"QUALITATIVE STUDY TO ASSESS THE QUALITY OF LIFE AND SOCIAL IMPLICATIONS AMONG CANCER PATIENTS AFTER HEMI-MANDIBULECTOMY"

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I hereby declare that this dissertation entitled "**Qualitative study to assess the Quality of life and Social implications among cancer patient after Hemi-mandibulectomy**" is a bonified and genuine research work carried out by me under the guidance of **Dr. G. Vijayalakshmi,** Professor and Principal of Sri Devaraj Urs College of Nursing, Tamaka, Kolar.

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ABSTRACT

Title: Qualitative study to assess the Quality of Life and social implications among cancer patient after Hemi-mandibulectomy.

Background: Cancer and its treatment profoundly affect multiple dimensions of an individual's life, including physical, psychological, and social well-being. Among oral cancer patients, those who undergo hemi-mandibulectomy experience not only the physical consequences of surgery but also facial disfigurement, speech difficulties, and impaired mastication and deep psychological and social challenges. The alteration in facial appearance often leads to reduced self-esteem, social withdrawal, stigmatization, reduced interpersonal relationships and community participation. Hence the present study was undertaken with as aim to assess the QOL and social implication among cancer patients after Hemi-mandibulectomy.

Methodology: Using descriptive research design, through purposive sampling technique, 30 cancer patient who underwent Hemi-mandibulectomy and coming to OPDs for follow up were assessed through interview method, data collected was analyzed using descriptive and inferential statistics for QOL and social implication using EORTC QOL-C30 and shame and stigma tool tools.

Results: The results revealed that, 67% of cancer patients had a good quality of life, 30% had a very good quality of life, and 3% had a poor quality of life. With regard to social implications, 36% of them experienced mild, 30% moderate, and 17% severe levels of social implications, indicating varying degrees of psychological and social adjustment after surgery.

Conclusion: The study concludes that most cancer patients after hemi-mandibulectomy maintain a good quality of life despite experiencing moderate social and emotional challenges. The study concluded that there is a need to strengthen the counselling services and social reintegration programs after hemi-mandibulectomy among cancer patients.

Key Words: Quality of Life, Social implication, Shame and stigma, Cancer patient, Hemi-mandibulectomy.

LIST OF ABREVATIONS

Sl no	Abbreviation	Expansion
1	QOL	Quality Of Life
2	HRQoL	Health Related Quality of Life
3	AYA	Adolescents and young adults
4	EORTC	European organisation for research and treatment of cancer
5	SSS	Shame and stigma scale
6	BPL	Below poverty level
7	SD	Standard Deviation
8	F	Frequency

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CHAPTER 1

INTRODUCTION

Head and neck cancers represent a significant global health burden, with oral cancer being one of the most common subtypes. Treatment for oral cancers often requires aggressive surgical interventions, such as hemi-mandibulectomy, which involves the partial or complete removal of one side of the mandible (lower jaw). This procedure is critical for disease control and prolonging survival. It frequently results in complex and life-altering consequences for patients, affecting not only physical functioning but also emotional, psychological, and social well-being.[1,2]

Hemi-mandibulectomy, particularly when not followed by adequate reconstructive surgery, may lead to visible facial disfigurement, functional impairments in speech and mastication, and challenges in daily social interactions. These changes often result in a significant decline in quality of life.[3,4] Patients may experience emotional distress, loss of self-esteem, social withdrawal, and altered body image.[5,6] For many, the ability to communicate effectively, eat normally, or appear in public without fear of judgment or stigma becomes compromised.[7]

Traditional medical assessments focus primarily on clinical outcomes such as tumour control, recurrence, and survival rates. However, these measures do not fully encompass the patient's subjective experience of living post-surgery, nor do they address how the procedure impacts their daily life, relationships, employment, and mental health.[3,6] It is therefore essential to explore the broader and more personal dimensions of health, as defined by the World Health Organization (WHO), which includes physical, mental, and social well-being but not merely the absence of disease and infinity.[4]

Given the complexity of these experiences, a qualitative research approach is particularly suited to capturing the depth and diversity of patient narratives. It allows

researchers to engage directly with patients' stories, uncovering insights that are often overlooked by quantitative methods.[8] Through open-ended interviews and thematic analysis, researchers can identify recurring patterns, emotional responses, and coping strategies that paint a more holistic picture of what it means to live after a hemi-mandibulectomy.[1,7]

Furthermore, understanding the social implications of such surgeries is crucial. In many cultures, the face is closely tied to identity, dignity, and social interaction. Disfigurement may lead to social stigma, discrimination, or exclusion, further compounding the psychological burden faced by patients.[6,9] Social support systems in both formal (e.g., counselling, rehabilitation) and informal (e.g., family, friends, peer groups) play a vital role in recovery and adjustment, but access to such resources is often uneven, especially in low-resource settings.[5,8]

This study, therefore, aims to delve into the lived experiences of patients who have undergone hemi-mandibulectomy, focusing on their quality of life and the social ramifications of their condition. By giving voice to these individuals, the research seeks to inform clinicians, policymakers, and caregivers about the real-world challenges faced by patients and to highlight areas where supportive care and rehabilitation services can be improved.

NEED FOR THE STUDY

Globally, head and neck cancers account for nearly 900,000 new cases and over 400,000 deaths annually, making them a major public health concern.[10] Among these, cancers of the oral cavity contribute significantly, particularly in regions with high tobacco and betel quid use.[11]

India alone bears a substantial burden, with over 135,000 new oral cancer cases each year, representing one-third of the global incidence. Within surgical management, hemi-mandibulectomy (removal of one side of the mandible) is a common procedure performed for advanced oral cancers, especially those involving the lower alveolus, buccal mucosa, and tongue. It is estimated that nearly 30 to 40% of oral cancer patients in India require mandibular resections as part of their treatment.[12]

In Karnataka, cancers of the oral cavity remain one of the leading contributors to the state's cancer burden, particularly among men. According to the Population-Based Cancer Registry (PBCR), Bengaluru, oral cancers consistently rank among the top three malignancies reported in the state (National Centre for Disease Informatics and Research [NCDIR], ICMR 2020). With an annual cancer incidence of nearly 86,000 new cases statewide, a significant proportion of those with advanced lesions of the lower alveolus, buccal mucosa, and tongue require surgical management involving the mandible (Kidwai Memorial Institute of Oncology, 2024). Clinical audits and hospital records from major oncology centres such as Kidwai, Bengaluru, indicate that mandibular resections (segmental and hemi-mandibulectomy) are performed in thousands of patients each year as part of curative treatment for advanced oral cancers (Kidwai Annual Report, 2022).[13] While precise state-wide census data specific to hemi-mandibulectomy is not yet published, available institutional studies suggest that 20–30% of surgically treated oral cancer patients in India undergo procedures involving partial or hemi-mandibular resection.[14,15]This underscores the

significant clinical and rehabilitative demand for such patients, particularly in relation to speech, mastication, and quality-of-life outcomes.

Head and neck cancers, particularly oral cancers, are prevalent worldwide, especially in regions with high tobacco and alcohol consumption. Surgical management, including hemi-mandibulectomy, remains a cornerstone for treating advanced mandibular malignancies. Although the procedure can be life-saving, it often results in significant physical deformities, functional limitations, and psychosocial distress, all of which severely affect the quality of life (QoL) of survivors.[1,4]

Patients undergoing hemi-mandibulectomy often experience challenges such as difficulty in chewing, speaking, swallowing, and maintaining facial aesthetics, which further leads to social isolation, low self-esteem, depression, and stigma.[6,7] While several studies have evaluated the clinical outcomes and functional rehabilitation of patients post-surgery, there is a lack of in-depth qualitative research exploring how these individuals perceive and navigate their altered lives following the operation.[9,5]

Most available literature relies on quantitative tools like QoL scales, which may not adequately capture the emotional and social challenges that patients face. A qualitative approach is essential to explore these lived experiences, including how patients cope with body image disturbances, rebuild their identity, and adjust to new social dynamics.[3,16]

Moreover, understanding these subjective experiences can inform patient-centred care, psychosocial support interventions, and rehabilitation services, ultimately helping clinicians and caregivers to better address the holistic needs of these patients [(8)]. This study is especially important in resource-limited settings, where access to reconstructive surgery, counselling, and long-term rehabilitation may be limited, increasing the burden on patients to adjust without adequate support.[2]

Thus, there is a critical need to explore the quality of life and social implications among cancer patients after hemi-mandibulectomy, which can guide future policies and practices in comprehensive cancer care.

CHAPTER 2
OBJECTIVES

This chapter deals with the statement of the problem, objectives of the study operational definitions, assumptions, hypothesis, conceptual framework which provides a frame of reference for the study.

STATEMENT OF THE PROBLEM

Qualitative study to assess the quality of life and social implications among cancer patient after Hemi-Mandibulectomy.

OBJECTIVE OF THE STUDY

1. To assess quality of life among cancer patients after hemi-mandibulectomy by using quality of life questionnaire developed by EORTC QLQ-C30.

2.To assess the social implication among cancer patient by using Shame and stigma tool developed by Kissane et al.

OPERATIONAL DEFINITIONS

1. **Quality of life:** In this study it refers to cancer patients overall well-being, including physical health, psychological state, level of independence, social relationships, and personal beliefs after receiving hemi-mandibulectomy.
2. **Social implication:** in this study it refers to the concern patients perceived positive and negative consequences on individual relationship in the community it is measured with shame and stigma tool.

3. **Cancer Patient:** In this Study it refers to the patient who have undergone Hemi-mandibulectomy and coming for follow up to Oncology OPD.
4. **Hemi-Mandibulectomy:** In this study it would refer to the patient who underwent head and neck surgery.
5. **Shame and stigma:** In this study it refers to a standardized tools given by Kissane et.al using for assessing the social implication.

Assumption:

1.Cancer patient with hemi mandibulectomy may be having low quality of life.

2.Cancer patient with hemi mandibulectomy may be suffering with some type of shame and stigma.

THEORITICAL FRAMEWORK

Theoretical Framework is the structure that support a research study and describes the theory that explains why the researcher problem under the study exist.[17]

The present study is descriptive in nature and assesses the Quality of life and social implication among Cancer patient after Hemi-mandibulectomy.

The theoretical framework adopted for the study was based on General System theory with input, throughput, output, and feedback as essential components which was first introduced by Ludwig Von Bertalanffy in 1984.[18]

System theory functions as a whole, and the behaviour of each part affects the entire system. In health research, this theory helps to explain how biological, psychological, and social factors interact to influence a patient's overall wellbeing.

Open System

In this study, each cancer patients is considered an open system who interacts with internal and external factors[18] such as health status, employment status, family support and social environmental factors that influencing the Quality of life and Social implication**.**

Input

In this study input includes the cancer patient's Age, gender, education, occupation, marital status, place of residence, type of family, stage of cancer, and type of treatment they were taking.

Throughput/ Process

In this study, it refers to the assessment of Quality of life by using EORTC QLQ-C30 questionnaire and Social Implication by using shame and stigma scale among cancer patients who underwent for hemi-mandibulectomy.

Output

In this study, it refers to the measured scores in terms of Quality of life and social implications.

Feedback

Feedback is the process whereby the output of the system is redirected and throughput if health-related quality of life and social implication is poor. The system input and throughput have to be re-evaluated which is not included in the present study.

Summary

This chapter outlines the introduction, need for the study, problem statement, objectives, assumptions, operational and conceptual framework.

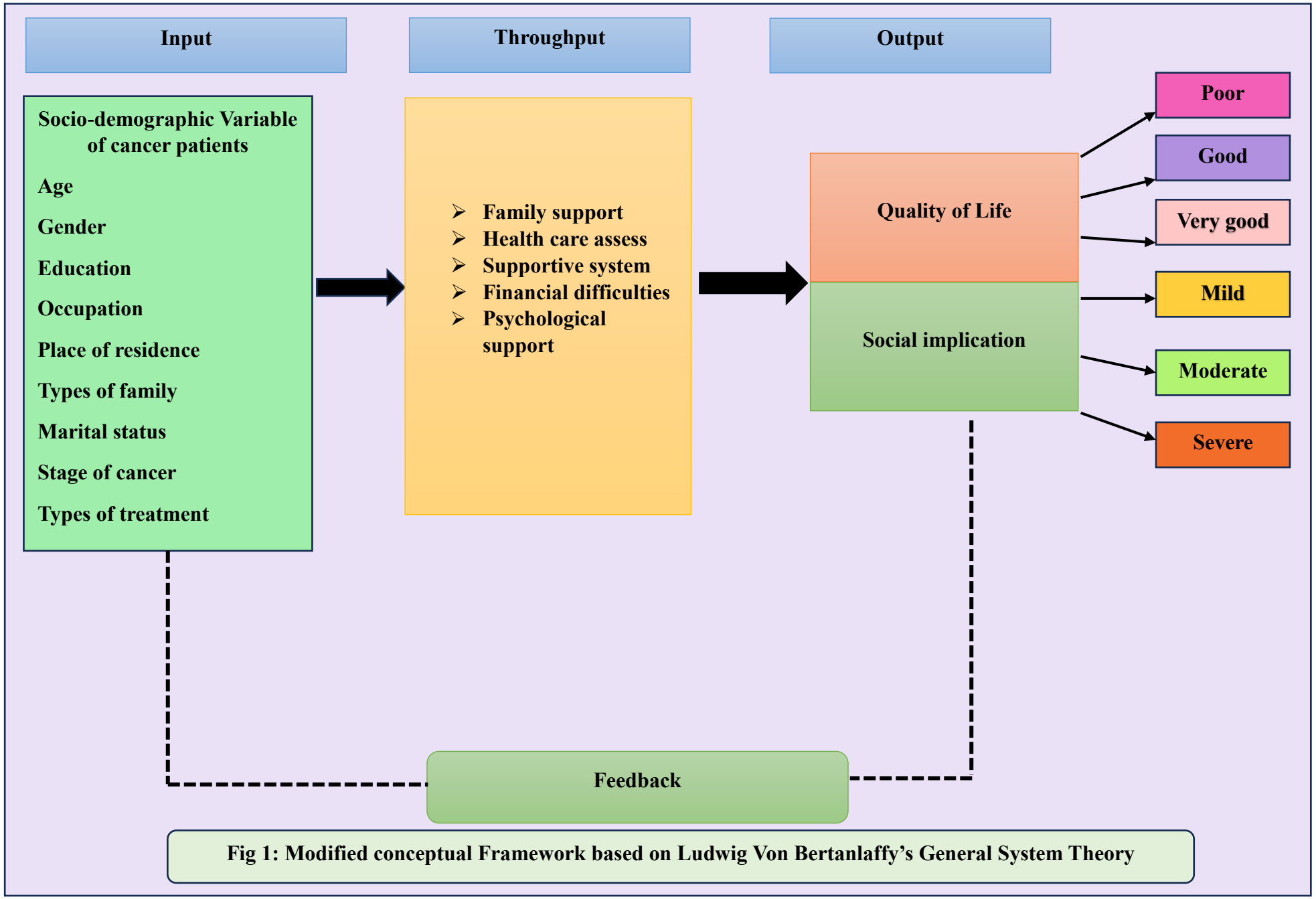

Fig 1: Modified conceptual Framework based on Ludwig Von Bertanlaffy's General System Theory

CHAPTER 3

REVIEW OF LITERATURE

A review of literature is a systematic summary, synthesis, and critical evaluation of existing published or unpublished scholarly works relevant to a specific topic or research problem (Hart and the American Psychological Association). The literature review can serve a number of important functions in the research process and they can play a critical role of nurses seeking to develop evidence-based practice.

The review of literature for present study has been categorized under the following headings:

1. Studies related to Quality of Life among Cancer Patients.
2. Studies related to social implications among Cancer Patients.

1. Studies related to quality of life

A cross-sectional study was conducted to examine the relationship between illness uncertainty, coping strategies, and quality of life among prostate cancer patients at North Carolina. A total of 263 prostate cancer patients were recruited through a randomized clinical trial. The findings revealed that illness uncertainty had a significant negative impact on both physical well-being ($p < .001$) and mental well-being ($p < .05$). Furthermore, illness uncertainty was positively associated with avoidant coping strategies ($p < .001$). Both active and avoidant coping strategies were found to significantly influence mental well-being ($p < .001$). The study concluded that illness uncertainty not only directly affects mental health but also indirectly contributes to poor mental well-being through the use of avoidant coping strategies. These findings underscore the

importance of addressing psychological responses to uncertainty in cancer care, particularly the role of coping mechanisms in shaping patient outcomes[19.]

A cross-sectional study was conducted to examine health-related quality of life (HRQoL) among cancer survivors residing in rural China. Utilizing a sample of 425 cancer patients who were at least eight months post-diagnosis, the study employed the five-level EuroQol-5-Dimension (EQ-5D-5L) questionnaire to assess HRQoL. The .self-care, usual activities, pain/discomfort, and anxiety/depression. The findings revealed that 58.6% of participants reported at least slight levels of pain or discomfort, while 39.2% experienced at least slight anxiety or depression. Several socio-demographic and clinical variables were found to influence HRQoL, including cancer stage at diagnosis, tumour site, the presence of comorbidities, annual household income, and rural-to-urban migrant worker status. Notably, lung cancer survivors reported the lowest HRQoL scores among all cancer types. In contrast, individuals with higher household income and those with rural-to-urban migration status demonstrated better HRQoL outcomes. The study concluded that cancer survivors in rural China generally experience deteriorated HRQoL, with a substantial proportion facing persistent physical and psychological symptoms. These results highlight the urgent need for targeted health interventions and supportive care programs, particularly in underserved rural regions where access to healthcare resources may be limited[20.]

