Late presentation of patients with cervical cancer to a tertiary hospital in Lagos: what is responsible?

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Summary

Objectives: To determine the factors contributing to late presentation of patients with cervical cancer to a tertiary hospital in Lagos.

Methods: Cervical cancer patients who attended the hospital between September 2000 and December 2001 were interviewed to determine the healthcare facilities visited at the onset of symptoms and time interval between presentation and referral.

Results: There were 127 patients with a mean age of 54.6 ± 13.4 years. Common symptoms at onset of disease were post-menopausal bleeding (55.9%) and vaginal discharge (48.8%). Of the patients, 60.7.1% first went to private hospitals. The interval between onset of symptoms and seeking healthcare was 6.10 ± 9.31 months; time elapsing between seeking healthcare and referral to a tertiary hospital was 9.35 ± 12.9 months. Stage 3A cervical cancer was diagnosed in 71.8%.

Conclusion: Patients' delay in seeking healthcare and care providers' delay in referring patients to a tertiary hospital contributed to the late presentation.

Key words: Cervical cancer; Late presentation.

Introduction

Cervical cancer is the commonest gynaecological cancer in Nigeria and a leading cause of death in women [1]. It accounts for 12.7% of all cancers affecting women in south-western Nigeria [1]. In the northern part of Nigeria, cervical cancer is the commonest cancer among females [2]. The reported age-adjusted incidence rate of approximately 24.1 per 100,000 from the Ibadan-Nigeria Cancer Registry (1998-1999) [3] may even be a very conservative estimate as many women, especially those in rural areas, die of the disease unnoticed. The morbidity and mortality of this preventable disease continues to remain high in non-industrialized countries while in industrialized countries it continues to be on the decline. This disease, unfortunately, is yet to be recognized as an important public health problem in Nigeria and is also yet to be seen as an important cause of misery in women.

In Nigeria, as in many non-industrialized countries, most women present with advanced stage disease. The care of the terminally ill is very poor in most of these countries because of limited resources for palliative care. Oral morphine is not even available in many of these places. Many women with cervical cancer therefore die undignified and painful deaths. While in Nigeria there is no national screening programme and there are no plans for one in the near future, there is the need for interventions, which would at least make it possible for women with this disease to present at an early treatable stage or at a stage with a good 5-year survival rate following treatment. To find solutions to this problem of late presentation of patients with cervical cancer we performed this study to identify some of the contributing factors. We looked at the care seeking behaviour of patients when they develop symptoms of the disease and also areas where there were lapses or delays in the course of getting them to the tertiary centre for definitive treatment.

Materials and Methods

Study Area

This study was carried out in the gynaecological clinics and the Joint Oncology Clinic (JOC) of Lagos University Teaching Hospital. The JOC is run once a week by a team of gynaecological oncologists and radiotherapists. Lagos and its environs have a population of about 12 million [4]. A large number of patients with cancer of the cervix are seen in the clinics as the hospital is one of the four centres in Nigeria (population 120 million [4]) with facilities for radiotherapy.

Patients

The participants of our study were patients with cervical cancer who attended the clinics between 1st September 2000 and 31st August 2001. Consecutive patients who attended the clinic during the period who gave a verbal consent to participate in the study were interviewed by one of us (LO) using a structured questionnaire. The questionnaire asked about personal characteristics, duration of symptoms, healthcare facilities visited at the onset of symptoms, interval between onset of symptoms and

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seeking healthcare, and interval between onset of symptoms and presentation at a specialist centre.

Permission for the study was obtained from the Research Ethics Committee of the Lagos University Teaching Hospital. All the patients were provided with information on the study before being asked to give verbal consent.

