ISSN: 1676-4285

Sociodemographic and clinical profile of oncological patients who seek treatment at a general public hospital: descriptive study

Mayara Rodrigues Tavares Faria[1], Cristiane Decat Bergerot[1], Edvane Birelo Lopes De Domenico[1]

1 Federal University of São Paulo, SP, Brazil

ABSTRACT

Objective: To discover the sociodemographic and clinical characteristics of oncology patients attended in emergency care units; identify the symptoms present in the last 24 hours; evaluate the correlation between the sociodemographic and clinical data with the symptoms presented. **Method:** Descriptive, cross-sectional, quantitative, carried out in an emergency care unit of a pubic general hospital in the municipality of São Paulo. **Results:** Nonprobabilistic sample with 44 patients. The most prevalent cancers are geniturinary (15.9%) and hematological (15.9%). The most common signs and symptoms were: pain with an average of 6.6 (0-10; SD = 3.9) and altered appetite 6.6 (0-10; SD = 3.8). As for the intensity of symptoms, the item "concern" was prevalent with a mean of 7.1 (0-10; SD = 3.6). Regarding the symptom's ability to interfere with life, the most prevalent item was "activities in general" with an average of 9.1 (0-10; SD = 2.2). **Conclusion:** Sociodemographic and economic characteristics correlated with clinical characteristics.

Descriptors: Emergencies; Oncology; Neoplasms.

Faria MR, Bergerot CD, Domenico EB. Sociodemographic and clinical profile of oncological patients who seek treatment at a general public hospital: descriptive study. Online Braz J Nurs [Internet]. 2020 [cited year month day];19(2):e20206274. Available from: https://doi.org/10.17665/1676-4285.20206274

INTRODUCTION

Cancer is the second leading cause of death in developed and developing countries, accounting for 21% of deaths worldwide. Global demographic and epidemiological transitions signal an increasing impact of the burden of cancer in the coming decades[1]. However, with the development of new diagnostic strategies and drug treatments, there was a considerable increase in the survival of patients maintained in outpatient care for treatment[2]. However, it is observed that cancer patients present with at least one emergency during the course of their disease[2]. A cancer emergency (CE) is defined as an "acute condition caused by cancer or its treatment, which requires rapid intervention to prevent death or serious permanent injury"[2].

A study in the last decade shows the increase in the number of visits in emergency units due to signs and/or symptoms resulting from diagnosis and/or oncological treatments[2]. Cancer patients pose a challenge to the emergency team as they may have acute symptoms of undiagnosed malignancy, disease-related symptoms, and/or complications due to cancer treatment. Although cancer is a chronic disease, signs and symptoms such as pain, nausea, vomiting, diarrhea, fever, leukopenia, vertigo, changes in the level of consciousness, among others, may indicate serious clinical conditions that require emergency treatment[3].

Most CEs can be categorized as metabolic, including hypo/hypercalcemia, hypo/hypernatremia, syndrome of inappropriate secretion of antidiuretic hormone, tumor lysis syndrome; hematological, such as thrombocytosis, erythrocytosis, neutropenia, thrombocytopenia; compression of the spinal cord, cardiac tamponade, superior vena cava syndrome. The emergency sectors should be prepared to act effectively, performing accurate diagnoses of the current condition, predicting complications that may unfold after hospital discharge, as well as considering the process of cancer illness so that the patient's quality of life is constantly evaluated and considered.

Given the complexity of emergency treatment for cancer patients, the study questions were: what are the sociodemographic characteristics of cancer patients treated in the emergency room of a public university hospital? What are the general clinical conditions related to the type of cancer, staging, and type of current treatment? What symptoms have been present in the last 24 hours?

OBJECTIVES

- Describe the sociodemographic and clinical characteristics of cancer patients treated in emergency rooms (emergency and first aid);
- Identify the symptoms present in the last 24 hours in these patients;
- To evaluate the correlation between sociodemographic and clinical data with the symptoms presented.

METHOD

Study design, location and population

This is a cross-sectional, correlational, quantitative study conducted in the Emergency Room unit of hospital São Paulo, linked to the Federal University of São Paulo, UNIFESP, located in the city of São Paulo, São Paulo (SP), Brazil. Convenience sampling was performed with 44 patients who met the eligibility criteria and who were attended between December 2015 and March 2016, on weekdays during the daytime. Inclusion criteria: over 18 years of age; patients in the diagnostic or therapeutic phase, and may be surgical, antineoplastic chemotherapy, radiotherapy or combined. Exclusion criteria: patients in current follow-up or disease-free conditions; with psychological and/or mental alterations that prevented them from responding to the instruments; both conditions are described in medical records. Not aware of the cancer diagnosis, a condition attested by the doctor or family member.

