

Cancer in Kenya: Outlook and Perspectives

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Surgery fulfils a critical role in the care of patients with cancer. The Annals of African Surgery, since its inception, has recognized the importance of reporting on cancer in our settings(1,2). Surgeons, to appropriately care for our patients, must advocate for the prevention, diagnosis, curative treatment, and palliation of cancer. To do this well, we must share our experiences through high-quality research.

As the region struggles to identify and address the causes of oesophageal cancer, other gastrointestinal malignancies, such as colorectal cancer, may be on the rise. Reports from single institutions (3-5) have helped to drive the narrative and advance dialogue. And, the increase in cancer registries throughout the region allow for improved data collection and analysis(6). Collectively, we are gaining a better understanding of how cancer impacts our communities.

An overarching characteristic of gastrointestinal cancer in East Africa is the young age at which patients commonly present. Case reports(7) and series(3,4,8) have documented this phenomenon. While this may be partially attributable to the young population structure in our region, it seems there may also be a difference in tumor biology. This was evident in the work of our recently departed colleague, Professor Saidi, whose findings indicated that 27% of patients with colorectal cancer were aged 40 years or younger. These younger patients were more likely to have poorly differentiated histology when compared to older patients (1). When one of the authors of this editorial (RW) first arrived in Kenya in 1996, an experienced Kenyan thoracic surgeon personally reported his age cutoff to operate on oesophageal cancer as 40 years of age. As RW responded that it seemed unfair to exclude older patients, the surgeon corrected him to say that because

the tumours are so aggressive in young patients, he actually excluded the younger patients from curative operations.

While we have come a long way since then, the concern remains that there is something different about the biology of the cancers in our patient population. Traditional risk factors for cancer, such as tobacco use, should be curbed; however, these risk factors seem inadequate as an explanatory etiology for the cancers we see. Therefore, we must also investigate the potentially unique associations that exist in our population as well as their implications. One example is the association between oesophageal squamous cell carcinoma and family history as described in a case-control study by Machoki et al. (8); however, the finding was not supported by the recent urban experience reported in a case series by Ojuka et al(4). Although globally there is increasing focus on oncology and non-communicable diseases, we must discover and report local patterns to contribute findings relevant to patients in our region. As surgeons, we have been the primary avenue for cancer cure in our communities as curative surgery improves survival in our setting (unpublished). It is now imperative that we work together in multi-disciplinary teams to advance overall cancer care and research (6).

Further investigative efforts to explore cancer etiology and treatment are necessary. Oncology research has suffered from recall bias in risk factor recollection(8), limited personnel and capacity to conduct proper research, and a lack of prospective follow-up of our patients(5). We must continue to advocate for our patients and as advocates, surgeons should continue to be involved in the discussions on the way forward.

References

1. Saidi H, Nyaim EO, Karuri D et al. Young patients with colorectal cancer at a tertiary hospital in Kenya, 1993–2005. *Ann Afr Surg.* 2007;1:10-15
2. White RE, Parker RK. Oesophageal cancer: an overview of a deadly disease. *Ann Afr Surg.* 2007;1:33-48
3. Parker RK, Dawsey SM, Abnet CC et al. Frequent occurrence of esophageal cancer in young people in western Kenya. *Dis Esophagus.* 2010;23(2):128-135
4. Ojuka D, Dindi K, Awori M. Prevalence of Esophageal Adenocarcinoma. *Ann Afr Surg.* 2017;14(2):82-85
5. Saidi H, Abdihakim M, Njihia B et al. Clinical Outcomes of Colorectal Cancer in Kenya. *Ann Afr Surg.* 2011;7(1):42-45
6. Topazian H, Cira M, Dawsey SM et al. Joining Forces to Overcome Cancer: The Kenya Cancer Research and Control Stakeholder Program. *J Cancer Policy.* 2016;7:36-41.
7. Siboe MM, Abdalla RO, Lakati KC et al. Adenocarcinoma of the Colon in a 10-year-old child. *Ann Afr Surg.* 2010;5:47-51
8. Machoki MS, Saidi H, Raja A et al. Risk Factors for Esophageal Squamous Cell Carcinoma in a Kenyan Population. *Ann Afr Surg.* 2015;12(1):38-43.