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REVISTA DE ENFERMAGEM DA UFSM

UFSM
Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 10, e56, p. 1-18, 2020
DOI: 10.5902/2179769240000
ISSN 2179-7692

Original Article Submitted: 13/09/2019 Approved: 08/05/2020 Published: 13/07/2020

Sociodemographic and clinical-pathological profile of women hospitalized with metastatic or advanced local breast cancer

Perfil sociodemográfico e clínico-patológico de mulheres hospitalizadas com câncer mamário localmente avançado ou metastático

Perfil sociodemográfico y clínico-patológico de mujeres hospitalizadas con cáncer de mama localmente avanzado o metastásico

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Abstract: Objective: to characterize the sociodemographic and clinical-pathological profile of women hospitalized with metastatic or advanced local breast cancer. **Method:** quantitative descriptive study, carried out in a hospital in Rio de Janeiro, Brazil, from March to July 2017. The study included 199 women hospitalized in the clinical ward. Data were collected from the medical records and through interviews, using a form that contained the variables of the profiles. The analysis was conducted using the Statistical Package for the Social Sciences, version 24. **Results:** 153 (76.88%) women were from 40 to 69 years old; 80 (40.20%) had incomplete elementary education; 181 (90.95%) lived with up to two minimum wages; 107 (53.77%) were diagnosed with stage III cancer; 145 (72.86%) were already in stage IV. 73 (36.68%) had the worst performance status, followed by 70 (35.18%) with performance status 3. **Conclusion:** the profile has shown delayed diagnoses and high levels of dependency, mostly in women with low educational levels and low socioeconomic conditions.
Descriptors: Breast Neoplasms; Palliative Care; Hospitalization; Nursing; Health Profile

Resumo: Objetivo: caracterizar o perfil sociodemográfico e clínico-patológico de mulheres hospitalizadas com câncer de mama localmente avançado ou metastático. **Método:** estudo quantitativo, descritivo, realizado em hospital no Rio de Janeiro, Brasil, entre março e julho de 2017. Participaram 199 mulheres hospitalizadas nas enfermarias clínicas. Coletaram-se dados nos prontuários e por entrevista aplicando formulário contendo variáveis dos perfis. Para análise utilizou-se o *Statistical Package for the Social Sciences* versão 24. **Resultados:** 153 (76,88%) mulheres tinham de 40 a 69 anos de idade; 80 (40,20%) com ensino fundamental incompleto; 181 (90,95%) viviam com até dois salários mínimos; 107 (53,77%) foram diagnosticadas no estadiamento III; 145 (72,86%) já se encontravam no estadiamento IV; e 73 (36,68%) apresentavam pior *performance status*, seguidas de 70 (35,18) mulheres com *performance status* 3. **Conclusão:** o perfil demonstrou ocorrência de diagnóstico tardio e elevado nível de dependência, em sua maioria em mulheres com pouco escolaridade e baixa condição socioeconômica.

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Descritores: Neoplasias da mama; Cuidados paliativos; Hospitalização; Enfermagem; Perfil de saúde

Resumen: **Objetivo:** caracterizar el perfil sociodemográfico y clínico patológico de mujeres hospitalizadas con cáncer de mama localmente avanzado o metastásico. **Método:** estudio cuantitativo, descriptivo, realizado en hospital en Rio de Janeiro, Brasil, entre marzo y julio de 2017. Participaron 199 mujeres hospitalizadas en las enfermarías clínicas. Se recogieron datos en los prontuarios y por entrevista aplicando formulario conteniendo variables de los perfiles. Para análisis se ha utilizado el *Statistical Package for the Social Sciences* versión 24. **Resultados:** 153 (76,88%) mujeres tenían de 40 a 69 años de edad; 80 (40,20%) con enseñanza fundamental incompleta; 181 (90,95%) vivían con hasta dos salarios mínimos; 107 (53,77%) han sido diagnosticadas en el estadificación III; 145 (72,86%) ya se encontraban en el estadificación IV; y 73 (36,68%) presentaban peor *performance status*, seguidas de 70 (35,18%) mujeres con *performance status* 3. **Conclusión:** el perfil demostró ocurrencia de diagnóstico tardío y elevado nivel de dependencia, en su mayoría en mujeres con poca escolaridad y baja condición socioeconómica.
Descriptores: Neoplasias de la mama; Cuidados paliativos; Hospitalización; Enfermería; Perfil de salud

