A REVIEW OF HUNDRED AND THREE (103) HISTOLOGICAL CONFIRMED CASES OF CARCINOMA OF THE CERVIX AT THE UNIVERSITY OF ILORIN TEACHING HOSPITAL, ILORIN, NIGERIA.

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SUMMARY

During a ten-years period from January 1991 to December 2000, 103 patients with histological confirmation of cervical cancer were managed at the University of Ilorin Teaching Hospital, Ilorin. Eighty-Three of these patients with adequate information in their folder constitute the study group. Overall, 103 cases of confirmed cervical carcinoma were seen and constitute 2.6% of gynaecological admissions. The highest incidence, (31,3%) each was found in two age groups, 40 – 49 and 60 69 years. There was no patient below 30 years of age. There was high parity among the patients, with 97.5% being multiparous. History of multiple sexual partners or having multiple sexual cohorts was high (69.9) among the studied patients.

The commonest symptom was bleeding pervaginam in 81.9% of the patients, followed by vaginal discharges in 54.2%. Majority of the patients presented after more than one mouth after onset of symptoms (96.3%) and already had advanced stage (IIb) and above disease at presentation (75.9%). The commonest histological type of cervical cancer was squamous carcinoma accounting for 81.3%.

It is noted that clerking of patients with suspected carcinoma of the cervix is deficient in terms of epidemiological documentation. Majority of our patient still present late with advanced stage disease although cervical caner is largely a preventable disease. It is suggested that efforts are directed at majority improving the epidemiological documentation, which will assist in identifying risk factor for preventive measures such as screening of those with the identified risk factors.

All over the world, women, especially those that [illegible] suffer from higher rate of morbidity and mortality form cervical cancer than previously noted (1). Cervical cancer is most common genital tract cancer in Africa (2), the second leading cause of death for women worldwide, and the leading cause of death form cancer among women in developing countries (3)

In the US an estimated 15,000 cases of cervical cancer and an estimated 5,000 Death occur annually. This relatively low incidence figures is far from what obtains in developing countries, where an estimated 500,000 new cases are discovered very year, and one-half of these women will die from the disease (1;3). Even in affluent societies, like the US, cervical carcinoma is a poor women's disease, as statistics show higher rate among poor, elderly and minority patients (1).

One of the most significant clinical findings of recent years is that more younger women than ever before are afflicted with cervical dysplasia and carcinoma. Additionally, the mean age of women diagnosed with and dying form cervical carcinoma appears to be decreasing. The median age for discovery of high grade dysplasia has shifted from 40 to 28 years (1). This problem is further compounded in undeveloped and underdeveloped countries, where women report with late and advanced disease, and therefore have poor prognosis at presentation (2)

Cancer of the cervix can be of squamous, or glandular in origin, leading to squamous, adenosquamous or adenocarcinomatous variants of the disease. Adenocarcinoma accounts for less than 5% of all cervical cancers while squamous carcinoma accounts for 80 – 90%.

Strong risk factors for cervical cancer and its precursor have been identified and include: early age at first intercourse (16 years or younger), a history of multiple sexual partners, a history of genital human papilloma virus (HPV) infection, or other sexually transmitted diseases, the presence of other genital tract neoplasia, and prior squamous interpithelial lesion (SIL) (7- 10). 95% of invasive cancer occur in multiparae. The association with bearing of many children is not accounted for by cervical injury or infection during labour, but by the sexual intercourse, which results in the pregnancies (5). Additional risk factors include active or passive smoking, a current or past sexual partner with risk factors for sexually transmitted diseases, immunodeficiency or HIV positivity and poor nutrition (11,12). Long term users of oral contraceptives (5 years or more) have an increased incidence particularly of adenocarcinoma (7,13,14).

Some experimental evidence also points to deficiency of micronutrients particularly vitamins A, C, and E, folate and carotenes as possible risk factors for the development of cervical carcinoma (18,19).

examination of the cervix will reveal either a nodule or small ulcer, which often bleeds on contact. As it advances, the lesion becomes a crater shaped ulcer or often a friable warty looking mass (20).

