vol.3 No.2 ISSN:18235-2016

PALLIATIVE CARE NEEDS OF WOMEN WITH ADVANCED BREAST CANCER AT ONCOLOGY CENTER MANSOURA UNIVERSITY, EGYPT.

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Abstract:

Advanced breast cancer also called metastatic breast cancer, a breast cancer that has extend from the breast to other organs in the body as lungs, liver, bones and brain. Women with advanced breast cancer needs a special care called as a palliative care needs related to psychological, social, spiritual, physical and educational aspects. Aim of the study is to assess palliative care needs of women with advanced breast cancer. **Methods**:a descriptive cross sectional design was used in this study. A convenient sample of 100 women with advanced breast cancer was selected. TheTool used divided into two parts including demographic data, palliative care needs of women with advanced breast cancer. **Setting:** This study was conducted in inpatient department and outpatient clinics at Oncology Center Mansoura University (OCMU).**Results**: The results of this study revealed that women identified the greatest areas of palliative care needs in relation to poor activity of daily living (41%), the majority of the studied women had poor psychologicalissues (98%), all of them had poor financial issues and additional expenses (100%),the highest percentage of them had severe physical issues (85%),about two third of them had poor self-dependence issues (69%) and poor educational issues (73%). **Conclusions**:This study indicates that women with advanced breast cancer have high levels of palliative care needs, especially in relation to the areas of activity of daily living, psychological, physical, financial, self-dependence and educational issues that requiring interventions aimed at meeting palliative care needs of women with advanced breast cancer. Advanced breast cancer have statistically significant high levels of palliative care needs.

Key words: Advanced breast cancer, Palliative care needs**.**

Introduction:

Metastatic breast cancer, also known as advanced breast cancer or stage IV, is usually a breast cancer which has extend from the breast to additional bodily organs as the lungs, liver, bones and also brain. However metastatic breast cancer has extended to another organ in the body, it is counted and also treated as breast cancer. Several women have advanced breast cancer at the first diagnosed**(**1**)**.

Symptoms created by metastatic breast cancer differ by the site of the spread of disease **(2)**Effective management of metastatic breast cancer requires corresponding efforts by the healthcare team, mainly the advanced practitioners who specialize in breast care, when possible. Physicians, nurses, counselors, and also other healthcare professionals are all required to plan proper care and provide patient-centered communication, support, and continuity of care as metastatic breast cancer is terminal, when possible, patients should be active participants in treatment decisions**(3).**

Assessing and also satisfying what's needs and concerns of cancer patients is an essential responsibility for health-care professionals research shows that there are substantial levels of not satisfied needs. Among cancer patients; the most important regards to providing of information and psychological support, health related communication, daily living activities, physical symptoms, social needs, spiritual needs and also financial needs **(4, 5).**

Several patients having cancer are experiencing advanced disease and related symptoms because cancer becomes a chronic illness, adequate attention to patients' symptoms and psychosocial requires in the community setting requires positioning of palliative care besides a cancer care. Palliative care is proper care directed to improve quality of life of patients who have a severe and life-threatening disease, as cancer. The goals of palliative care is to avoid and treat, as soon as possible, the symptoms and side effects of the disease and its treatment, as well as the related, social, spiritual and psychological problems. The aim isn't to cure. Palliative care is also named supportive care, symptom management and comfort care**(6).**

Palliative care is defined by the World Health Organization as "an approach which enhances patient and their family's quality of life who have problems related to life threatening disease, during the avoidance and relieving of the pain by simply ways as early discovery, assessment and management of pain and also additional physical, spiritual, and psychosocial problems**(7).**

Palliative care provides relief from pain as well as other stressful symptoms; support life and regards dying as a normal process; intends neither to postpone death; incorporate the psychological and also spiritual aspects of patient care; provides a support system to aid patients live as actively as possible until death; offers a support system to assess the family cope during the patients illness and also in their own respect**(7*).***

Palliative care needs of women with advanced breast cancer includes: **activity of daily living.** Women with advanced breast cancer may possibly experience a feeling of inability as they are unable to manage daily living activities as housekeeping also are unable to look after themselves and also their families. As a side effect of cancer treatment it is hard for women to carry out occupational activities. such as sleeping, resting, dressing, cooking, eating, maintaining personal hygiene, handling money, shopping, using public or personal transportation,

education, work, play, walks, visits to a family member, using internet, reading and social participation **(8, 9)**

In addition to caring of **Physical symptoms** as pain, fatigue, loss of appetite, nausea, vomiting, shortness of breath, cough, lump, skin puckering or dimpling, rash on or around nipples, discharge from nipples, change shape of the nipple become inverted, bone, joint pain, itching, , fever, chills, jaundice, sexual dysfunction and insomnia. Many of these symptoms can be relieved by medicines or by using other ways, as nutrition therapy, physical therapy, or deep breathing techniques. Also, chemotherapy, radiation therapy, or surgery that produces pain and other complications **(6).**