A study was conducted on Systematic review of the health-related quality of life issues facing adolescents and young adults with cancer MEDLINE, EMBASE, CINAHL, PsycINFO and the Cochrane Library Databases were searched for publications reporting Health-related QOL of AYAs. Issues generated from interviews with AYAs or from

responses to patient reported outcome measures adolescents and young adults (PROMs) were extracted. 166 papers were reviewed in full and comprised 72 papers covering 69 primary studies, 49 measurement development or evaluation papers and 45 reviews. The result revealed that Of the 69 studies reviewed, 11 (16%) used interviews to elicit AYAs' descriptions of HRQoL issues. The majority of the PROMs used in the studies represent adaptations of paediatric or adult measures. HRQoL issues were organised into the following categories: physical, cognitive, restricted activities, relationships with others, fertility, emotions, body image and spirituality/outlook on life. The study concludes that The HRQoL issues presented within this review are likely to be informative to health care professionals and AYAs and the impact of a cancer diagnosis and treatment during adolescence and young adulthood is widespread and reflects the complexities of this developmental phase.[21]

A cross sectional study on Demoralisation in oral cancer inpatients and it's association with spiritual needs, quality of life and suicidal ideation was conducted in Taichung veterans General hospital, Taiwan. For this study 155 samples were selected by purposive sampling technique. The result revealed that Only overall quality of life scores <62.5 and spiritual needs <3.7 significantly predicted the occurrence of high demoralization.[22]

A retrospective multicentre study on postoperative sequelae and therapy-related impairments among oral cancer patients was conducted by the German-Austrian-Swiss Cooperative Group on tumours of the Maxillofacial Region. Data from 1,359 patients who underwent surgical treatment for oral squamous cell carcinoma across 43 oral and maxillofacial clinics in Germany, Austria, and Switzerland were analyzed. The study results revealed that physical impairments such as appearance, mouth opening, mandible

mobility, breathing, and shoulder/arm mobility significantly increased with time since surgery. Esthetic appearance showed the highest perception of worsening. Psychological disorders such as depression and poor future outlook increased with time, while fear of tumour recurrence decreased. However, the overall quality of life did not show significant variation across different postoperative periods. Continuous adaptation of supportive therapy was recommended to address the changing needs of oral cancer survivors.[23]

A systematic review on the psychosocial impacts and quality of life among early-onset colorectal cancer patients was conducted following the PRISMA guidelines. The review included 15 observational studies with a total of 18,146 participants, of whom 5,015 were diagnosed with early-onset colorectal cancer. The results revealed that younger patients had significantly poorer quality of life compared with older patients, with three out of four comparative studies showing worse mean QoL scores ($P \leq 0.05$). Secondary outcomes such as sexual dysfunction, body image disturbance, financial strain, career disruption, emotional distress, and social and family issues were more severely affected among early-onset colorectal cancer patients. The review concluded that early-onset colorectal cancer has distinct and more profound psychosocial and quality-of-life impacts, emphasizing the need for targeted supportive interventions for younger adults with colorectal cancer.[24]

A cross-sectional study was conducted to explore the challenges faced by cancer survivors referred for rehabilitation in primary healthcare settings. The study utilized standardized health-related quality of life (HRQOL) measures and patient-reported outcomes (PROs) to assess survivors' concerns. HRQOL was measured using the Functional Assessment of Cancer Therapy-General (FACT-G) scale, which revealed the

lowest scores in functional well-being (14.4) and emotional well-being (16.6), while higher scores were observed in physical well-being (18.9) and social/family well-being (21.1). Responses to open-ended questions indicated that cancer survivors were most concerned about managing everyday life, maintaining normalcy, and the future well-being of their families. The study concluded that cancer survivors experience multidimensional challenges that require a holistic rehabilitation approach, including psychological support, coping strategies, and family-centered care. The findings also emphasized that combining validated HRQOL tools with open-ended PROs provides a more comprehensive understanding of the complex needs of cancer survivors in primary healthcare rehabilitation.[25]

2. Studies related to social implications among Cancer Patients.

A meta-analysis was conducted to evaluate existing studies on shame and stigma among head and neck cancer patients and to identify gaps in current research. The review compiled literature published over the years using a predefined data extraction matrix, focusing on study objectives, sample size, findings, and methodological limitations. The results revealed that shame and stigma are significant psychological domains affecting patients with head and neck cancer, often resulting from facial disfigurement and altered appearance following surgical treatment. These factors contribute to emotional distress, social withdrawal, and a decline in quality of life. However, the review found that this area remains underexplored, with limited validated psychometric tools available for measuring shame and stigma in this population. The study concluded that future research should address these gaps by developing and validating standardized instruments to assess shame and stigma more accurately. It also recommended the use of a

methodological checklist to guide future studies aimed at improving the assessment and management of psychological well-being in head and neck cancer patients.[26]

A cross-sectional study was conducted to examine the interrelationship between stigma, anxiety, and depression among patients with head and neck cancer (HNC). The study recruited inpatients from a medical center and employed standardized assessment tools, including the Shame and Stigma Scale (SSS), the Hamilton Anxiety Rating Scale (HAM-A), the Hamilton Depression Rating Scale (HAM-D), and the Explanatory Model Interview Catalogue (EMIC). The findings revealed that patients experiencing stressors such as worries about health ($t = 5.21$, $p < 0.001$), job ($t = 2.73$, $p = 0.007$), family ($t = 2.25$, $p = 0.026$), and economic issues ($t = 2.09$, $p = 0.038$) had significantly higher stigma scores. The total SSS scores showed a strong positive correlation with both anxiety ($r = 0.509$, $p < 0.001$) and depression ($r = 0.521$, $p < 0.001$), indicating that higher perceived stigma is closely associated with psychological distress. Structural equation modeling demonstrated that stigma directly influenced anxiety ($\beta = 0.51$, $p < 0.001$), which in turn contributed to the development of depression ($\beta = 0.90$, $p < 0.001$). The study concluded that stigma plays a central role in the psychological well-being of HNC patients, acting as a key factor leading to anxiety and depression. It emphasized the importance of early identification and management of stigma-related distress and suggested integrating stigma reduction strategies into the psychosocial care of head and neck cancer patients.[27]

A cross-sectional study was conducted to assess the perceived stigma among cancer patients within the Arabic and Islamic cultural context. The study included 190 Arab Muslim patients with cancer recruited from two government-designated hospitals. Participants were assessed using the Social Impact Scale, which measures four

dimensions of perceived stigma—social rejection, financial insecurity, isolation, and internalized shame. The findings revealed a high overall stigma score (M = 82.36), indicating a substantial level of perceived stigma among participants. Among the dimensions, social rejection was the most prominent (M = 3.69), followed by financial security concerns (M = 3.35), feelings of isolation (M = 3.34), and internalized shame (M = 3.16). The study highlighted that cultural and religious beliefs significantly shape how patients perceive and experience stigma related to cancer. It concluded that within Arab Muslim populations, stigma often manifests through social exclusion and fear of rejection, which can adversely affect psychological well-being and delay help-seeking behaviour. Therefore, culturally sensitive interventions that consider religious and social values are essential to reduce stigma and improve the overall quality of life among cancer patients in this population.[28]

A scoping systematic review was conducted to explore patient experiences of weight stigma within cancer care settings. The review examined studies addressing shame, prejudice, bias, and stigma related to weight in connection with cancer diagnosis, treatment, and survivorship. A systematic search was performed across five databases—PubMed, CINAHL Plus Full Text, Cochrane Library, PsycINFO, and Scopus—covering publications between October 2012 and February 2023. A total of five peer-reviewed studies involving 113 participants met the inclusion criteria. Most of the studies focused on women and cancers predominantly affecting them, such as breast, cervical, and endometrial cancers. The included studies represented all stages of the cancer continuum, encompassing screening, treatment, and post-treatment survivorship phases. Findings revealed that patients frequently experienced weight discrimination and weight-biased stereotypes during cancer care. Four studies reported internalization of weight bias, where patients absorbed societal prejudices, leading to feelings of shame, guilt, and self-blame.

One study also identified implicit weight bias among healthcare providers. The review concluded that although evidence on weight stigma in cancer care is limited, existing research indicates its presence and negative influence on patient experiences and healthcare engagement. It emphasized the urgent need for further research to determine the prevalence, mechanisms, and psychosocial impact of weight stigma in cancer screening, treatment, and survivorship, along with developing interventions to foster weight-inclusive and compassionate oncology care.[29]

A randomized controlled trial was conducted to evaluate the effectiveness of narrative therapy in reducing stigma among oral cancer patients who had undergone major surgical treatment. The study included 100 participants who were randomly divided into two groups: an intervention group that received narrative therapy alongside standard care, and a control group that received only standard care. Multiple standardized questionnaires were used to assess levels of stigma, shame, self-esteem, and social functioning. Data were analyzed using analysis of variance and paired t-tests. The results showed that patients who received narrative therapy experienced a significant reduction in feelings of shame and perceived stigma compared to the control group. Additionally, improvements were observed in self-esteem and social relationships, indicating enhanced psychological adjustment and interpersonal confidence. The study concluded that narrative therapy is an effective psychosocial intervention for mitigating stigma and promoting emotional well-being among oral cancer survivors. These findings highlight the potential of narrative-based approaches in cancer rehabilitation, emphasizing the importance of integrating psychological interventions into routine post-surgical care to improve overall quality of life.[30]

A study was conducted to culturally adapt and validate the Cataldo Cancer Stigma Scale (CCSS) for use among cancer patients in Tanzania. The short version of the CCSS (21 items), along with 12 locally-derived items, was administered to 146 adult cancer patients. Exploratory factor analysis identified a 17-item scale with four distinct subscales: enacted stigma, shame and blame, internalized stigma, and disclosure concerns. Psychometric evaluation demonstrated strong internal consistency and reliability, and the scale showed good convergent validity with measures of depression, anxiety, social support, quality of life, and illness acceptance. Findings indicated that overall cancer-related stigma was low, except for concerns regarding disclosure of the diagnosis. Higher stigma scores were associated with increased depression and anxiety, and with lower social support, quality of life, and illness acceptance. The study concluded that the adapted scale provides a culturally appropriate and reliable measure of cancer stigma in Tanzania, highlighting its potential use in future research to assess stigma's impact on care engagement and to guide interventions aimed at reducing stigma and improving patient outcomes.[31]

A pilot study was conducted in Nigeria to evaluate the feasibility and effectiveness of an empathic communication skills training program aimed at reducing cancer-related stigma among patients. Thirty healthcare providers from University College Hospital, Ibadan, and Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, participated in a 2.25-hour didactic and experiential training session. Surveys completed before and after training demonstrated highly favourable evaluations, with at least 85% of participants rating the training as relevant, novel, clear, and effective. Self-efficacy for empathic communication with patients improved significantly from pre-training (Mean [SD] = 3.93 [0.28]) to post-training (Mean [SD] = 4.55 [0.15]; $t29 = 3.51$, $P < .05$).

Additionally, participants reported increased empathy toward lung cancer survivors, more positive attitudes toward lung cancer care, and reduced tendencies to assign blame to patients. The study concluded that empathic communication training is feasible, well-received, and effective in improving healthcare provider attitudes and behaviours, suggesting its potential to reduce patient experiences of stigma and enhance engagement, treatment satisfaction, and quality of life in oncology settings.[32]

After reviewing literature, the researcher found that the study was done either with Quality of life or social implication but not both the areas and most of the studies were descriptive studies not intervention.

CHAPTER 4

RESEARCH METHODOLOGY

This chapter deals with the research methodology adopted for the study. It includes the research approach, research design, study setting, sample and sampling technique, description of the tool, data collection procedure and plan for data analysis.

Methodology of the research indicates the general patterns of organizing the procedure for empirical study together with the method of obtaining valid and reliable data for problem under investigation.

The present study aimed at assessing the Quality of Life and social implications among cancer patients after receiving Hemi- mandibulectomy.

RESEARCH APPROACH

Research approach is the basic procedure for the research enquiry. The research approach helps the researcher to determine what data to collect and how to analyse it. It also suggests possible conclusion to be drawn from the data (Kothari C.R. 2003). For the present study Quantitative research approach was used.

RESEARCH DESIGN

A research design is an investigators overall plan for obtaining answers to the research questions (Polit and Hungler,1999). For the present study, descriptive research design was used.

SETTING OF THE STUDY

Setting refers to the area where the study was conducted (Burns and Groove 2002). The present study was conducted at R.L Jalappa hospital and research center, Kolar. It is a multi-specialty hospital with 1200 bedded capacity. In this hospital the department of oncology has different OPDs (ENT OPD, surgical oncology OPD, radiation and chemotherapy OPD) and it functions weekly 5 days from Monday to Friday for 7 hours and Saturday for 4 hours. This setting was selected based on the availability of subjects and feasibility of conducting the study.

POPULATION

The population referred as the target population, which represent the entire group or all the elements like individuals or objects that meet certain criteria for inclusion in the study (Burns and Groove, 2002). In the present study, population consist of cancer patient who were underwent Hemi-mandibulectomy and coming for follow up to different oncology OPDs.

SAMPLE AND SAMPLE SIZE

Sample refers to a portion of population which represent the entire population (Burns and Groove, 2002). In this study sample consist of cancer patients who underwent for hemi-mandibulectomy and coming for follow up in RLJH&RC OPDs.

The estimated sample size for this study on quality of life among cancer patients after hemimandibulectomy was calculated using Cochran's formula. The sample size was determined using **Cochran's formula** with finite population correction, which is given by:

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

Where:

n_0= Cochran's standard value= 385

N= Total Population = 40 (Available for follow-up in OPD)

E= Marginal error = 0.05

Substituting the values:

$$n = \frac{385}{1 + \frac{(385 - 1)}{40}}$$

$$n = \frac{385}{1 + 9.6}$$

$$n = \frac{385}{10.6}$$

$$n = 36.32 \approx 36$$

Hence, the estimated sample size = 36.

Considering the feasibility of conducting in-depth qualitative interviews and ensuring adequate data saturation, the final sample size was fixed at 30 participants who underwent hemi-mandibulectomy and reported for regular follow-up at RLJH & RC OPD, selected using purposive sampling technique.

SAMPLING TECHNIQUE

Sampling defines the process of selecting a group of people or other elements to conduct the study (Burns and Groove, 2002). For the present study Purposive sampling technique was used.

CRITERIA FOR SELECTING THE SAMPLE

Inclusion criteria:

Cancer Patient who were:

- Between the age group of 17-60 years
- Coming for regular follow up.
- Able to express their feeling fluently in Kannada language.

Exclusion criteria:

Cancer patient:

- Whose Response was not able to understand.

SELECTION AND DESCRIPTION OF THE TOOL

The following steps were used for selection and description tool

DESCRIPTION OF THE TOOL

Based on the research problem and objectives of the study, the following tool was used.

SECTION-I: Socio-Demographic Variables

This section consist of 9 variables like age, gender, education, occupation, place of residence, marital status, stage of cancer and types of treatment.

SECTION-II: Quality of life questionnaire of EORTC QLQ-C30 (VERSION-3)

This section consists of standardized tool on European Organisation for Research and Treatment of Cancer (EORTC QL-C30) and the tool consist of 9 domains under the following headings:

Table no -1: Distribution of Questions According to the Domains of Quality-of-Life Scale

SL NO.	DOMAIN	QUESTION NO.
1	Physical functioning	3,4,5,6,7
2	Role functioning	8,9
3	Dyspnoea	10
4	Pain,	11,12
5	Insomnia,	13,14,15,16,17,18,19,20,21
6	Cognitive functioning	22,23
7	Emotional functioning	24,25,26,27,
8	Social functioning	28,29,30

SECTION-III: Shame and stigma tool developed by Kissane et al. in 2013.

This tool developed by Kissane et al. in 2013 to assess social implication among cancer patients. This tool consists of 20 items under the following headings:

Table no -2: Distribution of Questions According to the Domains of shame and stigma tool

SL NO.	DOMAIN	ITEMS NUMBER
1	Shame with appearance	1,2,3,4,5,6,7,8
2	Sense of stigma	9,10,11,12,13
3	Regret about life style and disease	14,15,16,17
4	Speech and social concern	18,19,20

TRANSLATION OF THE TOOL

The tool was in English and then it is translated to Kannada language by subject experts and it was retranslated to English by English expert.

ETHICAL CLEARANCE

Before conducting the study, the ethical clearance was obtained from the institutional ethical committee of Sri Devaraj Urs College of Nursing, Tamaka, Kolar which is enclosed.

DATA COLLECTION PROCEDURE

The data was collected from 23-05-2025 to 23-06-2025 under the following steps:

Step-1 (Preparatory phase):

Ethical clearance was obtained from the institutional ethical committee of Sri Devaraj Urs College of Nursing. A formal written permission was obtained from the Medical superintendent of R.L Jalapa hospital and research centre and HOD of oncology departments. Based on the inclusion criteria through purposive sampling technique, 30 cancer patients were selected for the study.

STEP 2 (Intervention phase):

The researcher introduced herself to the participants and explained the purpose of the study than an informed consent was obtained from study participants. First socio demographic variables were assessed followed by quality of life and social implication on social implication was assessed using EORTC QLQ-C30 and shame and stigma tool respectively. To collect data, interview method was used and it took approximately 60 minutes for each patient.

STEP 3 (Closing phase):

Then the researcher thanked each cancer patients who participated in the study.

PLAN FOR DATA ANALYSIS

The data obtained from the cancer patient who underwent Hemi-mandibulectomy was analysed using descriptive and interferential statistics as follows:

1. Socio demographic variables will be analysed using the frequency and percentage.
2. Quality of life will be analysed using frequency, percentage, mean and standard deviation.
3. Social implication on Stigma and Shame will be analysed using frequency, percentage, mean and standard deviation.

SUMMARY:

This chapter deals with the methodology, research approach, research design, setting, population, sample and sampling technique, development and description of the tool and plan for data analysis.

CHAPTER 5

DATA ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of data gathered to assess the Quality of Life and Social Implications among Cancer patient.

The analysis and interpretation of the study are based on the data collected from cancer patients after hemi-mandibulectomy on QOL and social implication.

Objectives:

1. To assess quality of life among cancer patients after hemi-mandibulectomy by using quality of life questionnaire developed by EORTC QLQ-C30.

2.To assess the social implication among cancer patient by using Shame and stigma tool developed by Kissane et al.

Assumption:

1.Cancer patient with Hemi-mandibulectomy may have low quality of life.

2.Cancer patient with Hemi-mandibulectomy may be suffering with some type of shame and stigma.

The collected data is analyzed and presented based on the objectives of the study under following section:

Section-I: Distribution of cancer patients based on their Socio-Demographic variables.

Section-II: Quality of Life among cancer patient after Hemi-mandibulectomy

Section-III: Social Implication among cancer patient after Hemi-mandibulectomy.

SECTION-I

Distribution of Cancer patients based on their Socio-Demographic variables.

This section deals with Socio-Demographic variables of Cancer patient after receiving Hemi-mandibulectomy. Before assessing the Quality Of Life and Social Implication among Cancer patients, they were assessed for their socio-demographic variables and it is presented from table 3 to 11.

Table no-3: Distribution of cancer patient based on their age group.

N=30

Sl. No.	Age in years	Frequency	Percentage
1	20-29	1	3
2	30-39	4	14
3	40-49	7	23
4	50 above	18	6
	Total	**30**	**100**

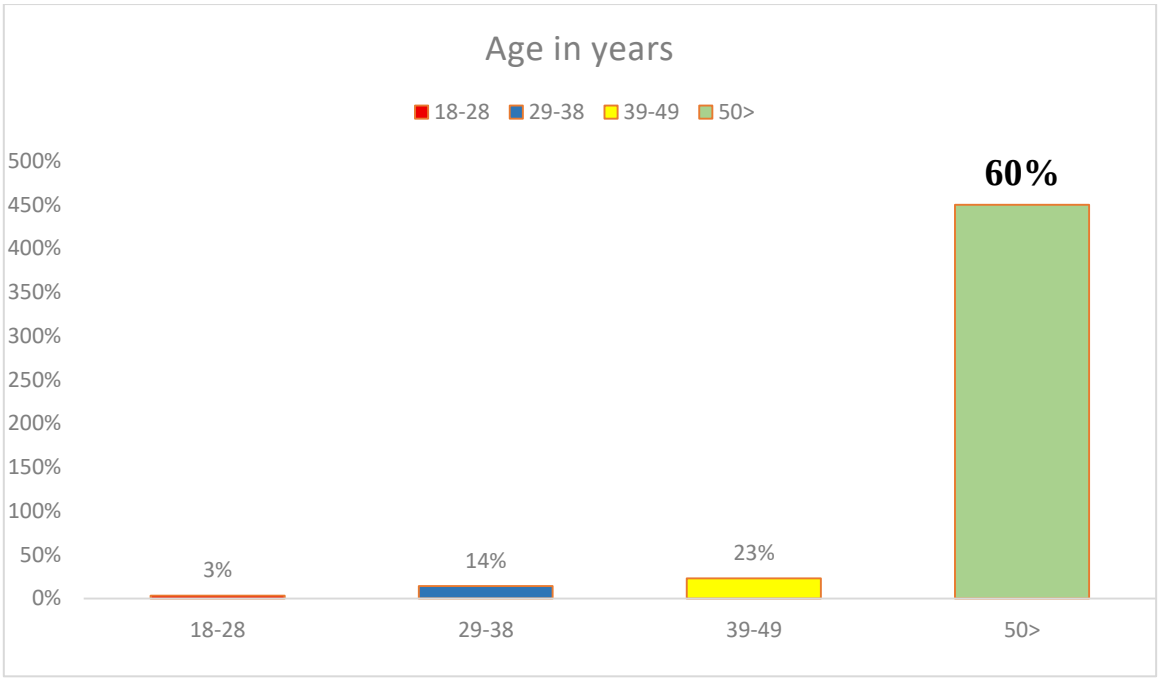

Fig 2: Bar diagram showing distribution of patients based on Age group

The above table and bar diagram shows that, majority (60%) of cancer patients were found to be more than 50 years of age, 23% of them were between 30-49years, 14% of them were between 30-39 years and only 3% were between 20-29 years of age group.