Definitions

Primary health centres (PHC) are healthcare facilities that focus mainly on disease prevention and health promotion. They are mainly government owned, though a few are missionary owned. *Private hospitals* are owned by private individuals – most of them offer basic medical care and a few large ones have specialist services. General practitioners man most private hospitals. *General hospitals* are government owned and have specialists; they serve as referral centres for patients from PHC centres and private hospitals, and are usually not as equipped as tertiary hospitals. *Tertiary hospitals* provide highly specialized care and usually have subspecialties in various disciplines. They are referral centres for all the healthcare facilities mentioned above. General hospitals and tertiary hospitals are usually located in urban areas.

Data analysis

Data obtained were entered into a computer and analysis was done using the Epi Info 2000 statistical software package.

Results

All the 127 patients seen during the period consented to be interviewed. The mean age of the patients was 54.6 (SD 13.72) years with a range of 30-86 years. About one-third (29.8%) of the patients were in the 51-60 years age group (Table 1). The mean parity was 6.9 (SD 2.64) with a range of 0-13; 46.5% had no formal education and almost half of them (44.2%) were in a polygamous marriage.

Table 1. — *Demographic characteristics of patients (n = 127).*

	No.	Percentage
Age (years)		
< 30	3	2.4
31-40	19	15.5
41-50	25	20.2
51-60	41	29.8
61-70	24	19.0
71-80	11	8.3
> 80	4	4.8
Marital status		
Single	5	3.9
Married	73	57.5
Widowed	41	32.3
Divorced	6	4.7
Separated	2	1.6
Parity		
0	2	3
1-3	4	4.8
4-6	44	34.5
7-9	47	36.9
10-13	27	21.4
Educational status		
No formal education	59	46.4
Primary school	45	35.8
Secondary school	16	12.5
Post secondary school	7	5.5
Dwelling place		
Rural	89	70.1
Semi urban/urban	38	29.9

Table 2. — *Symptoms that prompted patients to seek healthcare and healthcare facilities first visited.*

	No.	Percentage
*Symptoms**		
Postmenopausal bleeding	71	55.9
Vaginal discharge	62	48.8
Lower abdominal pain	42	33.1
Postcoital bleeding	41	32.3
Backache	20	15.7
Intermenstrual bleeding	8	6.3
Menorrhagia	6	4.7
Healthcare facility first visited		
Primary health centre	18	14.2
Private hospital	77	60.6
General hospital	24	18.9
Traditional herbalist home	8	6.3

* Some women had more than one symptom.

Eighty-nine (70.1%) of the patients dwelled in rural areas from where they were referred to urban areas for treatment. The average number of healthcare facilities patients visited before finally getting to a tertiary hospital was about three [2, 7]. Postmenopausal bleeding was the commonest presenting symptom (55.9%), followed closely by vaginal discharge (48.8%) and postcoital bleeding (32.3%) (Table 2). Ninety-four (73.9%) had three or more episodes of bleeding before seeking healthcare. The majority (60.7%) of the patients first presented with symptoms to private hospitals.

Table 3 shows the time lapse from the onset of symptoms to receiving definitive treatment. The mean time interval between the onset of symptoms and seeking healthcare was 6.10 (SD 6.93) months, between seeking healthcare and referral to a tertiary hospital was 9.35 (SD 12.94) months and between onset of symptoms and final presentation to a tertiary hospital for expertise care was 12.58 (SD 13.29) months. The clinical stage of disease at presentation to a tertiary hospital is shown in Table 4; 76 (59.6%), 12 (9.6%) and three (2.3%) of the patients presented with Stages IIIB, IIA, and I disease, respectively.

Discussion

The mean age of 54.6 years found in this study indicates that most of the patients with invasive carcinoma were postmenopausal and is comparable to 51.8 years reported from Ibadan-Nigeria [5] and 52.0 years reported in a study from Ghana [6] a neighbouring West African country. This means that presently the main target group for an interventional programme to prevent late presentation of this disease in Nigeria should be concentrated mainly on women who are 40 years or older.

