in the "Other" group as described in Section 3.2, Tables 3.2, and 3.3.1. Categories are defined as follows: Localised means cancers localised to the organ or tissue of origin of the neoplasm; regionally spread includes regional lymph node metastases, and extension into contiguous tissue structures from the site of origin; it includes Locally advanced cancers or Loco/Regional disease in current oncologic parlance. Advanced means Distantly Metastasized cancers or those labelled "Too Advanced", in the patient's chart.

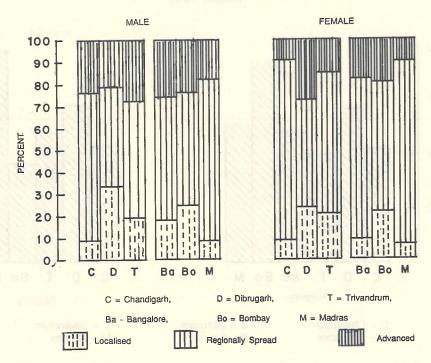
Data are shown in Table 3.3.2 and Fig. 3.3.2.

Table 3.3.2 : Extent of Disease* - All Cancers HCRs, 1986

Registry	Evalu	Patients lated for Disease	Localised %			onally ad %	Adv	Advanced %		
	Male	Female	Male	Female	Male	Female	Male	Female		
- 13 TS	288			0.05	255					
Chandigarh	862	1042	8.9	9.4	76.8	81.3	14.3	9.3		
Dibrugarh	664	275	33.6	23.6	45.0	48.7	21.4	27.6		
Trivandrum	1840	1436	19.1	20.8	53.1	64.3	27.8	15.0		
17.9	466	3162			288	70.0	00.5	10.5		
Bangalore	2185	2588	18.1	9.2	55.5	72.3	26.5	18.5		
Bombay	4395	3370	24.5	21.8	51.4	58.8	24.1	19.4		
Madras	1533	2003	8.7	6.7	72.6	84.0	18.7	9.2		

^{*} After excluding patients not evaluated for cancer spread: Other group

Figure 3.3.2: EXTENT OF DISEASE - ALL CANCERS excluding Patients not evaluated : Other Groups HCRs, 1986



Anywhere from 9-34% male and 7-24% female patients in 1986 have localised cancers. Higher frequencies of around 20-25% localised cancers in both gender groups in the Bombay hospital registry may reflect the existence of the Tata Memorial Hospital since 1941 in the city with a resulting greater awareness of cancer in its populace.

About a half to three-fourths of male and slightly more female patients have cancers regionally spread/locally advanced at first diagnosis. Figures are least in Bombay and Dibrugarh where many of these patients may be classified as Localised or Advanced. Their frequencies are highest in Chandigarh and Madras where advanced and localised cancer frequencies are least. Female percentages are higher than male within each registry, most prominently in the south Indian registries at Bangalore, Madras and Trivandrum perhaps because of the common occurrence of cervical cancer. Advanced cancer frequencies are higher in males than females in all registries except Dibrugarh, where the number of female patients is also least.

Differences in recording, coding and "staff" factors between the registries rather than a real difference in stage of cancer at diagnosis may well be the reason for these differences. Until we know that extent data is obtained or recorded in the same way in all centres, it may be wise to refrain from drawing firm conclusions.

3.4 TREATMENT PATTERNS OF PATIENTS ACCORDING TO THE EXTENT OF SPREAD OF THEIR CANCERS

Cancer therapeutic decisions are usually based on the extent of cancer at first diagnosis. The patterns of cancer treatment therefore are analysed only in patients evaluated for extent of disease.

Tha data are presented in Tables 3.4a & b, and Figs. 3.4 a-c.

A few major points emerge:

- i) Treatment patterns are distinct in the two types of reporting institutions, regardless of patient gender or degree of cancer spread. In the general hospitals cancer—directed treatment is given to a larger proportion of patients (by 10 to 30%) compared to cancer centres.
- ii) The frequencies of treated patients are lower with increasing dissemination of disease assuming that dissemination follows a stepwise pattern as envisaged when the AJC classification was developed. This as we know, may not always be the case. This treatment pattern is observed in both the gender groups and types of institutions.
- iii) Around 5% more females than males with localised cancers get treated. Treated males with advanced cancers are higher in frequency than females in most registries. Reasons for this are not clear but may include general societal biases in favour of males, more apparent when the cancer is advanced.
- iv) Finally, around 10% unknown data for treatment in the reporting institution in some registries need explaining. It may indicate a need for improved record keeping in the institution.

Table 3.4a: Treatment Patterns according to Extent of Spread - All Cancers
HCRs, Males, 1986

remerial Hospital since	GENERAL	HOSPITAL RE	GISTRIES	CANCER	CENTRE REC	SISTRIES
populace.	Chandi- garh	Dibru- garh	Trivan- drum	Banga- lore	Bombay	Madras
LOCALISED CANCERS N	77	223	351	395	1078	133
Treatment Status %	ilegol es l					
Treated	95	93	82	60	72	61
Not Treated	5	6	17	15	8	39
Treatment not accepted	0	0	0	18	21	0
Unknown	0	al quincer.	alvier in co	8	0	0
REGIONALLY SPREAD N	662	299	977	1212	2257	1113
Treatment Status %						
Treated	84	89	84	63	64	59
Not Treated	16	11	14	16	10	41
Treatment not accepted	0	0	0	13	25	0
Unknown	0	0 0	2	8	islw edityen	0
ADVANCED CANCERS N	123	142	512	578	1060	287
Treatment Status %						
Treated	68	77	65	49	35	37
Not Treated	32	22	28	37	39	63
Treatment not accepted	0	0	0	6	24	0
Unknown	0	1	8	9	2	0

Table 3.4b : Treatment Patterns according to Extent of Spread – All Cancers HCRs, Females, 1986

	GENERA	AL HOSPITAL	REGISTRIES	CANCE	ER CENTRE	REGISTRIES
nstitutions, regardless	Chandi- garh	Dibru- garh	Trivan- drum	Banga- lore	Bomba	y Madras
LOCALISED CANCERS	N 98	65	298	237	736	135
Treatment Status	%					
Treated	98	97	87	61	81	73
Not Treated	2	3	13	16	7	27
Treatment not accepted	0	wis lon vo	O CONTRACTOR	16	12	0
Unknown	0	0	0	7	0	ado al monac
REGIONALLY SPREAD	N 847	134	923	1871	1981	1683
Treatment Status	%					
Treated	87	92	88	58	68	59
Not Treated	13	8	11	18	10	41
Treatment not accepted	0	0	0	8	21	0
Unknown	0	0	2	16	0	0
ADVANCED CANCERS	N 97	76	215	480	653	185
Treatment Status	%					
Treated	56	82	65	40	34	38
Not Treated	44	18	27	41	41	62
Treatment not accepted	0	0	0	6	23	0
Unknown	0	0	8	13	2	0

3.4a: TREATMENT STATUS OF PATIENTS WITH LOCALISED CANCERS HCRs, 1986

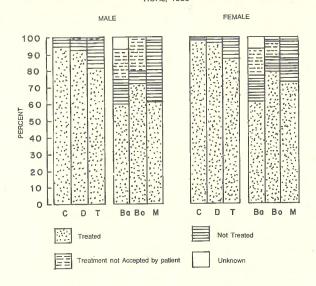
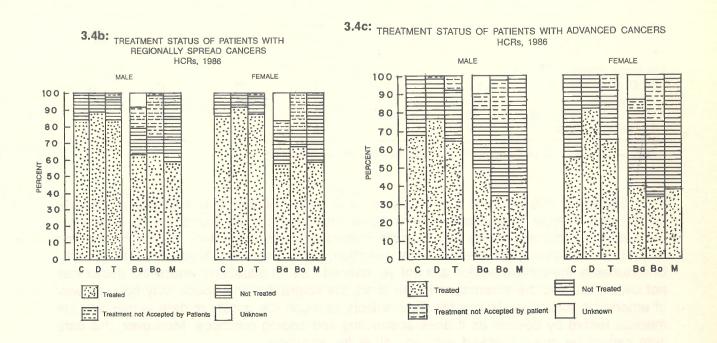


Figure 3.4.a-c



3.5 CONDITION AT DISCHARGE OF TREATED PATIENTS ACCORDING TO THE EXTENT OF SPREAD OF THEIR CANCERS

Tables 3.5a & b and Figs. 3.5 a-c present the data.

Table 3.5a: Condition at Discharge of Treated Patients according to Extent of Spread - All Cancers
HCRs, Males, 1986

		GENERAL	HOSPITAL F	REGISTRIES	CANCER	CENTRE RE	GISTRIES
		Chandi- garh	Dibru- garh	Trivan- drum	Banga- lore	Bombay	Madras
LOCALISED CANCERS	N	73	208	287	235	773	81
Discharge Status	%						
NED*, Regressed		96	95	77	68	90	94
Unchanged		4	3	8	20	3	2
Prog, Too Adv, Died		0	2	10	12	6	4
Unknown & Other		0	0	6	0	1	0
REGIONALLY SPREAD	N	554	265	824	763	1445	661
Discharge Status	%						
NED, Regressed	70	83	62	60	61	80	93
Unchanged		17	23	19	13	7	3
Prog*, Too Adv*, Died		0	10	18	23	12	4
Unknown & Other		0	5	3	3	1	0
ADVANCED CANCERS	N	84	110	331	282	375	107
Discharge Status	%						
NED, Regressed		57	6	22	26	37	82
Unchanged		41	32	38	21	17	9
Prog*, Too Adv*, Died		2	57	36	52	46	9
Unknown & Other		0	5	4	1	0	0

^{*} NED = No Evidence of Disease; Prog = Progressed, Adv = Advanced

Codes for this variable in the current HCR proforma are: No evidence of disease (NED) and Cancer Regressed - to indicate improved patient condition at discharge; Unchanged to indicate Status quo; Cancer Progressed, was Too advanced, or Patient died to indicate worsening of the patient's condition, and Unknown data or Other specify. Unfortunately the clinical entries are not yet defined - i.e. in situations where the doctor has not clearly entered the information in the chart, the abstractor and coder may have no way of entering it accurately. Hence the data reflects as much the quality of data entries into the medical record by doctors as it does abstracting and coding practices. Moreover, this data item cannot be cross checked with any other for accuracy.

These limitations in the data limit interpretations of findings which are nevertheless, interesting and may be, plausible. Where the patient was treated as an outpatient, the data implies his/her condition at the end of the first planned cancer-directed treatment in the hospital. The data examines only those patients with a solid malignancy who are treated for

3-5a: CONDITION AT DISCHARGE OF TREATED PATIENTS WITH LOCALISED CANCERS HCRs, 1986

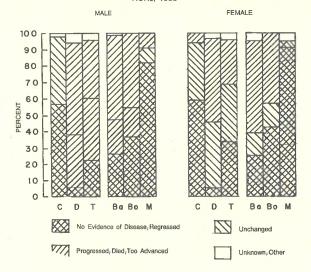


Figure 3.5a-c

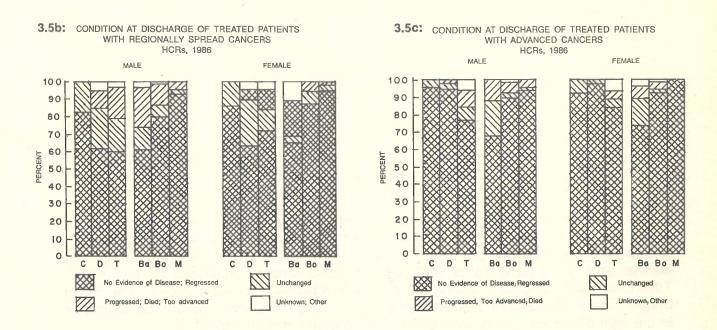


Table 3.5b : Condition at Discharge of Treated Patients according to Extent of Spread - All Cancers HCRs, Females, 1986

	GENERAL H	OSPITAL RE	EGISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandi- garh	Dibru- garh	Trivan- drum	Banga- lore	Bombay	Madras
				15 // 1 of		
LOCALISED CANCERS N	96	63	258	144	596	98
Discharge Status %						
NED*, Regressed	93	98	85	74	93	100
Unchanged	7.	2	5	16	2	0
Prog, Too Adv, Died	0	0	5	7	4	0
Unknown & Other	0	0	6	3	1	0
REGIONALLY SPREAD N	738	123	809	1078	1355	998
Discharge Status %						
NED, Regressed	86	63	72	65	87	95
Unchanged	14	27	12	4	6	3
Prog, Too Adv, Died	0	6	12	20	6	2
Unknown & Other	0	4	4	11	0	0
ADVANCED CANCERS N	54	62	139	191	219	70
Discharge Status %						
NED, Regressed	59	5	33	25	42	91
Unchanged	35	40	36	14	15	4
Prog, Too Adv, Died	6	52	27	57	43	4
Unknown & Other	0	3	4	4	0	0

^{*} NED = No Evidence of Disease; Prog = Progressed, Adv = Advanced

the first time in the reporting institution. Major points to emerge:

- i) It is essential that Discharge data (Tables 3.5) and Treatment data (Tables 3.4) be studied in conjunction with each other. There are high proportions of No Evidence of Disease (NED) and Regressed cancers in some registries with lower frequencies of treated patients. This is especially true in some cancer centres. This may reflect a selection bias which should be kept in mind while interpreting the data.
- ii) The cancer centre/general hospital dichotomy observed with treatment patterns is not as prominent. About 90-95% patients with localised cancers show NED or regression at discharge in Chandigarh, Bombay, Madras and Dibrugarh. Chandigarh, Bombay and Madras as a group have higher NED and regressed cancer frequencies than Dibrugarh, Trivandrum and Bangalore among patients with regionally spread cancers. The higher frequencies of NED and Regressed cancers at discharge in Madras need to be interpreted in the light of the lower frequencies of treated patients in that centre.

3.6 THE ROLE OF THE HCR DATA IN THE NATIONAL CANCER CONTROL PROGRAMME

Primary prevention of tobacco-related cancers, early diagnosis and treatment of cervical cancers, and the provision of adequate therapeutic services with pain relief are the three goals of the National Cancer Control Programme (NCCP). Fruitful efforts directed to

these goals should result in a long-term reduction in incidence and prevalence of tobaccorelated cancers, and in downstaging of, and improved survival from, those and cervical cancers.

HCR data as provided in this chapter and the next two chapters, are critical in supporting and monitoring the NCCP. Tables 3.2 and 3.6 provide a preliminary overview of the entire HCR dataset. The findings should be viewed with caution. Limitations include lack of uniformity in criteria used for evaluating extent of disease, definitions for condition at discharge; variations in available equipment, bed and therapeutic facilities between different centres; and still as yet unknown problems such as different patient-bed ratios in different centres. Please note that treated patients are only those identified from Patients Evaluated for Extent of Disease - i.e. "new-new" patients not treated elsewhere and without hematologic or impalpable malignancies. Hospitals treat many more "old" patients. The NED and Regressed figures relate only to patients who took cancer—directed treatment for the first time.

Despite these limitations, the main points that emerge are :

(i) There are about 35-40% nontreated patients in general hospitals and 55-60% such patients in cancer centres. As shown earlier in this chapter, 20-30% localised and 30-40% regionally spread cancer patients are not treated. Reasons for this include patient noncompliance and nonacceptance of treatment. The causes of these need elucidating. They may include fear and ignorance, logistic problems, overloaded facilities, etc.