Furthermore treatment-associated effects, one need to also consider the **psychological effects** of the disease as fear of (death, rejection, being stigmatized, mutilation, recurrence), difficulties in accepting the disease and also difficulties concerning the meaning of death, side effects of the chemotherapy, other patient worries about their family, worries about the future,sense like being a burden., and increase spiritual worries. These worries may be decreased whenever there are few resources to help patients and their families. All health professionals dealing with cancer patients should have a training in the psychosocial and spiritual concerns and breast-cancer-specific complications related to body image and sexual health**(10, 11).**

Financial issues can be a greater concern for people with metastatic breast cancer than for other breast cancer survivors. After the emotional and physical effect of a breast cancer diagnosis, financial decisions can appear overwhelming. Main issues as insurance coverage, paying for medication and getting transportation to and from treatment can be challenging. However a patient with early breast cancer has a set time period of treatment, a patient with metastatic breast cancer does not have a time limit for treatment. Treatment may possibly stay over years rather than months. There are many financial support programs that can aid. For instance, people who are (or have recently been) working may qualify for Social Security aids and people with low income or who are unemployed may qualify for Medicaid (***12***).

Also **social issues** as: Finding it difficult to speak about the illness, because of not bothering others, the others denied the severity of their illness and treatment also, this denial lead to avoid discussing their illness as well as feeling discomfort when discussing it, loss of

emotional closeness in their relationships, their family members and friends had difficulty accepting their diagnosis, difficulties in make connection with the children, family, friends, neighbors or social group, avoid to discuss their illness and prognosis with her husband, limited their illness-related disclosure in order to protect their loved ones from additional emotional stress, family and friends were uncomfortable talking about their medical diagnosis and treatment. Frustration and feeling of loneliness following uncomfortable conversations with family and friends concerning their illness***(13).***

Patients' information needs are important; women with breast cancer need information to help them cope with their illness**.** Complete and reliable information is essential to them both during and after treatment. It helps patients to take treatment decisions, dealing with immediate effects of treatment, and decreasing feelings of helplessness. It can also rise health fitness and provide patients a feeling of control over the disease. There were five categories of information needs among breast cancer patients: 1) nature of disease, its process and prognosis, 2) cancer treatments, 3) investigative tests, 4) preventive, restorative, and keep physical care and 5) patient's or family's psychosocial concerns. Nevertheless some patients need to talk about psychological and spiritual concerns and some of them not need, it is important to assess each patient and his companions' and families' needs for this type of care. Denying patients and their support system chance to determine psychological as well as spiritual concerns is now as dangerous as making them to deal with problems they also don't have not to deal with**(14).**

Regarding **treatment specialist issues** such as: That the specialist discussing things that went wrong in the past, That the specialist ensures adequate privacy through a consultation, That the specialist organizes the arrangements, That the specialist also supports you, That the specialist helps you to make difficult decisions, That the specialist tells you honestly and openly how your conditions, That the specialist explains honestly things in easy words and also that the specialist involves your family in his care ***(*15).**

This work aimed to assess palliative care needs of women with advanced breast cancer at Oncology Center Mansoura University.

Research questions: what are palliative care needs of women with advanced breast cancer?

Methods:

Design: Cross sectional descriptive design.

Operational definition of palliative care needs: Palliative care is the active, total care of the patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount***(16)***

Operational definition of advanced breast cancer: also called metastatic or stage IV breast cancer is breast cancer that has spread from the breast to other organs in the body most often the bones, lungs, liver or brain ***(17)***

Setting: This study was conducted in inpatient department and outpatient clinics at Oncology Center Mansoura University (OCMU). OCMU consists of four surgical wards and two medical wards and each ward consist of five big rooms and three small rooms. The big rooms consist of eight beds and the small rooms consist of three beds.

Subjects: The sample is purposive convenient sample of adult female with advanced breast cancer through a period of 6 months at previously mentioned above setting, patients with D.M, hemiplegia and handicapped were excluded.

Tool for data collection: One tool was used in the present study "**palliative careened assess men questionnaire**", to assess women's palliative care needs. This tool was adapted from **(*15*)**, modified and translated into simple Arabic language by the researcher. This tool was consisted of two parts:-

Part 1:- Demographic characteristics and medical history: This part was used to assess women's demographic characteristics and medical history related breast cancer. It consists of (7) question which include: Age, Marital status, Family history of breast cancer, metastasis related organs, medical treatment, and itsside effects and finally complementary therapy used by the study sample.