Introduction

Despite technical-scientifical advances, late diagnoses of breast cancer are still a reality in Brazil, especially considering the characteristics of the disease, which include fast progression, aggressivity, and its possible resistance to measures taken as treatment to cure it. Breast cancer is the most common neoplasm in women, and the interval between the diagnoses and the beginning of treatment has been a concern of many developed and developing countries, since delays in this path directly interfere in the prognostic and in the quality of life of the patient.[1]

Literature highlights that, in some realities, characteristics of the sociodemographic profile of women, such as age, educational level, and economic standards, are often associated to delays in the confirmation of a diagnostic and in the definition of a plan of assistance, which has repercussions on the clinical-pathological profile, with high rates of morbidity and mortality related to breast cancer.[1-2] These evidences suggest further studies seeking for converging data, especially in developing countries and/or large countries with sizeable cultural variations, social inequalities, and high population density, such as Brazil.

The magnitude of breast cancer as a worldwide health problem demands investments in researches that can aid in the search for an early diagnostic and in the promotion of quality of life. Studies on the health profile of these women can direct strategies of assistance to help them confronting the physical, psychological, economical, and social impacts of the disease. That is especially true for women with a profile of social vulnerability.[1-2]

The question that guides this study is: What is the sociodemographic and clinical-pathological profile of women hospitalized with metastatic or advanced local breast cancer? The objective of this investigation is to characterize the sociodemographic and clinical-pathological profile of women hospitalized with metastatic or advanced local breast cancer.

Methods

This is a quantitative and descriptive study, carried out in a Center for High Complexity Oncological Assistance (CHCOC), in the city of Rio de Janeiro, Brazil. This CHCOC has five units, which are structured according to their specialties. Four of them are designed to diagnose and treat cancer, and the fifth, to offer palliative care. The setting of the study was the specialized breast cancer ward, in the clinical hospitalization unit, where there are 26 beds in seven rooms.

The population was made up of women with breast cancer who were hospitalized in this ward from March to July 2017, a total of 289 patients. After the application of inclusion and exclusion criteria, which took place through a consultation to medical records, all eligible women participated in the study, that is, 199 women. This number was higher than the sample size of 180 resulting from the Anova test, whose estimates were based on the population of 383 women who were hospitalized in the second semester of 2016.

The inclusion criteria were: 18-year-old or older women; with stage II B and III (A, B, and C) breast cancer, including women with local advanced breast (cases in which the tumoral mass

in the diagnostic is bigger than five centimeters, or is of any size, but invades adjacent structures and/or compromises lymph nodes)[3] and women with high probability of developing metastasis; and women who were in stage IV, with confirmed metastasis.

Exclusion criteria were: women with mental confusion or prostration and cognitive commitments which affected their ability to read and their understanding; whose initial tumor was not in the breast; with any factor that limited data collection, such as pain, which prevented three attempts of approaching her in the data collection period; who did not have an available medical record in the sector; or who started their treatment out of the institution mentioned. Mental confusion and cognitive impairment were assessed through a reading of the medical records, in which records were identified that indicated symptoms such as psychomotor agitation, altered levels of awareness, and cognitive alterations. The members of the health team who were responsible for the assistance were also consulted with regards to this information at the moment of data collection.

From the 90 patients who did not participate in the study, 67 had mental confusion or prostration; eight refused participation; in five, the initial tumor was not in the breast; in four, the disease was in stage I (A or B) or IIA; four started their treatment in a different institution, and did not know to which treatment they had been submitted; and two did not have their medical records.

Data collection was carried out by the researcher herself, through a consultation to the medical records and a structured interview. A form containing the following variables of the clinical-pathological profile was applied: histopathological type; presence, placement, and number of metastases; previous and current treatment; performance status; complications; initial stage in the first medical consultation; and current stage. The variables of the sociodemographic profile were: age; educational level; *per capita* income; religion; and marital status.

