Scientific Research Publishing

Problem of Invasive Cervical Cancer's Management in the Obstetric Gynecologic Department of the National Hospital Donka, Conakry

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Abstract

Introduction: The objectives of this study were to describe the diagnostic and therapeutic aspects, identify problems and evaluate the survival rate of invasive cervical cancer patients. **Patients and method:** It was a retrospective descriptive study of 7 years from 1 January 2006 to 31 December 2012. Records of invasive cervical cancer were histologically confirmed. The clinical and therapeutic data collected were transferred to Epi info 7 and SSPS version 18 software with a significance level $p < 0.05$. The telephone network was used to provide information on the vital condition after confidential agreement. Kaplan Meier was used to assess the overall survival rate. **Results:** Invasive cancer of the cervix was frequent (58.79%) with an annual median rate of 16.7%, with extremes of 5.8% and 20.6%. 88.70% of the patients was referred from regions of the country (54.02%); the median age was 50 years with extremes of 16 and 84 years and a peak of 29.6% between 35 and 44 years; 76.20% were housewives; uneducated women were about 60.12%; Stage III was about 45.3%. Most of the patients were confirmed histologically after 30 days (68%). The means of treatment were surgery about 91 (29.26%), palliation 75 (24.12%), radiotherapy 59 (18.97%) and chemotherapy 41 (13.18%) with surgery (9, 65%) or radiotherapy (4.82%). The main complication was metrorrhagia, 164 cases (56.55%), with overall survival rate of 51.8% at 2 years and 5.1% at 5 years. **Conclusion:** Invasive cervical cancer in later stages is treated for low survival in the context of our work. Early detection and treatment of precan-

cerous lesions would reduce the incidence and mortality of this cancer.

1. Introduction

Cervical cancer is one of the most common gynecologic cancers in the world. It is the second most common cancer of women in the world with 493,000 new cases per year and responsible for more than 275,000 deaths a year, 88% of which occur in low-limited countries [1]. In the United States, where cancer is the second leading cause of death, 12,200 new cases of invasive cervical cancer have been diagnosed and 4210 cases of deaths within Afro and Asian populations [2]. In Latin America and the Caribbean, The mean incidence is 10.4% [3].

The risk of cervical cancer during life is estimated at 4% in developing countries and less than 1% in industrialized countries [4].

In Africa, this cancer is at the forefront of female cancers [5]. Its reported standardized incidence in West Africa is 29.3 per 100,000 [6] [7].

In Guinea, it is the first of the gynecological cancers of Guinean women with an age-standardized incidence of 56.3 per 100,000 [8]. Among them, the most frequent is invasive cervical cancer in the obstetric and gynecologic department at the National Hospital Donka of the Conakry's Teaching Hospital.

The objective of this study is to describe the diagnostic aspects, to identify the difficulties related to the management and to evaluate the outcome of the patients received for invasive cancer of the cervix in our work context.

2. Materials and Methods

We carried out a quasi-retrospective descriptive study of cases of invasive cervical cancer collected at the Obstetric Gynecology Department of the Donka National Hospital of Conakry' teaching Hospital for a period of 7 years from 1st January 2007 to 31st December 2012. Cases *in situ* cancers and micro invasive cancers were excluded.

The study involved the description of epidemiological characteristics, management difficulties and analysis of the survival rate of invasive cervical cancer's patients at the 31/12/2012 point date.

Data on the patient's vital status, obtained after obtaining their consent and the assurance of confidentiality by telephone call, were reported on an anonymous survey form and transferred in Epi Info7 and SPSS software version 18 for analysis with a threshold of significance $p < 0.05$.

Survival curves were performed by the methods of Kaplan Meier. The lost to follow up with a poor general condition, and whose responsible persons could not be reached on the telephone, were considered dead patients.

3. Results

During the 7-year study period, 311 cases of invasive cervical cancers, histologically confirmed in Donka's pathological anatomy, were collected on 515 gynecological cancers about 58.79% (Text 1).

The median annual rate of service attendance was 16.7% with extremes of 5.8% in 2011 and 20.6% in 2008. Patients came from Regions 168 (54.02) and were referred by a health care provider in 88.70% (Text 2).

The median age was 50 years with extremes of 16 and 84 years, with a peak in the age range of 35 - 44 years 92 (29.6%), followed by age groups of 55 - 64 years And 45 - 54 years in 21.5% respectively. And 22.5% (**Figure 1**).

Housewives 237 (76.20%) were the most affected socio-professional group followed by the liberal 58 (18.65%). They were uneducated in 60.10% of cases, followed by those having primary education (15.60%) and secondary education of (12.40%) (**Figure 2**).

Patients used traditional treatment in 80.38% before going to health facilities or having their orientation in the structure health facilities (Text 3).