Data collection procedures

Patients were invited to participate in the study during their period of permanence in the emergency room of the hospital. The instruments were completed by the main researcher, after receiving the participant´s signed Free and Informed Consent Form (TCLE). The research was approved by CEP-UNIFESP under number 0796/2015. Data were obtained from patients and supplemented with information from the electronic medical records. Sociodemographic data: date of birth, gender, race, marital status, education, religion, housing, occupation and the number of times they were seen in the Emergency Room after diagnosis. Clinical data: treatments performed (surgical, radiotherapy or cytotoxic chemotherapy), comorbidities, clinical objects (such as probes, catheters, prostheses), MD Anderson Symptom Inventory (MDASI-core). The MDASI-core was developed in the United States, translated and validated into Portuguese, and presents general Cronbach's Alpha, symptoms and interferences, of 0.857, 0.784 and 0.794 respectively[4]. Its objectives are to evaluate the intensity of symptoms and the daily impact on cancer patients in the last 24 hours prior to the investigation. It consists of 2 components: intensity of symptoms (pain, fatigue, feeling sick and nausea, sleep problems, worries, dyspnea, difficulty remembering things, lack of appetite, drowsiness, dry mouth, sadness, vomiting, numbness/tingling); and symptoms that interfere with life (activity in general, mood, work, relationships, walking and pleasure of living). All on a scale from zero (no symptom) to 10 (as strong as you can imagine). MDASI data were collected from patients, in a self-applicable form, or with the help of the principal researcher, whenever requested.

Data analysis procedure

The MDASI instrument was corrected according to the criteria described in the literature[4]. For the score of component 1, the mean value obtained in the 13 items

was calculated. The total proportional score was obtained when the patient scored at least seven of the 13 items, using the formula: (sum of the items answered) X 13/number of items answered[4]. The same mean score was obtained for component 2, representing the distress associated with general symptoms. This average can be used if more than 50% (four of six items) are answered, in the formula: (sum of items answered) X 6/number of items answered[4].A descriptive statistical analysis was performed to characterize the sample in relation to sociodemographic variables (gender, age, marital status, education, race, religion, economic class, housing, current occupation) and clinical (year of diagnosis, ER visits after diagnosis, staging, primary tumor, metastasis, site of metastasis, recurrence, surgical treatment, radiotherapy, chemotherapy, family history, comorbidities, medications, previous surgery and clinical artifacts). This same analysis was performed to analyze the score obtained on the MDASI scale, to evaluate the intensity of symptoms and symptoms that interfere with life. For this purpose, enteral tendency and dispersion measurements were used. The simple linear correlation was used to evaluate the association between the variables of the MDASI scale and sociodemographic and clinical data. Statistical analysis was performed with the aid of the Software Statistical Package for Social Science 22.0 software program.

RESULTS

Forty-four cancer patients who met the eligibility criteria participated in the study. According to the data in Table 1, the majority were males (63.6%), mixed race (47.7%), mean age of 61.4 years (25-89; SD= 15.8), married/stable union (59.1%), catholic religion (65.9%), who had only completed elementary school level education (63.6%), belonging to economic class C (61.4%), residents of São Paulo capital (63.6%) and who declare themselves not professionally active (95.5%).

Table 1 - Distribution of patients in the diagnostic or therapeutic phase treated in the emergency room of a general public hospital in the city of São Paulo, according to sociodemographic/socioeconomic characteristics

Sociodemographic/socioeconomic characteristics	N	%
Sexo n (%)		
Male	28	63,6
Female	16	36,4
Age M (SD)		
25 - 89	61,4	15,8
Marital Status n(%)		
Married/ Stable Union	26	59,1
Single	10	22,7

Separated/Divorced	6	13,6
Widower	2	4,5
Schooling n(%)		
No instruction	5	11,4
Elementary School	28	63,6
High School	9	20,5
Higher Education	2	4,5
Race n(%)		
White	16	36,4
Black	5	11,4
Brown	21	47,7
Yellow	2	4,5
Religion n(%)		
Catholic	29	65,9
Evangelical	11	25
Atheist	1	2,3
Other	3	6,8
Brazil Economic Classification Criterion[9] n(%)		
A	1	2,3
B	13	29,5
C	27	61,4
D	2	4,5
And	1	2,3
Location where you live n(%)		
Sao Paulo Capital	28	63,6
Greater São Paulo	10	22,7
Great ABC	4	9,1
Other	2	4,5
Current work n(%)		
Yes	2	4,5
No	42	95,5
Total	44	100

Source: Brazilian Association of Research Companies, 2012.

Regarding the clinical variables, the period of patient diagnosis is subdivided into 0 - 6 months (45%), 7 - 12 months (14%), 13 - 24 months (9%), over 2 years (25%), and patients who did not know the date of diagnosis corresponded to 7%. The most prevalent cancers were genitourinary (15.9%) hematological (15.9%), followed by lung cancers (13.6%) gastrointestinal (13.6%). About 23 (52.3%) patients had no record of tumor staging data in medical records up to the time of evaluation. Thus, 47.7% of those with staging in the medical records corresponded to 57% stage IV; 19% stage III; 14% stage II and 10% stage I.

