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Qualidade de vida de mulheres mastectomizadas matriculadas em um programa de reabilitação

Quality of life of mastectomized women enrolled in a rehabilitation program

Calidad de vida de mujeres con la mastectomía inscritas en un programa de rehabilitación

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ABSTRACT

Objective: To evaluate the quality of life in mastectomized women enrolled in a rehabilitation program, according to sociodemographic and clinical variables. **Methods:** This is a descriptive study, conducted at the Rehabilitation Program for Mastectomized Women, at Espírito Santo, Brazil. The sample consisted of 53 women interviewed according to the standards of Visual-Analogue Quality of Life Scale for Head and Neck Cancer Carriers adapted to Breast Cancer Carriers with the consent of the authors. The data received statistical analysis by SPSS version 17.0 software and sociodemographic variables were assessed using Pearson's correlation coefficient. **Results:** It was found that younger women without breast reconstruction married and submitted to chemotherapy or hormonal therapy had greater loss of quality of life. **Conclusion:** Therefore, there is the importance of interventions to promote a better quality of life for these patients, with effective interdisciplinary action by the health team.

Descriptors: Breast Neoplasms, Quality of Life, Rehabilitation, Women's Health.

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RESUMO

Objetivo: Avaliar a qualidade de vida em mulheres mastectomizadas matriculadas em um programa de reabilitação, segundo as variáveis sociodemográficas e clínicas. **Métodos:** Trata-se de um estudo descritivo, realizado no Programa de Reabilitação para Mulheres Mastectomizadas, no Espírito Santo, Brasil. A amostra foi composta por 53 mulheres entrevistadas através da Escala Análogo-Visual de Qualidade de Vida de Portadores de Cânceres de Cabeça e Pescoço, adaptada para Portadores de Câncer de Mama com aquiescência dos autores. Os dados obtidos receberam tratamento estatístico no programa SPSS versão 17.0 e as variáveis sociodemográficas foram avaliadas através do coeficiente de correlação de Pearson. **Resultados:** Identificou-se que mulheres mais jovens, sem reconstrução da mama, casadas e em tratamento de quimioterapia ou hormonioterapia apresentaram maiores perdas da qualidade de vida. **Conclusão:** Diante disso, destaca-se a importância de intervenções que promovam melhor qualidade de vida a essas pacientes, com atuação interdisciplinar eficaz por parte da equipe de saúde.

Descritores: Neoplasias da mama, Qualidade de Vida, Reabilitação, Saúde da Mulher.

RESUMEN

Objetivo: Evaluar la calidad de vida en las mujeres con mastectomía inscritas en un programa de rehabilitación, de acuerdo con las variables sociodemográficas y clínicas. **Métodos:** Se trata de un estudio descriptivo, realizado en el Programa de Rehabilitación para Mujeres Mastectomizadas, en Espírito Santo, Brasil. La muestra consistió en 53 mujeres entrevistadas por la Escala Analógica-visual para la Calidad de Vida de Portadores de Cánceres de la Cabeza y Cuello adaptado para las pacientes con cáncer de mama, con el consentimiento de los autores. Los datos recibidos fueron analizados con el programa SPSS versión 17.0 y las variables sociodemográficas se evaluaron utilizando el coeficiente de correlación de Pearson. **Resultados:** Se encontró que las mujeres más jóvenes sin reconstrucción mamaria, casadas y en la quimioterapia o terapia hormonal tenían una mayor pérdida de calidad de vida. **Conclusión:** Por lo tanto, existe la importancia de las intervenciones para promover una mejor calidad de vida de estos pacientes, con una acción interdisciplinaria eficaz por parte del equipo de salud. **Descriptor:** Neoplasias de la mama, Calidad de Vida, Rehabilitación, Salud de la Mujer.

INTRODUCTION

Cancer reaches larger indexes every year. Considered the second largest cause of death in Brazil, the National Cancer Institute estimates that there will be approximately 576,000 new cases of this disease in the year of 2014.¹ This corresponds to 20.8% of all cancers in women.¹ The World Health Organization estimated that there are over one million new cases of breast cancer worldwide each year.²

Featuring an estimate of 57,000 new cases of breast cancers for 2014, this disease reaches the first place among the types of cancers more incident in women, except for skin cancer non-melanoma.¹ In the southeast region the estimate for the same period is of 30,740 new cases, corresponding to 21.5% of all cancers in women, and higher than the estimate of the country, and more than all Brazilian regions.¹ Given these data, we can see the increase of women affected by

this disease, which implies the need to develop effective treatment strategies in health care networks considering the quality of life (QOL) of patients.

