

Cervical Cancer Screening: A Survey of Current Practice Amongst Nigerian Gynaecologists.

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Abstract

Context: Cervical malignancy is the commonest genital tract malignancy in Nigeria. In the absence of a national screening programme, any hope of minimising death from invasive cervical carcinoma in Nigeria is through increased opportunistic cervical screening by physicians. Recent evidence showed a high awareness but a low practice of cervical screening among Nigerian women, a situation that the respondents attributed to poor physician referral.

Objective: To study the attitude toward and practice of cervical cancer screening amongst Nigerian gynaecologists, on whom the burden of treating cervical cancer rests.

Study Design, Setting and Subjects: A self-administered, questionnaire survey of 113 Nigerian gynaecologists who attended the Annual General Meeting and Scientific Conference of the Society of Gynaecology and Obstetrics of Nigeria (SOGON) held in Abuja in November 2000.

Results: The 86 (76.1%) gynaecologists who practised in centres with cervical screening services estimated that they screened $15.0 \pm 18.9\%$ of their gynaecology patients. Pap smear was available to 85 (76.1%) gynaecologists, colposcopy to 28 (32.6%), direct visual inspection (after applying 5% acetic acid solution) to 16 (18.6%), human papillomavirus (HPV) DNA testing to 2 (2.3%) and cervicography to 1 (1.2%). Thirty gynaecologists had definite cervical screening programmes, most of which were selective and based on specific indications. All the respondents favoured a national cervical screening programme.

Conclusion: Despite general agreement amongst Nigerian gynaecologists on the need for a national cervical screening programme, their level of opportunistic screening of patients is currently low. A plea is made for increased opportunistic screening pending the establishment of a national screening programme.

Key Words: Cervical Screening, Smears, Gynaecologists, Nigeria. [Trop J Obstet Gynaecol, 2001, 18: 78-81]

Introduction

Cervical cancer is the commonest genital tract malignancy in Nigeria with the majority of cases presenting in late stages, which have low probability of cure¹. However, the malignancy is curable if detected in the pre-invasive stage. Interestingly, such an early detection is feasible through a number of screening procedures such as Pap smear, human papillomavirus (HPV) DNA testing and direct visual inspection of the cervix after the application of 5% acetic acid²⁻⁴. Experience from countries with established screening programmes has shown that cervical screening is cost-effective and decreases the incidence of, and mortality from, invasive disease⁵. In Nigeria, there is no national cervical screening programme. A recent survey of 166 Nigerian female health professionals showed that despite being highly aware (72.9%) of the importance of cervical screening, only 9.6% of the respondents had ever had a cervical smear performed on them⁶. In that study, the majority of the respondents attributed their low uptake of cervical screening to poor physician referral. To test whether this is actually the case, the attitude and practice of cervical cancer screening

amongst Nigerian gynaecologists, on whom the burden of treating cervical cancer rests, were studied.

Methods

The study was done by means of a self-administered pre-tested questionnaire. The questionnaires were administered to all gynaecologists who attended the annual general meeting and scientific conference of the Society of Gynaecology and Obstetrics of Nigeria (SOGON) held in Abuja from 22nd to 25th of November 2000. A sample of the questionnaire is shown in Table 1. SOGON is an affiliate of FIGO. The responses were analysed with descriptive statistics for continuous variables and simple percentages for categorical variables using the statistical package SPSS for MS Windows.

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Results

Out of 145 questionnaires administered, 115 were correctly filled and returned giving a 79.3% response rate. Two Nigerian-born gynaecologists, practicing in Germany and the United States of America respectively, filled 2 out of the 115 questionnaires. After excluding these two questionnaires, 113 questionnaires were finally analysed.

