

ORIGINAL ARTICLE

CERVICAL ADENOCARCINOMA AND THERAPEUTIC DROPOUTS: THE PERSPECTIVE OF NURSES IN A CITY IN THE EXTREME NORTH OF BRAZIL

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ABSTRACT

Objective: to describe, from the perspective of nurses, the causes of dropout of users in treatment for cervical adenocarcinoma and analyze the proposals to reduce this dropout. Method: the study is descriptive, qualitative, of narrative research type. Seven care nurses, working in a high complexity oncology unit in the city of Macapá, capital of the state of Amapá, Brazil, participated. The study was conducted in the period from December three to 20, 2019. Data were submitted to categorical thematic analysis. Results: two categories emerged: main causes of dropout of users in treatment for cervical adenocarcinoma and nurse strategies for the reduction of treatment dropout by users. Conclusion: to promote the rescue of the users, the participating nurses propose a Nursing consultation and a multi-professional action plan, respecting the singularities of each woman.

DESCRIPTORS: Nursing; Adenocarcinoma; Patient Dropouts; Treatment Adherence; Nurse.

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INTRODUCTION

In Brazil, every year, the incidence of uterine cervical neoplasm is increasing, so that the new diagnoses in some cities exceed the averages of the states and regions, being, as highlighted by the National Cancer Institute (INCA), the first most incident in the Northern region of Brazil (26.24/100,000)(1). In the state of Amapá, the incidence of cases is 33.00/100,000, and in the capital city (Macapá) it is 35.52/100,000⁽¹⁾. Cervical adenocarcinoma is of endocervical glandular epithelial incidence, asymptomatic and requires early diagnosis.

The Brazilian Unified Health System (SUS) must guarantee the diagnosis and all treatment of cancer, offering the following services: Oncological Surgery, Clinical Oncology, Radiotherapy, Hematology and Pediatric Oncology services in a High Complexity Oncology Assistance Unit, based on Ordinance No. 741, of December 19, 2005. Early diagnosis helps the user to face the cervical adenocarcinoma, and the chances of cure are increased if the triad: cytology, colposcopy, and histology are previously offered⁽²⁾. The diagnosis and therapy require a psychic and socioeconomic effort from the user, which can lead her to feelings of fear, among others.

In view of this, Law No. 12,732/12, in effect since May 23, 2013, establishes that the first oncologic treatment for malignant neoplasms at SUS should begin within a maximum of 60 days from the signing of the pathology report or within a shorter period, according to the therapeutic need of the case recorded in the patient's medical record. In 2019, Law No. 13,896 was sanctioned, which adds an item in the second paragraph to the 2013 Law, determining that exams related to cancer diagnosis must be performed within up to 30 days⁽³⁾.

Therefore, this study is justified, above all, by the growing incidence of uterine cervical neoplasm in the state of Amapá, as well as the experience in the researchers' practice in a highly complex oncology unit, when fragility was observed in the early diagnosis and treatment, and a deficit in the comprehensive care of women's needs, favoring dropout of treatment.

Given the problems presented, this study aimed to describe, from the nurses' perspective, the causes of dropout among users undergoing treatment for cervical adenocarcinoma and to analyze their proposals to reduce this dropout.

METHOD

The study is descriptive, qualitative, narrative research type. The participants were seven care nurses, inserted in the scope of the Unit for High Complexity Assistance in Oncology (Unacon), in the period from December three to 20, 2019, on a day and time according to the convenience of the participants. The interviews were conducted face to face, at the Reference Center for Neoplasia Care in the State of Amapá.

Inclusion criteria were to be an assistance nurse and to have worked at Unacon for at least 12 months. As exclusion criteria, professionals who for some personal reason did not agree to continue in the research.

The semi-structured interview technique was used, based on a form with closed and open questions. The closed questions were related to the characterization of the nurses' work profile, while the open questions were about the research participants' perspective on the causes of dropout by users of cervical adenocarcinoma treatment, as well as the nurses' strategies to reduce this dropout.

The interviews were conducted by the researchers at Unacon, in a private environment, lasting 25 minutes, and recorded on digital media, with the following trigger questions: comment on the factors related to cases of treatment dropout for adenocarcinoma; do you have an intervention plan to reinsert women who abandoned treatment? if yes, comment; if no, comment on what your intervention proposal would be.

Throughout the interview, the researcher allowed free speech and, simultaneously, the outline of the conversation, seeking to keep the interview tuned to the research objectives and, to determine the number of participants, the saturation method was used⁽⁴⁾. Subsequently, the interviews were transcribed by the researchers into the Word program.

