

Breast Cancer-Why We Present Late

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Abstract: Breast cancer incidence is relatively lower in Africa. However, despite its relatively lower incidence, the mortality rate is quite high compared to the west. One of the reasons for the high mortality is late presentation.

This prospective study sought to find out the reasons for the late presentation.

Materials And Methods

Consecutive patients diagnosed with Breast Cancer at any stage were recruited into the study. A well-structured questionnaire was prepared, oral consent obtained after carefully explaining the purpose of the study. History was taken and physical examination done. The patients were then classified into stages and those in stages III and IV were included in this study. The questionnaires were filled by directly questioning the patients.

Data was analyzed by IBM SSPS statistics 24.

Result

There were 131/191 (68.6%) respondents who presented late in stages III & IV, all females, with an age range of 25-88 years and a mean of 48.69 (SD 11.35). The highest incidence is in the age range 40-49 with 25.2% (33/131) while the least incidence is found in the age range 80-89 with 4.6% (6/131) only. Of 131 respondents, 75 (57.3%) sought unorthodox help initially when they noticed a problem in their breasts, 4(34.4%) sought some form of orthodox help including visiting health workers at home, going to chemists/ pharmacies while only 11 (8.3%) presented first to our center. Out of 131 respondents, 14.8% (18/131) cited lack of funds, 30.3% (37/131) church/pastors/priests/prayers, 11.5% (14/131) fear of mastectomy, 30.3% (37/131) lack of awareness/knowledge, 39.3% (48/131) herbal remedy. Other reasons include self-medication, trust in God, hope, etc.

Keywords: Breast Cancer, Late Presentation, Mastectomy, Neoadjuvant Chemotherapy

I. INTRODUCTION

Breast cancer incidence is relatively lower in Africa, with the women said to have one of the lowest incidence rates in the world¹ but this has been projected to gradually increase with an estimated 119918 new cases by 2023¹. However, despite its relatively lower incidence, it has high mortality rates^{1,2} compared to the west and other high-incidence countries due to poor survival. For example, comparing the incidence and mortality rate of Breast cancer in different parts of the world, it was found that while the incidence rates are 18.2 and 103.7 cases per 100,000 population in West Africa and the developed part of the world, the mortality rates are 12.6 and 30.9 per 100,000 respectively³. Similar studies in South Africa showed 48%⁴ of new patients required neoadjuvant or palliative treatment because of late presentation.

This is the situation in Enugu Nigeria where Ezeome found that 17.5% of patients reported first to alternative practitioners⁵.

Late presentation worsens prognosis and increases mortality and there is a need to promote early presentation in our patients. This requires that the reasons for late presentation are identified.

This study is designed to determine the factors responsible for late presentation of breast cancer.

II. PATIENTS AND METHODS

Consecutive patients diagnosed with Breast Cancer at any stage were recruited into the study. A well-structured questionnaire was prepared, oral consent obtained after carefully explaining the purpose of the study. History was taken and physical examination done. The patients were then classified into stages and those in stages III and IV were included in this study. The questionnaires were filled by directly questioning the patients.

Data was analyzed by IBM SSPS statistics 24.

Patients who were too ill to answer questions or died either before investigations were concluded or before treatment were excluded from the study. Others who discontinued treatment before conclusion of investigations were also excluded.

III. RESULTS

Table 1. Descriptive Statistics

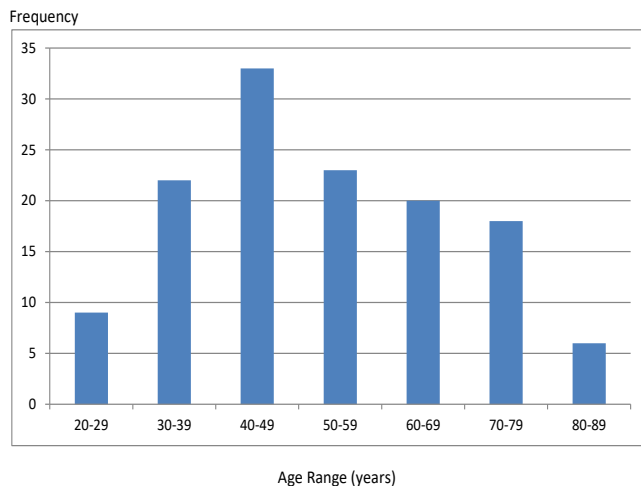
	N	Minimum	Maximum	Mean	Std. Deviation
Age At Presentation	131	25	88	48.69	11.351
Age at Onset	22	26.00	58.00	43.0909	10.22559
Height (m)	131	1.00	1.88	1.6094	.09509
Weight (kg)	131	49.00	108.00	71.5046	12.46017
BMI(Obesity)	131	14.61	70.00	27.9982	7.17222
Duration (Days)	111	2.00	9125.00	547.7658	1252.7511
Duration (Years)		0.005	25 Years	1 Yr,6 Mths	0 3.43 years
Age at Menarche	119	8.00	20.00	14.2353	2.36036
Age at Menopause	51	36.00	58.00	50.1176	4.81932
Age at 1st Pregnancy	97	15.00	47.00	23.8557	5.13361
Duration (Breastfeeding) in days	95	90.00	730.00	399.6000	161.74339
Duration (Family planning) in days	5	90.00	1095.00	558.0000	379.64786
Valid N (listwise)	0				