The Performance Status (PS) scale, from the Eastern Cooperative Oncology Group (ECOG), quantifies the stage in which the disease is affecting the daily life abilities of the patient. Its score can vary from zero to five. A score of 0 indicates that the patient has not suffered any changes in their lifestyle, and continues normally to perform as they did before their pathological condition; a patient with score 1 has some restrictions that prevent them from exercising more tiring activities, but can perform light ones; score 2 indicates that the patient can perform self-care, but cannot work, and stays out of bed for more than 50% of the time; the patient in score 3 has limited capacity for self-care and remains restricted to the bed or to a wheelchair more than 50% of their waking time; a score 4 patient is completely incapable of self-care and entirely restricted to the bed or wheelchair; a score of 5 is given to a patient who is dead.[4]

The setting of the study applies the PS-ECOG scale, which is an important tool for professionals to base decision-making processes and prognostic evaluations.

The interviews were carried out to complete information that had been previously collected in medical records. As a result, all 199 women were interviewed individually, in the clinical ward or in a private room in the ward, if they preferred so and could leave their beds. Interviews in the ward were carried out at a moment with low transit of people and the voices were kept low, to guarantee the privacy of the patient.

Data was treated based on descriptive statistical analysis. The software Statistical Package for the Social Sciences (SPSS), version 24, was used to present absolute and relative values, means and medians.

The research project was approved by the Research Ethics Committees under opinions No. 1.930.696 and No. 1.951.238, in March 2017, respecting the ethical principles regarding researches with human beings, according to Resolution No. 466/2012 from the National Council of Health. All women signed the free and informed consent form.

Results

Women from 40 to 69 years old and those with incomplete elementary education stood out in regards to their sociodemographic profile. Economically, 90.95% had a *per capita* income of up to two minimum wages. Most women had a religion and a partner (Table 1).

Table 1 - Sociodemographic profile of women hospitalized with metastatic or advanced local breast cancer. Rio de Janeiro, RJ, 2017.

Variable	N	%
Age group		
18 to 29	2	1.01
30 to 39	22	11.05
40 to 49	51	25.63
50 to 59	65	32.66
60 to 69	37	18.59
70 to 79	18	9.05
80 to 90	4	2.01
Educational level		
Illiterate	6	3.01
Incomplete elementary education	80	40.20
Complete elementary education	19	9.55
Incomplete high school	10	5.03
Complete high school	59	29.65
Incomplete higher education	10	5.03
Complete higher education	13	6.53
Post-graduation	2	1.00
Per capita* income in minimum wages		
Lower than 1 minimum wage	91	45.73
From 1 to 2 minimum wages	90	45.22
More than 2 minimum wages	18	9.05
Religion		
Catholic	81	40.70
Evangelical	97	48.74
Another religion	16	8.04
No religion	5	2.52
Marital status		
Has a partner	106	53.27
Does not have a partner	93	46.73

* Minimum wage = R$ 937.00 in Brazil in 2017.

After analyzing the summary with the descriptive statistical analysis regarding the age of the women in the sample, the minimum age was 28 years, and the maximum, 90, with a median

of 53 and a mean of 53.68 years. At least 75% of women were younger than 61.5, and some were older than 80 (87, 85, and 90), thus being considered as outliers (since their age was very distant than that of the other women).

The most common histopathological tumor type was the invasive ductal carcinoma. Nearly 145 (72.86%) women had metastases, mostly in the bones and lungs; 96 (48.24%) had two or more sites of metastasis. Chemotherapy was the most common treatment, be it among previous or current treatments; surgeries were not being used as treatment at the moment. Tumoral wounds were the most frequent complication, followed by lymphedemas and medullary compression syndrome. Regarding the PS of the women, most had PS 4, followed by those with PS 3 (Table 2).

Table 2 - Clinical-pathological profile of women hospitalized with metastatic or advanced local breast cancer. Rio de Janeiro, RJ, 2017.

