

The Experience of a Newly Set up Breast Clinic in a Resource Limited Hospital

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Abstract

Introduction: Breast cancer is one of the commonest cancers in Kenya with very devastating outcomes due to poor screening and low awareness amongst women. In Kenya outside Nairobi there are no organized breast care clinics in public hospitals which can help to ease the breast disease burden. It was in view of this that department of surgery decided to set up a breast clinic at Kisii Level 5 Hospital to cater for the population in the south western Kenya region. An audit was done to assess the progress of the clinic.

Results: 103 patients were seen over a three month period with an

average of 10.3 patients per clinic visit. Benign breast conditions were commonest condition with 27% of this being fibroadenomas. Twenty two percent of patients had malignant disease with 79% presenting in stage 3 and 4. Challenges encountered included lack of radiotherapy and chemotherapy.

Conclusion: Breast disease in resource limited facilities is sizeable and centralized breast management centers is necessary and possible. Mentorship and support of newly developing breast clinics is essential for their success.

Introduction

Breast cancer accounts for 23% of all female cancers worldwide (1). It is the commonest cause of death and disability, especially among young women living in low income countries (2). Most patients present at advanced stage of breast disease (3). This may be attributed to poor access to breast care.

In Kenya, breast care is established in central health facilities such as Kenyatta National Hospital where most patients are unable to access due to geographical and financial constraints. Further, the few breast care facilities cannot handle the overwhelming cases of breast disease in the country due to the limitations in terms of infrastructure and adequately trained personnel.

In view of this, establishing breast clinics in the rural towns will aid alleviate the breast burden in health care. Early diagnosis and screening of breast cancer will improve health services. With this in mind, a breast clinic was started in Kisii level 5 Hospital. This article highlights the experience in this clinic.

Methods

Hospital profile: Kisii level 5 hospital (KL5H) is a government facility in Kisii County, Nyanza Province. It is a referral centre for Nyamira, Homabay, Migori, Kisii, Transmara counties. Patients from Tarime district in neighbouring country of Tanzania are also treated at KL5H. It serves

a population of 4,613,174 (4). The hospital has several consultant led units which include surgical, medical, paediatric, obstetrics and gynaecology, out-patient and psychiatry. It has a bed capacity of four hundred and sixty three patients and serves as an internship training facility for nursing officers, clinical officers, pharmacists and medical officers.

Initiative to start breast clinic: An observation was made that sizeable number of breast patients were scattered in different clinics and in in-patient wards within the hospital which translated to poor patient follow up. Most of the patients were seen at advanced stage of breast disease. The initiative to start a breast clinic was aimed at centralising the management of breast patients, documentation of breast burden, to institute uniformity in management of breast disease and to improve follow up of patients. Discussions were held with heads of surgical, radiology, out-patient, obstetrics and gynaecology and medicine units. Consultation with breast specialists in Kenyatta National Hospital was made. It was agreed to have the breast clinic run once a week by the surgical team. Patient follow up was achieved through a database with mobile numbers of patients, their close relatives or neighbours. This helped when patients missed their appointments.

Analysis: An analysis of the breast clinic was done six months after the clinic started. The aim of this was to assess the profile of patients seen and the success of the clinic.

All patients seen at the breast clinic over a period of three months were assessed, data were collected in an excel spread sheet and analysed.

Results

The total number of patients seen at the breast clinic over three months was one hundred and three. This included new patients, re-visits and post-operative follow ups. The number of new cases was eighty five patients (85) with 77 females (91%) and 8 males (9%). The average number of patients seen per visit was 10.3. The diagnosis of cases seen at the breast clinic is shown in tables 1-2. The mean age of the male patients was 25.98 years. Half of them presented with gynaecomastia. Nineteen patients had breast cancer (17 females, 2 males). The age at presentation of breast cancer 27-86 years with a mean of 48.6 years. Most cancers were stage three (table 2). Overall, 79% of patients presented to the clinic in late stage of breast cancer (stage 3 and 4) having varied reasons (Table 3).