The age of the gynaecologists ranged from 31 to 70 years. The average (mean \pm SD) was 43.9 ± 8.9 years. The gynaecologists had practised for a mean of 10.9 ± 8.6 (range: 1-40) years. Two (1.8%) gynaecologists had a rural-based practice only, 102 (90.3%) an urban-based practice only, while 9 (8.0%) combined urban and rural practices. Seventy-eight (69%) of the gynaecologists were based in 16 out of the 17 southern states of Nigeria compared to 35 (31%) based in 10 out of the 20 northern states including the Federal Capital Territory (FCT), Abuja. The 113 gynaecologists interviewed saw an estimated 171,392 new gynaecological cases per annum.

A cervical cancer screening service was not accessible to the patients of 27 (23.9%) of the gynaecologists while it was for the remaining 86 (76.1%). Seventy three (84.9%) and 13 (15.1%) of the 86 gynaecologists whose patients had access to screening services described them as willing and unwilling respectively to accept cervical cancer screening. Of the women who had access to cervical cancer screening service, screening was performed on an estimated $15.0 \pm 18.9\%$ (range: 0.15-85.0%). Pap smear was available to 85 (98.8%) gynaecologists, colposcopy to 28 (32.6%), direct visual inspection (after the application of 5% acetic acid solution) to 16 (18.6%), human papillomavirus (HPV) DNA testing to 2 (2.3%) and cervicography to 1 (1.2%) gynaecologist(s) with screening facilities.

Of the 86 gynaecologists whose patients had access to screening facilities, 30 (34.9%) had definite screening programmes, most of which were selective and based on specific indications such as postmenopausal or postcoital bleeding. Only one gynaecologist in Kaduna, Northern Nigeria, reported that he screened all his new gynaecological outpatients for cervical cancer. Of the 58 gynaecologists with screening facilities excluding colposcopy, 22 (37.9%) would do cone biopsy, 31 (53.4%) total hysterectomy, 2(3.4%) would re-screen in 3 to 6 months while 3 (5.2%) would refer to a tertiary centre for further investigations in the event

that a screening result suggests, for example, moderate dysplasia.

All (100%) of the respondents favoured a national cervical screening programme. However, 28 (24.8%) of them felt that it was not feasible at the moment in Nigeria. The respondents reported the following as likely impediments to a national screening programme: insufficient number of cytopathologists - 95 respondents (84.1%); government may be unwilling to fund such a programme - 81 respondents (71.8%); likely poor utilization by the women for whom it is intended - 71 respondents (62.8%); lack of awareness about screening amongst Nigerian women - 16 respondents (14.2%); cervical cancer not a health priority in Nigeria - 15 respondents (13.3%); logistics - 10 respondents (8.8%); poverty - 8 respondents (7.1%) and illiteracy - 3 respondents (2.7%).

Discussion

The current membership of SOGON stands at over 500⁷. It is difficult to say whether the views expressed by the 113 gynaecologists interviewed in the present study are representative of the others who did not attend the conference. In order to increase the number of respondents, a postal survey was contemplated before the SOGON conference but was not embarked upon because of the inefficient postal services in Nigeria. Since the interviewees came from 26 out of the 37 states (including the FCT), the survey sample appears representative enough. The questionnaires filled by the two foreign-based gynaecologists were excluded from analysis because their practice patterns were grossly different from those of the home-based ones as revealed in their responses.

This study has shown a consensus among the respondents that a national cervical screening programme is long overdue in Nigeria. With grossly inadequate facilities for treating invasive disease, emphasis should be placed not only on prevention but also on early detection of pre-invasive disease through screening. Such a programme will no doubt reduce mortality from invasive cervical cancer as has been shown in other countries with established screening programmes⁵. Establishing a national screening programme will, however, face several impediments highlighted by the respondents. For these reasons, a national programme may take time to materialize.

Table 1

Cervical Cancer Screening: A Survey Of Current Practice Amongst Nigerian Gynaecologists. Questionnaire

- (1) Your age: _____ years.
- (2) For how long have you practiced as a gynaecologist? _____ years.
- (3) Where is your practice based? Urban 1 Rural 2 Both 3
- (4) Please specify the state and town/village where your practice is based.
State: _____ Town/Village: _____
- (5) Type of hospital: Tertiary 1 Secondary 2 Private 3
- (6) Estimate the number of new gynaecological patients you see in a week: _____
- (7) Is a cervical cancer screening service accessible to your patients?
Yes 1 No 2

If your answer to question 7 is No, please skip questions 8-16 and proceed to question 17.