Minayo³ conceptualizes QOL as follows:

Quality of life concerns the standard that society itself defines and mobilizes to attain, consciously or unconsciously; and to all public and social policies that lead and guide human development, positive changes in habits, conditions and lifestyles, thus assigning a significant portion of this formulation and responsibilities to the so-called health sector.

In spite of this definition, there is a difficulty in achieving a consensus on the concept of QOL, because it is linked to its subjective nature and therefore it is of difficult conceptualization.⁴ In view of this subjectivity, the individual's perception, their feelings and their health conditions can affect their QOL.⁵

Considering the importance of the health condition, the diagnosis of cancer certainly has a big impact on the life of the patient. In the case of breast cancer, the effect is devastating for women due to the fact that the breast is closely linked to femininity, the hypothesis of change or removal of the breast leads to an impairment of QOL.⁵

It is important to understand that the worsening in QOL is related to the limitations on mobility, daily activities and the ability to work, resulting in a significant reduction in the level of independence,⁶ therefore, it is up to the health team to be aware of these factors, valuing the patient holistically, trying to understand the welfare, well-being, well-having and well-living of each individual.⁷ Nursing, in particular, for it is directly involved in all processes, from diagnosis to rehabilitation and resocialization of this women, becomes an important pillar in perceiving and supporting mastectomized women, who find themselves weakened. To understand well and get involved effectively in this process it is fundamental and at the same time challenging, often due to the lack of preparation, willingness and sensitivity of some professionals, or even, for the knowledge they have on the weight that this disease brings and the stigma it carries, underestimating their own capacity to intervene in the situation.

This work is justified by its relevance as it highlights the importance of assessing the quality of life of these patients, so that actions can be carried out in the promotion of QOL and of a holistic care to the patient, aiming to evaluate the quality of life of women enrolled in Rehabilitation Program for Mastectomized Women (PREMMA), according to the socioeconomic and clinical variables, and in accordance to a Visual-Analogue Quality of Life Scale.⁷

METHODS

This is a cross-sectional study with a quantitative approach. Held in PREMMA located at the Ylza Bianco clinic at Santa Rita de Cássia Hospital (HSRC) of the Women's Education and Fight Cancer Association (AFECC), in Vitória/ES, Brazil. The PREMMA is the result of a partnership between the Nursing Department of the Health Sciences Center of the Federal University of Espírito Santo and the HSRC/AFECC. It is an interdisciplinary program in which are performed dynamics and rehabilitation exercises aimed at prevention of injuries related to the occurrence of breast cancer, from the moment of post diagnosis so that the patient has support at all treatment stages.

The sample was randomly composed. For size calculation, the Bioestat 5.0 program was used. For calculation purposes the following data were used: Alpha 5%, Beta 80%.

The minimum *n* calculated was 41 women diagnosed with breast cancer, by the end, 53 women were interviewed and remained in the study.

Inclusion criteria were: being female; be in treatment/monitoring at the HSRC/AFECC and be enrolled in PREMMA; to be of age equal or superior to 18 years; agree to participate in the study by signing the Free and Enlightened Term of Consent.

Quality of life was measured by the Visual-Analogue Quality of Life Scale of Head And Neck Cancers Carriers, adapted to Breast Cancer Carriers with the consent of the authors. The variables were age, marital status, ethnicity, education level, occupation, origin, clinical staging, time of participation in PREMMA, spiritual support, family support and treatments performed.

The data collection process occurred by individual interviews conducted by the investigator himself, in the period from May to July of 2012. The collection instrument was the Visual-Analogue Quality of Life Scale of Head And Neck Cancers. This is a Visual-Analog scale that consists of 34 questions; the latest version in Portuguese received authorization from Antoni Font Guiteras to be adapted to the Brazilian population.⁷

The patient responded to this semi-structured questionnaire, indicating a line up to one hundred (100) millimeters representative of how much each factor reached. The straight line corresponds from 0 to 100 percentage points where the left margin is the option indicator of normal (0), given the factor under consideration, and on the other side, the option indicator of the maximum commitment of factor in the analysis (100), hence, indicating a loss in QOL indicators.