Part11: This part was modified by the researcher from **(15)** to assess women's palliative care needs it consists of eight main components:

1-Activity of daily living included 11 items such as (Difficulties in body care, washing, dressing, use of the toilet, walking, climbing stairs, preparing meals or cooking, difficulties in shopping, difficulties in personal transportation, difficulties in doing light housework and difficulties in doing heavy housework.)

This part assesses activity of daily living of the women using Likert scale. It was ranging from good to poor into three categories. All 11 items of activity of daily living were included in the questionnaire, each item ranked from either good

take 2, fair take1 or poor take 0 depending on the ability of women to do activity of daily living so the total score for items was ranged between (0-22).

Scoring system: scores more than 75% are considered good practicing of activity of daily living, scores from 50%-75% are considered fair and scores less than 50% are considered poor practicing of daily living.

2-(A)physical symptoms due to disease included 9 items : Pain, Lump, Fatigue, Skin puckering or dimpling rash on or around nipples Discharge from nipples, Change shape of the nipple become inverted, Warmth and redness throughout the breast, Un explained weight loss and Fever, chills

Likert scale was used to assess physical issues. If the symptoms present, take 1, if not present take 0. So the total score for items was ranged from (0-18).

Scoring system: scores more than 75% are considered sever, scores from 50%-75% are considered moderate and scores less than 50% are considered mild.

(B)Physical symptoms due to metastasis included 4 main items:

- Bones (bone pain, bone swelling and pathologic fracture)
- Liver (jaundice, ascites, abdominal pain and anorexia)
- Lungs (cough, shortness in breathing and chest pain)
- Brain (severe headache, nausea, vomiting, dizziness and visual changes).

To assess physical issues due to metastasis Likert scale was used. If the symptoms present take 1, if not present take 0. All 4 main items of physical issues due to metastasis were included in the scale.

Scoring system: scores more than 75% are considered sever, scores from 50%-75% are considered moderate and scores less than 50% are considered mild.

3-Financial issues included 2 items:

- Extra expenditure because of the disease,
- Reduce income because of the disease.

Likert scale was used to assess financial issues. If it present take 1, if not present take 0so the total score was ranged from (0-4).

4-Social issues included 11 items:

- Problems in the relationship with life companion
- Difficulties talking about the disease with life companion
- Problems in the contact with the children
- Problems in the contact with family, friends, neighbors or colleagues
- Finding it difficult to talk about the disease, because of not wanting to burden others**,**
    - Finding others not receptive to talking about the disease

- Experiencing too little support by others
- Difficulties in finding someone to talk to (confidant)
- Experiencing too little support by your life companion and your family.
- Others denying the severity of the situation**,**
- Loneliness

To assess social issues of the women Likert scale was used. The Likert scale included three categories, ranging from good to poor. All 11 items of social issues were included in the scale, each item ranked from either good take 2, fair take1 or poor take 0. So the total score for items was ranged between (0-22).

Scoring system: scores more than 75% are considered good, scores from 50%-75% are considered fair and scores less than 50% are considered poor.

5- Psychological issues included 13 items:

- Feeling depressed.
- Lack of a sense of pleasure or happiness
- Fear for physical suffering
- Fear of treatment
- Fear of metastasis
- Fear of loneliness and being alone
- The fear of death
- Guilt feeling
- Feelings ashamed of the disease
- Difficulty accepting the change in body shape and appearance
- Fear of making decisions toward disease
- Fear of participating in useful activities
- Difficulty in accepting the disease

Likert scale was used to assess psychological issues the Likert scale included three categories, ranging from good to poor. All 13 items of psychological issues were included in the scale, each item ranked from either good take 2, fair take1 or poor take 0. So the total score for items was ranged between (0-26).

Scoring system: scores more than 75% are considered good, scores from 50%-75% are considered fair and scores less than 50% are considered poor.

6- Self dependence issues included 5 items:

- Do you find it difficult to exercise normal activities?
- Do you find it difficult to exercise social activities, such as appearing at events such as weddings and other?
- Do you become dependent on others?
- Do you feel frustrated because you cannot rely on yourself?
- Do you find it difficult to ask for help from others?

To assess self-dependence issues Likert scale was used. The Likert

scale included three categories, ranging from good to poor. All 5 items of self-dependence issues were included in the scale, each item ranked from either good take 2, fair take1 or poor take 0. So the total score for items was ranged between (0-10).

Scoring system: scores more than 75% are considered good, scores from 50%-75% are considered fair and scores less than 50% are considered poor.

7-Educational issues included 6 items:

- Do you know the agencies that provide assistance?
- Do you know the causes of disease?
- Do you know the availability of treatment?
- Do you know the physical symptoms that can be exposed?
- Do you know the proper nutrition?
- Do you know the side effects that can be exposed?

The Likert scale was used to assess educational issues. The Likert scale. All 6 items of educational issues were included in the scale. If it present take 1, if not present take0. The total score for items was ranged from (0-12).