Data analysis occurred through the organization of the analysis, and the thematic-categorical technique was used⁽⁵⁾. This method is a set of communication analysis techniques, whose objectives focus on overcoming uncertainty and enriching the reading and in its heuristic function, which corresponds to an exploratory attempt to increase the propensity to discover.

The organization of the analysis was operationalized through three methodological stages: the first is the pre-analysis, phase of the organization itself, in which there is the reading of the material produced; in the second, the exploration of the material, the categorization of the results obtained is performed, through the dismemberment of the text in units, in categories according to degrees of affinity of the themes; and finally, the third stage, treatment and interpretation of the results, followed by inferences to culminate in interpretations and, with this, the information is organized and guided by the delimitation of the themes related to the object of study⁽⁵⁾.

After transcribing the participants' speeches, the collected information was organized and separated and coded to preserve their identities, using the letter E, initial of the word nurse, followed by the number corresponding to the order of the interviews, E1, E2, and so on. The interpretation of the data collected is supported by the argumentation of the information and there must be an organization and the distinct stages of content analysis, pre-analysis, probing of the material and the results: conclusion and interpretation through categorization.

The study was approved by the Research Ethics Committee of the Federal University of Amapá under opinion number 3.661.636.

RESULTS

The sample was composed of seven care nurses, aged between 41 and 54 years, mostly female, from Macapá-AM, where they work at the Unacon between one and three years, inserted in the scope of the Unacon in the period from December three to 20, 2019. According to the convenience of the participants, the interviews were conducted face to face. After an analytical and explanatory process about the experiences, two categories emerged: Glimpsing the causes of dropout of users in treatment for cervical adenocarcinoma from the nurse's perspective and unveiling the nurse's strategies for the reduction of dropout of treatment by users.

Glimpsing the causes of dropout of users in treatment for cervical adenocarcinoma from a nurse's perspective

In this category, three causes of dropout emerged. The first is the deficiency in the organization and functioning of the health system, according to the following statements.

Here there is a slow pace of treatment since chemotherapy sessions are constantly cancelled

due to a lack of medications and supplies. In addition, the lack of radiotherapy support in the state is another obstacle. (E1)

The information about dropout is not communicated either by the TR (technical responsible) or by the assisting physician; only once the oncologist communicated and asked us to contact a patient. So, when it reaches us, it is very late. (E2)

The second cause is the family absence. The absence of the family with these women at the time of treatment and diagnosis is an essential factor for adherence or non-adherence to treatment.

Many patients drop out of treatment, mainly because of lack of family support, they feel rejected, and this contributes to their withdrawal from treatment. (E1)

We observed a lack of family support for some clients, and when they return, there is nothing more to be done, due to the advance of the disease. (E6)

Finally, from the nurses' perspective, women lack knowledge about the pathology. Users do not understand their disease, the therapy, and the opportunities for control, and this favors dropout.

Yes, they are patients who, for not accepting the disease, give up the treatment, for lack of information about it, [...] and in some cases, we manage to contact them, but there is resistance to return to the unit. (E2)

Yes, it usually happens due to beliefs, social, economic factors, lay patients who can't assimilate the gravity of this dropping out. (E5)

Unveiling the nurse's strategies for decrease in treatment dropout by users

The professional nurse, to minimize dropout, suggests two possibilities. One of them is the implementation of the Nursing consultation, as reported below.

Ideally, there should be more nurses to share the responsibilities, so that we can make the nursing consultation at the outpatient clinic, because during the consultation we could better orient the patient throughout her treatment. (E2)

The nursing consultation brings the user closer, provides more of a patient-professional bond, stops being that very mechanistic care, and develops humanized practice. (E4)

The other possibility suggested by the nurses is the construction of an action plan for the rescue. It is noteworthy, on the part of the professionals, an uneasiness in the way in which adequate guidance is given to the patients, aiming at the benefit to their health, and they reported the construction of a plan to encourage these users not to abandon the treatment.

It would be interesting to have an action plan to identify possible absences in the treatment sessions, and with this we would try to rescue them in a shorter time, because when we know the user doesn't show up. (E3)

I would like to build an action plan to identify and solve absences in treatment, also involving other professionals, and perhaps have support from people with expertise in the cause. (E7)

DISCUSSION

To minimize morbidity and mortality from uterine cervical neoplasm, the Ministry of Health, through Ordinance GM/MS No. 3712 of December 22, 2020, established a financial incentive to strengthen actions of screening, diagnosis, and early treatment of cancer in SUS⁽⁶⁾. This ordinance establishes in its article 1, on an exceptional and temporary basis, a federal financial incentive to fund the goal of strengthening the access to cancer prevention, early detection, and control actions during the pandemic, in the SUS, by reorganizing the care network and its care flows.