The scoring index for the quality of life subscales was carried out as follows: Patient score by scale is equal to the sum of the percentage of patients in each subscale divided by the total number of items forming the subscale. Data were organized in tables in Excel 2007 and for the statistical analysis, Statistical Package Package for Social Sciences (SPSS)

version 17.0 was used. The sociodemographic variables were assessed using Pearson's Correlation Coefficient.

In regard to the Resolution 196/96 of the National Health Council, this study was approved by the Ethics Committee of the Federal University of Espírito Santo under n°. 29888 in May 2012. The study was also approved by the HSRC Studies Center (ANNEX W).

RESULTS

Table 1 demonstrates that 58.5% of the women interviewed are of ages ranging from 40 to 59 years and are married. Occupation retired/pensioner corresponds to 26.4% of women. Of these subjects, 92.5% reside in urban areas, and 77.4% live in households located in the Great Victoria. The sample was predominantly self-declared brown (69.9 %) and have studied from the first to the fourth grade of elementary school (47.1%). Of the women, 92.5% claimed to have family support and 100% reported having some kind of spiritual support.

Table 1 - Socio-demographic profile of the participants in the rehabilitation program for mastectomized women

Variable	Category	N	%
Age distribution	20-39	3	5.7
	40-59	31	58.5
	60-79	19	35.8
Marital status	Married	31	58.5
	Not married	22	41.5
Occupation	Housewife	7	13.2
	Housekeeper	8	15.1
	Retired/pensioner	14	26.4
	Working woman	8	15.1
	Farmer	5	9.4
Residence	Urban	49	92.5
	Rural	4	7.5
City	Great Vitória	41	77.4
	Countryside	12	22.6
Ethnicity	White	12	22.6
	Brown	37	69.9
	Black	4	7.5
Education Level	Illiterate/Elementary school incomplete	39	73.6
	Elementary school complete	5	9.4
	Highschool complete	5	9.4
	Undergraduate school complete	4	7.5
Family support	Yes	49	92.5
	No	4	7.5
Spiritual Support	Yes	53	100
	No	0	0

As to the clinical variables, it can be observed that there was a prevalence of the initial clinical staging (78.6%), mastectomy was the most performed procedure (54.7%) and patients who underwent chemotherapy sessions, radiotherapy and hormonal therapy accounted for 75.4%, 67.9% and 56.6%, respectively. Most patients did not perform breast reconstruction (92.5%), 62.5% are in treatment, and participating in PREMMA from the period of zero to twelve months (41.4%).

Table 2 - Clinical profile of participants in the rehabilitation program for mastectomized women

Variable	Category	N	%
Clinical staging	Early	33	78.6
	Late	9	21.4
Treatment received			
Kind of surgery	Mastectomy	29	54.7
	Quadrantectomy	24	45.3
Chemotherapy	Yes	40	75.4
	No	13	24.6
Radiotherapy	Yes	36	67.9
	No	17	32.1
Hormonal therapy	Yes	30	56.6
	No	23	43.4
Breast reconstruction	Yes	4	7.5
	No	49	92.5
Current treatment	Undergoing treatment	33	62.5
	After treatment	20	37.5
Time of participation in PREMMA	0- 12 months	22	41.4
	13-60 months	20	37.7
	Over 5 years	11	20.9

In Table 3, the Pearson correlation test was used to compare the age of patients and the dimensions of quality of life, and age with due expectations. It was observed that the higher the age, the lower the loss in the daily habits dimensions, psychological habits and overall evaluation of QOL.

Table 3 - Correlation coefficients between the dimensions of quality of life and age, according to visual-analog scale (n = 53)

DIMENSION	R
Physical	-0.24
Everyday habits	-0.45**
Social/Family	-0.23
Psychological	-0.35**
Overall evaluation of QOL	-0.29*
Theoretical expectation	0.25
Self-referenced expectation	-0.15
Self-efficacy expectation	0

*p ≤ 0.05; **p ≤ 0.01

Table 4 shows QOL loss, which overall was greater in the physical and social/family dimensions. In the first one, patients of 20-39 years showed average (A) of 36.6, much higher when compared to the ones of 60-79 years (A 13.7).