Variable	N	%
Histopathological type		
Invasive ductal carcinoma	162	81.41
Other	37	18.59
Metastasis		
Yes	145	72.86
No	54	27.14
Place of metastasis		
Central nervous system	38	19.10
Liver	44	22.11
Bones	97	48.74
Lungs	70	35.18
Other	48	24.12
Number of metastases		
0	54	27.14
1	49	24.62
2	45	22.61
3 or more	51	25.63
Previous treatments		
Chemotherapy	173	86.93
Radiotherapy	117	58.79
Surgery	109	54.77
Hormone therapy	102	51.26
No previous treatment	12	6.03
Current treatment		

Chemotherapy	104	52.26
Hormone therapy	64	32.16
Radiotherapy	29	14.57
Symptom control	18	9.05
Complications		
Tumoral wounds	34	17.09
Lymphedema	32	16.08
Medullary compression syndrome	22	11.06
Performance status (PS)		
Performance status 1	19	9.55
Performance status 2	37	18.59
Performance status 3	70	35.18
Performance status 4	73	36.68

According to the distribution of the stages of the disease, chart 1 shows that, in the initial stage, the moment of the first specialized consultation, 107 women were diagnosed as stage III. There were women in stages 0 and 1, and 21 women were diagnosed in the most advanced stage (IV). The analysis of the current stage, the stage during data collection, showed that 145 women were already in stage IV.

Chart 01 - Distribution of initial and current stages of the disease

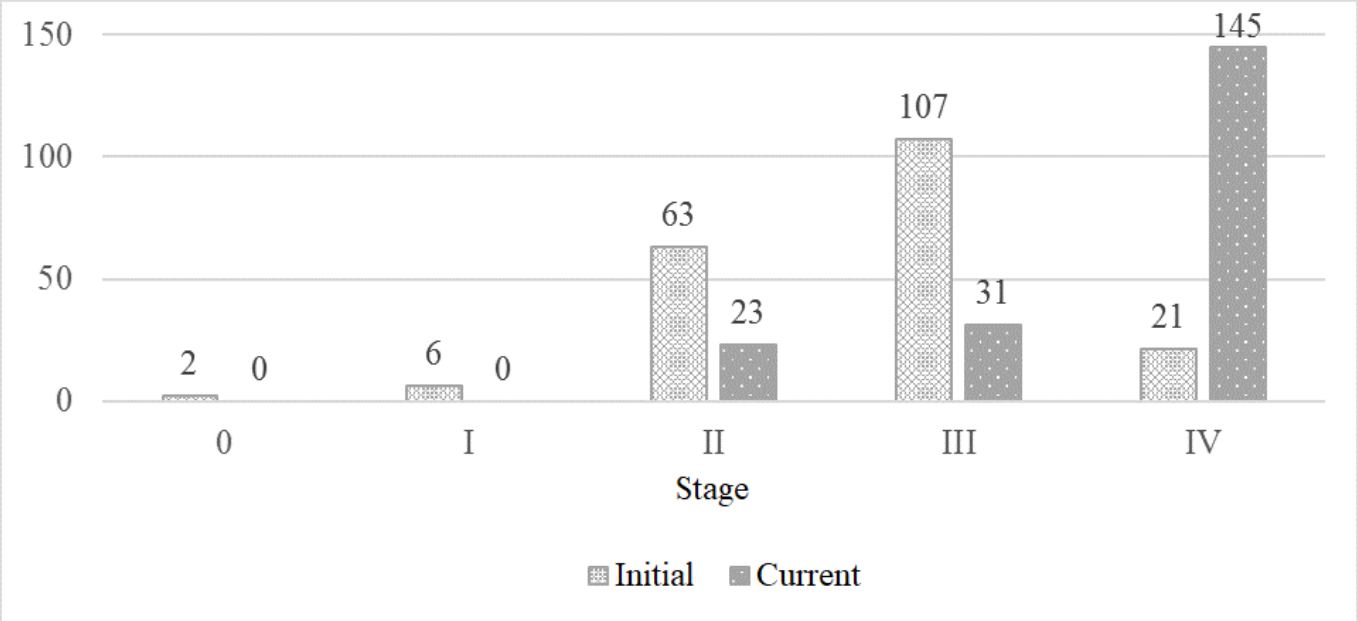

Table 3 shows the evolution from the initial stage to the moment of data collection. From the 107 women who were diagnosed as stage III, 27 were still in the same stage, while 80 others

had advanced to stage IV. In general, the clinical worsening, with progression in the stage of the disease, was significant, since the number of women in stage IV went from 21 to 145.

