

CONCLUSION

It is obvious that a diagnosis of breast cancer causes stress to both the patient and the family caregivers. Coping strategies employed could either be problem-focused or emotion-focused. Predominant coping strategies are; (a) seeking social support, (b) reliance on God, (c) positive suggestion/attitude or re-affirmation and (d) acquisition of information and education. The strategy employed influences adaptation to the diagnosis. Despite the demonstrated relationship between coping strategies and adaptation nothing is known about how Zambian breast cancer patients and their care givers cope and adapt. A study to explore the coping strategies used by patients with breast cancer and family care givers in Zambia is highly suggested. Further, a study on the association between coping strategies and adaptation is recommended. This will result in increased awareness about coping with breast cancer; consequently encourage the use of culturally sensitive coping strategies which will promote adaptive coping.

REFERENCES

1. Parkin, D.M., Bray, F., Ferlay, J. and Pisani, P. Global Cancer Statistics, 2002. *Cancer Journal of Clinicians* 2005; 55: 74-108.
2. World Health Organization. National Cancer Control Programmes: Policies and Guidelines, Geneva: WHO; 2002.
3. Zambia Cancer Society. 2010. Cervical Cancer in Zambia. <http://www.zambiacancersociety> [accessed 19/04/10].
4. Carver, C. G. and Scheier, M. F. Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*. 1989; 56 (2) 267-183
5. Kearney, N. and Richardson, A. (2006). Nursing Patients with Cancer: Principles and Practice. Elsevier, London.
6. Guex, P. Introduction to Psycho-oncology. 1989. Routledge, London.
7. Lackey, N.R., Gates, M.F. ad Brown, G. African Americans Women's Experiences with the initial Discovery, Diagnosis and Treatment of Breast Cancer; *Oncol Nurs Forum*. 2001; 28:219-227.
8. Lazarus, R. S. and Folkman, S. Stress, Appraisal and Coping. New York: Springer; 1984.
9. Tung, H.H., Hunter, A. and Wei, J. Coping, Anxiety and Quality of life after coronary artery bypass graft surgery. *Journal of Advanced Nursing* 2008; 61 (6) 651-663.
10. Livneh H. Psychological adaptation to cancer: the role of coping strategies. *J Rehabil*. 2000; 66(2):40-49
11. Li, J. and Lambert, V.A. Coping strategies and predictors of general wellbeing in women with breast cancer in the People's Republic of China. *Journal of Nurs Health Sci*. 2007; 9 (3) 199-204.
12. Manuel, J., Burwell, S., Crawford, S. et al. Young women' perception of coping with breast cancer. *Journal of Cancer Nursing* 2007; 30 (2): 85-94.
13. Mitchell, D. Stress, coping and appraisal in an HIV Sero-positive Rural Sample: 2004
14. Hack, T.F. and Degner, L.F. Coping responses following breast cancer diagnosis predict psychological adjustment three years later. *Journal of Psychoncology* 2004; 13 (4): 235-247.
15. Zakowski, S., Hall, A., Klein, L. and Baum, A. Appraised control, coping and stress in a community Sample. A test of the goodness-of-fit hypothesis, *Annals of Behavioral Medicine* 2001; 23 (30) 158-165.
16. Vitaliano, P., Russo, J, Carr, J. et al. The ways of coping Checklist. Revision and Psychometric properties. *Multivariate Behavioral Research* 1985; 20 2-36.
17. Folkman, S, Lazarus, R.S., Dunkel-Scheter, C. et al. Dynamics of a stressful encounter: Cognitive appraisal, Coping and encounter outcomes. *Journal of Personality and Social Psychology* 1968; 50 992-1003.
18. Landmark, B.T., Bohler, A. Loberg, K and Wahl, A.K. Women with newly diagnosed breast cancer and their perceptions needs in a health-care context. *Journal of Nur Health Care Chronic illn*. 2008; 17 (3): 192-200.
19. Culver, J.L., Arena, P.L., Antoni, M.H. and Carver, S.C. coping and distress among women under treatment of early stage breast cancer: Comparing African Americans, Hispanic and