Table 4 - Averages and standard deviations of the loss of quality of life according to sociodemographic and clinical variables

	Domain (A and SD)			
	Physical	Everyday Habits	Social/ Family	Psychological
Total	22.4 ±21.5	2.8 ±1.4	20.1 ±16.4	19 ±15.5
Age group				
20-39	36.6 ±32.3	3.9 ±1.9	33.2 ±27.6	31.2 ±20.5
40-59	26.4 ±21.7	3 ±1.1	20.6 ±15.2	22.1 ±15.4
60-79	13.7 ±17.2	2.1 ±1.4	17.2 ±16.4	11.9 ±12.7
Marital status				
Married	24.5 ±21.7	3.1 ±1.2	22.7 ±16.2	18.4 ±14.9
Not married	19.5±21.3	2.2 ±1.3	16.4 ±16.3	19.7 ±16.7
Treatment stage				
Undergoing treatment	22.5 ±23.4	3.1 ±1.2	21.4 ±16.4	20.1 ±16.4
Pots-treatment	22.2 ±18,5	2.5 ±1.4	18 ±16.6	17 ±14.1
Current treatment				
Chemotherapy	32.7 ±38.7	3.8 ±1.5	26.4 ±4.9	12.5±10.1
Radiotherapy	14.5±20.5	1.6 ±1.9	1.1 ±1.6	6.5 ±9.1
Hormonal therapy	26 ±23.3	3.3 ±1.1	24 ±18.9	25.3±15.8

Table 4 (continued) - Averages and standard deviations of loss in the quality of life according to sociodemographic and clinical variables

	Domains (A and SD)			
	General Evaluation QOL	Theoretical Expectation	Self-referenced Expectation	Self-efficacy Expectation
Total	7.9 ±21.7	4 ±11.5	2 ±8.5	0 ± 0
Age group				
20-39	33.3 ±57.7	4 ±6.9	16.6 ±28.8	0 ± 0
40-59	9.3 ±21.7	0.9 ±3.5	1 ±5.9	0 ± 0
60-79	1.5 ±6.8	9 ±17.7	1.1 ±4.8	0 ± 0
Marital status				
Married	9 ±24.2	4.5 ±12.4	3.5 ±11	0 ± 0
Not married	6.3 ±17,9	3.2 ±10.3	0 ±0	0 ± 0
Treatment stage				
Undergoing treatment	12.1 ±26.5	1.7 ±4.6	2.2 ±10.2	0 ± 0
Post-treatment	0.9 ±4	7.8 ±17.4	1 ±4.6	0 ± 0
Current treatment				
Chemotherapy	32±27.2	0 ±0	0 ± 0	0 ± 0
Radiotherapy	0±0	5.5 ±7.7	0 ± 0	0 ± 0
Hormonal therapy	11 ±26.8	1.6 ±5	4.3 ±13.3	0 ± 0

In regards to the everyday habits dimension, all women obtained A, SD and AD adjacents, but not in the social/family factor where once again the patients with ages between 20 and 39 years reached higher values (33.2 A) in comparison to the other patients. Still in this dimension, married patients achieved higher values A 22.7 (16.2 SD and 23.1 AD) than unmarried ones A 16.4 (16.3 SD and 12.6 AD).

In assessing the psychological dimension, patients with ages between 20 and 39 years showed A 31.2 (20.5 SD and 38.6 AD), a higher value when compared with patients of 40 to 59 years A 22.1 (15.4 SD and 21.3 AD) and even higher in relation to patients with ages between 60 and 79 years A 11.9 (12.7 SD and 9 AD).

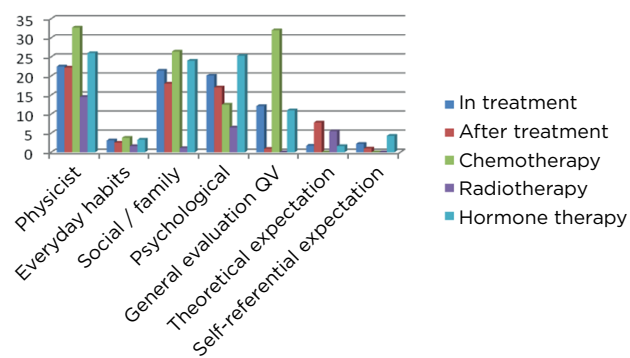
In the QOL general evaluation, women of 20-39 years (33.3 A, 57.7 SD and 0 AD) had much higher values in comparison to the patients of 40 to 59 years (9.3 A, 21.7 SD and 0 AD) and to the ones of 60 to 79 years old (1.5 A, 6.8 SD and 0 AD).

