RESEARCH COMMUNICATION

Gastric Cancer in Iran 1966-2006

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Abstract

This review was carried out to provide an up-to-date perspective on gastric cancer clinicoepidemiological characteristics, to explain geographical differences, and to define public health priorities for prevention and early detection programs in Iran. A comprehensive search was conducted using different search engines and over 147 Persian medical journals from 1966 to December 2008. Inclusion criteria were published studies on gastric cancer clinical and epidemiological data. Abstracts only were excluded. Twenty five studies and two national cancer registry reports were also included. The average gastric cancer incidence rates were reported to be 15.2 (8.1 to 49.1) and 6.7 (4.9-25.4) per 100,000 in males and females, respectively, with a ratio of 2.3:1 (1.5 to 2.7). More than two thirds of them were diagnosed in stage IV. Crude mortality rates were estimated at 15.5 and 8.4 per 100,000 in the two genders. The trend for gastric cancer cases was increase from 1969 to 2004; antral adenocarcinomawas shifted to cardia adenocarcinoma in this period. The gastric cancer epidemiological aspects have changed during 4 decades; a Western pattern has been started in Iran where the incidence rate of adenocarcinoma of the most proximal cardia region and adjacent gastro-oesophageal junction has increased. Developing a gastric cancer early detection program, investigating gastric cancer risk factors, preventing patient and system delays, and providing national guidelines for treatment and palliation are all recommended. It is expected the gastric cancer incidence cases will increase at the start of this program, and will decreased thereafter.

Key Words:  Gastric cancer - epidemiology - incidence - mortality - early detection - Iran

Literature Survey


The following terms were used in the PubMed Database search: “Gastric cancer”, Gastrointestinal cancer”, “Stomach cancer” combined with the word “Iran” in their titles and abstracts. The search was repeated by replacing “cancer” with “malignancy” and “tumor”. For SID and IranMedex Databases search, the Persian terms for gastric cancer were used. For the incidence rate data, the authors contacted each registry in Iran for a report.

The efforts to gather all published articles, particularly those published in Persian medical journals showed was the fact that they did not have a citation index, therefore many of them were searched by hand. Over 4000 issues of 147 Persian medical journals were assessed manually...
from Iranian libraries Medical College Library of Tehran University, Iran University Reference Medical Library and Central Library of Tabriz University of Medical Sciences. Several authors were asked to provide us copies of their published manuscripts. In addition, references cited in the identified articles were searched manually. Abstracts were not included in this review. Inclusion criteria were published studies on gastric cancer clinical and epidemiological data.

Using these approaches, reports on gastric cancer clinicoepidemiological aspects were found in 29 full-text articles and one unpublished national database was added to this review (National Cancer Registry, 2008). Four studies were excluded because duplicated publication in Persian (Sharifi et al., 1999; Yazdanbod et al., 2000; Zahedi et al., 2005; Babaei et al., 2006), and 6 studies were excluded because the gastric cancer results were also reported in other publications (Mehrabi et al., 2004; Yazdanbod et al., 2001; 2004; Sadjadi et al., 2005; Esmaeilnasab et al., 2006; Marjani et al., 2007). Two studies were excluded because they were underreporting or lacking basic data (Azarm et al., 1997; Ganji et al., 2006). Finally, three studies were excluded because their full text was not available (Habibi, 1970; Haghhighi, 1971; Dutz et al., 1979). Therefore, a total of 25 studies, and two national cancer registry reports (Mousavi et al., 2008; National Cancer Registry, 2008) were used for calculating summary statistics. There was no hypothesis for statistical testing. Range of data and standard sex ratio were used for presenting the findings.

