

Prognosis of skin cancers in the Conakry Cancer Department, Guinea

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ABSTRACT

Objective: The objective was to study the prognosis of skin cancers in the oncology department of Conakry. **Materials and Methods:** This was a 14-year retrospective, descriptive, and analytical study conducted from April 11, 2007, to January 1, 2021, including patients with histologically confirmed cancer. **Results:** We collected 227 histologically confirmed cases. The mean age was 45.8 ± 20.8 years. Males represented 51.5% of the cases. The consultation delay was greater than six months (65.6%). The clinical aspect was mainly ulcerative-proliferative (50.7%). The lesions were located in the head/neck region (46.2%) and lower limbs (37.9%). The cancers included non-melanoma epithelial carcinomas (70.9%) and melanoma epithelial carcinomas (21.6%). The mean lesion size was 11.02 ± 9 cm. Clinical stages were locally advanced (79.7%) and metastatic (11.9%). Treatment consisted of surgery (68.3%), chemotherapy (30.9%), and radiotherapy (0.7%). After an average follow-up of 8.43 ± 10.3 months, 32 cases (23.0%) relapsed. Recurrence was local (53.1%) or metastatic (40.6%). Overall survival at 12 months was 23%. Good prognostic factors were statistically significant for iterative resection (0.01) and initiation of treatment (0.01). **Conclusion:** Skin cancer is a common pathology in our context. Diagnosis at an advanced stage and limited access to treatment make the prognosis poor for these otherwise curable cancers. This study showed that early diagnosis and appropriate management could reverse this prognosis.

Key words: Prognosis, Skin cancer, Guinea

INTRODUCTION

Skin cancers are malignant tumors that develop from one of the skin components, which may be epidermal, dermal, hypodermal, melanocytic, or adnexal in origin. These cancers are characterized by an uneven distribution worldwide [1]. Depending on the affected tissue, they may be carcinomas, melanomas, Kaposi's sarcoma, or other types (sarcoma, lymphoma), differing in clinical, evolutionary, and histological expression [2]. According to the WHO, skin carcinomas are 15 to 20 times more frequent than melanomas. Between two and three million non-melanoma skin cancers are recorded worldwide [3]. In Africa, all histological types of skin cancer are observed, but with different proportions [4]. Their incidence has increased

significantly in recent decades, although still relatively rare in the African literature [5]. The most frequent risk factors are exposure to UV rays, albinism, chronic ulcers, and burn scars. A biopsy with histopathological confirmation is necessary for diagnosis, evaluation, management, and prognosis [6]. In Guinea, Traoré B. et al. [2], in 2017, reported that the overall survival of patients with skin cancer after surgical treatment was 65.2%, with prognostic factors including iterative tumor resection, surgical margins, ulceration, and recurrence [7]. In general, cancer management is multidisciplinary. In our context, several difficulties are encountered, including late diagnosis, the high cost of chemotherapy, and the absence of radiotherapy. In the oncology department of Donka National Hospital, surgery has been the standard treatment

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since 2007. The global incidence of these cancers, their prevalence in Guinea, and the need to improve patient management and prognosis motivated this study, which aimed to assess the prognosis of skin cancers in the oncology department of Conakry.

MATERIALS AND METHODS

This was a retrospective cohort study conducted over 14 years, from April 11, 2007, to January 1, 2021. It included all histologically confirmed cases of skin cancer during the study period. Epidemiological aspects, characteristics of skin cancers, therapeutic approaches, and patient follow-up were described. Data was analyzed using SPSS 21.0 software. Categorical variables were expressed as frequencies or percentages, and quantitative variables as means (\pm standard deviations) or medians with interquartile ranges (IQR). Survival was calculated using the Kaplan–Meier method, and factors associated with survival were analyzed using the Cox model. A test was considered significant when $p < 0.05$.

RESULTS

We recorded 227 cases of skin cancer (Fig. 1), representing 1.3% of all cancers during the study period. The mean patient age was 45.8 ± 20.8 years. Males accounted for 51.5%, with a sex ratio of 1.02. Most patients resided in rural areas (51.5%), were married (65.2%), illiterate (73.1%), and had low socioeconomic status (81.5%). Hypertension (16.7%) and HIV (5.7%) were the main comorbidities. Risk factors included sun exposure (81.5%), albinism (10.1%), burn scars (8.4%), smoking (24.2%), and combined tobacco-alcohol use (15.0%). Patients consulted for swelling (70%), nodules (16.3%), or ulceration (13.6%), with a consultation delay greater than 6 months (65.6%). Lesions were ulcerative-proliferative (50.7%) and ulcerated (21.1%), infiltrative (60.8%), and unique

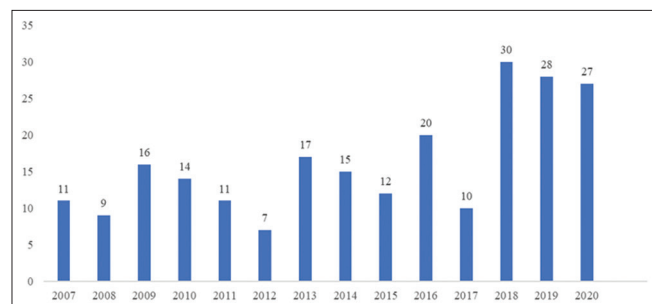


Figure 1: Distribution of selected patients by year.