Table -4: Distribution of cancer patient based on their Gender

N=30

Sl No	Gender	Frequency	Percentage
1	Male	14	47
2.	Female	16	53
	Total	**30**	**100**

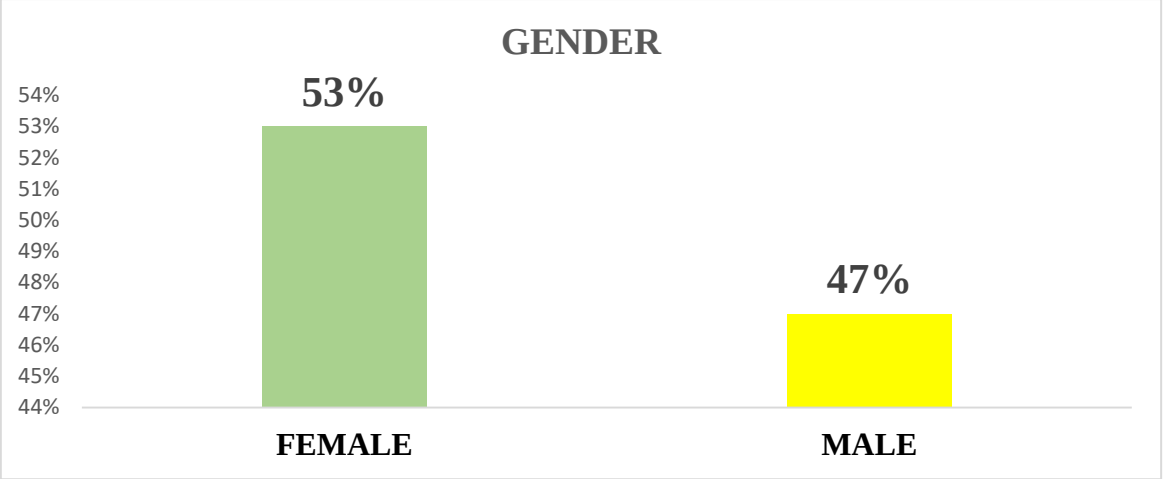

Fig 3: Bar diagram showing distribution of patients based on Gender

The above table and bar diagram shows that, majority (53%) of cancer patients were found to be Female, where as only 47% patients were found to be male.

Table no -5: Distribution of cancer patient based on their Education qualification.

N=30

Sl. No.	Education Qualification	Frequency	Percentage
1	Primary school	4	13
2	Secondary school	2	7
3	Graduate	2	7
4	No formal Education	22	73
	Total	**30**	**100**

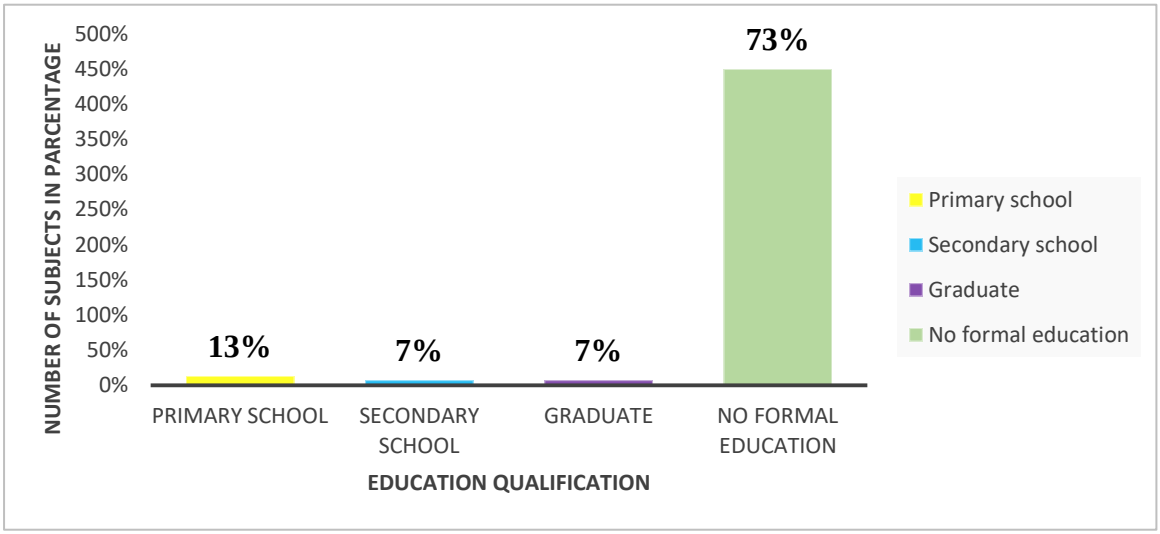

Fig 4: Bar diagram showing distribution of patients based on Education qualification

The above table and bar diagram shows the majority (73%) of patients were not having any education qualification, 7% of patients were graduates, 7% of them were with Secondary schooling and 13% of them were with Primary schooling.

Table no -6: Distribution of Cancer patients Based on their Occupation

N=30

Sl. No.	Occupation	Frequency	Percentage
1	Homemaker	15	50
	Government job	1	3
2	Private job	3	10
3	Labours	11	37
4			
	Total	**30**	**100**

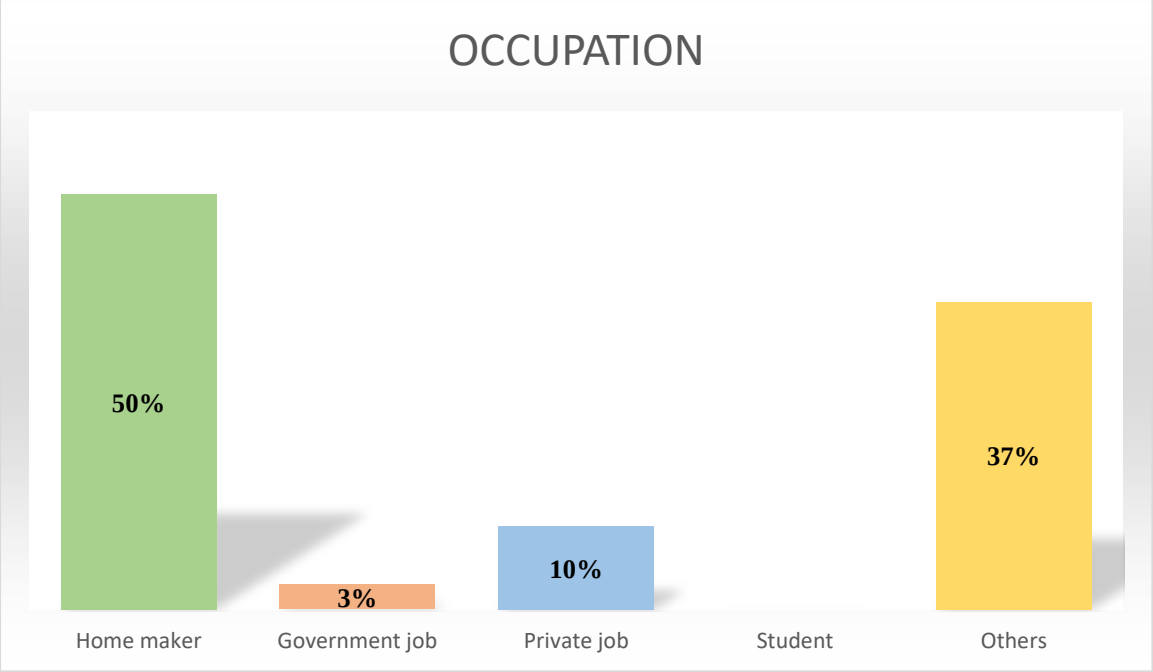

Fig 5: Bar diagram showing distribution of patient based on Occupation

The above table and bar diagram shows that majority (50%) of patients were homemakers, 10% of them were in Private job, 3% of them were in Government job and 37% of them were labourers.

Table no-7: Distribution of Cancer patients Based on their Place of Residence

N=30

Sl. No	Place of Residence	Frequency	Percentage
1	Urban	13	43
2	Rural	17	57
	Total	**30**	**100**

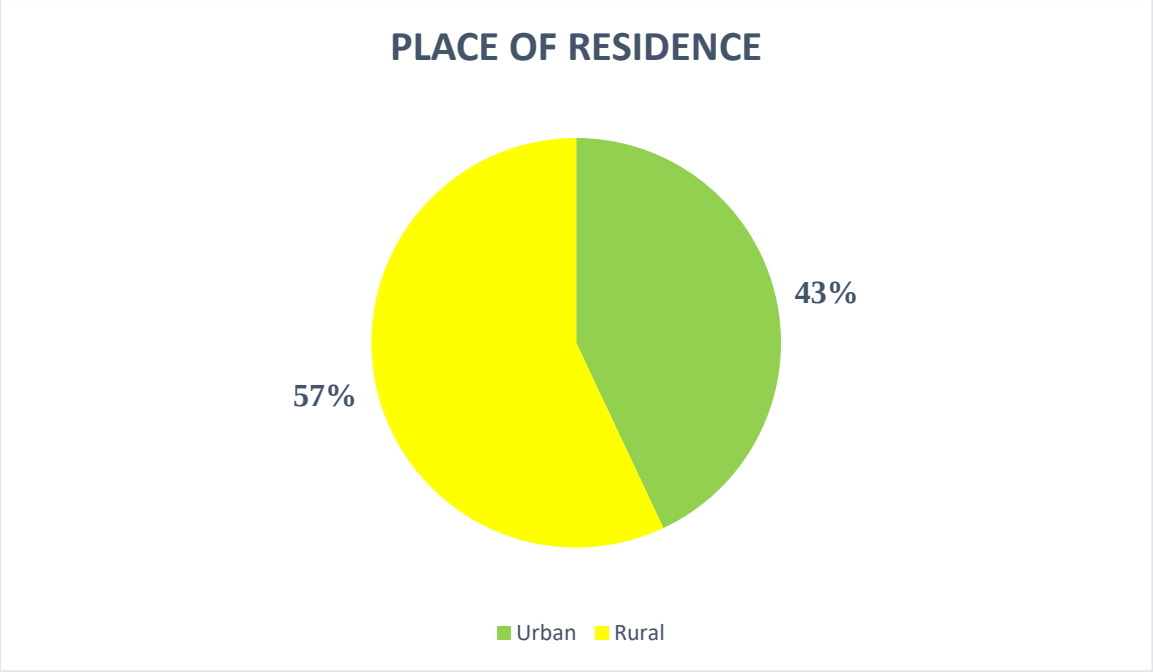

Fig 6: Pie diagram showing distribution of patient based on their Place of Residence

The above table and Pie diagram shows that majority (57%) of patients were residing in Rural area and 43% of them were from Urban area.

Table no-8: Distribution of Cancer patients Based on their Type of Family

N=30

Sl. No.	Types of Family	Frequency	Percentage
1	Nuclear	17	57
2	Joint	13	43
	Total	**30**	**100**

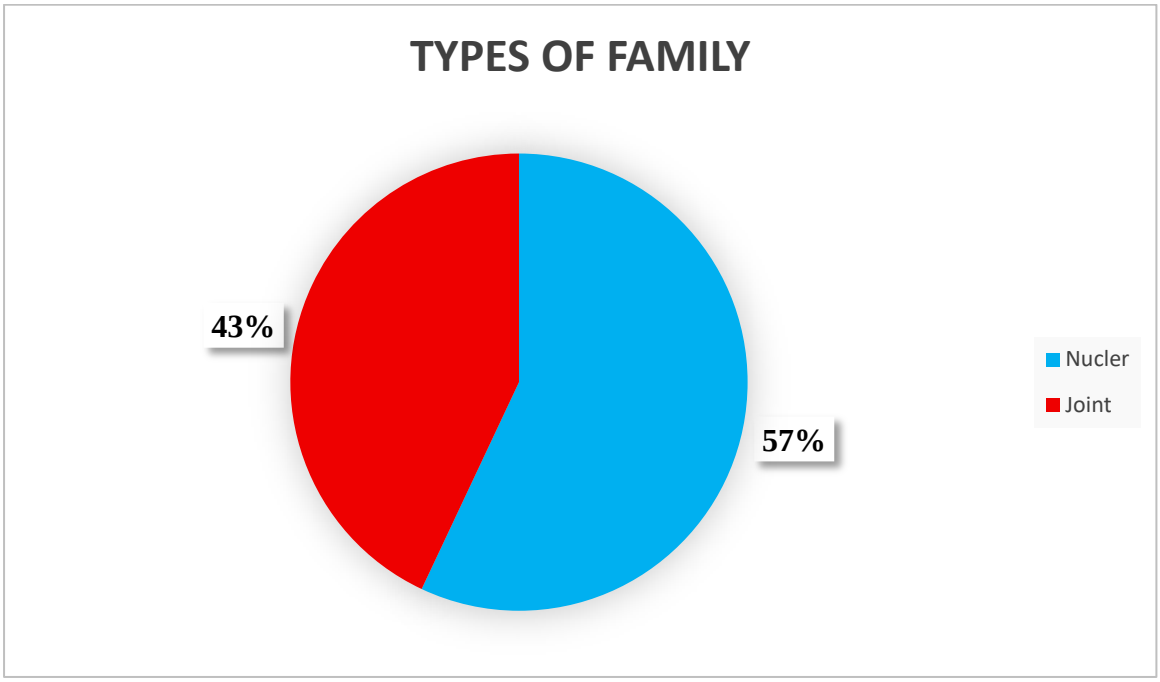

Fig 7: Pie diagram showing distribution of patient based on their type of family

The above table and the Pie diagram shows that majority (57%) of patients are belongs to nuclear family and the 43% of them were belongs to joint family.

Table no-9: Distribution of Cancer patients Based on their Marital Status

N=30

Sl. No	Marital Status	Frequency	Percentage
1	Married	27	90
2	Unmarried	3	10
	Total	**30**	**100%**

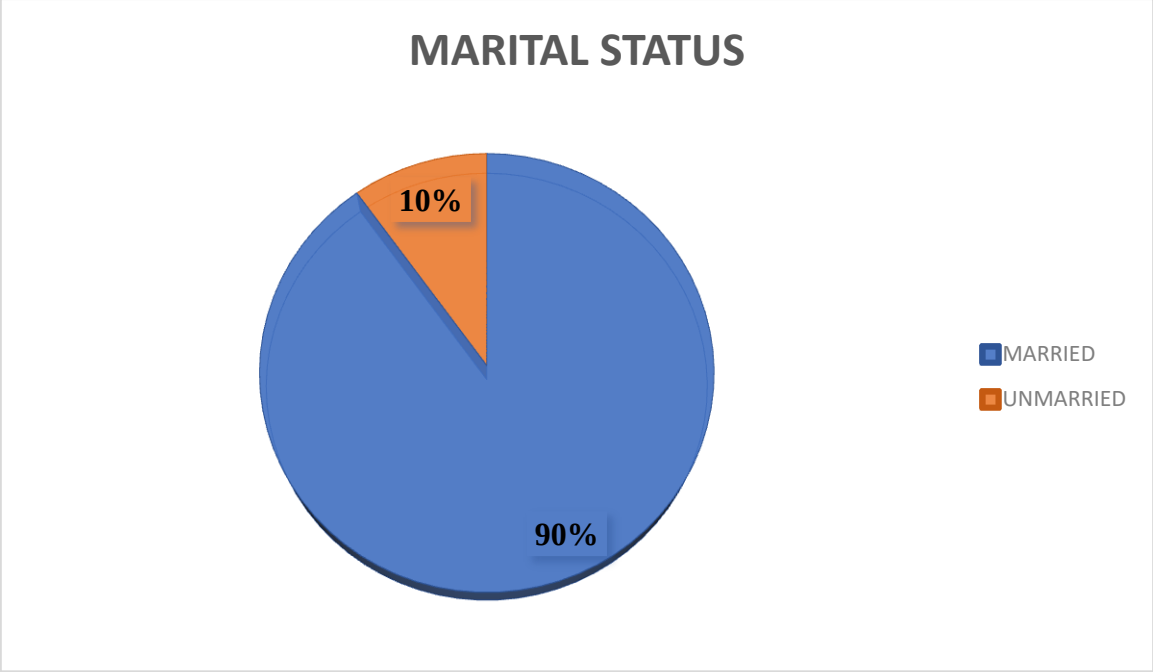

Fig 8: Pie diagram showing distribution of patient based on their Marital Status

The above table and the Pie chart shows that the majority (90%) of patients were married and 10% them were unmarried.

