

Brief Report

A study of patients who appear with far advanced cancer at Yaounde General Hospital, Cameroon, Africa

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Abstract

Background: This is a preliminary study to identify patients with cancer who appeared with very advanced disease and to report the common reasons for their delay. It was undertaken because the numbers of such patients appeared to be increasing.

Method: A convenience sample of 20 patients were identified by the oncologist (P.N.) as appearing with very late stage disease or appearing and not returning until a late stage. They were interviewed by the psychologist (A.E.) to determine: symptom onset; treatment sought; reasons for seeking consultation; beliefs, fears, and level of information about cancer; and willingness to be treated.

Results: The primary reasons given for waiting so long to seek care were: inability to pay for medical care (10); inadequate diagnosis by general doctors leading to time lost before coming for consultation; (9); beliefs, fears, cultural factors, ignorance (9). More than one factor could be identified in half the patients.

Conclusion: Understanding the factors that influence delay is important to improving the outcomes for cancer patients. Factors that contribute to delay in developing countries appear to be largely the paucity of appropriate health care, coupled with poor information, and beliefs and fears about cancer.

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Introduction

Reasons for seeking consultation for cancer-suspicious symptoms have been studied in western countries since the 1940s examining patient and doctor related factors [1]. Scant information is available, however, about factors associated with delay in resource-limited countries. This paper is a preliminary report on the factors associated with extreme delay as seen at the Oncology Division of Yaounde General Hospital in Cameroon, located in western Africa. The country has a population of 16 million for which there are two medical oncologists, four radiotherapists, seven pathologists, and a few surgeons. There is no health insurance and most of the population has an income below the poverty line. Cancer therapy is very expensive so these socioeconomic factors are powerful determinants of little or no treatment. Equally strong are the effects of educational level and cultural fears and beliefs about cancer in the absence of education about it. These factors were examined in a group of patients with extreme delay who came to the oncologist (PN) in Yaounde.

A significant, single study from Nigeria examined 2154 women of whom 87% presented with

stage III and IV disease. Only 13% came with early stages. Fear of mastectomies was the reason for delay in 45%, while 14% chose to go to prayer and spiritual healing houses. Twenty-three percent preferred native or herbalist doctors and 10% gave economic reasons as the cause for delay. Nine percent believed it was an infection [2].

A key clinical point is the strong evidence that delayed presentation of symptomatic cancer is associated with lower patient survival [3]. An understanding of factors influencing delay is important to improve outcomes of cancer patients. The reports have largely divided causes into delay by *patients*, and delay by *providers* [3]. Caplan and Helzlsouer [4] wrote that patient-defined delay is the time it takes a patient to seek help once a symptom has been detected. Delay by providers is the time from seeking help to being treated [4]. The earliest study by Pack and Gallo [1] used a definition of delay as greater than three months from initial symptom; however, definitions have varied in studies conducted in developed countries.

Older age is associated with delay [3–7]. This may be due to poor information and the presence of other medical problems and disabilities. Marital status is generally not seen as a factor in delay. [3,4,8].

Socioeconomic factors are related to patient delay. Several reports of breast cancer delay suggest that a symptom other than a lump may not be recognized [3,8–11]. The role of lower socioeconomic status has been described by [6,10,12–14]; the influence of fewer years of education [1,12]; the lack of medical information [14,15]; and non-white ethnic origin in western countries [3].

Psychosocial factors are failure to disclose a symptom to another person [3,8,9,14,16]; absence of a close relationship [14]; prior experience of a close friend or relative who died or suffered from cancer [12]; fears about cancer treatment [8]; shame or embarrassment with their symptoms [16]; and a negative attitude towards their physician [8,12,17].

Methods

A convenience sample of 20 patients were interviewed over a 3-months period based on criteria of appearing for first consultation in far advanced stage, or having re-appeared at an advanced stage, having abandoned treatment. There were 55 patients who appeared over the 3 months, but only 20 were able to be studied.

The diagnosis of a very advanced cancer was made during the initial medical oncology consultation. The patient was then seen by the psychologist and the following information was obtained using a questionnaire: identification data, date of first sign of illness, date of first consultation, information about illness, family involvement in patient care, knowledge, beliefs and fears about cancer. The psychologist then talked with close family members to learn their view of the patient's illness. During hospitalization, additional interviews were held, if needed, to evaluate their delay.