Women aged 60 to 79 years reached higher values (9 A, 17.7 SD and 0 AD) in the theoretical expectation dimension when compared to other age groups.

As for the self-referenced expectation, there is a discrepancy between the patients of 20 to 39 years (16.6 A, 28.8 SD and 0 AD) in relation to other age groups. Married women presented higher values (3.5 A, 11 SD and 0 AD) than not married ones (0 A, 0 SD and 0 MD).

In graphic 3 the diagram shows that the physical dimension of the patients undergoing treatment (22.5 A, 23.4 SD and 19 AD) presented similar values to the ones in post-treatment (22.2 A, 18.5 SD and 25.2 AD). Still in this dimension is noted that women on chemotherapy reached higher values (32.7 A, 38.7 SD and 27.5 AD) followed by patients in hormonal therapy (26 A, 23.3 SD and 24.4 AD) and in radiotherapy (14.5 A, 20.5 SD and 14.5 AD), therefore greater loss of QOL.

Graphic 3 - Configuration of the average quality of life, according to current treatment and types of treatment variables



In everyday habits dimension, all patients achieved low and similar values within each other, which did not occur in the social/family life where patients undergoing treatment (21.4 A, 16.4 SD and 18 AD) had slightly higher values compared to the post-treatment ones (18 A, 16.6 SD and 15.9 AD), but the major difference was noted in the analyses of patients on chemotherapy (26.4 A, 4.9 SD and 25.3 AD) and hormonal therapy (24 A, 18.9 SD and 18 AD) with the ones on radiotherapy (1.1 A, 1.6 SD and 1.1 AD).

Patients undergoing treatment (20.1A, 16.4 SD and 14.5 AD) showed similar values on the psychological scale, if compared to post-treatment patients (17 A, 14.1 SD and 20 AD), while women on hormonal treatment (25.3 A, 15.8 SD and 29 AD) achieved higher values than patients on chemotherapy (12.5 A, 10.1 SD and 8.2 AD) and radiotherapy (6.5 A, 9.1 SD and 6.5 AD).

The comparison of the dimension Overall Evaluation of QOL amongst patients undergoing treatment (12.1 A, 26.5 SD and 0 AD) and post-treatment patients (0.9 A, 4 SD and 0 AD) a big difference can be seen between these groups. The same is true for patients on chemotherapy (32 A, 27.2 SD and 29 AD) compared to patients on hormonal therapy (11 A, 26.8 SD and 0 AD) and radiotherapy (0 A, 0 SD and 0 AD).

A difference is perceived in the theoretical expectation dimension when it is identified that women in treatment (1.7 A, 4.6 SD and 0 AD) present lower values than the post-treatment patients (7.8 A, 17.4 SD and 0 AD); and the patients in radiotherapy (5.5 A, 7.7 SD and 5.5 AD) had higher values in this dimension in relation to patients ongoing hormonal therapy (1.6 A, 5 SD and 0 AD) and chemotherapy (M 0 , DP 0 and 0 MD).

As for the self-referenced expectation dimension, patients undergoing hormonal therapy showed higher values (4.3 A, 13.3 SD and 0 AD) than all other patients. It is important to highlight that in the self-efficacy expectation dimension, women of all groups presented value 0.

DISCUSSION

Surgical treatment for breast malignant neoplasm provokes significant changes in the individual. When mastectomy is performed, which is the case with most of this sample, the altered body image of women as well as causing feeling of mutilation and loss of sensuality, due to the absence of the breast,⁸ also causes reduction in leisure, religious and sexual activities,⁹ such factors interfere directly in the Social/Family and psychological dimensions of the patients studied. The importance of an effective clinical approach to psychosocial aspects is worth noting, thus it requires awareness and training of the professional in order for them to perform effective interventions in these situations.¹⁰ As a result it becomes essential to prepare the nurses, staff daily involved in this process.

Mastectomy may also cause symptoms of severe pain, so it is up to these professionals to develop preventive measures to mitigate post-operative pain, in a manner that causes the least nerve damage possible, besides that it is important to carry out with close monitoring starting in the post-operative period, aiming to minimize most of the limitations imposed¹¹ by pain and fear. In this study, the factor which further contributed to the physical dimension resulting in decreased QOL was pain, for few patients reported nausea in the last twenty-four hours prior to the interview. This factor can be better controlled if the nursing staff is attentive and willing to know the patients which serve, as signs and symptoms of pain can be easily identified by a well-trained staff, and minimized when the team is committed to bringing comfort and welfare to these people.