Comment

The figures seen at the breast clinic in Kisii level 5 Hospital are comparable to those reported for Kenyatta National Hospital (5). The average number of patients seen per visit in KNH is 11 which is similar to 10.3 in KL5H. The female gender preponderance of 91% is consistent with worldwide rates. For males, as is the case with KNH (5) and Saudi Arabia (6), gynaecomastia was the commonest condition. The mean age at presentation of 48.6 years also mirrors the average of 47 years at the national referral hospital (7).

Majority of patients presented at advanced stage of breast disease. A similar trend characterises the disease in African and Arab countries (8-10). In Nigeria 75% of patients present at stage III and IV(8). Lack of a breast protocol in peripheral health facilities may explain the late presentation at diagnosis. Patients are treated and reassured of a breast lump being benign without benefit of a biopsy. Efforts aimed at early diagnosis may improve stage at diagnosis and potentially improve probability of survival and cure (3).

The challenges faced in our breast clinic included lack of mammography unit in the hospital and the wider county. Patients have to travel over 130 kilometres to have a mammogram done. There was no chemotherapy or radiotherapy being offered at KL5H or provincial hospital. We still referred patients to the national referral hospital. This leads to overcrowding of the services and long waiting time for the patients leading to inefficient services rendered and some patients giving up all together.

In conclusion, the burden of breast disease in the periph-

Table 1-distribution of breast pathologies

Diagnosis	Frequency	Percentage (%)
Fibroadenoma	23	27
Breast cancer	19	22
Mastalgia	18	21
Others	20	24

Others-benign breast enlargement, ductal papilloma eczema,galactocele,lipoma,mastitis, polyp,cyst,gynaecomastia

Table 2-stage at presentation of breast cancer

Clinical stage N=19	Frequency	Percentage
Stage 1&2	4	21
Stage 3	11	58
Stage 4	4	21

Overall, 79% of patients presented to the clinic in late stage of breast cancer (stage three and four). The reasons cited for late presentation were varied (table 3).

Table 3-reasons for late presentation

Reasons given for late presentation

- did not think it was serious
- had no funds to seek medical attention earlier
- treated and reassured at a peripheral facility
- visited a herbalist

eral health facilities is sizeable. Centralised and organized management of breast disease is essential and possible in resource limited health facilities. We recommend periodic breast care training of medical officers and clinical officers working in peripheral health facilities to enhance delivery. Mentorship and support in terms of funding is essential in encouraging newly developing breast clinics.

References

1. Saghir NS, Khalil MK, Eid T. Trends in epidemiology and management of breast cancer in developing Arab countries: a literature and registry analysis. *International J. Surg.* 2007;5(4):225-233
2. Porter P. "Westernizing" women's risks? Breast cancer in lower-income countries. *New Eng J. Med.* 2008;358(3):213-216
3. Tfayli A, Temraz S, Abou Mrad E, and Shamseddine A. Breast Cancer in Low- and Middle-Income Countries: An Emerging and Challenging Epidemic. *J Oncology*, vol. 2010, Article ID 490631, 5 pages, 2010. doi:10.1155/2010/490631.
4. Kenya demographic survey- 2009
5. Otiemo ES, Kimende SK, Micheni JN. Patterns of breast disease at Kenyatta National Hospital. *Ann Afri* 2008; 2:97-101 6.

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6. Chiedozi LC, El-Hag IA, Kollur SM; Breast Diseases in the northern region of Saudi Arabia. *Saudi Med J*; 2003;6:623-7
 7. Otieno ES. Delayed presentation of breast cancer patients. *EAMJ* April 2010; 87(4) 147-50.
 8. Anyanwu SNC. Temporal trends in breast cancer presentation in the third world. *J. Experimental Clin Ca Res*. 2008;27(1):17
 9. Elattar I, Zaghloul M, Omar A, Mokhtar N. Breast cancer in Egypt. Cairo, Egypt: NCI Cairo Pub
 10. Abdel-Fattah M, Lotfy NS, Bassili A. Current treatment modalities of breast-cancer patients in Alexandria, Egypt. *Breast*. 2001;10(6):523-529