A study from our institution two decades ago [7], like this study, also reported postmenopausal bleeding as the

Table 3. — *Time lapse from onset of symptoms to receiving definitive treatment.*

	No.	Percentage
Interval between onset of symptoms and seeking healthcare (months)		
< 1	17	13.4
1-4	39	30.7
5-8	38	29.9
9-12	15	11.8
> 12	18	14.2
Mean 6.10 ± 6.93 (range 3 days to 36 months)		
Interval between seeking healthcare and referral to specialized centre (months)		
< 1	8	6.2
1-4	48	37.8
5-8	27	21.4
9-12	12	9.4
> 12	32	25.2
Mean 9.35 ± 12.9 months (range 3 days to 66 months)		
Interval between referral and presenting at a specialized hospital (weeks)		
< 1	51	40.1
1-4	54	42.5
5-8	11	8.7
9-12	8	6.3
> 12	3	2.4
Mean 4.26 ± 11.32 weeks (range 2 days to 73 weeks)		
Interval between onset of symptoms and presenting at a specialized hospital (months)		
< 1	6	4.7
1-4	26	20.5
5-8	47	37.0
9-12	12	9.5
13-24	23	18.1
> 24	13	10.2
Mean 13.07 ± 14.26 months (range 7 days to 72 months)		

most common form of abnormal vaginal bleeding among patients with cervical cancer. This makes it an important symptom for carcinoma of the cervix in this part of the world. In a study from Jamaica, which also has as high a concentration of black people as Nigeria, 20% of the women with postmenopausal bleeding had malignancy (endometrial cancer, 9.5%; cervical cancer, 6.8% and endometrial sarcoma, 3.5%) [8]. Most of the women in our study had an average of three episodes of this symptom before seeking healthcare. This may be due to lack of awareness of the disease, lack of knowledge of its basic symptoms, and cultural beliefs [9-11]. It is reported that some women interpret menopause as a punishment from the gods and welcome postmenopausal bleeding as a gift of youth from the gods [10]. The majority of our patients resided in rural areas where cultural beliefs, ignorance, and poverty abound. A similar observation was also made in Ghana, a neighbouring West African country [12]. Rural women tend to shy away from reporting symptoms of genital tract disease like vaginal discharge and postcoital bleeding. They are also reluctant to submit themselves to pelvic examination [13]. These may be some of the reasons for the late presentation of cervical cancer.

Table 4. — *Clinical stage of disease on presentation to a tertiary hospital.*

Stage of disease	No.	Percentage
1	3	2.4
2A	9	7.1
2B	11	8.7
3A	21	16.5
3B	78	61.4
4	5	3.9

The average length of time it took before these women got referred to a tertiary hospital was disturbing. This is a reflection of the inefficient healthcare delivery in the country. In one report from Sweden, where healthcare delivery is efficient, the interval between onset of postmenopausal bleeding and referral to specialized hospitals was only five weeks [14] whereas it was 12 months in our study. The significantly short interval, a matter of weeks, between the time-referral to a tertiary hospital was made and the time patients showed up means that when these women are aware of the nature and seriousness of the disease they have, they waste no time in seeking healthcare.

Complete ignorance of the disease may be one of the reasons for delay in seeking healthcare at the onset of symptoms. Programmes that would educate women on cervical cancer and the signs and symptoms of early disease must be put into place. Such programmes should not be concentrated only in urban areas but must indeed be taken to rural areas. Rural women can be approached using churches, mosques, and local women's and community groups. Educational programmes on cervical cancer can also be integrated into existing programmes in family planning and mother and child health clinics. Clients of these clinics who are usually young mothers can further educate their friends, mothers and relatives about this disease. Further research is required to assess rural women's knowledge of cervical cancer and attitudes towards symptoms of the disease, as assessments of their knowledge and understanding of the disease will generate information that will allow integration of some essential cultural beliefs into programme design.

Healthcare providers, especially those in general practice, need to be given refresher courses on cervical cancer with emphasis on the need to act fast when women with abnormal vaginal bleeding present. Finally, the Nigerian government as well as governments in many developing or non-industrialized countries should recognise cervical cancer as a very important public health issue that should be given the same attention as malaria, childhood immunisations and HIV.

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