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The Recognition of a Recurrent Form of Albino Skin Cancer

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Abstract

It is well known that albinos undergo operations when they suffer from sunlight induced cancers. Not so well known is that some of them undergo such operations several times. Does this represent a "recurrent variant"? A histopathology data pool established at a Reference Laboratory serving the Igbo ethnic group in Nigeria was searched for a 30-year period in respect of the number of operations recorded for the albino patients. A total of 133 cases became available. Whereas 90 patients were operated on once, four underwent 4 operations or more, the highest number being 7 times. It is hypothesized that the "recurrent variant" of keloids, which has already been reported in the literature, probably also holds true among Igbo albinos. In addition, whether this is "familial" or not ought to be determined through epidemiologic research worldwide.

Keywords: Skin; Albino cancer; Keloid; Recurrences; Nigeria

Introduction

From the western region of Nigeria, Oluwasanmi et al. [1] presented 435 Negro patients with superficial skin cancers, 15 of them being albinos. Incidentally, they noted that, out of this particular subset, "the lesions recurred several times after removal." Unfortunately, they did not specify what constituted "several times."

Times during which surgical operations are carried out in different settings need to be reckoned with. Accordingly, my personal experience among the Igbos, [2] a large ethnic group in Nigeria, is presented in order to clarify with pertinent data the intriguing question, "Is there a recurrent form of albino cancer?"

Materials and Methods

Between 20th February, 1970, when the Nigerian Civil War had just ended, and 19th February, 2000, I received surgical specimens brought to my personal base at Enugu, the original capital of the Eastern Region of Nigeria. The service was largely

rendered free in a Central Reference Laboratory. The caveat was that my circular must be followed so carefully that the submitted specimens would be accompanied with well filled Request Forms. In this way, I established a deep histopathology data pool in accordance with the practice of Macartney et al. [3]. Its analysis constitutes the present investigation.

Results

A total of 133 specimens were submitted during 30 years by 35 doctors working in 19 hospitals. **Table 1** shows that 90 patients were operated upon but once. On the other hand, the highest operation of 7 times occurred in only one case.

Table 1 Number of operations on Igbo albinos.

Operation	Male	Female	Total
1	64	32	96
2	13	8	21
3	6	2	8
4	3	1	4
5	2	–	2
6	1	–	1
7	1	–	1
Total	90	43	133

Case analysis indicated that those operated on more than four times numbered only four, i.e., 3%. All these turned out to be males. **Table 2** shows the worst case presentation.

Table 2 Operations performed on the worst case.

Age (yrs)	Date	Sites	Maximum Size (cm)
26	31/10/75	Face, Neck	3.5
27	12/11/76	Lower lip	4.0
32	8/5/81	Forehead, Neck	3.0
33	24/4/82	Forehead, Weak	6.0
34	22/4/83	Neck	3.0

46	3/3/95	Cheek	2.5
46	11/10/95	Peri-auricular	2.5

Discussion

This result is to some extent reminiscent of the comparable novel finding by Manchester researchers, [4] who delineated, as “aggressive keloid,” a subset consisting of those suffering seriously from this other skin lesion. Consequently, on a comparative basis, it should be hypothesized that “aggressive or recurrent albino cancer” ought to be recognized also as a novel subset especially among males.

Also to be noted is that both albinism and keloid exhibit pathologic lesions among Negro peoples, i.e., ethnicity is involved. But, is the “familial” relationship found among patients with aggressive keloid [4] also present in albino cancer of the same peoples? On searching my data, the surnames scarcely revealed any such relationships.

Relationships do matter. In all probability, the delineated recurrent subset will repay epidemiologic research efforts. In particular, future researches among Igbos albinos and other peoples should be slanted towards eliciting from each afflicted patient whether his/her relatives experienced merely limited or mostly recurring lesions. In this way, the classical familial aggressive type in keloid will be separated from any non-familial type of manifestation. Certainly, the researches being undertaken in the related field of hypertrophic scar formation by Dasu et al. [5] and Niessen et al. [6] indicate a positive approach to investigating how to alleviate human suffering due to skin diseases.

Conclusion

Diseases pertaining to albino skin cancers have been studied in this paper with what Macartney et al. [3] called a histopathology data pool. In their view, such a pool should not only cover a defined population but also contain well coded parameters in order to facilitate epidemiological analysis. I submit that the present paper meets these stipulations. Incidentally, the ultimate solution rests on prevention as I

detailed elsewhere with surgical biopsy [7,8]. Therefore, in conclusion, such biopsy slants presented here are recommended for Third World researchers. Hopefully, any intriguing questions would be answered satisfactorily.

Incidentally, it may be questioned whether the presently reported 133 cases are representative of the whole population. Be that as it may, I am persuaded that this unique skin lesion has such picturesque potentials for research that even single cases of it have been published personally [9,10].

References

1. Oluwasanmi JO, Williams AO, Alli AF (1969) Superficial cancer in Nigeria. *Br J Cancer* 23: 714–728.
2. Basden GT (1966) *Niger Ibos*. Cass, London.
3. Macartney JC, Rollason TP, Codling BW (1980) Use of a histopathology data pool for epidemiological analysis. *J Clin Pathol* 33: 351–355.
4. Bayat A, Ollier WER, Ferguson MWJ, Arscott G, McGrouther DA (2003) Aggressive keloid: A severe variant of familial keloid scarring. *J Roy Soc Med* 96: 554–555.
5. Dasu MRK, Hawkins HK, Barrow RE, Xue H, Herndon DN (2004) Gene expression profiles from hypertrophic scar fibroblasts before and after IL-6 stimulation. *J Pathol* 202: 476–485.
6. Niessen FB, Schalkwijk J, Vos H, Timens W (2004) Hypertrophic scar formation is associated with an increased number of epidermal Langerhans cells. *J Pathol* 202: 121–129.
7. Onuigbo WIB (2015) No albino should suffer from extensive skin cancer-let alone die there from it. *J Cancer Prev Cur Res* 2:00040.
8. Onuigbo WIB (2015) The influence of Pott’s irritation theory of occupational cancer during the 19th Century: A review with hypothesis on albinism sunlight induced cancer. *J Cancer Prev Cur Res* 2: 00053.
9. Onuigbo WIB, Nnabuko RE (2009) Three different carcinomas clustered in one facial focus in albino. *Nigerian Journal of Surgical Sciences* 19: 38-40.
10. Onuigbo WIB, Nwozo JC, Nnabuko RE (2014) Rhabdomyosarcoma followed six episodes of squamous cell carcinoma in a Nigerian Albino: A case report. *International Journal of Medicine and Medicine Science* 6: 236-238.