A 39 year old man with Penile Ulcer and Relationship Strain

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Tuesday, July 23, 2019

BOTSOGO
BOTSWANA ONCOLOGY
GLOBAL OUTREACH

Continuing Medical Education Announcement

Harvard Medical School

RSS 3081: Monthly BOTSOGO Tumor Board; 2019 - 2020 Academic Year

Today's Objectives:

- Describe the need for timely cancer case presentation and referral to treatment
- Formulate a multi-disciplinary plan for the care of common and complex oncologic cases
- Adopt successful, sustainable strategies to mitigate barriers to quality cancer care common in resource constrained environments

Target Audience:

Oncologists, internists, surgeons, radiation oncologists, infectious disease specialists, nurses, physicists, therapists, technicians, research staff, administrators, policy makers.

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Statements

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This activity meets the criteria of the Massachusetts Board of Registration in Medicine for 1.0 credits of Risk Management Study

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Claim your CME credits!

- To claim your CME credit for attendance at this session of the BOTSOGO Tumor Board, please fill out our survey following the Tumor Board.
- You can do this at your convenience on your personal or work computer by navigating to www.botsogo.org
  - Click “What We Do”
  - Click “Tumor Board”
  - Click the link under the section “Continuing Education Credits,” and complete and submit the survey
- A link to the survey is also sent to the BOTSOGO Tumor Board email list following each Tumor Board.

Core Principles of Case Review

Clinicians, pathologists, and other other members of the health care team uniformly strive to provide the best possible clinical care.

Despite these efforts, adverse outcomes still occur.

Reflection on, and re-evaluation of, our practices and outcomes are imperative to continuously improve the care we provide to patients.

Core Principles of Case Review

Discussion will focus on medical decision-making and reporting systems.

Discussion is privileged and content should not be discussed outside of this forum.

We seek to create a safe, collaborative, open and respectful atmosphere for discussion, learning, and improvement

CASE: 39 yo M HIV+ with penile ulcer

Social history:

Working for non government organization in Northern Botswana;

Bisexual, of Christian faith;

Holds a degree from North American university and has done postgraduate work in Eastern Africa;

Struggled with sexual identity after high school;

Had girlfriend, and has two kids: 3 yrs and 2 years respectively;

Quit smoking and drinking 3-4 years ago(2015);

Never been on recreational drugs.

Clinical History/Timeline

Tested HIV+ in 2000, started on HAART (Combivir + Neverapine) in 2004.

Current cd4 56: July 2019

Current vl <400: July 2019

Warty penile lesion noted in 2012; presented to a local IDCC (HIV) clinic and BOFWA (sexual and reproductive health) clinic.

Treated at the clinic in Gaborone for the warts.

Clinical History/Timeline -2018-2019

In late 2018, warty penile lesion recurred with rapid growth;

Plan was to circumcise, but was changed by physician.

Biopsy done in early 2019 in Letlhakane; sample taken to NRH lab.

Pathology report,

Prepuce of the Penis; BIOPSY:

- Gross Description:

Two small fragments of tissue measuring 1*0.5cm, white, irregular and firm

Microscopy: Skin covered tissue with ulceration, sheet and cords of pleomorphic anaplastic SCC with hyperchromatic nuclei, showing keratinization of some places

Diagnosis: SCC in situ of the skin(bowel disease) small areas of microinvasion (May 2019)

Partial Penectomy specimen

Penile specimen:

Gross description: penile tissue measuring 7*4.5*4 cm with fungating grey white masses to the foreskin, extending into the penile skin and distorting the head of the penis

Tumor gross section 1-2,1-3,1-4,1-5,1-6,1-7

Microscopy: section shows keratinization well differentiated, infiltrating SCC with marked koilocytic change in the skin epethelial. All surgical margins are clear.

Diagnosis: Invasive SCC, Grade One with free margins

Imaging /Timeline 2019

Imaging: Abdominal, testes, scrotum-done May 2019 with normal findings

Seen in July 2019 at Oncology-stable patient, with good performance status.

Staging-T1NxMx

- Tiny inguinal nodes, felt on palpation, MRI ordered (MRI not yet performed as of today's tumor board)

Plan: If nodes + for lymph nodes dissection, then for oncology review.

If nodes are neg, then for routine oncology routine visits.

Urology/Consultation: First visit, May 2019

Urology clinic

- Seen by the Urologist & Psychiatric nurse.
- Urologist explained penectomy as the only available option for the patient.
- Patient read on internet about other alternative cancer treatment remedies, e.g. marijuana oil.

Urology /Consultation: first visit (continuation)

Patient left the consultation room, was depressed, felt no need to live.

Was not given an alternative to explore other treatment options.

Was told the tumor will grow and he risks dying;

Went back in the consultation room and agreed to go with penectomy.

Urology clinic second visit: May 2019

Pre Op preparation: came to sign the consent form for penectomy.

Still feeling devastated, and depressed

His treatment options still not considered

Surgery/Timeline

- May 2019: Had fractured his leg and was admitted at orthopaedic ward; discharged in few days.
- Went to ask the Police if he can use marijuana as treatment option for cancer, but was told he is doing it at his own risk.
- Mid-May 2019: Admitted at surgical ward for penectomy.
- Mid-May 2019: Was seen by Psychology for counselling after self seeking of their intervention.
- Late May 2019: Partial Penectomy done.
- After penectomy, during admission at surgical ward, pt was seen by Palliative physician and nurse.

Clinical Psychology/Timeline 2019

Pre-Operative assessment

Presenting problem

- Pt was scheduled to undergo surgery;
- Referred a day before surgery;
- Only one session was held.

Assessment

Patient was in distress due to the following issues:

- New diagnosis;
- Uncertanties post-surgery;
- Concerns with sexual satisfaction

Adjustment to the diagnosis

1. Psycho-education focusing on the diagnosis and prognosis including treatment;
2. Coping mechanisms

Topics covered:

- Open communication;
- Explore negative and positives;
- Explored ways he coped with the HIV diagnosis;
- Explored challenges with negative thoughts;
- Stress management

Psychological implication Post surgery

Diagnosis

Grief

Adjustment

Depression

Clinical Psychology-Recommendations

Timely referrals to allow for patients to be able to better cope with illness;

Medical Counselling.

Family challenges/Timeline

June 2019:

- Disclosed to the girlfriend but not family
- Girlfriend saw the operation and decided to abandon him immediately.
- Currently depressed, suicidal, feeling worthless, and isolated from people.
- Got a phone call from the palliative nurse during the trying times.

Key questions

- What is the typical pathway of Counselling pre- and post-penectomy?
- Need to explain other treatment options that patients might be aware of.
- The need to listen to patient and give them time to make their own decisions.
- Need for Multi-disciplinary Urology clinic in PMH.
- Need to have Psychology at the initial stage of diagnosis.

Challenges

1. No Urology multi-disciplinary intervention:
   Psychology involved late;
   Limited time for the patient to explain treatment options they are aware of.

2. Need to listen to the patient despite their knowledge levels.