Case Report

Hospital Treatment Delays due to Prayer Ministries: A Report of Three Tumor Cases in a Private Specialist Hospital, Southeast Nigeria

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Abstract

Prayer ministries that profess miracles through prayers and vigils to heal sick persons abound in our clime. In many cases, this causes so much delay before the search for appropriate medical solutions. Often, the worsening conditions of enlarging tumor masses, pain, anemia, and weight loss may be the compelling reasons for surgical consultations. By this time, a varying number of them may not respond positively to treatment because of the late presentations. This report aims to draw attention to the problems caused by these religious groups whose *modus operandi* are the use of prayers and miracles to solve all medical conditions and inadvertently cause delays in accessing proper medical treatment by the patients, thus resulting in more complications.

Key words: Delay medical treatment, miracles, Nigeria, prayer ministries

Introduction

The belief in miracles through prayers and vigils is common knowledge in a highly religious society like Nigeria. The citizen's right to practice any religion of choice is fundamental. This has caused the proliferation of prayer ministries, which unfortunately do not just pray, teach, and practice the tenets of religion and morality but play hosts to some members and nonmembers of their congregations who are sick for the sole purpose of healing them through prayers and miracles. Some religious groups do not accept doctors and medicines but teach prayers as solution to ill health. Similarly, spiritualists and diviners attend to sick persons in their homes and practice healing by supposedly communing with unseen forces, and their established methods are well known.[1] The patronage of prayer ministries and these alternative health-care providers is very high in our society and is on the rise.[2,3] The belief that illnesses are not ordinary but are due to witchcraft and sorceries,[1,4] the belief that orthodox medicine cannot heal certain kinds of illnesses and the misplaced fear of the cost of orthodox treatment and fear of removal of body part by medical doctors[2] are other reasons why some sick people are taken for alternative treatment and prayers by family and friends, who are the major influences.[5] Exorcism is an ancient religious way of healing a victim that the exorcist thinks is possessed by demons of mental and other illnesses. However, it is recommended that the victim should be examined medically to exclude organic illness that is amenable to treatment before carrying out the rituals of exorcism.[6,7] This practice is still obtainable in some prayer ministries today, but it is uncertain whether this medical assessment is carried out in all cases. When patients with apparently small lumps like our index patients, decided to remain within the confines of prayer ministries for months with worsening conditions, it could imply ignorance of the usefulness of medicine or their ardent beliefs or faiths in religion. Unfortunately, the lesions continued to enlarge and in some cases fungated through their skins. It is in these advanced stages that our patients presented.

Neoplastic diseases have natural histories. Usually, the interplay between the disease factors and patient's factors determines how the natural history turns out. While a carbuncle

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can heal by suppuration and expression of the pus, lesion like malignant neoplasm will continue to grow and establish to take over local and distant organs until the patient is overwhelmed. This new growth has lost control by the innate body homeostasis[8] and without medical interventions, the lesion is likely to continue to enlarge. When patients present early to the hospital, detecting the lesions and instituting the appropriate treatment could be the only way of ensuring their short- or long-term survivals. Late presentations following delays in prayer ministries on the other hand make treatments more difficult and results less successful.

The aim of this report is to draw attention to the problems brought on patients presenting to a private specialist hospital in the southeastern part of Nigeria by the treatment delays caused by some of the prayer ministries and to recommend ways to curb this practice and possibly to eradicate it. This report is one of the very few documented cases in the medical literature in our sub-region.

Case Report

The first patient was a 19-year-old male, school leaver who complained of an increasing right thigh mass for 8 months. An earlier surgical consult was made in a tertiary hospital, and the patient was then booked for biopsy on the next theater session. However, the patient's family members took him to a prayer ministry 4 weeks later. He remained in the ministry for 7 months during which the mass continued to increase in size and until he was unable to walk. On presentation, examination showed a chronically ill-looking young man with a large, firm to hard fusiform-shaped mass in the lower thigh and an underlying fracture [Figure 1]. He had occasional bouts of coughs and breathlessness. Plain radiographs of the thigh and chest showed femoral osteolysis, pathological fracture, and cannon balls, respectively. After informed consent, an urgent incisional biopsy was done under local anesthesia and sedation. A histopathological diagnosis confirmed osteosarcoma. This advanced malignancy, Enneking grade III could only be managed by palliation. To reduce the burden of the painful, heavy cancerous leg, a high above knee amputation was done under spinal anesthesia. By the 10th day, the patient had recovered sufficiently from the operation, and he started ambulating with crutches. By the end of the 3rd week, the breathlessness worsened, associated with hemoptysis and anemia. He succumbed to his disease 3 weeks later.

