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Assignment

1. Cancer is a public health problem worldwide affecting all ages. It is the second commonest cause of death in developed countries and among the three leading causes of death in developing countries. WHO reported that about 24.6 million people live with cancer world-wide. There are 12.5% of all deaths are attributable to cancer and if the trend continues, it is estimated that by 2020, 16 million new cases will be diagnosed per annum out of which 70% will be in the developing countries. There are 11 cancer registries in Nigeria; located in various tertiary hospitals in various parts of the country. Most of these Registries are poorly funded and cancer screening program is at minimal level except probably The Ibadan Cancer Registry, however they all produce hospital-based data. This review focuses on the current trend of cancer in Nigeria which may be used to adjust the cancer control programs in order to reduce cancer deaths in the country and also to call the attention of both the clinical research based organization, institution and in individual researchers and the government to use the trend of cancer in Nigeria for setting priorities in cancer control programs/researches.( Parkin, *et al.,*2014) There were 847,000 new cancer cases (6% of the world total) and 591,000 deaths (7.2% of the world total) in the 54 countries of Africa in 2012, with about three quarters in the 47 countries of Sub-Saharan Africa. While the cancer profiles often differ markedly between regions, the most common cancers in men were prostate (16.4% of new cancers), liver (10.7%), and Kaposi sarcoma (6.7%); in women, by far the most important are cancers of the breast (27.6% of all cancers) and cervix uteri (20.4%).
2. **Osteosarcoma** is a type of cancer that produces immature bone. It is the most common type of cancer that arises in bones, and it is usually found at the end of long bones, often around the knee. Most people diagnosed with **osteosarcoma** are under the age of 25, and it is thought to occur more often in males than females. Osteosarcomas (OS), especially those with metastatic or unresectable disease, have limited treatment options(Harrison *et al.,* 2018. The greatest advancement in treatments occurred in the 1980s when multi-agent chemotherapy, including doxorubicin, cisplatin, high-dose methotrexate, and, in some regimens, ifosfamide, was demonstrated to improve overall survival compared with surgery alone. However, standard chemotherapeutic options have been limited by poor response rates in patients with relapsed or advanced cases. It has been reported that VEGFR expression correlates with the outcome of patients with osteosarcoma and circulating VEGF level has been associated with the development of lung metastasis. At present, it seems to us that progress has not been made since Grignani reported a phase II cohort trial of sorafenib and sorafenib combined with everolimus for advanced osteosarcoma, which, in a sense, have become a milestone as a second-line therapy for osteosarcoma. Although the recognization of muramyltripepetide phosphatidyl-ethanolamine has made some progress based on its combination with standard chemotherapy, its effect on refractory cases is controversial. Personalized comprehensive molecular profiling of high-risk osteosarcoma up to now has not changed the therapeutic prospect of advanced osteosarcoma significantly.( Lindsey,2017). Thus, how far have we moved forward and what therapeutic strategy should we prefer for anti-angiogenesis therapy? This review provides an overview of the most updated anti-angiogenesis therapy in OS and discusses some clinical options in order to maintain or even improve progression-free survival.

Refrences

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