Table 3.6 : Proportions of Patients Analysed for Cancer Extent, Treatment, & Condition at Discharge
All Cancers, HCRs, 1986

Registry	Number of Total Patients (T)		Patients not Evaluated for EOD (n)		Patients Evaluated for EOD (N)		Treated Patients		NED & Regressed	
	М	F	M %	F %	M %	F %	M %	F %	M %	F %
Chandigarh	1090	1325	21	21	79	79	65	67	53	57
Dibrugarh	928	385	28	29	72	71	63	64	40	37
Trivandrum	2297	1935	20	26	80	74	63	62	34	44
Bangalore	2874	3152	24	18	76	82	45	45	24	27
Bombay	6939	5508	37	39	63	61	37	39	29	33
Madras	2046	2408	25	17	75	83	41	48	38	46
Overall Total	16174	14713	29	27	71	73	46	48	32	38

⁽ii) Accurate assessment of staging and prevalence of cancers at diagnosis and at followup can be done through HCR data. Therepeutic services and efforts at early diagnosis and treatment can thus be monitored and assessed.

The immediate major need as clear from 1986 HCR data, is to determine and tackle the causes of patient noncompliance and nonacceptance of available therapy. This alone may contribute more to downstaging the leading cancers in males and females than does earlier diagnosis without adequate treatment facilities.

⁽iii) Once accurate follow-up data are available, therapeutic effectiveness can be assessed by survival rates, assessment of quality of life after diagnosis, etc.

4. BREAST & UTERINE CERVICAL CANCERS

Cervical and breast cancers are the first and second leading cancers in women in the HCRs in 1986, except in Dibrugarh where oesophagus is second and Bangalore where oral cavity is second, followed in each by breast in third place. Details are in Chapter 2. This chapter reviews the diagnosis, extent, treatment and condition at discharge of these cancers registered in the six HCRs for 1986, and of histologic types of cervical cancer in 1985.

4.1 NUMBER OF CANCERS AND THEIR DIAGNOSIS

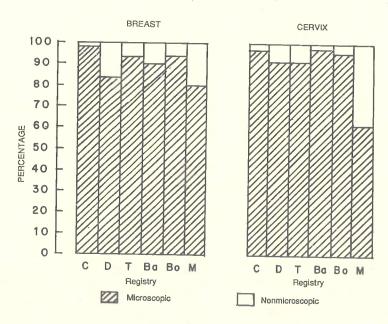
Information on the number of cancer cases and diagnosis from 1984 to 1986 is given in Table 4.1 and Fig. 4.1.

TABLE 4.1 : Patients' Number and Microscopic Diagnoses : Cancer Breast and Cancer Cervix
HCRs, Females, 1984-1986

		Total Patients		Breast			Cervix	
Registry &	Year	n n	n	(MV%)	%	n	(MV%)	%
Chandigarh	1984	1220	167	(96)	14	474	(96)	39
	1985	1285	182	(97)	14	570	(97)	44
	1986	1325	192	(100)	14	568	(99)	43
	1984-86	3830	541	(98)	14	1612	(97)	42
Dibrugarh	1984	335	33	(88)	10	62	(98)	19
3 054	1985	355	35	(71)	10	71	(94)	20
	1986	385	48	(90)	13	88	(84)	23
	1984-86	1075	116	(84)	11	221	(91)	21
-3 -м								
Frivandrum	1984	1755	286	(93)	16	457	(93)	26
	1985	1790	325	(93)	18	447	(90)	25
	1986	1935	352	(94)	18	468	(93)	24
	1984-86	5480	963	(94)	18	1372	(92)	25
Bangalore	1984	2733	286	(86)	10	1154	(97)	42
24	1985	3020	308	(91)	10	1288	(97)	43
	1986	3152	325	(93)	10	1325	(99)	42
	1984-86	8905	919	(90)	10	3767	(98)	42
32 23	25		T	95				
Bombay	1984	4871	972	(86)	20	1660	(96)	34
	1985	5465	1146	(96)	21	1750	(98)	32
	1986	5508	1205	(92)	22	1634	(96)	30
	1984-86	15844	3321	(91)	21	6044	(97)	32
Madras	1984	2166	306	(80)	14	1027	(63)	47
	1985	2359	306	(80)	13	1099	(56)	47
	1986	2408	313	(80)	13	1128	(66)	47
	1984-86	6933	925	(80)	13	3254	(61)	47

Cervical cancers contribute around 45% of cancers in each of Bangalore, Chandigarh and Madras; 30% in Bombay, 25% in Trivandrum, and 22% in Dibrugarh. Breast cancers comprise from 10-15% of all cancers in four HCRs, 18% in Trivandrum and 22% in Bombay. In Bombay and Trivandrum, although cervical cancer registrations exceed those of breast, the margin is the least of the six HCRs (See Ch. 2).

Figure 4.1 BREAST AND CERVICAL CANCERS
PERCENTAGES OF MICROSCOPIC DIAGNOSIS,
Females, 1984 - 86 HCRs



Some 85-95% breast cancers are microscopically verified in five registries and 80% in Madras. Microscopic diagnosis of cervical cancers range from about 90-99% in five registries and around 60% in Madras. Reasons for the low frequency of microscopic diagnosis in Madras need elucidating.

4.2 HISTOLOGIC TYPES OF CERVICAL CANCERS - INTER-REGISTRY PANEL OF PATHOLOGISTS STUDY

Histologic types of cancer cervix in India are of interest because of increasing adenocarcinomas reported, mostly from the west (1). Slides of cervical cancer cases registered in 1985 were studied by the InterRegistry Panel of Pathologists - a group of pathologists affiliated with each registry. Since such study requires cleaned, analysed data, it is not possible to study the previous year's data than that of the year being reported. Hence the use of 1985 rather than 1986 data. The following analysis is of data as registered, not as reviewed by the panel.

4.2.1 Diagnoses of Cervical Cancer, 1985

It is obvious that histologic types can be observed only in microscopically confirmed cases. Table 4.1 shows the microscopic diagnoses in the HCRs in 1985; - Madras stands out with 56% microscopic diagnoses against the background of 94-97% such diagnoses in the other five registries.

⁽¹⁾ Elliott PM, Tattersall MHN, Coppleson M, etal : Brit Med J, 1988, in press

4.2.2 Major Histologic Types of Cervical Cancer, 1985

These are shown in Table 4.2.2. Squamous cancers are over 90% of cervical cancers in all registries.

Table 4.2.2 : Major Histologic types of Cervical Cancer HCRs, Females - 1985

Registry		Chandi- garh	Dibru- garh	Trivan- drum	Banga- lore	Bombay	Madras
Microscopically diagnosed	N	553	67	401	1247	1712	611
Squamous Cancers	%	96	93	94	95	91	95
Non Squamous Cancers	%	3	7	6	5	8	5

4.2.3 Histologic Types of Squamous Cell Carcinoma Cervix in the HCRs, 1985

Table 4.2.3 presents this data. Some points are observed :

Table 4.2.3 : Histologic types Squamous Cell Carcinoma Cervix HCRs, Females - 1985

	Chandi-	Dibru-	Trivan- drum	Banga- lore	Bombay	Madras
	garh	garh	druill	ЮТӨ		Ronos
n	533	62	377	1186	1551	583
		Alphi in				
%	94	27	83	98	99.7	45
%	4	11	5	(7)	(5)	3
%	1.7	52	11	1.0	0	40
%	2	10	(4)	0	0	7
%	0	0	0	0	0	5
%	0	0	0	0	0	0
	% % % %	% 94 % 4 % 1.7 % 2 % 0	% 94 27 % 4 11 % 1.7 52 % 2 10 % 0 0	% 94 27 83 % 4 11 5 % 1.7 52 11 % 2 10 (4) % 0 0 0	% 94 27 83 98 % 4 11 5 (7) % 1.7 52 11 1.0 % 2 10 (4) 0 % 0 0 0 0	% 94 27 83 98 99.7 % 4 11 5 (7) (5) % 1.7 52 11 1.0 0 % 2 10 (4) 0 0 % 0 0 0 0 0

Figures in parentheses refer to actual numbers-too few for percentage calculation

- i) Registries with the most cases i.e. Bangalore and Bombay, label most cervical cancers "Squamous" without further specification as Keratinizing, and Nonkeratinizing (NK) small and large cell. The classification has prognostic relevance (1) and is accepted worldwide (2). Chandigarh and Trivandrum also record high frequencies of cancers recorded as Squamous, Not otherwise specified. Registries with fewer cases, relatively, ie Madras, Dibrugarh, do use the WHO classification.
- ii) Unless a prognostically relevant, internationally accepted classification is used, studies of survival for carcinoma cervix cannot be correlated with histology.
- iii) Where the WHO classification is used, i.e. Madras and Dibrugarh, NK large cell carcinoma greatly exceeds keratinizing carcinoma, which is followed by small cell NK in frequency.

4.2.4 Histologic Types of Nonsquamous Carcinoma Cervix, 1985

Table 4.2.4 shows the data regarding nonsquamous carcinoma cervix. The majority of the few cases are adenocarcinoma. Many in Bombay and Trivandrum are called "Epithelial, NOS", a rubric that may include adenocarcinomas and small cell undifferentiated or poorly differentiated carcinomas with very different natural histories. These cannot be separated when lumped together. More specific diagnoses may help identify each group.

Table 4.2.4 : Histologic types of Non-Squamcus Cancer Cervix HCRs, Females - 1985

Registry	Chandi- garh	Dibru- garh	Trivan- drum	Banga- lore	Bombay	Madras
Microscopically diagnosed						
Total	19	5	23	62	136	28
Adeno						
(ICDO 8140, 8260, 8310)	11	1	4	29	56	18
Adeno Squamous						
(ICDO 8560)	1	0	2	4	15	4
Epithelial, Nos						
(ICDO 8010)	3	1	12	6	46	5
Other	4	3	5	23	19	1

4.2.5 International Comparisons

Tables 4.2.5a shows 1985 NCRP-HCR data in comparison with that 15 years ago, from one centre in the U.S., and for one in Australia, in 1988. Patterns of Squamous versus Nonsquamous cancer are similar in India today with the U.S. nearly two decades ago.

¹ Wentz WB & Reagan. Cancer 1959; 12, 384

² Poulsen HE, Taylor CW etal. International Histological Typing of Female Genital Tract Tumours; WHO, Geneva, 1975

Table 4.2.5b shows the types of squamous cancers in India and the west in perspective. Whether decades ago or today, American and Australian frequencies for Large cell NK predominate followed by Keratinizing squamous and Small cell NK carcinoma. In India, Squamous not specified, leads by far at 89% followed by Large cell NK (8%) and by Keratinizing Squamous (2%) and Small cell NK (1%).

Table 4.2.5 a): Histologic types of Cancer Cervix: International Comparisons

Registry	Total cases	Squamous %	Adeno- carc %	Adeno- squam %	Other
Stage et al (1974) U.S.A.	which is follow	ng čarcinoma.			
1950-72 Cases	259	95	3	1	1
Elliott et al (1988) Australia					
1953-86 · Cases	2196	84	8	000000000000000000000000000000000000000	3
NCRP, 6HCRs (1988) India 1985 Cases	4565	94	2.6	0.6	3

(Number in parentheses refer to actual members percentage too small)

Table 4.2.5 b): Types of Squamous Carcinoma Cervix: International Comparisons

Bornozy knoras	Total	Keratin- izing %	Non Keratinizing		Squamous	Other	
	cases		LC * %	SMC *	NOS*	%	
125 25	53	ES ES					
*Ng Atkins (1973) U.S.A. 1954-67 cases	362	26	71	3	0	0	
Elliott et al (1988) Australia							
1953-86 cases	1851	37	53	6		0	
NCRP, 6HCRs (1988)							
India 1985 cases	4292	1.7	7.7	1.2	88.6	0.7	

^{*} LC = Large Cell; SMC = Small Cell; NOS = Not otherwise specified

4.2.6 Conclusion

Major points which emerge from this study are :

- i) An increase in microscopically diagnosed cervical cancers is needed in Madras or reasons for its lower frequencies need to be elucidated.
- ii) Classifying squamous cell cancers into keratinizing and nonkeratinizing large or small cell is important and needed, for prognostic and survival studies of cancer cervix in India. This is especially true in centres and hospitals with the most cases. This is an area required more careful largescale studies to determine the utility of this classification in India.

4.3 BREAST AND CERVICAL CANCER EXTENT PATTERNS

The method followed in this evaluation is described in Chapter 3, Section 3.2.

4.3.1 Patients not Evaluated for Extent of Disease - "Other" Group

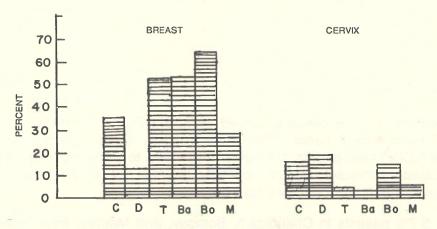
Breast and cervical cancer patients who cannot be evaluated for extent of spread are termed "Other" group, and are excluded. Data are in Table 4.3.1 and Fig 4.3.1.

Table 4.3.1 : Patients not Evaluated for Extent of Disease "Other" group Breast and Cervical Cancer
HCRs, Females, 1986

Registries	BREAST			CERVIX		
	Total T	Other n	%	Total T	Other n	%
Chandigarh	192	67	34.9	568	105	18.5
Dibrugarh	48	6	12.5	88	21	23.9
Trivandrum	352	180	51.1	468	13	2.8
Bangalore	325	174	53.5	1325	43	3.2
Bombay	1205	745	61.8	1634	333	20.4
Madras	313	88	28.1	1128	59	5.2

This "Other" group consists of 50-60% of breast cancer patients in Bangalore, Bombay, Trivandrum, and around 30% in Madras and Chandigarh. Among cervical cancer patients in Bombay, Chandigarh, and Dibrugarh around 20%, and in Bangalore, Madras and Trivandrum around 5% or fewer patients, are in this group.

Figure 4.3.1: PATIENTS NOT EVALUATED FOR EXTENT OF DISEASE "OTHER" GROUP, 1986



These data may reflect two facts. First, since initial breast cancer treatment in India is still largely surgical, and since surgical facilities are readily available in the cities where cancer centres are based, it may mostly occur outside the reporting institution. Such facilities may be less easily available outside the medical college in populations served by general

hospitals. Scrutiny of "treated previously or elsewhere" data in the "Other" group suggests this. Relatively lower frequencies in most registries of "Other" patients with Cervical compared to Breast cancer, may be because cervical cancer is largely treated by radiotherapy, not widely available outside the large institutions. Second, if radiotherapy facilities are available outside the reporting institution, or patient awareness of cancer is high, as may be in Bombay, larger proportions of patients may get treated outside the reporting institution first - eg. in cervical, and may be, breast cancers too.

4.3.2 Extent of Disease - Breast and Cervical Cancer Patients after Excluding "Other" group

4.3.2a Breast Cancer

Localised cancers range from 11-18% except in Madras with 4% and Bombay, with 33%. The Bombay figures of 30% localised patients may be a measure of the "existence phenomenon". That is, the very existence and fame of the Tata Hospital for nearly 50 years in the city may create enough awareness of cancer that patients come earlier for diagnosis and treatment. Patients with regionally spread disease are around 55-80% and advanced disease patients compose about 10-30% of those evaluated.

Table 4.3.2a : Extent of Disease : Breast Cancers HCRs, Females, 1986

	The state of the s			
Registry	Patients Evaluated for Extent of Disease	Localised	Regionally	Advanced
riogistry	N N	%	%	%
Chandigarh	125	11.2	78.4	10.4
Dibrugarh	42	11.9	64.3	23.8
Trivandrum	172	16.9	69.2	14.0
Bangalore	151	18.5	54.3	27.2
Bombay	460	32.6	53.5	13.9
Madras	225	4.4	78.7	16.9

4.3.2b Cancer Cervix

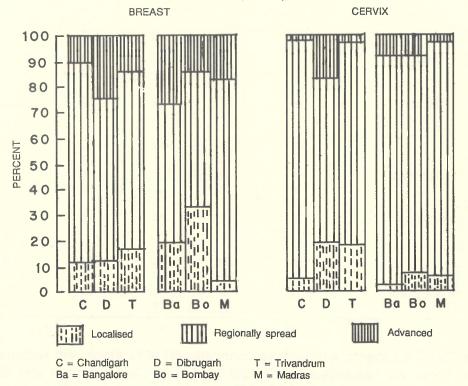
Classification of these cancers' spread using the FIGO system is more appropriate than the AJC system used herein. Part of the problem is the present coding system as defined in the NCRP from and its manual is not geared to using the FIGO system without using complicated intermediate codes. Hopefully, the new revised form should address this issue. Meantime, this is the best available data.