The care network is essential in the prevention and recovery of patients with cervical adenocarcinoma, but it presents structures and care functionalities that are disproportionate to the clinical, socioeconomic, and emotional demands of the users, compromising health care, besides the interruption of one or more stages of the antineoplastic therapeutic cycle due to the absence of radiotherapy.

Additionally, a study from the state of Rio de Janeiro addressed organizational barriers such as limited geographical area and difficulty of access of patients to the health unit, identifying that the limits to access services regarding the diagnosis of Cervical Cancer (CC) (or uterine cervical neoplasm) were related to organizational barriers and limits in the action of health professionals⁽⁷⁾. Another obstacle that hinders the access to information on cervical cancer (or uterine cervical neoplasm) is the low socioeconomic level, since people with less purchasing power have greater difficulty in accessing health services, and consequently less access to reliable information on the pathology⁽⁷⁾.

As occurs in high complexity, the patient without information does not understand the importance and purpose of antineoplastic therapy and chooses to give up the treatment, without understanding the damage that may suffer because of this premature decision. In this context, health education should be one of the essential tools in confronting misinformation since this gap should not exist in the relationship between the user and the health professional who seeks alternatives to disseminate knowledge in an understandable language.

Ratified in the study among Ethiopian women, which identified that encouraging the engagement of stakeholders in the battle, such as the provision of organized education at various levels of schooling, using different media and traditional associations, with the purpose of reaching the entire population⁽⁸⁾. Sharing this understanding, another study identified that schooling, age at first intercourse and age at menarche, family history, and cervical cancer screening plans were factors that affected knowledge and screening for cervical cancer (or uterine cervical neoplasm) diagnosis⁽⁹⁾.

This study identified that the patients have a low level of education, and the access and understanding of information are deficient, caused by factors such as: the limited geographical area, the difficulty of access of patients to the health unit, low or no purchasing power, thus contributing to the absence of periodic preventive examinations and cervical antineoplastic therapeutic follow-up, favoring the dropout of treatment, and bringing irreversible consequences.

It was observed that the therapeutic actions against cervical neoplasms in the research environment are still short of what is desired, with no improvements in the physical structure of the health service for years and having only one reference hospital for the entire state, where all patients diagnosed with cancer seek care at the same time. Thus, Unacon is in a fragile situation, since the number of nurses is limited and they absorb several care attributions with the intense daily demand, besides the emergency situations present in the work activities, highlighting, therefore, the need for more professionals.

The lack of planning and investment is often seen in everyday situations, such as the absence of more qualified environments, human resources proportional to the demand, medications, supplies, and the like, besides the fact that communication among care professionals needs to be more effective.

Intercommunication among the multi-professional team about the patients is primordial in the assistance - if there is a failure in this process, the patient may feel helpless, unmotivated, favoring the dropout of treatment, and when there is a late return to the unit, her clinical condition will be compromised due to the pathological evolution⁽¹⁰⁾.

However, abandonment by the partner, friends or family affects the patient even more, making her vulnerable, depressed, without the prospect of emotional support in her most fragile scenario⁽¹¹⁾. In the process of becoming ill with cervical adenocarcinoma, it is up to health professionals to pay attention to the health of the patient and her family together, seeking to solve doubts, alleviate concerns, to mitigate treatment evasion. In the interviews, the participants mentioned the absence of loved ones as one of the main causes for dropping out treatment.

In addition, the stigmatization of the pathology originated by the society, partner or family group also causes more suffering to the patient with uterine cervical neoplasm, allowing her to experience feelings of uselessness, disservice in relation to people and the space she inhabits, also culminating in the dropout of antineoplastic therapy⁽¹²⁾. Another factor is anxiety, fear of death, uncertainty of cure and improvement of the patient's health status, constant feelings in the scenario of cancer diagnosis and treatment, especially in the terminal phase. Associated with these feelings, high mortality rates and fear of death become constant, and the family is an important source of support⁽¹²⁾.

A study developed in Ethiopia highlights that, in parallel, the role of the male figure during the process of his companion's illness for uterine cervical neoplasm is decisive, when there is the commitment of this not only with the health itself of the spouse, but also in supporting her and accompanying her in consultations, diagnosis. The support of men to their partners during uterine cervical neoplasm screening and treatment can be essential to reduce deaths from this disease⁽¹²⁾.

Partners may indirectly participate as an agent in combating cervical neoplasm incidence and mortality. On the other hand, the authors also reinforce that not all male partners supported their female partners; some uterine cervical neoplasm patients reported that they had no support whatsoever from their male partners.

The implementation of practices for uterine cervical neoplasm screening in favor of women who started sexual activity early is essential, due to the susceptibility in exposure and action of conditioning agents for the emergence of cervical adenocarcinoma. About the understanding of qualified knowledge among the female audience, it is observed that the absence of information favors the abandonment of treatment.