The second patient is a 35-year-old pastor who was first seen under our service 6 years previously with the complaint of a right gluteal lump. He was well nourished. A 3 cm × 4 cm deep-seated, firm mass attached to the gluteal muscles was found. Excision biopsy was carried out, but unfortunately, the relative misplaced the specimen that was meant for histopathology. Having removed the mass and coupled with his belief that he was healed, he did not accept the possibility of recurrence. "It is not my portion" were his words when he was told that a possible differential was malignancy. Two years later he felt a recurrent lump, but he resorted to prayers with some of his pastor friends for 4 years until his second presentation with a large gluteal mass that had fungated and was painful. He was anemic and chronically ill looking. The recurrent mass measured 20 cm × 15 cm [Figure 2], attached to the skin and underlying gluteal muscles. Pelvic and chest radiographs were normal. After informed consent, incisional biopsy was done, and histopathological examination confirmed rhabdomyosarcoma. The plan was to downstage the tumor with neo-adjuvant radiotherapy, but the patient was unable to comply with the referral to a distant radiotherapy center. The alternative was a wide local excision and so we cross-matched three units of fresh whole blood for the procedure [Figure 3]. His recovery was uneventful and 3 weeks postoperation, he was commenced on combination chemotherapy (Vincristine, Adriamycin, and Cyclophosphamide-Avastin regimen). He completed six courses of three weekly cytotoxics and made a progressive recovery without local recurrence or distant metastases. We planned a referral for adjuvant radiotherapy but again he was lost to follow-up.

The third patient is a 38-year-old lady who was brought to our emergency department with a huge, painful, fungated, and bleeding right breast lesion. She resorted to a prayer ministry from the onset of the breast lesion and delayed for 6 months despite the continued enlargement of the breast until she developed fever and uncontrollable bleeding from the ulcer. These made her to present to us. Clinical examination revealed an apparently healthy looking lady with a huge right breast mass, bosselated surface, fungated, with completely eroded nipple and discolored skin [Figure 4]. Apart from the bleeding, there was also purulent discharge from the breast. The breast was mobile on the chest wall. There was a single 2 cm × 2 cm tender, mobile level I right axillary lymph node. Chest radiograph was normal. A provisional diagnosis of malignant phyllodes tumor was made based on the above characteristic features. Owing to the bleeding and the risk of further uncontrollable hemorrhage on incisional biopsy, the infection, and foul smelling grotesque breast mass, we carried out a simple mastectomy after an informed consent and under general anesthesia. Specimens taken from the breast postmastectomy confirmed benign phyllodes tumor. The patient recovered uneventfully and was discharged 3 weeks later. However, she was re-admitted after another 3 weeks, with complaints of persistent vomiting and abdominal pain and distension. After workup and inconclusive investigations, we carried out an exploratory laparotomy and discovered morbid adhesions from inoperable, generalized mesenteric bubble like seedlings [Figure 5]. Biopsy confirmed cystosarcoma phyllodes. She was discharged home on request after 10 days.

