



A DISCOURSE ON THE THEOLOGY OF HEALTH OF WOMEN IN DELTA STATE:
THE BIBLICAL IMPACT ON BREAST SELF EXAMINATION

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ABSTRACT

The goal of this study is to explore the biblical understanding of health theology in 3 John 1:2 in relation to women's health in the church. The aim of the study was to examine how the church sees the practice of breast self-examination, to find out whether church women practice BSE and to also ascertain the inhibiting factors against the practice of BSE in Effurun. A representative sample of 240 females from different churches in Effurun metropolis of Uvwie Local Government Area of Delta State, Nigeria was randomly selected. The study revealed that many church women are ignorant of self breast examination. It also revealed that the church is not doing enough emphasis on breast cancer and its prevention as it relates to breast self-examination among church women. Out of 240 respondents 44% representing 105 church women in Effurun opine that the church is silent about the practice of breast self examination. The bible portion which was explored also revealed that the physical and spiritual health of the Christian is expected to prosper.

Keywords: Theology, Health, Woman, Church, Breast Self Examination

1. INTRODUCTION

Religion, medicine, and healthcare have been related in one way or another in all population groups since the beginning of recorded history (Koenig, King and Carson, 2012:15-34). Some times the church in Nigeria over-spiritualise the issue of the body to the extent that people neglect their health. Most of the people who attend church in Nigeria, Effurun inclusive are the female folks. A lot of teachings go on in the church. One of such teachings is the issue of masturbation. Breast-self-examination is regarded as a process of masturbation among some churches who believe in exorcism. In the midst of this believe, many women in such churches have either died of breast cancer or diagnosed and even operated for breast cancer. For example, in the Baptist Church in Delta State, in 2013, a woman died of breast cancer and two were operated for breast cancer.

This raises the issue of the place of health theology in the church. Here 3 John 2 will be used as pivotal scripture for health in this paper. Teaching people about health can be seen as part of the ministry because the ministry of Jesus included preaching, teaching and healing. Although, the issue of health concerns both male and female, for the purpose of this study, it shall focus on women as it relates to breast self-examination because we have more cases of breast cancer among women than men in Effurun.

1.1 Statement of the Problem

The church has not done enough on breast cancer awareness. Sometimes the church even make members to feel that the mention of virginal, penis and the woman's breast in the church is a sign of pervasiveness. The church seemed to have forgotten that God Almighty created man and woman and gave them all the parts of the body and these are names given to such parts of the body. Somebody's world view about an issue or phenomenon can inform the person's perception and attitude towards such issue or phenomenal. For instance, from among the Urhobo in Uvwie in Delta State of Nigeria, it is believed by the traditional women that the breast is a gift of motherhood used to grow up a child and as such when a child socks off the breast milk, the breast will be fine. Moreover, it is also perceived that the self-manipulation of the breast is an aberration. It is very important to note that a woman's world view cannot prevent breast cancer from occurring. This is why education about breast cancer and breast self-examination among women becomes pertinent in Uvwie society and as such, the church has a responsibility to help in the education of women about breast self-examination for early detection of cancerous lumps in the breast. Some patient are reluctant to conduct Breast self-examination because, they fear what they might find. The nurse needs to understand and find a way of educating the patient. Patient often offers these reasons for avoiding Breast self-examination: "I do not have time" and "I just do not think of doing it." Some even feel that it does not matter.

Another reason for not conducting breast self-examination is a reluctance to handle one's own breast. Manipulation may be associated with fondling and masturbation. These reasons often go unexpressed among older women and some religious and cultural groups. Changing such attitudes frequently requires in depth counseling as well as accurate information about breast self-examination. Lack of proper education is also a problem in the sense that the patience was not thought what to do. In spite of the grave consequences accompanying negligence of breast self-examination in women, it is possible that some women in Uvwie land do not practice Breast self-exam. The issue here is how to determine the perception of church women in Effurun, Uvwie land about breast self-examination and educate them as to the importance of and how self-breast examination can prevent them from dying from breast cancer. Having found out the perception and attitude towards Breast self-examination, the research will also, find out whether the knowledge acquired was comprehensive and comprehended and the factors that are interplaying to hinder the use of knowledge acquired.

1.2 Research Questions

- How Does the Church regard the issue of women's health regarding breast self-examination in Effurun?
- Do Church women do self breast examination in Effurun?
- How often do Christian women engage in breast self-examination in Effurun?
- What are the factors that inhibits the practice of self breast examination in Effurun?
- Does the church Support the practice of Self breast examination in Effurun?

1.3 Aim and Objectives

- To examine how the church see the practice of breast self-examination in Effurun;
- To find out whether Christian women participate in self breast examination in Effurun;
- To know the frequency of Church women's engagement on the practice of breast self-examination in Effurun;
- To ascertain the factor that inhibits church women's participation in breast self-examination in Effurun; and
- To encourage women in Effurun to practice breast self-examination.

1.4 Hypothesis

There is no significant difference in the observation of self breast examination among church women and the church teaching on health in Effurun metropolis.

2. REVIEW OF RELATED LITERATURE

The breast is an important part of the human body. Both male and female possess this gift of nature from God the creator. Women and men both have breasts, but women have more breast tissue than men. The Canadian Cancer Society (2013) in the description of the breast say that each breast lies over a muscle of the chest called the pectoral muscle and that the female breast covers a fairly large area which extends from just below the collarbone (clavicle), to the armpit (axilla) and across to the breastbone (sternum). In this research work, focus shall be on the female breast because it appears the incidence of breast cancer is more prevalent in female than male in the terrain of this research. Researchers have done some works on the subject matter. The available once therein shall be explored here.

