



# Newsletter

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## EDITORIAL

### *BODY IMAGE – A PSYCHOSOCIAL ISSUE*

Body image is recognized as a critical psychosocial issue for cancer patients. Body image is a complex construct that extends well beyond how one views his or her physical appearance. It has most consistently been defined as a multifaceted construct that involves perceptions, thoughts, feelings, and behaviors related to the entire body and its functioning. There are broad range of bodily changes a cancer patient can undergo due to the disease and treatment that can affect body image. These include appearance alterations (e.g. hair loss, scarring, swelling), sensory changes (e.g. pain, numbness) and functional impairment (e.g. dysphagia, dysarthria, impotence).

*A woman with breast cancer tells the doctor, she can no longer stand to look at herself in the mirror or show her body to her husband after a mastectomy.*

*A man who underwent an orbital exenteration rarely leaves the house because he does not want others staring or making comments about his appearance.*

*A patient with lymphoma undergoing chemotherapy recently lost her hair and a significant amount of weight. She experiences daily crying spells about her body changes and is preoccupied with whether her hair will grow back or not.*

*A male patient with rectal cancer is refusing to undergo treatment due to concerns that he will not be able to conceal his colostomy bag from others and that his spouse will no longer find him sexually attractive.*

*A woman who underwent partial glossectomy and radical neck dissection has debilitating anxiety about returning to work and being around others because of her unclear speech and difficulties with eating.*

More than 55 % of cancer patients have negative body image. Seventy seven percent patients with oral cavity cancer have appearance-related concerns and 63% of the cancer patients suffer from not being attractive. No meaningful relationship is found between the type of cancer and body image; hence, all types of cancers can change the body image. Across numerous disease sites, body image concerns are significantly correlated with higher levels of anxiety and depression (breast, colorectal), worse quality of life (breast, head and neck, prostate) and sexual functioning difficulties (breast, gynecological, testicular). Patients are found to be most concerned about body image

in the immediate post-operative period and soon after completing other forms of treatment. Body image issues, at least for breast cancer patients, appear to subside and stay relatively stable after about two years.

Because body image concerns are widespread among cancer patients and associated with significant adverse psychosocial outcomes, it would be ideal to discuss body image with every patient during each encounter in the same way we reconcile medications. However, such a universal approach is not feasible in busy clinical practice. We therefore recommend that clinicians focus on patients who are most likely to develop body image concerns, namely those whose disease or treatment cause significant self-perceived changes in physical appearance or function.

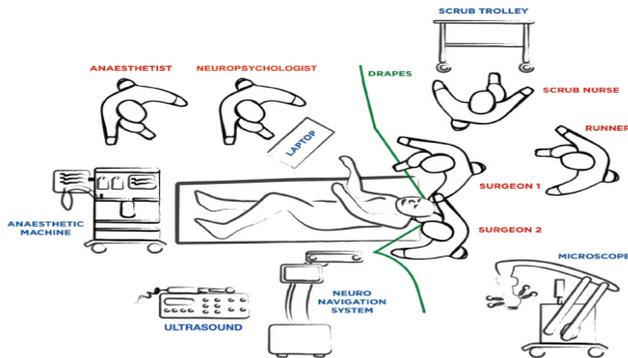
Regardless of a patient's diagnosis, we should address body image issues with those who voluntarily raise concerns or who behave in ways that indicate body image difficulties. Some patients may develop body image concerns that interfere with treatment, like the patient who declined treatment for rectal cancer. Other body image difficulties become evident following treatment, such as the breast cancer patient who avoids viewing herself postoperatively and refuses to allow her husband to view her breasts. Body image problems can also persist into survivorship, as reflected by ongoing distress, anxiety, or depression. If left untreated or unrecognized, the patient with debilitating anxiety about returning to work and engaging in social situations following a partial glossectomy may ultimately become reclusive and be unable to resume routine activities.

Principles of patient centered communication are critical for addressing body image concerns. Open ended questions and phrases, such as "Tell me more" and "What is that like for you?" encourage expression. Many people think of communication as talking and educating, but listening well is arguably the most powerful aspect of effective communication. Healthcare providers, especially doctors, tend to do most of the talking in an attempt to "educate" patients, pose a series of closed-ended questions, and interrupt patients after only a few seconds. Many doctors worry that allowing patients to express themselves takes too much time. However, encouraging expression typically adds only a few minutes to the encounter. In other words, the meeting may take a few minutes longer, but the time investment pays