Results

Gastric cancer incidence rates of the 6 studies (Sadjadi et al., 2003; Babaei et al., 2005; Mohagheghi and Mosavi-Jarrah, 2006; Mousavi et al., 2008; Semnani et al., 2008) and one national report (National Cancer Registry, 2008) are presented in Table 1. The gastric cancer incidence rate was reported 15.2 (8.1 to 49.1) and 6.7 (4.9-25.4) per 100,000 in males and females respectively, male to female standard ratio was 2.3 (1.5 to 2.7). The gastric cancer constituted 12.7 (7.7-36.6) and 6.2 (5.1-24.5) percent of all cancers in male and female respectively. A study on 10.125 male, 9.105 female immigrants to British Columbia (Canada) reported, the gastric cancer incidence rate was 6.5 per 100,000 in females from 1988 to 2003; the data for male gastric cancer were not presented (Yavari et al., 2006).

Table 2 shows the gastric cancer demographic aspects based on 13 studies in Iran from 1988 to 2005. Fourteen percent of gastric cancer was reported in patients under 40 years old (Davood Abadi et al., 2003), and the minimum age group for stomach cancer was 5-9 years (Sadjadi et al., 2003; Babaei et al., 2005; Mohagheghi and Mosavi-Jarrah, 2006).

Estimated mortality rate and burden of gastric cancer are shown in Table 3. Crude mortality rate of gastric cancer was estimated 15.5, and 8.4 per 100,000 in male and female respectively (Naghavi, 2006; 2008). More than two third of gastric cancer were diagnosed in the stage IV and less than 10% of cases were reported stage I or II (Hajiani et al., 2006; Sadighi et al., 2005).

Discussion

This report presents gastric cancer epidemiological data for the period 1966 to 2006. A major problem in this review was the fact that there is not a completed citation

Table 1. World population age standard incidence rate of gastric cancer in Iran

<table>
<thead>
<tr>
<th>Geographical Setting</th>
<th>Pop (x10^7)</th>
<th>DCA Sex</th>
<th>Incidence Rate per 100,000 population</th>
<th>Crude</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Cancer Registry Program (2008)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iran 03-7</td>
<td>68</td>
<td>NA</td>
<td>0.1</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Ardebil 06</td>
<td>1.2</td>
<td>23.9</td>
<td>1.0</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Golestan 06</td>
<td>1.6</td>
<td>12.8</td>
<td>0.0</td>
<td>1.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Isfahan 06</td>
<td>4.0</td>
<td>1.9</td>
<td>0.3</td>
<td>0.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Kerman 06</td>
<td>2.0</td>
<td>2.0</td>
<td>1.2</td>
<td>0.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Lorestan 06</td>
<td>1.8</td>
<td>37.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Provincial Cancer Registry Programs

| Ardebil 96-9 | 1.1 | 3.6 | F | 1.8 | 0.0 | 1.7 | 12.4 | 41.4 | 96.4 | 114.1 | 142.5 | 24.5 | 1.9 |
| Kerman 96-00 | 2.0 | 3.2 | M | 1.0 | 4.1 | 11.2 | 57.4 | 186.0 | 356.0 | 314.9 | 41.9 | 36.6 |
| Semnani 97-01 | 0.3 | NA | F | 0.0 | 1.0 | 1.0 | 14.4 | 41.4 | 96.4 | 114.1 | 142.5 | 24.5 | 1.9 |
| Babaei, 2005 | 0.5 | 0.8 | F | 1.0 | 4.1 | 11.2 | 57.4 | 186.0 | 356.0 | 314.9 | 41.9 | 36.6 |
| Golestan 06 | 1.6 | 8.9 | M | 0.0 | 1.0 | 1.0 | 14.4 | 41.4 | 96.4 | 114.1 | 142.5 | 24.5 | 1.9 |
| Semnani, 2008 | 0.5 | 0.8 | F | 1.0 | 4.1 | 11.2 | 57.4 | 186.0 | 356.0 | 314.9 | 41.9 | 36.6 |