The Johns Hopkins Hospital Department of Pathology (2012) explains that breast cancer is the most common cancer occurring in women, with over 200,000 new cases diagnosed yearly in the United States alone, and it is the second leading cause of cancer-related deaths in women. Breast cancer and benign breast tumors can also rarely occur in men, adolescents and children. Breast cancer consists of a heterogeneous group of diseases, with many different subtypes of both invasive and non-invasive cancers that have different treatment options and prognoses. The diagnosis of breast cancer is increasing, in part due to early detection of disease through imaging such as screening mammography. Many women undergo breast biopsies to evaluate whether a radiologic abnormality is due to a benign or neoplastic (cancerous) process.

The blood supply from the breast comes primarily from the internal mammary artery, which runs underneath the main breast tissue. The blood supply provides nutrients, such as oxygen, to the breast tissue. The lymphatic vessels of the breast flow in the opposite direction of the blood supply and drain into lymph nodes. It is through these lymphatic vessels that breast cancers metastasize to lymph nodes. Most lymphatic vessels flow to the axillary (under arm) lymph nodes, while a smaller number of lymphatic vessels flow to internal mammary lymph nodes located deep to the breast. Knowledge of this lymphatic drainage is important, because when a breast cancer metastasizes, it usually involves the first lymph node in the chain of lymph nodes. This is called the "sentinel lymph node," and a surgeon may remove this lymph node to check for metastases in a patient with breast cancer. Physiologically, the breast is an organ specialized for milk formation (lactation). Many additional changes are seen in the breast tissue during pregnancy and lactation due to the changes in hormones during those times (Johns Hopkins Hospital Department of Pathology, 2012).

If a new "big picture" approach to breast cancer is to emerge, it is necessary to step back from the gene-dominated approaches to causation and examine what might cause this

cancer at the gross level and what issues there are in establishing preventative or delaying techniques rather than aggressive treatment approaches. There are well known causes of breast cancer, such as the “Western diet” and the fact that Asian women have a reduced incidence until they come to reside in the West, smoking, and radiation exposure (Brennan, et al., 2010; Thomson and Thomson, 2009; Lof and Weiderpass, 2009; Gaudet, et al., 2013; Luo, et al., 2011; Johnson, et al., 2011; Pijpe, et al., 2012; Ronckers, et al., 2005; Mettler, 2012) . There is also an ongoing controversy concerning the old idea dating back to 1943 that breast cancer may be caused by a handful of known oncogenic viruses (Joshi and Buehring, 2012).

The candidate viruses are mouse mammary tumor virus, human papilloma viruses, Epstein–Barr virus, and bovine leukemia virus. The latter may explain the East–West breast cancer issue via consumption of cow’s milk and meat, but the evidence is very limited. It is possible that these viruses may collaborate with each other. The viral breast cancer hypothesis has a long history, with past failure to establish sound evidence of causation. The above scholars, explain further that, while diet, smoking, and control of oncogenic viruses are the subject of health education and guidance, radiation is not controlled to reduce risk; in fact, medical use of radiation represents the greatest radiation exposure to humans and, in our modern world, the risk of getting breast cancer may increase due to increasing elective or imposed medical radiation exposure. The female breast is, according to the International Commission on Radiation Protection (2007), a very radiosensitive tissue. While “safe” doses are generally determined as those that will not harm the most sensitive tissue, they depend on models using “reference man”, that is, an ideal hermaphrodite body shape and epidemiologic data from the atomic bomb survivors of Hiroshima and Nagasaki (Pentreath, 2004; Boyd, 2012). These approaches estimate safe doses based on old and outdated radiation biology while ignoring modern research, which could mean the “safe” dose is not so safe or even positively beneficial. It is important to know because exposures, particularly in the low-dose exposure region, are increasing. Mammograms (which involve breast irradiation) are offered on an annual basis to women over 50 years in spite of controversy about their effectiveness, the anxiety caused by false positives, and the potential risks of radiation exposure in sensitive individuals (Schopper and Wolf, 2009; Quanstrum, 2010; Drukteinis, 2013).

Computer axial tomography scans have grown in popularity as elective tests during annual physical examinations. In the United States of America, it is estimated that 90 million scans will be performed in 2014 and a “wellness scan” is a common gift. This is very big business for medical doctors and hospitals as well as for producers of instrumentation. However, members of the public, who intensely fear very small environmental releases of radiation, do not seem aware that the wellness scan involves a whole body radiation dose of 3–20 mGy or more, depending on the specific test and the competence of the technician of which in some cases, this is more than the annual dose limit for the general population (Baker and Bhatti , 2006; Brenner, 2010; Malone, et al., 2012).

There has been a lot of publicity about the risks of these scans for children, but there could also be an enhanced risk for females developing breast cancer (Krille, et al., 2012; Hall and Brenner, 2012; Brenner and Hall, 2012). Seymour and Mothersill (2013) say that another new exposure, which is not so elective, is the use of backscatter X-ray machines as screening devices in airports. Again, they are said to be harmless, but that perception is based on the models referred to above and not on real data. The true risk will only emerge as the big human experiment with these machines progresses. Already there are concerns about skin cancer risk as the X-rays are low energy and do not penetrate far, but the breast is just under the skin and therefore at risk. As security paranoia increases, so may the energy of X-rays used, to enable more and more detail to be seen and to enable body cavities to be “searched”. This is already done in diamond mines in parts of Africa.