Around 5-7% patients in Chandigarh, Bombay, and Madras, have localised cancers, 18-20% in Dibrugarh and Trivandrum, and 1.5% in Bangalore. Regionally spread cancers constitute around 80-90% in all registries except Dibrugarh, with 64%. Assuming these include Stages II, III according to FIGO, around 80-90% cancers are in these two stage groups.

Table 4.3.2b : Extent of Disease : Cervical Cancers
HCRs, Females 1986

Registry	Patients Evaluated for Extent of Disease	Localised	Regionally Spread	Advanced
	N	%	%	%
Chandigarh	463	5.2	92.7	2.2
Dibrugarh	67	19.4	64.2	16.4
Trivandrum	455	18.0	79.3	2.6
Bangalore	1282	1.5	90.0	8.5
Bombay	1301	6.8	84.6	8.5
Madras	1069	6.1	90.6	3.4

Figure 4.3.2: EXTENT OF DISEASE - BREAST & CERVICAL CANCERS Females, HCRs, 1986



4.3.3 Conclusion

By far, most (over 80%) cervical cancers are spread at diagnosis, whereas around half to three-fourths breast cancers may be so. These extent data should be correlated with the treatment and discharge data to see how clinical downstaging of these common cancers can be achieved.

4.4 TREATMENT AND DISCHARGE PATTERNS OF BREAST AND CERVICAL CANCER PATIENTS ACCORDING TO THEIR EXTENT OF SPREAD

4.4.1 Breast Cancers

Treatment data are shown in Table 4.4.1a and Discharge data in Table 4.4.1b. Corresponding Figs 4.4. a-c are for treatment in different extent of disease categories and Figs 4.4. d -f for corresponding discharge data. Very few unknowns are observed.

Regardless of degree of spread of the cancer, higher frequencies of smaller numbers of patients get treated in the general hospitals than in the cancer centres. Treated patient frequencies are highest when the cancers are least disseminated, i.e. localised, and decrease with dissemination.

Table 4.4.1a: Treatment Patterns according to Extent of Spread: Breast Cancers
HCRs, Females - 1986

		Hons	, I ciliales	1300	The factor		
(A)	G	ENERAL	HOSPITAL I	REGISTRIES	CANCER C	ENTRE RE	GISTRIES
	Cł	nandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS	N	14	5	29	28	150	10
Treatment status	%						
Treated		100	100	97	75	93	90
Not treated		0	0	3	7	3	10
Treament not accepted		0	0	0	18	4	0
Unknown		0	0	0	0	1	0
REGIONALLY SPREAD	N	98	27	119	82	246	177
Treatment status	%						
Treated		93	96	95	62	83	90
Not treated		7	4	5	22	6	10
Treatment not Accepted		0	0	0	16	11	0
Unknown		0	0	0	0	0	0
ADVANCED CANCERS	N	13	10	24	41	64	38
Treatment status	%						
Treated		100	80	75	41	58	76
Not treated		0	20	17	32	11	24
Treatment not accepted		0	0	0	27	31	0
Unknown		0	0	8	0	0	0

About 75-90% patients with localised cancers, 60-90% those with regionally spread, and 40-75% those with advanced disease get treated in cancer centres and nearly 100% localised, 95% regionally spread, and 75-100% advanced cancers, in the general hospitals. Around 90-100% of these treated patients with localised cancers are improved at discharge and around 70-95% of those with regionally spread disease and 40-50% those with advanced disease. The condition at discharge must necessarily be correllated with the proportions of patients treated. Corresponding proportions of patients with improved condition at discharge, i.e. NED or regressed cancers, - decrease with increasing spread of disease, but do not show significant differences between general hospitals or cancer centres.

The remaining patients do not get treated, for whatever reason - including noncompliance, and nonacceptance of therapy. These nontreated patients range, therefore, from around 10-25% localised, 10-40% regionally spread, 24-60% advanced cancer patients in cancer centres and around 3% localised, 5% regionally spread and 20% advanced cancers in general hospitals.

Table - 4.4.1b : Condition at Discharge of Treated Patients according to Extent of Spread
Breast Cancers
HCRs, Females, 1986

	GE	NERAL H	HOSPITAL RE	GISTRIES	CANCER C	ENTRE REG	SISTRIES
	Cha	ndigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS	N	14	5	28	21	139	9
Discharge status %							
NED*, Regressed		100	100	86	90	99	100
Unchanged		0	0	0	5	0	0
Prog*, Too Adv*, Died		0	0	0	5	1	0
Unknown & Other		0	0	14	0	0	0
REGIONALLY SPREAD	N	91	26	113	51	204	160
Discharge status %							
NED*, Regressed		98	96	74	73	93	84
Unchanged		1	4	4	14	1	5
Prog*, Too Adv*, Died		1	0	8	14	6	0
Unknown & Other		0	0	13	0	0	11
ADVANCED CANCERS	N	13	8	18	17	37	29
Discharge status %							
NED*, Regressed		46	13	44	41	41	55
Unchanged		46	50	39	18	5	10
Prog*, Too Adv*, Died		8	38	17	35	54	3
Unknown & Other		0	0	0	6	0	31

^{*} NED = No Evidence of Disease; Prog = Progressed; Adv = Advanced

4.4.2 Cervical Cancers

See Table 4.4.2a and Figs 4.4. a-c for Treatment data and Table 4.4.2b and Figs 4.4.d-f for Discharge data.

Treatment patterns of cervical cancers in the reporting institution are of interest for several reasons. First, it is the most common cancer in women; second, it is very amenable to radiotherapy, which is less available outside the registry institutions than in them. This is seen also by the relatively lower frequencies of Other Group patients with cervical cancer compared to cancer breast patients. Third, from a cancer control point of view, if clinical downstaging of this cancer is to become a reality - as many as possible of early stage disease patients, i.e., localised to regionally spread in AJC terms, require easily available appropriate treatment. Early detection without adequate treatment facilities will not downstage this preventable disease.

Table 4.4.2a Treatment Patterns according to Extent of Spread : Cervical Cancers HCRs, Females, 1986

		GENERAL	HOSP	ITAL R	EGISTRIES	CAN	NCER (CENTRE R	EGISTRIES
		Chandigarh	Dib	rugarh	Trivandru	m Bang	galore	Bombay	/ Madra
LOCALISED. CANCERS	N	24		13	82		19	89	65
Treatment status %									
Treated		100		92	90		63	79	85
Not Treated		0		8	9		37	10	15
Treatment not accapted		0		0	0		0	11	0
Unknown		0		0	ATTISATOR		0	0	0
REGIONALLY SPREAD	N	429		43	361	- 11	154	1101	968
Treatment Status %									
Treated		90		86	91		55	67	52
Not Treated		10		14	8		38	9	48
Treatment not accepted		0		0	0		6	24	0
Unknown		0		0	0		0	0 0	0
ADVANCED CANCERS	N	10		11	12		109	111	36
Treatment Status %									
Treated		60	1	00	67		8	14	3
Not Treated		40	74	0	33		90	81	97
Treatment not accepted		0		0	0		1	5	0
Unknown		0		0	0		1	0	0

Table-4.4.2b Condition at Discharge of Treated Patients according to Extent of spread-Cervical Cancers
HCRs, Females, 1986

	(eneral H	ospital Regis	tries	Cancer Cen	tre Registrie:	S
010000000000000000000000000000000000000	Ch	andigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS	N	24	12	74	12	70	55
Discharge status %							
NED*, Regressed		96	100	86	75	96	100
Unchanged		4	0	4	0	0	0
Prog*, Too Adv*, Died		0	0	5	17	3	0
Unknown & Other		0	0 182 10	01 0-0 4 4	8	A eld1T	0
REGIONALLY SPREAD	N	384	37	328	640	738	501
Discharge status %							
NED*, Regressed		86	51	83	62	90	97
Unchanged		14	43	7	2	83	3
Prog*, Too Adv*, Died		0	3	8	20	0	0
Unknown & Other		0	3	2	17	ar era yu c	0
ADVANCED AANOEDO	NI.		100	0	0	16	E KALI IN
ADVANCED CANCERS	N	6	111	8	9		
Discharge status %							
NED*, Regressed		83	0	25	11	44	100
Unchanged		17	55	50	0	13	0
Prog*, Too Adv*, Died		0	36	25	78	44	0
Unknown & Other		0	9	0	11	0	0

^{*} NED = No Evidence of Disease; Prog = Progressed; Adv = Advanced

4.4a: TREATMENT STATUS OF PATIENTS WITH LOCALISED CANCERS OF BREAST AND CERVIX

HCRs, Females 1986

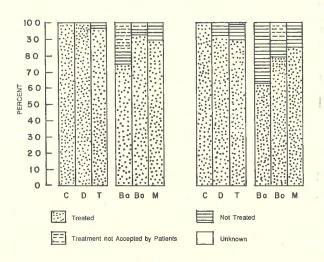
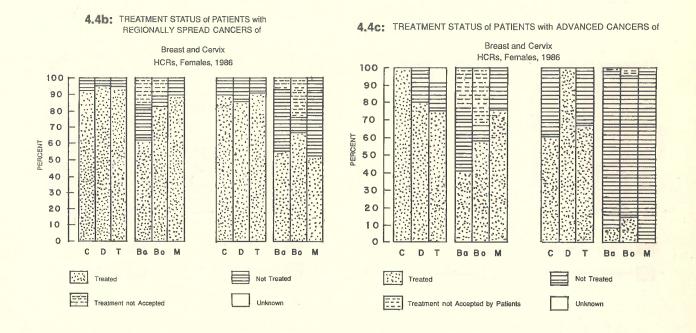


Figure 4.4a-c



4.4d: CONDITION AT DISCHARGE of TREATED PATIENTS with LOCALISED CANCERS of

Breast and Cervix HCRs, Female, 1986

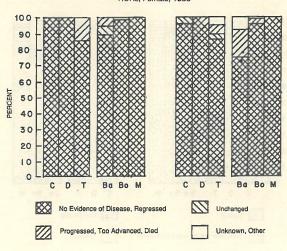
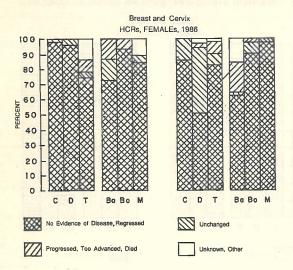
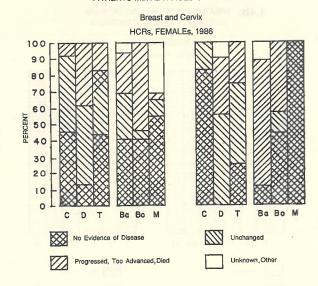


Figure 4.4d-f

4.4e: CONDITION AT DISCHARGE of TREATED PATIENTS WITH REGIONALLY SPREAD CANCERS OF



4.4f: CONDITION AT DISCHARGE of TREATED PATIENTS with ADVANCED CANCERS OF



The major points to emerge from the data are:

i) Around 55-85% of patients with localised and regionally spread cancer get treated in the cancer centres and around 85-100% in the general hospitals.

ii) Patients not treated range from 15% to nearly 40% of those with localised and 33-48% with regionally spread cancers in the cancer centres and from 8-14% in general hospital patients in both groups. Reducing these proportions and understanding the factors for these high frequencies of noncompliance and nonacceptance of treatment in early stage disease is exceedingly important in cancer control strategy.

iii) Around 95-100% patients with localised cancers, and 75-85% in the other two registries, show NED & regressed cancer at discharge. Some 80-95% patients with regionally spread cancers in Chandigarh, Bombay, Madras and Trivandrum and 60% in Bangalore similarly are improved at discharge. Patients are few in Dibrugarh. No pattern distinguishes types of institutions.

The discharge status of patients with advanced cancers are associated with very low

frequencies of treated patients.

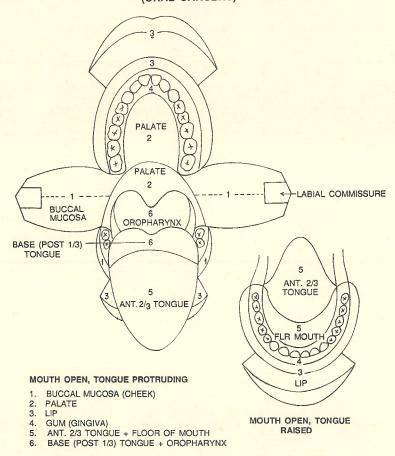
5. ORAL, PHARYNGEAL, LARYNGEAL CANCERS Diagnosis, Extent of Spread, Treatment & Discharge Patterns

This chapter describes the diagnosis and extent assessments, treatment and condition at discharge of oral, pharyngeal, and laryngeal cancer patients registered in the six hospital registries in 1986. These are the leading cancers in males and among the major cancers in females although their numbers are small in some registries.

5.1 ANATOMIC CLASSIFICATION USED

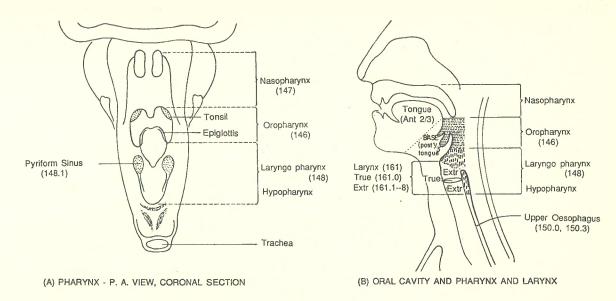
Cancers are grouped according to their classification by the ICD9 4th digit subcode, as described in Ch. 2. The areas of the mouth and other structures that come under the purview of Oral Cavity are shown in Fig. 5.1a. They exclude the base (posterior 1/3) tongue, soft palate and uvula. Those anatomic structures which belong to the Pharynx (Oro-, Hypo-, and Naso- pharynx,) are shown in Fig. 5.1b. Nasopharyngeal cancers, which are aetiopathogenetically and biologically different from the other pharyngeal cancers, are excluded. They are also few in all the registries except in Dibrugarh, but even in this registry they are prominent only in one ethnic group. The remaining pharyngeal cancers are known to be related to bidi smoking and smoking plus chewing.