Regarding surgical treatment, 45.5% underwent biopsy and 29.5% biopsy and curative surgery. Antineoplastic chemotherapy treatment was performed in 54.5% of patients. Regarding radiotherapy, 29.5% of patients underwent this treatment modality. Regarding family history, 43.2% of the patients evaluated reported having a family member with cancer, with the most prevalent siblings (13.6%), followed by a father (9.1%) and mother (6.8%).

Among the patients interviewed, 88.6% had some aggravating condition, such as: smoking (63.6%), systemic arterial hypertension (56.8%), alcohol consumption (47.7%), diabetes mellitus (29.5%), nephropathies (15.9%), heart disease (11.4%) and pulmonary disorders (9.1%). Continuous use of medications was reported by 93.2%, with an average of 3.4 (0-5; SD= 1.8) daily medications. Among the total, 50% had undergone previous surgery. 68.2% of the patients had clinical objects, 13.6% had nasoenteral or nasogastric catheters (SNE/SNG), 4.5% had gastrostomy or jejunostomy, 2.3% had colostomy or ileostomy, 6.8% tracheostomy, 25% had a urinary catheter, 9.1% with central venous catheter (CVC), 13.6% had a surgical wound and 4.5% had an oncological wound.

The average number of visits in the ER after diagnosis was 2.7 visits (0-5; SD= 1.7), as described in Table 2.

Table 2 - Clinical conditions of patients in the diagnostic or therapeutic phase treated at a general public hospital in the city of São Paulo

Clinical Condition	**N**	**%**
Diagnosis period n(%)		
0 - 6 months	20	45
7 - 12 months	6	14
13 - 24 months	4	9
> 2 years	11	25
They didn't know	3	7
Diagnosis n(%)		
Head and Neck	4	9.1
Lung	6	13.6
Mama	4	9.1
Genitourinary	7	15.9
Gynecological	4	9.1
Hematologic	7	15.9
Gastrointestinal	6	13.6
SNC	4	9.1
Other	2	4.5
Treatment in PS post Dx M (DP)		
0 - 5	2,7	1.7
Primary tumor n(%)		

Yes	44	100
Metastasis M(DP)		
1 - 3	1,9	0.6
Location n(%)		
Does not apply	38	86.4
Bone	3	6.8
Liver	1	2.3
Brain+Bone	2	4.5
Recurrence n(%)		
Yes	4	9.1
No	40	90.9
Staging n(%)		
I	2	4.5
II	3	6.8
III	4	9.1
IV	12	27.3
Absent	23	52.3
Surgical treatment n(%)		
Yes	33	75
Reason n(%)		
Biopsy	20	45.5
Bx+Dressing	13	29.5
Radiotherapy n(%)		
No	31	70.5
Chemotherapy n(%)		
Yes	24	54.5
Family background n(%)		
Does not apply	25	56.8
Father	4	9.1
Mother	3	6.8
Brothers	6	13.6
Grandparents	2	4.5
Parents	1	2.3
Mother and Brothers	2	4.5
All	1	2.3
Comorbidades n (%)		
Yes	39	88.6
Previous surgery n(%)		
Yes	22	50
Medication n(%)		
Yes	41	93.2
0 - 5 M(DP)	3,4	1.8
Clinical Objects n(%)		

Yes	30	68.2
Total	44	100

Source:Elaborated by the authors.

Several problems were reported regarding the analysis of The M.D. Anderson (MDASI)-core Symptom Inventory, as described in Table 3. In the descriptive analysis (mean and standard deviation) the mean intensity of the item concern was 7.1 (0-10; SD= 3.6), these patients still reported pain with a mean intensity of 6.6 (0-10; SD= 3.9), mean appetite change of 6.6 (0-10; SD= 3.8), mean fatigue of 6.5 (0-10; SD= 3.9), mean sadness of 6.4 (0-10; SD= 3.9) and mean insomnia of 6.2 (0-10; SD= 4). The sum of the components represented an average of 69.2 (8-130; SD= 31.1).

Table 3 - Intensity of symptoms reported by cancer patients in emergency care, according to the Inventory of Signs and Symptoms of M.D. Anderson (MDASI) - core

Intensity of symptoms	**M**	**DP**
Pain		
0 - 10	6.6	3.9
Fatigue		
0 - 10	6.5	3.9
Nausea		
0 - 10	4.6	4.6
Insomnia		
0 - 10	6.2	4
Concerns		
0 - 10	7.1	3.6
Shortness of breath		
0 - 10	3.4	4
Memory		
0 - 10	3.4	4
Appetite		
0 - 10	6.6	3.8
Drowsiness		
0 - 10	5.7	4.4
Dry Mouth		
0 - 10	5.7	3.9
Sadness		
0 - 10	6.4	3.9
Vomiting		
0 - 10	3.4	4.5
Numbness/ Tingling		
0 - 10	3.4	4.4

Sum of components		
8 - 130	69,2	31,1

Source: Elaborated by the authors.