A number of researchers have asserted that breast cancer occur more in woman than men. VandenBussche, et al (2013) assert that young women with ductal carcinoma in situ treated by breast-conserving therapy have a higher recurrence rate than do older women, and a younger age at diagnosis is associated with worse overall survival after recurrence. Moreover, Vanden Bussche, et al (2013) study explores the clinical, pathologic, and immunohistochemical characteristics of ductal carcinoma in situ lesions diagnosed in women 40 years and younger with a focus on molecular subtypes to elucidate features that may contribute to the purported worse outcome for the particular patient population. Forty-one patients diagnosed with ductal carcinoma in situ at age 40 years and younger were identified over a 10-year period; 31 cases were used to construct tissue microarrays. In their research, the microarrays were labeled with antibodies to estrogen receptor, progesterone receptor, HER2, Ki-67, CK5/6, epidermal growth factor receptor, and p53 and subsequently classified as luminal A, luminal B, HER2, basal-like, or unclassifiable triple negative. In the final analysis, all patients had high-grade (73.2%) or intermediate-grade (26.8%) ductal carcinoma in situ. The molecular subtype breakdown was 61.3% luminal A, 22.6% luminal B, 13% HER2, and 3.1% unclassifiable triple negative. The mean Ki-67 by subtype was 4.2%, 14%, 9.5%, and 50%, respectively.

Mastectomy was performed in 33 patients (80%). Eight patients (20%) underwent excisional biopsy without subsequent mastectomy. In addition to a predominance of high-grade lesions, young patients had a high proportion of luminal B subtype, which may contribute to an increased rate of local recurrence in this population. A larger series was seen as necessary to confirm the impact that the molecular subtypes of ductal carcinoma in situ in younger patients might have on outcome. In the same vein, Han, et al (2012), Determined that the risk of recurrence after local excision of ductal carcinoma in situ (DCIS) remains a challenge and that molecular profiling based on immunohistochemical staining to oestrogen receptor (ER), progesterone receptor (PR) and HER2neu improved risk prediction in invasive breast cancer, but that few studies have evaluated if molecular classification of DCIS predicts local recurrence. Han, et al (2012) evaluated the expression of ER, PR and HER2neu in DCIS to determine if molecular classification predicts local recurrence after breast-conserving therapy for DCIS. In the final analysis, 180 cases of DCIS were included in the study (luminal A, n=113; luminal B, n=25; HER2neu type, n=29; triple negative, n=13). The median follow-up time was 8.7 years. They observed higher rates of local recurrence among luminal B (40%) and HER2neu type (38%) DCIS compared with luminal A (21%) and triple negative (15%) DCIS. On multivariable analysis, HER2neu overexpression was associated with an increased risk of local recurrence (hazard ratio=1.98; 95% confidence interval: 1.11, 3.53, P=0.02). Han, et al (2012) concluded in their research that HER2neu expression in DCIS is a significant predictor of local recurrence, whereas luminal A and triple negative phenotypes are associated with relatively low risks of local recurrence.

In Tsutsumi (2012) research, four hundred and forty breast cancers from 429 cases were immunostained for estrogen receptor, progesterone receptor, androgen receptor, human epidermal growth factor receptor type 2 (HER2), p53, Ki-67 and epidermal growth factor receptor. The lesions included 58 in situ malignancies (including 13 apocrine-type lesions) and 325 invasive ductal carcinomas (including 44 apocrine type). Out of 91 estrogen receptor-negative invasive ductal carcinomas, 44 (48%) belonged to apocrine-type carcinoma, and overexpression of human epidermal growth factor receptor type 2 and p53 was observed in 23 (52%) and 33 (75%), respectively. Histologically, 22 (50%) were categorized as classical apocrine carcinoma. Among 281 non-apocrine invasive ductal carcinomas, 30 (11%) were quadruple-negative (ER-/PgR-/AR-/HER2-) and 17 (6%) were hormone receptor-negative and human epidermal growth factor receptor type 2-overexpressed. Invasive ductal carcinomas in the triple-negative breast cancer category (n= 51) were divided into triple-negative, androgen receptor-positive (apocrine, n= 21) and

quadruple-negative (non-apocrine, n= 30). p53 overexpression was more often seen in the apocrine-type triple-negative breast cancer (18/21 = 86%) than in the non-apocrine type (14/30 = 46%) (P< 0.05). Ki-67 labeling was significantly higher in the non-apocrine type (58%) than in the apocrine type (37%) (P< 0.01). Epidermal growth factor receptor is consistently expressed in triple-negative breast cancers (16/16 = 100% in apocrine and 18/20 = 90% in non-apocrine).

Tsutsumi (2012) recommends that androgen receptor should be added to immunohistochemical panels, since apocrine-type invasive ductal carcinoma, resembling basal-like phenotypes, may show clinical behaviors different from the basal-like triple-negative breast cancer. Rakovitch, et al (2012) assert that ductal carcinoma in situ (DCIS) is a non-invasive form of breast cancer that may progress to invasive cancer and that identification of factors that predict recurrence and distinguish DCIS from invasive recurrence would facilitate treatment recommendations. Rakovitch, et al (2012) examined the prognostic value of nine molecular markers on the risks of local recurrence (DCIS and invasive) among women treated with breast-conserving therapy of which a total of 213 women who were treated with breast-conserving therapy between 1982 and 2000 were included; 141 received breast-conserving surgery alone and 72 cases received radiotherapy. Rakovitch, et al (2012) performed immunohistochemical staining on the DCIS specimen for nine markers: oestrogen receptor, progesterone receptor, Ki-67, p53, p21, cyclinD1, HER2/neu, calgranulin and psoriasin. They also performed univariable and multivariable survival analyses to identify markers associated with the recurrence. The result showed that the rate of recurrence at 10 years was 36% for patients treated with breast-conserving surgery alone and 18% for women who received breast-conserving surgery and radiotherapy. HER2/neu+/Ki-67+ expression was associated with an increased risk of DCIS recurrence, independent of grade and age (HR=3.22; 95% CI: 1.47-7.03; P=0.003) and as such, none of the nine markers were predictive of invasive recurrence. They concluded that Women with a HER2/neu/neu+/Ki67+ DCIS have a higher risk of developing DCIS local recurrence after breast-conserving surgery.