Figure 5.1a ORAL CAVITY, TONGUE AND OROPHARYNX DIAGRAM (ORAL CANCERS)



MODIFIED FROM: (SOURCE: ROED-PETERSEN / TIFR)

Figure 5.1b DIAGRAM



5.2 DISTRIBUTION AND DIAGNOSIS

Data are presented in Table 5.2 and Figs. 5.2a. These head and neck tobacco use-

Table 5.2 : Cancers of the Oral Cavity*, Pharynx**, Larynx -Patient Numbers & Microscopic Diagnoses

(a) HCRs, Males - 1986

		LIP & ORAL CAVITY PHARYNX						LARYNX			
Registry	Patients	n	(MV%)	%	n	(MV%)	%	n	(MV%)	%	
Chandigarh	1090	41	(95)	3.8	134	(99)	12.3	54	(98)	4.9	
Dibrugarh	928	59	(95)	6.4	349	(99)	37.6	44	(98)	4.7	
Trivandrum	2297	422	(88)	18.4	193	(92)	8.4	96	(96)	4.2	
Bangalore	2874	213	(98)	7.4	547	(94)	19.0	141	(87)	4.9	
Bombay	6939	858	(96)	12.4	1373	(94)	19.8	457	(92)	6.6	
Madras	2046	318	(57)	15.5	407	(70)	19.9	86	(81)	4.2	
TOTAL	16174	1911	(88)	11.8	3003	(91)	18.6	878	(91)	5.4	

(b) HCRs, Females - 1986

		LIP &	ORAL C	AVITY	PHARYNX			L	LARYNX			
Registry	Patients	n	(MV%)	%	n	(MV%)	%	n	(MV%)	%		
Chandigarh	1325	25	(96)	1.9	34	(97)	2.6	9	(100)	0.7		
Dibrugarh	385	23	(100)	6.0	44	(98)	11.4	2	(100)	0.5		
Trivandrum	1935	274	(85)	14.2	37	(84)	1.9	5	(80)	0.3		
Bangalore	3152	432	(99)	13.7	73	(93)	2.3	7	(86)	0.0		
Bombay	5508	402	(96)	7.3	212	(93)	3.9	50	796)	1.0		
Madras	2408	257	(61)	10.7	79	(65)	3.3	8	(,5)	0.0		
TOTAL	14713	1413	(89)	9.6	479	(88)	3.3	81	(93)	0.6		

^{*} Lip & Oral Cavity excludes base tongue, soft palate, uvula ** Pharynx ICD9 Codes 146-149 includes base tongue, soft palate, uvula and excludes nasopharynx MV = Microscopically Verified

related cancers compose around 5% - 20% of cancers in males and about 1 - 10% of cancers in females registered in the six hospitals. In males, pharyngeal cancers (12%-38%) lead in all registries except Trivandrum where oral cavity cancers (18%) lead. In females, oral cancer is the predominant head and neck cancer (2-14%) except in Dibrugarh (11% pharyngeal and 6% oral) and Chandigarh where the frequency of both these cancers in females is low. Laryngeal cancer is generally lower in frequency than pharyngeal and oral, and is particularly low in females.

Proportions microscopically verified are also shown in Table 5.2 and Fig. 5.2b. Around

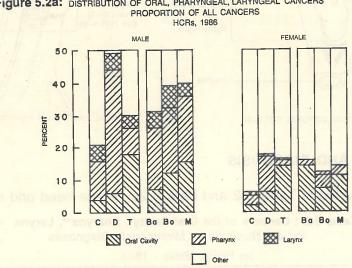


Figure 5.2a: DISTRIBUTION OF ORAL, PHARYNGEAL, LARYNGEAL CANCERS

80-100% diagnoses in males and around 90% in females with these three cancers are microscopic, except in Madras where around 60-80% such diagnoses in males and 60-70% in females are microscopic. Interestingly, the proportion so diagnosed in this registry increases from oral cavity to pharynx to larynx, i.e. it is least in the most accessible and most in the least accessible anatomic site for tissue sampling for microscopic examination.

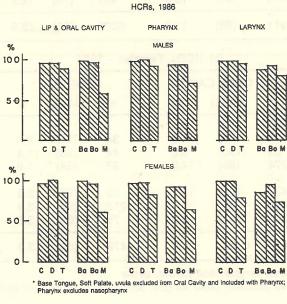


Figure 5.2b: ORAL*, PHARYNGEAL*, LARYNGEAL, CANCERS MICROSCOPIC DIAGNOSES

5.3 CANCER EXTENT PATTERNS

These are studied using the method described in Section 3.2, Ch. 3. First, patients who cannot be evaluated for extent of disease - "other" group in extent of disease - are excluded and the remaining cases are then analysed for extent patterns.

5.3.1 Patients Not Evaluated for Extent of Disease - "Other" Group

Please see Table 5.3.1. Bombay and Dibrugarh have higher percentages of these patients in males and females.

Table 5.3.1 : Oral*, Pharyngeal**, Laryngeal Cancers Patients Not Evaluated for Extent of Disease : "Other" Group HCRs, 1986

(a) Males

	LIP &	ORAL C	AVITY	Pl	HARYNX		LA	ARYNX	
Registry	Patients	n	%	Patients	n	%	Patients	n	%
Chandigarh	41	2	5	134	4	3	54	2	4
Dibrugarh	59	6	10	349	49	14	44	8	18
Trivandrum	422	17	4	193	3	2	96	2	2
Bangalore	213	11	5	547	9	2	141	2	1
Bombay	858	217	25	1373	200	15	457	81	18
Madras	318	35	11	407	31	8	86	7	8
TOTAL	1911	288	15	3003	296	10	878	102	12

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	LIP & C	DRAL C	AVITY	Pl	HARYN	X	L/	RYNX	
Registry	Patients	n	%	Patients	n	%	Patients	n	%
Chandigarh	25	0	0	34	0	0	9	0	0
Dibrugarh	23	2	9	44	8	18	2	1	50
Trivandrum	274	6	2	37	1	3	5	0	0
Bangalore	432	5	1 -	73	0	0	7	0	0
Bombay	402	90	22	212	23	11	50	7	14
Madras	257	31	12	79	9	11	8	0	0
TOTAL	1413	134	9	479	41	9	81	8	10

^{*} Lip & Oral Cavity excludes base tongue, soft palate, uvula

5.3.2 Extent of Disease of Oral, Pharyngeal, Laryngeal Cancers after excluding "Other" Group

Data are shown in Tables 5.3.2a-c and Fig. 5.3.2

5.3.2a Oral Cavity Cancers

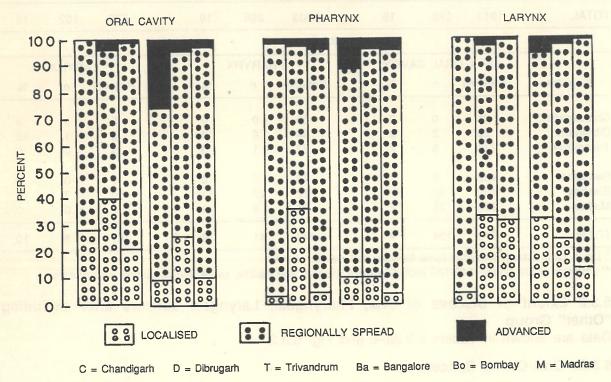
Numbers are small in Chandigarh and Dibrugarh in both gender groups. Dibrugarh shows around 40% localised cancers. Bombay, Chandigarh and Trivandrum register about 20-30% localised cancers; Madras and Bangalore are different with around 5-10% such cancers. Those regionally spread at diagnosis are about 90% of evaluable patients in Madras; in the other registries they range from 60-80%. Bangalore, where females exceed males with oral cancers, registers some 25-30% advanced cancers; in other registries these are less than 5%.

^{**} Pharynx ICD9 codes 146-149 including base tongue, soft palate, uvula and excluding nasopharynx

Table 5.3.2a: Lip & Oral Cavity* Cancers' Extent of Disease HCRs, Males & Females, 1986

Registry		Evaluated for of Disease	r Loca	alised	Regional	y Spread	Disseminated (Advanced)		
	M	F	M	F	М	F	M	F	
	n	n	%	%	%	%	%	%	
Chandigarh	39	25	28	32	72	64	0	4	
Dibrugarh	53	21	40	43	57	57	4	0	
Trivandrum	405	268	21	22	78	77	1	1	
Bangalore	202	427	9	8	65	60	26	32	
Bombay	640	312	26	26	70	71	5	3	
Madras	283	226	10	6	87	92	3	2	
TOTAL	1622	1279	20	16	74	72	6	12	

Figure 5.3.2: EXTENT OF DISEASE - ORAL, PHARYNGEAL, LARYNGEAL CANCERS Excluding Patients Not Evaluated - Other Group HCRs, Male 1986



5.3.2b Pharyngeal Cancers

Males with this cancer exceed females by far in all registries. In male and female patients evaluable in Dibrugarh, a larger proportion (36%) have localised and a smaller

proportion (around 60%) have regionally spread cancer at first diagnosis than in the other registries. The patterns in the other registries show around 10-15% localised cancer and about 80-85% regionally spread at diagnosis.

Table 5.3.2b : Pharyngeal * Cancers' Extent of Disease HCRs, Males & Females, 1986

Registry	Patients Evaluated for Extent of Disease		Localised		Regional	Regionally Spread		
	M n	F n	M %	F %	M %	F %	M %	F %
Chandigarh	130	34	3	9	95	91	2	0
Dibrugarh	300	36	36	36	61	58	3	6
Trivandrum	190	36	4	11	93	83	4	6
Bangalore	538	73	10	19	78	70	12	11
Bombay	1173	189	10	13	86	83	4	4
Madras	376	70	4	3	92	89	5	9
TOTAL	2707	438	11	14	84	80	5	6

5.3.2c Laryngeal Cancers

The data for males alone is studied as there are too few cancers in females. Even in males, only Bangalore and Bombay register more than 100 patients.

Localised cancers constitute around 25% of males with this cancer in all registries except for 10% in Chandigarh and Madras. Advanced cancers are few. Around 75% are regionally spread at first diagnosis.

Table 5.3.2c : Laryngeal* Cancers' Extent of Disease HCRs, Males & Females, 1986

Registry		Patients Evaluated for Extent of Disease		Localised		Regionally Spread		Disseminated (Advanced)	
	M n	F n	M %	F %	M %	F %	M %	F %	
Chandigarh	52	9	4	11	96	89	0	.0	
Dibrugarh	36	1	33	0	64	0	3	100	
Trivandrum	94	5	31	20	68	80	1	0	
Bangalore	139	7	32	0	62	86	6	14	
Bombay	376	43	24	21	73	79	3	0	
Madras	79	8	13	25	86	63	1	12	
TOTAL	776	73	24	18	73	78	3	4	

^{*} Excluding patients not evaluated for extent of disease; UICC classification

5.4 TREATMENT AND DISCHARGE PATTERNS OF MALE PATIENTS ACCORDING TO THEIR EXTENT OF DISEASE

Treatment patterns are studied in each specific cancer patient group according to extent of spread of the cancer.

The patient's condition at discharge, in the absence of follow-up data is the only available measure of therapeutic effectiveness. This is analysed, for treated patients only. Where cases are few, the data are not presented.

Each cancer group is described separately. Where numbers are very small, - e.g. treated laryngeal cancer in females, discharge data are not presented.

5.4.1 Oral Cavity Cancers

Tables 5.4.1a&b and Figures 5.4.1a&b present the data on treatment patterns and

HCRs, Males, 1986 LOCALISED REGIONALLY SPREAD ADVANCED 100 90 80 70 60 50 40 30 20 10 0 Ba Bo M С Ba Bo M Treatment not Accepted Not Treated Unknown

Figure 5.4.1a: TREATMENT STATUS OF PATIENTS WITH ORAL CAVITY CANCERS

Figure 5.4.1b: CONDITION AT DISCHARGE OF TREATED PATIENTS WITH ORAL CAVITY CANCERS

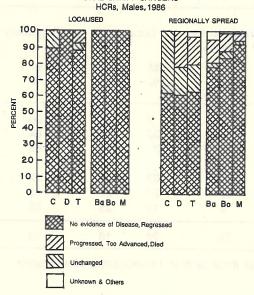


Table 5.4.1a : Treatment Patterns of Lip & Oral Cavity Cancers
According to the Extent of their Disease
HCRs, Males, 1986

	GENERAL Chandigarh	HOSPITAL F Dibrugarh	REGISTRIES Trivandrum	CANCER C Bangalore	ENTRE RE	GISTRIES Madras
	Chandigani	Dibrogam		24119414		
OCALISED CANCERS N	11	21	85	18	164	29
FREATMENT STATUS %						70
Treated	82	90	86	50	80	79
Not Treated	18	10	14	33	4	21
Treatment not accepted	0	0	0	17	16	. 0
Unknown	0	0	0	0	0	0
REGIONALLY SPREAD						
CANCERS N	28	30	317	132	447	245
REATMENT STATUS %	02	77	86	61	69	59
Treated	93 7	23	13	27	9	41
Not Treated	0	0	0	12	21	0
Treatment not accepted Unknown	0	0	1	1	1	ő
ADVANCED CANCERS N	0	2	3	52	29	9
TREATMENT STATUS %						
Treated	0	100	67	44	31	11
Not Treated	0	0	33	52	66	89
Treatment not accepted	0	0	0	4	3	0
Unknown	0	0	0	0	0	0

Table 5.4.1b : Condition at Discharge of Treated Patients with Lip & Oral Cavity Cancers
According to the Extent of their Disease
HCRs, Males, 1986

	GENERAL	HOSPITAL	REGISTRIES	CANCER (CENTRE R	EGISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS N	9	19	73	9	131	23
DISCHARGE STATUS %						
NED* Regressed	89	100	88	100	100	100
Unchanged	11	0	4	0	0	0
Prog*, Too Adv*, Died	0	0	8	0	0	0
Unknown & Other	0	0	0	0	0	0
REGIONALLY SPREAD						
CANCERS N	26	23	274	80	308	145
DISCHARGE STATUS %						
NED* Regressed	62	61	63	78	83	92
Unchanged	38	17	17	3	4	2 5
Prog*, Too Adv*, Died	0	22	17	14	11	5
Unknown & Other	0	0	3	6	1	1
ADVANCED CANCERS N	0	2	2	23	9	1
DISCHARGE STATUS %						
NED* Regressed	0	0	50	61	44	0
Unchanged	Ō	100	0	0	0	100
Prog*, Too Adv*, Died	- 0	0	50	39	56	0
Unknown & Other	0	0	0	0	0	0

^{*} NED = No Evidence of Disease; Prog = Progressed, Adv = Advanced

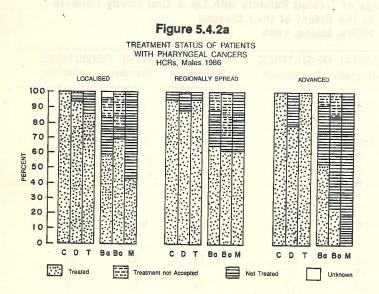
condition at discharge of treated male patients respectively. About 80-90% of localised cancers get treated in all registries except Bangalore where the cases are few. The number of treated patients with localised cancers is small except in Bombay and Trivandrum; around 90-100% show NED or regression at discharge.

Regionally spread cancer patients are distinct in cancer centres versus general hospitals. A larger proportion (80-90%) get treated in general hospitals but of those, about 60% show NED and regression at discharge. Whereas in cancer centres, while 60-70% get treated, about 80-90% of these show NED or regression at discharge. Advanced cancer cases are few; only Bangalore and Bombay have more than 10 cases; - 30-45% patients are treated.

5.4.2 Pharyngeal Cancers

See Fig. 5.4.2a & b and Tables 5.4.2a & b

Smaller frequencies of more patients with localised and regionally spread pharyngeal cancer are treated in cancer centres than in general hospitals. Localised cancers are few except in Dibrugarh and Bombay. Around 85-100% of these patients get treated in general hospitals compared to 45-70% in cancer centres. Some 83-100% patients with NED and regressed localised cancers at discharge are noted in the six registries; the distinction according to type of institution is less apparent with pharyngeal than with oral cancer. 90-95% patients with regionally spread disease get treated in general hospitals and 60-65% in cancer centres. Fewer patients with regionally spread cancer—some 60-80%—show NED or regression at discharge in most registries. Numbers of advanced cancers are small.