There were 131 respondents, all females, with age range 25-88 years and a mean of 48.69 (SD 11.35). Height ranged from 1-1.88 (Mean 1.60; SD 0.095). The weight ranged from 49-108 (Mean 71.5). Duration in days between onset of symptoms and presentation at the centre of definitive treatment is 2-9125 (0.005 to 25 years; Mean 1.5; SD 3.43).

Table 2. Age at Presentation

n =131]		Frequency (%)
Age at Presentation		
20-29		9 (6.8%)
30-39		22 (16.8%)
40-49		33 (25.2%)
50-59		23 (17.6%)
60-69		20 (15.3%)
70-79		18 (13.7%)
80-89		6 (4.6%)
BMI Obesity		
Less than 25		40 (30.5%)
25- 29		55 (42.0%)
30 Above		36 (27.5%)

Figure 1- Age Range



The figure shows that the highest incidence is in the age range 40-49 with 25.2% (33/131) while the least incidence is found at the age range 80-89 with 4.6% (6/131) only. Mean 48.69 (SD 11.35).

Table 3. Parity					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	8	6.1	7.5	7.5
	1.00	5	3.8	4.7	12.1

	2.00	17	13.0	15.9	28.0
	3.00	24	18.3	22.4	50.5
	4.00	15	11.5	14.0	64.5
	5.00	18	13.7	16.8	81.3
	6.00	10	7.6	9.3	90.7
	7.00	6	4.6	5.6	96.3
	8.00	4	3.1	3.7	100.0
	Total	107	81.7	100.0	
Missing		24	18.3		
Total		131	100.0		

Out of 107 respondents, only 7.5% (8) were nulliparous.

Table 3. Stage at Presentation

A.

Stage	Frequency	%
I	5	2.6
II	55	28.8
III	91	47.6
IV	40	21.0
Total	191	100

Of 191 respondents, 2.6% (5/191) presented in stage I, 28.8% (55/191) in stage II, 47.6% (91/191) in stage III and 21% (40/191) in stage IV.

B.

Stage	frequency	%
I & II	60	31.4
III & IV	131	68.6
TOTAL	191	100

A total of 68.6% (131/191) of respondents presented in both stages III & IV as against 31.4% (60/191) in stages I & II.

Table 4. Treatment sought before presentation

Items	Frequency	Percentage	Mean	SD
Unorthodox	75	57.3%		
Quasi- Orthodox treatment	45	34.4%		
FMC Ebute-metta, Lagos	11	8.3%		
Total	131	100%	1.44	0.498

Of 131 respondents, 75 (57.3%) sought unorthodox help initially when they noticed a problem in their breasts, 4(34.4%) sought some form of orthodox help including visiting health workers at home, going to chemists/pharmacies while only 11 (8.3%) presented first to our centre.

Table 5. Reasons for late Presentation				
		Responses		Percent of Cases
		N	Percent	
	Lack of Funds	18	11.1%	14.8%
	Church of Prayers	37	22.8%	30.3%
	Fear of Mastectomy	14	8.6%	11.5%
	Lack of awareness/Knowledge	37	22.8%	30.3%
	Herbal Remedy	48	29.6%	39.3%
	Others	8	4.9%	6.6%
Total		162	100.0%	132.8%
Out of 131 respondents, 14.8% (18/131) cited lack of funds, 30.3% (37/131) church/pastors/priests/prayers, 11.5% (14/131) fear of mastectomy, 30.3% (37/131) lack of awareness/knowledge, 39.3% (48/131) herbal remedy. Other reasons include self-medication, trust in God, hope etc.				

