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Gynecological and breast cancers: Epidemiological, clinical, and histological profile at gynecology-obstetrics department of Kara University Hospital (Togo)

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Abstract
Introduction: Gynecological and breast cancers are a major cause of death worldwide, especially in resource-limited regions where cancers are often diagnosed at an advanced stage.
Method: This was a retrospective and descriptive study conducted at the gynecology-obstetrics department of the university hospital center of Kara from April 1, 2021, to March 1, 2024.
Results: One hundred seventy-three cases were recorded. Breast cancer (46.8%) and cervical cancer (38.2%) were the most common. The overall mean age at diagnosis was 51.7 ± 13.1 years with extremes of 17 years and 82 years. The majority of patients were homemakers (67.57%), uneducated (48.65%), and multiparous (70.91%). Almost all (97.27%) had not undergone any screening for cervical or breast cancer. Forty-three percent (43.6%) of breast cancer patients and 19.1% of cervical cancer patients had sought traditional medicine before hospital consultation. Most women consulted at an advanced stage of the disease, stage III or IV of the FIGO TNM classification, in 78.1% of cases. The most frequent histopathological types were invasive ductal carcinoma (75.3%) for the breast, squamous cell carcinoma (95.5%) for the cervix, serous cystadenocarcinoma (64.3%) for the ovary, and endometrioid adenocarcinoma (83.3%) for the endometrium.
Conclusion: Breast and cervical cancers were the most common gynecological and breast cancers, often diagnosed at late stages. It is important to implement awareness and screening strategies for early diagnosis to improve the prognosis of gynecological and breast cancers in our settings.

Keywords: Gynecological and breast cancers, epidemiology, Togo

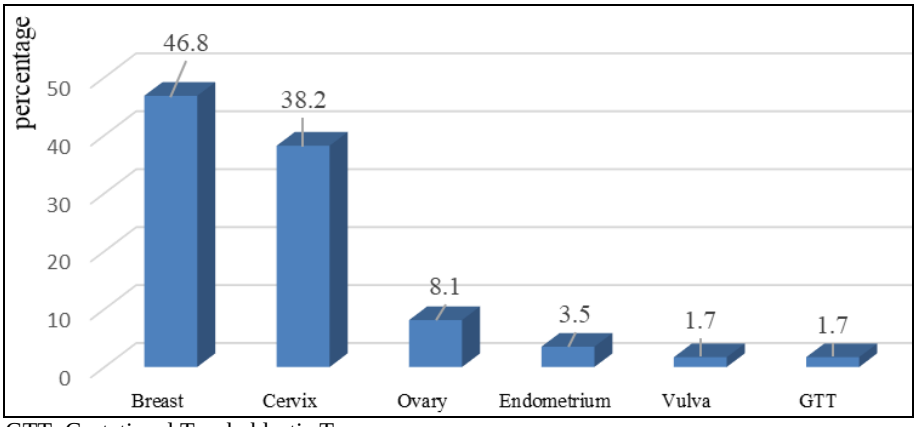
1. Introduction
A major public health concern worldwide, gynecological and breast cancers represent the leading cause of cancer-related morbidity and mortality in both sexes [1]. The situation is even more worrisome in developing countries where cancers are often diagnosed at an advanced stage [2, 3]. In Benin, Tonato *et al*. reported an advanced stage diagnosis in 65.23% of cases, corresponding to stages III and IV of the TNM classification of the International Federation of Gynecology and Obstetrics (FIGO) [4]. In Togo, there is no national organized screening program. Diagnosis is often made by the patient at an advanced stage of the disease. Today, the challenge remains in prevention and early detection of the disease. In order to contribute to the implementation of strategies to combat these cancers, we conducted this study with the objective of determining the epidemiological, clinical, and histological profile of gynecological and breast cancers.

2. Methods
This was a retrospective descriptive study conducted over a period of three years from April 1, 2021, to March 1, 2024, at the Kara University Hospital Center (CHU-Kara). The study included all women seen in consultation or hospitalized in the department for gynecological and breast cancer, with histological confirmation. Epidemiological, clinical, and histological data were collected from medical records and admission registers. Data results were processed and analyzed using Epi info version 7.2 and Excel 2016 software.

2. Results

2.1. Frequency

We recorded 173 cases of gynecological and breast cancers during the study period. Breast and cervical cancers were the most common, accounting for 46.8% (n=81) and 38.2% (n=66) of cases, respectively (Figure 1).



GTT: Gestational Trophoblastic Tumor

Fig 1: Distribution of patients according to cancer site

2.2. Socio-demographic data

The overall average age at diagnosis was 51.7 ± 13.1 years with a range from 17 years to 82 years (Table 1).