Scoring system: scores more than 75% are considered good, scores from 50%-75% are considered fair and scores less than 50% are considered poor.

8-Concerning treatment specialist issues included 7 items:

- Are the doctor discussed the bad habits of the past, which led to the occurrence of disease, with you?
- Did the doctor tell the truth illness?
- Are you a doctor explain everything frankly, simple and clear words?
- Is the doctor gives you privacy during the medical examination?
- Is the doctor allows you the presence of your family during treatment?
- Is the doctor provides you with help?
- Does the doctor help you to make difficult decision?

To assess treatment specialist issues Likert scale was used. The Likert scale included 3 categories, ranging from good to poor. All 7 items of treatment specialist issues were included in the scale. If it present take 1, if not take 0. The total score for items was ranged from (0-14).

Scoring system: scores more than 75% are considered good, scores from 50%-75% are considered fair and scores less than 50% are considered poor.

Method

1-An official approval for conducting the study was obtained from the Faculty of Nursing Mansoura University to

carry out the study.

2-An official letter to conduct the study was obtained from the hospital administrative authority after sending official letter from the faculty and explanation the aim and the nature of the study.

3-Palliative care needs assessment questionnaire was modified and translated into simple Arabic language by the researcher.

Validity and reliability:

4-The tool was tested for content-related validity by 5 experts, from the Faculty of Nursing Mansoura University, who reviewed the English and Arabic tool for clarity, relevance, understanding and applicability for implementation. According to their opinion minor modifications were done.

5- Tool was be tested for their content reliability by statistician using Cronbach's Alpha test (r.alpha) based on standardized items and found to be (r=0.75).

Pilot study:

6- A pilot study was carried on 10 women from inpatient department and outpatient clinics at Oncology Center Mansoura University to assess the clarity, and the applicability of the tool, and necessary modification was done prior to data collection. Those women were excluded in the main study.

7-Verbal explanation of the aim and the nature of the study to women to gain their cooperation in data collection.

8- Data was collected by using structured interview questionnaire sheet during a period of six months from the beginning of October 2014 till the end of March 2014, four or five sheets per week and every sheet answering took 15-30 minute on average depending on the degree of understanding and response of the women.

Human rights and ethical consideration:

- Prior to the study, consent was obtained from each patient enrolment into the study, and after clarification the aim and the nature of the study.
- The researcher was emphasize that participation is absolutely and confidential.
- Anonymity, privacy and safety of the subjects was assured and confidentiality of the collected data was maintained.
- Each participant had the right to withdraw from the study at any time without any affect.

Statistical analysis:

Data entry and analysis were performed using the statically package for social sciences “SPSS” version 16.0. The following statistical measures were used:

- The quantitative data were presented as numbers and percentages.

- The p value of < 0.05 indicates a significant result while, p value of > 0.05 indicates anon significant result.

Result:

The results of this study as (table one) revealed that around half of the studied women (54%) were between 50to 60 years old, only3% between 18to 30 years old. In relation to marital status, 72% of the studied women were married, but only 1% was single. The table also revealed that 30% of the studied women had +ve family history, while 70% of them had -ve family history of breast cancer.

Table (1): Socio-demographic characteristics, and medical history of studied women.

Items	Frequency n= 100	Percent %
(years): Age group		
18 <30	3	3
30<40	17	17
40<50	26	26
50-60	54	54
Mean ±SD29.23±9.90		
Marital status		
Single	1	1
Married	72	72
Divorced	4	4
Widow	23	23
Family history of breast cancer		
(+ve)	30	30
(-ve)	70	70
positive family history of breast cancer		
1st degree	28	28
2nd degree	2	2

The results of this study as (table two)show that about two third of the studied women (66%) had metastasis to bones, 26% metastasis to liver, 24% metastasis to lungs and 19% of them had metastasis to brain.

Table (2): Metastasis of breast cancer among studied women:

Items	Yes	No
Metastasis of breast cancer to bones	66	34
Metastasis of breast cancer to liver	26	74
Metastasis of breast cancer to lungs.	24	76
Metastasis of breast cancer to brain.	19	81

***There were more than one organ of metastasis.**

The results of this study as (table three) represent that more than half of the studied women (52%) treated by chemotherapy, 38% treated by radiotherapy, 9% treated by hormonal therapy but only1% of them treated by combined chemo therapy α radio therapy. In relation to using of complementary therapy, most of the studied women (92%) use vitamins supplementation, 42% use dietary supplement, 5% use herbs and none of them use Psycho or spiritual therapy.

