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Psychosocial Aspects of Colposcopic Assessment: Perspectives and Strategies for Physicians

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Abstract

The purpose of this work is to determine perspectives, misconceptions, psychology adjustments and useful strategies of women living with dilemmas about their malignant lesions which can be detected through the colposcopy. Colposcopic assessment following abnormal Pap test has resulted in a long list of concerns: fear of having cancer, periodic obligations related to follow-up, balancing treatment of premalignant disease with quality of life, pain or discomfort and long-term impact on their families or limited social support. How prepared are they to adapt to their diagnosis? New diagnosis results in patient not being able to listen well or to understand her medical situation. The success of the outcome and procedure takes time to deduce the concerns she has regarding her diagnosis, treatment and appropriate follow-up. Several physicians endorse a wide range of barriers with respect to diagnosis and management of the disease: organizational or patient issues. Furthermore, patient appears to be important for the effective treatment than to identify and assess psychosocial problems among women diagnosed with cancer. In conclusion, physician provides effective treatment, but fails to address psychosocial issues associated with the illness. It is necessary to define the condition more clearly by studying patients and their psychosocial problems.

Keywords: colposcopy, cancer patients, psychosocial

1. Introduction

The purpose of this work is to determine perspectives, misconceptions, psychology adjustments and useful strategies of women living with dilemmas about their premalignant or malignant lesions which can be detected through colposcopy.

In the last few decades, there has been growing interest in the field of psychosocial aspects on women diagnosed with cancer or severe dysplasia.

Approximately 10 million United States cancer patients require appropriate psychosocial interventions and support programmes [1].

Psychological impact of cancer is a universal phenomenon, but the caring concept varies among different countries and cultures. Thus, the physician-patient relationship forms the basis of what constitutes caring for the patient [2–4].

Psychosocial aspects are directed by the idea that psychosocial issues are integrated into the overall management and treatment of the disease [5].

Psychological reaction to their disease has become a challenge for the oncologist in the second part of the twentieth century.

Some of the patients will develop psychiatric disorders such as anxiety, depression and adjustment disorders [2, 6, 7].

Having cancer can affect the brain and cause discomfort to the patients or may change their relationship with family, friends or colleagues [3].

Unfortunately, the achievements in providing care for the women diagnosed with cancer have not been correlated by remarkable advances in providing care for psychological symptoms and social consequences of cancer [2, 3].

Health policymakers, researchers or health insurers should respond to the psychosocial aspects of cancer patients. Cancer leaves patients with nonreversible consequences and requires long period of care [3].

2. Objectives

As the entire cancer trajectory including follow-up care to survivorship, emotional, spiritual and cultural issues, family support including social needs, child assistance, financial assistance and their potential applications to our context (must be a part of supportive cancer care) has multiple dimensions, we elected to focus on the psychosocial aspects of cancer survivors [2, 3].

Also, the subject has multiple dimensions; thus, we choose to focus on psychosocial aspects for cancer patients and their potential applications to my country. The goals of supportive care experts are to identify psychological repercussions of cancer diagnosis including concerns about body image, about sexuality or fertility, discrimination, fear of relapse, family's support, maintaining their own employment or being re-assimilated by their colleagues or friends [2].

The objectives have been focused on how to integrate the psychosocial aspects of terminal illness into supportive care from the time of diagnosis toward the end of the patient's life.

3. Rebuilding psychosocial care for cancer patients diagnosed after colposcopy-guided biopsy: gathering information

Many women diagnosed with cancer can be managed as a chronic disease [3, 6].

Physical examination, vital signs, gynaecological examination, Pap test, biopsy and laboratory values such as haematology, chemistry, urinalysis and histological evaluation were used for cancer diagnosis.

The findings can be accepted and should be interpreted with caution.

In the last few decades, there has been growing interest in the field of psychosocial aspects on women diagnosed with cancer or severe dysplasia by colposcopic examination. Because diagnostic and treatment of cancer have been associated with a higher risk of severe depression, it is important to evaluate the relationship between gynaecologists and their patients in order to improve communication skills and to identify any clinically relevant abnormal findings [2, 3].

Women with abnormal cervical cytology are at a great risk of developing cervical cancer.