Cornfield, et al (2004) using the method of clinical and pathologic analysis, analyzed data from 151 patients who underwent wide local excision alone for DCIS that was diagnosed by mammography or as an incidental finding between 1982 and 2000. Using local disease recurrence as an endpoint, the Cornfield, et al (2004) sought to determine the prognostic significance of a large number of histopathologic parameters as well as biologic markers (estrogen receptor [ER], progesterone receptor [PR], p53, HER-2/neu, Ki-67, p21, and bcl-2), as determined by immunohistochemical staining of contemporary or archival tissue. The result showed that with a median follow-up of 65 months, 42 recurrences were reported to occur between 11 months and 97 months after definitive surgery and in a univariate analysis, tumor size, Van Nuys pathologic classification, and degree of necrosis demonstrated significant correlations with the rate of recurrence. Tumor size, necrosis, nuclear grade, and comedonecrosis were found to be associated significantly with the time to disease recurrence.

None of the biologic markers demonstrated a significant association with the rate of recurrence or the time to disease recurrence. In a multivariate analysis, only large tumor size (Van Nuys 2 or 3) and higher degrees of necrosis (Van Nuys 2 or 3) were found to be associated significantly with both the rate of recurrence and the time to recurrence. No biologic marker showed a significant correlation with recurrence. Using Classification and Regression-Tree Analysis and Tree-Structured Survival Analysis, PR > 3.5% and bcl-2 < 97.5% were associated with a higher recurrence rate in the subgroup of patients with small tumor size (Van Nuys size 1) and higher degrees of tumor necrosis (Van Nuys 2 or 3). The current results confirmed the value of conventional histopathologic parameters, as outlined in the Van Nuys classification system, in predicting local recurrence of DCIS. Using

traditional logistic analyses, no significant correlation was found between a variety of biologic markers and disease recurrence.

Livasy, et al (2007) postulate that microarray profiling of invasive breast carcinomas has identified subtypes including luminal A, luminal B, HER2-overexpressing, and basal-like and that the poor-prognosis, basal-like tumors have been immunohistochemically characterized as estrogen receptor (ER)-negative, HER2/neu-negative, and cytokeratin 5/6-positive and/or epidermal growth factor receptor (EGFR)-positive. Livasy, et al (2007), determining the prevalence of basal-like ductal carcinoma in situ in a population-based series of cases using immunohistochemical surrogates and a total of 245 pure ductal carcinoma in situ cases from a population-based, case-control study were evaluated for histologic characteristics and immunostained for ER, HER2/neu, EGFR, cytokeratin 5/6, p53, and Ki-67. The subtypes were defined as: luminal A (ER+, HER2-), luminal B (ER+, HER2+), HER2 positive (ER-, HER2+), and basal-like (ER-, HER2-, EGFR+, and/or cytokeratin 5/6+). The prevalence of breast cancer subtypes was basal-like (n = 19 [8%]); luminal A, n = 149 (61%); luminal B, n = 23 (9%); and HER2+/ER-, n = 38 (16%). Sixteen tumors (6%) were unclassified (negative for all 4 defining markers). The basal-like subtype was associated with unfavorable prognostic variables including high-grade nuclei (P < .0001), p53 overexpression (P < .0001), and elevated Ki-67 index (P < .0001). These studies demonstrate the presence of a basal-like in situ carcinoma, a potential precursor lesion to invasive basal-like carcinoma.

Kerlikowske, et al (2010) conducted a nested case-control study in a population-based cohort of 1162 women who were diagnosed with DCIS and treated by lumpectomy alone from 1983 to 1994 and collecting clinical characteristics and information on subsequent tumors, defined as invasive breast cancer or DCIS diagnosed in the ipsilateral breast containing the initial DCIS lesion or at a regional or distant site greater than 6 months after initial treatment of DCIS (N = 324). Kerlikowske, et al (2010) also conducted standardized pathology reviews and immunohistochemical staining for the estrogen receptor (ER), progesterone receptor, Ki67 antigen, p53, p16, epidermal growth factor receptor-2 (ERBB2, HER2/neu oncoprotein), and cyclooxygenase-2 (COX-2) on the initial paraffin-embedded DCIS tissue. Competing risk models were used to determine factors associated with risk of subsequent invasive cancer vs DCIS, and cumulative incidence survival functions were used to estimate 8-year risk.

The result shows that the factors associated with subsequent invasive cancer is differed from those associated with subsequent DCIS and eight-year risk of subsequent invasive cancer was statistically significantly (P = .018) higher for women with initial DCIS lesions that were detected by palpation or that were p16, COX-2, and Ki67 triple positive (p16(+)/COX-2(+)/Ki67(+)) (19.6%, 95% confidence interval [CI] = 18.0% to 21.3%) than for women with initial lesions that were detected by mammography and were p16, COX-2, and Ki67 triple negative (p16(-)/COX-2(-)/Ki67(-)) (4.1%, 95% CI = 3.4% to 5.0%). In a multivariable model, DCIS lesions that were p16(+)/COX-2(+)/Ki67(+) or those detected by palpation were statistically significantly associated with subsequent invasive cancer, but nuclear grade was not. Eight-year risk of subsequent DCIS was highest for women with DCIS lesions that had disease-free margins of 1 mm or greater combined with either ER(-)/ERBB2(+)/Ki67(+) or p16(+)/COX-2(-)/Ki67(+) status (23.6%, 95% CI = 18.1% to 34.0%). They concluded that biomarkers can be identified with women who were initially diagnosed with DCIS who are at high or low risk of subsequent invasive cancer, whereas histopathology information cannot. Zhou, et al (2010) sampling 458 women with a primary DCIS diagnosed between 1986 and 2004, in Uppland and Västmanland, Sweden were included. TMA blocks were constructed. To classify the DCIS tumors, they used immunohistochemical (IHC) markers (estrogen-, progesterone-, HER2, cytokeratin 5/6 and epidermal growth factor receptor) as a surrogate for the gene expression profiling. The association with prognosis was examined for basal-like DCIS and other subtypes using Kaplan-Meier survival analyses