- Non-Hispanic Whites. *Psycho-oncology* 2002; 11 495-505.
20. Bertero, C. and Chamberlain, W. M. Breast cancer diagnosis and its treatment affecting self: A Meta-synthesis. *Journal of Cancer Nursing*. 2007; 30 (3) 194-201.
 21. Doumit, M. A. A., Huijjer, H.A., Kelley, J. and Saghir, N. Coping with breast cancer: Phenomenological Study. *Journal Cancer Nursing* 2010;33 (2) 33-39.
 22. Teleghani, F., Yekta, Z. and Nasrabadi, A. N. Coping with breast cancer in newly diagnosed Iranian women. *J Adv Nurs*. 2006; 54 (3): 265-272.
 23. Halstead, M.T. and Fernsler, J.I. Coping strategies of long term cancer survivors. *International Journal of Cancer Care* 1994; 17 (2).
 24. Weaver, A.J. and Flannelly, K.J. The role of religion/spirituality for cancer patients and their caregivers. *South Med J*. 2004; 97 (12):1210-1214.
 25. Kalnins, I. Caring for the terminally ill: experiences of Latvian family caregivers. *International Nursing Review* 2006; 553, 19-135.
 26. Seymour, J., Ingleton, C., Payne, S. and Beddow, V. Specialist palliative care: patients' experiences. *Journal of Advanced Nursing*. 2003; 44 (1) 24-33.
 27. Erickson, E. and Lauri, S. Information and emotional support for cancer patient,s relatives. 2000; *Eur Journal of Cancer Care*. 4: 118-121.
 28. Gall, T. L. and Cornblat, M.W. Breast cancer survivors give voice. A Qualitative analysis of spiritual factors in long-term adjustment.2002. *Psycho-oncology*. 11:523-535.
 29. Meraviglia, M. Effects of spirituality on Breast cancer survivors. 2007. *Oncology Nursing Forum*. 33 (1) E1-E7.
 30. Mweemba, P. 2008. Quality of life among rural and urban Zambian men and women with HIV and AIDS. Personal communication.

CASE REPORT

Orbital Foreign Body, A Case Report

*M.K.I. Muma, Z. Sultanova, G. Chipalo-Mutati

*Eye Unit, Department of Surgery, University Teaching Hospital, P/Bag RW 1X,
Lusaka, Zambia*

ABSTRACT

Penetrating injury to the orbit is a common presentation to the ophthalmology outpatient section. An orbital foreign body may be overlooked because a small penetrating wound may be accompanied by minimal or no signs of inflammation early in the clinical course. A good history accompanied by Computer Tomography Scan (CT Scan) and/or Magnetic Resonance Imaging (MRI) plays a major role in the localization of such foreign bodies. We would like to report the case of an unusual intra-orbital foreign body. Its presence was not suspected on initial clinical examination and it was not visualized and could not be detected on CT Scan.

CASE REPORT

A 31-year old business man presented as a referral to the eye clinic from Luangwa District Hospital for a foreign body (FBs) on the Left Eye (LE) and with multiple body injuries. Some of the FBs in form of sticks were removed by referring officer from Luangwa. The patient presented in July 2009.

The patient was involved in Road Traffic Accident in the month of July 2009 and had History of loss of consciousness. He was seen at casualty by the doctor on call who removed a stick from the Left Eye (LE) and admitted the patient to the surgical ward for treatment for orbital cellulitis and multiple body injuries. He was put on Intravenous (IV) crystalline penicillin 2 mega units four times per day and

paracetamol 1gm three times per day. A week later the ophthalmologists were consulted as patient developed persistent fever. At this time the patient had developed headache associated with pain, discharge and poor vision in the left eye.

On examination patient had visual acuity (VA): - RE, 6/6 LE, No Perception of Light (NPL). He was febrile (39.0°C) with cellulitis of the eyelids, reduced extraocular motility in all positions of gaze, but there was no bruit. The LE was proptosed, conjunctiva chemosed and a healed linear scar was noted on the left upper eyelid. The Cornea was clear and anterior chamber normal. The left pupil was dilated with sluggish reaction to light. No abnormality was seen on fundus examination.

At this point an impression of orbital cellulitis to rule out orbital tumour was maintained. CT Scan was requested. Treatment was modified from crystalline penicillin 2 mega units to intravenous cefotaxim 1gm three times per day. Tetracycline Eye Ointment was prescribed for the LE to prevent corneal dryness and complications of exposure keratopathy.

14 days later the patient still had severe headache and temperature was still spiking (an average of 39.8°C). Chloramphenicol 1 gm IV QID was added. In the LUL it was noted that a fistula had formed from where pus was discharging. A pus swab for microbiology isolated staph. aureus sensitive to cefotaxim.

Treatment with cefotaxim was maintained, however, pus discharge still persisted. A decision was made to perform an Incision and Drainage and about 20 mls of pus drained.