In regard to patients who did not undergo breast reconstruction, 92.5% of the sample, it is worth noting the importance of a good organization of the public health system where these patients are met, for breast reconstruction aims to soften the physical and psychological consequences imposed by mastectomy, seeking to rebuild the body image and the women's self-esteem besides improving sexuality.^{12,13,14} Ergo, seek to reduce the waiting time to perform breast reconstruction without endangering the patient, is important to improve the QOL.

This study showed that older women had increased QOL in Everyday Habits, Psychological and Overall Evaluation of QOL dimensions when compared to the younger subjects. A study of 110 women with breast cancer found similar results, leading to the understanding that older women have more effective coping strategies and better acceptance regarding the development of the disease and its treatment.⁵ In addition, younger patients may have maternity plans postponed or abandoned as a result of the treatment. Studies have shown that these women have low positive counting of the estrogen receptor, decreasing the chances of hormonal therapy and possible sterility, although carcinoma is considered more aggressive in this age group.^{15,16}

The average presented by younger women reflects the greatest loss of quality of life in all dimensions and in the self-referenced expectations. However, we emphasize the limitation of this study due to the small number of women in this age group. The study converges with literature, which confirms that younger patients have a worse prognosis when compared to older women.^{15,17,18}

Married women had greater loss of QOL in the Social/Family dimension, showing difficulties in family and marital relationships. The literature confirms our research stating that the quality of the relationship has a direct influence on the QOL, indicating little satisfactory relationships.^{5,19} Other studies also point to the worsening of marital relationships after mastectomy, also emphasizing the need for a nursing and all health staff to assist the couple, who experiences a delicate moment in the married life.^{20,21,22}

Patients undergoing chemotherapy are the ones who present greater loss of QOL in most dimensions due to the side effects of the treatment.²³ However patients on hormonal therapy had higher losses in the psychological dimension featuring lower satisfaction with life in general due to health problems. A survey of 270 women treated with Tamoxifen showed that most of them complained of side effects caused by this medicine, especially the symptom of hot flashes²⁴ which contributes to the decreased of QOL.

Despite the loss of QOL proved by several dimensions, something that draws attention in this study is the fact that all patients believe fully in their ability to develop actions that contribute to overcoming their own health problems (expectation of self-efficacy). As seen in articles, interdisciplinary approach and integrative care for patients with breast cancer, promotes an increase of QOL.^{10,11} PREMMA has an operating model that seeks to assist patients in all areas of life, with a concept of health which seeks to balance the biopsychosocial, understanding the importance of integrality.^{4,7,25} By relishing interdisciplinary work, group treatment, listening and rehabilitation, the group, founded by a nurse, which now has a multi-professional group, has sought and achieved, a positive intervention in the QOL of women who attend it, offering, besides the essential, complicity, companionship and unconditional support.

CONCLUSION

This study made it possible to scale the loss of QOL in mastectomized women according to sociodemographic and clinical variables, with a Visual-Analog Quality of Life Scale, identifying that patients had lower QOL in Physical, Social/Family and Psychological dimensions, especially younger women and women undergoing chemotherapy.

This study had limitations on the sample sizes, given that in some groups few patients were evaluated. Furthermore, we found difficulties in correlating the study with others that used the Visual-Analogue Quality of Life Scale. We suggest that more studies be carried out with this instrument for better dimensioning of QOL.

We believe this is an important study to the academic world because it made possible to identify and evaluate the QOL of patients who have or are going through a situation of adaptation to the new condition of life imposed by breast cancer. It is worth noting the importance of awareness and training of the professionals so that they work in an interdisciplinary way aimed at promoting better QOL for these patients.

PREMMA seeks to contribute to the promotion of QOL, for as well as teaching and performing rehabilitation exercises, in the search to minimize complications such as lymphedema, it also promotes the work of various professionals in order to help each patient to meet the biopsychosocial balance. We suggest that professionals and managers should seek ways to implement such programs, aimed at the care of the being in a holistic manner, not only for cases of cancer but to the many health areas that focus on the maintenance and promotion of QOL.

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