Table (3): Medical treatment of breast cancer and complementary therapy used by the studied women:

Items	Frequency n =100	Percent %
Medical treatment of breast cancer now:		
Chemo therapy	52	52
Radiotherapy	38	38
Hormonal therapy	9	9
Chemo therapy α radio therapy	1	1
Use of complementary therapy:		
1-vitamins		
Yes	92	92
No	8	8
2-Herbs:		
Yes	5	5
No	95	95
3-Dietary supplement :		
Yes	42	42
No	58	58
4-Psychotherapy or spiritual:		
Yes	0	0
No	100	100

The results of this study as (table four) represent that all the studied women (100%) suffered from alopecia, anorexia and nausea α vomiting, the most of them (99%97%) complain from sever fatigue and sever pain, respectively more than two third of them (70%79%) had problems in memory and concentration and depression respectively.

Table (4): side effects of medical treatment:

Side effects of medical treatment:	Yes	No
1-Sever fatigue	99	1
2-alopecia	100	0
3-problems in memory and concentration	70	30
4-sever pain	97	3
5-Depression	79	21
6-anorexia	100	0
7-stomatitis	36	64
8-nausea& vomiting	100	0

In relation to Activity of daily living,41% had poor activity of daily living, 29% had fair daily living activity and 30% of them had good activity of daily living.

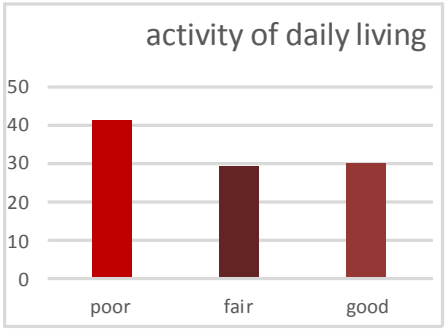

Figure (1): Activity of daily living as a palliative care needs of women with advanced breast cancer.

Regarding physical issues of the studied women, the highest percentage (85%) of them had severe physical issues while (9%, 6%) had mild and moderate physical issuesrespectively.

Figure (2): Physical issues as a palliative care needs of women with advanced breast cancer.

As regards financial issues, all of the studied women (100%) suffered from additional expenses**.**

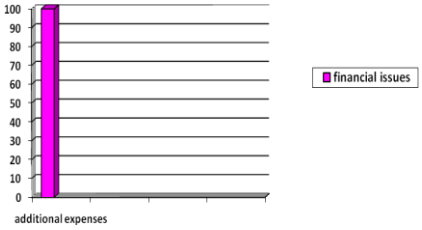

Figure (3): Financial issues as a palliative care needs of women with advanced breast cancer.

Regarding social issues, more than half of the studied women (60%) had good social issues compared with (16%) of them had fair and poor social issues.

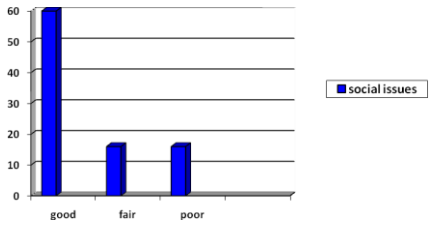

Figure (4): Social issues as a palliative care needs of women with advanced breast cancer.

Concerning psychological issues of the studied women, the majority (98%) of them had poor psychological issues, but only 2% had fair psychological issues.

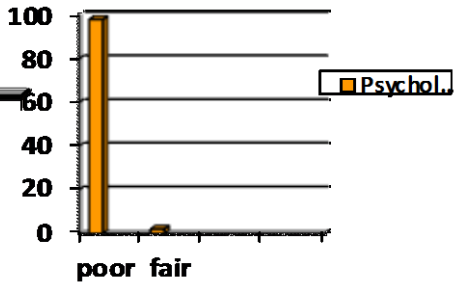

Figure (5): Psychological issues asa palliative care needs of women with advanced breast cancer

In relation to self-dependence issues, about two third of the studied women (69%) had poor self-dependence issues, 29% had fair self-dependence issues, but only 2% of them had good self-dependence issues.

Figure (6): Self dependence issues as a palliative care needs of women with advanced breast cancer.

Regarding educational issues, more than two third of the studied women (73%) had poor educational

issues, 15% had fair educational issues and 12% of them had good educational issues

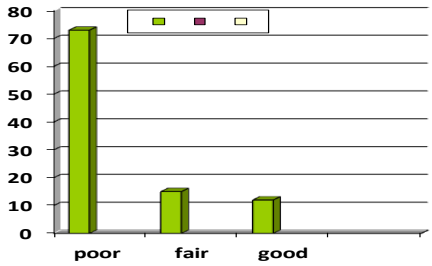

Figure (7): Educational issues as a palliative care needs of women with advanced breast cancer.

In relation to treatment specialist issues, more than half of the studied women (61%) had fair treatment specialist issues, 31% good treatment specialist issues, but only (8%) of them had poor treatment specialist issues.