and Cox proportional hazards regression models. Basal-like DCIS showed about a doubled, however not statistically significant risk for local recurrence and developing invasive cancer compared with the other molecular subtypes. Zhou, et al (2010) agree that molecular subtyping was a better prognostic parameter than histopathological grade.

Nassar, et al (2012) submit that basal-cell phenotype breast carcinoma has been associated with high-grade and metaplastic morphology, expression of basal-type cytokeratins, uniform negativity for ER and HER2, and decreased overall survival. Breast cancers occurring in young women are usually T2 disease at presentation, high-grade and of poor prognosis. They compared two groups of breast cancers, (a) ER-, PR-, HER2- (triple negative) [TNBrCa] and (b) non-triple negative breast cancers (non-TNBrCa) occurring in women under 35, using tissue microarray technology to characterize expression of the basal/myoepithelial cytokeratins (CK5/6, CK7, and CK14), luminal cytokeratins (CK8, CK18, and CK19), EGFR, p-cadherin, c-kit, p63, and p53. They also sought to identify characteristic histomorphologic features indicative of basal-like phenotype. The triple negative group showed preferential staining versus the age <35 group for CK5/6 (22% versus 4% $p = 0.05$), CK14 (44% versus 15%, $p = 0.013$), EGFR (83% versus 24%, $p < 0.0001$) and c-kit (19% versus 0% $p = 0.026$). Conversely, non-TNBrCa in women younger than 35 demonstrated increased expression of the luminal CK8 (92% versus 60%) compared with the triple negative patients ($p = 0.006$). The TNBrCa have characteristic histologic features including higher tumor grade, pushing tumor border, geographic necrosis, syncytial growth pattern, brisk mitotic activity, lack of/minimal in situ component, medullary-like and metaplastic differentiation. Invasive carcinomas in women younger than 35 usually have an associated in situ component, prominent nucleoli, central acellular fibrotic zone, and infiltrative tumor border. Triple negativity for ER/PR/HER2 coupled with EGFR, c-kit, and basal/myoepithelial cytokeratins (CK5/6, CK14) expression, and distinctive histomorphologic features predict morphology consistent with basal-cell phenotype. King, et al (2012) say that newly proposed models of breast tumorigenesis suggest that low- and high-grade lesions have distinct tumor progression pathways. They also examine the relationship between histologic grade and molecular subtype in women with lobular carcinoma in situ (LCIS) and ductal carcinoma in situ (DCIS) who developed subsequent ipsilateral invasive breast cancers.

In King, et al (2012) materials were available for 27 patients with classical LCIS who developed ipsilateral invasive cancer (12 invasive ductal cancer [IDC], 14 invasive lobular, 1 mixed), and 26 patients with DCIS (12 low-grade [LG], 14 high-grade [HG]) who developed ipsilateral IDC. No difference in age at diagnosis or median time to invasive cancer existed between groups with LCIS and DCIS. When stratified by grade, 0 of 12 LG-DCIS developed LG-IDC (3 grade II; 9 grade III), and only 1 of 12 LCIS patients who developed IDC had LG-IDC. Thirteen (93%) patients with HG-DCIS developed HG-IDC. In contrast, molecular subtype was maintained in 23 of 27 (85%) cases of LCIS and in 18 of 26 (69%) cases of DCIS. In the final analysis these data do not support a low-grade precursor pathway characterized by LCIS and LG-DCIS. ER/PR and HER2 status have a high rate of concordance between in situ and subsequent invasive lesions. Additional studies of metachronous in situ and invasive lesions are needed to better understand pathways of breast tumorigenesis.

3. BREAST SELF-EXAMINATION AND TREATMENT OF EARLY BREAST CANCER

Globally, about 25 million people are living with cancer (Harirchi, 2011). The LIVESTRONG Foundation (2013) recent estimates showed that cancer incidence will almost triple by 2030, with 20–26 million new cancer diagnoses and 13–17 million deaths. The WHO (2011) asserts that cancer is the second leading cause of death in the world and more than 70% of all cancer deaths occurred in low and middle-income countries. Of all

types of cancers, breast cancer is the most common cancer among women both in developing and developed countries (Rabia, 2008; Parkin, 2005). The Ethiopian Cancer Association (2012) confirms that cancer is the leading cause of death among women aged between 40 and 55 years. Bray, et al (2004) and Parkin, et al (1997) concurred that recent global cancer statistics indicated that breast cancer incidence is rising at a faster rate in populations of developing countries. Several studies assert that breast cancer is the most common cancer, and is the principal cause of cancer deaths in women and is therefore a world concern (Dibble, et al, 1997; Ferro, et al 1992; Odusanya and Tayo, 2001; Sadler, et al 2001; Maxwell, et al 2001; Blanchard, et al 2004; Demirkan and Alacacioglu, 2007; Elsie, et al 2010; Wabinga and Parkin, 2000). In the postulations of Tavafian, et al (2009) and Dündar, et al (2006), early detection of breast cancer plays an important role in decreasing its morbidity and mortality and breast self-examination (BSE) is one of the screening methods for early detection of breast cancer. However, women in developing countries do not perform breast self-examination for various reasons (Avci, 2008).