Table no-10: Distribution of Cancer patients Based on their Stages of Cancer

N=30

Sl. No.	Stages of Cancer	Frequency	Percentage
1	First	9	30
2	Second	17	57
3	Third	3	10
4	Fourth	1	3
	Total	**30**	**100**

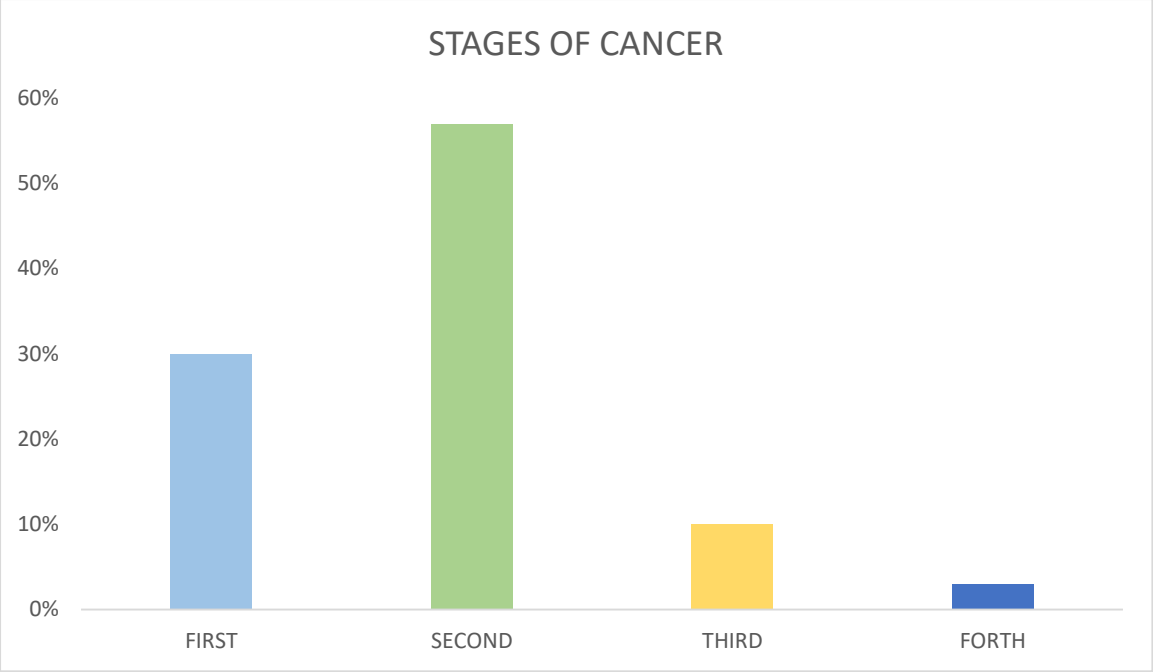

Fig 9: Bar diagram showing distribution of patients based on their Stages of cancer

The above-mentioned table and Bar diagram shows that, the majority (57%) of cancer patients were in second stage of Cancer, 30% were in first stage, 10% of them were in third stage and only 3% of them were in fourth stage of cancer.

Table no -11: Distribution of Cancer patients Based on followed treatment

N=30

Sl. No.	Types of treatment	Frequency	Percentage
1	Radiation therapy	13	43
2	Chemo therapy	6	20
3	Surgery	10	34
4	Dressing	1	3
	Total	**30**	**100**

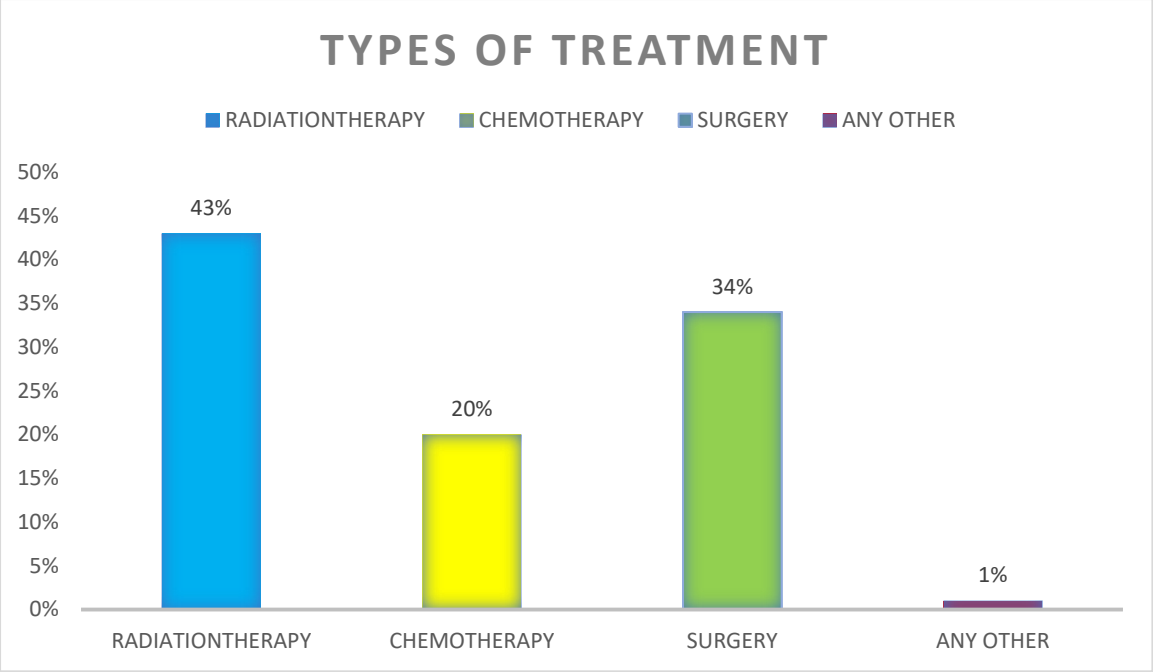

Fig 10: Bar diagram showing distribution of patient based on their types of treatment

The above table and the bar diagrams shows that, the distribution of Cancer patient who underwent Hemi-mandibulectomy and coming to OPD for follow up for their treatment. Majority (43%) of patients were coming for Radiation Therapy, 20% of them were coming for Chemotherapy, 34% of them were coming for surgery related procedure and only 3% of them were coming for dressing.

SECTION-II

Quality of Life among cancer patient after Hemi-mandibulectomy

This section deals with the first objective of the study that is to assess Quality of life among Cancer patient who undergone Hemi-mandibulectomy by using EORCT-QOL-c30 and presented from table no– 12 to17.

Quality of life among Cancer patient were calculated based on below mentioned formula and divided into three groups and presented in table no-12

$$\text{Percentage of QOL} = \frac{\text{Patient total Score}}{\text{Maximum possible score}} \times 100$$

Poor: who scored between 26%-50%

Good: who scored between 51%-75%

Very good: who scored between 76%-100%

Table No-12: Distribution of Cancer patient based on overall Quality of Life

N=30

Quality Of Life	Frequency	Percentage
Poor	01	3
Good	20	67
Very good	09	30
Total	**30**	**100**

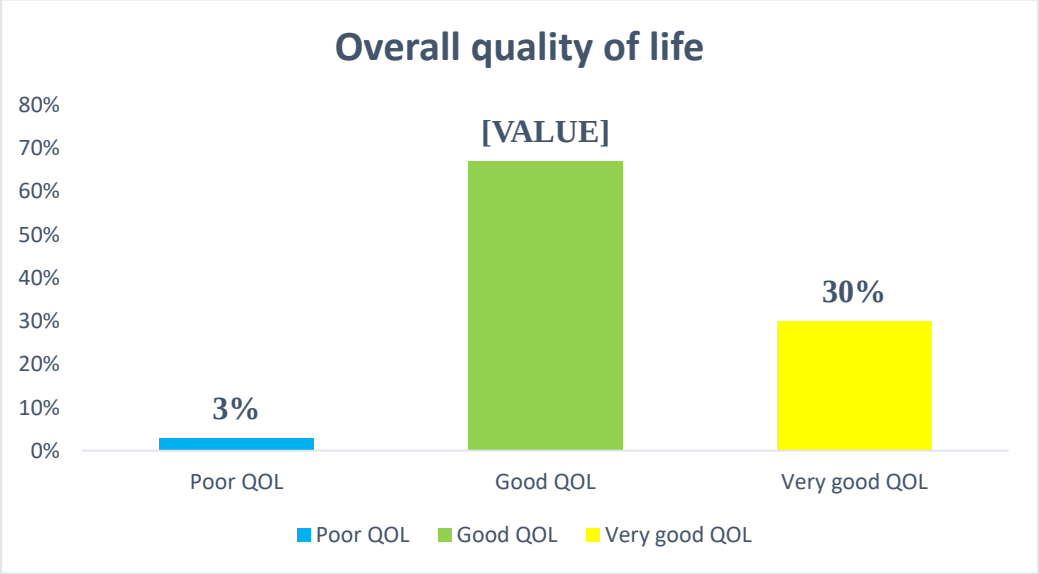

Fig 11: Bar diagram showing the distribution of overall Quality Of Life

The above-mentioned table and the Bar diagram shows that, out of 30 patients majority (67%) were having Good Quality of Life, 30% of them had Very good Quality of Life and 3%) of them had Poor Quality of Life.

Table no-13: Distribution Functional Scale among Cancer patient after Hemi-mandibulectomy

Domain	Poor		Good		Very good	
	Frequency	%	Frequency	%	Frequency	%
Physical Functioning	2	6.6	18	**60**	10	33.4
Role functioning	4	13	20	**67**	6	20
Emotional Functioning	3	10	13	43.4	14	**46.6**
Cognitive Functioning	4	13.4	11	**36.6**	15	50
Social Functioning	11	**37**	10	33	9	30

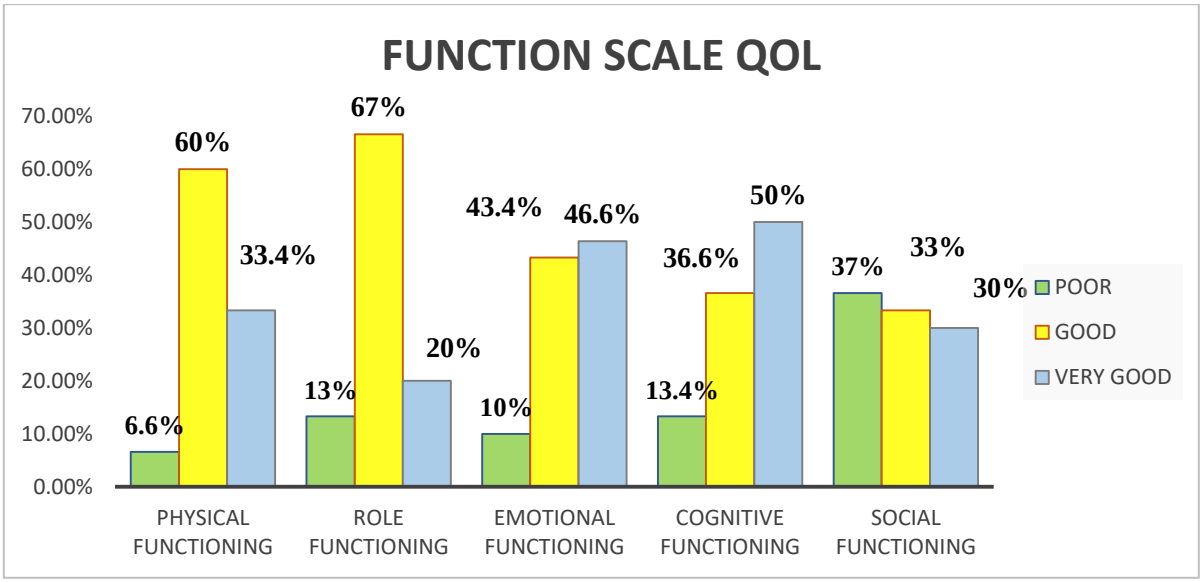

Fig 12: Bar diagram showing the distribution of Function scale Quality Of Life

The above table and bar diagram shows that, the distribution of Functional Scale among Cancer patient after Hemi-mandibulectomy. With regard to Physical Functioning, majority (60%) of patients had a good level, 33.4% of them had very good level and 6.6% of them had poor level of physical functioning. This indicates, most of the patients had well adapted physically functioning after mandibulectomy.

With regard to Role Functioning, majority (67%) of patient had good role functioning, 20% of them had very good and 13% had poor role functioning. This indicates, most of the patients were able to perform their daily roles and responsibilities to the satisfactory level.

With regard to Emotional Functioning, majority (46.6%) of patients had very good, 43.4% of them had good and 10% of them had poor emotional functioning. This indicate that despite surgical disfigurement or speech difficulties, many patients maintain their positive emotional adjustment.

With regard to Cognitive Functioning, 50% of patients had very good cognitive function, 36.6% of them had good, and 13.4% of them had poor cognitive function. This indicates that, after the surgery most of them retained their cognitive abilities like memory and concentration.

with regard to Social Functioning, majority (37%) of the patients had poor social functioning, 33% of them had good, and 30% of them had very good social function. This indicates that social relationships and interactions are significantly affected after surgery due to changes in facial appearance, speech, or stigma associated with the condition.

Description of the symptom Scale:

With regard to symptoms scale, the raw score (RS) of each domain was obtained by calculating the mean of all item responses belonging to that specific domain using the following formula:

$$\text{RS} = \frac{\text{Sum of item scores in the domain}}{\text{Number of items in that domain}}$$

To standardize the domain scores within a uniform range of 0 to 100, the EORTC transformation formula was applied. In the symptom scale the higher score represents a greater severity of symptoms and standardized score (S) was calculated as follows:

$$S = \frac{(RS - 1)}{\text{Range}} \times 100$$

The frequency (f) and percentage (%) of participants in each category were then computed using the following formula:

$$\text{Percentage} = \frac{\text{Frequency of category}}{\text{Total participants}} \times 100$$

Classification of symptoms scale:

All hemi-mandibulectomy patients symptoms scale assessed were divided based on the above-mentioned formula and classified as follows:

Mild: who scored between 0 to 33.3

Moderate: who scored between 33.4 to 66.6

Severe: who scored between 66.7 to 100

Table no-14: Distribution of Symptoms Scale among Cancer patient after Hemi-mandibulectomy

N=30

Domain	Severe		Moderate		Mild	
	Frequency	**%**	**Frequency**	**%**	**Frequency**	**%**
Fatigue	1	3.3	10	33.3	19	**63.4**
Nausea/vomiting	3	10	7	23.4	20	**66.6**
Pain	2	6.6	7	23.4	21	**70**

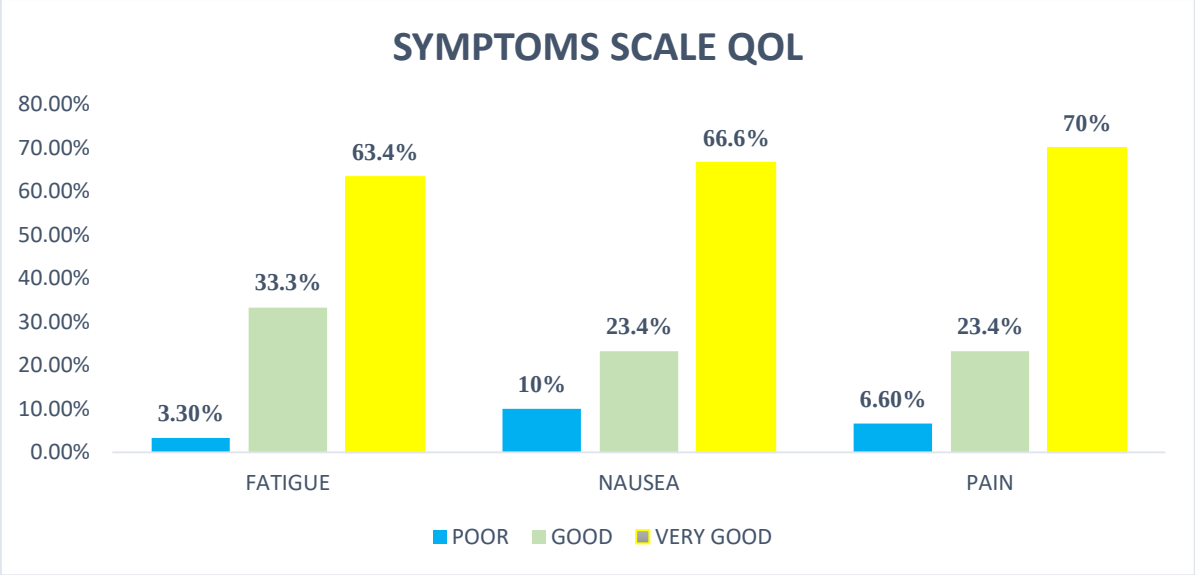

Fig 13: Bar diagram showing the distribution of Symptoms scale Quality of Life

The above table and bar diagram shows that, the distribution of symptom Scale among Cancer patient after Hemi-mandibulectomy. With regard to Fatigue majority (63.4%) of them had mild symptoms, 33.3% of them had moderate and 3.3% of them had severe symptoms.

With regard to Nausea and Vomiting, most (66.6%) of the patients had mild symptoms, 23.4% of them had a moderate and 10% of them had sever symptom of Nausea and vomiting due to chemotherapy or postoperative medication.

With regard to Pain, majority (70%) of patients had mild pain, 6.6% of them had severe pain- and 23.3% of them had moderate level of pain.

Table no-15: Distribution of single Symptoms Scale among Cancer patient after Hemi-mandibulectomy

Domain	Severe		Moderate		Mild	
	Frequency	%	Frequency	%	Frequency	%
Dyspnoea	2	6.6	6	20	22	**73.4**
Insomnia	4	13	6	20	20	**67**
Appetite	1	3	5	17	24	**80**
Constipation	1	3	4	13.6	25	**83.4**
Diarrhoea	0	-	3	10	27	**90**
Financial	4	13	11	37	15	**50**

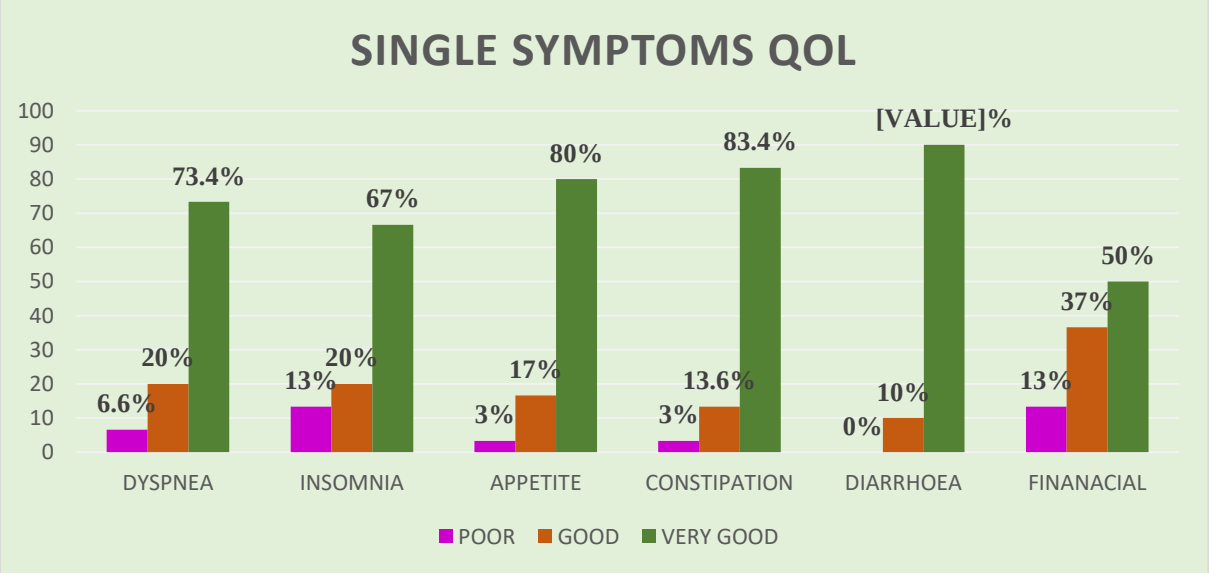

Fig 14: Bar diagram showing the distribution of Single Symptoms scale on QOL

Above mentioned table and Bar diagram shows that, with regard to dyspnoea, 6.6% of patients had severe, 20% of them had moderate and 73.4 of them had mild breathing difficulty.