Table 1: Distribution of patients according to the average age at diagnosis and cancer site

Cancer site	Average age (years)	Extremes (years)
Breast	50,7 ± 13,7	17-82
Cervix	51,7 ± 11,5	28-80
Ovary	57,4 ± 10,5	44-75
Endometrium	48,0 ± 27,2	17-81
Vulva	62,5 ± 3,5	60-65
GTT	37,0 ± 6,7	22-59

GTT: Gestational Trophoblastic Tumor

The patients were mostly homemakers (63.6%, N=110), non-educated (46.8%, N=81), and multiparous (71.1%, N=123) (Table 2).

Table 2: Distribution of patients according to socio-demographic data

Socio-demographic data	Count	Percentage
Occupation		
Homemaker	110	63.6
Vendor	33	19.0
Artisans	15	8.7
Others	15	8.7
Level of Education		
Non-educated	81	46.8
Primary	55	31.8
Secondary	32	18.5
Higher Education	5	2.9
Parity		
Nulliparous	9	5.2
Primiparous	7	4.0
Pauciparous	34	19.7
Multiparous	123	71.1
Menopause		
Yes	111	64.2
No	62	35.8

2.3 Patient History and Background

Three point six percent (3.6%) of patients had a family history of cancer. In 97.7% of cases, patients had not undergone any screening tests. For the 2.3% who had undergone screening, these were tests conducted during mass campaigns. Upon the onset of the first signs of the disease, 43.6% of breast cancer patients and 19.1% of cervical cancer patients resorted to traditional healers, self-medication, and church prayers before seeking medical attention. The consultation delay after the onset of the first symptoms was over six months in 50.6% of breast cancer patients (Table 3).

Table 3: Distribution of patients according to consultation delay and cancer site

Cancer site	Consultation Delay		Total
	Under 6 months n (%)	Over 6 months n (%)	n (%)
Breast	40 (49.4)	41 (50.6)	81 (100.0)
Cervix	49 (74.2)	17 (25.8)	66 (100.0)
Ovary	8 (57.1)	6 (42.9)	14 (100.0)
Uterine Corpus	6 (100.0)	0 (0.0)	6 (100.0)
Vulva	0 (0.0)	3 (100.0)	3 (100.0)
GTT	3 (100.0)	0 (0.0)	3 (100.0)
Total	106 1.3)	67 (38.7)	1730 (0.0)

2.4. Clinical Data

In 95.5% of cases, the disease is discovered due to clinical manifestations noticed by the patient herself. In 4.5% of cases, it was an incidental discovery during a clinical examination for another reason or during screening. The physical manifestations varied depending on the site of the cancer. Breast mass (38.3%, n=31) and exophytic appearance of the cervix (53.0%, n=35) were the most commonly found signs in breast and cervical cancers (Table 4), indicating an advanced stage of the disease, namely stages III and IV (75.7%) according to the TNM FIGO classification as illustrated in Figure 2.

Table 4: Physical signs according to cancer site

Physical signs of cancer	Count	Percentage
Breast		
Breast mass	31	38.3
Orange peel skin	27	33.3
Breast ulceration	18	22.2
Breast retraction	4	5.0
Nipple ulceration	1	1.2
Cervix		
Cervix budding	35	53.0
Necrotizing ulcerated cervix	17	25.8
Ulcerated cervix	11	16.7
Retracted cervix	3	4.5
Ovary		
Abdominal mass + ascites	8	57.1
Abdominal mass	4	28.6
Pelvic mass	2	14.3
Endometrium		
Endometrial bleeding	5	83.3
Sentinel polyp	1	16.7
Vulva		
Budding tumor	3	100.0
GTT	93	
Enlarged uterus	2	66.7
Vaginal tumor	1	33.3
Total	173	100.0