In a research on Self-Breast Examination, Azage, et al (2013) suggest that early detection of breast cancer using breast self-examination (BSE) plays an important role in decreasing its morbidity and mortality. Azage, et al (2013) using the methodology of Cross-sectional study design from October to November, 2012 in West Gojjam Zone of Amhara region, identified factors associated with BSE among health extension workers in Northwest Ethiopia. In their study, simple random sampling technique was used to recruit a total of 390 health extension workers (HEWs). A structured Amharic questionnaire was used to collect the data. Data were entered and analyzed using SPSS statistical package version 16.0. The study found that 37% of HEWs had ever practiced BSE and 14.4% practiced it regularly. The three main reasons for not doing regular BSE were no breast problem (53.2%), not knowing the technique of BSE (30.6%), and not knowing the importance of BSE (21.4%). Discussion with families on BSE and history of breast examination by health professionals were found significantly associated with ever practice of BSE. In conclusion, Azage, et al (2013) submit that BSE practice was found low in this study. Having information on the importance of BSE was predictor of BSE practice. Therefore, it is important to give training on BSE techniques and its role on breast cancer prevention for HEWs.

The studies by Davidson, et al (2014) say that evidence from the metastatic setting suggests that replacing conventional doxorubicin with nonpegylated liposomal doxorubicin (NPLD) for early breast cancer may maintain efficacy whilst reducing long-term cardiotoxicity, an important consideration with many patients going on to receive multiple lines of treatment. In their studies, consecutive patients with early breast cancer treated with NPLD were assessed for disease progression and changes in cardiac function according to left ventricular ejection fraction (LVEF). The results showed that among ninety-seven patients (median age at diagnosis 51 [32–76] years) which was studied, the majority received NPLD (60 mg/m² plus cyclophosphamide 600 mg/m²) adjuvantly (79.4%) and in sequence with a taxane (79.4%; docetaxel 75 mg/m²). 80.4% had radiotherapy and 15.5% received trastuzumab. Mean time to disease recurrence was 87.0 months (80.7–93.2 [95% confidence interval]) and 5-year disease-free survival was 86.0%. Mean LVEF values remained within the normal range of $\geq 55\%$ during treatment and throughout the cardiac follow-up period (median 7 months, range 1–21 months). Use of trastuzumab and age at diagnosis did not appear to influence LVEF. Davidson, et al (2014) concluded that NPLD appeared to be a well-tolerated substitute for conventional doxorubicin in patients with early breast cancer.

Nonpegylated liposomal doxorubicin (NPLD; Myocet, Teva UK) has potential advantages over conventional doxorubicin in the treatment of early breast cancer. Utilising a less cardiotoxic but equally effective treatment earlier in management may help to maximise therapeutic options later in the course of disease and thereby facilitate the use of multiple lines of therapy. In addition, substituting NPLD for doxorubicin as the standard anthracycline in early breast cancer may help address the growing concerns regarding the

longer-term impact of treatment on cardiac function, a key survivorship issue (Jones, et al 2007; Rahman, et al 2007). However, whilst NPLD has been extensively studied in metastatic breast cancer and is licensed in this regard data on its use in early disease are currently scarce (Batist, et al 2006; Schmid, 2005; Antón, 2009). British Society of Echocardiography Education Committee (2013) has observed that as advances in diagnosis, management, and treatment have led to improved breast cancer survival, the issue of longer-term, therapy-related cardiotoxicity has taken on increasing importance, with patients potentially facing multiple, coincident insults to the heart and many of the available adjuvant therapies, which are increasingly used in combination or sequence, have been associated with some form of cardiotoxicity during or after therapy, whilst increasing age, comorbid conditions, and disease-related decreases in physical activity can also contribute to cardiovascular disease. In addition to cumulative cardiotoxicity potentially limiting treatment options and therefore outcomes, acute improvements in breast cancer survival may be offset by increases in cardiovascular disease and mortality. Therefore, the challenge for the clinician, particularly in the early breast cancer setting, is to balance the need for anticancer efficacy against the potential for subsequent treatment-related cardiovascular disease and mortality.

4. THEOLOGY OF HEALTH AND SOME INTERPRETATIONS OF 3 JOHN 1:2

Sheahen (2004) highlighted Pope John Paul II theology of the body in an interview to mean the working of the human body according to God's design and that our bodies somehow reveal the mystery of divine love in the world. Moreover, the body was explained in relation to affection, medicine and human activities in general and as such, the pope's theology of the body is a reflection on the universal questions about life-why do I exist? Why did God make us male and female? How do I find happiness? What is my ultimate destiny? Why is there evil in the world? How do I overcome it? Then, what sort of model of health is around here. Williams (2003) using the analogy of the flesh in the Gospel and Pauline theology submitted that health is something that has to do with the bridging of a gulf between flesh and spirit and that often as we look at the Gospel stories of healing, as we look at them hard and carefully, we will see how healing there emerges in a situation, whereas we look more closely at it, there is some sort of concealed alienation, some sort of bruised relationship. Williams further buttressed his point by saying that God has made us to live as material beings in a material world and has made us, therefore, as creatures who have to learn how to live in our world, and that because we have intelligence and love and imagination, our living in our environment is a story, not just a given fact. A story of our salvation is the story of that learning and that teaching by the God who brings the very divine life itself to inhabit our world, to touch, to heal, to promise and to transfigure. Wong (2002,187) sees the theology of health as theology of wholeness. Beardsley (2002) describe the theology of health as wholeness as good relation with and man and man's God's given environment.

