Three men with pain and difficulty urinating

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BOTSOGO

BOTSWANA ONCOLOGY
GLOBAL OUTREACH

Continuing Medical Education Announcement

Harvard Medical School

RSS 3081: Monthly BOTSOGO Tumor Board; 2017-2018 Academic Year

Today's Objectives:

- Describe the need for timely cancer case presentation and referral to treatment
- Formulate a multi-disciplinary plan for the care of common and complex oncologic cases
- Adopt successful, sustainable strategies to mitigate barriers to quality cancer care common in resource constrained environments

Target Audience:

Oncologists, internists, surgeons, radiation oncologists, infectious disease specialists, nurses, physicists, therapists, technicians, research staff, administrators, policy makers.

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Statements

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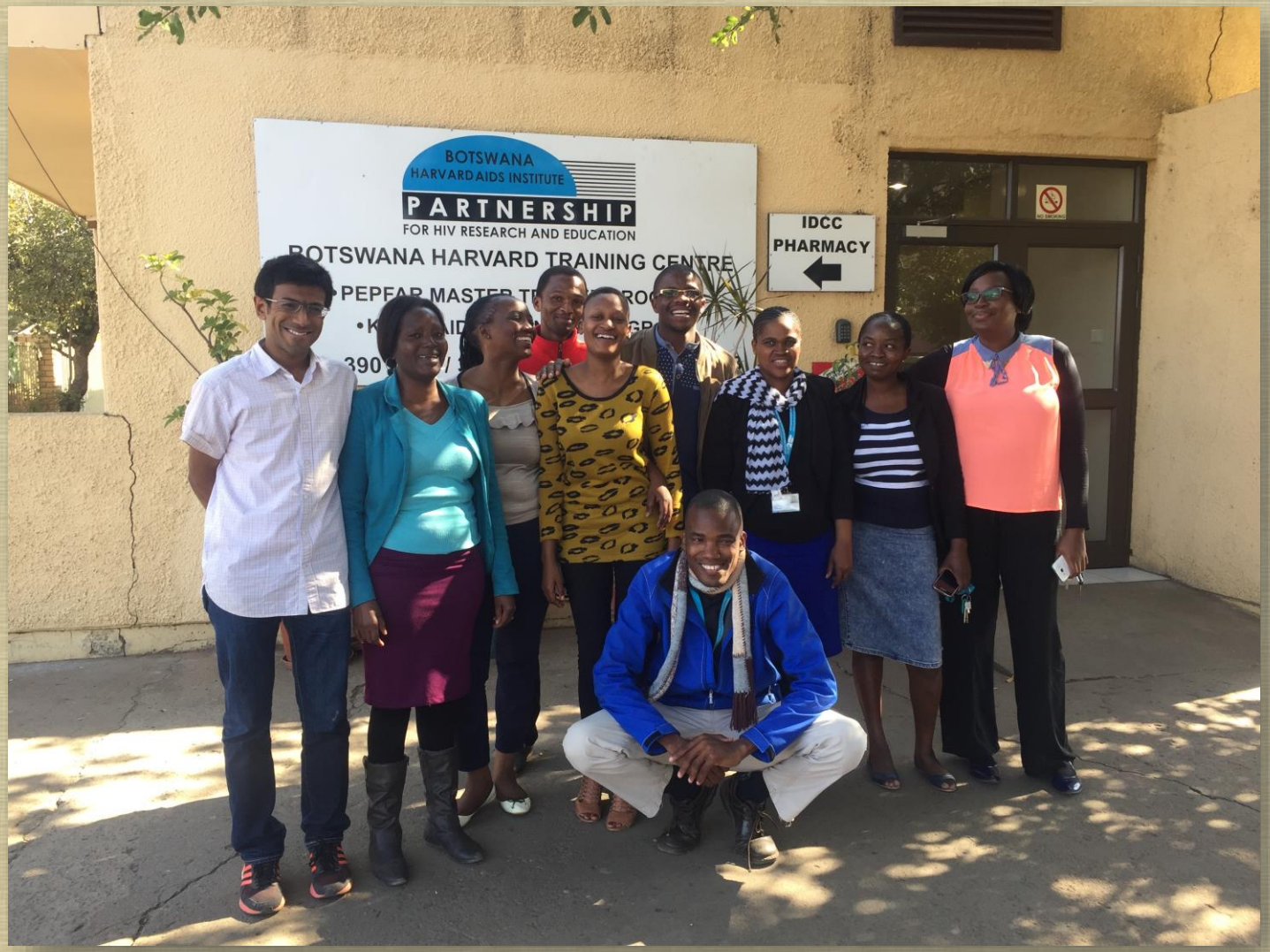
- To claim your CME credit for attendance at this session of the BOTSOGO Tumor Board, please fill out our survey after the Tumor Board.
- You can do this at your convenience on your personal or work computer by navigating to www.botsogo.org
  - Click “What We Do”
  - Click “Tumor Board”
  - Click the link under the section “Continuing Education Credits,” and complete and submit the survey
- Or follow the link that was emailed to our MGH BOTSOGO email list: www.tinyurl.com/tumourboard



Potlako Team

Men and diagnosis/treatment for cancer in Botswana:

Decreased access to diagnosis/treatment

- Men present at PMH/NRH/GPH/BPH with more advanced stage cancer than women
- Early Potlako data: men 4-times less likely to receive any cancer specific therapy, majority of men NOT treated for their cancer before dying
- Leading untreated cancers in men are prostate and esophageal cancer

Today's discussion:

Goal to start to define a diagnostic approach for patients with suspected prostate cancer

Key questions:

- Who in health system does prostate exam currently and who should be doing exams?
- What is the yield/utility of ultrasound?
- Is there a PSA cut-off where biopsy should always be attempted?
- Which patients should be referred to urology?
- When is treatment indicated for presumptive diagnosis without biopsy and/or PSA?