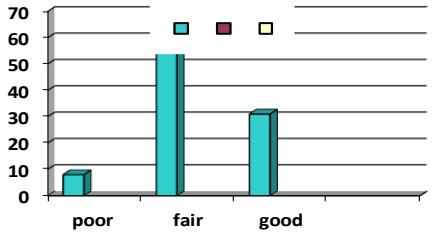

Figure (8): Treatment specialist issues as a palliative care needs of women with advanced breast cancer.

Regarding relations between socio demographic characteristics and palliative care needs of studied women:

The present study showed thatthere was a statistical significant differences between age and activity of daily living (P= 0.017), betweenage and self-dependence issues (P= 0.004),between the age and educational issues of the studied women (P=0.000).As in **Table(5-a), (5-b) and (5-c)**

Table (5-a): Relation between age and activity of daily living as a palliative care needs of studied women (n=100):

Variable	Activity of daily living						Test
	Poor		Fair		Good		
Age	N	%	N	%	N	%	
	1	33.3	0	0	2	66.7	χ^2 15. 4
18<30	6	35.3	2	11.8	9	52.9	P= 0.017*
30<40	6	23.1	10	38.5	10	38.5	
40<50	28	51.9	17	31.5	9	16.7	
50-60							

***Significance level p ≤ 0.05**

Table (5-b): Relation between age and self-dependence issues as a palliative care needs of studied women (n=100):

	Self-dependence issues						Test
	Poor		Fair		Good		
	N	%	N	%	N	%	
Age							
18<30	2	66.7	1	33.3	0	0	χ^2 =19.27
30<40	10	58.8	7	41.2	0	0	P =
40<50	11	42.3	13	50	2	7.7	0.004*
50-60	46	85.2	8	14.8	0	0	

***Significance level p ≤ 0.05**

Table (5-c): Relation between age and educational issues as a palliative care needs of studied women (n=100):

	Educational issues						Test
	Poor		Fair		Good		
	N	%	N	%	N	%	
Age							
18<30	2	66.7	1	33.3	0	0	χ^2 =30.295
30<40	7	41.2	6	35.3	4	23.5	
40<50	14	53.8	4	15.4	8	30.8	P =0.000*
50-60	50	92.6	4	7.4	0	0	

***Significance level p ≤ 0.05**

The results also revealed that, there was no statistical significant differences between age and social issues (P= 0.782), between age and psychological issues (P= 0.834). As in **Table (5-d), (5-e).**

Table (5-d): Relation between age and social issues as a palliative care needs of studied women (n=100):

Age	Social issues						Test
	Poor		Fair		Good		
	N	%	N	%	N	%	
18<30	0	0	1	33.3	2	66.7	=3.21χ^2
30<40	4	23.5	5	29.4	8	47.1	P= 0.782 *
40<50	4	15.4	4	15.4	18	69.2	
50-60	8	14.8	14	25.9	32	59.3	

***Significance level p ≤ 0.05**

Table (5-e): Relation between age and psychological issues as a palliative care needs of studied women (n=100):

Age	Psychological issues				Test
	Poor		Fair		
	N	%	N	%	
18<30	3	100	0	0	
30<40	17	100	0	0	χ^2 =0.86
40<50	25	96.2	1	3.8	P =0.834*
50-60	53	98.1	1	1.9	

***Significance level p ≤ 0.05**

Regarding the marital status, from table**(6-a) and (6-b)** we can see that there was a significant difference between the marital status and activity of daily living (p=0.045) andbetween the marital status and social issues (P=0.002).

Table (6-a): Relation between marital status and activity of daily living as a palliative care needs of studied women**:**

	Activity of daily living						Test
	Poor		Fair		Good		
	N	%	N	%	N	%	
Marital status							
Single	0	0	0	0	1	100	
Married	26	36.1	21	29.2	25	34.7	χ^2 =12.908
Divorced	0	0	2	50	2	50	P =0.045*****
Widow	15	65.2	6	26.1	2	8.7	

***Significance level p ≤ 0.05**

Table (6-b): Relation between marital status and social issues as a palliative care needs of studied women:

Marital status	Social issues						Test
	Poor		Fair		Good		
	N	%	N	%	N	%	
Single	1	100	0	0	0	0	
Married	12	16.7	18	25	42	58.3	χ^2 =20.276
Divorced	3	75	0	0	1	25	P =0.002*****
Widow	0	0	6	26.1	17	73.9	

***Significance level p ≤ 0.05**

The results also revealed that there was no significant differences between the marital status and psychological issues (P=0.829), between the marital status and self-dependence issues (P=0.721) and between marital status and educational issues (P=0.056). As in **table (6-c), (6-d), (6-e**).