Concerning the interpretation of 3 John 2, some scholars have opined that it is interpreted out of context by some preachers. Jones and Woodbridge (n.d., 109-110) observed that some American renowned preachers interpret 3 John 2 in the context of financial prosperity. Furthermore, their interpretation of this verse makes clear their claim that material prosperity is inseparably linked to spiritual growth. Barron (1987:62) reported that Oral Roberts, regarded by many to be the father of the prosperity gospel movement, claimed at the beginning of his ministry, during a time of search for direction, that God miraculously led him to 3 John 2, which he understood as a revelation of the prosperity gospel. Kantzer (1985:14) also pointed out that another faith teacher who has built his ministry around this faulty interpretation of 3 John 2 is Kenneth Copeland who universalized the concept of prosperity in conjunction with Abraham's blessings. A careful study of 3 John 2, however, reveals that this verse is not a carte blanche approval of prosperity gospel

teachings. Moreover, Jones, and Woodbridge (n.d., 109-110) noted that those who use 3 John 1:2 to support the prosperity gospel are committing two crucial errors, the first contextual and the second grammatical. First, con-textually, one is wise to note that John's purpose in writing 3 John 1:2 was not to teach doctrine; it was simply to open his letter with a greeting. This is not to say that doctrine cannot be derived from a nondoctrinal passage, for all Scripture is profitable for doctrine, but it is to say that one must be sensitive to the original author's intent. Therefore, the claim that 3 John 1:2 teaches the doctrine of prosperity ought to be regarded as suspect at best. Second, one is wise to note the meaning of the word "prosperity" as it occurs in this verse. Thayer (1981:86) say that the term translated "prosperity" is a form of the Greek word *eujodovw* and that this word, which is used only four times in Scripture, does not mean to prosper in the sense of "gaining material possessions," but rather means "to grant a prosperous expedition and expeditious journey," or "to lead by a direct and easy way."

5. MATERIALS AND METHOD

The study was carried out to investigate church women's awareness and participation on self breast examination in Effurun metropolis, Delta State, Nigeria. Accordingly descriptive survey method of research was used to conduct the study.

5.1 Sample and Sampling Technique

Uvwie Local Government Area of Delta State of Nigeria comprises of many communities but Effurun was selected for this study because of its metropolitan setting. Consequently, 240 women were chosen from the women groups in some selected churches in Effurun metropolis. The sampling procedure for this survey research was a simple random sampling procedure as shown in table 1.

Table 1: Distribution of Questionnaires and Retrieval

Church Donomination	No. of Questionnaires Distributed	No. of Questionnaires Retrieved
Pentecostal Churches	125	98
Orthodox Churches	125	142
Total	250	240

Out of the 240 questionnaires distributed, the researcher was only able to retrieve 218 questionnaires which we based our interpretation n of data.

5.2 Instrument for Data Collection

For the purpose of this research work, 240 questionnaires were self developed and self administered among the selected churches so chosen.

5.3 Validity and Reliability of the Instrument

The research instrument used in this study is valid because it was adapted from the questionnaire of a study by Azage, Abeje, and Mekonnen (2013) who carried out a similar research to this study and was successful. The aim of the instrument was to collect accurate data from the church women in Effurun metropolis of Uvwie Local Government Area while the validity of the instrument was to determine its reflection on the objective of the study. The Reliability of the instrument was determined by a pilot study carried out to pretest the instrument among 20 persons each in the Baptist Church, Anglican Church, and Methodist

church in Effurun metropolis who were excluded from the sample used. However, they have the same characteristics with the selected area used. Thus, the result of the pretest yielded a positive result in line with the sampled area. Data were collected through self-administration of the questionnaire. This means that the researcher distributed the instruments personally face to face to respondents and waited to collect them back immediately.

5.4 Data Analysis

The presentation of data in the random way in which it was gathered, posed a lot of difficulties when drawing conclusion, hence the researcher tends to help present data in a way that will make it easier to interpret. Thus, the simple method of tabulation was used to analyze the responses of respondents, while the simple percentage method was used to interpret the responses from the questionnaire retrieved. The presentation and analysis of data were based on the stated research questions. Each research question was followed by the analysis of data and findings.

6. RESULTS AND DISCUSSION

Table 1 above shows that 100% (240) of the populations sampled were females. The ages shows that 37%, (89), 30% (71) and 33% (80) of the population sampled where between ages 20-30, 31-41 and 42 years and above respectively. The occupation of respondents shows that 34% (81) of the population sampled were civil servants, while 19% (46) of the population sampled were traders, 25% (60) of the population sampled were self-employed. Also, 22% (53).

Table 2: Demographic Characteristics of the Respondents

Sex	Respondents (n1=240)	% (n2=100)
Male	0	0
Female	240	100
Ages		
20 - 30	89	37
31 - 41	71	30
42 and above	80	33
Occupation		
Civil servant	81	34
Trader	46	19
Self-Employed	60	25
Student	53	22
Educational Qualification		
SSCE	71	30
TCII	11	5
ND	82	34
NCE	39	16
First degree and above	37	15
Church Denomination		
Orthodox	142	59
Pentecostal	98	41
Marital Status		
Single	94	39
Married	144	60
Divorced	2	1
Residence		
Effurun Metropolis	154	64
Ekpan, Effurun	86	36

The educational background of the respondents points out that 36% (103), 3% (10), 7% (21), 33% (93) and 21% (59) of the population sampled were SSCE, TCII, ND, NCE, First Degree Holders and above respectively. This makes it clear that the population of study is relatively literate. The church denomination respondents indicates that 59% (240) of the population sampled belong to the churches under the category of orthodox churches, 41% (98) were among the Pentecostal churches. The marital status of the respondents shows that 39% (94) of the population sampled were single. While 60% (144) of the population sampled were married, 1% (2) of them were divorced. The residential location of the respondents explains that 64% (154) of the population sampled were resident in Effurun metropolis and 36% (86) of them were from Ekpan axis of Effurun.