**(Continued Page No. 4)**

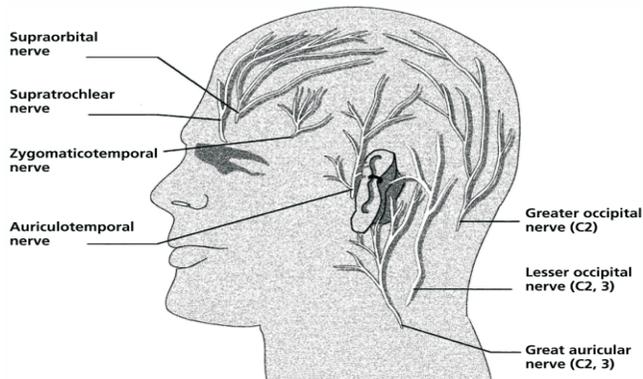
## AWAKE CRANIOTOMY FOR BRAIN TUMOR REMOVAL

The incidence of brain tumors in India ranges from 5 to 10 per 1,00,000 population with increasing trend and accounts for 2% of all malignancies. These may be located above or below tentorium cerebelli. Supratentorial tumors are much more common in adults as compared to children. Many of these tumors are near important centres of brain like that of speech or voluntary movements. These patients may present either as speech difficulty or limb weakness. Doctors have to be extra careful in removal of such tumors during surgery lest patient may wake up with new problem of difficulty in speech or weakness on one side of body once the effects of anaesthesia is over.



**Fig. 1: Operating Room Layout**

In such cases awake craniotomy is useful method of removing these brain tumors. During the procedure patient is fully awake and performs active acts of limb movements and speech which helps the surgeon during surgery. Unlike other organs brain does not have pain sensations so patient does not feel pain during surgery on brain. However scalp is richly supplied by nerves and has very good pain sensations so the scalp needs to be made numb by local anaesthesia before making skin incision.



**Fig. 2: Sites of Scalp Block**

Scalp block is given with local anaesthetic (LA) agent mixed with adrenaline which prolongs its effect and reduces toxicity. Supraorbital, supratrochlear, zygomaticotemporal, auriculotemporal, greater and lesser occipital nerves are blocked on both sides. LA is also given at the pin site of Mayfield clamp before fixing the head.

Patient is positioned to ensure maximum comfort during the period of surgery. He is placed on thick mattress on operation table with careful padding on pressure points. Normally the patient is either placed supine with head turned little to one side or in lateral / semilateral position depending upon location of tumor. Draping is done in such a way that the whole patient from face down is visible to the anaesthetist

during intraoperative functional testing. A close circuit video monitor allows the surgeon to see and hear the patient during surgery. After putting indwelling urinary catheter head is fixed to the table by Mayfield clamp.

The exact site and size of craniotomy is delineated by neuronavigation in relation to tumor and eloquent cortex and line of incision is marked. LA with adrenaline is infiltrated in the scalp at the incision site to block pain sensation and reduce bleeding. Skin incision and bone flap removal is done under LA with patient asleep under monitored anesthesia cover (MAC). Before opening dura the tumor is again localized with neuronavigation and intraoperative ultrasound. Then dura is opened accordingly for optimum access to the tumor and surrounding brain. Once the area of interest of the brain is exposed the patient is made awake by withdrawing the short acting sedation. The cortical surface is stimulated by special bipolar forceps using mild current to identify the speech centre (Brocas or Wernicke ) or motor cortex. For deep seated tumor, corticectomy is made well away from the eloquent cortex. Once tumor surface is reached it is removed gradually in piecemeal with surgical aspirator while anaesthetist is engaging the patient to perform different acts of limb movement and speech. As soon as there is hesitation or arrest of speech or decrease in limb activity the surgeon stops tumor removal in that area and moves to another part of the tumor. The motor or speech centre functions are continuously tested during tumor removal. All through the procedure ultrasound is used which is very valuable intraoperative tool to delineate remaining tumor and to plan strategy for its removal. At the end of procedure it also shows whether gross tumor removal has been achieved or not. Though main aim is to remove the tumor as much as possible without jeopardizing the functions yet in most of the cases gross total tumor removal can be done by this method. Once the tumor removal is complete with hemostasis the patient is made asleep again and rest of closure is done in the usual fashion.

Post-operative recovery is usually much quicker than with conventional craniotomy as patient did not undergo general anesthesia. In the post operative period patient usually has single IV line and a foley catheter which are removed next day. Patient can drink, eat or move around as soon as he feels. He is discharged in a day or two with advice to come for follow up and stitch removal in 5 to 7 days.



**Fig. 3: Patient After Surgery**

As it is evident that for awake craniotomy the confidence and active cooperation of the patient is very important. The patient is encouraged to visit the operation theatre before surgery to familiarize with sound

and equipments and thorough explanation of procedure to gain his confidence and agreement.

It is equally important that the anaesthetist develops a good personal rapport with the patient and explains the procedure including discomfort during surgery such as pain of needles during scalp block and loud noise of drill during craniotomy.