The survival of women with cervical cancer is related to the stage of the disease, the method of treatment chosen, and the experience of the radiotherapist or surgeon. The 5- years relative survival rate for all women treated for invasive cervical cancer in UK is 5% (4)

The purpose of this study was to analyze the risk factors and presentations of cervical cancer in our community and find out factors influencing its management.

ward of the University of Ilorin Teaching Hospital between January 1991 and December 2000; with cervical cancer and who had histological confirmation of the disease. One hundred and three (103) patients were seen. Of these, 83 case files had adequate information for analysis with respect to age, parity, on of sexual partners, duration of disease, stage of disease and clinical presentation. They form the subject of this review.

During the study period, 3910 patients were admitted into the gynaecological ward of the University of Ilorin Teaching Hospital, Ilorin. 103 cases of cervical cancer were diagnosed by histology of cervical biopsy tissue specimen. The overall incidence of confirmed cervical cancer in this study was 2.63%.

The age distribution of the patient is shown in Table 2. The highest incidences were found in two decades, 40 - 49 and 60 - 69 years, each accounting for 31% of the patients. Nine of the patients were below 30 years of age. Sixty-four (80%) of the patients were grandmultiparas, 17.5% were multiparaesexual while only 2.5% were nulliparous (Table 3)

The number of sexual partners and/or partner with multiple Partners as a risk factors for cervical cancer is depicted in Table 4. Fifty-eight case files have information on this, out of which 40 (69.9%) had more than one sexual partner who had no other sexual partner.

Table 5 shows the clinical features of the patients. 81.9% of the patients complained of one form of bleeding or the other (intermenstrual, post coital and or postmemnopausal), and 54.2% had history of vaginal discharge. Most of the cervical lesions were exophytic, fungating or friable in nature (74.7%) while 12.0% had uncreative lesions.

As show in Table 6, the majority of patient 96.3% presented with symptoms which had been present for 4 weeks or longer. Only 1 patient (1.2%) had symptoms of less than 1 month and 2 patients (2.5% had no symptoms one was diagnosed on histology of specimen of total abdominal hysterectomy dnoe for uterine fibroids and the other came for routine Pap smear and was found to have invasive cancer.

The sage of the disease at presentation is given in Table 7. stage III carcinoma was the most common diagnosis (48.7%) followed by stage IIB (19.2%). Squamons carcinoma is the most common histological type accounting for 81.3% followed by adenosquamous carcinoma (10%) and adenocarcinomatous (3.7%). Carcinoma in site was found in 2 patients (2.5%) (Table 8)

The treatment modalities of the patients is given in Table 8. Eleven (13,3%) of the

DISCUSSION

In this study, cervical cancer occurred more often in two in two age or decades of life, 40-49 and 60 – 69 years, with two peaks of age, about 45 years and at about 60 years. Two peaks of around 35 years and 50- 55 years have also been report in the literature (5,25). The higher peaks of age incidence in our community may be due to the fact that most of the patient do not undergo screening at an age and they present only when the condition has become a full blow and advanced disease and also because younger women might have treated by herbalists or not present at all for treatment.

Majority of the patients (97.5%) were multiparae while only 2.1% were nulliparae. This agrees with what obtains in other studies (2,26). It has been explained that the association between cervical cancer and bearing of children, is not accounted for by cervical injury or infection during labour but by the sexual intercourse, which result in the pregnancies. High parity usually means frequent coitus during many years, stating at a young age (5) and therefore worsen the tendencies when there is exposure to sexually transmitted disease, which can persist because of re-infection form one wife to the other. Poor socioeconomic condition, which usually accompanies high parity, is a recognized risk factor cervical cancer (1.5). Multiple sexual partner or having partners who have sex with other women are recognized risk factor for the development of cervical cancer (7-10,23). Majority (69.9%) of the patients reviewed had multiple sexual partners pr were married into polygamous homes.

In the majority of cases (96.3), symptoms have been present for 4 weeks or longer. Late presentation is a common feature of cervical cancer in developing counties, where women are ignorant of the disease and its symptoms, where adverse socioeconomic factors prevent them from presenting earlier for treatment and where nutrition deficient in micronutrients are the order of the day (2,27).

Abnormal vaginal bleeding and/or vaginal discharge were the most frequently reported symptoms in this study. This agrees fully with in the literature (2,5). Vaginal bleeding comes by surface ulceration of the growth, while vaginal discharge is caused by necrosis and attendant infection of necrotic tissue with saprophytes (5). An obvious cervical growth was present in the majority (86.7%) of the patient due to late and advanced presentation of the disease. Adadevoh, 1994 reported obvious cervical growth in 58.6% of his series (2). It is important to note that bleeding is usually cased by contact, and most women at the age they present are not sexual active and therefore would only bleed when ulceration occurs.