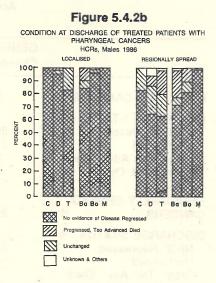


Table 5.4.2a : Treatment Patterns Pharyngeal ** Cancer According to the Extent of their Disease HCRs, Males, 1986

	GENERAL	HOSPITAL F	EGISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS N	4	108	7	54	119	14
TREATMENT STATUS %						
Treated	100	94	86	59	69	43
Not Treated	0	5	14	24	8	57
Treatment not accepted	0	0	0	13	24	0
Unknown	0	1	0	4	0	0
REGIONALLY SPREAD N	124	183	176	420	1010	345
TREATMENT STATUS %						
Treated	95	88	95	65	61	61
Not Treated	5	11	5	23	9	39
Treatment not accepted	0	0	0	13	29	0
Unknown	0	1	0	0	1	0
ADVANCED CANCERS N	2	9	7	64	45	17
TREATMENT STATUS %						
Treated	100	78	100	53	24	0
Not Treated	0	22	0	38	60	100
Treatment not accepted	Ö	0	0	9	16	0
Unknown	Ö	Ö	0	0	0	0

Table 5.4.2b : Condition at Discharge of Treated Patients with Pharyngeal* Cancer
According to the Extent of their Disease
HCRs, Males, 1986

	GENERAL	HOSPITAL R	EGISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS N	4	106	6	32	82	6
DISCHARGE STATUS % NED* & Regressed Unchanged Prog*, Too Adv*, Died Unknown & Other	100 0 0 0	95 3 1 1	83 17 0 0	84 6 9	96 2 1 0	100
REGIONALLY SPREAD N	118	169	168	272	616	210
DISCHARGE STATUS % NED* & Regressed Unchanged Prog*, Too Adv*, Died Unknown & Other	83 17 0 0	64 22 8 6	63 17 18 2	71 6 21 2	81 8 11 0	97 2 1 0
ADVANCED CANCERS N	2	10	7	34	11	0
DISCHARGE STATUS % NED* Regressed Unchanged Prog*, Too Adv*, Died Unknown & Other	100 0 0	20 0 80 0	29 14 43 14	74 3 24 0	9 9 82 0	0 0 0

^{*} NED = No Evidence of Disease; Prog = Progressed, Adv = Advanced

^{**} ICD 9 Codes 1460-1499; includes base tongue, soft palate, uvula; excludes nasopharynx (1470)

Table 5.4.3a : Treatment Patterns of Laryngeal Cancers
According to the Extent of Spread
HCRs, Males, 1986

	GENERAL	HOSPITAL F	REGISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS N	2	12	29	44	89	10
TREATMENT STATUS %						
Treated	100	100	86	50	80	100
Not Treated	0	0	10	20	4	0
Treatment not accepted	0	0	0	30	16	0
Unknown	0	0	3	0	0	0
REGIONALLY SPREAD N	50	23	64	86	276	68
TREATMENT STATUS %						
Treated	82	96	91	60	65	68
Not Treated	18	4	9	21	8	32
Treatment not accepted	0	0	0	19	25	0
Unknown	0	0	0	0	1	0
ADVANCED CANCERS N	U	1	1	9	11 THE	VANCED
TREATMENT STATUS %						
Treated	0	100	0	22	27	0
Not Treated	0	0	10	67	73	100
Treatment not accepted	Ö	Ö	0	11	0	0
Unknown	0	Ö	0	0	0	0

Table 5.4.3b : Condition at Discharge of Treated Patients with Laryngeal Cancer
According to the Extent of Spread
HCRs, Males, 1986

	GENERAL	HOSPITAL RE	GISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS N	2	12	25	22	71	10
DISCHARGE STATUS %						
NED*, Regressed	100	100	100	91	99	100
Unchanged	0	0	0	5	1	0
Prog*, Too Adv*, Died	0	0	0	5	0	0
Unknown & Other	0	0	0	0	0	0
REGIONALLY SPREAD N	41	22	58	52	180	46
DISCHARGE STATUS %			E/2			
NED*, Regressed	88	73	71	77	89	93
Unchanged	12	14	19	0	4	4
Prog*, Too Adv*, Died	0	5	10	17	7	2
Unknown & Other	0	9	0	6	1	0
ADVANCED CANCERS N	0	1	0	2	3	0
DISCHARGE STATUS %					1,442,743	L 11=1
NED*, Regressed		0	_ 0	50	0	PART OF
Unchanged		0	- 9	50	0	of bank
Prog*, Too Adv*, Died	•	1		0	100	100
Unknown & Other	*bances	0	and Discourage	0	0	-

^{*} NED = No Evidence of Disease; Prog = Progressed, Adv = Advanced

5.4.3 Laryngeal Cancers

See Fig. 5.4.3a & b and Tables 5.4.3a & b

Figure 5.4.3a: TREATMENT STATUS OF PATIENTS WITH LARYNGEAL CANCERS HCRs, Males 1986

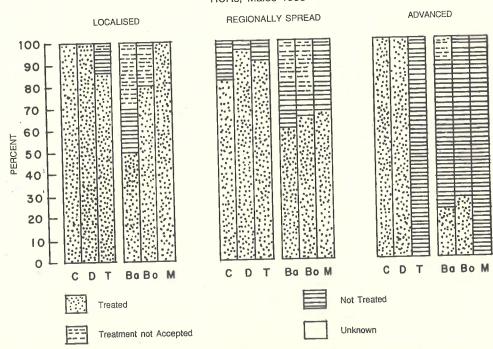
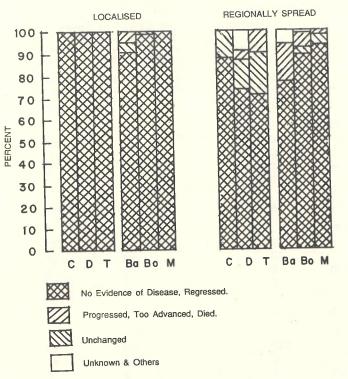


Figure 5.4.3b: CONDITION AT DISCHARGE OF TREATED PATIENTS WITH LARYNGEAL CANCERS
HCRs, Males 1986



Patients with localised laryngeal cancers are few except in Bangalore and Bombay. 85-100% get treated except in Bangalore. Treated patients with localised cancers are few but show over 90% with NED or regression at discharge. A general hospital/cancer centre dichotomy is apparent with regionally spread disease: 80-95% patients treated in general hospitals and 60-70% in cancer centres. Patients with regionally spread disease who get treated show around 70-75% NED and regression in Dibrugarh, Trivandrum and Bangalore while around 90% in Bombay, Chandigarh and Madras do so. Advanced cancers are too few for analysis.

5.5 TREATMENT & DISCHARGE PATTERNS OF FEMALE PATIENTS ACCORDING TO THEIR EXTENT OF DISEASE

Female patients are considered as a single group because their numbers are smaller than those of males with these cancers. In pharyngeal & laryngeal cancer, the numbers are so small as to not warrant discussion. Only oral cavity cancer patients are discussed.

5.5.1 Oral Cavity Cancers

Localised cancers are few, and about 85-100% get treated, except in Bangalore and Madras where 50% get treated. Around 70-100% show NED or regression at discharge. Patients with regionally spread disease show a clear distinction in treatment patterns by type of institution and are few in Chandigarh and Dibrugarh. 80-90% are treated in general hospitals and 60-70% in cancer centres. Discharge status patterns do not show such a distinction. Around 75-95% show NED and regression in five registries with 60% such in Trivandrum. Advanced cancers are too few except in Bangalore where about 50% such patients get treated - and 34% of those show NED and regression at discharge. In sum, the pattern for oral cancers in females are not too different from those in males except in Bangalore where females exceed males with this cancer.

Table 5.5.1a: Treatment Patterns of Lip & Oral Cavity Cancers
According to the Extent of Spread
HCRs, Females, 1986

	ANN-part INVI	nons, re	emales, 1986			
	GENERAL	HOSPITAL R	EGISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS N	8	9	58	32	81	14
TREATMENT STATUS %						17
Treated Not Treated	100	89	88	50	85	50
	0	11	12	44	2	50
Treatment not accepted	0	0	0	6	12	0
Unknown	0	0	0	Ö	0	0
REGIONALLY SPREAD N	16	12	206	007		
TREATMENT STATUS %	10	12	206	257	221	208
Treated						
	81	92	85	63	69	68
Not Treated	19	8	14	28	15	32
Treatment not accepted	0	0	0	8	16	0
Unknown	0	0	1	ő	0	0
ADVANCED CANCERS N	1	0		100		
TREATMENT STATUS %		U	4	138	10	4
Treated	100		50	53	20	50
Not Treated	0	-	50	47	60	50
Treatment not accepted	0	-	0	O	20	
Unknown	0	-	Ö	Ö	0	0

Table 5.5.1b : Condition at Discharge of Treated Patients with Lip & Oral Cavity Cancer
According to the Extent of Spread
HCRs, Females, 1986

	GENERAL H	OSPITAL RE	GISTRIES	CANCER	CENTRE RE	GISTRIES
	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
LOCALISED CANCERS n	8	8	51	16	69	7
DISCHARGE STATUS %						
NED*, Regressed	88	100	84	69	97	100
Unchanged	13	0	8	0	1	0
Prog*, Too Adv*, Died	0	0	6	13	0	0
Unknown & Other	0	0	2	19	1	0
REGIONALLY SPREAD n	13	11	176	163	152	141
DISCHARGE STATUS %						
NED*, Regressed	77	73	60	74	82	95
Unchanged	23	18	19	1	5	1
Prog*, Too Adv*, Died	0	0	18	20	11	2
Unknown & Other	0	9	3	6	2	1
ADVANCED CANCERS n	1	0	2	73	2	2
DISCHARGE STATUS %						
NED*, Regressed	100	-	0	34	0	100
Unchanged	Ó	-	0	10	0	0
Prog*, Too Adv*, Died	0	_	1	51	100	0
Unknown & Other	0		. 1	5	0	0

^{*} NED = No Evidence of Disease; Prog = Progressed, Adv = Advanced

5.6 GENERAL COMMENTS - ORAL, PHARYGEAL, LARYNGEAL CANCERS

If the data as coded represent the actual "spread" situation, these data may present the actual patient situation regarding these cancers which are classified with anatomical accuracy. The extent data have been crosschecked for accuracy against primary and secondary site histology codes. All patients previously treated or in any other way not accurately evaluable for extent of cancer have been excluded. Around 70-85% of all these cancers are regionally spread at first diagnosis. About 10-25% are localised. About 5% are disseminated.

Some 30-55% patients with localised pharyngeal cancer and about 40% with regionally spread disease in the cancer centres are not treated. Reasons for this needs evaluation. Since this is the leading cancer in males in the country, efforts to increase the proportion treated may yield valuable dividends in head & neck cancer downstaging.

It is important to correlate the proportions improved at discharge with the proportions treated - if the latter are fewer and selective, the outcome at discharge may show up as better.

We need to learn more about reasons for non-compliance and nonacceptance of treatment in women with oral cancer where 10-20% patients with regionally spread cancers in general hospitals and 30-40% such patients in cancer centres do not get treated.

6. POPULATION - BASED CANCER REGISTRIES

This is the fifth consolidated annual report of the National Cancer Registry Project (population - based cancer registries - PBCRs). The magnitude of cancer problem in a community can be studied through incidence rates. The population—based cancer registries assist in estimating such incidence rates in a well defined population of a geographical area.

6.1 DATA

This report includes incident cancer cases diagnosed during the five year period, between January 1, 1982 and December 31, 1986. New cases registered during the year 1986 by the three PBCRs i.e. Bangalore, Bombay and Madras are 11676. In earlier years, they had contributed 11217 cases in 1985, 10346 in 1984, 10191 in 1983 and 10088 in 1982.

The cases registered by Bhopal and Delhi registry during the year 1986 are 354 and 780 respectively. The registration data in these areas are still provisional.

Table 6.1 presents incident cancer cases registered by these registries.

Table 6.1 : Incident cases of Cancer Registered by the Population-Based Cancer Registries during the years 1982 through 1986 (Between January 1 and December 31)

Registry	Year	Males	Females	Totals
Bangalore	1982	969	1168	2127
	1983	979	1149	2137 2128
	1984	966	1178	2144
	1985	1043	1080	2123
	1986	1055	1162	2217
Bombay	1982	3128	2526	5654
STR. ON STR. OF STR.	1983	3125	2496	5621
	1984	3244	2715	5959
	1985	3470	2954	6424
	1986	3512	2987	6499
Madras	1982	982	1315	2297
	1983	1050	1392	2442
	1984	962	1281	2243
	1985	1133	1537	2670
	1986	1254	1706	2960
Bhopal *	1986	182	172	354
Delhi *	1986	434	346	780

^{*} Provisional Figures

[#] Cancer registries provided core data of registered cancer cases. Quality control checks, tabulations, statistical analysis and brief report has been done by Mr. D. K. Jain, Assistant Director, ICMR, New Delhi.

6.2 POPULATION

The population at risk covered by the five PBCRs are Bangalore 3.47 million (males: 1.83 million, females: 1.64 million), Bombay 10.07 million (males: 5.58 million, females: 4.49 million), Madras 3.63 million (males: 1.86 million, females: 1.77 million), Bhopal 0.97 million (males: 0.52 million, females: 0.45 million) and Delhi 7.72 million (males: 4.24 million, females: 3.48 million). The population has been estimated as on July 1, 1986 (the mid-point of the period between January 1, 1986 and December 31, 1986), from projections based on the 1971 and 1981 censuses.

These five registries cover a total urban population of 25.86 million which is about 3.7% of India's total population.

6.3 AGE INCIDENCE

The crude incidence rates for all ages, age - adjusted incidence rate (world population) and truncated (35-64 years) incidence rate (world population) per 100,000 population, among males and females, for all sites (ICD9: 140-208), in Bangalore, Bombay and Madras, for the years 1982 through 1986 are compared in Table 6.3. No attempt has been made to compute incidence rates for Bhopal and Delhi as the data of these registries is still provisional.

Table 6.3: Comparison of Incidence rates - Crude (CR), Age-adjusted (AAR) & Truncated (TR.), per 100,000 persons, between registries, 1982 through 1986. All sites (ICD. 9: 140-209). All Ages.

Registry	Year		Males		Females			
		CR	AAR*	TR**	CR	AAR*	TR**	
Bangalore	1982	60.8	110.8	187.5	82.0	146.7	317.8	
9	1983	59.2	108.5	175.1	77.9	139.4	306.4	
	1984	56.3	102.0	178.3	76.6	141.8	305.4	
	1985	58.8	109.5	173.6	67.8	124.8	264.5	
	1986	57.7	107.0	180.3	70.8	129.4	282.7	
Bombay	1982	64.4	123.7	192.8	66.5	117.5	223.7	
	1983	62.1	115.5	186.2	63.1	108.6	212.3	
	1984	62.3	122.0	182.6	65.8	113.9	225.9	
	1985	64.4	123.9	188.5	68.6	120.3	237.7	
	1986	62.9	118.9	181.3	66.5	115.2	226.4	
Madras	1982	57.8	90.8	167.2	82.3	117.6	276.2	
	1983	60.5	96.3	188.4	84.9	124.5	291.7	
	1984	54.1	86.4	161.7	76.1	111.9	255.4	
	1985	62.3	104.2	177.0	88.9	134.2	305.6	
	1986	67.4	116.0	202.7	96.2	144.3	333.1	

^{*} World Population; ** (35-64 years : World Population)

The truncated incidence rate (TR), 35-64 years, is the most useful rate for comparing incidence data. Most of the cancer cases (more than 60%) in the Indian registries are in these ages and majority of the affected patients in these age groups usually come to hospital for treatment thus providing reliable information for cancer control programmes Truncated rates perhaps also reduces the problems of unknown ages in older ages and of

under registration. The TR also show that there is some variation in the cancer incidence rates in males and females in these age groups in the Indian registries. This also suggests a possibility of differential under registration in the three registries to account for differences in the AAR.

6.4 CUMULATIVE INCIDENCE RATE

The cumulative incidence rate is a summary measure of the risk experience of a population over a longer time span or age interval. The cumulative incidence rate is a direct form of age-standardisation and it has a useful probabilistic interpretation. It is obtained by summing up the annual age-specific incidences for each year in the defined interval. It is a good approximation to the actuarial or cumulative risk. The cumulative incidence rates for the year 1986 for Bangalore, Bombay and Madras are compared with the Connecticut and presented for selected sites in Table 6.4

Table 6.4: Cumulative Incidence Rates 0-74 years (Percent) of developing cancer for selected sites in Bangalore, Bombay, Madras and Connecticut (USA).