Persistent HPV infection is necessary for the development of cervical cancer.

To facilitate the best possible care for women with abnormal Pap test, colposcopy is performed. For women with abnormal cytology results, colposcopic examinations have the advantage of prompt diagnosis. A colposcope is used to indicate and evaluate the presence of precancerous or cancerous lesions. After examination, the physician may obtain for directed biopsies from abnormal areas.

In Romania, National Cervical Screening Program is associated with a reduction in the incidence of invasive cervical cancer. This program is safe, effective, efficient and based on evidence.

Women colposcopic assessment following an abnormal Pap test has resulted in a long list of concerns: fear of having cancer, periodic obligations related to follow-up, balancing treatment of premalignant disease with quality of life, concern about pain or discomfort and long-term impact on their families or limited social support [3, 8].

How prepared are they to adapt to their diagnosis?

An abnormal cytology result can cause alteration in understanding the recommendations they receive and types of reactions. It may be helpful to provide information about medical procedures in order to maintain the balance of the physician-patient conversation.

The damage caused by hormone therapy, radiotherapy or chemotherapy often leads to functional disabilities or limitations in activities of daily living or capacity for work. Physical symptoms interfere with their mental functions. Despite the administration of analgesics, the pain is not eliminated and the distress of living with physical problems can create psychological distress [2, 9].

High stress levels can interfere with doctor ability to provide emotional support.

Patients who experience prolonged hospitalizations are at a particular risk for psychological problems [2, 3, 9].

Many patients reported that some physicians still do not consider psychosocial support as component of cancer treatment and may fail to recognize depression in cancer survivors [2, 3].

Therefore, poor communication between patient and her clinician has been identified as the first level that potentially contributes to healthcare providers' failure in the management of those illnesses. Evidences that support its effectiveness need additional research and more attention to psychosocial aspects needs in cancer from policymakers [2, 3, 9].

Many women diagnosed with cancer can be managed as a chronic disease.

New diagnosis results in patient not being able to listen well or to understand her medical situation.

When patient education has been found to be lower or among women who are young or unmarried, the physician's first task is to provide patient with specific information about her disease process and support her fear of having cancer [3].

Several physicians endorse a wide range of barriers with respect to the diagnosis and management of the disease: organizational or patient issues [2, 3].

The Pap test is the first step in cervical cancer finding. An abnormal Pap test cannot tell for certain if a cancer or a precancer is present. Therefore, the result of the Pap test will guide your gynaecologist to the next step: colposcopy, cone biopsy or endocervical curettage.

Colposcopic examination of cervix is done to look for areas of abnormal tissue if we have high-risk type of HPV, genital warts, biopsy of the abnormal areas, follow-up care after treatment, and so on.

Colposcopy is most often done when the result of a Pap test is abnormal. During the test, doctors can take a small sample of tissue called biopsy. Then, the sample will be observed under a microscope by a pathologist, who can confirm us if cancer is present or is likely to develop. Cone biopsy may be used as a treatment to cervical precancers or some very early cervical cancers.

Doctors should be familiar with two aspects of caring: expressive behaviours and instrumental activities. The first one provides emotional support to the patient and the second one involves medical treatment [3, 10].

In our care system, there is a comprehensive care plan based on the needs of the oncology patients.

Physician's technical skills are valued and respected by a proportion of patients. Healthcare professionals found that patients viewed competent clinical-surgical expertise as the most important component of doctor-patient interaction. When the patient trusted the doctor's competence, the result of this linkage can make the moment of diagnosis easier [3, 9].

Many patients are stunned by such news. Receiving such a message can produce questions as 'why me' and conclude that they are being punished by God for had acts of the past. Depending

on the severity of the disease, a few patients may even contemplate death for themselves. Accepting the diagnosis and situation take time for most patients. It is important not to compare their disease with the others because that causes stress and pressure to themselves [2, 3, 9].

A considerable number of the women diagnosed with cancer are an intrinsically vulnerable population due to psychological factors. Women who showed less interest or lower intention to engage in cancer screening programs and women with lower educational qualifications or emotional barriers such as embarrassment could be associated with no improvement in the mental health status [2, 3, 9].

Some believed that women will only participate in screening programs if they are forced to do so.