The commonest histological type of cervical cancer in this study was squamons carcinoma, accounting for 81.3% while 3.7% were adenocarcinomas, and the remainders are of a mixed carcinoma type. This agreed with the literature where about 80-90% is attributed to squamous type and less than 5% to adenocercinoma (4,5). Younger women (those under 40) have been reported to have a higher proportion of the mixed tumor pattern, which in a series in Manchester was as high as 30-40% (5). However, all the 9 cases of cervical cancer diagnosed below 40 years of age in this study were all squamous carcinoma. This might be explained by the fact that long-tern use of oral contraceptive (5 years of more), which has been linked development of particularly adenocarcinoma, is rare in this environment (7,13,14).

Arising from the presentation and advanced stage of the disease only 11(13.3%) of the patient could be helped with radical surgery with the intent of cure. All these patients had between CIN III and stage Iia disease. Moreover, 6 out of the patients so treated, came back with evidence of recurrence after 6 month to 3 years of operation. This is explained in part by fact that half of these patient primarily had total abdominal hysterectomy for other condition other than cervical cancer , so that the full extent of spread of the disease was unknown at the time of surgery (23).

This study has shown that cervical cancer is a disease of grandmultiparous women who had multiple sexual partners or had partners with multiple sexual partners. Moreover, women reported late with the disease and often symptoms have been present for more than a month. This is an unfortunate picture considering that cervical cancer is a preventable disease. Education of all women on risk factors for cervical cancer and how to reduce these factors by practicing "safe sex" – using a condom, avoiding promiscuous sexual activity, and fidelity are perhaps the most important preventative measure a women can take to reduce the risk of cervical dysplasia and carcinoma. All women, once they start practicing sex, should be encourage to have regular Pap smear to detect the premalignant states of this disease. Radiotherapy facilities to treat these patient are also needed in most centres in Nigeria. Documentation of all known epidemiological factors associated with cervical cancer need to be strengthened to allow for proper identification of the population at risk for screening purposes. The institution should also invest in the new screening test called Human papillomavirus testing recommended as a secondary test following an abnormal or equivocal low grade screening cytology result. The poor results from surgical treatment is in favour of referring all histologically confirmed cases of carcinoma of the cervix for radiotherapy.

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Table 2: Age Distribution of patients

Age (Years)	*No*	*% Total*
30-39	9	10,9
40-49	28	33.7
50-59	10	12.1
60-69	26	31.3
70-79	5	6.0
≥ 80	5	6.0

Table 3 Distribution of Patient by parity

Parity	*NO*	*% Total*
0	2	2.5
1-4	14	17.5
≥ 5	64	80

Table 4: No sexual Partner and or Sexual partner with more than one partner

Sexual partner	*No*	*% Total*
1 Sexual partner	18	31.1
> 1 Sexual partner and/or sexual partners with more than one partner	40	69.9

Table 5: Clinical Presentation of Cervical Cancer

Symptoms and signs	**No**	**% Total**
Virginal Bleeding	68	81.9
Virginal discharge	45	54.2

Ulcerative lesion	10	12.0
Exophytic/hard and craggy/fungating friable lesion.	62	74.7

Table 6: Duration of illness

Duration	*NO*	*% Total*
< 1 month	1	1.2
1-3 month	35	44.4
4-6 month	15	18.4
7-12 month	19	23.5
> 1 year	8	9.9
Asymptomatic	2	2.5

Table 7: stage of Disease

Stage	*No*	*% Total*
Carcinoma in situ	2	2.6
I	10	12.8
IIA	7	8.9
IIB	15	19.2
III	38	48.7
IV	6	7.8

Table 8: Histological Types

Histological Types	*No*	*% Total*
Squamons	65	18.3
Adeosquamous	8	10.0
Adenocarninoma	3	3.7
Anaplastic	2	2.5
Carcinoma in situ	2	2.5

Table 9: Modalities of Treatment

Modalities of Treatment	*NO*	*%*
Total Abdominal Hysterectomy	11	13.3
Referral for Radiotherapy	25	30.1
Palliative treatment/lost to follow-up	47	56.6
Total	**83**	**100**