Results

Twenty patients were interviewed, one man and 19 women, ranging in age from 34 to 63. The patients had the following sites of cancer: breast cancer (9); HIV related cancer (4); lymphoma (2); thyroid cancer (1); soft tissue cancer (1); ovarian cancer (1); rectal cancer (1); lung cancer (1); cancer of unknown origin (1). Factors contributing to delay could be categorized in 3 areas (some patients had more than 1 factor): inability to pay for treatment (10); inadequate diagnosis by general physician leading to time loss (9); and beliefs, fears, culture, ignorance (9). More than 1 factor was identified in half the patients.

Case example of delay related to inadequate finances

Case 1: B.C was a 46-year-old single, unemployed woman who had the first sign of breast cancer in

March 2003. In September 2004, she started treatment, but had to stop because she could not pay for treatment. She appeared at the Oncology Division in Yaounde in January 2005 with an ulcerating left breast cancer and diffuse bone metastases. Her disease was advanced and she was hospitalized the same day. One cycle of chemotherapy was given. However, 1 month later she did not have the money to buy the medication for the second cycle. Palliative treatment was begun and consisted of Tamoxifen and wound dressing. The family abandoned the patient in the hospital because neither she nor her family could pay her hospital bills.

Case example of beliefs, culture

Case 2: Patient was a 63-year-old widow who owned and managed a business begun by her late husband. She consulted the oncologist (PN) in June 2003 with clinical presentation of breast cancer. She was given medication to take at home. The patient did not comply, but instead embarked on a program of intensive prayer in a sanctuary. The family persuaded her, after a year, to seek medical treatment and brought her to the hospital for treatment in June 2004 when she presented with advanced breast cancer, malnutrition, and dehydration. She was hospitalized and chemotherapy was begun (Docetaxel, and wound dressing); however, she died after three cycles of treatment.

Case example of delay due to poor knowledge

Case 3: E.L.S. was a 34-year-old single priest who noticed the first sign of his illness in May 2002. His first consultation was in July 2003 when he presented with generalized Kaposi's sarcoma related to HIV/AIDS for which he received two cycles of chemotherapy. Patient had a very good response, and when he felt better, he stopped taking the medication. He was also embarrassed by the diagnosis. In June 2004, he consulted the medical oncologist (PN) when he had developed advanced stage disease and was treated with chlorambucil as a palliative measure.

Discussion

This report from Yaounde gives a description of 20 patients who appeared for treatment at far advanced stage of disease when only palliative or hospice care was possible. It suggests that, in a country with so few medical resources and with most of its citizens living below the poverty line and unable to pay for their medicines, socioeconomic factors either directly or indirectly affect the ability to seek care. The fact that native doctors and traditional healers are much less expensive and

often fit with cultural fears, superstitions, and beliefs about cancer pushes patients away from medical treatment and toward the spiritual and herbal care.

The general belief in the country is that cancer causes death and it is inevitable. Therefore, there is no benefit to go to the hospital. This belief, coupled with the idea that cancer is induced by wizards or some member(s) of one's family or friends, leads to seeking out native doctors or priest exorcists. These patients spend time and money with non-medical practitioners and only come to the hospital when they are close to death, or when they realize that the native treatment was not effective.

Beliefs and fears exert a much greater effect in the absence of good education and information about cancer, which could counter the powerful beliefs. The work of SOCHIMO, a non-governmental organization, is an effort to educate and help reduce the costs of tests and treatment by 50%. In addition, cancer patients are provided with psychological support and assistance through education about care to dispel long-held myths and beliefs.

The studies of delay in the developed countries are in the context of communities where people are well-informed about cancer, most have health insurance, and cancer clinics are available. In the environment of Yaounde, the paucity of resources of all kinds outweighs the negative factors found in western countries. Addressing this inequity requires attention to the training of doctors and nurses and establishing facilities in geographically well-located areas of the country. Health insurance from the state is badly needed. NGOs should increasingly play a role in the education of the public about cancer to dispel beliefs that keep patients away from treatment that is curative at early stage. They will need to become integrated in communities as a buffer between native healers and physicians.

The study from Nigeria of women with breast cancer confirms the tendency to delay until advanced stages of disease, based to a large extent on fear of treatment. Patients who appear at stages that cannot be cured would benefit from education about and access to palliative care, given either at home (teaching the family) or in a hospice that would emphasize pain and symptom control and concern for spiritual and psychological well being.

The scarcity of trained doctors and nurses is a major factor in provider-related delay, especially in rural areas where recruitment of new staff is difficult and where medical staff is chronically overworked. This is true in Zimbabwe, a country with an acute loss of nurses to other countries [18]. These nurses are leaving to fill positions open due to the worldwide crisis in nursing [19]. The global issue of physician brain drain, taking the best graduates of medical schools in developing coun-

tries and appointing them to fill posts in developed nations, constitutes a problem of international concern [20].

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