Regarding the data on the intensity of the interference of symptoms in the patient's life, it is observed in Table 4 that the item with the highest score was activities in general with an average of 9.1 (0-10; SD= 2.2), followed by walking with an average of 8.2 (0-10; SD= 3) and mood with an average of 6.8 (0-10; SD= 3.6). The sum of the components presented an average of 43.9 (0-60; SD= 15).

Table 4 - Interference of symptoms reported by cancer patients in emergency care, according to the M.D. Anderson Symptom Inventory (MDASI) - core

Life-threatening symptoms	**M**	**DP**
Activities in general		
0 - 10	9.1	2.2
Humor		
0 - 10	6.8	3.6
Work		
0 - 10	4.7	4.3
Relationships		
0 - 10	4.7	4.3
Walk		
0 - 10	8.2	3
Pleasure in living		
0 - 10	6.1	3.9
Sum of components		
0 - 60	43,9	15

Source: Elaborated by the authors.

In the simple linear correlation, the correlation between schooling and nausea (p=0.03) (Figure 1) indicates that patients who had no level of education had a higher occurrence of nausea, with a prevalence in females.

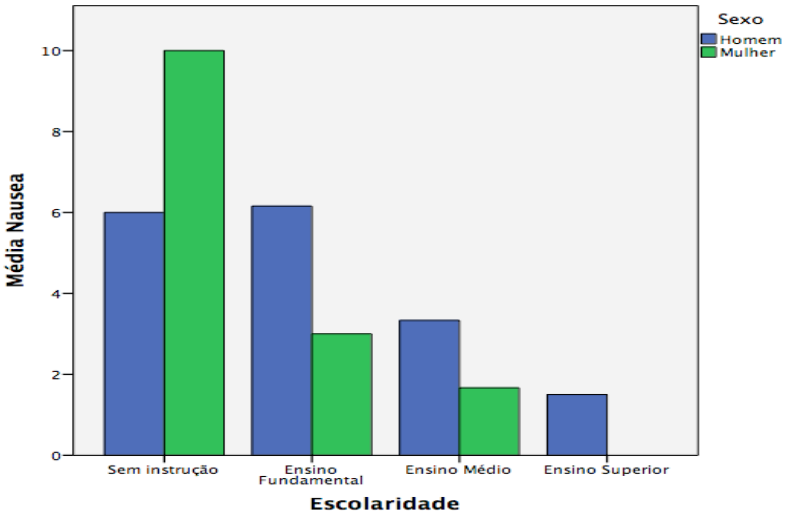

Figure 1 - Significant correlation between schooling and nausea
Source: Elaborated by the authors.

Regarding the correlation between tumor location and the presence of pain (p=0.03) (Figure 2), the prevalence for breast cancer in women, head and neck tumor in men, hematological tumors in males, with lung cancer only showing a prevalence in both sexes.

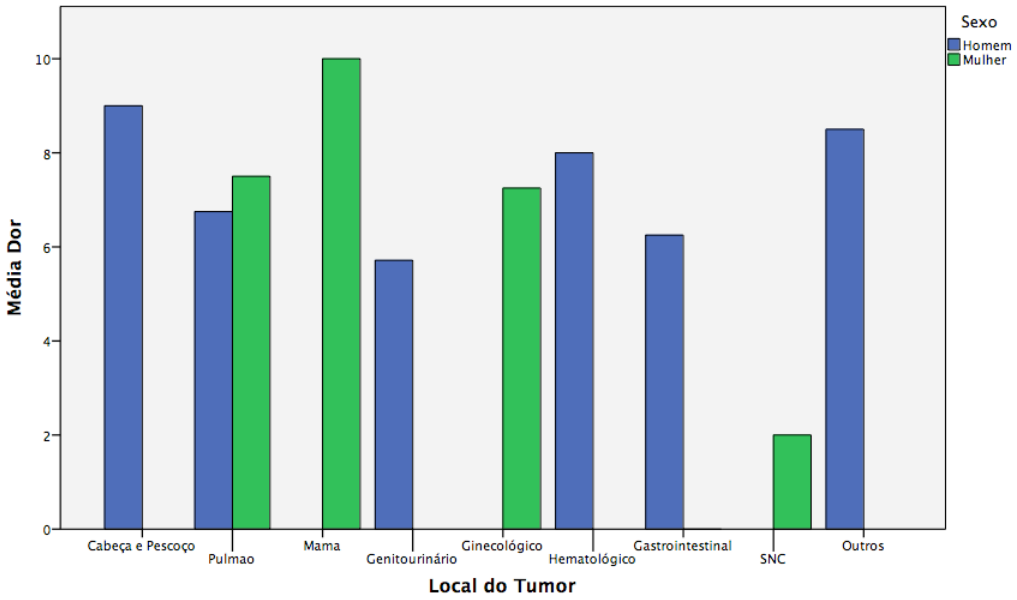

Figure 2 - Significant correlation between tumor location and pain
Source: Elaborated by the authors.