- (8) If your answer to question No 7 is Yes, please estimate the percentage of your patients whom you screen for cervical cancer: _____%
- (9) How would you assess the willingness of your patients to accept cervical cancer screening?
1 Willing 2 Unwilling
- (10) What cervical cancer screening methods are available in your centre? (You can tick more than one option)
Yes(1)No(2)
! ! Pap smear
! ! Human papillomavirus (HPV) DNA testing
! ! Direct visual inspection after the application of a 5% acetic acid solution
! ! Cervicography

- (11) Do you as a practitioner, or does your hospital as an establishment, have a definite cervical screening programme?
Yes 1 No 2

If your answer to question 11 is No, please skip question 12 and go to question 15.

- (12) If your answer to question 11 is Yes, do you screen all your gynaecology patients or only those with specific indications.
All-inclusive 1 Selective 2

- (13) If your screening programme is all-inclusive, how often do you screen the women? Please choose one of these two options.
Option 1
For all women, once every _____ years.
Option 2.
For premenopausal women, once every _____ years.
For postmenopausal women, once every _____ years.

- (14) If your screening programme is selective, please list the major indications for cervical screening.

- (15) Is colposcopy available in your hospital?
Yes 1 No 2

- (16) If your answer to question 15 is No, what next step do you usually take in the event that a screening result suggests, for example, moderate cervical dysplasia in a postmenopausal woman.

- 1 Cone biopsy 2 Total hysterectomy
- 3 Re-screen patient in 3-6 months. 4 Refer to another facility for further investigations.
- Any other (please specify) _____

- (17) Do you favour a national cervical screening programme in Nigeria?
Yes 1 No 2

- (18) If your answer to question 17 is Yes, do you think that such a national screening programme is feasible at the moment in Nigeria?
Yes 1 No 2

- (19) What in your opinion is (are) the likely impediment(s) to such a national screening programme? (You can tick more than one option)

- Yes(1) No(2)
- ! ! Insufficient number of cytopathologists - Cervical cancer not a health priority in Nigeria
- ! ! Government may be unwilling to fund such a programme - Likely poor utilization by the women for whom it is intended.
- ! ! Lack of awareness about screening amongst Nigerian women.
- ! ! Poverty. - Illiteracy - Logistics.

Others _____

In the absence of an organized national screening programme, which all the respondents agreed was necessary, one expected them to have been more involved in opportunistic cervical screening of patients they care for. The low level of such screening observed in this study is rather disappointing. It affirms a previous finding that poor physician referral is one of the major reasons why many more women do not presently take up cervical screening⁶. Since another recent study also did show that no age group in Nigeria is exempt from cervical cancer¹, every sexually active woman who is not screened for cervical cancer is a missed opportunity at preventive medicine at its best. We share the views of the 73 respondents who felt that, if appropriately counselled, most Nigerian women can afford and would do a Pap smear once in two to three years. Since the majority of Nigerian gynaecologists have screening facilities, they have no convincing reason, except perhaps lack of interest, for not screening all women for whom they care. We recommend that pending the establishment of a national cervical screening programme,

individual obstetricians and gynaecologists should increase opportunistic cervical screening while tertiary-care centres should establish all-inclusive cervical screening programmes. With the present number of registered members of SOGON at over 500⁷ and with one gynaecologist seeing approximately 1560 new women yearly, approximately 750,000 women will be screened within the first year of such an exercise. We further recommend that in order to increase the coverage, medical undergraduate curricula must emphasize early detection of cervical cancer through cervical screening. The above measures, if implemented, will facilitate the implementation of a national cervical screening programme when one is established.

It is concluded that despite general agreement amongst Nigerian gynaecologists on the need for a national cervical screening programme, their level of opportunistic screening of patients is currently low. A plea is made for increased opportunistic screening pending the establishment of a national screening programme.

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