Patient cooperation is of paramount importance in order to evaluate language and motor skills. Patients who are uncooperative are contraindicated. Children are psychologically unfit to undergo this procedure. For the success of awake craniotomy experience of surgeon, anethetist and every other member of team is equally important. As the patient's head is fixed to the table by Mayfield clamp he can move every part of body except his head which becomes uncomfortable if tumor removal continues for long time. So the procedure needs to be completed efficiently and fast.

Neuronavigation (image guidance system) helps in localization of the tumor and its relation to the eloquent cortex hence important during awake craniotomy. Intra operative ultrasound is also very helpful tool as it is real time and tells where and how much tumor is left for removal.

The risks of awake surgery for brain tumor removal are same as those for conventional surgery, but small risk of seizures during stimulation. Though antiepileptic drugs are already given in the morning of surgery however if seizure does occur during surgery it is treated by cold irrigation and appropriate medication. Very rarely this may require conversion to general anaesthesia.

**Dr. (Prof.) Ishwar Chandra Premsagar**  
Sr. Consultant and Chief of Neuro & Spine Surgery

### CME – IMA JALANDHAR

RGCIRC organized a CME in association with IMA Jalandhar on Friday, 27<sup>th</sup> July 2018 at The Regent Park Hotel, Jalandhar, Punjab. Dr. Rupinder Sekhon, Sr. Consultant and Chief of Gynae Oncology delivered a lecture on “Robotics in Gynae Oncology” and Dr. Ullas Batra, Sr. Consultant and Chief of Thoracic Medical Oncology spoke on “Approach to Breast Cancer” in the said CME.



### SILVER JUBILEE CONFERENCE OF IMA ROHINI



RGCIRC participated in Silver Jubilee Conference organized by IMA Rohini on Sunday, 5<sup>th</sup> August 2018 at Hotel Crowne Plaza, Rohini, Delhi. The theme of the conference was Knowledge is Power. Dr. (Prof.) I. C. Premsagar, Sr. Consultant and Chief of Neuro & Spine Surgery delivered a lecture on “Headache & Backache: A Clinician's Prospective” and Dr. Sunil K. Khetarpal, Chief of Operation cum Medical Superintendent spoke on “Quality in Healthcare and NABH Accreditation” in the said conference.

### CME – SOUTH DELHI BRANCH

RGCIRC organized a CME in association with South Delhi Branch on Friday, 8<sup>th</sup> August 2018 at India Habitat Centre, Lodhi Road, New Delhi. Dr. Sajjan Rajpurohit, Consultant – Medical Oncology delivered a lecture on “Kidney Cancer” in the said CME.



### FOGSI FORCE HARYANA– PG ACADEMIC PROGRAMME



RGCIRC participated in FOGSI Force Haryana– PG Academic Programme organized by Kalpana Chawla Government Medical College on Sunday, 19<sup>th</sup> August 2018 at Kalpana Chawla Government Medical College, Karnal, Haryana. Dr. Rupinder Sekhon, Sr. Consultant and Chief of Gynae Oncology and Dr. Divya Sehra from Surgical Oncology delivered a lecture on “Gestational Trophoblastic Neoplasia”. Dr. Rupinder Sekhon also chaired a session on “Ca Cervix” in the said conference.

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huge dividends in trust, rapport, and patient satisfaction in the short and long term. Many doctors are uncomfortable during emotional encounters, because they do not know how to respond to emotions. Many doctors offer premature reassurance by saying things like "You look great!" or "Stop worrying, in a few months you will look completely normal". Others offer a treatment plan rather than simply staying with emotions for a few moments. We should offer reassurance, education, and further treatment options only after patients have had the chance to express their concerns.

There are some other suggestions for the oncologic team to effectively address body image issues. These include: 1) educate patients about what to expect in terms of appearance and functional outcomes, 2) connect patient's with relevant community resources, 3) refer patients to psycho-oncologist for brief or intensive therapy if needed, and 4) follow-up of patients with known body image issues about their concerns at each clinic visit.

One of my oral cancer patients who was adequately counselled regarding body image issues commented.

***"Life is all about perception. Positive versus negative. Whichever you choose will affect and more than likely reflect your outcomes. The moment you change your perception is the moment you reunite the chemistry of your body".***

***"Life is based on perception. Perception is based on opinion. Opinion is based on thoughts. Thought comes from the mind. Change your mind, change your life".***



**Dr. A. K. Dewan**  
Director - Surgical Oncology

## CME – PGIMS, ROHTAK, HARYANA



RGCIRC organized a CME in association with Department of Radiation Oncology, Pandit Bhagwat Dayal Sharma Post Graduate Institute of Medical Sciences (PGIMS), Rohtak on Wednesday, 22<sup>nd</sup> August 2018 at Hotel Apsara, Rohtak, Haryana. Dr. Ullas Batra, Sr. Consultant and Chief of Thoracic Medical Oncology delivered a lecture on "Updates in Lung Cancer" in the said CME.

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