(90.7%). The most common locations were the head and neck (46.2%) and lower limbs (37.9%). Histologically, non-melanoma epithelial carcinoma (70.9%) and melanoma (21.6%) were the most frequent. Tumors were mainly T4 (59.5%), with inguinal lymphadenopathy (39.2%) and stages III (79.7%) and IV (11.9%). Only 139 cases (61.2%) received specific treatment (Table 1): surgery (41.8%), chemotherapy (18.9%), and radiotherapy (1 case). Follow-up was less than 3 months in 63.3% of cases and more than 6 months in 25.9% (Table 2). Recurrence was observed in 23.0% of cases: local (53.1%), locoregional (6.3%), and metastatic (40.6%). At the last follow-up, 47.1% of patients were alive, 30.8% had died, and 22% were lost to follow-up. Overall 12-month survival was 23% (Fig. 2). Iterative surgery and initiation of treatment (surgery or chemotherapy) were statistically significant good prognostic factors (Table 3).

DISCUSSION

Over 14 years, we recorded a notable frequency of skin tumors (1.3%). This proportion is lower than that reported by Traoré B. et al. in the Journal of Cancer Therapy (7.8%) [7] and much lower than that of Diallo et al. in Senegal (16%) [8], but higher than that of Andrianarison M. et al. in Madagascar (0.5%) [1]. This difference may be

Table 1: Distribution of the patients according to specific treatments.

Characteristic	Number (n=139)	Percentage (%)
Surgery	95	68.3
Chemotherapy	43	30.9
Radiotherapy	1	0.7

Table 2: Distribution of the patients according to progression (recurrence) after treatment.

Characteristic	Number (n=139)	Percentage (%)
Follow-up		
< 3 months	88	63.3
3–6 months	15	10.8
> 6 months	36	25.9
Progression		
Recurrence	32	23.02
Not specified	107	76.9
Recurrence (n=32)		
Local	17	53.1
Locoregional	2	6.3
Metastatic	13	40.6
Status at last update		
Alive	107	47.1
Deceased	70	30.8
Lost to follow-up	50	22.0

Table 3: Distribution of the prognostic factors according to follow-up.

Factor	Alive		O.R	P-value	C.I
	Yes	No			
Age (yrs.)					
<40	75	17	1.06	0.51	0.88–1.27
≥40	83	52			
Sex					
Female	80	32	0.87	0.15	0.73–1.04
Male	78	37			
Time to consultation					
≤3 months	30	10	0.79	0.6	0.62–1.00
>3 months	128	59			
Lymph node involvement					
N0	113	41	0.90	0.31	0.74–1.09
N+	45	28			
Tumor size (cm)					
≤5	19	6	1.05	0.73	0.77–1.42
>5	58	40			
Stage					
Stages I and II	21	13	0.96	0.80	0.74–1.24
Stage III	108	61			
Stage IV	9	15			
Repeat resection					
Yes	12	6	1.49	0.01	1.07–2.08
No	146	63			
Treatment					
No	114	49	1.64	<0.01	1.34–2.01
Yes	44	20			
Surgery					
Yes	34	13	1.55	<0.01	1.24–1.93
No	124	56			
Chemotherapy					
Yes	12	8	1.41	0.03	1.03–1.92
No	147	60			
Recurrence					
Local	12	5	1.07	0.19	0.96–1.19
Locoregional	2	0			
Metastatic	0	1			

explained by limited diagnostic and therapeutic facilities in Guinea and patient neglect. Our series was marked by a peak in 2018, possibly due to cancer screening campaigns. The mean age of patients was 45.8 years, lower than that reported in Burkina Faso (48.5 years) [5] and Morocco (57.7 years) [9]. This suggests skin cancer often affects older individuals with greater UV exposure. We observed a slight male predominance (sex ratio 1.02), similar to studies in the French Antilles [10] and other African reports [11,12], though Ouédraogo et al. [5] found female predominance in Burkina Faso. Tobacco use was significant (55%), and albinism was present in 10.1% of cases, higher than Mali (2.3%) [13,14]. The long consultation delay (average 21.4 months) contributed to advanced disease stages, worsened by traditional medicine and self-medication. Clinically,

**Figure 2:** Overall survival curve for the patients with skin cancer.**Figure 3:** Direct suture after a wide excision of a squamous cell carcinoma of the cheek in a 34-year-old female patient on postoperative day 1.

most tumors were ulcerative-proliferative, consistent with squamous cell carcinoma. Lesions were mainly located in the head/neck (46.2%) (Fig. 3) and lower limbs (37.9%), matching literature findings [15-17]. Histologically, squamous cell carcinoma predominated, while basal cell carcinoma was rare, as reported in African studies [2,5,7,8,18]. Advanced stage tumors (mostly T4) reflected delayed diagnosis. Surgery was the primary treatment (68.3%) (Figs 3 and 4), though access to radiotherapy remains absent in Guinea. Recurrence was observed in 23%, lower than Traoré et al. (28.8%) [7]. Overall 12-month survival was only 23%, compared to 75% at 5 years in India [19,20]. Poor outcomes reflect advanced presentation and limited treatment access. Prognostic factors included iterative resection and initiation of treatment, consistent with previous Guinea findings [7].



Figure 4: Scar from a wide excision of a squamous cell carcinoma of the cheek in a 34-year-old female patient.

CONCLUSION

Skin cancer is a frequent pathology in our context. Advanced-stage diagnosis and limited access to treatment lead to poor prognosis for these otherwise curable cancers. Early diagnosis and appropriate management could significantly improve patient outcomes.

Statement of Human and Animal Rights

All the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the 2008 revision of the Declaration of Helsinki of 1975.

Statement of Informed Consent

Informed consent for participation in this study was obtained from all patients.

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