Figure 3 shows the correlation between tumor location and appetite change (p=0.01). The most prevalent tumors were lung cancer for both sexes, gynecological for females and hematological cancers for males.

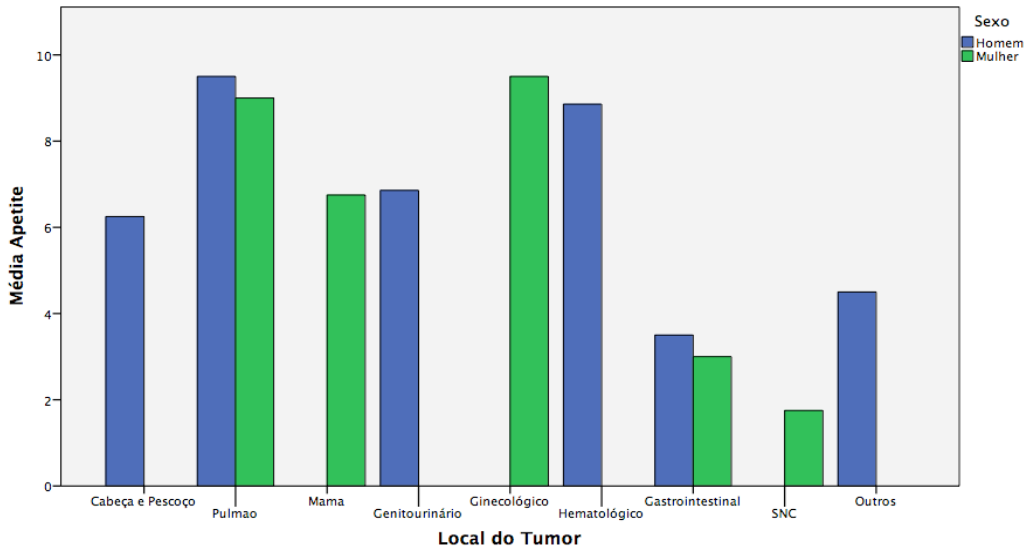

Figure 3 - Significant correlation between tumor location and appetite change
Source: Elaborated by the authors.

There was no significant correlation regarding age, staging, comorbidities, treatment or type of tumor in relation to the intensity of symptoms and their interference in the daily life of patients.

DISCUSSION

In the present study, the prevalence of pulmonary, gastrointestinal and genitourinary cancers was verified, reinforcing the incidence of this group of tumors as the most recurrent according to the epidemiological estimate for Brazil in the biennium of 2018/2019[1]. Hematological tumors represented a significant number in the sample, contrasting with epidemiological data described in the literature. However, the increased prevalence of these patients in an emergency situation is justified by the condition of greater clinical vulnerability to diagnosis, added to the intense drug therapeutic arsenal, the side effects of antineoplastic chemotherapy, hematological changes, such as febrile neutropenia and anemia; such as tumor lysis syndrome; in addition to significant pain caused by bone metastases and spinal compression[6].

According to the National Cancer Institute (NCI), the number of new cancer cases indicates the prevalence of males for most tumors, in addition to a slight predominance in both incidence (53%) mortality (57%)[1].

Cancer is the leading cause of death in women and men aged between 60 and 79 years. Studies estimate that by 2030 approximately 70% of cancers will be diagnosed in adults 65 years of age or older[7]. The development of certain cancers associated with physiological changes, comorbidities and response to treatment change according to age, influencing the tolerability and management of adverse events in this group of patients. The literature shows that adequate support help in the tolerance and performance of these patients during the treatment phase.

Specific comorbidities have shown an impact on the prognosis and outcome of cancer patient treatment, thereby increasing the amount of drugs administered. In the present study, we identified that 88.6% of the patients had some type of comorbidity and 93.2% were continuously using medications.

In a randomized adjuvant chemotherapy study of 3,759 patients with high-risk stage II and III colon cancer, patients with diabetes mellitus had a significantly higher rate of overall mortality and cancer recurrence compared to patients without diabetes[7].