What we can all agree on is that the absence of a set of practical clinical guidelines or incomplete recommendations on monitoring for psychosocial aspects of women with cancer put patients and healthcare providers at risk [2].

The factors who predict vulnerability to psychological symptoms or physical health should be viewed in the context of a cancer diagnostic as having high life consequences [3, 9].

Psychological factors have an important role in the relationship between perceptions about the consequences of symptoms and cancer diagnostic experience.

By applying patient health questionnaire or Zung Self-Rating Depression Scale, it was found that loss of libido, impaired sexual performance or menstrual disturbances would be predictive regarding the presence of depression in cancer patients [2, 3, 9].

Factors contributing to depression include patient's age, race/ethnicity and type and stage of cancer.

To diagnose depression, this requires somatic symptoms such as weight loss, appetite loss, fatigue or loss of energy, psychomotor agitation, insomnia or hypersomnia or cognitive symptoms as poor concentration, excessive or inappropriate guilt, suicidal thoughts or recurrent thoughts of death. Also, genital symptoms could be loss of libido, menstrual disturbances or impaired sexual performance [2, 3, 11].

Suicidal thoughts, psychotic symptoms or profound guilt can be associated with major depression [3].

The effect of the immune system on the course of the disease can be considered as a period of special need for body image disturbance, relationship difficulties, depression or anxiety [16, 18].

Patient's immediate question is likely to be: 'what does this mean for me?'

This is a difficult situation and they must learn to treasure every single moment. Instead of feeling awkward, they may go through this journey by encouraging themselves to open the conversation with doctor [9].

When you are dealing with something so difficult, the consequences can be unbearable [12].

4. Prognosis of psychosocial disorders in cancer patients

Patients with depression are more likely to have an adverse impact on disease prognosis [13].

The biological connections of the immune system have been suggested as the mechanism for disease prognosis [3, 14].

At the present time when medicine strives to be evidence based, the psychosocial disease course has always been an important factor in cancer prognosis and psychological morbidity [2, 3].

Stress hormones can influence the prognosis of somatic disorders such as cancer. Therefore, the psychosocial care of cancer patients remains a challenge [2, 3].

The survival rate after cancer screening programs has improved prognosis and the number of cancer survivors has increased in developing countries [3, 9].

Also, behavioural and social factors might affect cancer prognosis and the length of patient's life.

5. Treatment of psychosocial disturbances

Standards of care include preventive strategies and treatment recommendation plans for follow-up cancer patients [3, 4].

Despite the increased curability of cancer worldwide, the psychosocial need of cancer survivors is an emerging reality in developing countries [22, 23].

The cancer treatment, psychological treatment and counselling or social support all include challenges relevant to the patient [3, 9].

In principle, support to quickly facilitate return to work has become interesting for the health-care system. On the other hand, no patients require being treated by a specialist who does not have expertise and are somehow not integrated into innovative diagnostics or procedures and do not have the ability to deal with any psychological discomfort caused by treatment [18].

Most patients need support, but they just do not know how or they do not have experience in this area. Unfortunately, there have not been much studies about social support including family members, spouses, children, friends or colleagues. Patients who have a lack of social support have a higher risk of depression [2, 9].

It seems that lifestyle modifications can contribute or confers a positive influence on women which has been diagnosed with cancer and need further examination and measurements [3].

Evidence suggests that physical exercise can induce compensatory behaviours that lead to possible impact in the mental status [14].

Psychosocial care departments of cancer services can be delivered depending on levels of depression or anxiety in disease stage or course of cancer in order to develop an effective treatment plan [2, 9].

It will be necessary to ensure that patients with pre-existing depressive disorders could be integrated into management programs in order to establish the most effective method of detecting serious symptoms in order to treat them or to improve the quality of life [2, 3].

The use of mental status examination and psychosocial screening for cancer patients can improve the detection of depressions.

The oncology staff needs to be able to deliver some level of psychological care that may be high at some point in order to improve the rates of detection of psychological symptoms in patients showing anxiety or depression and help them reduce the symptoms [3, 4, 15].

Providing psychological support and analgesic use is highly effective in reducing pain [13].

The use of nonthreatening terms to treat anxiety, fear or sense of loss of control has been shown to improve or provide psychological support for cancer patients [2].

