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Cancer Surgical Situations and their Effects on Patients

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Introduction

The obvious reaction in any person informed of the need for a surgical procedure for cancer is anxiety. The term Surgery may evoke the idea of a threat to life as in amputation, loss of voice as in larynx cancer surgery, disfigurement as with mastectomy or uncertainty in coping up with the challenges of survival and disability following oncosurgery. Other psychological factors such as neurosis, stress and depression which cause psychiatric co-morbidity in an already disease stricken patient may interplay and add to the anxiety [1]. The Cincinnati series reports an incidence of depressive reactions in surgical patients, only second to delirium. The diseased patient may become non-cooperative by showing distinct lack of interest in his treatment which may complicate the surgeon's problems and impede his own recovery [2]. The depressive reactions may be accompanied by physiological changes as well as functional and psychological symptoms. Moore demonstrated the effects of emotion on the Hypothalamic-Pituitary-Adrenal Axis during immediate and subsequent post-operative periods which can interfere with the clinical assessment of a surgical patient. The factors which modify the degree of depression in a surgical patient are manifold. Depression is seen to be more common in older age group which is attributed to the blunted ability to cope up with a surgical insult. The prevalence rate is almost double in females compared to males which; is related to the increase in physiological stress and presence of gynaecological cancers in females. Emotional strength and endurance of the patient are also important contributory factors [3]. Lack of financial support causes and aggravates depression in the lower socio- economic class. Losing occupational skills due to limb loss in a limb sarcoma or voice problems in laryngeal cancer surgery in a professional singer may cause depression [4]. A patient in a public hospital is more prone to depression than a patient in a private hospital. This may be related to financial problems, surgical environment, lack of rapport with the operating surgeon and having little or no say in choosing the surgeon. Prolonged nature of the illness as in breast cancer after mastectomy during or after chemo-radiation may precipitate depression. It may be interesting to note that the only specific tumour outside the nervous system which may present as depression is the cancer of the pancreas. The pancreatic neuropeptides have been incriminated as mediators in these patients [5]. Others include tumors of the Pituitary, Para-thyroids and those seen in Para-neoplastic syndromes. Patients with depression often become nicotine and alcohol dependent which may aggravate pre-existing illnesses as chronic pancreatitis and peripheral vascular diseases the nature of the surgery, the chance of its success and the trust of the patient in the operating surgeon have tremendous effects on the nature and course of depression. It has been seen that cancer virtually disrupts every aspect of the patient's life [6]. Depression is further compounded by the chronic nature of the illness, its treatment, pain, generalized lassitude and anorexia and the thought of death. Buckberg found a direct relationship between depression and level of physical disability in cancer. The combination of the surgical procedure and the awareness of the implications of the illness test the emotional stability of the patient [7]. Depression is a response that stems from loss of health and physical integrity resulting from disease, disfigurement and discomfort, financial problems resulting from cost of treatment and loss of job, rejection by friends and loved ones including separation to receive treatment [8]. Sutherland and his associates are of the opinion that loss of a bodily part or valued activity or function is more depressing than fear or expectation of death. This is most commonly seen in surgeries performed for malignancies of the head and neck region and for breast cancer. Maguire series reports an incidence of depression following mastectomy related to appearance and sexual dysfunction. Since head and neck malignancies are highly related to abuse of alcohol and tobacco, these patients suffer increased anxiety related to substance withdrawal as well as pain and depression related to feelings of guilt. In a patient with colostomy, depression occurs from sexual and social disability. Free and open communication between the patient and the surgeon helps with overcoming the patient's fear for the disease and his emotional and mental difficulties [9]. A healthy relationship is fostered by trust on part of the patient and interest on part of the surgeon. Since biological behaviour of cancer differs in different patients, rigid prognostication of the disease should be avoided as far as possible. Psychological support and education are necessary in order to alleviate the patients' depression and fear to deal with disability resulting from the disease or the therapy. Examples include training in case of a colostomy by an enterostomal therapist. Patients who require ostomies like a colostomy or ileostomy should be visited preoperatively by a stromal therapist and a member of the ostomy club who can share the feelings and concern of the patient. Patients with breast cancer treated by mastectomy may be helped to alleviate the problems of altered body image by referring to rehabilitation clinics [10]. An important point especially in breast cancer and gynaecological surgery is that patient's spouse should be included as an active participant in all the discussions of the disease and treatment.

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Conflict of Interest

None

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