Alcohol consumption and smoking are established risk factors for the development of different types of cancer. In this study, it was found that 63.6% of the patients are smokers and 47.7% are alcoholics. In 2012, 5.5% of all new cancer occurrences and 5.8% of all cancer deaths worldwide were estimated to be attributable to alcohol[8]. Most studies which evaluate the direct effects of alcohol use in cancer treatment have focused on patients with upper digestive tract cancer, because 34% to 57% continue to drink after diagnosis[8].

Alcohol abuse also complicates treatment outcomes among cancer patients, contributing to longer hospitalizations, increased surgical procedures, prolonged recovery, higher health costs, and higher mortality. Alcohol use and smoking during and after radiotherapy has been associated with an increased risk of jaw osteoradionecrosis in patients with mouth and oropharyngeal cancer[8].

Maintaining smoking after cancer diagnosis increases the risk of the appearance of a second tumor, recurrence of the primary tumor, and development of cardiovascular and respiratory diseases. A recent study conducted at an oncology center in the United States showed that the overall mortality rate was 20% higher in smokers compared to patients who recently quit smoking[9].

Hospitalizations for acute symptoms account for 48% of total cancer expenditures. Patients undergoing chemotherapy have on average 1 hospitalization and 2 visits to the emergency departments per year, with 40% to 50% resulting from symptoms related to treatment[10]. In the present study, 54.5% of the patients were undergoing chemotherapy and had an average number of emergency room visits after the diagnosis of 2.7 visits.

The prevalence of chronic diseases and morbidity rates reveal gradients that tend to present the highest values in economically disadvantaged areas. The statistically significant association between education level and morbidity is consistent with that reported in the literature, thus demonstrating that the educational level is one of the most used indicators for the analysis of social inequalities in health[11]. In the sample, a low socioeconomic (classes C, D and E combined reached 68.2%) and educational level (presence of illiteracy and, most, only up to elementary school) was observed, creating a challenge for health services and cancer treatment, because the entire therapeutic process can

fail due to the lack of adequate sanitary conditions, food, locomotion and transportation conditions and, mainly, low schooling and cognitive capacity directly influence the management of the signs and symptoms arising from cancer and its treatment.

Nausea and vomiting induced by the disease and antineoplastic treatment have a direct impact on the quality of life of patients, and may result in other adverse events such as lack of appetite, weight loss and metabolic imbalance.

Guidelines on antiemetic therapy that have been developed by various cancer societies show broad consensus on the main objectives, including that prophylaxis should be the primary goal of antiemetic therapy and should be implemented for groups of patients at 10% or more risk of chemotherapy-induced nausea; that the duration of prophylaxis should cover the entire period of risk; that oral and intravenous routes of administration have the same efficacy; and that the most effective antiemetic treatment is determined based on the emetogenicity of chemotherapy, the history of the patient with chemotherapy-induced nausea and vomiting, and additional patient-related factors[12].

The management of nausea and vomiting is a common clinical challenge, especially in developing countries, due to the low education of the population and its socioeconomic condition, in addition to the difficulty of access to more effective antiemetic drugs, since the value of these drugs is higher and increase the total cost of patient treatment, leading to changes in treatment planning and the incidence of the use of health care resources, including those coming to the emergency department.

Studies show that more than 30% of cancer patients have chronic pain, and that it is one of the main causes for the search for emergency care[13]. The present study pointed out that breast, head and neck, hematological and lung cancers were the most common types in patients affected by pain, probably due to the anatomical structures involved, tumor extension, tumor pathophysiology, presence of metastases, polypharmacy, antineoplastic chemotherapy and endocrine therapy combined with surgery and radiotherapy. In view of this scenario of related causes, it is necessary to consider the emotional aspects characterized by anxiety and depression that can aggravate the perception of pain and its tolerance.

Other aggravating factors are the underestimation of pain by the care team in the course of cancer treatment and inadequate management, from the perspective of evaluation, invariably without a validated and structured instrument to provide more accurate information about the patient's conditions, as well as the inadequate prescription of analgesics[14].

When patients seek the emergency department, there is still the aggravating factor of negligence due to the non-characterization of the condition of life and death of pain, in addition to the obstacles previously reported[14-15].

Impaired appetite and consequent weight loss are common problems in cancer patients. Multiple factors can affect appetite or eating habits, such as tumor location, taste disorder, antineoplastic treatment, and psychological aspects such as worries and sadness.

Impaired nutrition is associated with prolonged hospitalization, higher degree of treatment-related toxicity, worse quality of life and worse prognosis[16]. Depending on the stage and type of cancer, unintentional weight loss and malnutrition occur in approximately 30% to 80% of patients, most frequently occurring in patients with head and neck, gastrointestinal and lung cancer, and those with advanced disease[17].

Adding to the vulnerability picture, 68.2% of the patients used some type of artifact or clinical condition that required care, such as probes (nasoenteral, gastric or bladder), catheters, stomas and wounds (surgical and/or oncological), this demand for care has specificities that require an educational-care process for the training of both the patient and his caregiver, promoting self-management of care and decreasing the rehospitalizations.

