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REVIEW ARTICLE

Oral cancer in Libya and development of regional oral cancer registries: A review



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Abstract The aims of this paper are three-fold: (1) to summarize the current epidemiological data on oral cancer in Libya as reported in the published literature and as compared to other national oral cancer rates in the region; (2) to present both the history of the early development, and future goals, of population-based oral cancer tumor registries in Libya as they partner with the more established regional and international population-based cancer tumor registries; and, (3) to offer recommendations that will likely be required in the near future if these nascent, population-based Libyan oral cancer registries are to establish themselves as on-going registries for describing the oral cancer disease patterns and risk factors in Libya as well as for prevention and treatment. This comprehensive literature review revealed that the current baseline incidence of oral cancer in Libya is similar to those of other North Africa countries and China, but is relatively low compared to the United Kingdom, the United States, and India. The recently established Libyan National Cancer Registry Program, initiated in 2007, while envisioning five cooperating regional cancer registries, continues to operate at a relatively suboptimal level. Lack of adequate levels of national funding continue to plague its development. . .and the accompanying quality of service that could be provided to the Libyan people.

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1. Background and aims

A cancer registry is an organization which systematically collects, stores, analyzes, interprets and reports data on subjects with cancer. There are two main types of cancer registries: hospital-based cancer registries and population-based cancer registries (dos Santos Silva, 1999; Morse et al., 1995; O'Brien et al., 2013; Pollock and Birch, 2008).

Hospital-based cancer registries deal with recording information of cancer patients seen in a particular hospital. The data collected are mainly used for administrative purposes and for evaluating clinical performance. To a certain extent; these data may benefit epidemiological purposes, the main limitation being that hospital-based registries usually cannot define their catchment populations as a geographically defined source for all their cases. In contrast, population-based cancer registries deal with data collection on all new cases of cancer occurring within a well-defined population living in a well-defined geographical region. This critical characteristic allows population-based registries to fulfill their main purpose which is to produce useful epidemiological data, specifically prevalence and incidence statistics on cancer burden that are vital in establishing public health priorities for a defined geographical, and usually politically-defined, population. Further, these data from population-based registries are also useful both for the planning and conducting of etiological studies into the causes of cancer for that well-defined population, as well as for monitoring and analyzing the efficacy of implemented cancer control activities on that population (dos Santos Silva, 1999).

The first population-based cancer registry in the world was set up in Hamburg, Germany in 1926. Based upon routine visits at regular intervals to both hospitals and medical practitioners in that city, new cancer patients identified and recorded with those data transferred to a central listing in the registry which was compared weekly with official death certificates. Subsequently, with Hamburg serving as the model, two state cancer registries were then established in the United States, one for New York State in 1940, the other in Connecticut in 1941 (but with registered cases retrospectively collected back to 1935). The public health value of these early population-based registries for both the study and control of cancer led, over the next 15 year period, to the rapid growth of population-based cancer registries around the world, with approximately 20 being established in various countries by 1955 (dos Santos Silva, 1999). This growth continued and even

accelerated over the next 70 years until at present in 2013, more than 300 population-based cancer registries, which collectively cover about 11% of the world's population, exist world-wide (Curado et al., 2007).

The availability of these world-wide data from population-based cancer registries, and the rapid development of established standardized protocols for the collection of those data across these registries, led to the centralized publishing of these cancer data from these worldwide cancer registries within the Cancer Incidence in Five Continents series of monographs (CI5, 1966–2013). This centralized reporting and publishing via CI5 monographs began with Volume I which was published in 1966 and reported on worldwide cancer statistics from 1960 to 1962 covering 35 populations as reported from 32 population-based registries in 29 countries. There are now ten volumes published by CI5, the latest being Volume X published in 2013 and which reported on cancer statistics from 2003 to 2007 now covering more than 300 populations as reported from 290 registries in 68 countries (Curado et al., 2007; Forman et al., 2013).

Table 1 shows the history of the North Africa geographical regional coverage in the ten successive volumes of CI5, which has been both recent and sporadic (Curado et al., 2007; Forman et al., 2013). The initial North Africa regional contributions to the CI5 dataset appeared in Volume VI which first reported on 1986–89 cancer statistics from the Sétif Cancer Registry in Algeria and then again on Volume VII on the 1990–93 cancer statistics. A second North Africa site, the regional cancer tumor registry in Algiers, Algeria contributed cancer data in Volume VIII of the CI5 monograph series for cancer statistics from 1993 to 1997. In CI5 monograph series published in 2007, three North Africa cancer registries contributed 1998–2002 cancer statistics to Volume IX, these data coming from the initial-regional contributor, the one in Sétif, Algeria, and two first-time contributors, the cancer registries in Gharbiah in Egypt and the Central Region in Tunisia. Most recently, four North Africa cancer registries contributed to the latest CI5 monograph series; the two cancer registries in Sétif, Algeria and Gharbiah, Egypt contributed data for cancer statistics from 2003 to 2007 and two contributors where for the first time, Benghazi Cancer Registry in Libya along with North Registry in Tunisia contributed data for cancer statistics from 2003 to 2005 to CI5 monograph series.

The aims of this paper are tri-fold: (1) to summarize the current epidemiological data on oral cancer in Libya as reported in the published literature and as compared to

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