Abstract

OBJECTIVES: To determine the patterns of leukaemias seen in Malawians at Queen Elizabeth Central Hospital (QECH) and to compare the findings with those from elsewhere. An overview of the problems encountered in the management of leukaemia in developing countries especially those in sub-Saharan Africa are highlighted. DESIGN: Retrospective descriptive analysis of consecutive leukaemia cases seen from January 1994 through December 1998. RESULTS: Of the 95 leukaemia patients diagnosed during the study period, childhood (0-15 years) leukaemia occurred in 27 (28.4%) patients while adulthood (above 15 years) leukaemia accounted for 68 (71.6%) patients. The main leukaemia types were: acute lymphoblastic leukaemia (ALL) 14 (14.7%), acute myeloblastic leukaemia (AML) 25 (26.3%), chronic myeloid (granulocytic) leukaemia (CML) 32 (33.7%), chronic lymphocytic (lymphatic) leukaemia (CLL) 22 (23.2%) and hairy cell leukaemia (HCL) two (2.1%) patients. Most of the acute leukaemia (AL) cases occurred in the six to 15 year age bracket with a male preponderance. In ALL, lymphadenopathy was the commonest presenting feature followed by pallor (92.9%) while in the AML group, pallor occurred in 80% of cases. Abdominal swelling (87.5%) due to splenomegaly (81.3%) were the main clinical features in the CML group whereas lymphadenopathy (63.6%) followed by splenomegaly (59.1%) were the dominant presenting features in CLL. Haematologically, although leucocytosis characterised both acute and chronic leukaemias, most cases of acute leukaemia presented with more severe anaemia (Hb < 7 g/dl) and marked thrombocytopenia (Platelet count < 50 x 10(9)/l) than the chronic leukaemias. CONCLUSIONS AND RECOMMENDATIONS: The study shows that leukaemias are not rare in Malawi and cases which were diagnosed in this series probably only represent the tip of the iceberg. While there is need to increase diagnostic awareness among clinicians and laboratory staff, the severe chronic shortage of cytotoxic drugs and lack of supportive care facilities commonly encountered in developing countries should be realistically addressed through cost-sharing, cost recovery, adequate government subvention and donations from charitable organizations