Cancer itself together with the toxicities arising from antineoplastic treatment affect the patient in its entirety, making multidisciplinary, individualized and patient centered care necessary.

The reduction of physical and mental functionalities in general added to the conditions of socioeconomic precariousness and the low level of education are reflected in the persistence of a state of concern. A study conducted in the State of São Paulo pointed out that, among cancer patients undergoing treatment, almost half were excluded from daily activities, most of them paid, which contributed to a lower family income and represented a higher socioeconomic cost in the country[4]. In the present study, 95.5% of the patients were not working, which confirms the findings in the literature. Usually, cancer survivors have difficulty in maintaining their activities that require physical and cognitive effort, because they still present an overload of symptoms and, sometimes, bodily changes and depressive symptoms which make it difficult to return to work activities[4]. Cancer is emotionally, socially and financially costly.

It is necessary to recognize that health-related factors are an important measure of the effect of social inequalities on morbidity and mortality. The reduction of these inequalities is dependent on the expansion of coverage and quality of health services at all levels of complexity, lacking technological, diagnostic and therapeutic resources that are not always accessible to the less favored population, on a team with theoretical and practical knowledge, in addition to the development of skills that guide their professions, thus providing quality in the care provided.

Regarding the limitations of the study, there are impediments to generalizations of the data due to the restricted sample size, collected in a single institution, with general emergency service, and not specialized in oncology.

The accomplishment of this study allowed the evaluation of the potential of MDASI-core to produce relevant data for situational diagnosis in emergency departments, favoring the design of intervention studies that consider the demands of cancer patients in critical situations.

CONCLUSION

The highest incidence of the patients interviewed was male. On average, consisting of elderly, married, with low income and low schooling, diagnosed with advanced diseases, presence of comorbidities, associated with the number of medications used daily (polypharmacy) and the need to use clinical artifacts, which may be associated with the intensity of the signs and symptoms presented and how much these interfere in their daily life.

It was observed that sociodemographic and economic characteristics correlate with the clinical characteristics found, influencing the intensity of symptoms and their management, in addition to psychological and financial aspects. Pain was associated with the diagnosis of breast cancer in women, head and neck tumor and hematological in men and the diagnosis of lung cancer in both sexes. Among eating disorders, nausea and appetite disorder were associated with illiteracy and female gender, and tumor location (pulmonary, gynecological, hematological).

Knowledge of the characteristics of cancer patients in emergency and emergency services is important for the proper management of their signs and symptoms. The impact of demand on these services impairs the communication process, which may compromise the safety of these patients. The development and implementation of care flows are alternatives to assist the care team in the care of these patients.

REFERENCES

1. Instituto Nacional do Cancer. Estimativa 2018 – Incidência de Câncer no Brasil [Internet]. Rio de Janeiro: INCA; 2018 [cited 2019 jun 15]. Available from: http://www.inca.gov.br/estimativa/2018/estimativa-2018.pdf
2. Sadik M, Ozlem K, Huseyin M, AliAyberk B, Ahmet S, Ozgur O. Attributes of cancer patients admitted to the emergency department in one year. World J Emerg Med [Internet]. 2014 [cited 2019 jun 15];5(2):85-90. Available from: https://www.researchgate.net/publication/281025957_Attributes_of_cancer_patients_admitted_to_the_emergency_department_in_one_year. doi: http://doi.org/10.584720/wjem.j.issn.1920-8642.2014.0220.001
3. Borges G, Rovere RK, Maman KAS, Zabel MCJ, Dagnoni C, Corrêa CEG et al. Perfil dos pacientes oncológicos que procuraram o departamento de emergência de um hospital de blumenau no período de 01 abril de 2011 a 31 de outubro de 2011. Rev Bras Oncol Clín [Internet]. 2013 [cited 2019 jun 15];9(34):130-4. Available from: http://sboc.org.br/revistasboc/pdfs/34/artigo1.pdf
4. Kolankiewicz ACB, De Domenico EBL, Lopes LFD, Magnago TSBS. Portuguese validation of the symptom inventory of the M.D. Anderson Cancer Center. Rev Esc Enferm USP [Internt]. 2014[cited 2019 jun 15];48(6):998-1003. Available from: https://www.scielo.br/scielo.php?pid=S0080-62342014000600999&script=sci_arttext. doi: https://doi.org/10.1590/S0080-623420140000700006

5. Associação Brasileira de Empresas de Pesquisa. Critério de classificação econômica Brasil [Internet]. São Paulo: ABEC; 2012 [cited 2019 jun 15]. Available from: www.abep.org/Servicos/Download.aspx?id=07