Table 3 - Distribution of initial and current stages of the disease. Rio de Janeiro, RJ, 2017.

Initial stage	Current stage						Total	
	II		III		IV			
	N	%	N	%	N	%	N	%
0	0	0.00	0	0.00	2	100.0	2	100.0
I	1	16.67	0	0.00	5	83.33	6	100.0
II	22	34.92	4	6.35	37	58.73	63	100.0
III	0	0.00	27	25.23	80	74.77	107	100.0
IV	0	0.00	0	0.00	21	100.0	21	100.0
Total	23	11.56	31	15.58	145	72.86	199	100.0

Discussion

In the sociodemographic analysis of data, most participants were found to be from 40 to 69 years of age. This result, despite showing some particularities in the extremes, with a group of outliers, is in consonance with the age profile of the Brazilian population that is affected by the disease and with public policy, considering the target-population for actions to screen for cases of breast cancer and diagnose them early.[5]

When the variable “age” is compared in the international setting, the possible differences related to the level of economic development of a country stand out. In countries considered to be "developed" by the United Nations (UN), higher means were observed, as well as minimum ages higher than the one found in this study. However, when compared to other countries in "developing" economies, such as China, the youngest portion of the population was found to be susceptible to the development of the disease.[6-7]

Despite the higher incidence in certain age groups, the population as a whole must be informed about the benefits of early diagnostic. Even health professionals and caregivers must be made aware of the problem, so that everyone is informed that breast cancer affects all ages.[6]

Another feature of the sociodemographic profile was found in 40.20% of women, who had less than nine years of formal education, with incomplete elementary education, reflecting a particularity of the setting — public healthcare service — when compared to another study, which found higher educational levels in women attended in the private health network.[8]

One of the greatest challenges of health professionals who work directly with patient care is establishing clear and effective communication, adapted to the capacity each person has of understanding. Communication must consider the educational level, the previous knowledge, and the context of the life of each person and each family. That facilitates the establishment of bonds of trust and the adherence to instructions.

In addition to the low educational level, the *per capita* income of women also stood out, since 90.95% of women live with up to two minimum wages. The income analysis also is associated with the study setting, since the low educational level may be directly related to the low income.[8] A study carried out in Curitiba, Paraná, from 2012 to 2013, found that the family income of women with breast cancer who received care at a public teaching hospital had a mean of 3.9 minimum wages, while the mean income of the women cared for in a private clinic was 13.8 minimum wages.[8]

Considering this comparison, the financial situation of the women in this study must be considered carefully, since they earn up to two minimum wages, which reflects the recession that has been affecting Brazilian economy since the second quarter of 2014, according to data from the Committee for the Dating of the Economic Cycle (CODACE), from the Getúlio Vargas Foundation.[9]

It stands out that patients with breast cancer who are in worse economical situations may present a significantly higher risk of being diagnosed late, when compared to individuals in a better economic situation.[10] In addition, patients with lower socioeconomic power, or those

diagnosed in the more advanced stages of the disease, are more likely to become bankrupted or die.[11]

Metastatic or local advanced breast cancer is a very aggressive disease that affects all dimensions of the person, and the symptoms that result from treatments and/or from the evolution of the disease can lower personal performance, leading to absenteeism at work, work leaves, and disability retirements, which can compromise the income of the family.[12]

In this research, the investigative approach was not related to spirituality, but with religion. 97.48% of women declared to have a religion. A predominance of evangelical women was found (48.74%), followed by catholic women (40.70%). This result is very similar to that of another study, carried out in Italy, in which 94% of women were found to have a religion.[6] However, declaring that they have a religion does not mean that the needs of the spiritual dimension of the woman are well cared for, since they may not be practicing their religion frequently and it may not help them achieve peace, acceptance, strength, resilience, or other positive feelings to deal with the situation at hand.

