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*Harcourt*¹ in this edition of the West African Journal of Medicine, the true prevalence of HIVAN among African children is largely unknown due to lack of surveillance and reporting. Similar to Anochie et al the authors reported on the similar number of cases (10) of HIVAN seen over a longer period of 6years but with a better outcome. They documented a HIVAN prevalence of 8.9% considered lower than earlier Nigerian studies. The finding of vertical transmission as the major route in their study is in keeping with observations reported in other studies. However, the homosexual route of transmission identified in the study has rarely been reported among the paediatric population. The practice of homosexuality is a new mode of HIV transmission the authors reported among adolescent paediatric cases. Whether this will affect the clinical history in

children is yet to be known.

The benefit of screening for HIVAN should be part of the routine follow-up tests for individuals with HIV on basis of 4 - 6 months to enable early diagnosis. This should include urine for albuminuria, proteinuria and plasma test for creatinine and eGFR.

PROF. ALEBIOSU C.O.

*Department of Medicine,
College of Health Sciences,
Osun State University, Osogbo.*

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PRIMARY LUNG CANCER: CHALLENGES IN DEVELOPING COUNTRIES

Lung cancer even though is one of the most preventable of all the major malignancies, it is the leading cause of cancer incidence and mortality worldwide.¹ Deaths from lung cancer is projected to reach over 2million deaths by 2030 globally.¹ Developing countries still bearing the brunt of communicable diseases, are unfortunately witnessing rising cases of lung and other cancers. According to report from GLOBOCAN “majority of the global cancer burden now occurs in developing countries, these proportions will rise in the next decades if rates remain unchanged.”² Given the demographic transition that is ongoing in developing countries, the absolute numbers of lung cancers will almost certainly rise in the future. The estimated number of lung cancer deaths in Sub-Saharan Africa (Africa without Algeria, Egypt, Libya, Morocco, Tunisia, West-Sahara) has risen from 11,503 in 2003 to 13,732 in 2008.²

Becher and Winkler have even argued that the burden of lung cancer may even be much higher than these.³

If this scenario is viewed i.e. rising incidence of lung cancers, against a background of ravaging effects of emerging and re-emerging communicable diseases, poor health care funding and huge infrastructural gap, then it becomes apparent that actionable and practical steps are required to mitigate this.

Cigarette smoking is the major risk factor for lung cancers globally.¹ Though, the rates of smoking is on the decline in most developed countries, it appears to be on the rise in developing countries.¹ Factors documented in primary lung cancers in developing countries includes smoking and many other non-smoking risk factors. Studies have shown that about 50% of primary lung cancers in Nigeria, for instance, were in lifetime non-smokers.⁴ This is

also corroborated with the retrospective study in Ilorin, published in this edition of the WAJM, where only 40% of lung cancers patients have documented history of cigarette smoking. This brings to the fore the challenge of identifying other risk factors. Of course, there are lots of industrial and environmental pollution which increase the risk of lung cancer in developing countries other than smoking. There is therefore a need to coordinate efforts for in depth evaluation of other exposures, determine the carcinogenicity of each agent and develop an action plan to halt these.

An important factor in managing lung cancers in most developing countries is patients delay. Patient delay in presentation is a common occurrence in most developing countries. This is partly fueled by ignorance/ lack of awareness, cost of seeking health care and other factors. As a result, majority of

patients present late with advanced disease. This is exactly the situation among patients seen in Ilorin (published in this edition of the WAJM) where more than 80% presented with advanced disease. This definitely has a negative effect on survival which is already abysmally low.

Health system structure and functionality is also a major challenge with regards to managing primary lung cancers. Majority of tertiary centers lack functional facilities for diagnosis like bronchoscopy, VATS, and others. Since diagnosis rest squarely on histological confirmation which requires a representative tissue, non-availability of diagnostic equipment constitutes a major challenge. Where available, turn-over time for histological results could be as high as 59 days in Kenya⁵ and 3-18 days in Nigeria.⁶ Institutional delays caused by nonavailability or non-functional equipment, wearies and erodes patients' and care givers' confidence in the system.

Immunohistochemistry, genomic analysis of tumor cells which will make individualized and targeted treatment possible are prohibitively expensive when available. This is a major challenge in most developing countries.

In most developing countries, access to care is limited. For example, in many parts of Africa, there are fewer than 1 teletherapy unit per 10 million people.⁷ In Nigeria for instance, with a population of 200Million, there are less than 20 active radiotherapy centers. This means patients will have to travel hundreds of kilometers to access radiotherapy, that is a big challenge. As shown in the study by Desalu et al, none of the patients were able to receive radiotherapy. This deficiency in health system and function does not only complicate and lengthen delay in diagnosis or mis-diagnosis, it also lengthens delay in treatment initiation or sometimes patients may not receive any treatment at all. Perception of most health care workers and care giver on

palliative medicine hampers the utilization of such expertise. Palliative medicine will contribute and assist in improving quality of life and care for patients with advanced and even early disease. So patient suffers in pain till death!

Health insurance coverage can increase access to care and protect households from the detrimental economic effects of chronic ill-health especially cancers.⁸ Health insurance schemes often provide coverage for inpatient care to mitigate sudden high financial burden due to hospitalization and treatment in lung cancer.⁹ However, the models of health insurance operational in low and middle-income countries leave most households uncovered by any sustainable health insurance. Majority therefore spend large proportions of out-of-pocket health care expenditures on medicines including cancer drugs.⁸

But all these can change. Investing in the health sector and that of the people is the best investment any government can do. In 2001, all African Union countries, pledged to spend 15 percent of its annual budget on health care. But most AU countries have never come close to reaching that goal. It is time to ensure that! It is time to make health care affordable, available and accessible to all. Opportunities should be made available for training and re-training in some skills and expertise. There must be urgent steps to ensure adoption of effective control measures, including smoking cessation, enforcing use of industrial parks, and control of diesel exhaust pollution. These together with adoption of healthy lifestyles may stem the tide of the looming epidemic of lung cancers in developing countries.

PROF. O. O. ADEWOLE,
*Department of Medicine,
College of Health Sciences,
Obafemi Awolowo University,
Ile-Ife, Osun State.*

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