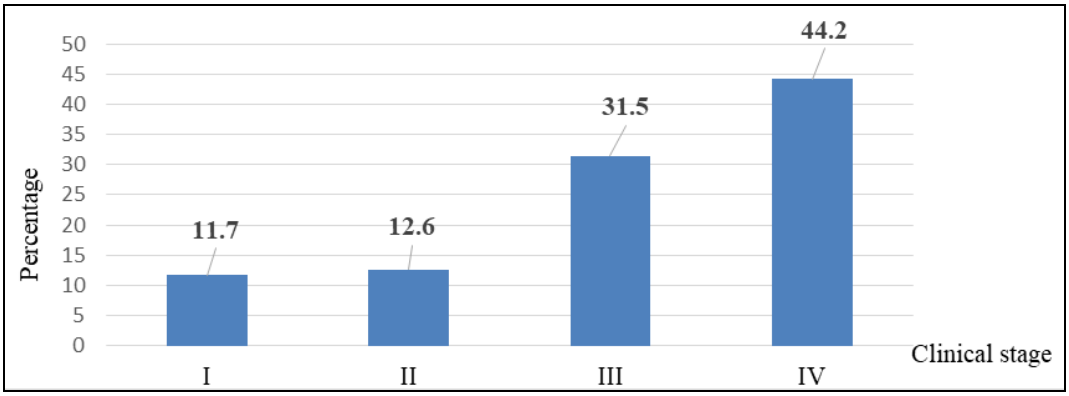


Fig 2: Distribution of patients according to FIGO TNM stage at diagnosis of the disease

2.5. Histological Data

Invasive ductal carcinoma accounted for 75.3% (n=61), Squamous cell carcinoma for 95.5% (n=63), and Serous cystadenocarcinoma for (n=9) were the most commonly found histological types concerning breast, cervical, and ovarian cancer, respectively (Table 5).

Table 5: Distribution of patients according to histological type

Histological Type	Count (n)	Percentage (%)
Breast		
Invasive Ductal Carcinoma	61	75.3
Invasive Lobular Carcinoma	8	9.9
Ductal Carcinoma In Situ	4	4.9
Papillary Carcinoma	3	3.7
Medullary Carcinoma	2	2.5
Inflammatory Carcinoma	1	1.2
Paget's Disease	2	2.5
Cervix		
Squamous Cell Carcinoma	63	95.5
Adenocarcinoma	3	4.5
Ovary		
Serous Cystadenocarcinoma	9	64.3
Mucinous Cystadenocarcinoma	4	28.6
Granulosa Cell Tumor	1	7.1
Uterine Corpus		
Endometrioid Adenocarcinoma	5	83.3
Leiomyosarcoma	1	16.7
Vulva		
Squamous Cell Carcinoma	3	100.0
GTT		
Choriocarcinoma	2	66.7
Implantation Site Tumor	1	33.3
Total	173	100.0

3. Discussion

Over a period of three years, we recorded 173 cases of gynecological and breast cancers at CHU-Kara, averaging about 57.7 cases per year. A lower frequency was recorded by Adenin-Ifè *et al.* [5] in Lomé in 2021, who registered 202 cases over a period of 7 years. However, Hounkponou *et al.* in Benin [6] and Sando *et al.* in Cameroon [2] found higher frequencies, at 119.3 and 94.2 cases per year, respectively. The low frequency in our series does not truly reflect the frequency of gynecological and breast cancers in our environment. This could be explained by the low consultation rate due to difficulties in accessing healthcare, fear of the disease, and socio-cultural considerations [3, 5]. In fact, 43.6% of breast cancer patients and 19.1% of cervical cancer patients resorted to traditional self-medication and church prayers at the onset of the disease before seeking consultation in a healthcare center. The delay in consultation after the onset of symptoms was more than 6 months in 38.7% of cases, with 75.7% consulting at an advanced stage (Stages III and IV). Lack of awareness of early signs of the disease, lack of information, and mass screening policies could explain this delay. Furthermore, 97.7% of patients in our study had not undergone any screening tests.

In our series, like that of Hounkponou *et al.* [6], breast cancer ranked first in terms of frequency, followed by cervical cancer (38.2%). Ovarian cancer (8.1%), endometrial cancer (3.5%), vulvar cancer (1.7%), and gestational trophoblastic tumors (1.7%) were also present. In contrast, Sando *et al.* in Mali and Hailu *et al.* in Ethiopia [2, 7] recorded cervical cancer in the first position, followed by breast cancer. Our results are consistent with the literature. Indeed, breast cancer and cervical cancer are the two main cancers in women, with breast cancer remaining the most common worldwide [8].

Breast Cancer: The most common cancer in women worldwide and in our series, it affected women with an average age of 50.7 ± 13.7 years. This average age in our study is higher than those reported by Essiben *et al.* [9] and Gueye *et al.* [10], at 42.9 years and 47 years, respectively.