Discussion

Delaying patients from getting the appropriate medical care often leads to the development of complications. Due to lateness, more resources would be consumed in the patient's

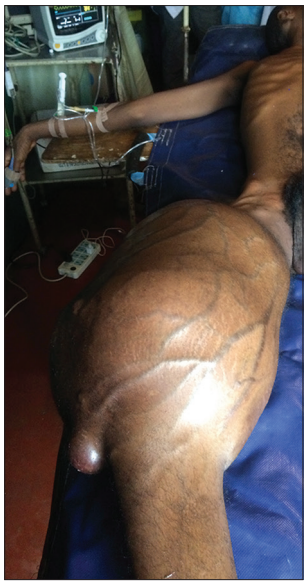

Figure 1: The right thigh mass with prominent coursing blood vessels, cachectic patient with the limb weighing one-third of the body weight as measured after amputation

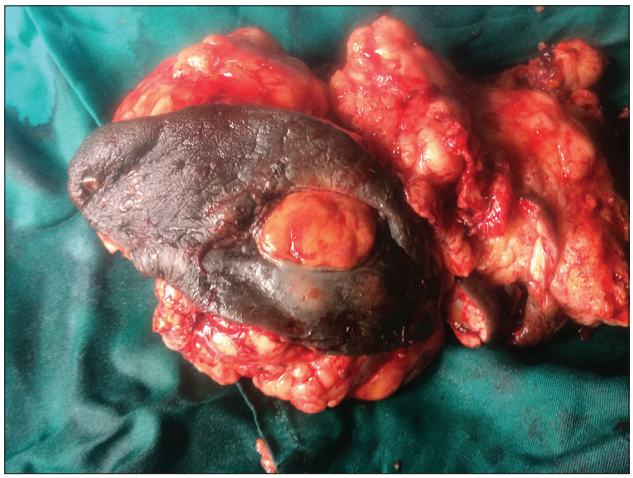

Figure 3: Complete excision of mass

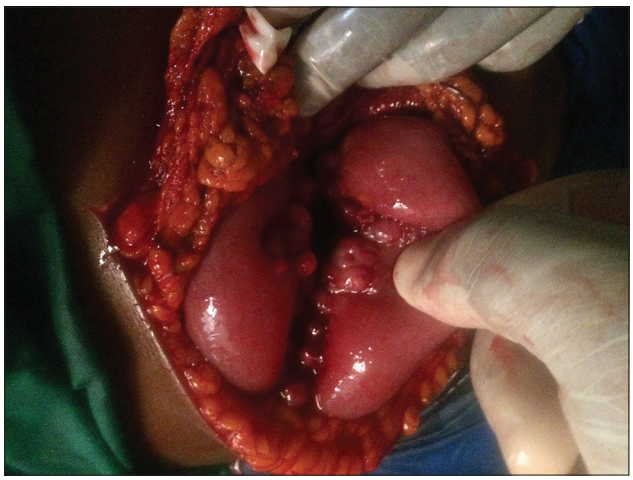

Figure 5: Inoperable abdominal metastases with mesenteric and intestinal seedings causing morbid adhesions

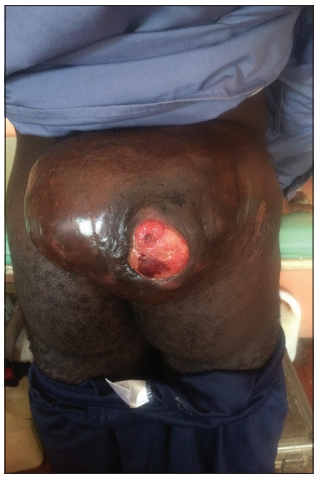

Figure 2: Huge right gluteal mass, fungated

Figure 4: Bleeding, fungated, and infected whole breast mass

management, and even then, recovery is either slow or may be impossible. It is the common medical knowledge that early detection and early treatment lead to higher survivorship in cancer patients. In our subregion, early detection is not commonplace as ignorance, and lack of easy access to medical facilities mitigate against cancer screening. Hospital consultation happens only when a mass is felt, and by this time it could be in advanced stage. Even so, some patients do not want to continue with orthodox treatment and may prefer to go to the prayer ministries once the clinician suspects cancer. Such diagnosis is often greeted by "not my portion" and so it is not treated with the urgency that is required. Many uninformed patients see it as a spiritual problem especially with the recurrences associated with cancer management.