Cancer is a chronic disease which, in some cases, is incurable. Its diagnostic puts patients through painful experiences. Spiritual beliefs may influence the way in which they will deal with- the disease and, often, its terminal aspect, since people are unique. Patients who have a religion/spirituality live a life with less health-related issues and, therefore, with more quality. Spirituality may be an important strategy for dealing with stressing situations, such as cancer.[13]

It stands out that the nursing team is made up by the professionals who spend the most time with the women, especially when they are hospitalized. It has an important role in their integral care, which is related to the need of discovering this variable from the sociodemographic profile, and, as a result, to the possibility of attending to the needs the patient has for spiritual care. The nurses see spirituality as a source of strength, comfort, and faith, which contributes for the improvement of the clinical framework of patients under

palliative care, since it facilitates their acceptance and their confrontation of the process of disease and of the end of life.[13]

It was found that 53.27% of women lived with a partner, corroborating a study which analyzed data from 137,593 women who had been diagnosed with breast cancer in the Brazilian public health system, finding that 54.2% of them were married or lived in a consensual stable union.[5] It should be noted that the health-disease process of the woman with metastatic or advanced local breast cancer provokes fear and uncertainty not only in their lives, but also in the lives of people who are close to them, including close relatives, such as children and spouses, who share their suffering.

Couples can have positive and negative experiences from the effects of the diagnostic and treatment of breast cancer. Studies have shown that an adequate social support from family, friends and neighbors can significantly improve the quality of life of women with breast cancer. It may have an important role in dealing with this disease and self-managing its chronic condition.[14-15]

With regards to the planning of assistance, the importance of recognizing the needs of women with regards to social support stands out. Therefore, it is important to identify the people or institutions that constitute this network. The presence of the family can make the hospital discharge easier, whenever possible and desired by the patient, since it is an opportunity for the nursing team to teach how this type of healthcare can be provided at home.[16]

When the clinical-pathological profile of women was analyzed, it was found that most of (81.41%) were diagnosed with invasive ductal carcinoma, which was found to be the most common in literature, regardless of age or of the stage of the disease.[5-7]

The most common initial stage was III (53.77% - 107 women), which does not corroborate other studies carried out with Brazilian women, according to which the most common clinical stage, in isolation, was stage II.[5,17] The late diagnostic of breast cancer interferes in the choice of

treatment, impacts in the responses expected, that is, in the possibility or not of a cure, in the estimates of the survival time and on quality of life. A piece of data that should be highlighted is the fact that 10.55% of women were diagnosed in the most advanced stage of the disease, that is, stage IV, and certainly, the treatment then started was palliative. A similar result was found in a retrospective study carried out in the south of China, which found that 10.7% (26 women) found they had the disease when it was in stage IV.[7]

Regarding the current stage of the 199 women analyzed, 145 (72.86%) were found to be in the most advanced stage of the disease. It became evident that the number of women in stage IV considerably increased starting from the moment of the diagnostic, going from 21 to 145 women.

From the 145 women who presented metastases, 96 had two or more sites compromised. The most common sites for the metastases were, respectively, the bones, the lungs, the liver, and the central nervous system. Multiple metastases, when compared to a metastasis in a single place, mean that the women have less time for treatment and a significantly smaller survival time. Patients who presented multiple metastatic sites, due to the involvement of multiple organs, tend to present even worse clinical results, can have more symptoms and, as a consequence, a worse quality of life.[18]

The modalities of treating breast cancer may be local or systemic. To choose the best treatment, many factors must be considered, such as the stage of the disease, its biological characteristics, and the clinical characteristics of the patient. The situation should also be widely discussed with the patient, and their preferences considered.[19]