Table (6-c): Relation between marital status and psychological issues as a palliative care needs of studied women:

Marital status	Psychological issues				Test
	Poor		Fair		
	N	%	N	%	
Single	1	100	0	0	
Married	71	98.6	1	1.4	=0.886χ^2
Divorced	4	100	0	0	P =0.829
Widow	22	95.7	1	4.3	

***Significance level p ≤ 0.05**

Table (6-d): Relation between marital status and self-dependence issues as a palliative care needs of studied women:

	Self-dependence issues						Test
Marital status	**Poor**		**Fair**		**Good**		
	N	**%**	**N**	**%**	**N**	**%**	
Single	1	100	0	0	0	0	=3.675χ^2
Married	46	63.9	24	33.3	2	2.8	
Divorced	3	75	1	25	0	0	
Widow	19	82.6	4	17.4	0	0	P =0.721*

***Significance level p ≤ 0.05**

Table (6-e): Relation between marital status and educational issues as a palliative care needs of studied women:

	Educational issues						Test
Marital status	**Poor**		**Fair**		**Good**		
	N	**%**	**N**	**%**	**N**	**%**	
Single	0	0	1	100	0	0	=12.276χ^2
Married	49	68.1	12	16.7	11	15.3	
Divorced	3	75	0	0	1	25	P =0.056*
Widow	21	91.3	2	8.7	0	0	

***Significance level p ≤ 0.05**

Regarding family history of the studied women, from **table (7)**we can see that there was no significant differences between family history of breast cancer and palliative care needs of women with advanced breast cancer (P> 0.05).

Table (7): Relation between family history of breast cancer and palliative care needs of studied women:

Palliative care needs of women with advanced breast cancer	**Family history of women with advanced breast cancer**		**Test**
	+ve	**-ve**	
Activity of daily living:			χ^2=3.12
Poor	32.3%	44.9%	
Fair	25.8%	30.4%	P =0.209*
Good	41.9%	24.6%	
Social issues :			
Poor	16.1%	15.9%	χ^2=0.051
Fair	22.6%	24.6%	
Good	61.3%	59.4%	P=0.975*
Psychological issues:			
Poor	100%	97.1%	χ^2=0.91
Fair	0	2.9%	
Good	---	---	P=0.338*
Self-dependence issues:			
Poor	67.7%	69.9%	χ^2=1.073
Fair	32.3%	27.5%	
Good	0	2.9%	P=0.585*
Educational issues :			
Poor	67.7%	75.4%	χ^2=2.093
Fair	22.6%	11.6%	
Good	9.7%	13%	P=0.351*
Treatment specialist issues:			
Poor	9.7%	7.2%	χ^2=0.24
Fair	58.1%	62.3%	
Good	32.3%	30.4%	P=0.885*

***Significance level p ≤ 0.05**

Discussion:

The result of the current study revealed that studied women′s age ranged from18-60 years old and more than half of the study from 50 to 60 years old as in the study of (**18**) who found that about quarter of new breast cancer cases were

younger than 50 years. The present study finding congruent with (**19**) in which breast cancer is the most common cancer among women with age around 50 years. This is may be due to the time of the menopause.

In the current study, it revealed that increase breast cancer occurrence with increasing the age. That is in agreement with ***(20, 21,*****22**) that informed that more than two third of the women were in the age 50-60 years old. They also mentioned that increase breast cancer occurrence with increasing the age. Also ***(23)***confirmed that in Egypt, the median age at diagnosis of breast cancer is ten years younger than in the United States and Europe.

In the current study, we found that more than two third of the study were married. This is in line with ***(20)***who found that approximately 55% of the studied sample in his research were married. This information aided the researcher determine the ratio of the studied women who had family duties. In addition, married women may have their spouses as providers of emotional support.

Concerning to family history of breast cancer, 30% of women had positive family history of breast cancer. This in the same line with***(24,*** **21**), who showed that 40% of women had positive family history. I see that it may be due tofamilies with positive history of breast cancer often carry gene mutations.

In relation to metastasis of breast cancer, the present study showed that, more than two third of the studied women had metastasis to bone and 19% had metastasis to brain. This goes in line***(25),*** they mentioned that bone was the most commonly site of metastasis and the brain was less frequent site of metastasis.

The findings were also in disagreement with ***(26,*** **27**) in a study done in Western Europe, that mentioned that the most commonly site of metastasis was lymph 88% .
In my study, more than half of the studied women treated by chemotherapy, 38% treated by radiotherapy and 9% treated by hormonal therapy. In contrast to ***(28, 1)***who mentioned that most of the women were treated by chemotherapy and 30% treated by radiotherapy. The findings were disagreement with(**29**) who found that about 37% of the studied women treated by hormonal therapy and a rare of them treated by targeted therapy.

