Reviewer's report

Title: Cancer mortality patterns in Ghana: a 10-year review

Version: 2  Date: 18 April 2006

Reviewer: Paola Pisani

Reviewer's report:

General

Because of the lack of data on the cancer burden in Ghana, this descriptive report is of some interest. It is based on autopsies and medically certified cancer deaths that occurred at the Teaching hospital of Korle-Bu in 10 years. The main limitation of the series examined is that it is highly selected, much more than the authors are prepared to recognize. The two major sources of estimates of cancer mortality for Sub-Saharan Africa are the GLOBOCAN database, and the WHO Global Burden of Disease (GBD2000, http://www.who.int/research/en/). The crude death rates due to cancer estimated in the two databases (independently and taking into account different sources of information) are 36 and 61 (M+F) per 100,000 respectively. These correspond to an expected number of annual deaths in Ghana from 7200 to 12200. The 3659 deaths in 10 years examined in the article represent therefore 3% to 5% of all, hardly a representative sample. Most important, it is well known that access to health facilities is very limited for the rural population in Africa. The good quality certified deaths examined cannot be assumed therefore to reflect cancer patterns in the country.

Most of the comments in the conclusions are not supported by the data presented. For example, the relative frequency of specific cancer sites (e.g. female breast and cervix top 2 sites) is not sufficient to advocate early detection screening programmes. One of the principles of screening is that the disease should be sufficiently common (incidence/mortality rate) to justify a very expensive intervention that would be otherwise very little cost-effective.

I think that this material deserves a short communication. Both the introduction and discussion should be drastically reduced and comments limited the comparisons with estimates with other countries in the region.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Drastic reduction.

The “ASR” abbreviation should not be used because misleading (it is normally used for the Age-standardized rate). The appropriate abbreviation used by cancer registries is ASCAR (age-standardized cancer ratio, Jensen et al, 1991, Cancer Registration Principles and Methods, IARC Sc.P No.95)

Page 7, second period: there is no standard age distribution. The authors should simply list the age-groups which they used.

Page 7, line 9 from bottom. The paper quoted (Boffetta & Parkin) is not based on data from Globocan2000 or Globocan 2002.
Page 11, last period: the statement about the relationship between Globocan mortality estimates and WHO mortality database as such is incorrect and misleading. Globocan includes WHO mortality statistics for countries where these are available, which is not the case of Ghana and most of Africa. Otherwise IARC estimates mortality based on incidence and survival. The WHO GBD programme also produces estimates following a different methodology. Indeed the latter estimates are much less conservative than those of IARC (see above).

Tables 3 and 4 and figure 1 are not informative.

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

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Discretionary Revisions (which the author can choose to ignore)

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No

Declaration of competing interests:

I declare that I have no competing interests.