6. Rabagliati R, Bertín P, Cerón I, Rojas H, Domínguez I, Vera A et al. Epidemiología de neutropenia febril en pacientes adultos con leucemia aguda y linfoma. Estudio de cohorte en hospitales público y privado de Santiago, Chile. Rev Chil Infectol [Internet]. 2014 [cited 2019 jun 15];31(6):721-728. Available from: https://scielo.conicyt.cl/scielo.php?pid=S0716-10182014000600013&script=sci_arttext&tlng=en

7. Hurria A, Wildes T, Blair SL, Browner IS, Cohen HJ, Shazo M et al. Senior Adult Oncology Clinical Practice Guidelines in Oncology. J Natl Compr Canc Netw [Internet]. 2014 [cited 2019 jun 15];12(1):82-126. Available from: https://jnccn.org/view/journals/jnccn/12/1/article-p82.xml?print&print&print&print

8. LoConte NK, Brewster AM, Kaur JS, Merrill JK, Alberg AJ. Alcohol and Cancer: A Statement of the American Society of Clinical Oncology. J Clin Oncol [Internet]. 2017 [cited 2019 jun 15];36(1):83-93. Available from: https://www.finut.org/wp-content/uploads/2017/11/jco.2017.76.1155.pdf

9. Sitas F, Weber MF, Egger S, Yap S, Chiew M, O'Connell DL. Smoking Cessation After Cancer. J Clin Oncol [Internet]. 2014 [cited 2019 jun 15];32(32):3593-3595. Available from: http://researchpubs.cancercouncil.com.au/cancercounciljspui/handle/1/1900. doi: http://doi.org/10.1200/JCO.2014.55.9666

10. Daly B, Nicholas K, Gorenshteyn D, Sokolowski S, Gazit L, Adams Lynn. Misery Loves Company: Presenting Symptom Clusters to Urgent Care by Patients Receiving Antineoplastic Therapy. J Oncol Pract [Internet]. 2018 [cited 2019 jun 15];14(8):492-495. Available from: https://ascopubs.org/doi/full/10.1200/JOP.18.00199

11. Barros ABM, Francisco BSMP, Zanchetta LM, César CLG. Tendências das desigualdades sociais e demográficas na prevalência de doenças crônicas no Brasil, PNAD: 2003- 2008. Ciênc Saúde Col [Internet]. 2011 [cited 2019 jun 15];16(9):3755-3768. Available from: https://www.scielo.br/scielo.php?pid=S1413-81232011001000012&script=sci_arttext&tlng=pt

12. Navari RM, Aapro M. Antiemetic Prophylaxis for Chemotherapy-Induced Nausea and Vomiting. N Engl J Med [Internet]. 2016 [cited 2019 jun 15];374:1356-1367. Available from: https://www.nejm.org/doi/full/10.1056/NEJMra1515442

13. Swarm RA. The Management of Pain in Patients With Cancer. J Natl Compr Canc Netw [Internet]. 2013 [cited 2019 jun 15];11(5.5):702-704. Available from: https://jnccn.org/view/journals/jnccn/11/5S/article-p702.xml

14. Money S, Garber B. Management of Cancer Pain. Curr Emerg Hosp Med Rep [Internet]. 2018 [cited 2019 jun 15];6:141–146.Available from: https://link.springer.com/article/10.1007/s40138-018-0170-9

15. Won YH, Choi YJ, Ahn S, Lee JL, Park JY, Kim S et al. Improving the Quality of Cancer Pain Management in an Academic Medical Center Emergency Department. Clin J Oncol Nursing [Internet]. 2014 [cited 2019 jun 15];18(6):626-629. Available from: https://pdfs.semanticscholar.org/ef56/e702acb8d15338b1e13663c10e2c687d79f9.pdf

16. Oh SY, Koh SJ, Baek JY, Kwon KA, Jeung HC, Lee KH et al. Validity and Reliability of Korean Version of Simplified Nutritional Appetite Questionnaire in Patients with Advanced Cancer: A Multicenter, Longitudinal Study. Korean Cancer Association. Cancer Res Treat [Internet]. 2019 [cited 2019 jun 15];51(4):1612-19. Available from: https://www.e-crt.org/upload/pdf/crt-2018-505.pdf

17. Platek ME, Johnson J, Woolf K, Makarem N, Ompad DC. Availability of

Outpatient Clinical Nutrition Services for Patients With Cancer Undergoing Treatment at Comprehensive Cancer Centers. J Oncol Pract [Internet]. 2015 [cited 2019 jun 15];11(1):1-5. Available from: https://ascopubs.org/doi/full/10.1200/jop.2013.001134

Submission: 08/29/2019

Reviewed: 05/15/2020

Approved: 05/15/2020

Copyright © 2020 Online Brazilian Journal of Nursing

This article is under the terms of the Creative Commons Attribution License CC-BY-NC-ND, which only permits to download and share it as long the original work is properly cited.