Case 1—73yoM HIV- with fatigue and abdominal pain:

"Difficulty urinating, dysuria, and abdominal pain"

- Previously seen at 4 different facilities: primary clinic, PMH, BLH, and GPH
- Enrolled in Potlako at SLH/SOPD in mid-March 2017, felt to be low probability of cancer (BPH most likely)
- Hematuria and catheter placed, PSA drawn
- Symptomatically improved for 2-3mo, going monthly to try to get PSA results, not available
- Potlako team asked for help from NHL/UB pathology, 'will get back to you', team reviewing for results in IPMS frequently

Case 1—73yoM HIV- with fatigue and abdominal pain:

Clinical decline

- July 2017, gasping for breadth presented to BLH, pleural and pericardial effusion diagnosed
- Admitted to PMH and catheterized with improvement in symptoms and able to return home, but further details of treatments uncertain to patient
- Still no PSA results

Case 1—73yoM HIV- with fatigue and abdominal pain:

In person visit with Potlako coordinator at SLH, Sept 2017

- Review of records with 2 ultrasounds readings suspicious for prostate cancer
- Patient with leg swelling, occasional SOB, variable urine stream that improves after catheterization but doesn't last
- Record of PSA being drawn but no results
- Current referral for cardiology given 'water around liver'
- Never referred to urology, because awaiting PSA result
  - Patient frustrated w/ health system
  - Potlako coordinator booked with urology

Case 1—73yoM HIV- with fatigue and abdominal pain:

PMH Urology

- Seen at PMH urology and CT ordered, 1mo wait
- Potlako team found PSA result, >150 ng/mL
- Reviewed again in urology, but biopsy needles out of stock
- Patient requested by urology to call PMH minor theatre regularly to see if needles have come in stock
- Patient and Potlako team have called this week, still no needles

Case 2—76yoM HIV- with inguinal swelling:

"Long standing inguinal swelling and periodic pain"

- Symptoms started about 10yrs ago
- No cutaneous sores
- Seen at local clinic and SLH, biopsy planned but told possibility that 'could not wake up' so refused
- Getting worse
- Enrolled in Potlako in April 2017

SLH evaluation- May 2017

- Ultrasound with 'fingerlike projection in bladder'
- PSA drawn

Case 2—76yoM HIV- with inguinal swelling:

Awaiting PSA results

- Returned 5 times to get PSA results at SLH
- Referred to PMH urology and traveled to Gaborone, but turned away at reception as no PSA results
- Potlako coordinator learnt that contract for PSA testing lapsed between NHL and some private LAB for PSA reagents, NHL seeking new tender/contract
- Potlako discussed with urology, need to get a new PSA drawn

Case 2—76yoM HIV- with inguinal swelling:

New PSA draw- Sept 2017

- Patient returned to SLH to have new PSA draw, but turned away by security as OPD cards said should be drawn in October
- Potlako advised to return and explain why needed draw
- PSA returned in early Oct 2017 at 54.34 ng/mL in IPMS

Case 3—58yoM HIV- with back pain:

"Waist ache and bone aches all over body"

- Symptoms started in Dec 2016
- Seen at local clinic
- Seen by private doctor who obtained X-ray
- Admitted to SLH MSW with bony lesions, late Jan 2017
- Ultrasound with prostate mass, **no biopsy or PSA done**

PMH Oncology

- Seen during SLH admission, referred for RT
  - Started RT at GPH in early April 2017

Summary of today's discussion:

Goal: Start to define a diagnostic approach for patients with suspected prostate cancer.

Key questions:

- Who in health system does prostate exam currently and who should be doing exams?
  - We confirmed that all doctors in Botswana have received training in prostate exam; discussion revealed that not all doctors actually perform this and may have limited experience in identifying nodules. Further dedicated training may be warranted.

- What is the yield/utility of ultrasound?
  - Transrectal ultrasound is preferable to abdominal ultrasound but neither are ideal diagnostic tools, and do not take the place of a digital rectal exam.

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Today's discussion:

Key questions, continued:

- Is there a PSA cut-off where biopsy should always be attempted?
  - Discussion yielded no clear cutoff PSA; PSA over 20 rarely seen in settings of prostatitis (or other non-cancer diagnoses) and PSA over 10-20 should be followed by biopsy when available.
- When is treatment indicated for presumptive diagnosis without biopsy and/or PSA?
  - PSA over 100 may warrant treatment even without biopsy; this is a topic that will benefit from continued discussion.