They were received in the department with clinically advanced lesions in stages II and III in 39.20% and 45.3%, respectively, for a histological confirmation waiting period greater than 30 days in 68% (**Table 1**).
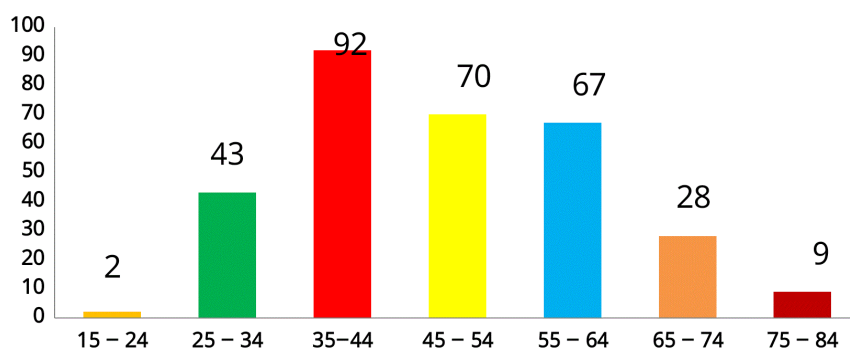

Figure 1. The distribution of invasive cervical cancers according to age groups at the Obstetrics and gynecologic department of National Hospital Donka.
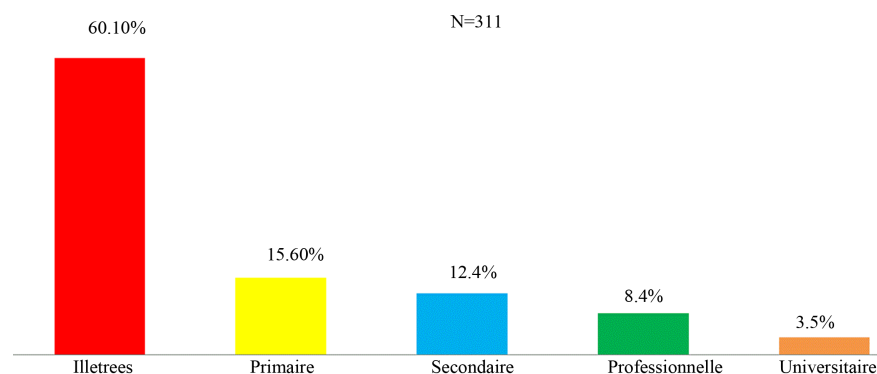

Figure 2. Distribution of invasive cervical cancers according to level of education in gynecology department Donka Obstetrics.

For treatment, patients were treated with surgery 91 (29.26%), palliation with analgesics 75 (24.12%), radiotherapy 59 (18.97%) and chemotherapy 41 (13.18%). Therapeutic combinations were surgery with chemotherapy (9.65%) and chemotherapy with radiotherapy (4.82%) (Table 2).

Radiotherapy was performed outside the country in 59 (18.97%) cases at the Juliot Marie institute of Dantec in Dakar and 1 (0.32%) in Morocco (Text 4).

The main complications were metrorrhagia with 164 cases (56.55%), pelvic pain, 46 (15.86%), urine retention, 38 (13.10%), constipation, 23 (7.93 %) And anemia, 19 (6.56%) (Text 5).

In general, overall survival at 2 years was 51.8% and 5.1% at 5 years at 31/12/2012 (Figure 3 and Figure 4).

We did not analyze survival factors such as age, education, parity and clinical stage.

4. Discussion

Invasive cancer of the cervix was the most important gynecological and mammary cancer with a higher proportion (Text1) than the average of 43.65% in sub-Saharan Africa [9] and 56.3% in Tunisia [10]. Annual attendance was variable with a median of 16.7% and a peak of 20.6% in 2008. The low rate in 2011 is lower than that of 7.5% (400 cases) reported by Essomba Biwole M. *et al.* In Douala [11], significantly higher than the 1.7% was found in 5 years by N'Guessan K. *et al.* at the Cocody Hospital [12].

Table 1. Distribution of invasive cervical cancers according to the clinical stages of the FIGO classification (TNM) in the service of Gynecology and Obstetrics of Donka National Hospital.

Clinical Stages (TNM)	Effectif	%
Stage I	18	5.80
Stage II	122	39.20
Stage III	141	45.30
Stage IV	30	9.70
Total	311	100

Table 2. Distribution of invasive cervical cancers according to treatment in the Gynecological-Obstetric Department of Donka National Hospital.

