LEADING ARTICLE

PSYCHOLOGICAL IMPACT OF BREAST CANCER

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The investigation, diagnosis and treatment of any cancer cause severe mental stress on the afflicted. Breast cancer is no different. In addition to the psychological impact of having cancer, malignancy of the breast is different in that a part of the body, which is often the symbol of womanhood and sexuality, is diseased. Hence, any form of treatment, be it lumpectomy or total mastectomy, can have a profound impact on body image, self worth, sexuality and intimate relationship of the patient.

As breast cancer continues to be a leading cause of cancer among women, much attention is being focused on its management. Adjuvant hormonal therapy and chemotherapy constitute therapeutic advances which have resulted in the improvement of systemic control and overall survival. The impact of this disease on the psychological well-being of the patient is becoming increasingly important. We are beginning to realise that successful control of the disease may not mean return to normal life. Life after breast cancer changes.

The absence of a breast visibly alters one's body image. Unlike a hemicolectomy for cancer of the colon or a lobectomy for lung cancer, where loss of the organ is hidden, a mastectomy leaves a unilateral flattened chest. This deformity can alter physical activity, clothing preferences, and sexual posturing. Breast conservation procedures like lumpectomy, segmentectomy and quadrantectomy, in appropriate patients can alleviate the morbidity, leaving behind a smaller but nevertheless aesthetically acceptable breast[1]. Breast reconstruction with silicone implants or tissue flaps offers an alternative in cosmesis. However, it is important to remember that the quest for improved cosmesis should never be allowed to compromise disease control.

While the physical morbidity of breast surgery can be modified and reduced, the psychological impact is less readily corrected. The psychological effects of mastectomy compared with breast conservation on global psychologic assessment, have been evaluated in several studies. McArdle et al evaluated patients with the General Health Questionnaire and Leeds Scales of Anxiety and Depression at 6, 9, and 12 months after treatment[2]. Although patients with mastectomy had greater psychologic distress on all measures at all assessment times, none were statistically significant. No significant differences in anxiety and depression between mastectomy and breast conservation patients were noted in a similar study by Fallowfield et al[3]. The emerging consensus is that the major determinant of global psychologic distress in patients recently diagnosed to have breast cancer are the patients' premorbid psychologic states and the threat to life posed by cancer.

On the other hand, one consistent finding among women with breast conservation is the more positive feeling which they have about their bodies, especially their appearance in the nude, than women with mastectomy. The impact of breast surgery on sexuality is uncertain. Mastectomy may have subtle disadvantages compared to breast conservation. Some studies suggest that breast caressing decreases in importance and frequency after mastectomy[4-6]. The frequency of sex does not appear to be influenced by the choice of surgery[7,8]. However, more detailed studies are needed to address the issues of desire for sex, need for masturbation, satisfaction with sexual intercourse, and range of sexual practices etc.

Sexual dysfunction may not be entirely due to loss of a breast. The induction of early menopause either from adjuvant chemotherapy, or hormonal manoeuvre by drugs, radiation or surgical oophorectomy can also cause sexual morbidity. For premenopausal women with breast cancer, combination chemotherapy often results in ovarian failure. The probability of premature menopause that is permanent, increases after the age of 35 to 40[9]. Women with premature menopause often experience dryness and burning pain during coitus. In postmenopausal women, tamoxifen is the most common antiestrogen drug. While it induces menopause, the problem of vaginal dryness does not occur because the drug has mild estrogenizing effects on the vaginal mucosa.

In a conservative society like ours, sexual needs and inadequacies tend to be subliminal. Patients tend not to express or question issues related to sex as it is considered a taboo or embarrassing subject. This is particularly true in breast cancer patients in the older age group. It is not surprising how little we know about the magnitude and effects of treatment-related sexual dysfunction in our patients. To think that sexual dysfunction is a lesser issue in our women, as compared to Western women, is being presumptuous. The problem needs further study so that they can be better defined.

To assist breast cancer patients in their psychological adjustment to the illness, a multidisciplinary approach involving the surgeons, medical oncologists, radiation oncologists, nurses, social workers, self help groups and psychologists is recommended. Both individual counselling and group therapy should be explored. Many studies have demonstrated positive effects of group therapy intervention for cancer patients on psychological variables, including mood, adjustments and pain[10,11].

Self help groups, such as the Reach-To-Recovery programme operated by the Singapore Cancer Society, have a special role to play in breast cancer rehabilitation. They share the philosophy that people who have experienced a crisis or a life-threatening situation have a unique contribution to make to others who are currently undergoing the same experience. The service is run by volunteer counsellors, most of whom have had breast cancer. The counsellors visit the patients both in the hospital and at home. They are said to be most helpful at transition points, when fear and anxiety about the unknown is most intense[12].

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Treating the psyche is as important as treating the disease. However, care for the mental well-being should not be allowed to compromise the odds of adequate disease control. For example, a patient may be acutely distressed upon finding a lump in her breast. To cope with this discovery, she may choose not to seek help from a doctor because of her fear that the lump is cancerous. Instead, she deals with the problem by ignoring the problem or finding solitude in religion. While this satisfies the needs of the mind, it can compromise her chances of being cured of her breast cancer. It is best when one can heal both mental and physical illness. But, when one has to choose between healing the body or the mind, we feel that the body should come first. With adequate control of the disease, the mind heals with time.

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