With regard to insomnia, 13% of them had severe, 20% of them had moderate, and 67% of them had mild level of insomnia, indicating that sleep disturbances were limited among Hemi-mandibulectomy patients.

With regard to loss of Appetite, majority (80%) of them had mild, 17% of them had moderate and 3% of them had severe loss of appetite.

with regard to constipation, majority (83.4%) of them had mild,13.6% of them had moderate and 3% of them had severe constipation.

With regards to diarrhoea, majority (90%) of them had mild, 10% of them had moderate, and none of them had severe diarrhoeal symptoms.

With regard to financial difficulties, majority (50%) of them had mild, 37% of them had moderate and 13% of them had severe financial crisis due to BPL and Ayushman Bharat health scheme.

Description of Global Health:

Quality of Life (QoL) domain of the EORTC QLQ-C30 consists of two items (Questions 29 and 30) of Global Health Status that measure the overall health of patients. In this regard each item is rated in 7-point Likert scale, where 1 indicates Very poor and 7 indicates Excellent and it's calculated as follows:

Calculation of Raw Score (RS)

The raw score is the mean of the two items in the global health domain:

$$\mathrm{RS} = \frac{\text{Sum of item scores for Q29 and Q30}}{2}$$

Standardization of Score

To transform the raw score to a 0–100 scale, the following EORTC linear transformation formula is applied:

$$\mathrm{S} = \frac{(\mathrm{RS} - 1)}{\text{Range}} \times 100$$

Where:

- RS = Raw score
- Range = Difference between the maximum and minimum possible values (for this scale, 7 − 1 = 6)
- S = Standardized (transformed) score ranging from 0 to 100

Thus:

$$S = \frac{(RS-1)}{6} \times 100$$

Based on the transformed scores, all hemi-mandibulectomy patients Global Health assessed were classified as follows and presented in table -13.

Poor: Who scored between 0 to 33.3

Moderate: Who scored between 33.4 to 66.6

Very good: Who scored between 66.7 to 100

Table no-16: Distribution of Global Health among Cancer patient after Hemi-mandibulectomy

N=30

Domain	Poor		Moderate		Very Good	
	Frequency	%	Frequency	%	Frequency	%
Global Health QOL	5	16.6	25	83.4	-	-

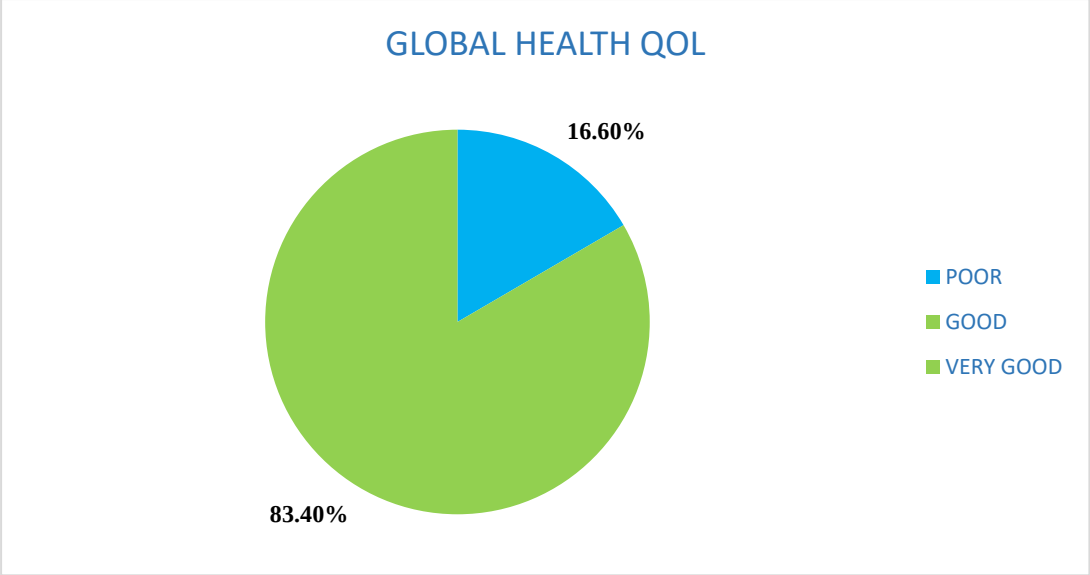

Fig 15: Bar diagram showing the distribution of overall Health Quality of Life

The above-mentioned table and bar diagram shows that, majority (83.4%) of cancer patients had overall good health, 16.6% of them had poor and none of the them had a very good level of global health status.

Table no-17: distribution of domain wise mean score on quality of life among cancer patients

N=30

DOMAINS	MAX SCORE	MEAN	SD
FUNCTIONAL SCALE			
Physical Functioning (Transformed)	93	56.03	20.18
Role Functioning (Transformed)	100	59.10	20.77
Emotional Functioning (Transformed)	91	64.67	21.41
Cognitive Functioning (Transformed)	100	70.27	24.66
Social Functioning (Transformed)	100	54.20	30.62

SYMPTOMS SCALE			
Fatigue (Transformed)	77	28.23	21.74
Nausea/vomiting (Transformed)	100	25.93	31.08
Pain (Transformed)	83	32.97	21.08
SINGLE SYMPTOMS SCALE			
Dyspnoea (Transformed)	100	36.37	28.03
Insomnia (Transformed)	100	28.70	35.65
Appetite loss (Transformed)	100	24.23	28.74
Constipation (Transformed)	100	24.23	27.40
Diarrhoea (Transformed)	66	17.60	22.48
Financial difficulties (Transformed)	100	49.63	29.93
GLOBAL HEALTH QUALITY OF LIFE (Transformed)	**66**	**48.13**	**29.93**

The above table shows that, the mean score on quality of life among Cancer patients after Hemi-mandibulectomy. With regard to functional scale, the highest mean score (70.27) was seen in cognitive domain with an SD of 24.66 and the lowest mean score(54.20) was in social domain with SD of 30.62. With regard to Symptoms scale, the highest mean score(32.97) was in pain domain with SD of 21.08 and the lowest mean score (25.93) was in Nausea/vomiting with SD of 31.08. In single symptoms Scale, the highest mean score (17.60) was in Diarrhoea with SD of 22.48 and the lowest mean score (49.63) was in financial difficulty domain with SD 29.93. With regard to the Global Health QOL , the mean score was 48.13 with SD of 29.93.

SECTION-III

Social Implication among cancer patient after Hemi-mandibulectomy

This section deals with the second objective of the study that is to assess social implications among Cancer patient after Hemi-mandibulectomy by using Shame and stigma tool developed by Kissane et al. and presented from table no-18 to 20.

The Shame and Stigma tool is a 5point writing scale, the minimum score 0 and the maximum score is 4. The score interpretation is made for each domain and the total scale as follows:

Calculate Raw Score $= \frac{\text{Sum of item scores}}{\text{Number of items}}$

Apply Linear Transformation Formula

To standardize to a 0–100 scale, use:

$$S = \frac{(RS - 0)}{(4 - 0)} \times 100$$

or simply,

$$S = \frac{RS}{4} \times 100$$

Based on the transformed scores, all hemi-mandibulectomy patients Social Implication assessed were classified as follows and presented on table-15

Very Low: Who scored between 0 to 20

Mild: Who scored between 21 to 40

Moderate: Who scored between 41 to 60

Severe: Who scored between 61 to 80

Very severe: Who scored between 81 to 10

Table no-18: Distribution of Overall Social implications among Cancer Patients

N=30

	Very Low		Mild		Moderate		Severe	
	Frequency	**%**	**Frequency**	**%**	**Frequency**	**%**	**Frequency**	**%**
Social implication	**5**	**17%**	**11**	**36%**	**9**	**30%**	**5**	**17%**

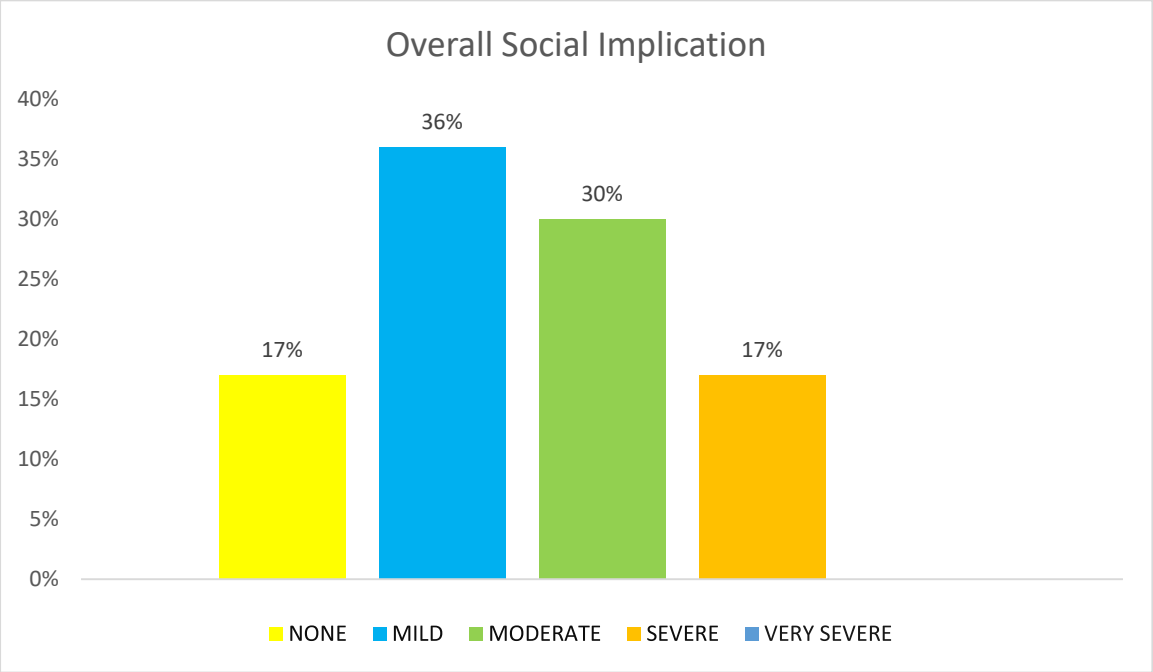

Fig 16: Distribution of Overall Social implications among Cancer patient

The above-mentioned table and Bar diagram shows that , majority (36%) of cancer patients had experienced mild,30% of them had moderate, 17% of them had severe and 17% of them had Severe social implications and None of them reported very severe Social implications.

Distribution of Domain wise social Implication among Cancer Patient

In the Shame and stigma tool, Items 1, 4, 7 and 20 are reverse-scored because they are positively worded and their interpretation are made as follows:

$$\text{Reversed score} = 4 - \text{original score}$$

For each domain:

$$\text{RS} = \frac{\text{Sum of item scores}}{\text{Number of items}}$$

This gives a mean value between 0 and 4.

Transform to 0–100 Scale

Use the linear transformation formula:

$$\text{S} = \frac{(\text{RS} - 0)}{4} \times 100$$

Where,

RS-indicates Raw score

S- indicates standardized score

0- indicates Minimum possible score

4- indicates maximum possible score

Based on the transformed scores, all hemi-mandibulectomy patients Social Implication were assessed Domain wise and classified as follows and presented in table -16

Mild: Who scored between 0 to 33.3

Moderate: Who scored between 33.4 to 66.6

Severe: Who scored between 66.7 to 100

Higher Score: Grater Shame and stigma

Table no -19: Distribution of Social implications among Cancer Patients

N=30

Domain	Mild		Moderate	
	Frequency	**%**	**Frequency**	**%**
Appearance of Shame	-	-	30	100%
Sense of Stigma	6	20%	24	80%
Regrate of Personal Guilt	22	73%	8	27%
Speeches and Social Concern	30	100%	-	-

The above table presents the domain-wise classification of social implications among patients after hemi-mandibulectomy.

With regard to Appearance of Shame domain, all participants (100%) experienced a moderate level of shame. This finding indicates that physical alterations in facial appearance following surgery had a considerable emotional impact, leading to self-consciousness and concerns about body image.

With regard to Sense of Stigma domain, 80% of the participants exhibited a moderate level and 20% of them had a mild level. This suggests that, most of Cancer patients perceived social judgment or avoidance due to visible treatment effects, which may have affected their social confidence and interactions.

With regard to Regret and Personal Guilt, 73% of patients reported a mild level and 27% had a moderate level. This indicates that although a few patients experienced feelings of self-blame regarding their illness, the majority accepted their condition without significant guilt.

With regard to Speeches and Social Concern domain, all patients (100%) demonstrated a mild level of concern, indicating that speech-related or social communication difficulties were minimal.

Table no-20: Distribution of mean score on social implications among cancer patients

Sl No	Domain	Mean	SD
1	Appearance of shame	2.07	0.98
2	Sense of Stigma	2.62	0.94
3	Regrate and personal guilt	2.73	0.84
4	Speech and Social Concern	3.03	0.81

The above table presents the domain-wise mean scores and standard deviation for social implications among cancer patients.

With regard to Appearance of Shame domain, the mean score was 2.07 with SD of 0.98, indicating that patients experienced a moderate level of distress related to changes in physical appearance following surgery.

With regard to Sense of Stigma domain had a mean score of 2.62 with SD of 0.94, reflecting that patients moderately perceived social judgment, avoidance, or differential treatment by others.

With regard to Regret and Personal Guilt, the mean score was 2.73 with SD of 0.84, which also falls in the moderate range, suggesting that, some patients experienced feelings of guilt or self-blame regarding their illness.

With regard to Speech and Social Concern domain, the highest mean score was 3.03 with SD of 0.81, indicating that patients experienced noticeable difficulties in communication and social interaction, which affected their social confidence and participation.

CHAPTER 6

DISCUSSION

This chapter presents the major findings of the study and discusses them in relation to similar studies conducted by other researchers. The study intended to assess the QOL and Social Implication among Cancer patients after Hemi-mandibulectomy.

The findings of the study are discussed under the following headings;

Section-I: Distribution of Cancer patients based on their Socio-Demographic variables.

Section II: Quality of Life among cancer patient after Hemi-mandibulectomy

Section III: Social Implication among cancer patient after Hemi-mandibulectomy

Section-I

Distribution of Cancer patients based on their Socio-Demographic variables

With regard to socio demographic variables majority (60%) of Cancer patients were found to be more than 50 years of age group, 53% of them were females, 73% of them were not having formal education, 50% of them were homemakers, 57% of them were residing in rural area, 57% of them were from nuclear family, 90% of them were married, 57%of them were identified cancer during second stage and 43% of them were coming to the hospital for Radiation Therapy. This was supported by many studies.[34-42]

Section II

Quality of Life among cancer patient after Hemi-mandibulectomy

With regard to the Quality of Life, the overall QoL among hemi-mandibulectomy patients revealed that 67% of patients had a good quality of life, The analysis of Table 9 revealed that 30% experienced a Very Good QoL, and only 3% fell into the Poor QoL category. This indicates that most patients adapted reasonably well following hemi-mandibulectomy, maintaining functional and psychosocial well-being postoperatively. [43]

With regard to the functional domain it was found that, 60% of Cancer patients were having good physical functioning, 67% of them had good role functioning, 46.6% of them had very good emotional functioning, 50% of them had very good cognitive functioning and 37% of them had poor social functioning and this was supported by the previous study.[44]

With regard to the symptoms scale, 63.4% of them had mild fatigue, 66.6% of them had mild Nausea and vomiting and 70% of them had mild pain due to effect of analgesics given after surgery and this is similar to the findings of another study conducted in Norway, Sweden, and the Netherlands. [45]

With regard to the single symptoms scale, 73.4% of them had mild level of Dyspnoea, 67% of them had mild Insomnia, Majority (67%) of them were had mild level of fatigue and loss of appetite indicating manageable post-operative side effects and 50% of them had financial difficulties who were supported by BPL and Ayusman Bharath Schemes and this finding supported by the news one of the leading newspapers in Karnataka. [46]

With regards to the global health QoL 83.4% of them had moderate global health, this indicates that most of the patients perceived their health is satisfactory, the overall perception

of global health remains moderately affected due to post-surgical and socio-economic factors. This is supported by Rogers et al. (2002) emphasized that global health perception is influenced by both physical and psychosocial recovery after post-surgery.[47]

Overall, these findings highlight that while hemi-mandibulectomy significantly affects physical appearance, social interaction, and symptom experience. most patients maintain a good quality of life, particularly in cognitive and emotional domains. This indicates their is a need for comprehensive postoperative care, including psychological support, speech rehabilitation, and social reintegration in order to enhance QOL.

Section III

Social Implication among cancer patient after Hemi-mandibulectomy

The findings revealed that social implications were present to varying degrees across different domains, reflecting the multidimensional impact of facial surgery on patients' psychosocial well-being.

With regard to the overall social implication 36% of them had mild social implications, 30% of them had moderate, 17%of them were severe social implications and none of them were with severe social implications. This findings indicate that, most patients experienced some level of social difficulty following surgery but it was manageable.

With regard to the appearance of Shame, all patients (100%) experienced moderate levels of shame related to physical appearance. This finding highlights the significant psychological impact of facial disfigurement following hemi-mandibulectomy. Changes in facial aesthetics can lead to heightened self-consciousness and concerns about body image, consistent with

findings by Hsieh CE et al. (2010), who reported that facial changes after head and neck surgery contribute to patients' feelings of embarrassment and reduced self-esteem.[47]

With regard to the sense of stigma, 80% of patients experienced moderate stigma and 20% reported mild stigma. This indicates that most patients perceived social judgment, avoidance, or differential treatment due to visible treatment effects and this was supported by the previous study.[49]

With regard to the Regrate of personal Guilt, 73% of patients had mild regret or guilt, and 27% of them had moderate levels of regret of personal guilt and the same was observed by the researcher while collecting data as patients mentioned that I feel like I committed some sins in my previous life, so today God is punishing me for my sins like this. This suggests that while some patients may experience self-blame regarding their disease or treatment, the majority are able to cope and accept their condition and the finding was supported by the previous study. [50]

With regard to the speech and social concern 100%of them had mild speech and social concerns, but the mean score in this domain was the highest (3.03 ± 0.81), indicating noticeable challenges in communication and social interactions. This discrepancy suggests that even when patients rate their concern as mild, it can still have significant implications for daily social participation and this finding is consistent with previous studies, which have shown that post-mandibulectomy patients often experience significant challenges in speech and social participation, despite perceiving their difficulties as minor (Kumar et al., 2017; Patel et al., 2018). [50-51]

Overall, the findings demonstrate that hemi-mandibulectomy has a considerable impact on patients' social functioning, particularly concerning appearance and social stigma. The moderate levels of shame and perceived stigma suggest the need for psychosocial

interventions, such as counselling, support groups, and speech therapy, to enhance social reintegration and emotional adjustment and this was supported by the many studies[52]

CHAPTER 7

SUMMARY

This chapter deals with overall analysis, implications and recommendation regarding Quality of Life and Social implications among cancer patients.

The objectives of the study are:

1. To assess quality of life among cancer patients after hemi-mandibulectomy by using quality of life questionnaire developed by EORTC.

2. To assess the social implication among cancer patient by using Shame and stigma tool developed by Kissane et al.

Assumption:

1.Cancer patient with Hemi-mandibulectomy may be having low quality of life.