Treatment	*Effectif* (311)	%
Surgery	91	29.26
Palliative	75	24.12
Radiothérapy	59	18.97
Chimiothérapy	41	13.18
Surgery + Chimiotherapy	30	9.65
Radiotherapy + Chimiotherapy	15	4.82

Fonction de survie
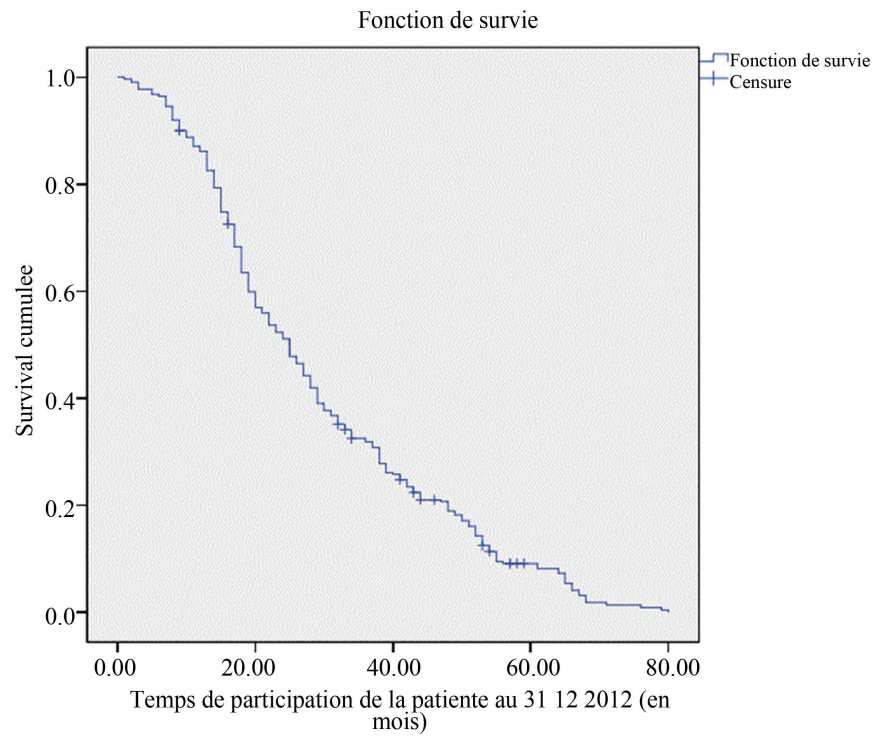
Figure 3. Survival curve at 2 years of patients with invasive cervical cancer.
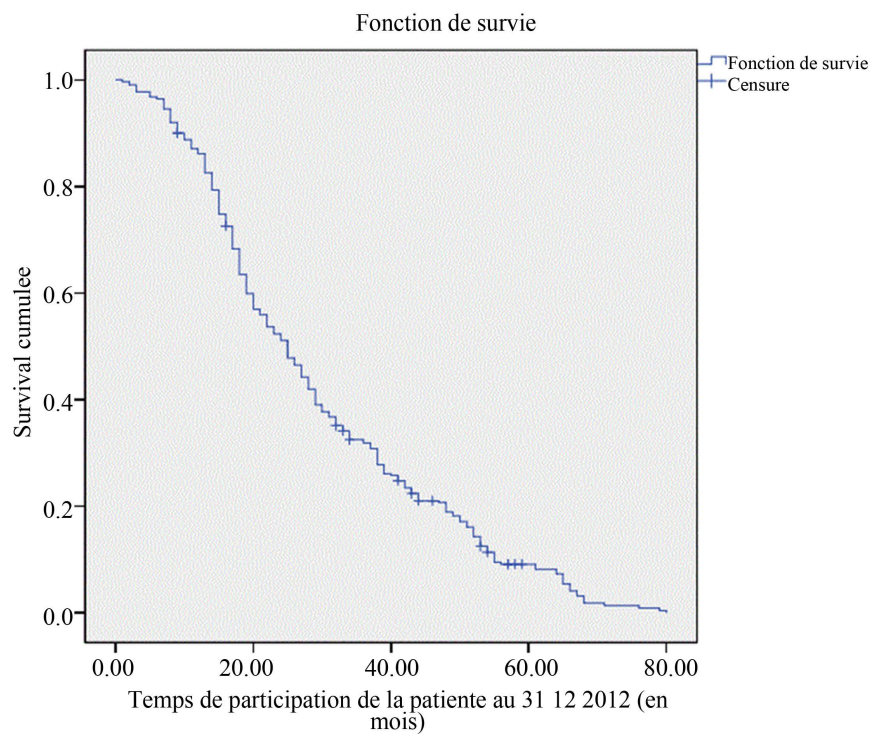
Fonction de survie

Figure 4. Survival curve at 5 years of patients with invasive cervical cancer.

The origin of the patients outside the capital (Text 2), is contrary to that reported in Madagascar where the patients resided in 73.7% in Antananarivo in

2003 [13]. It is due to the lack of skills for regular oncological consultations in the provinces.

