

Editorial

Management of Breast Cancer in Developing Countries

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Breast cancer is a global problem, and more than 1 million new cases are diagnosed per year [1]. Approximately two thirds of deaths due to breast cancer occur in Developing Countries (DCs), whereas in developed countries, an estimated 800,260 new cases of breast cancer are diagnosed each year, and mortality due to this disease is decreasing [2]. In contrast, breast cancer in DCs represents one-half of all breast cancer cases and 62% of the deaths.

Developing countries have limited healthcare resources and use different strategies to diagnose breast cancer. In many developing countries, the incidence of breast cancer is now rising sharply due to changes in reproductive factors, lifestyle, and increased life expectancy. Most of the population depends on the healthcare system, which affects the diagnosis of the tumor. Thus, the indicators observed in developed countries cannot be directly compared with those observed in developing countries because the healthcare infrastructures in developing countries are deficient [3]. Despite advances in medicine, breast cancer is diagnosed in the late stages in countries with limited resources because early detection, diagnosis, and treatment cannot be efficiently promoted.

We need to address the reality that many women, particularly those with less income and education, may not seek care when they feel a breast mass, because they are unaware of what it represents, are concerned about the stigma of cancer and being rejected by their community and their partners, fear the potential loss of the breast, or believe there are no effective therapies for the disease especially if all the women they have known with breast cancer died. HIV-a stigma-laden disease, that if untreated is universally fatal-provides important lessons. These same issues prevented many patients with

HIV from seeking care. By contrast, it has been demonstrated that by combining education, with better and more accessible healthcare facilities, trained medical personnel, and effective therapy, patients do seek and comply with treatment and benefit from it.

Large-bore core needle biopsy is a reliable method to obtain tissue for diagnosis and can be performed by trained personal in relatively simple ambulatory settings. Ultrasonography, widely available in developing countries, can effectively localize tumors for biopsy. Pathology services must be available to process the specimens but can be located regionally or outsourced globally. In many developing countries, surgery and chemo radiotherapy is available in regional centers, although additional training of surgeons and oncologists in appropriate techniques may be needed, and women will require financial support and transportation [4]. Where radiation therapy is not available, as is the case in many low-income countries, the surgery should be a mastectomy.

It is difficult to compare or evaluate the health systems of DCs, and it is also difficult to evaluate their improvement. Based on this condition, it is important to consider indicators that indirectly reflect the status and evolution of public health systems related to breast cancer screening and diagnosis. It is a challenge to identify possible indicators associated with the diagnosis of early breast cancer because these populations lack real indirect indicators related to breast cancer screening and indicators that can evaluate progressive improvements to the healthcare system or that can compare healthcare systems among DCs.

References

1. Alawad AA. Evaluation of clinical and pathological response after two cycles of neoadjuvant chemotherapy on Sudanese patients with locally advanced breast cancer. *Ethiopian journal of health sciences*. 2014; 24: 15-20.
2. Ahmed AA. Clinicopathological profile of female Sudanese patients with locally advanced breast cancer. *Breast disease*. 2014; 34: 131-134.
3. Alawad AAM. Management of Inflammatory breast cancer: current concepts. *Int J Case Rep Images*. 2015; 6: 460-461.
4. Alawad A, Alshiekh A, Alhaj A. Demographic Characteristics and Review of Patients with Locally Advanced Breast Cancer in Sudan. *Afrimedical Journal*. 2014; 4: 5-8.