2.Cancer patient with Hemi-mandibulectomy may be suffering with some type of shame and stigma.

MAJOR FINDINGS OF THE STUDY

1. Socio-Demographic Variables

➤ Majority (60%) of patients were above 50 years of age.

➤ Females (53%) slightly outnumbered males (47%).

➤ Most patients (73%) had no formal education.

➤ Homemakers (50%) and labourers (37%) formed the majority of the occupational group.

➤ 57% resided in rural areas, and 57% belonged to nuclear families.

➤ 90% were married.

➤ Most (57%) were in the second stage of cancer at diagnosis.

➤The most common treatment received was radiation therapy (43%), followed by surgery (34%).

2. Quality of Life (QOL)

social interaction and speech-related issues were the most affected areas. Overall Qol:67% had good QOL, 30% very good, and 3% poor. With regard to Functional Domain Findings: Cognitive functioning had the highest mean score (70.27). Emotional functioning (64.67) was also satisfactory. Social functioning was lowest (54.20), showing social and communication challenges. With regard to Symptom Domain Findings: Pain (32.97) and fatigue (28.23) were the most reported symptoms. Other symptoms such as nausea, insomnia, and appetite loss were mild to moderate. With regard to Global Health:83.4% had moderate overall health perception.

3. Social Implications

Overall Social Implication Levels: Mild in 36%, Moderate in 30%, Severe in 17%. Domain-wise Findings: With regard to appearance-related shame: Moderate in all patients (100%). With regard to sense of stigma: Moderate in 80%, mild in 20%. With regard to regret and personal guilt: Mild in 73%, moderate in 27%. With regard to speech and social concern: All patients (100%) reported mild level but with highest mean score (3.03 ± 0.81).

Social stigma, altered appearance, and speech difficulties were the most significant psychosocial challenges faced by patients.

IMPLICATIONS OF THE STUDY

Nursing Education

➤ Findings highlight the need to include psycho-oncology and rehabilitation care in nursing curriculum.

➤ Nursing students should be trained to address psychological distress, speech difficulties, and social stigma in cancer survivors.

➤ Encourages interdisciplinary learning (collaboration with speech therapists, psychologists, and oncologists).

Nursing Administration

➤ Nurse administrators should ensure availability of counselling services and rehabilitation programs in oncology departments.

➤ Policies should promote multidisciplinary care involving social workers, psychologists, and speech therapists.

➤ Training programs should be organized for nurses on communication, empathy, and psychosocial care for disfigured patients.

Nursing Practice

➤ Nurses should provide holistic care addressing physical, emotional, and social dimensions.

➤ Incorporate individualized counselling to help patients cope with appearance.

➤ Facilitate family education and community reintegration programs.

➤ Regular follow-up and support sessions can enhance adherence and QOL.

➤ Encourage rehabilitative exercises and speech therapy for better recovery.

Nursing Research

➤This study opens scope for further qualitative and longitudinal studies on cancer patients post-surgery.

➤Can be replicated with larger and more diverse samples for validation.

➤ Future studies can focus on interventions to improve social functioning and reduce stigma.

➤ Encourages development of Indian context-specific QOL tools for oral cancer patients.

Limitations of the Study

➤ Conducted on a small sample (n=30), limiting generalizability.

➤ Study confined to a single hospital (RLJH & RC, Kolar).

➤ Purposive sampling may introduce selection bias.

➤ Self-reported data could be influenced by emotional and social desirability bias.

➤ Cross-sectional design does not measure changes over time.

Recommendations

➤ Conduct studies on a larger sample across multiple oncology centers for better generalization.

➤ Implement counselling and peer support programs to reduce stigma and improve social confidence.

➤ Develop structured rehabilitation guidelines for post-hemi-mandibulectomy patients.

➤ Introduce psycho-oncology modules in nursing training programs.

➤ Encourage long-term follow-up studies to assess changes in QoL over time.

➤ Explore family-based and community-level interventions for sustained psychosocial suppor

CHAPTER 8

CONCLUSION

The study aimed to assess the quality of life and social implications among cancer patients after undergoing hemi-mandibulectomy. A qualitative research approach with a descriptive design was used, and 30 patients were selected through purposive sampling from the OPD at RLJH & RC. Data were collected using semi-structured interviews focusing on physical, emotional, social, and psychological domains. The findings revealed that patients experienced significant challenges in communication, social participation, and emotional well-being, while some domains like role functioning were relatively preserved. Social support and family involvement played a key role in coping and maintaining quality of life. The study concluded that hemi-mandibulectomy has notable impacts on both the physical and psychosocial aspects of patients' lives, emphasizing the need for comprehensive postoperative care, psychological support, and social reintegration programs.

CHAPTER IX

BIBLIOGRAPHY

1. Rogers SN, Lowe D, McNally D, Brown JS, Vaughan ED. Health-related quality of life after mandibular resection for oral cancer: a comparison between rim and segment. Head Neck. 2004;26(1):54–62.
2. Chaukar DA, Das AK, Deshpande MS, Pai PS, Pathak KA, Chaturvedi P, et al. Quality of life in head and neck cancer survivors: a cross-sectional survey. Eur Arch Otorhinolaryngol. 2009;266(3):425–30.
3. Ojo B, Genden EM, Teng MS, Milbury K, Misiukiewicz KJ, Badr H. A systematic review of head and neck cancer quality of life assessment instruments. Oral Oncol. 2012;48(10):923–37.
4. de Graeff A, de Leeuw JRJ, Ros WJG, Hordijk GJ, Blijham GH, Winnubst JAM. Long-term quality of life of patients with head and neck cancer. Laryngoscope. 2000;110(1):98–106.
5. Katre C, Chhabria A, Shetiya SH. Quality of Life with the Rehabilitation After Partial Mandibulectomy: A Systematic Review. Indian J Surg Oncol. 2023;14(2):292–300.
6. Dropkin MJ. Body image and quality of life after head and neck cancer surgery. Cancer Pract. 1999;7(6):309–13.
7. Fingeret MC, Vidrine DJ, Reece GP, Gillenwater AM, Gritz ER. Multidimensional analysis of body image concerns among newly diagnosed patients with oral cavity cancer. Head Neck. 2010;32(2):200–9.
8. Luckett T, King MT, Butow PN, Oguchi M, Rankin N, Price MA, et al. Choosing between the EORTC QLQ-C30 and FACT-G for measuring health-related quality of

life in cancer clinical research: issues, evidence, and recommendations. Ann Oncol. 2011;22(10):2179–90.

9. Vickery LE, Latchford G, Hewison J, Bellew M, Feber T. The impact of head and neck cancer and facial disfigurement on the quality of life of patients and their partners. Head Neck. 2003;25(4):289–96.
10. Barsoum A, Aluru JS, Rawla P, Saginala K, Barsoum A. Epidemiology, risk factors, and prevention of head and neck squamous cell carcinoma. Med Sci. 2023;11(2):42.
11. Galizia D, Minnie S, Mali E, et al. How risk factors affect head and neck squamous cell carcinoma (HNSCC) tumour immune microenvironment (TIME): their influence on immune escape mechanisms and immunotherapy strategy. Biomedicines. 2022;10(10):2498.
12. Nair D, Mair M, Singhvi H, Mishra A, Nair S, Agrawal J, et al. Outcomes of surgically treated oral cancer patients at a tertiary cancer center in India. Indian J Cancer. 2017;54(4):616-20.
13. Kidwai Memorial Institute of Oncology. Annual report 2022 [Internet]. Bengaluru: Kidwai Memorial Institute of Oncology; 2022 [cited 2025 Oct 18]. Available from: https://kmio.karnataka.gov.in
14. Nair D, Mair M, Singhvi H, Mishra A, Nair S, Agrawal J, et al. Outcomes of surgically treated oral cancer patients at a tertiary cancer center in India. Indian J Cancer. 2017;54(4):616-20.
15. Shekhar gouda S, Patil DB. Comparative study of marginal, segmental, and hemi-mandibulectomy in oral cavity cancers. Int J Appl Dent Sci Head Neck Biol. 2022;7(1):45-50.

16. Graeff A, de Leeuw JRJ, Ros WJG, Hordijk GJ, Blijham GH, Winnubst JAM. Long-term quality of life of patients with head and neck cancer. Laryngoscope. 2000;110(1):98–106.
17. Polit DF, Beck CT. Nursing research: Generating and assessing evidence for nursing practice. 11th ed. Philadelphia: Wolters Kluwer; 2021. p. 126–128.
18. Bertalanffy L von. General system theory: Foundations, development, applications. Revised ed. New York: George Braziller; 1984. p. 55–89
19. Semple CJ, Dunwoody L, George Kernohan W, McCaughan E. Changes and challenges to patients' lifestyle patterns following treatment for head and neck cancer. J Adv Nurs. 2008;63(1):85–93.
20. Guan T, Santacroce SJ, Chen DG, Song L. Illness uncertainty, coping, and quality of life among patients with prostate cancer. Psycho-oncology. 2020 Jun;29(6):1019-25.
21. Su M, Hua X, Wang J, Yao N, Zhao D, Liu W, Zou Y, Anderson R, Sun X. Health-related quality of life among cancer survivors in rural China. Quality of Life Research. 2019 Mar 15;28(3):695-702.
22. Chang TG, Huang PC, Hsu CY, Yen TT. Demoralization in oral cancer inpatients and its association with spiritual needs, quality of life, and suicidal ideation: a cross-sectional study. Health and Quality of Life Outcomes. 2022 Apr 2;20(1):60.
23. Jehn P, Spalthoff S, Lentge F, Zeller AN, Tavassol F, Neuhaus MT, Eckstein FM, Krüskemper G, Gellrich NC, Korn P. Postoperative quality of life and therapy-related impairments of oral cancer in relation to time–distance since treatment. Journal of Cancer Survivorship. 2022 Dec;16(6):1366-78.
24. Waddell O, Mclauchlan J, McCombie A, Glyn T, Frizelle F. Quality of life in early-onset colorectal cancer patients: systematic review. BJS open. 2023 Jun;7(3):zrad030.

25. Sandager MT, Rossen S, Hofland DT, Nielsen CV, Maribo T. Health-related quality of life, needs, and concerns among cancer survivors referred to rehabilitation in primary healthcare setting. Acta Oncologica. 2024 Mar 14;63:19636.
26. Goyal AK, Bakshi J, Panda NK, Kapoor R, Vir D, Kumar K, Aneja P. Assessment of shame and stigma in head and neck cancer: a meta-analysis. Journal of Maxillofacial and Oral Surgery. 2024 Feb;23(1):16-22.
27. Tseng WT, Lee Y, Hung CF, Lin PY, Chien CY, Chuang HC, Fang FM, Li SH, Huang TL, Chong MY, Wang LJ. Stigma, depression, and anxiety among patients with head and neck cancer. Supportive Care in Cancer. 2022 Feb;30(2):1529-37.
28. Alaloul F, Al Qadire M, Al Omari O, Al Sabei S, Al Adawi M, Al-Habsi Z. Perceived cancer-related stigma among Arab patients: A cross-sectional study. PLoS One. 2025 Sep 26;20(9):e0333185.
29. Hawley N, Green J, Ahlich E, Hauff C, Hermer J, Skiba MB, James DL, Nash SH. Patient perspectives of weight stigma across the cancer continuum: A scoping review. Cancer Medicine. 2024 Feb;13(3):e6882.
30. Sun L, Liu X, Weng X, Deng H, Li Q, Liu J, Luan X. Narrative therapy to relieve stigma in oral cancer patients: A randomized controlled trial. Int J Nurs Pract. 2022 Aug;28(4):e12926. doi: 10.1111/ijn.12926. Epub 2021 Apr 5. PMID: 33817894.
31. Knettel B, Minja L, Msoka E, Tarimo C, Katiti V, Pan W, Mwobobia J, Juhlin E, Knippler E, Watt M, Suneja G. Culturally-informed adaptation and psychometric properties of the Cataldo Cancer Stigma Scale in Northern Tanzania. Journal of psychosocial oncology. 2024 Mar 3;42(2):286-98.
32. Banerjee SC, Asuzu C, Mapayi B, Olunloyo B, Odiaka E, Daramola OB, Gilliland J, Owoade IA, Kingham P, Alatise OI, Fitzgerald G. Feasibility, acceptability, and initial

efficacy of empathic communication skills training to reduce lung cancer stigma in Nigeria: a pilot study. JNCI Monographs. 2024 Jun 1;2024(63):30-7.

33. Sodergren SC, Husson O, Robinson J, Rohde GE, Tomaszewska IM, Vivat B, Dyar R, Darlington AS, EORTC Quality of Life Group. Systematic review of the health-related quality of life issues facing adolescents and young adults with cancer. Quality of Life Research. 2017 Jul;26(7):1659-72.
34. Jain A, Ganesh B, Bobdey S, Sathwara J, Saoba S. Sociodemographic and clinical profile of cervical cancer patients visiting in a tertiary care hospital in India. Indian J Med Paediatr Oncol. 2017;38(3):291-5.
35. Tanawade PK, Anap YS, Pawar RS, Kapale IJ, Bhaskar S. Sociodemographic features of cancer patients registered at a single rural cancer hospital in western India. Indian J Med Paediatr Oncol. 2020;41(3):372-7.
36. Ganguly K, Basu S, Mondal S, Bhaisare R, Choudhary D. Study on sociodemographic profiles and health-seeking behaviour in cervical cancer patients in a tertiary healthcare centre in Central India. J Family Med Prim Care. 2023;12(5):2696-702.
37. Neha EL, Kondakasseril NR, Bansal R, Yadav P. Sociodemographic, reproductive and clinical profile of women diagnosed with advanced cervical cancer in a tertiary care institute of Delhi. J South Asian Feder Obst Gynae. 2014;6(3):158-62.
38. Singh S, Sabharwal S, Srivastava A. Sociodemographic and clinical profile of cervical cancer patients: a study from a tertiary care centre. Indian J Community Med. 2017;42(2):93-6.
39. Bhattacharya S, Basu S, Mandal S, Bhattacharya A. Sociodemographic profile and clinical presentation of women attending cancer detection centre in Kolkata. Indian J Cancer. 2019;56(4):348-52.

40. Jeseena K, Nayan S, Bharti N, Kumari N. Socio-demographic factors and their impact on quality of life among cancer patients in a tertiary health institute of Jharkhand. Int J Res Med Sci. 2024;12(3):816-22.

41. Singh A, Patel J, Shah K, Patel P, Patel M. Sociodemographic and clinical characteristics of breast cancer patients: a cross-sectional study in Gujarat. Clin Cancer Investig J. 2019;8(3):117-21.

42. Shankar A, Roy S, Malik A, Julka PK, Rath GK. Socio-demographic and clinical profile of head and neck cancer patients in a tertiary care center in India. Indian J Cancer. 2015;52(3):537-40.

43. Vartanian JG, Carvalho AL, Yueh B, Furia CL, Toyota J, McDowell JA, et al. Long-term quality-of-life evaluation after head and neck cancer treatment in a developing country. Head Neck. 2005;27(3):219-25.

44. Rogers SN, Lowe D, Brown JS, Vaughan ED. The University of Washington Quality of Life Scale: validation in the UK and functional adaptation after major head and neck cancer surgery. Clin Otolaryngol Allied Sci. 2002;27(5):404-12.

45. Bjordal K, Kaasa S, Mastekaasa A. Quality of life in head and neck cancer patients: validation of the EORTC QLQ-C30 and EORTC QLQ-H&N35. Acta Oncol. 1999;38(6):829-35.

46. Kumar S, Jadhav S, Sahu S, Singh S, Sharma P. Financial toxicity among cancer patients in India and its effect on quality of life. J Clin Diagn Res. 2017;11(7):XC01-XC05.

47. Rogers SN, Lowe D, Brown JS, Vaughan ED. The University of Washington Quality of Life Scale: validation in the UK and functional adaptation after major head and neck cancer surgery. Clin Otolaryngol Allied Sci. 2002;27(5):404-12.

48. RC, Silva DR. Impact of facial disfigurement on social functioning and quality of life. J Craniofac Surg. 2013;24(1):e1–e5.
49. Chen AY, et al. Psychosocial adaptation following major surgery: The role of supportive care. J Clin Psychol Med Settings. 2012;19(4):456-463.
50. Suh JD, Lee JH, Lee YS, et al. The impact of speech dysfunction on the quality of life of patients with oral cancer. Head Neck. 2005;27(7): 573–579.
51. Shin JH, Kim YS, Lee YS, et al. Psychological and social effects of speech dysfunction in patients with oral cancer. J Korean Assoc Oral Maxillofac Surg. 2011;37(4): 243–248.
52. Kissane DW, Bloch S, Street A, et al. The Shame and Stigma Scale: A tool for assessing shame and stigma in head and neck cancer. Psychooncology. 2004;13:622–632.

CHAPTER X

ANNEXURE – I

Sri Devaraj Urs Academy of Higher Education & Research
POST BOX NO.62, TAMAKA, KOLAR-563 101, KARNATAKA, INDIA
Research and Development Cell
Ph:08152-210604, 210605, 243003, 243009, ,ext. 480. E-mail: dir research@duaher.ac.in
Central Ethics Committee Re- registered under CDSCO -Registration No. ECR/425/Inst/KA/2013/RR-20 dated 28.4.2020

CENTRAL ETHICS COMMITTEE

Date: 04-03-2025

To:
Miss. Rimpa Modak
I Year MSc Nursing Student (B.Sc. Nursing)
Dept. of Medical Surgical Nursing
SDUCON.

Sir/Madam,

Ref: SDUAHER/KLR/R&D/CEC/ SDUCON/ S/ PG/ 13 /2024-25

Sub: Quality of life and social implications among cancer patients after hemi-mandibulectomy.

The Central Ethics Committee of Sri Devaraj Urs Academy of Higher Education and Research, Kolar has examined the PG dissertation synopsis and the detailed work plan on 10th February 2025.

The Central Ethics Committee has unanimously approved the PG dissertation synopsis and granted permission to investigator to carry out the research work. The project has to be conducted as per ICMR guidelines on biomedical research and Health research (2017) in human beings and adhere to the principles of Good Clinical Practice updated guidelines.

The final report of the research project (PG) to be submitted to Scientific Review Committee, SDUCON.

The Co- Investigator for the project is **Dr. G Vijayalakshmi.**

Dr. Kalyani. R
Member Secretary
Prof. Dr. Kalyani. R.
Member Secretary
Central Ethics Committee
Research and Development Cell
SDUAHER

Dr. S.R. Prasad
Chairman
Prof. Dr. S. R. Prasad
Chairman
Central Ethics Committee
Research and Development Cell
SDUAHER

NOTE: Please quote CEC reference number for all future communication

ANNEXURE-II

PERMISSION TO CONDUCT STUDY

From,
Ms. Rimpa Modak
I year M.Sc. (N) Student
Sri Devaraj Urs College of Nursing
Tamaka, Kolar – 563101.

Date: 03/05/2025
Place: Kolar.

To,
The Medical superintendent,
R L Jalappa Hospital and Research Center,
Tamaka, Kolar- 563101.

Respected Madam / Sir,
Through the principal,
SDUCON, Kolar.

Sub: Requesting permission to collect data from cancer patient who are underwent Hemi--mandibulectomy.