To minimize the dropout of treatment by the study participants, the nurses propose the nursing consultation, a private function of the same, one of the instruments used in the approach to the patient, aiming to identify her needs, establish a reliable bond with her, with the information inherent to her health condition, helping her to accept the diagnosis of uterine cervical neoplasm and the treatment. The selection of the therapeutic plan and its effects, without the proper guidance to the patient, can cause feelings of insecurity, doubt, and fear; besides the integral support, that is, support to the vulnerable human being.

Consultation with the nurse is essential and should be implemented in the routines of high complexity units. Through this step, the access to information about the clinical picture and the evaluation of possible changes in this set of data help in the adequacy and development of new managements, aiming to better assist the patient, reducing possible situations such as stress, feelings of guilt, loss of days and times of chemotherapy sessions, which cause decisions such as dropping out the treatment.

The nursing consultation, besides providing the nurse with the patient's data, favors the strengthening of the bond between them. The nurse also plays the role of educator during the nursing consultation, since he/she must explain to the patient and family

members all possible changes that may occur during treatment, as well as the ways to manage each one of them, giving both instruments that favor the early identification of diseases and autonomy at home and even in the hospital⁽¹³⁾.

The execution of the nursing consultation is primordial from primary care to high complexity, in which the collection of nursing data such as history, diagnosis, planning, implementation of actions and evaluation of these is maximized, covering the patient in all areas. The nursing consultation, as a private nursing care activity, can be considered fundamental in Primary Health Care, since it leads to the identification of health problems, diagnosis, care planning, interventions, and evaluation of the resolution of each patient, and it is possible to resume the steps until the effectiveness of care⁽¹⁴⁾.

Given this context, another possibility opens in the eyes of the nurse, who must be attentive to details not shared by the patient and which, if not identified in time, can lead to decisions such as treatment abandonment, originated by several factors, among them, the absence of an intervention plan to identify these cases and reinsert the user in a timely manner.

The active participation of nurses as educators for cancer patients also reaffirms their importance within the multi-professional team. The nurse as educator transforms behaviors and leads the individual to think about his/her life practices, strengthens the client/nurse bond and enables the client to self-care, making him/her a fundamental part of the rehabilitation process⁽¹⁵⁾. Additionally, the planning of nursing care actions involves unifying and solving specific problems of the patient, always seeking new clinical managements, interpersonal strategies to build an intervention plan, and contemplating scenarios such as facing dropping out of treatment.

The nurse has a highly relevant role in the whole uterine cervical neoplasm process, from prevention, early screening to treatment⁽¹⁵⁾. Including, the care and bureaucratic actions of nurses require time and effort beyond the usual, which prevents these professionals from instituting the proper attention to the patient, especially in situations such as cases of dropping out of treatment, in which it is visible the need for the institution to present intervention strategies against dropout and promote the continuous updating of nurses.

In this scenario, the nurse as a member of the multidisciplinary team plays a key role with the team in meeting the needs of women diagnosed with uterine cervical neoplasm, from primary care to high complexity, so that the levels of care are interconnected to the point of unifying care, as well as building a better resolution of situations, and inserting the user as the focus of health services. Therefore, the need to improve the systems for monitoring women is up to the network of care, ensuring access to care⁽¹⁶⁾.

This study presented as limitations speeches that mirror the personal interpretations of the participants, of a single category, making the research finite for the theme. However, it points to paths of change for the current scenario of the reality under study, in which nurses play a leading role.

CONCLUSION

The motivations for dropping out treatment by the service users were the fragility in the organization and structure of the state in developing the appropriate treatment for each case, the absence of family members in the treatment follow-up, and the low understanding of the pathology, which influences the understanding of the importance of continuing the treatment and, consequently, decreases the chances of quality of life.

Therefore, there is an evident and urgent need for adjustments in the health services

in face of the frailties of women diagnosed with cervical adenocarcinoma, and for better working conditions for nurses, who strive intensively to ensure dignified and humanized care in a scenario that already brings with it feelings of insecurity and hopelessness in relation to the pathology, besides the compromising of the health system's resoluteness, which directly interferes with therapeutic follow-up.

In view of the facts, the participants pointed out, for the reduction of dropouts, the implementation of the Nursing consultation and an action plan aimed at improving the reception, attending to the singularities of each user. Additionally, it was noticed the need for comparison with the perception of service users who initiated and abandoned the treatment, in the same reference center.

The study can contribute to the understanding of the dropout factors in this specialized center, and the reflection and experiences of the nurses can improve the management of the service, clarifying and empowering the users with hope and autonomy, as well as promoting the recognition of the Nursing actions.

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