ICD. 9	SITE	Sex	Bangalore*	Bombay*	Madras*	Connecticut #
141	Tongue	М	0.50	0.00	0.70	ALST TOPICS VALUE
141	rongue	F TO A	0.50 0.11	0.83 0.34	0.70 0.14	0.4
150	Oesophagus	М	1,22	1.10	0.88	0.7
	sole-mail	F	1.65	0.84	0.82	0.2
151	Stomach	M F	1.70 0.72	0.75 0.50	2.46 0.97	1.2 0.5
162	Lung	M F	1.64 0.22	1.28 0.21	1.18 0.18	7.7 2.2
174	Breast	F	2.15	2.76	2.49	8.6
180	Cervix	F	3.52	2.07	5.84	0.8

^{*} For the year 1986 # For the years 1973-1977

One reason for interest in the cumulative incidence rate is that it has a useful probabilistic interpretation. For instance, among women, in Madras the probability of developing uterine cervix cancer between 0-74 years is 5.84% while among Bombay women it is 2.07% and in Bangalore it is 3.52%. On the other hand the risk of developing uterine cervix cancer among women residing in Connecticut (USA) between 0-74 years is only 0.8%.

APPENDIX

THE HOSPITAL REGISTRY DATA AND ITS QUALITY CONTROL

A.1 DATA COLLECTION AND PROCESSING

Data are obtained from hospital patient records and personal interview of cancer patients by the social investigators in each registry in standarized forms. After coding, these data are entered into a computer in separate numeric (record length 124) and alphanumeric (record length 122) files.

The 1986 HCR data were received at the TW from the six registries from February to November 1988 on different media: magnetic tape, five-inch or eight-inch floppy diskettes, or on raw forms (from Dibrugarh and Trivandrum - not yet computerised). Data were transferred at the TW to five-inch diskettes or to a hard disk, after data entry, if necessary, for cleaning and further processing.

Computer programmes at the TW matched (i) the numbers of records in the numeric and alpha files (ii) checked for coding errors; (iii) cross-checked between data items for inconsistencies; and (iv) finally identified duplicate cases within each registry. The registries provided corrected codes in response to these requests for clarification from the TW. Data were then edited and tabulated for despatch to registries and analysis. The schedule of data receipt and processing is shown in Table A.1.

TABLE A.1 - SCHEDULE of 1986 HCR DATA RECEIPT & PROCESSING

Event	Chandigarh	Dibrugarh	Trivandrum	Bangalore	Bombay	Madras
				Before		Before
Date of complete data set receipt at TW	8.3.88	22.2.88	28.11.88	1.7.88	31.7.88	1.7.88
Developme	ent of New Che	cklist Comput	er Programme a	at TW from 22.6	6.88 to 10.8.88	
First Checklist Printout sent by TW	16.8.88	16.8.88	30.9.88	18.8.88	22.9.88	16.8.88
Final corrected data received at TW	2.9.88	4.10.88	30.12.88	30.9.88	8.10.88	8.9.88
Tabulations sent by TW to Registry	12.9.88	7.10.88		6.10.88	13.10.88	22.9.88

A.2 CODING ERRORS AND INCONSISTENCIES IN 1986:

Overall, 1996 records (6.4%) of 31,258 needed clarification by the registries. The range was 1.48 to 14.9% of submitted cases. Specific problems existed in certain registries. Date of diagnosis prior to 1986 was commonly found in some data, indicating that late registrations were lumped with 1986 data. Late registrations should be sent in separate files for the given year's cases to make data processing easier both in the registries and at the TW.

Coding errors were few and most of these were new codes devised by the registries for specific situations they faced, but about which the TW was not previously informed. Improved communication is also a great need.

Inconsistencies between data items were mostly between ICDO and ICD9 site codes; extent of disease and site codes; extent of disease and existence of a metastasis; unknown extent codes with known histology of the metastasis, and similar medical data.

A.3 ISSUES FROM 1986 DATA CHECKS

Problems arose in checking the data when new codes were used by the registries without informing the TW, when date of diagnosis was not 1986 and when the record length was different from that used in previous years and/or not the one specified in the Coding Manual. One registry added a data item at the end of the numeric file.

Processing of the data would be easier if registries organised (sorted) data in the order of case number before sending them to the TW. Despatch of data needs to be more timely; half-yearly or quarterly submission may help in ensuring this.

There were many unknowns in items of treatment, discharge status and extent of disease. Extent coded as unknown was usually seen when the primary site was unknown but a metastatic site had been sampled. In this situation some registries coded extent as regionally or distantly spread or advanced, while others coded it as unknown. There needs to be a consensus on this isssue.

A.4 RATIONALE FOR A REVISED FORM

As mentioned above, there were many unknowns for certain data items and imconsistencies between data items on extent of disease and treatment. Further, codes in some data items, e.g. extent of disease, were not mutually exclusive, leading to ambiguity in the data. Therefore it seems adviseable to simplify the proforma to make it easier to abstract and code data, thus reducing inaccuracies. It should also make the coding system more unequivocal. Also, so far no mechanism of collecting follow-up information on patients exists. This is needed to asssess treatment effectiveness on a longer term by survival analysis.

In view of this, a new HCR draft form has been developed in the past year, including comments and suggestions from several registries and the entire project. This form should be ready for pretesting this year.

PART II

INDIVIDUAL HOSPITAL CANCER REGISTRY DATA

FOR 1986

HOSPITAL CANCER REGISTRIES

CHANDIGARH (Post-graduate Institute of Medical Education and Research)

DIBRUGARH (Regional Cancer Centre)
TRIVANDRUM (Regional Cancer Centre)

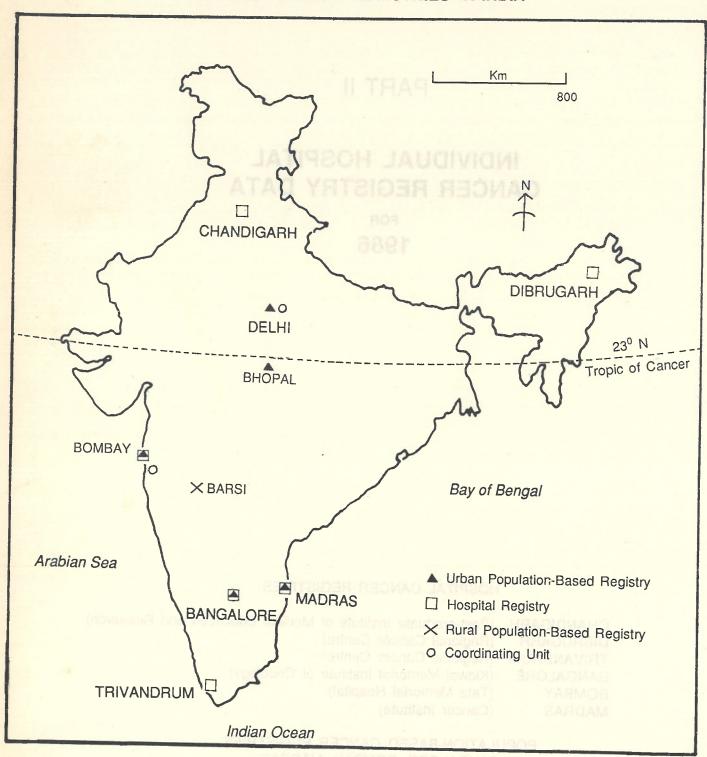
BANGALORE (Kidwai Memorial Institute of Oncology)

BOMBAY (Tata Memorial Hospital)

MADRAS (Cancer Institute)

POPULATION-BASED CANCER REGISTRIES BANGALORE, BOMBAY, MADRAS

NATIONAL CANCER REGISTRIES IN INDIA



HOSPITAL CANCER REGISTRY: CHANDIGARH

This hospital registry is located in the Post-Graduate Institute of Medical Education and Research (PGI), a major referral and speciality - oriented medical centre in the Union Territory of Chandigarh. Its population is 450,061 people, according to the 1981 census

From the inception of this registry in 1982 until 1986, a total of 12,021 cancer patients have been registered, of which 7,269 were registered from 1984 to 1986. The patients are from different states - 45 % Punjab, 17 % Himachal Pradesh, 14 % Haryana, 8 % the Union Territory of Chandigarh, and 16% elsewhere (Uttar Pradesh, Rajasthan, Jammu & Kashmir, and others). The most frequently spoken language in this patient catchment area is Punjabi followed by Hindi. Religious affiliations identify cultural and lifestyle factors; the major religious groups in the population are Sikh, Hindu and Muslim.

Cancer patients report to various clinics and departments of the Nehru Hospital attached to PGI. Data collecting cells are based in the Radiotherapy, Surgery, Neurosurgery, Pathology, and the Central Registration Departments. Their records are screened by cancer registry staff and pertinent cases abstracted in the cancer registry files.

Whenever possible histopathology reports are obtained; if not, the diagnosis is based on clinical, radiologic and other grounds. A special file, completed by medical personnel and cancer registry staff, records treatment and follow-up. Registration of cancer patients attending various OPDs besides those of gynecology and obstet, ENT, eg. orthopedics and dermatology, is also attempted.

Data collected are pooled in the Central cell in the Dept of Radiotherapy. Registry data are screened, matched for duplicates, and coded by registry staff. All registered cases are fed into a computer; records are maintained for retrieval.

COMMENT: A total of 2415 cancer patients were registered in 1986 compared to 2428 in 1985 and 2426 in 1984. The total hospital bed strength was 794 in these three years, a fraction of which were for cancer. Lung cancer was the most frequent cancer in males (around 11%), consistently since 1982. In women, the leading cancers were cervix uteri (over 40% in 1985 and 43% in 1986), followed by breast (15% in 1986). Interestingly, this registry included gall bladder cancer, relatively rare in other parts of India, among the ten most frequent cancers in women. The rate of microscopic diagnoses was over 90%. Around 10% cancers both in males and females - were diagnosed when localised. Over 90% of patients with localised cancers, and 83-84% with regionally spread disease, took cancer directed treatment.

SENIOR STAFF as of DECEMBER 1988

Dr. B.D.GUPTA, Project Chief Dr. D.P.SINGH,Sr Research Officer (Med.) Mr. S.P.S.BHATIA, Bio-statistician Dr. S.PANDIT, Jr Research Officer (Med.) Mr. S.SROA, Medical Record Officer (till 31 July 1988)

HOSPITAL CANCER REGISTRY: CHANDIGARH

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HOSPITAL CANCER REGISTRY CHANDIGARH NUMBER OF INCIDENT CASES OF CANCER BY AGE AND SITE , AND PERCENTAGES

3.09 14.49 0.08 42.87 0.00 1325 100.00 0.15 0.91 0.68 0.83 0.08 0.00 .08 TOTAL 0 ANS 11 75+ 69-69 20 60-64 106 55-59 146 50-54 209 104 193 40-44 178 35-39 150 30 - 3491 25-29 99 20-24 15-19 16 10-14 91 5-9 13 OTH DIG SYS NASAL CAVIT LAKYNX LYMPH MYEL MONO OTH SP UNSPEC SEC RES ETC SEC OTH PRIM UNK VAGINA URI BLADDER KIDNEY HODGK DIS NODE OTH KES SYS BONE CONNECTIVE SKIN MEL UTERUS UNS CERVIX UTER MY ELOM GL FL OF MOUTH OTHER MOUTH HY POPHARY NX GALLBLADDER SKIN OTH BREAST FEM BODY UTEKUS NEKV SYST THYK GLAND OTH ENDO GI ILLDEF SITE NASOPHARYNX PHARYNX ETC STOMACH SM INTEST KETKOPEKIT OKOPHAKYNX OESOPHAGUS SALIVARY PLACENTA PANCKEAS LYMPHOSA SITE SEC LY PL EURA RECTUM THYMUS OVARY BRAIN COLON LIVER MULT LEUK CEUK LUNG ICD. 9

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* BASE TONGUE, SOFT PALATE, UVULA

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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

YEAK : 1986	
HOSPITAL CANCEK REGISTRY CHANDIGAKH DETAILED AGE-SEX DISTRIBUTION OF CANCERS OF LIP, ORAL CAVITY & STRUCTURES RELATED TO OKOPHAKYNX *	

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* BASE TONGUE, SOFT PALATE, UVULA

YEAK : 1986	S TOTAL
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EGISTRY CHANDIGARH DETAILED AGE-SEX DISTRIBUTION OF CANCERS OF PHARYNX EXCLUDING NASOPHARYNX, OESOPHAGUS AND LARYNX	SITE 0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+
SEX K DISTRIBUTION OF CANCERS OF PHA	10-14 15-19 20-24 25-29 30-34 38
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

HOSPITAL CANCER REGISTRY CHANDIGARH

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* EXTENT OF DISBASE GROUPS: LOC=Localised; REG=Directly extended, regional lymph nodes (rln) involved, directly extended with rln involved; DIS=Distant metastasis, too advanced

** OTHER GROUP: Not palpable; not applicable, eg hæmatological cancers; treated elsewhere; recurrent; or unknown

HOSPITAL CANCER REGISTRY: DIBRUGARH

This registry in Dibrugarh is located in the Assam Medical Colleged (established in 1947). From 1982 to date, this general hospital has 1200 beds some of which are used for cancer patients. As the only cancer care facility till recently in North-East India, patients come from a large hinterland. The Assam Valley comprises about 58,274 square kilometers from 25°N to 27°N and 89°E to 96°E, with about 23 million people of diverse ethnic origins, caucasoid, mongoloid, and genetic mixtures. Religious communities include Hindus, Musllims, Christians; other subgroups are plains and hill tribal people each with distinctivecultures and life styles. Roughly 90-93% cancer patients are from eastern and southern Assam; 7-10% from the adjoining states of Arunachal Pradesh, Nagaland and Manipur. A variety of languages and dialects, some Indo-European and others Tibeto-Burmese in origin are used in the region. In Assam, the areca (betel) nut ("Tamol") which is chewed differs from that consumed elsewhere in India ("Supari"). Tamol contains very high levels of arecoline and is prepared by keeping the areca nut buried for about four months in an underground pit lined with straw and palm leves.

Cancer registry data are obtained primarily from different Out-Patient Departments, In-Patient Wards, and the pathology, radiology and medical records departments. Every cancer patient is contacted at the point of entry to the hosptal before any definitive care in begun. Suspected and provisionally diagnosed cancer patients are followed through their investigation and treatment period. The assistance of attending physicians is sought whenever needed.

A few points specific to this registry: Some patients receive radiotherapy and/or chemotherapy from outside the hospital because of its high bed-occupancy rates. Records of these patients are retrieved from the Department of Radiology and Pathology. The daily returns are checked for completeness and correctness. The investigators revisit patients when incomplete data arw detected. Second, in a large number of patients biopsies are examined in outside laboratories. The histopathological slides of these cases are collected, stored, and later reviewed, in the Pathology Department for coding.

The registry maintains separate files for each patient registered, and alphabetically arranged name-index and disease index cards to eliminate duplicates and also distinguish a new from an old or a recurrent case. Each patient discharched alive in followed up at the time of check-up or by mailing a reply-paid post card to the patient's permanent addres. The information obtained is entered in the follow-up register.

COMMENT: Total registrations in 1986 were 1313; 1211 in 1985 and 1198 in 1984. Male : female ratios were predominantly (2.4:1) in favour of males in all three years. Around 85% cancers were microscopically diagnosed. The leading cancers using UICC definitions for oral cavity and pharynx, were : cervix (22.9%) followed by oesophagus (12.7%) and breast (12.5%) in females; and pharynx (37.6%) followed oesophagus (17%) in males. Over 90% patients with localised and around 90% with regionally spread disease were treated for cancer.

SENIOR STAFF as of DECEMBER 1988

Dr. K.C. Baruah, MD., Project Chief Dr. M.S. Ali, Ph.D. Sr Biostatistician Positions Vacant - Sr Research Officer (Med.) - Sr Research Fellow (Med.)