With the subject to the above, I the under signed student of I year M.Sc Nursing under the Department of Medical-Surgical Nursing specialty would like to collect data for the mini research study on **assess the quality of life and social implications among cancer patients after Hemi-mandibulectomy** as a partial fulfilment of my M.Sc Nursing curricular requirement.

Hence I request you to grant permission to collect data from Cancer Patient of RLJH and RC and do the needful. Herewith I am enclosing my research objectives, tool and ethical clearance for your kind consideration.

Thanking you

Yours Faithfully,
Ms. Rimpa Modak

Enclosure:

- **Synopsis**
- **Tool**
- **Ethical clearance letter**

Copy to:

1. Head, Department of Oncology, RLJHC& RC, Kolar
2. Dr. Zeenath careena J, Chief Nursing Officer, RLJHC& RC, Kolar.

Forwarded to Medical Superintendent, RLJH&RC

Sir, Kindly permit above mentioned student collect data from cancer patients

05/05/25

Principal
Sri Devaraj Urs College of Nurs
Tamaka, Kolar-563103

Permitted

Medical Superintendent
R.L. Jalappa Hospital & Research Centre
Tamaka, Kolar-563103.

Forwarded for necessary action
6/5/25

ANNEXURE -III

CERTIFICATE FROM STATISTICIAN

I hereby certify that I have provided statistical guidance in analysis to Ms. Rimpa Modak, II Year MSc Nursing student, for her research study titled as **"Qualitative study to assess the Quality of Life and Social Implications among Cancer Patients after Hemi-mandibulectomy."**

Date: 27/10/2025

Place: Tamaka

Mr. S. Ravisankar
Assistant Professor
Dept. Of Community Medicine
SDUAHER, Tamaka, Kolar

ANNEXURE – IV

ENGLISH EDITING CERTIFICATE

CERTIFICATE OF ENGLISH EDITING TO WHOME SO EVER IT MAY CONCERN

This is to certify that, Ms Rimpa Modak, I year M.Sc. Nursing, SDUCON, Tameka, Kolar has done a research study entitled "**Quality of life and social implications among cancer patient after Hemi-mandibulectomy**".

The study was edited for English Language appropriateness by,

Signature

Date: 29-7-25

Place: Gumlapura

ANNEXURE-V

KANNADA TRANSLATION CERTIFICATE

CERTIFICATE OF KANNADA EDITING TO WHOME SO EVER IT MAY CONCERN

This is to certify that, Ms Rimpa Modak, I year M.Sc. Nursing, SDUCON, Tameka, Kolar has done a research study entitled "**Quality of life and social implications among cancer patient after Hemi-mandibulectomy**".

The study was edited for Kannada Language appropriateness by,

ಮುಖ್ಯೋಪಾಧ್ಯಾಯರು
ಸರ್ಕಾರಿ ಪ್ರೌಢ ಶಾಲೆ, ಗುಮ್ಮಲಾಪುರ
ಮುಳಬಾಗಿಲು ತಾ||, ಕೋಲಾರ ಜಿಲ್ಲೆ

signature

Date: 29-07-25

Place Gumlapura

ANNEXURE-VI

Patient information consent sheet

I am the below mentioned patient who underwent Hemi-mandibulectomy and willing to participate in the research study Topic: **Quality of life and social implication among cancer patient after Hemi-mandibulectomy** Conducted by Ms. Rimpa Modak, 1st year M.Sc Nursing student with Medical Surgical Nursing specialty. I am giving my full consent to participate in this study.

Sl No.	Date	Patient Name	Contact number	Signature/ Thumb impression
1	23/05/25	Mrs. Munipathnamma	7353904936	[illegible]
2	23/05/25	Smt. Venkatamma	9480388030.	Venkatamma.
3	23/05/25	Smt. Seethamma	9880879822	
4	24/05/25	Mrs. Parvathamma	97249629259	
5	27/05/25	Smt. Papamma.	9845315989.	
6	28/05/25	Naveen	9704600491	[illegible]
7	29/05/25	Mr. Nasrulla Khan	9739481707.	[illegible]
8	02/06/25	Smt. Savithnamma	9071342081	
9	04/6/25	Mrs. Sunandamma	9538405839	[illegible]
10	04/6/25.	Mrs. Ramananjumma	9900897358	[illegible]
11	05/6/25	Mrs. Gangarathnamma	8971994194	
12	05/06/25	Mrs. Papenava.	8971185509	
13	4/6/25.	Mrs. Rathnamma	593991	
14	06/06/25	Mrs. Parvathamma	333090 9731767188	
15	06/6/25	Mrs. Suyathamma	74878	
16	06/6/25	Mr. Hanumappa	438443 9972626904	
17	7/6/25	Mrs. Rathnamma	380729 9611722268	
18	7/6/25.	Mrs. Sarojamma	592244. 9480401418	
19	8/6/25	Mr. Veerabhadrappa	558828. 9035686367	
20	9/6/25	Mrs. Varalakshma-amma	512786 7795468229.	
21	9/6/25	Mrs. Savithramma	542186. 9071342081	
22	10/6/25	Mr. Aleem Khan	9591700249.	A.Khan
23	13/6/25	Mr. Babajan	56	
24	28/6/25	Mr. Dasarath K.	9148353583	DASARTH K
25	21/6/25	Mrs. Muniyamma.	9945906402	[illegible]
26	21/6/25	Mrs. Narayanamma	9008849539	[illegible]
27	21/6/25	Mrs. Lakshmamma.	7780239419.	[illegible]
28	21/6/25	Nanjunda.	9980800931	[illegible]
29	23/6/25	Manjunath Prasad	9008075207.	Manjunath Prasad
30	23/6/25	Lakshmidevamma	9687061298	

ANNEXURE -VII

SECTION-A

SOCIO-DEMOGRAPHIC VARIABLES

Age in years

a. 18-28
b. 29-38
c. 39-49
d. 50+ above

2. Gender

a. Male
b. Female

3. Education

a. Primary
b. Secondary
c. Graduate
d. Post graduate

4. Occupation

a. Home maker
b. Government job
c. Private job
d. Student
e. Others

5. Place of residence

a. Rural
b. Urban

6. Types of family

a. Nuclear
b. Joint family

7. Marital status

a. Married
b. Unmarried

8. Stage of cancer

a. First stage
b. Second stage
c. Third stage
d. Fourth stage

9. Types of treatment

a. Radiation therapy
b. Chemo therapy
c. Surgery
d. Any other--------

Section -B

Structured knowledge questionnaire on quality

Of life by

European Organisation For Research And

Treatment Of Cancer

EORTC QLQ-C30 (version 3) We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Please fill in your initials:

Your birthdate (Day, Month, Year):

Today's date (Day, Month, Year):

1. **How do you rate your overall health during the past week?**

   1 2 3 4 5 6 7
   Very poor Excellent

2. **How would you rate overall quality of life during the past week?**

   1 2 3 4 5 6 7

   Very poor Excellent

Sl no	Description	Not at all	A little	Quite a bit	Very much
3	**Functional scale Physical functioning** Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	1	2	3	4
4	Do you have any trouble taking a long walk outside of the house?	1	2	3	4
5	Do you have any trouble taking a short walk outside of the house?	1	2	3	4
6	Do you need to stay in bed or a chair during the day?	1	2	3	4

7	Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4
8	**Role Function:** Were you limited in doing either your work or other daily activities?	1	2	3	4
9	Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
10	**Dyspnoea:** Were you short of breath?	1	2	3	4
11	**Pain:** Have you had pain?	1	2	3	4
12	Did you need to rest?	1	2	3	4
13	**Insomnia:** Have you had trouble sleeping?	1	2	3	4
14	Have you felt weak?	1	2	3	4
15	Have you lacked appetite?	1	2	3	4
16	Have you felt nauseated?	1	2	3	4
17	Have you vomited?	1	2	3	4
18	Have you been constipated?	1	2	3	4
19	Have you had diarrhoea?	1	2	3	4
20	Were you tired?	1	2	3	4
21	Did pain interfere with your daily activities?	1	2	3	4
22	**Cognitive Functioning:** Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4

23	Have you had difficulty remembering things?	1	2	3	4
24	**Emotional Functioning:** Did you feel tense?	1	2	3	4
25	Did you worry?	1	2	3	4
26	Did you feel irritable?	1	2	3	4
27	Did you feel depressed?	1	2	3	4
	Social Functioning:				
28	Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
29	Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
30	Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

For the following questions please circle the number between 1 and 7 that best applies to you

31. How would you rate your overall health during the past week?

1 2 3 4 5 6 7

Very poor Excellent

32. How would you rate your overall quality of life during the past week?

1 2 3 4 5 6 7

Very poor Excellent

SECTION-C

It consists of shame and stigma tool developed by Kissane et al.in 2013 to assess social implications among cancer patients.

CODE	ITEM	NEVER	SELDOM	SOMETIMES	OFTEN	ALL THE TIMES
SS-1	I like my appearance	0	1	**2**	3	4
SS-2	I avoid looking at myself in the mirror	0	1	**2**	3	4
SS-3	I am ashamed of my appearance	0	1	**2**	3	4
SS-4	I am happy with how my face or neck looks	0	1	**2**	3	4
SS-5	I feel people stare at me	0	1	**2**	3	4
SS-6	I avoid meeting people because of my looks	0	1	**2**	3	4
SS-7	I enjoy going out in public	0	1	**2**	3	4
SS-8	I am distressed by the changes in my face or neck	0	1	**2**	3	4
SS-9	I feel others consider me responsible for my cancer	0	1	**2**		
SS-10	I am embarrassed when I tell people my diagnosis	0	1	**2**	3	4
SS-11	I feel ashamed for having developed cancer	0	1	**2**	3	4
	People avoid me					

SS-12	because of my cancer	0	1	**2**	3	4
SS-13	I have an urge to keep my cancer a secret	0	1	**2**	3	4
SS-14	I sense that others feel strained when around me	0	1	**2**	3	4
SS-15	I have a strong feeling of regret	0	1	**2**	3	4
SS-16	I would do many things differently if given a second chance	0	1	**2**	3	4
SS-17	I feel sorry about things I have done in the past	0	1	**2**	3	4
SS-18	I am embarrassed by the change in my voice	0	1	**2**	3	4
SS-19	I avoid talking with others	0	1	**2**	3	4
SS-20	I am able to join conversations	0	1	**2**	3	4

ವಿಭಾಗ-ಎ

ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾ ಅಸ್ಥಿರಗಳು

1. ವರ್ಷಗಳಲ್ಲಿ ವಯಸ್ಸು

ಎ. 18-28

ಬಿ. 29-38

ಸಿ. 39-49

ಡಿ. 50+ ಮೇಲೆ

2. ಶಿಕ್ಷಣ

ಎ. ಪ್ರಾಥಮಿಕ

ಬಿ. ಮಾಧ್ಯಮಿಕ

ಸಿ. ಪದವಿ

ಡಿ. ಸ್ನಾತಕೋತ್ತರ ಪದವಿ

3. ಉದ್ಯೋಗ

ಎ. ಗೃಹಿಣಿ

ಬಿ. ಸರ್ಕಾರಿ ಉದ್ಯೋಗ

ಸಿ. ಖಾಸಗಿ ಉದ್ಯೋಗ

ಡಿ. ವಿದ್ಯಾರ್ಥಿ

ಇ. ಇತರರು

4. ವಾಸಸ್ಥಳ

ಎ. ಗ್ರಾಮೀಣ

ಬಿ. ನಗರ

5. ಕುಟುಂಬದ ಪ್ರಕಾರಗಳು

ಎ. ಪರಮಾಣು

ಬಿ. ಅವಿಭಕ್ತ ಕುಟುಂಬ

6. ವೈವಾಹಿಕ ಸ್ಥಿತಿ

ಎ. ವಿವಾಹಿತ

ಬಿ. ಅವಿವಾಹಿತ

7. ಕ್ಯಾನ್ಸರ್ ಹಂತ

ಎ. ಮೊದಲ ಹಂತ

ಬಿ. ಎರಡನೇ ಹಂತ

ಸಿ. ಮೂರನೇ ಹಂತ

ಡಿ. ನಾಲ್ಕನೇ ಹಂತ

8. ಚಿಕಿತ್ಸೆಯ ವಿಧಗಳು

ಎ. ವಿಕಿರಣ ಚಿಕಿತ್ಸೆ

ಬಿ. ಕೀಮೋ ಚಿಕಿತ್ಸೆ

ಸಿ. ಶಸ್ತ್ರಚಿಕಿತ್ಸೆ

ಡಿ. ಬೇರೆ ಯಾವುದಾದರೂ-------

ವಿಭಾಗ - ಬಿ

ಜೀವನದ ಗುಣಮಟ್ಟದ ಕುರಿತು ರಚನಾತ್ಮಕ ಜ್ಞಾನ ಪ್ರಶ್ನಾವಳಿ
ಯುರೋಪಿಯನ್ ಆರ್ಗನೈಸೇಶನ್ ಫಾರ್ ರಿಸರ್ಚ್ ಅಂಡ್ ಟ್ರೀಟ್ಮೆಂಟ್ ಆಫ್ ಕ್ಯಾನ್ಸರ್

EORTC QLQ-C30 (ಆವೃತ್ತಿ 3) ನಿಮ್ಮ ಮತ್ತು ನಿಮ್ಮ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ಕೆಲವು ವಿಷಯಗಳಲ್ಲಿ ನಾವು ಆಸಕ್ತಿ ಹೊಂದಿದ್ದೇವೆ. ದಯವಿಟ್ಟು ನಿಮಗೆ ಉತ್ತಮವಾಗಿ ಅನ್ವಯವಾಗುವ ಸಂಖ್ಯೆಯನ್ನು ವೃತ್ತಿಸುವ ಮೂಲಕ ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳಿಗೆ ನೀವೇ ಉತ್ತರಿಸಿ. ಯಾವುದೇ "ಸರಿ" ಅಥವಾ "ತಪ್ಪು" ಉತ್ತರಗಳಿಲ್ಲ. ನೀವು ಒದಗಿಸುವ ಮಾಹಿತಿಯು ಕಟ್ಟುನಿಟ್ಟಾಗಿ ಗೌಪ್ಯವಾಗಿರುತ್ತದೆ.

ದಯವಿಟ್ಟು ನಿಮ್ಮ ಮೊದಲಕ್ಷರಗಳನ್ನು ಭರ್ತಿ ಮಾಡಿ:

ನಿಮ್ಮ ಜನ್ಮ ದಿನಾಂಕ (ದಿನ, ತಿಂಗಳು, ವರ್ಷ): ಇಂದಿನ ದಿನಾಂಕ (ದಿನ, ತಿಂಗಳು, ವರ್ಷ):

1. ಕಳೆದ ವಾರದಲ್ಲಿ ನಿಮ್ಮ ಒಟ್ಟಾರೆ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ನೀವು ಹೇಗೆ ರೇಟ್ ಮಾಡುತ್ತೀರಿ?

1	**2**	**3**	**4**	**5**	**6**	**7**

ತುಂಬಾ ಕಳಪೆ ಅತ್ಯುತ್ತಮ

2. ಕಳೆದ ವಾರದಲ್ಲಿ ಒಟ್ಟಾರೆ ಜೀವನದ ಗುಣಮಟ್ಟವನ್ನು ನೀವು ಹೇಗೆ ರೇಟ್ ಮಾಡುತ್ತೀರಿ?

1	**2**	**3**	**4**	**5**	**6**	**7**

ತುಂಬಾ ಕಳಪೆ ಅತ್ಯುತ್ತಮ

ಕ್ರ.ಸಂ	ವಿವರಣೆ	ಖಂಡಿತ ಇಲ್ಲ.	ಸ್ವಲ್ಪ	ಸ್ವಲ್ಪ ಮಟ್ಟಿಗೆ	ತುಂ ಬಾ
3	**ಕ್ರಿಯಾತ್ಮಕ ಪ್ರಮಾಣ ದೈಹಿಕ ಕಾರ್ಯನಿರ್ವಹಣೆ** ಭಾರವಾದ ಶಾಪಿಂಗ್ ಬ್ಯಾಗ್ ಅಥವಾ ಸೂಟ್‌ಕೇಸ್ ಅನ್ನು ಹೊತ್ತುಕೊಳ್ಳುವಂತಹ ಶ್ರಮದಾಯಕ ಚಟುವಟಿಕೆಗಳನ್ನು ಮಾಡಲು ನಿಮಗೆ ಯಾವುದೇ ತೊಂದರೆ ಇದೆಯೇ?	1	2	3	4
4	ಮನೆಯ ಹೊರಗೆ ದೀರ್ಘ ನಡಿಗೆ ಮಾಡಲು ನಿಮಗೆ ಏನಾದರೂ ತೊಂದರೆ ಇದೆಯೇ?	1	2	3	4
5	ಮನೆಯಿಂದ ಹೊರಗೆ ಸ್ವಲ್ಪ ನಡೆಯಲು ನಿಮಗೆ ಏನಾದರೂ ತೊಂದರೆಯಾಗುತ್ತಿದೆಯೇ?	1	2	3	4
6	ನೀವು ಹಗಲಿನಲ್ಲಿ ಹಾಸಿಗೆಯಲ್ಲಿ ಅಥವಾ ಕುರ್ಚಿಯಲ್ಲಿ ಇರಬೇಕೇ?	1	2	3	4
7	ನಿಮಗೆ ಊಟ, ಬಟ್ಟೆ ಧರಿಸುವುದು, ಸ್ನಾನ ಅಥವಾ ಶೌಚಾಲಯ ಬಳಸಲು ಸಹಾಯ ಬೇಕೇ?	1	2	3	4
8	**ಪಾತ್ರ ಕಾರ್ಯ:** ನಿಮ್ಮ ಕೆಲಸ ಅಥವಾ ಇತರ ದೈನಂದಿನ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ನೀವು ಸೀಮಿತರಾಗಿದ್ದೀರಾ?	1	2	3	4
9	ನಿಮ್ಮ ಹವ್ಯಾಸಗಳು ಅಥವಾ ಇತರ ವಿರಾಮ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ನೀವು ಸೀಮಿತರಾಗಿದ್ದೀರಾ?	1	2	3	4
10	**ಡಿಸ್ಪ್ನಿಯಾ:** ನಿಮಗೆ ಉಸಿರಾಟದ ತೊಂದರೆ ಇತ್ತೇ?	1	2	3	4
11	**ನೋವು:** ನಿಮಗೆ ನೋವು ಇದೆಯೇ?	1	2	3	4
12	ನಿಮಗೆ ವಿಶ್ರಾಂತಿ ಬೇಕಾಗಿತ್ತೆ?	1	2	3	4
13	**ನಿದ್ರಾಹೀನತೆ:** ನಿಮಗೆ ನಿದ್ರಿಸಲು ತೊಂದರೆಯಾಗಿದೆಯೇ?	1	2	3	4
14	ನೀವು ದುರ್ಬಲರಾಗಿದ್ದೀರಾ?	1	2	3	4
15	ನೀವು ಹಸಿವಿನ ಕೊರತೆಯನ್ನು ಅನುಭವಿಸಿದ್ದೀರಾ?	1	2	3	4
16	ನೀವು ವಾಕರಿಕೆ ಅನುಭವಿಸಿದ್ದೀರಾ?	1	2	3	4
17	ನೀವು ವಾಂತಿ ಮಾಡಿದ್ದೀರಾ?	1	2	3	4
18	ನೀವು ಮಲಬದ್ಧತೆ ಹೊಂದಿದ್ದೀರಾ?	1	2	3	4
19	ನೀವು ಅತಿಸಾರವನ್ನು ಹೊಂದಿದ್ದೀರಾ?	1	2	3	4
20	ನೀವು ದಣಿದಿರಾ?	1	2	3	4
21	ನೀವು ನಿಮ್ಮ ದೈನಂದಿನ ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋವು ಅಡ್ಡಿಯಾಗಿದೆಯೇ?	1	2	3	4
22	**ಅರಿವಿನ ಕಾರ್ಯ:** ಪತ್ರಿಕೆ ಓದುವುದು ಅಥವಾ ದೂರದರ್ಶನ ನೋಡುವಂತಹ ವಿಷಯಗಳ ಮೇಲೆ ಗಮನಹರಿಸಲು ನಿಮಗೆ ತೊಂದರೆಯಾಗಿದೆಯೇ?	1	2	3	4