In relation to using of complementary therapy the finding of the present study represented that, most of the studied women use vitamins and none of them use psycho or spiritual therapy. This agreed with***(30)*** who mentioned that the majority of the studied

women use vitamins. But ***(30)*** disagree with this study because they found that two third of their study sample use psycho or spiritual therapy as guided imagery, meditation and hypnosis. They also mentioned that the majority of breast cancer patient used at least one complementary practice to assess body nature healing, assess other treatment, relieve symptoms and increase quality of life.

Concerning side effects of medical treatment, the majority of the studied women suffered from alopecia, loss of appetite, nausea vomiting, mouth sores, weakness and fatigue, depression, bleeding, anemia and a higher risk for infection. This result comes in consistent with***(31,32, 33)***, who showed that the most common side effects of medical treatment were alopecia, loss of appetite, nausea, vomiting and mouth sores.

Regarding to palliative care needs of women with advanced breast cancer, more than two third of the studied women had poor activity of daily living, two third of them had good social issues, the highest percentage of them suffered from severe physical symptoms. This in the same line with***(34,35,36)*** who showed that women who had advanced breast cancer experience high levels of palliative needs in relation to activity of daily living, social and physical issues. I supposed that it may be due to lack of energy due to effect of disease and treatment.

Concerning to palliative care needs of women with advanced breast cancer, the current study showed that the majority of the studied women had poor psychological issues and two third of them had poor self-dependence issues. This in consistence with***(37, 38,39, 40)*** as they showed that women with advanced breast cancer had change in their life concerning autonomy and independence which could generate psychological problems. I supposed that it may be due to cancer treatments and worry about body image and sexuality, psychological stress, anxiety, fear of recurrence, sleep dysfunction, fear of loss of fertility, pain, fatigue and impaired physical, emotional and quality of life functioning.

In the current study, more than half of the studied women had fair treatment specialist issues, as in the study of **(41)** who reported that more than two third of their study sample had high needs for the medical information/ communication. I supposed that it may be due tohealth-care providers may not be aware that patients have needs in these areas due to lack of communication between treatment specialist and patients. Another explanation may include deficits in health-care providers' training and education.

Concerning to financial issues as a palliative needs of women with advanced breast cancer, the current study showed that all of the studied women suffered from additional expenses. This goes in line with***(42, 43)***who showed that the majority of their study sample have additional expenses. They also mention that this financial distress have a significant negative impact on health outcomes of women This may be duo to increase cost of medical care and effect of disease onemployment, including reduction of income and loss of employment-based insurance**.**.

Concerning to relation between socio demographic characteristics and palliative care needs of women with advanced breast cancer. The present study showed that more than two third of the study who at the age between (18-30 years) had good activity of daily living and more than half of the study at the age between (50-60 years) had poor activity of daily living. This is in line with ***(44)*** who reported that activity of daily living decrease at the age between (50-60years).I supposed that it may be due to effect of disease or treatment, lack of energy and feeling of tiredness.
In this study, there is a statistical significant difference between age and activity of daily living which in agreement with the study of **(45)**, who found that there was a statistical significant difference between age and activity of daily living. This may be due to changes in age.

Concerning relation between age and educational issues, this study showed that, the majority of the studied women who at the age between (50-60 years) had poor educational issues. This result was in disagreement with ***(46, 47, 48, 49, 50)*** in the studies conducted in Europe and North America that found that younger women had a greater need for information than older women.
Also in this study, there is a highly statistical significant difference were observed in relation between the age and educational issues. This in the same line with***(46)*** who found that a statistical significant difference between total information needs and age among there sample study.

This study portrayed that there were a statistical significant difference between marital status and activity of daily living and social issues as a palliative care needs of the studied women. These findings were also congruent with **(51)** who found that there were a statistical significant between marital status and activity of daily living and social issues as a palliative care needs of women with advanced breast cancer. It may be due to married women experience less distress, anxiety and depression than unmarried

women as a partner could share the emotional burden and provide social support.

Conclusion: This study concluded that Psychological issues was the highest palliative care needs among women with advanced breast cancer followed by physical issues, financial issues and social issues,all women suffered from additional expensesas a financial need of women with advanced breast cancer.There was a statistical significant difference between age and activity of daily living among advanced breast cancer women.There was a statistical significant difference between the age and self-dependence issues among advanced breast cancer women.A statistical significant difference was observed in relation between the age and educational issues among advanced breast cancer women.There was a statistical significant difference between the marital status and activity of daily living among advanced breast cancer women.There was a statistical significant difference between the marital status and social issues.

Recommendations:This study recommended that: developing palliative care programme to oncology nurses who caring for women with advanced breast cancer. Developing tool to assess and evaluate palliative care needs for women with advanced breast cancer. Establish written protocol about palliative care for women with advanced breast cancer.Strategies should focus on prevention and early detection programmes to decrease the rate of advanced breast cancer women in Egypt.

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