HOSPITAL CANOER REGISTRY: DIBBUGARH

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* BASE TONGUE, SOFT PALATE, UVULA

YEAK	
	YNX, OESOPHAGUS AND LAKYNX
SEX : MALE	STRIBUTION OF CANCERS OF PHARYNX EXCLUDING NASOPHAR
HOSPITAL CANCER REGISTRY DIBRUGARH	DETAILED AGE-SEX DI

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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

YEAR	
	STRUCTURES RELATED TO OROPHARYNX *
SEX : FEMALE	THE DESCRIPTION OF CANCERS OF LIP. ORAL, CAVITY & STRUCTURES RELATED TO OROPHARYNX
OSPITAL CANCER REGISTRY DIBRUGARH	בשרא הש דד גשמה

1986	TOTAL	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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* BASE TONGUE, SOFT PALATE, UVULA

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YEAR : 1986	!!	TOTAL
YEAR		ANS
ZNX		75+
SEX : FEMALE : LON OF CANCERS OF PHARYNX EXCLUDING NASOPHARYNX, OESOPHAGUS AND LARYNX		70-74
US AN		69-5
SOPHAG		0-64 6
X, OE	E1 F1 F1	-59 6
PHARYN		-54 55
NASOI	61 61 51 31	49 50-
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S OF 1		30-34
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HOSPITAL CANCER REGISTRY DIBRUGARH DETAILED AGE-SEX DISTRIBUT		SITE 0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

HOSPITAL CANCER REGISTRY DIBHUGÄRH
EXTENT OF DISEASE GROUPS* EXCLUDING PATIENTS NOT EVALUATED FOR CANCER SPREAD (OTHER GROUP)**

140 LIP 50 141 TONGUE 37 142 SALIVARY GLANDS 0 143 GUM 42 144 FL OF MOUTH 0 145 OTHEK MOUTH 38 146 ONOPHARYNX 32 149 PHARYNX ETC 55 150 OESOPHAGUS 69 151 STOMACH 11 152 SM INTEST 0 153 MINTEST 0 154 KECTUM 25 155 LIVER 0 155 LIVER 0 155 LIVER 0 156 GALLBLADDER 0 157 PANCHEAS 0 158 KETTOPERIT 0 158 KETTOPERIT 0 159 OTH DIG SYST 0 160 NASAL CAVITY 50	33.3.3.50.00.00.00.00.00.00.00.00.00.00.00.00.	K W W W W W W W W W		00000000000000000	6 1 1 7 2 2 34 89 10 134	0.0	100.0 81.3 0.0 0.0 0.0 25.0	0.0	100.0	2		2 25	7 78 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 8 2 2 8 2 8 2 2 8 2 2 8 2 2 8 2 2 8 2 2 8 2 2 2 8 2 2 2 2 2 8 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	010	0.0000
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HODGK DIS		0.0	0.0	2.0	0	0.0	0.0		0 0					100	0
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LEUK MONO	0.	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0		0	0 0.	0	0.0
LEUK OTH SPE	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0		0	0 0.	0	0 0.0
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LOC=Localised; REG=Directly extended, regional lymph nodes (rln) involved, directly extended with rln involved; DIS=Distant metastasis, too advanced * EXTENT OF DISEASE GROUPS:

** OTHEK GKOUP: Not palpable; not applicable, eg haematological cancers; treated elsewhere; recurrent; or unknown

HOSPITAL CANCER REGISTRY: TRIVANDRUM

The hospital cancer registry in the Regional Cancer Centre (RCC) Trivandrum. registers patients from institutions under the Medical College administrative complex, and from the Regional Cancer Centre located in the same campus.

The Trivandrum Medical College, established in 1953, is the oldest Medical College in Kerala. Institutions included under it are the Medical College Hospital, Dental College Clinic, Sree Avittom Thirunal Hospital for women and children from 0-12 years. The Medical College Hospital (MCH) is a teaching hospital with 1329 beds; it caters only to referred patients, and admits about 36,000 patients annually. The Dental College Clinics are attached to the Medical College complex, hold regular out-patient clinics, have no beds, so inpatients are admitted to MCH wards. The Sree Avittom Thirunal Hospital with 706 beds for women and children, is a teaching hospital of the MCH. It admits more than 38,000, mostly maternity patients, annually. The RCC established in 1981 by the Government of India is the radiotherapy teaching wing of the Medical College but maintains its autonomy in all other activities. It has 129 beds exclusively for cancer inpatient services. Over 96% of more than 4000 patient referrals annually have cancer. It is the largest radiotherapy centre in the state and currently has all cancer treatment facilities.

Patients diagnosed and treated elsewhere for cancer either completely or partially are also referred to this centre for further treatment or advice. The majority of patients attending this centre are drawn from southern Kerala where Trivandrum is situated and also from the adjoining districts of Tamil Nadu. The registry started data collection from January 1982.

COMMENT: In 1986, 4232 cancer cases were registered, compared to 3857 in 1985, 3852 in 1984. Males consistently outnumbered females (1.2:1) from 1984. With oral cavity defined according to UICC criteria excluding base tongue, soft palate and uvula, it was the leading cancer (18.4%) in males in 1986, followed by lung (11.4%) and then by pharynx including base tongue, soft palate and uvula (8.4%). In females, cancer of the cervix (24.2%) was first, followed by breast (18.2%), oral cavity (14.2%), ovary (5.1%) and thyroid (3.7%). About 83-84% cancers in males and 88-89% in females were microscopically diagnosed. Around 20% male and 25% female patients in 1986 were excluded from extent of cancer assessments. After these exclusions, around 20% male and female patients were first diagnosed with localised cancers, and around 28% male and 15% female, with advanced disease. Cancerdirected treatment was given to about 70% male and 87% female patients with localised disease and around 70% male and 88% female with regionally spread cancers at first diagnosis, in 1986.

SENIOR STAFF as of DECEMBER 1988

Dr. M. Krishnan Nair, Project Chief

Mr. P. Gangadharan, Sr Bio-statistician

Dr. R.Sankaranarayanan, Sr Research Officer

Dr. T.K.Padmanabhan, Co-investigator

Dr. M.A. Aleykutty, Co-investigator

Dr. C.K.Sugathan, Co-investigator

Mr. R.Raveendran Nair, Medical Records Officer Dr. N.Sreedevi Amma, Co-investigator

HOSPITAL CANCER REGISTRY: TRIVANDRUM

	c c	n % n %	CLINICAL ONLY n %	OTHERS	TOTALS n 8
LIP	72	0.0	5 27.8	0 0 0 0	18 100.0
SALIVARY GLANDS	14 87.5	00,	2 12.5		16 100
GUM FL OF MOUTH	59 88.1 16 88.9	0.0	2 11.1		~ 60
OTHER MOUTH	85.	0 0	30 13.7		10
OKOPHAKYNX	98			0.00	69 100.0
NASOPHAKYNX	57 90.3		0.10	2 33.1	4
PHAKYNX ETC	9 0				5 100.0
OESOPHAGUS	7	-	3 2.4	6 4.	126 100.0
STOMACH	82 63.6	16 12	6 4 4 7	25 19.4	D C
SM INTEST	OOT				
K D L C L C L C L C L C L C L C L C L C L	36 92.3			2 5.1	
LIVER				0.0 0.0	0
GALLBLADDER	28	1 14.3		57.	
PANCKEAS	11 40.7	2 7.4		51.	27 100.0
KETKOPEKIT	7	0.0			3 100.0
OTH DIG SYST		0.0			0.1
NASAL CAVITY	00 0		0.8		
LAKYNX	26		7.0	1.0	
LUNG	707 1.1.	1 50 0	8.0	0.0	3 0
PLEUKA	3 100 0		•		
THIMUS	0.00			0.0	0.0
	10			0.0	26 100.0
CONNECTIVE TISS	6 9		0.0	0.0 0.0	17 100.0
		0.0 0.0	1 7.1	0.0 0.0	4
SKIN OTH	44 100.0	•	0.0	0.0	44 100.0
BKEAST MALE	-	0.0	0.0	0.0	7
PROSTATE	1.8 60.0		6 20.0	2 6.7	30 100.0
TESTIS	7		0.0	0.0	10
PENIS ETC	35 83.3		7 16.7	0.0	707
URI BLADDER		1 4.0	0.0	4 16.0	TOT
KIDNEY			0.0	0.0	26 100.0
EYE	-	0.0	0.0	0.0	
BRAIN		37 36.3	1 1.0	0.0	102 100.0
NEKV SYST	6 85.7	1 14.3	0.0	0.0	7 10
THYR GLAND		0.0	1 3.1	0.0	32 100.0
OTH ENDO GLDS	7 100.0	0.0	0.0	0.0	7 100.0
ILLDEF SITE	1 100.0	0	0.0	0.0	1 100.0
SEC LY NODE	59 93.7		2 3.2	0.0 0	3
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HODGK DIS	4	0.0	1 2 . 9	0.0	5 100
OTH LYM PHOMA	, ,	0.0	1 2.4	0.0	2 10
MILT MYELOMA		1 3.6	1 3.6	9 32.1	8 10
LEUK LYMPH		0.0	0.0 0.0	0.0	0 1
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SKIN MEL SKIN MEL SKIN MEL SKIN MEL SKIN OTH UTEROS UNS CERVIX UTEROS BODY UTEROS OVARY VAGINA UKI BLADDEN KIDNEY EXE BKAIN NEKV SYST	ıc	100.0	0	0.0	0	0.0	0	0.0		100.0
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* BASE TONGUE, SOFT PALATE, UVULA

YEAK : 1986	5+ ANS TOTAL	
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

YEAK : 1986	
SEX : FEMALE	ISTRIBUTION OF CANCERS OF LIP, ORAL CAVITY & STRUCTURES RELATED TO OROPHAKYNX *
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* BASE TONGUE, SOFT PALATE, UVULA

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* EXTENT OF DISEASE GROUPS: LOC=Localised; REG=Directly extended, regional lymph nodes (rln) involved, directly extended with rln involved; DIS=Distant metastasis, too advanced

** OTHEK GKOUP: Not palpable; not applicable; eg haematological cancers; treated elsewhere; recurrent; or unknown

HOSPITAL CANCER REGISTRY: BANGALORE

This registry is located in the Kidwai Memorial Institute of Oncology, (KMIO), one of ten Regional Centres for Cancer Treatment & Research in India since 1980. It is a Comprehensive Cancer Centre and a referral institution with 210 beds till 1986, and 252 beds from 1987. Additional 200 ambulatory patients with an equal number of attendants can stay in a Dharamashala on the Institute campus while utilizing its services. The institute is structured into five major divisions, viz. pathology, and surgical, radiation, medical, and preventive oncology. About 52% patients are from different parts of Karnataka, about 16% from the adjacent States of Tamil Nadu, Andhra Pradesh, Kerala, and Maharashtra, and the rest from the Bangalore Urban Agglomerate. Patient turnover has greatly increased in recent years due to cancer awareness created through Mobile Cancer Education and Detection camps. Diagnosis and treatment facilities are comprehensive, and multidisciplinary. The KMIO hospital cancer registry, functional since 1980, came into the NCRP network from Janyary 1, 1984.

Registry staff collect information on every patient attending KMIO in the NCRP questionnaire. After initial encounter as an outpatient with a General Duty Doctor in the hospital, the patient is triaged to medical records. The referral department is indicated according to the complaint or site of malignancy. After a case record is prepared, the patient is interviewed by the Social Investigator of the Registry. Data so collected and medically-related information abstracted by doctors are entered onto floppy diskettes for transmission to the Technical Wing. The registry sends follow-up cards to all patients except those with proven benign tumours. A follow-up register is separately maintained.

COMMENT: A total of 6026 patients were registered in 1986 compared to 5777 in 1985 and 4993 in 1984. The male: female ratio was consistently in favour of females (0.8, 0.9 and 0.9) in these three years. In 1986, (using the UICC definition for oral cavity - excluding base tongue, soft palate and uvula which are related to the oropharynx) the leading cancers in females were cervical (42% in 1986), followed by oral cavity (13.7%) and then by breast (10%). In males, cancers of the pharynx (19%), esophagus (10.3%), and lung (9%) predominated in 1986. Interestingly, females exceeded males by 2:1 for oral cavity cancers, and in their proportions of oral cancers (13.7% to 7.4%). About 85-90% cancers in men and over 90% in women were microscopically diagnosed since 1984. After excluding patients not evaluable for extent of diease, in 1986, around 18% male and 9% female solid cancers were first diagnosed when localised; about 25% male and 18% female when distantly spread and the remainder had spread to regional structures at first diagnosis before any treatment. Around 60% of localised cancers and of regionally spread disease in both males and females were treated in the institution in 1986. Treatment status was unknown in 7-8% patients. The remainder did not take cancer-directed treatment.

SENIOR STAFF as of DECEMBER 1988

Dr. M.K. Bhargava, MD., Project Chief

Mr. K.R. Reddy, Chief Biostatistician

Mr. C. Ramesh, Biostatistician

Mr. D.J. Jayaram, Sr. Investigator/Scientific Asst.

HOSPITAL CANCER REGISTRY : BANGALORE

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30NE CONNECTIVE 'FISS SKIN MEL SKIN OTH SKEAST MALE PROSTATE PESTIS PESTIS	25	98.0	0		100				27
CONNECTIVE TISS SKIN MEL SKIN OTH SKEAST MALE PROSTATE PESTIS PENIS ETC	67		1	1	001			0	
SKIN MEL SKIN OTH SKEST MALE PROSTATE PESTIS PENIS ETC	1.0	7.06	-i C		> 1	•			1001
SKEAST MALE PROSTATE FESTIS PENIS ETC 14T BLADDER	37	94.9	0 0		2	• •	0	0	10
PROSTATE FESTIS PENIS ETC 14T RLANDER	7	87.5	0		0	0.0	1 12	.5	8 100.
PENTS PENTS PENTS BTC	23	88.5	8		1	3.8	1 3	3.8 2	
PENIS ETC	32	97.0	0		1	3.0	0 0	0.	
THT RIADDRA	43	95.6	0		2	4.4	0 0	0.	
	43	89.6	2		2	4.2	1 2	2.1 4	8 100.
TINES THE TANK TANK	22	78.6			7	7.1	1	3.6 2	8 100
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OTH	35	85.4	9	14.6	0	0.0	0 0	0.	10
->	e	42.9	2	28.6	2	28.6	0	0.0	7 100.
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ALT CIRDS MORALS	25.88	0 00	121	4.2	118	4.1	47	1.6 287	4 100

METHODS OF DIAGNOSIS OF CANCER BY SITE NUMBERS AND PR	51
SITE MICROSCOPIC RADIOLOGIC CLINICAL ONLY OTHERS	TOTALS

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	34	97.1	0	0.0	> ⊢	2.9	0	0.0	35	100.0
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-	1	33.3	2	9	0	0	0	0.0	m	100.0
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	7	100.0	0		0	0.0	0	0.0	7	0
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	0	0.0	0		D	0.0	0	0	0	0.0
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	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
	37	28.1	0		c	7.1	С	0.0	42	0
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	19	95.0	0	0.0	-1	5.0	0	0.0	20	T00.0
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	7	100.0	0	0.0	0	0.0	0	0.0	7	100.0
CERUTX	1307	98	C	0-0	14	[[4	0.3	1325	100.0
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	17	94.4	-	5.6	0	0.0	0	0.0	18	100.0
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ICD.9	40																157													1/3				181					189										200	200							208		

1986	TOTAL	81470000	168 127 0 0 1 1 0 0 0 39	43 3 3	26 1 0 25 25	114 66 0 0 14 11 11 0
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OF	30-34	0000000	10000000	0100	0001	400001100
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* BASE TONGUE, SOFT PALATE, UVULA