Cancer is a malignant lesion that occurs when gene mutation in the cell reorders the cell to divide uncontrollably.[8,9] The cancer cells have high division rate, enlarge rapidly, erode into normal surrounding tissues, blood, and lymphatic vessels and could spread to distant organs. The enlargement of the cancer mass and the possibilities of local and distant metastases are dependent on the patient's immune status, tumor biology, medical intervention, and most importantly the passage of time

without the proper management. These factors determine the prognosis.[10] The passage of time in the prayer ministries in addition to other possible factors may have been responsible for the grotesque shapes and sizes of these lesions in our patients, the pathological fracture, the foul smelling ulcerations and anemia. This practice is likely to continue for a long time until the pastors and the sick persons alike realize that organic illnesses should be treated in the hospitals and that treatments do not diminish the values of faith, prayers, and miracles which should be seen as complementary to timely medical interventions.

Timely resuscitations of these patients with oxygen therapy, fluid, blood transfusion, and ensuring adequate urine output enabled us to establish the diagnoses and chart the courses of definitive treatments. Histopathological diagnoses were made within 2 weeks in the first two patients to warrant amputation and wide excision, respectively. The third patient had a whole breast involvement, with sloughs, unhealthy skin, eroded nipple, and uncontrollable bleeding and this informed our choice of simple mastectomy to remove the infected tumor load without a prebiopsy. Some authors cited similar reasons for mastectomy without prebiopsy in phyllodes tumor.[11] Management of these patients understandably stretched our lean resources.

The poor resource is often given as one of the reasons for preferring these ministries to hospitals. This fear is usually misplaced because the cost of treatment for early diseases in the hospital cannot be compared to the man-hour spent, the physical, and the emotional sufferings from worsening diseases the patients may have encountered in the prayer ministries. It would be right to advise a sick person to see a qualified medical practitioner first for an expert opinion while prayers that are conducted at the same time even at different venues should be seen as efficacious and complementary. The complementary effects of prayers and faiths on medical treatment are most exemplary in the free medical missions organized from time to time in poor regions of the world by international bodies such as Christian Broadcasting Network, Christian Healthcare Ministries, and Mercy Ship. In our subregion, on the other hand, a rare but more complicating situation for a patient in a prayer ministry had occurred when an uninformed pastor directly combines unwarranted medical interventions and prayers for healing.[3] The pastor could also indirectly encourage a sick person to discountenance the possibility of orthodox treatment like in our third patient. In this case, the pastor capitalized on the fear of possible breast removal in the hospital expressed to him by the patient. This fear was reinforced when the pastor agreed with her and assured her that with prayers, the lump would dissolve. Consequently, she got the support needed to avoid hospital treatment, which at that early stage may not have warranted a mastectomy. Financial gains could be the reason why some pastors carry on with this practice[3] and this was the case with one of the patients.

The reasons sick persons resort to prayer ministries have been alluded to previously. Misconstruing the origins of diseases[1,4] and misunderstanding the facts of religion by some pastors and persons are some of the banes of prayer ministrations in our environment. Whatever reason, it is important to emphasize that medical treatment should not be sacrificed for prayers and miracles; rather, the latter should be seen as complementary. Health education at all school levels, public enlightenments and training and retraining of pastors will help to position many people properly in considering matters relating to health. Religious bodies should also help to educate members of their congregations or the public through the use of pulpit preaching or the media. However, the sensitivity of religious matters in a country like Nigeria makes it very difficult to bring these ministries under heavy scrutiny. The patients that survive should be encouraged to tell their stories without bias and to recommend early hospital visits to their friends and family members. By doing so, they would have contributed to curbing this unhealthy trend. The relevant medical associations should wade into this problem and institute a channel for members to report such wrong treatments to a committee that would then forward established cases to the relevant government agency for further investigations and sanctions.

Conclusion

Sick persons are supposed to go to the hospitals early in their disease conditions and not to seek healing in the prayer ministries primarily. This activity of the prayer ministries is on the increase in our subregion, and the continued patronage is festering the malady. The late presentation of our patients is mainly contributory to the morbidity and mortality recorded.

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Conflicts of interest

There are no conflicts of interest.

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