Patient's expectations influence the response to treatment even before chemotherapy or radiotherapy is administered depending on local cultures and expectations. Those diagnosed with cancer should be led to understand that they can fight against cancer [3, 16].

Psychological factors have an impact on how disease affects patients and their tendency to catastrophize the situation [3].

Pre-existing psychosocial issues as unhealthy lifestyle, depressive illness or substance abuse have been shown to be very important in the progression of the disease after surgery [2, 3].

Also, inactivity or obesity is a serious impediment to improvement in social dysfunction [3, 14].

It has been noted that if cancer patients are allowed to develop behavioural dysfunction, then prescribing medication is not effective [2].

The behavioural dysfunction begins in response to the presence of the diagnostic of cancer [9].

Some patients have had good improvement of their mental disorders with graduated exposure therapy [3]. This is a process developed by psychologist Mary Cover Jones.

Treating the physical symptoms alone can exacerbate emotional issues in a substantial number of patients. Some patients are actually using antidepressant agents to treat anxiety or depression in non-malignant pain [2, 3].

Patients' social support network can greatly help reduce the risk of committing suicide and increased the quality of life for patients with psychological disorders [9, 17].

In addition, family members want to offer support, but they just do not know how to maintain healthy relationship [3].

Some people going through genital cancer treatment are embarrassed about the sexual or intimate changes [18].

In fact, most of the medical professionals avoid the issue of sexual changes because they do not have experience or enough time. Unfortunately, doctors avoid the functional aspects of

patients' sexuality after cancer diagnosis or treatment because it is not a life or death problem for the cancer patients [19, 20].

Depression is associated with slow recovery and reduced rate of survival [3].

Treatment can include psychotherapy and pharmacotherapy. Psychotherapy involves counselling, cancer education or support groups, and pharmacotherapy includes the use of antidepressants [3, 6, 21].

6. Conclusion

In conclusion, the physician provides effective treatment, but fails to address and gear the psychosocial issues associated with the illness.

Healthcare professionals will need to improve their skills in the detection of psychological problems in the patients with cancer. They should know how to diagnose anxiety or depression in cancer patients [2, 9].

Physician can effectively help patients to live as normal as possible despite dysfunctional reactions, behaviours, thoughts, women depression or sociocultural aspects [9].

Furthermore, patient appears to be important for the effective treatment than to identify and assess psychosocial problems among women diagnosed with cancer [3].

It is necessary to define the condition more clearly by studying patients and their psychosocial problems. It is important to receive accurate information and understand all their options. There is no tradition of multidisciplinary team causing a lack of integrated data solutions on psychosocial problems which appears to be important for the management of the disease [2, 3, 9].

The success of the outcome and procedure is taking time to deduce the concern she has regarding her diagnosis, treatment and appropriate follow-up [3].

Standards of care include preventive strategies and treatment recommendation plans for follow-up cancer patients [2].

Despite the increased curability of cancer worldwide, the psychosocial need of cancer survivors is an emerging reality in developing countries [22, 23].

The more healthcare professionals seek to understand patient's experience of being diagnosed with cancer.

As oncology experts, they have to support patients and their families in navigating healthcare system [24].

Cancer patient's psychological symptoms need to be understood and integrate them within their cultural values, religious and spiritual elements [3].

Cancer care specialists as part of multidisciplinary teams assume the role of providing care of patients towards the end. Therefore, oncology professionals are essential for patients and their families [2, 9].

Prevention and management of the psychosocial aspects of cancer, with respect to psychological symptoms from diagnosis through treatment and post-treatment care, have not been fully established [25].

Understanding the impact of psychological conditions can help physicians to advice patients by referring them to the appropriate multidisciplinary setting [2, 6].

Screening programs for distress may be useful among cancer patients [15, 16].

As a part of cancer treatment, psychological interventions should be included in the major cancer centres from all over the world. Researchers and clinicians have analysed the relationship between physician and oncology patient [2].

International conferences focusing on issues of psychosocial aspects of cancer visit prestigious centres and learn from their strategies, improving training for researchers and increasing international collaboration will lead to increased curability of cancer worldwide [26].

Doctors provide state-of-the-art treatment of cancer but fail to address psychosocial problems.

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