	14	,
YEAR : 1986	20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+ ANS TOTAL	
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1	75+	
AND LAKYN	70-74	
AGUS AM	62-69	
DESOPH?	60-64	
KYNX, (55-59	
ASOPHA	50-54	
DING	45-49	
RYNX EXCLUDING NASOPHAKYNX, OESC	40-44	
SEX : MALE PHARYNX EXC	4 35-35	
OF	SITE 0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+	
F CANCERS (4 25-2	
ION OF	9 20-2	
TRIBUT	4 15-1	
SEX DIS	9 10-1	
BANGAI	4 5-	
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

YEAR : 1986		
ITAL CANCER REGISTRY BANGALORE	DETAILED AGE-SEX DISTRIBUTION OF CANCERS OF LIP, ORAL CAVITY & STRUCTURES RELATED TO OROPHARYNX *	

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20			$\omega = \omega$	TONGUE BASE TONGUE BORSUM TONGUE BORDER & TIP VENTH TONGUE ANT Z/3KD TON JUNCT ZONE LING TONSIL TONGUE OTHER	GUM UPPER GUM LOWER GUM GUM OTHER GUM NOS FLOOR MOUTH	PP	田区 川
	GIT		LIP VERMIL VERMIL MUCOSA MUCOSA MUCOSA LIP OTILIP LIP OTILIP	TONGUE BASE TO DOKSUM BOKDER VENTR ANT 2/ JUNCT LING TONGUE TONGUE	GUM UPPER LOWER GUM OT GUM NC FLOOR	LAI FL FL MOUT FL MOUT MOUTH (BUCCAL VESTIB HARD PI SOFT PI	UVULA PALATI RETRON MOUTH MOUTH
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YEAK : 1986	ANS TOTAL	
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YNX	75+	11 11 11 11
ND LAK	70-74	
AGUS AI	69-59	
SEX : FEMALE DETAILED AGE-SEX DISTRIBUTION OF CANCERS OF PHARYNX EXCLUDING NASOPHARYNX, OESOPHAGUS AND LARYNX	1 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+	
RYNX,	55-59	
ASOPHA	50-54	11
JDING N	45-49	15
FEMALE K EXCL	9 40-44	
SEX : FEMALE PHARYNX EXCL(4 35-3	H
KS OF	9 30-3	11 11 11 11
CANCE	4 25-2	11
TION OF	9 20-2	
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ANGALORE AGE-SEX DISTE	0-4 5-9 10-14	
BANGAI	5-5	
TAILED	0 – 4	
HOSPITAL CANCER REGISTRY BANGALORE DETAILED AGE-SEX D	SITE	i
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

HOSPITAL CANCER REGISTRY BANGALORE
EXTENT OF DISEASE GROUPS* EXCLUDING PATIENTS NOT EVALUATED FOR CANCER SPREAD (OTHER GROUP)**

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LOC=Localised; REG=Directly extended, regional lymph nodes (rln) involved, directly extended with rln involved; DIS=Distant metastasis, too advanced * EXTENT OF DISEASE GHOUPS:

** OTHER GROUP: Not palpable; not applicable, eg haematological cancers; treated elsewhere; recurrent; or unknown

HOSPITAL CANCER REGISTRY - BOMBAY

This registry is located in the Tata Memorial Hospital, established by the Dorabji Tata Trust in 1941 as the pioneer cancer hospital in India. This hospital is one of two units of the Tata Memorial Centre. The other unit is the Cancer Research Institute, founded in 1952 to conduct basic research in cancer. Administrative control of the Centre is with the Department of Atomic Energy, Government of India.

The Tata Memorial Hospital (TMH) is a well equipped comprehensive cancer care hospital with departments of surgery, anaesthesiology, pathology, cytology, biochemistry, blood bank, radiodiagnosis, radiotherapy, medical oncology, medical records and statistics, social service, rehabilitation and administration. Total staff strength is 1780, consisting of 207 medical and scientific, 357 technical, 170 administrative and 1046 auxiliary personnel. As of 1986 the hospital has 370 beds, a 22-bedded intensive care unit and 8 operation theatres.

Patients come from all over India to the hospital. During 1986, of the 12,447 cancer patients diagnosed 28.2% were from Bombay city, 34.1% from Maharashtra state (excluding Bombay), 9.1% from Uttar Pradesh, 6.1% from Madhya Pradesh, 4.9% from Gujarat and 15.8% from other parts of India.

The Hospital Cancer Registry, functioning under the Department of Medical Records & Statistics since 1941, joined the NCRP network from January 1, 1984. The TMH registry now collects data on the NCRP-HCR proforma in addition to its own forms. As of 1986, staff assigned to the registry include one clinical investigator, 2 scientific assistants and 1 upper division clerk.

A NORSK Data ND 550-CX mini computer with 24 interactive terminals was installed at TMH in November 1985. All abstracted cancer patient data have been entered in the computer. So far data on 35,000 cancer patients registered from 1984-1986 are available on the computer for clinical research, epidemiological studies and education.

COMMENT :

In 1986, around 12,500 cases were registered, compared to 12,002 in 1985 and 10,615 in 1984. Male:female ratio was 1.3 in 1986, similar to previous years. When head & neck cancers were classified by UICC criteria, the leading cancer in men was of the pharynx (19.8%), then lip & oral cavity (12.4%), and esophagus (8.1%). In women the leading cancer was cervical (29.7%), then breast (21.9%), oral cavity with lip (7.3%). Some 93-94% cancers were microscopically diagnosed. About 20-25% were localised and half to three-fourths regionally spread at first diagnosis. About 80% males with localised, 70% with regionally spread, and 35% with advanced cancers were treated. Among female patients, around 90% with localised or regionally spread disease, and 40% with advanced cancers were treated.

SENIOR STAFF AS OF DECEMBER 1988/JANUARY 1989

Dr. P. B. Desai, Project Chief

Mr. D. N. Rao, Biostatistician & Medical Records Officer

Dr. P. D. Shroff, Clinical Investigator

HOSPITAL CANCER REGISTRY - BOMBAY

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PLECKA THYMUS OTH RES SYST BONE CONNECTIVE TISS SKIN MEL SKIN OTH BRAST FEM OTERUS UNSP CERVIX UTERUS OVARY VAGINA UKI BLADDEK KIDNEY KIDNEY KEYEN	-	0.0	>		4 0	6	100.00
THYMUS OTH RES SYST BONE CONNECTIVE TISS SKIN MEL SKIN OTH BREAST FEM OTERUS ONSP CERVIX UTERUS BODY UTERUS OVARY VAGINA URI BLADDER KIDNEY EXT			_			H C	0.07
OTH RES SIST BONE CONNECTIVE TISS SKIN MEL SKIN OTH BEAST FEW UTERUS UNSP CERVIX UTERIS BODY UTERUS OVARY VAGINA UKI BLADDEK KIDNEY EXEKT			0 0) C	0	0.0
BONE SKIN MEL SKIN MEL SKIN MEL SKIN OTH BREAST FEW UTERUS UNSP CERVIX UTERIS PLACENTA BODY UTERUS OVARX VAGINA ULL BLADDER KIDNEY					9 4		
CONTROLLY INTERCULATION OF THE SKIN MEL SKIN OTH BREAST FEW UTERUS UNSPECTORY OF THE STATE OF THE STATE OF THE SKIN OF THE SKI					1.8	5.5	100.0
SKIN MELSIKIN MELSIKIN MELSIKIN OTH BREAST FEM II UTERUS UNSP CERVIX UTERI IS PLACENTA BODY UTERUS OVARY VAGINA UKI BLADDEK KIDNEY ETSE					1 0		0.000
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CERVIX UTERI PLACENTA BODY UTERUS OVARY VAGINA URI BLADDER KIDNEY EYE			, 0	-	o	1634	100.0
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HODGK DIS		0	0.0			37	100.0
OTH LYMPHOMA	-	0	0		0	20	100.0
MUL'E MYELOMA	94.	0	0		2	19	100.0
LEUK LYMPH	100	0	0		0	95	100.0
LEUK MYEL 1		0	0		1.	102	100.0
LEUK MONO		0	0	0	0.	7	100.0
LEUK OTH SPE		0.0	0.	0	0	0	
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69-59	210111741608 200000000000000000000000000000000000	344
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40-44	4 0 1 1 1 1 1 1 2 2 2 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	710
35-39	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	515
30-34	144411444466600001100011040000014688	306
25-29	0 4 0 0 1 0 1 0 1 0 0 1 1 0 1 0 0 0 1 1 0 1 0 0 1 4 0 0 0 1 0 1	177
20-24	0100004400400000440804080400000810440800000000	92
15-19	00000000000000000000000000000000000000	99
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.9 SITE	LIP TONGUE SALIVARY GL GUM TONGUE SALIVARY GL GUM OTHER MOUTH OCOPHARINX HASOPHARINX HASOPHARINX HASOPHARINX HASOPHARINX HANDOPHARINX HANDOR LIVER GALLBLADDER FECTUM LIVER GALLBLADDER LARYNX LUNG FECTUM GARINA UNG LEURA NUT HENDO GL LILDEF STE EXE EXE EXE NOTH ENDO GL LILDEF STTE SCC TH PRIN UNK LINDEY SEC CTH PRIN UNK LIMPHOSM LEUR MULT MYELOM LEUR MULT MYELOM LEUR LYMPHOSM LEUR LYMPHOSM LEUR LYMPHOSM LEUR LYMPH LEUR LYMPHOSM LEUR LYMPH LYM	TOTAL
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* BASE TONGUE, SOFT PALATE, UVULA

1986	ANS TOTAL	11
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) LARY	70-74	
US AND	5-69	2 11 11 11 11
SOPHAGU)-64 6	
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LUDING	44 45-	
SEX : MALE PHAKYNX EXCLUDIN	39 40-	
SEX : PHARY	34 35-	
SKS OF	4 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+	#
F CANCER	4 25-2	
ION OF	9 20-2	
TRIBUT	1 15-1	
X DIS	10-14	
OMBAY AGE-SE	0-4 5-9 10-1	
SEX : MALE SETAILED AGE-SEX DISTRIBUTION OF CANCERS OF PHARYNX EXCLUDING NASOPHARYNX, OESOPHAGUS AND LARYNX	0-4	
OSPITAL CANCER REGISTRY BOMBAY DETAILED AGE-S	SITE	
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

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* BASE TONGUE, SOFT PALATE, UVULA

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50-54	00000000000000000000000000000000000000	295
45-49	80000000000000000000000000000000000000	246
40-44	0.0044460000000000000000000000000000000	142
35-39	080077147876104770000400077870000501100700171004000	117
30-34	1008005%%00707707700000000000000000000000	79
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20-24	000000000000000000000000000000000000000	42
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HOSPITAL CANC	ICD9 4 TH DIGIT	1400.0 1400.0 1400.0 1400.3 1400.4 1400.6 1400.8	141 141 141 141 141 141 141 141 155 160 160 160 160 160 160 160 160 160 160	1443 1443 1443.1 1443.8	144 144.0 144.1 144.8	114455.0 14455.2 114455.2 114455.2 114455.3 114455.3

* BASE TONGUE, SOFT PALATE, UVULA

YEAR : 1986 ID LARYNX	70-74 75+ ANS TOTAL	
SEX : MALE DETAILED AGE-SEX DISTRIBUTION OF CANCERS OF PHARYNX EXCLUDING NASOPHARYNX, OESOPHAGUS AND LARYNX	SITE 0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75+ A	
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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

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* BASE TONGUE, SOFT PALATE, UVULA

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* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

HOSFITAL CANCER REGISTRY MADRAS
EXTENT OF DISEASE GROUPS* EXCLUDING PATIENTS NOT EVALUATED FOR CANCER SPREAD (OTHER GROUP)**

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* EXTENT OF DISEASE GROUPS: LOC-Localised; REG-Directly extended, regional lymph nodes (rln) involved, directly extended with rln involved; DIS-Distant metastasis, too advanced

** OTHER GROUP: Not palpable; not applicable, eg haematological cancers; treated elsewhere; recurrent; or unknown

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HOSPITAL CANCER REGISTRY: MADRAS

The hospital tumour registry of the Cancer Institute has been in existence since the inception of the hospital in 1955. Since January 1, 1984 the hospital cancer registry is part of the National Cancer Registry Project (ICMR) network of registries.

The Institute is a 405 bed comprehensive cancer centre. The clinical research facilities comprise the divisions of surgical, radiation, medical oncology and tumour epidemiology. A micro computer DCM-Tandy TRS 80 Model 4 is used for quality checking and analysis of hospital cancer registry data. Social investigators abstract data from patient records. These are verified by a medical officr, then coded, checked for duplicates, computerised, and sent to the Technical Wing for further processing and tabulation.

Cancer patients registered have the following regional distribution: Tamil Nadu 53%, Andhra Pradesh 37%, and 10% from other parts of India and from neighbouring countries. Major language groups of patients include Tamil, Telugu and Malayalam; major religious groups represented are Hindu, Christian and Muslim.

COMMENTS: The total of 4454 cases registered in 1986 consisted of 2046 males and 2408 females. Comparatively, 4344 cases (males - 1985, females - 2359) were registered in 1985; and in 1984, 3973 cases (males - 1807, females - 2166). Females have consistently outnumbered males by a small margin since 1984. The male to female ratio in 1986 was 0.9.

The leading cancers in males in 1986, [when oral cavity and pharynx were defined according to UICC criteria] were pharynx (19.9%), oral cavity and lip (15.5%), followed by esophagus (9.9%), stomach (7.0%) and lung (6.0%). The most frequent cancers in 1986 in females, using the same criteria, were cervix, (46.8%), followed by breast (13.0%), oral cavity and lip (10.7%).

After excluding the 25% males and 17% of female patients who could not be assessed for cancer spread, among the assessable patients, 9% of male and 7% of female cancers were localised; 73% and 84% were regionally spread respectively in males and females; and the rest were advanced/disseminated at first diagnosis. Cancer directed treatment was taken by 61% of the male patients with localised cancers and 73% of the female; 59% of those with regionally spread disease in both gender groups; and nearly 40% of those with advanced cancers.

SENIOR STAFF AS OF DECEMBER, 1988

Dr. V. Shanta, Project Chief

Dr. C. K. Gajalakshmi, Officer-in-Charge

HOSPITAL CANCER REGISTRY BOMBAY

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* EXTENT OF DISBASE GROUPS: LOC=Localised; kEG=Directly extended, regional lymph nodes (rln) involved, directly extended with rln involved; DIS=Distant metastasis, too advanced

Not palpable; not applicable, eg haematological cancers; treated elsewhere; recurrent; or unknown

** OTHER GROUP:

YEAR : 1986	
SEX : FEMALE	DISTRIBUTION OF CANCERS OF PHARYNX EXCLUDING NASOPHARYNX, OESOPHAGUS AND LARYNX
HOSPITAL CANCER REGISTRY BOMBAY	DETAILED AGE-SEX DISTRI

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E	OROPHARYNX * TONSIL TONS FOSEA TONS PILLARS VALLECULA ANT EPIGLOTT JUNCT REGION ÍAT WALL ORO POST WALL ORO ORO OTHER	HYPOPHAKYNX POSTCKICOID PYKIF SINUS AKYEPIGL FOL POST WALL HYPOPH OTHER	PHAKYNX NOS PHAKYNX NOS WALD KING PHAKYNX OTH	OESOPHAGUS CERVICAL OES THORACIC OES ABDOM OESOPH MID 3RD OESO MID 3RD OESO LOW 31 D OESO OESOPH OTHER OESOPH NOS	
ICD9	1146.1 1146.1 1146.1 1146.1 1146.2 1146.5 1146.5 1146.5 1146.9	148 148.0 148.1 148.2 148.3	149.0 149.0 149.1 149.8	150 150 150 150 150 150 150 150 150 150	161.0 161.0 161.1 161.2 161.3 161.8

* UICC DEFINITION INCLUDES BASE TONGUE, SOFT PALATE, UVULA