Twenty percent (20%) representing 49 respondents have knowledge about self breast examination and 75% representing 180 respondents were ignorant about self breast examination. 11 respondents representing 5% did not give any response. 47% representing 113 church women in Effurun regard breast self-examination among women as something good. Moreover, 3% representing 6 church women in Effurun regard breast self-examination among women as something that is not good. While 5% representing 13 church women in Effurun regard breast self-examination among women as unbiblical, 45% representing 108 church women in Effurun opine that the bible is silent about breast self-examination among women. 39.6% (95) indicated that they carry out self breast examination as Christian women and 60.4% (145) say that they do not carry out self breast examination. 15% representing 35 church women do breast self-examination regularly but 30% representing 73 church women seldomly do self breast examination. While 44% representing 105 church women do not like the idea, 11% representing 27 church women were indifferent about breast self examination. 29.6% (71) opine that lack of encouragement from church leadership on breast self-examination is one of the factors inhibiting the practice among church women in Effurun. 30.8% (74) showed that traditional understanding is another reason inhibiting church women from carrying out breast self-examination in Effurun. It also showed that 38.8% representing 93 church women say ignorance is also responsible for women not carrying out self breast examination in Effurun. A very few church women standing for 0.8% (2) say myth is responsible for church women not carrying out breast self examination. 28% representing 67 church women say that the church Effurun support women doing breast self examination. 24% representing 58 church women in Effurun say that the church does not support breast self examination. Moreover, 44% representing 105 church in Effurun opine that the church is silent about the practice of breast self-examination but 4% (10) say they do not know.

6.1 Analysis Of 3 John 1:2 And Its Implication For The Contemporary Church In Nigeria

The biblical section of 3 John 1:2 reads: Beloved, I wish above all things that you may prosper and be in health, even as your soul prospers (RSV, 1952). In the context of this work, two main themes shall be analyzed from the passage in view. First, is the concept of prosperity. The Greek word used for prosperity in the passage is *εὐδοκῶ* (*euodoo*) and it means to grant a prosperous and expeditious journey, to lead by a direct and easy way, to grant a successful issue, to cause to prosper, to prosper, to be successful (Strong, 2001). It is used in the present active indicative and in the passive voice and infinitive count signifying to have prosperous journey (Vine, 1996:495). Second, is the concept of health. The Greek word used for health in the passage is *ὑγιαίνω* (*hugiaino*) and it means to be sound, to be well, to be in good health, to be whole, wholesome, safe and sound. Metaphorically, its meaning relate to a Christian whose opinions are free from any mixture of error and of one who keeps the graces and is strong (Vine, 295). When viewed from the perspective of healing, it connotes physical (example, Matt.24; 10:8; Lk.5:17; Jn.4:47) and spiritual (example, Heb.12:13) health. Other two main words used in relation to health are *therapeuo*

(which is used ten times in reference to Jesus' miracles) and *iaomai* which has to do with restoration from apostasy or sin (Guthrie, 2004:261).

The contemporary church in Nigeria is not unaware of the physical and spiritual necessity of good health among church members. While faith is expected to be applied, preventive health is equally important. Health in this context include cancer free living among humans including women. This is why the church in Nigeria should encourage women to prevent breast cancer by doing self breast examination from time to time.

6.2 Discussion

An overall assessment of the respondents showed that some high percentages of church women in Effurun are aware of breast cancer but not deeply aware of the trend of self breast examination. By implication, many church women are not aware of breast self-examination in Effurun. It also showed that the church and her leadership are yet to adequately emphasize the importance of breast self-examination among women. Apart from the church not emphasizing it, traditional understanding com ignorance are also inhibiting factors that prevent church women from carrying out breast self-examination in Effurun metropolis in Uvwie Local Government Area, Delta State, Nigeria.

By this result it is probably the same problem in many other parts of Nigeria. It also showed that for reasons best known to some women, they feel that breast self-examination is not normal. This may be due to moral perception informed by some church and traditional understandings. In summary, it is obvious that the church has not been able to do much in terms of awareness geared towards change in the perception and attitude of church women towards Breast self-examination.

7. CONCLUSION

The sensitization of church women in Effurun as to how to conduct breast self-examination so as to help in the prevention of breast cancer is yet to yield maximum results; and the practice of breast self-examination among church women has not yet improved. The over findings are as follows:

- a) The church in Effurun is silent about the practice of breast self-examination;
- b) While some Christian women participate in self breast examination in Effurun majority do not;
- c) Those church women who participate in breast self-examination either carry it out seldomly or not at all;
- d) The factors seen to be inhibiting church women's participation in breast self-examination in Effurun include church and traditional beliefs and ignorance.

8. RECOMMENDATIONS

- Churches should see the issue of breast self-examination among women as health issue and emphasize that church members should routinely undertake breast self-examination.
- The government of Delta State and the churches should synergize effort in the organization of seminars on self breast examination for church women and all women the state.
- Apart from the practice of self breast examination among church women, they should be encourage to do regular check-ups on their breast and other aspect of their health so as to adopt a preventive measure towards dangerous diseases.

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