23	ನಿಮಗೆ ವಿಷಯಗಳನ್ನು ನೆನಪಿನಲ್ಲಿಟ್ಟುಕೊಳ್ಳಲು ಕಷ್ಟವಾಗಿದೆಯೇ?	1	2	3	4
24	**ಭಾವನಾತ್ಮಕ ಕಾರ್ಯನಿರ್ವಹಣೆ:** ನೀವು ಉದ್ವಿಗ್ನರಾಗಿದ್ದೀರಾ?	1	2	3	4
25	ನೀವು ಚಿಂತೆ ಮಾಡುತ್ತಿದ್ದೀರಾ?	1	2	3	4
26	ನಿಮಗೆ ಕಿರಿಕಿರಿ ಅನಿಸಿತಾ?	1	2	3	4
27	ನಿಮಗೆ ಖಿನ್ನತೆ ಅನಿಸಿತಾ?	1	2	3	4
	ಸಾಮಾಜಿಕ ಕಾರ್ಯ:				
28	ನಿಮ್ಮ ದೈಹಿಕ ಸ್ಥಿತಿ ಅಥವಾ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಯು ನಿಮ್ಮ ಕುಟುಂಬ ಜೀವನದಲ್ಲಿ ಹಸ್ತಕ್ಷೇಪ ಮಾಡಿದೆಯೇ?	1	2	3	4
29	ನಿಮ್ಮ ದೈಹಿಕ ಸ್ಥಿತಿ ಅಥವಾ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಯು ನಿಮ್ಮ ಸಾಮಾಜಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ಹಸ್ತಕ್ಷೇಪ ಮಾಡಿದೆಯೇ?	1	2	3	4
30	ನಿಮ್ಮ ದೈಹಿಕ ಸ್ಥಿತಿ ಅಥವಾ ವೈದ್ಯಕೀಯ ಚಿಕಿತ್ಸೆಯು ನಿಮಗೆ ಆರ್ಥಿಕ ತೊಂದರೆಗಳನ್ನುಂಟು ಮಾಡಿದೆಯೇ?	1	2	3	4

ವಿಭಾಗ-ಸಿ

ಇದು ಕ್ಯಾನ್ಸರ್ ರೋಗಿಗಳಲ್ಲಿ ಸಾಮಾಜಿಕ ಪರಿಣಾಮಗಳನ್ನು ನಿರ್ಣಯಿಸಲು ಕಿಸ್ಸಾನೆ ಮತ್ತು ಇತರರು 2013 ರಲ್ಲಿ ಅಭಿವೃದ್ಧಿಪಡಿಸಿದ ಅವಮಾನ ಮತ್ತು ಕಳಂಕ ಸಾಧನವನ್ನು ಒಳಗೊಂಡಿದೆ.

ಸಂಖ್ಯೆ	ವಿಷಯ	ಎಂದಿಗೂ	ವಿರಳವಾಗಿ	ಕೆಲವೊಮ್ಮೆ	ಆಗಾಗ್ಗೆ	ಎಲ್ಲಾ ಸಮಯಗಳು
ಎಸ್ಎಸ್-1	ನನ್ನ ರೂಪ ನನಗೆ ಇಷ್ಟ	0	1	2	3	4
ಎಸ್ಎಸ್-2	ನಾನು ಕನ್ನಡಿಯಲ್ಲಿ ನನ್ನನ್ನು ನೋಡಿಕೊಳ್ಳುವುದನ್ನು ತಪ್ಪಿಸುತ್ತೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-3	ನನ್ನ ರೂಪದ ಬಗ್ಗೆ ನನಗೆ ನಾಚಿಕೆಯಾಗುತ್ತದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-4	ನನ್ನ ಮುಖ ಅಥವಾ ಕುತ್ತಿಗೆ ಕಾಣುವ ರೀತಿ ನನಗೆ ಸಂತೋಷವಾಗಿದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-5	ಜನರು ನನ್ನನ್ನು ದಿಟ್ಟಿಸಿ ನೋಡುತ್ತಾರೆಂದು ನನಗೆ ಅನಿಸುತ್ತದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-6	ನನ್ನ ನೋಟದಿಂದಾಗಿ ನಾನು ಜನರನ್ನು ಭೇಟಿಯಾಗುವುದನ್ನು ತಪ್ಪಿಸುತ್ತೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-7	ಸಾರ್ವಜನಿಕವಾಗಿ ಹೊರಗೆ ಹೋಗುವುದನ್ನು ನಾನು ಇಷ್ಟಪಡುತ್ತೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-8	ನನ್ನ ಮುಖ ಅಥವಾ ಕುತ್ತಿಗೆಯಲ್ಲಿನ ಬದಲಾವಣೆಗಳಿಂದ ನಾನು ದುಃಖಿತನಾಗಿದ್ದೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-9	ನನ್ನ ಕ್ಯಾನ್ಸರ್‌ಗೆ ಇತರರು ನಾನೇ ಕಾರಣ ಎಂದು ಭಾವಿಸುತ್ತೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-10	ನನ್ನ ರೋಗನಿರ್ಣಯವನ್ನು ಜನರಿಗೆ ಹೇಳಿದಾಗ ನನಗೆ ಮುಜುಗರವಾಗುತ್ತದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-11	ನನಗೆ ನಾಚಿಕೆಯಾಗುತ್ತದೆ	0	1	2	3	4

ಎಸ್ಎಸ್-12	ನನ್ನ ಕ್ಯಾನ್ಸರ್ ನಿಂದಾಗಿ ಜನರು ನನ್ನನ್ನು ದೂರವಿಡುತ್ತಾರೆ.	0	1	2	3	4
ಎಸ್ಎಸ್-13	ನನ್ನ ಕ್ಯಾನ್ಸರ್ ನಿಂದಾಗಿ ಜನರು ನನ್ನನ್ನು ದೂರವಿಡುತ್ತಾರೆ	0	1	2	3	4
ಎಸ್ಎಸ್-14	ನನ್ನ ಕ್ಯಾನ್ಸರ್ ಅನ್ನು ರಹಸ್ಯವಾಗಿಡುವ ಹಂಬಲ ನನಗಿದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-15	ನನಗೆ ಬಲವಾದ ವಿಷಾದದ ಭಾವನೆ ಇದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-16	ಎರಡನೇ ಅವಕಾಶ ಸಿಕ್ಕರೆ ನಾನು ಅನೇಕ ಕೆಲಸಗಳನ್ನು ವಿಭಿನ್ನವಾಗಿ ಮಾಡುತ್ತೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-17	ನಾನು ಹಿಂದೆ ಮಾಡಿದ ಕೆಲಸಗಳ ಬಗ್ಗೆ ನನಗೆ ವಿಷಾದವಿದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-18	ನನ್ನ ಧ್ವನಿಯಲ್ಲಿನ ಬದಲಾವಣೆಯಿಂದ ನನಗೆ ಮುಜುಗರವಾಗಿದೆ	0	1	2	3	4
ಎಸ್ಎಸ್-19	ನಾನು ಇತರರೊಂದಿಗೆ ಮಾತನಾಡುವುದನ್ನು ತಪ್ಪಿಸುತ್ತೇನೆ	0	1	2	3	4
ಎಸ್ಎಸ್-20	ನಾನು ಸಂಭಾಷಣೆಗಳಿಗೆ ಸೇರಲು ಸಾಧ್ಯವಾಗುತ್ತದೆ	0	1	2	3	4

ANNEXURE – VIII

SOCIO-DEMOGRAPHIC DATA OF CANCER PATIENTS AFTER HEMI-MANDIBULECTOMY

AGE	EDUCATION	OCCUPATION	PLACE OF RESIDENCE	TYPES OF FAMILY	MARITAL STATUS	STAGE OF CANCER	TYPE OF TREATMENT
4	4	5	1	1	1	2	4
4	4	1	1	2	1	2	1
4	4	1	1	2	1	3	2
4	4	1	1	1	1	2	3
4	4	3	1	2	1	2	3
2	3	3	2	1	2	1	3
3	3	3	2	1	1	1	3
1	4	1	1	2	2	2	1
3	4	5	1	1	1	2	3
3	4	5	1	2	1	2	2
2	4	5	1	2	1	2	2
4	4	5	1	1	1	2	1
4	4	1	1	1	1	2	1
4	4	5	2	1	1	2	1
4	4	1	1	1	1	2	1
4	4	1	1	1	1	2	2
4	4	1	1	1	1	1	2
4	4	1	1	2	1	1	1
4	1	1	1	1	1	1	1
4	4	1	1	1	1	2	1

4	**4**	**1**	**1**	**1**	**1**	**1**	**1**
5	**4**	**5**	**1**	**1**	**1**	**1**	**1**
4	**1**	**5**	**1**	**1**	**1**	**4**	**1**
3	**1**	**2**	**2**	**1**	**1**	**2**	**3**
2	**2**	**5**	**2**	**2**	**2**	**3**	**3**
3	**1**	**1**	**2**	**2**	**1**	**3**	**3**
2	**2**	**1**	**2**	**2**	**1**	**2**	**3**
3	**4**	**1**	**2**	**1**	**1**	**1**	**1**
3	**4**	**5**	**2**	**2**	**1**	**2**	**2**
4	**4**	**5**	**2**	**2**	**1**	**1**	**3**

QUALITY OF LIFE QUESTIONNAIRE

q1	q2	q3	q4	q5	q6	q7	q8	q9	q`10	q11	q12	q13	q14	q15	q16	q17	q18	q19	q20	q21	q22	q23	q24	q25	q26	q27	q28	q29	q30
3	1	2	4	4	2	3	1	3	3	1	2	1	1	1	1	1	1	2	3	1	4	4	3	2	4	4	4	4	4
2	4	4	1	1	4	1	4	4	4	4	4	4	2	1	1	1	1	4	4	4	4	4	4	4	4	4	4	3	3
4	3	3	2	3	3	2	2	4	4	3	1	2	1	1	1	1	2	3	3	1	4	4	4	4	3	4	4	1	1
2	3	2	3	1	1	2	1	1	2	2	2	1	2	2	3	2	2	1	1	3	2	1	3	4	4	4	4	5	4
3	2	3	3	3	2	3	1	1	2	2	2	2	3	3	3	3	4	3	2	3	3	4	3	4	4	4	3	4	5
2	3	2	1	3	1	3	1	1	1	1	1	1	1	1	1	1	1	2	2	1	2	3	4	4	2	3	1	4	4
3	2	2	2	4	3	3	3	3	3	3	2	3	1	1	4	4	2	1	3	3	3	3	4	2	3	3	3	4	4
1	2	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	2	2	3	3	2	2	2	1	3	3	3	5	5
2	3	3	2	1	2	3	2	3	2	3	2	3	3	2	3	2	1	3	2	2	4	3	2	3	3	2	2	4	4
2	3	2	1	2	3	2	1	1	1	1	1	1	1	1	1	1	1	2	3	3	4	3	2	2	2	3	3	4	5
2	1	1	1	1	2	1	2	2	1	1	1	1	2	2	2	1	1	1	2	1	2	2	2	1	2	1	2	4	5
2	2	2	3	3	1	3	4	4	2	1	3	4	4	2	2	2	1	1	2	2	1	2	2	1	2	1	2	3	4
2	2	2	3	3	3	3	2	1	1	1	1	1	2	2	3	2	2	3	1	2	3	2	3	2	1	1	2	4	4
2	2	3	3	3	3	3	2	1	1	1	1	1	1	1	1	1	1	1	2	2	2	3	3	3	2	2	3	4	4
3	2	2	2	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	2	2	1	1	1	1	3	3	3	4	5
3	3	3	3	3	2	2	1	1	1	1	1	1	1	1	1	1	1	1	2	3	2	2	2	3	3	4	4	5	4
2	2	2	3	3	2	1	2	3	2	3	3	3	2	2	3	3	1	1	2	1	1	1	2	2	3	3	3	4	4
2	2	2	2	2	1	1	2	1	2	2	1	1	2	1	2	2	1	2	1	1	2	2	3	2	3	3	1	4	4
2	3	3	3	2	3	4	3	2	3	2	2	1	3	3	3	3	3	1	1	3	2	3	2	1	2	3	3	4	4

2	1	2	1	2	1	3	1	2	4	2	3	4	1	1	1	1	1	2	3	3	2	3	4	2	2	3	3	4	4
2	1	1	2	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	2	2	3	2	3	3	3	2	3	4	4
2	3	2	3	3	2	3	2	3	3	2	3	2	2	2	2	1	1	1	2	1	2	2	2	3	2	2	3	4	4
1	2	2	2	2	1	2	2	2	1	2	2	2	2	2	1	1	1	1	2	1	1	2	2	2	2	2	3	4	4
4	3	3	3	3	2	2	3	1	1	1	1	1	2	1	1	2	1	3	2	2	1	1	1	1	1	1	1	4	4
4	3	2	2	3	2	3	2	3	2	3	3	3	3	2	3	2	3	1	2	3	3	2	2	3	3	3	3	5	5
2	2	3	1	2	2	3	2	1	2	2	3	2	1	1	1	1	1	1	3	2	3	1	1	1	1	1	1	5	5
2	1	2	3	2	2	2	2	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	2	2	3	3	3
3	1	2	2	4	2	2	3	2	3	2	3	2	2	2	1	1	1	1	2	1	1	2	2	1	1	2	2	5	5
2	2	1	1	1	2	2	2	1	1	1	1	1	2	3	2	3	3	3	1	3	3	3	3	3	2	2	2	3	2
4	4	4	4	4	4	4	2	1	1	1	1	1	1	1	1	1	1	1	3	1	1	1	1	3	3	4	3	1	1

SHAME AND STIGMA SCALE

ss-1	ss-2	ss-3	ss-4	ss-5	ss-6	ss-7	ss-8	ss-9	ss-10	ss-11	ss-12	ss-13	ss-14	ss-15	ss-16	ss-17	ss-18	ss-19	ss-20
1	2	0	0	0	1	0	4	2	3	2	0	0	2	0	0	2	3	3	3
0	2	2	0	0	4	1	4	3	4	4	4	3	4	4	4	4	4	4	2
0	3	3	2	3	3	2	2	4	4	3	1	2	1	2	4	2	2	2	3
2	3	3	3	4	4	2	4	4	3	3	4	4	4	4	4	3	4	4	4
3	3	2	2	3	2	2	3	2	2	2	2	3	3	3	4	4	4	4	4
2	3	3	3	4	2	3	3	3	4	4	4	2	3	3	3	4	2	2	4
2	3	3	3	2	2	2	2	3	3	4	4	2	3	3	3	3	3	2	2
1	1	2	2	1	1	2	1	1	1	4	2	2	2	2	3	2	1	1	1
1	1	2	2	3	4	3	3	3	4	1	2	2	1	1	2	2	3	3	2
2	2	3	4	2	2	2	3	3	3	4	3	2	3	4	3	4	3	4	3
1	2	1	1	3	1	2	1	1	2	2	2	3	3	4	4	4	3	2	3
0	2	1	2	1	1	3	3	2	1	4	4	2	3	4	4	4	3	3	4
2	3	3	4	3	4	4	4	4	3	3	3	3	4	4	4	4	4	4	4
1	2	3	2	2	3	4	3	4	3	4	3	3	4	4	4	3	3	4	3
1	2	2	1	0	1	2	3	3	2	2	3	3	4	4	3	3	2	2	3
2	2	1	1	1	2	1	0	1	2	2	1	2	1	2	3	3	2	3	4
1	2	2	2	3	3	3	2	3	3	3	3	2	2	2	3	3	3	3	4
0	1	1	2	2	2	2	2	3	3	3	3	2	3	2	3	2	3	3	2
2	2	3	3	3	2	2	2	3	2	3	3	4	2	2	3	3	3	3	3
0	1	2	1	3	1	1	2	1	2	1	2	2	3	3	3	3	3	4	4
1	2	3	3	3	3	2	4	2	3	2	3	2	3	2	3	2	2	3	3
2	4	3	2	3	3	2	2	3	3	3	2	2	3	3	3	2	3	3	4

1	2	3	3	3	4	4	4	3	3	3	3	2	2	2	2	3	3	4	3
2	1	1	3	4	3	3	3	3	2	3	3	3	2	2	2	3	3	3	3
3	3	4	3	4	3	3	3	4	3	4	3	4	3	3	3	4	3	3	3
0	3	3	3	3	3	2	3	3	3	4	3	3	2	3	3	2	3	4	3
3	2	3	3	1	4	3	3	4	4	3	4	4	3	3	4	4	4	4	4
0	1	2	2	3	3	2	3	3	3	4	4	3	3	4	4	3	4	3	2
0	3	2	3	3	3	2	3	2	2	2	2	2	3	2	3	2	3	2	3
2	2	2	2	3	3	3	3	2	3	3	2	2	2	2	2	3	2	3	2

ANNEXURE – IX

RESEARCH PHOTOS


2025
06


2025
06
JUNE

ANNEXURE – X

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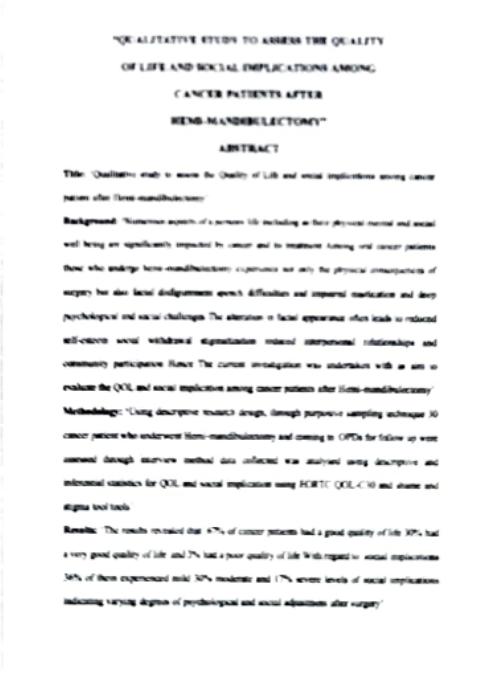

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ABSTRACT