Our result is similar to that of Ngatali *et al.* (49 ± 11.97) [11]. In developed countries, this average age is even higher. Rugo *et al.* [12] reported an average age of 61 years in the USA. The relatively higher average age at diagnosis than that found in the African series is related to late diagnosis, as 50.6% of patients consulted 6 months after the onset of first signs. Our data are consistent with those reported by Darré *et al.* in Togo [13], where the average time to consultation was 23.6 ± 46.1 years. According to Darré *et al.*, factors associated with late diagnosis were difficulties in geographical accessibility to healthcare centers, fear of diagnosis, resorting to traditional healers and traditional self-medication, and lack of breast self-examination. In our series, 43.6% of patients resorted to traditional healers and traditional self-medication. It is therefore necessary to implement mechanisms for individual and organized mass screening to achieve early detection of precancerous lesions and to establish early management. The most commonly found histological type was invasive ductal carcinoma in 75.3%. The same finding was reported by Essiben *et al.* in Cameroon (73.8%) [9] and Gueye *et al.* in Senegal (94.7%) [10].

Cervical Cancer: It is the second most common cancer in women worldwide and in our series. The average age at diagnosis was 51.7 ± 11.5 years. This result is similar to those of Sando *et al.* (52.43 ± 3.82 years) [2] and Mapoko *et al.* (52.82 ± 12.36 years) [14]. At the onset of the disease, 19.1% of patients resorted to traditional medication and church prayers, resulting in late hospital consultation, with 25.8% consulting 6 months later in cases. The same facts were reported by Binka *et al.* in Ghana [15]. Indeed, delays and obstacles to diagnosis result from socio-cultural factors at the community level. They are related to beliefs, religion, and the use of traditional medicine. According to Binka *et al.*, cervical cancer is the consequence of promiscuity and therefore a divine punishment, according to patients. For this reason, they prefer to resort to churches and spiritual healing centers [15]. Another sociocultural barrier identified by Binka *et al.*, as in our study, is the belief in traditional medicine. Despite being aware of the importance of hospital care, many believe

that resorting to traditional healers and self-medication should be the first step. Thus, these considerations contribute to diagnosis at an advanced stage, as in our series. Strengthening awareness and implementing a national program for the screening of precancerous lesions of the cervix will improve screening and therefore management. The most commonly found histological type was squamous cell carcinoma in 95.5%, consistent with the literature [2, 16].

Ovarian Cancer: It represented the 3rd cancer in our series with a rate of 8.1%. It occupied the same position in the studies of Hounkponou *et al*., Sando *et al*., and Bagna *et al*. [2, 6, 17]. The mean age at diagnosis was 57.4 ± 10.5. Our result is comparable to that of Nzeribe *et al*. [18], who reported an average age of 55 years in Nigeria in 2022. It is higher than that of Ngatali *et al*., who reported an average age of 50 ± 14 years [11] in Congo Brazzaville, and that of Raherinantenaina *et al*. (43 years) [19] in Madagascar. It appears that the average age of onset of ovarian cancer varies from one region to another. Regarding histological type, serous cystadenocarcinoma (64.3%) and mucinous cystadenocarcinoma were the most represented. These results are consistent with the literature [5, 15].

Endometrial Cancer: It ranked 4th among gynecological and breast cancers in our series and 3rd most frequent gynecological cancer with a rate of 3.5%. This rate is comparable to those of Dem *et al*. and Traore *et al*., who reported rates of 2% and 3.3%, respectively [20, 21], but lower than the 9.5% reported by Tonato *et al*. [17] and 15.1% reported by Nayama *et al*. [22]. Endometrial cancer is more frequent in developed countries, particularly in Canada, where it is the most common gynecological cancer [23]. Metrorrhagia is the most common symptom of cervical cancer [15], which explains why we found endometrial bleeding in 83.3% of patients.

Vulvar cancer and gestational trophoblastic tumor: Vulvar cancer and gestational trophoblastic tumor each represented 1.7% of gynecological and breast cancers in our study. Nos données sont inférieures à celles rapportées par Adani *et al.* au Togo [5] et peut s'expliquer par la difference de méthode d'étude. Quoiqu'il en soit, le carcinome épidermoide et choriocarcinome étaient le types histologiques les plus frequents. Dans la littérature, le cancer de la vulve est décrit comme un cancer de la femme agé [18] ce qui est retrouvé dans notre étude où les femmes atteintes du cancer de la vulve sont les plus âgées soit 62,5 ± 3,5ans. Contrairement aux données de Sando *et al.* [2] qui rapportaient un stage moins avancé au diagnostic du faite de l'accessibilité anatomique de la vulve, dans notre série, ces cancers sont découverts à un stade avancé. D'où l'importance d'inclure dans les messages de sensibilisation, le cancer de la vulve.

Conclusion

Gynecological and breast cancers are common. Breast cancer ranks first followed by cervical cancer in terms of frequency. Diagnosis is often delayed. It is therefore necessary to develop strategies for the screening of precancerous lesions and to reinforce awareness for early and adequate management.

Conflict of Interest

The authors declare no conflicts of interest.

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