Chemotherapy was found to be the most used treatment, which corroborates a study carried out in China, in which, after being diagnosed with metastasis, 88.1% (214 patients) of patients were treated with chemotherapy.[7] This conduct is in accordance with the recommendations of the National Program for the Control of Breast Cancer, according to which

systemic treatment, such as chemotherapy, is the most recommended for stage IV, so there is balance between a tumoral response and the possibility of a longer survival time. Surgery, on the other hand, was not used for these women; the higher the stage, the lower the incidence of surgery, since the routine conduct is to carry out surgeries when breast cancer is diagnosed in its initial stages.[20]

Considering the negative repercussion of the treatments in the lives of these women, health professionals must assist them in an integral and humanized way, aiding them to deal with the disease and with the possible complications of treatments. The quality of life of women may be changed due to the chemotherapy, leading to impacts in the physical, sexual, and social functioning, pain control, body image, and future perspectives.[8]

Regarding the PS, most women (71.86%), at the moment of data collection, had PS3 or PS4. This prevalence made it possible to infer that most women were incapable of caring for themselves and leading a normal life. They were restricted to their bed all the time or nearly all the time and needed interventions from the nursing team and, sometimes, from people they wanted by their side, thanks to the dependency for self-care activities and to other health professionals from the health team, considering the conditions that affect quality of life.

Among the main complications of breast cancer, the data from this study highlight the tumoral wounds, the lymphedema, and the medullary compression syndrome. Tumoral wounds are mainly characterized by "fast progression, absence of healing, hemorrhages, fetid smell, large amounts of exudate, high risk of infection, high risk of myiasis, tissue necrosis, pain, pruritus, and aggression to healthy peri-lesion tissues".[21:308] In a study carried out in Japan, 80% of patients with tumoral wounds complained about pain.[22] The symptoms above lead to feelings of shame, embarrassment, disability, social isolation, and worse quality of life.

In the multidisciplinary team, the nurse has an important role in managing the care to the woman who has tumoral wounds in the breasts, bringing together skills and competences to

control the symptoms that this complication exacerbates and considering all aspects affected, such as the psychological and social ones. As a result, their objective is promoting the quality of life through the relief of signs and symptoms, the improvement of the appearance, and psychosocial reactions, such as fear, anxiety, depression, and low self-esteem.[22]

The disease itself, its sequelae, and the complications in the treatments, such as the lymphedema, are possible risk factors for the psychological suffering of women. They have negative impacts on their body image and make it more difficult for them to continue with their daily activities and social interactions. Health professionals, including the nurse, should intervene, preventing or minimizing these complications and this suffering, to improve the quality of life of these women.[14]

Conclusion

Knowing the sociodemographic and clinical-pathological profiles of women hospitalized with metastatic or advanced local breast cancer contributes to identify the characteristics that can lead to inequalities in the access to the health service, and thus, to late diagnoses to the disease.

As a result, it contributes to offer an integral perspective, respecting the individualities and focusing actions of care for the profile of the population who has been affected by the disease. Consequently, it subsidizes the strategic, tactical, and operational fields of assistance. Guidance to manage care in the scope of the interdisciplinary team stand out, as do guidance to manage health, considering the demands involved in cases where the disease is advanced, leading to worse PS and quality of life, especially in the socially vulnerable portions of the population.

This study suggests, with regards to its limitations: evaluations lasting for longer periods; the association and inclusion of other variables, such as type of surgery, motive and time of

hospitalization, up to the point of the outcome, be it death or discharge; and its expansion into other settings.

In addition, the setting includes only women who were attended by the public health system, which can limit the applicability of the results, considering the profile of the late diagnostic, the low educational level, and the poor socioeconomic conditions of the participants. It is important to note that, in Brazil, there are different social, demographic, and cultural characteristics, and the replication of results for other populations should be done with caution, since their characteristics may be different from the characteristics of the population interviewed here.

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1 – Eunice de Oliveira Lacerda Lima
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How to cite this article

Lima EOL, Silva MM. Sociodemographic and clinical-pathological profile of women hospitalized with metastatic or advanced local breast cancer Rev. Enferm. UFSM. 2020 [Acesso em: Anos Mês Dia]; vol.10 e56: 1-18. DOI:https://doi.org/10.5902/2179769240000