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2006

The gastric cancer incidence rate was reported higher in Ardebil (North West) than the other provinces. It might be due to the differences in the method for cancer registration, prevalence data from referral endoscopic clinic, facilities for diagnosis, and high probable risk factors. It should be suggested; after establishing the endoscopic clinic at Ardebil by Digestive Disease Research Center (Malekzadeh et al., 2004), more endoscopies were done (Derakhshan et al., 2004). During this intervention, more gastric cancers were diagnosed and all of them were registered by an established population based cancer registry (Sadjadi et al., 2003; Babaei et al., 2006). This data are more supposed to be the prevalence cases than the incidence cases. However, this pattern is more like to the report for esophageal cancer in the North of Iran: esophageal cancer incidence rate was reported 263 and 206 per 100,000 in female and male respectively in Caspian Littoral in 1975 (Horomozdiari et al., 1975), it was reported 19.9 percent and 22.8 percent respectively in Caspian Littoral in 2006 (Semnani et al., 2008); these data show the esophageal cancer incidence rate has decreased more than 10 times during 3 decades without any organized intervention in that region which it seems impossible; the decrease in esophageal cancer cases by 18% to 48% in Shiraz and Tehran from 1972 to 1995 seems more reliable (Yazdizadeh et al., 2005). These documents show the esophageal cancer data for 1975 in the northern regions of Iran that might be prevalence cases. However, this interpretation might be used for Golestan (north east) and all of them were registered by an established population based cancer registry (Sadjadi et al., 2003; Babaei et al., 2006). This data are more supposed to be the prevalence cases than the incidence cases. However, this pattern is more like to the report for esophageal cancer in the North of Iran: esophageal cancer incidence rate was reported 263 and 206 per 100,000 in female and male respectively in Caspian Littoral in 1975 (Horomozdiari et al., 1975), it was reported 19.9 percent and 22.8 percent respectively in Caspian Littoral in 1975 (Horomozdiari et al., 1975), it was reported 19.9 percent and 22.8 percent respectively in Caspian Littoral in 1975 (Horomozdiari et al., 1975), it was reported 19.9 percent and 22.8 percent respectively in Caspian Littoral in 1975 (Horomozdiari et al., 1975), it was reported 19.9 percent and 22.8 percent respectively in Caspian Littoral in 1975 (Horomozdiari et al., 1975).
methodology (Yavari et al., 2006). More investigations should be carried out to study gastric cancer among Iranian immigrants in multi geographical settings (e.g. USA, Canada, Sweden, etc.) to find the environmental effects on gastric cancer incidence rate (Tsugane et al., 1990; Maruyama et al., 1998; Hemminki et al., 2002; 2003).

Figure 1 shows an overall increasing trend for age peaking at age 80-84 with a declining trend for older men and women in 2006. This pattern was defined for the other cancers in Iran (Mousavi et al., 2008). Case ascertainment methods, data collection and sources of information, and misdiagnosed cases in over 85 years old persons might be part of factors.

A study in Ardabil in 1973 reported 64% of all cancer deaths were due to esophageal and gastric cancers (56% esophagus and 8% stomach) (Mahboubi et al., 1973); this pattern had changed in 2004 where 45.5% of all cancer deaths were reported due to esophageal and gastric cancers (11.7% esophagus and 33.8% stomach) (Naghavi, 2006). According to available data (Yazdizadeh et al., 2005; Abdi-Rad et al., 2006), the trend of gastric cancer cases has increased from 1969 to 2004; it was explained the prevalence of cancers in the upper and middle third of the stomach have increased and that of the lower third has decreased. These changes were seen in both sexes and age groups and it was more significant in younger persons (Abdi-Rad et al., 2006), however in comparison with the report on 1971 (Haghighi, 1971), the percentage of gastric cancer to total cancer has not increased; based on this study, antral adenocarcinoma (distal part) was considered to be the predominant type of gastric cancer in Iran. As Table 2 shows, near to all studies supported this finding, but cardia adenocarcinoma (proximal part) was found to be more common gastric cancer localization by the studies in Kashan, Golestan, and Ardabil (Davood Abdi et al., 2003; Islami et al., 2004; Derakhshan et al., 2004). Zanjan study reported 56% antrum adenocarcinoma from 1988 to 1992 (Babaei, 1993), this was changed to cardia adenocarcinoma up to 49.2% in 2005 (Hosseini et al., 2007). These findings suggest, the western pattern has been started in Iran; where the incidence rate of adenocarcinoma of the most proximal cardia region and adjacent gastro-esophageal junction has increased over the past 25 years (Powell et al., 1990; Blot et al., 1991; Botterweck et al., 2000); in contrast, adenocarcinoma of the more distal stomach (non-cardia cancer) has been progressively falling in incidence at least for the last 50 years (Kelley et al., 2003).

