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Colorectal carcinoma then and now: What we are learning by comparing two Libyan cancer studies

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To The Editor,

In a previous issue, Elzouki *et al*. described the pattern of colorectal carcinoma (CRC) in two tertiary hospitals in Benghazi.[1] I applaud their impressive work in helping to fill the void that exists in Libyan cancer epidemiology. The data gathered by the research team covered 2007–2009, before a specialized Oncology department was established at the Benghazi Medical Center and was used as the focal point for all cancer patients in eastern Libya. Similarly, another study regarding colorectal carcinoma in eastern Libya was published dealing with patients diagnosed in the year 2012.[2] By looking at these two recent articles, we can ascertain certain trends regarding our cancer epidemiology:

- In the 3-year period between 2007–2009, 152 patients were collected as the cohort for CRC cases in Benghazi, whereas that figure jumped to 174 patients in a single year (i.e. 2012). This reflected on the ASR with the figure increasing from 16.14 and 13.89 to 17.5 and 17.2/100,000 for males and females, respectively. The current incidence rate for CRC in eastern Libya is the highest in North Africa[2,3]
- Women are more likely to be affected by a right colon tumor while the opposite is true for men. Table 1 highlights some key comparisons between the two studies
- While the mean age of diagnosis has increased for both genders, colorectal cancers are being caught at earlier stages (especially stage I which was non-existent in 2007–2009). This is most likely a sequelae of the increased usage of colonoscopy services in Benghazi
- Mirroring the change in stage of diagnosis, more malignancies are found to be well-differentiated. These are all factors that positively influence the prognosis. The overall portrait painted by these studies is one where increased colonoscopy services are helping to diagnose more colorectal carcinoma cases at earlier stages and at better pathological grades. There seems to be a slight shift of site similar to trends observed in Western countries.

Table 1: Comparison of key parameters seen in colorectal patients in 2007-2009 and 2012

	Male		Female		Overall	
Number (*n*|%)						
2007-2009[1]	84	55	68	45	152	100
2012[2]	90	51.7	84	48.3	174	100
Average Age (years)						
2007-2009[1]	56.73		58.13		57.4	
2012[2]	57.3		60.1		58.7	
Stage (*n*|%)						
I						
2007-2009[1]	0	0	0	0	0	0
2012[2]	6	9.1	4	6.8	10	8.1
II						
2007-2009[1]	26	30.9	21	30.9	47	30.9
2012[2]	18	27.3	21	35.6	39	31.2
III						
2007-2009[1]	24	28.6	21	30.9	45	29.6
2012[2]	16	24.2	12	20.3	28	22.3
IV						
2007-2009[1]	34	40.5	26	38.2	60	39.5
2012[2]	26	39.4	22	37.3	48	38.4
Differentiation (*n*|%)						
Well	14	16.7	12	17.7	26	17.1
2007-2009[1]	17	35.4	12	30.8	29	33.3
2012[2]						
Moderate	29	34.5	23	33.8	52	34.2
2007-2009[1]	27	56.3	20	51.3	47	54
2012[2]						
Poor						
2007-2009[1]	36	42.9	29	42.6	65	42.8
2012[2]	4	8.3	7	17.9	11	12.7
Undifferentiated						
2007-2009[1]	5	5.9	4	5.9	9	5.9
2012[2]	0	0	0	0	0	0
Site (*n*|%)						
Right						
2007-2009[1]	17	20.2	13	19.1	30	19.7
2012[2]	14	18.9	16	24.2	30	21.4
Left						
2007-2009[1]	67	79.8	55	80.9	122	80.3
2012[2]	60	81.1	50	75.8	110	78.6

Screening programs have yet to be established and executed in our hospitals. Individually, gastroenterologists have been doing a large amount of admirable work, carrying the patient load in relatively nascent departments and implementing screening programs on families with hereditary colorectal cancer diseases. Just as colonoscopy usage raised the ASR of colorectal carcinoma in Libya, a

screening program would help to reveal the hidden part of the iceberg.

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