IV. DISCUSSION

Breast cancer can be classified to four stages based on the extent of disease progression. It is divided stages I-IV. Stages I and II are early while stages III and IV constitute late breast cancer. Breast cancer is a major public health issue in low-and medium-income countries with high case fatality rates⁶. In this study, we had 60 respondents in stages I & II and 131 respondents in Stages III & IV. These 131 respondents are the focus of this study since they are the ones that constitute late presentation. By the time of presentation, usually, the lesion in the breasts would either be fungating (Picture 2), extremely big in size compared to the contralateral side (Picture 3) or would have developed satellite lesions (Picture 4). These breast lesions are usually quite offensive and associated with bleeding. In some, there is metastatic spread to distant organs. There is usually associated weight loss, difficulty in breathing, loss of appetite and anaemia.

Picture 1.



Fungating Breast Cancer

Picture 2.



This is bilateral Breast Cancer showing a Fungating mass on the right and peau d'orange on the left.

Picture 3.



This shows Left Breast Cancer with satellite lesions

Of the 131 respondents here, 47.6% presented in stage III while 21% presented in stage IV, making a total of 68.6% presented late (Stages III & IV) while only 2.6% presented in stage I and 28.8% in stage II, making a total of 31.4% presented early (Stages I & II). In Enugu, Southeast Nigeria, 73.4%⁵ patients had delayed presentation. Others found it to be 81.6%⁷, 73.4%⁸.

Several reasons have been adduced for this poor outcome in developing countries including lack of advanced technologies for early detection and treatment. While majority of cases in the USA are detected early, detection in developing countries occurs late⁹. There were 131 respondents, all females who presented late in this study. The age ranges from 25-88 with a mean of 48.69. The highest incidence occurred in the age group 40-49 with 25.2% (33/131). Ukwenya *et al* found that delays were associated not just with younger patients¹⁰, but with a poor level of Western education and residing outside the location of the hospital. On the treatment sought before reporting to the hospital, 57.3% (75/131) sought unorthodox help first. This includes herbalists, traditional healers, and

local herb sellers. Others sought spiritual healing from religious leaders like pastors, priests, prophets, imams, and traditional religious leaders. Of the remaining, 34.4% (45/131) sought the help of orthodox healthcare workers but not in a proper hospital setting. This includes regular visits to chemists/pharmacies and healthcare workers for home treatments and wound dressing for those with fungating tumours. Those who got treated in these quasi-orthodox settings were convinced of receiving the same treatment they will get at regular hospitals but at a cheaper cost. Only 8.3% (11/131) of the respondents reported at our centre for definitive treatment.

The reasons given for late presentation were lack of funds, 14.8%, church prayers 30.3%, fear of mastectomy 11.5%, lack of awareness/knowledge 30.3%, preference for herbal remedies 39.3% and others, 6.6%, which includes self-medication, trust in God for healing and just watching. The high preference for alternative remedies could be attributable to their inherent belief in the efficacy of alternative methods¹¹, which includes herbs, traditional healers, use of antioxidants, acupuncture, homeopathy, naturopathy, and witch doctors. It was found that patients who received these forms of treatment were unlikely to accept conventional treatment and have a higher risk of death than others¹². Preference for these forms against chemotherapy is due to the belief that chemotherapy causes multiple problems¹³ like psychiatric disorders, hopelessness without necessarily helping them out medically.

Fear of losing a breast to mastectomy was the reason in 11.5% of respondents for presenting late. They thought the only treatment modality was mastectomy. This is especially commoner in younger age groups. In 1991, Ajekigbe¹⁴ found that 44.7% of respondents presented late because they didn't want to lose their breasts and in 2018, it was still an important factor in Ghana¹⁵.

Spiritual healing is one of the reasons patients presented late in the hospital. While positive effects of such have been documented¹³ when combined with conventional treatment, there is no record of spiritual healing alone as an effective modality of cancer treatment. Going to religious houses and religious leaders, for consultation and treatment, without recourse to conventional treatment, of breast cancer, only increases risk of late presentation and death.

V. CONCLUSION

It is important to improve patient education and increase breast cancer awareness so that delays in presentation can be reduced to the barest minimum. Patient education should include early detection and prompt hospital presentation, rather than visiting alternative practitioners or religious healers. Policies like mass screening should be put in place so that cases are detected early, and treatment commenced immediately. This obviates the need for mastectomy as more patients will qualify for breast-conserving surgery (BCS), thereby removing mastectomy, which is a major reason for

coming late to the hospital. Early presentation saves more lives.

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