The average age at diagnosis of 50 years ± 4 years (**Figure 1**) is su-per-imposable at the average ages of 49 - 50 reported by Acharki A. *et al.* [14] in Morocco in 2002 and Monchy D. *et al.* [15] in Cambodia in 2005. The peak in the age group of 35 - 44 years, 92 (29.6%) cases (**Figure 1**), is the opposite of 61 - 70 years in Tunisia, where in 2004, the mean age was 54 years with 12.5% under 40 years [10]. In other African series, the average age between 43 and 48 years has been reported in Cameroon [10] and Senegal [16].

The appearance of invasive cervical cancer at a relatively young age in Africa compared to the countries of Europe and America would be linked to the up-surge of risk factors such as early sexual intercourse, multiple sexual partner-ships, infections sexually transmitted diseases that expose human papilloma vi-rus (HPV) and HIV, early and forced marriage.

Multiparity, known as a risk factor for cervical cancer, at a very high rate in our series, was certainly linked to forced and unprotected marriages and forced sex at home.

This is consistent with the high number of 237 (76.20%) in our series of housewives from disadvantaged socio-economic backgrounds with very limited access to health care due to lack of health information and illiteracy.

Ninety percent of women had no education at all, a rate higher than those of 60.10% and 62% of illiterates respectively in Douala [11] and Abidjan [12]. The predominance of women (**Figure 2**) is certainly related to the girl's low enroll-ment rate about 48% in primary school and 11% in secondary school in Guinea in 2005 [17].

The insidious evolution of the disease, the lack of knowledge of the signs of cancer and the retention of patients in health facilities for irrational and even surgical care, would be linked to the late reference due to a lack of skills within the country where there are only 3 no functional representations of the CERFFO-PCG.

The financial, transport and correspondence problems in Conakry, because the patients reside mostly outside the capital, would contribute to the second delay in diagnosis at a locally advanced clinical stage II and III of 39.20% and 45%, respectively, 3% (**Table 2**). We agree with Essomba Biwole M. *et al.* [11] that the long delay between onset of symptoms and use of care and the absence of a national screening and vaccination policy would explain the high rate of these FIGO Stages.

The promotion of screening for precancerous and cancerous lesions has led to a drastic decline in the rate of advanced stages to 33% in Kenya in 2013 [18].

The current strategy of Donovan, Conakry, CERFFO-PCG in recent years is the organization of an annual cervical cancer screening campaign with early treatment of precancerous lesions in hospitals in the interior of the country. All targets do not have access to this strategy, one of whose objectives is to reduce

the 3rd delay between the clinical diagnosis and the surgical procedure.

This delay, which was prolonged by a long waiting time for the results of histological confirmation greater than 30 days and extension exploring the field, is aggravated by the lack of respect for the surgery programs by certain patients because of lack of financial means.

Some patients in Stage I came back with advance stage when surgery cannot been done and for whom hospitalization for palliation occurred in 75 (24.12%) cases, at the reception they only received analgesics, analgesics, antibiotics and blood transfusion in case severe anemia at their charge. The country does not subsidize the treatment of cancers in Guinea.

Patients were counseled for radiotherapy or brachytherapy performed by some 59 (18.97%) in Dakar at an estimated cost of 20,244,602 GNF (1,451,043 CFA or 21,310 €) in the first month which does not include the lorry fair or cost of living, and 1 (0.32%) in Morocco (Text 4).

This therapy, a lack of means in Guinea, was associated with chemotherapy in 15 (4.82%) cases. The cost includes the costs of consultation, hospitalization, complementary examinations, surgery, postoperative care and 6 chemotherapy sessions, estimated at between 24,000,000 and 36,000,000 Guinean francs (GNF). 25,263,158 to 37,894,737 €, is higher than those estimated between 777 and 7458 Tunisian Dinar (DT) *i.e.* 431 - 4143 € in Tunisia [19] and between 9164 in Stage I and 26886 € in Stage IV in France [20].

Twenty-nine, twenty-six percent of the patients had undergone surgery by the enlarged iliac lymphadenectomy (Wertheim surgery) surgery (**Table 2**) for a flat rate of 600,000 GNF (42857,143 CFA or 631,579 €) (2,835,000 GNF or 2984,21 €) or of medication This rate is far superior to the 5,2% of indications of hysterectomy in Bobo Dioulasso in Burkina Faso in 2011 [21].

The progression was often accompanied by complications, mainly metrorrhagia, 164 cases (56.55%) with severe anemia (Text 5).

Overall survival at 2 years of 51.8% was lower than the 68% survival reported by Ngomo J *et al.* [22]. However, at the peak date of 31/12/12 (**Figure 3** and **Figure 4**), overall 5-year survival was 5.1%, significantly lower than 41% found by Acharki A *et al.* [13], Would be linked to the diagnosis of cancer at an advanced stage, to the therapeutic and financial difficulties of the patients.

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