Based on a report on Ardebil and Meshkinkhahr from 2000 to 2001 which was more like a screening program, the gastric cancer detection rate was 0.3% among people over 40 years old. The stage of gastric cancer was not defined in this study, but the participation rate was very high (more than 90%) (Malekzadeh et al., 2004). However, mortality reduction, cost effectiveness and cost benefits of this method should be assessed by more pilot studies before recommending this method for gastric cancer control program at the national level.

The estimated mortality data for gastric cancer (Naghavi, 2006, Naghavi, 2008) were similar to its incidence data; this is compatible to the reports on gastric cancer survival studies (Sadjadi et al., 2005; Yazdanbod et al., 2005; Zeraati et al., 2005; Moghimi et al., 2007).

Gastric cancer’s specific feature in Iran: the patients are diagnosed at advanced stages (III, IV) mostly. The probable causes can be classified into two categories. The first one might be due to Patients’ Delay: all factors which caused delaying for caring by the patients. Patients’ low socioeconomic level and low awareness to the diseases’ symptom and prevention might be the most association factors. The second might be due to System’s Delay: all factors which caused delaying for providing diagnostic and treatment facilities by the health system. Mismanagement and ineffective cares by general practitioners or specialists, lack of access to the health care systems, high costs of diagnostic and treatment interventions, and lack of supportive cares might be played as a part of this delay (Hajiani et al., 2006; Hosseini et al., 2007; Khorgami et al., 2007). It is recommended to select the evidence based strategies for preventing these delays for gastric cancer control program. Mass awareness, revising the medical education, providing the basic facilities for diagnosis and treatment might be the essential activities. The results of gastric cancer clinical trial are not interpreted by this review because of little studies (Ghavamzadeh et al., 1993; Sadjadi et al., 2006).

Regarding future activities and perspectives, it can be concluded that gastric cancer prevention should be a governmental priority in Iran. Implementing the Comprehensive National Cancer Control Program (CNCCP) is recommended (Mousavi et al., 2007; 2008) in this field. Research on gastric cancer risk factors and investigation of the causes of geographical differences in incidence rates are high priorities for research centers.

The gastric cancer control program should be integrated in the CNCCP by focusing on prevention, and early detection. Although on currently available evidences, population screening cannot be recommended; gastric cancer early detection should be piloted and its methods for case finding and referring the suspected cases should be clarified. The cost benefit and cost effectiveness of this method should be assessed and reported before implementing this method at the national level.

The local clinical trials should be supported to provide the evidences for the next 5-10 years in the area of gastric cancer treatment and palliative cares, and using experts’ consensus for patient treatment at the present time for an
urgent strategy to provide its national guideline protocol. Palliative therapy and supportive cares are neglected issues for the gastric cancer cares in Iran, it is highly recommended to provide its national protocols and to integrate it in the primary health care settings. It is expected the gastric cancer incidence cases will increase at the starting point of the gastric cancer early detection program in Iran, and then it will decrease after these stages. This pattern might be used as an index for assessing and evaluating in future.

Acknowledgments

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