*Corresponding Author

M K Muma
Eye Unit, Department of Surgery, University Teaching
Hospital, P/Bag RW 1X,
E-mail: mkmuma@yahoo.com

On the CT Scan, the radiologist report read a Tumour in the Left orbit irregular in shape and measuring 4cm X 5cm and sinuses were free of tumour with no bone involvement. A differential diagnosis of pseudotumour or abscess to rule out malignancy was suggested. Biopsy of the mass was recommended.

Therefore an exploratory anterior orbitotomy through the superior orbital fissure approach was performed under GA. There was foul smelling dark pus and deep to orbital septum was a pocket of burnt charcoal sticks shown below.

After the operation VA LE improved to 6/24 from NPL, proptosis reduced, ptosis reduced, pupil reaction became normal and fever was no more. Presently the eye is normal with VA LE 6/9 and no proptosis.

Critique

- The clerking and Examination in both the casualty and ophthalmology unit was very casual and deficient.
- CT Scan took so long to be done because the machine was out of order and was misleading because information given to radiologists was inaccurate.
- There is need for timely interunit and interdepartmental clinical meetings to discuss complicated cases.



DISCUSSION

The presence of a foreign body although recorded in the referral note was overlooked at the casualty and was not suspected initially due to inadequate history and paucity of clinical findings. An object that penetrates through the orbit may leave only a small entry wound.¹ These patients may have normal vision, a normal neurological examination and normal plain radiographs, despite trauma that may lead to significant Complications.²

A CT Scan of the orbit performed when the fistula formed showed the presence and exact location of the foreign body although this was reported as tumour. This could be attributed to the misleading information that was given to the radiologists. Therefore it is important to note that it is important to give a detailed history to the radiologists so that as they are reporting they are as accurate as possible. The plain radiographs taken did not show any radio-opaque foreign body. This shows that X – rays have no role in certain type of foreign bodies such as wood and plastics. Again history taking plays a key role in this aspect as if it is well taken one can tell what type of foreign body to suspect. CT Scan is the most recommended for most of the ocular foreign bodies and MRI gives a better alternative except for magnetic sensitive type of foreign bodies. Non-visualization of a foreign body on US may be because the foreign body is isoechoic to orbital fat or because of other factors such as a smooth surface or a posterior location in the orbit.

The incidence of intra-orbital foreign bodies in orbital trauma was found to be 2.9% in a series of 677 patients as reported by Barkowski et al.³ Intra-orbital foreign bodies usually result from occupational accidents, gunshot injuries and road traffic accidents. Self inflicted injuries have also been reported.⁴ Most of the foreign bodies are metallic, wooden particles or glass pieces.

Accurate localization of foreign bodies in the region of the orbit is vital for correct management.⁵ CT Scan or MRI are the investigation of choice. Both axial and direct coronal views are preferred with 3mm sections proving sufficient for most orbital injuries.⁶ In an age when plastics are used in most day to day objects and are largely replacing metal and glass, it must be remembered that plastic is not particularly radio-opaque and can be missed on plain radiographs. The superior sensitivity of CT for detecting small variations in X-ray absorption allows easy and accurate detection of such foreign bodies.

REFERENCES

1. Bullock JD, Warwwar RE, Bastley GB, Waller RR, Henderson JW. Unusual orbital foreign bodies. *Ophthal Plast Constr Surg* 1999; 15: 44-51.
2. Wesley RE Anderson SR, Weiss PIR, Smith HP. Management of orbital cranial trauma. *Adv. Ophthal Plastic Reconstruct. Surgery* 1987; 7: 3-26.
3. Barkowski S, Kurek, M, Stypulkdisa, J. Krystkova KM and Zapala, J. Foreign bodies in the orbit Review of 20 cases. *Journal of Maxillo-facial surgery* 1984;12: 97-102.
4. Green KA, Dickman CA, Smith KA, Kinder EJ, Zabramski, JM. Self-inflicted orbital and intracranial injury with a retained foreign body, associated with psychotic depression: case report and review. *Surg Neurol* Dec1993; 40: 499-503.
5. Etherington R.J. Houriham M.D. Localistaion of intraocular and intraorbital foreign bodies using computed tomography. *Clinical Radiology* 1989; 40: 610-614.
6. Peter AD Rubin Jurij R Bilyk John Wshore. Management of orbital trauma: Fractures, hemorrhage and traumatic optic neuropathy. *Focal points*. 1994; 12: 1-17.