

QUALIDADE DE VIDA DE PACIENTES ONCOLÓGICOS EM CUIDADOS PALIATIVOS

QUALITY OF LIFE OF ONCOLOGICAL PATIENTS UNDER PALLIATIVE CARE

CALIDAD DE VIDA DE LOS PACIENTES ONCOLÓGICOS EN CUIDADOS PALIATIVOS

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RESUMO

Objetivo: Avaliar a qualidade de vida de pacientes oncológicos em cuidados paliativos, por meio de instrumento validado. **Método:** Trata-se de um estudo descritivo, quantitativo com pacientes internados em uma unidade de oncologia de um hospital de grande porte do Centro-Oeste de Minas Gerais. **Resultado:** observou-se uma perda importante na qualidade de vida dos participantes, em especial no domínio de “bem-estar emocional” e “bem-estar funcional”. Contudo, os domínios de “bem-estar físico” e “bem-estar social-familiar” foram bem avaliados pelos participantes. **Conclusão:** A equipe de saúde, em especial a de enfermagem, necessita se instrumentalizar para a identificação e resolução oportuna de questões que podem trazer prejuízo às diferentes dimensões da vida da pessoa com câncer, atentando para a manutenção do controle dos sintomas, fomentando a participação da família nos cuidados e fornecendo o suporte emocional e funcional adequados às demandas individuais da pessoa sob cuidados paliativos.

Descritores: Qualidade de vida; Cuidados paliativos; Enfermagem; Oncologia.

ABSTRACT

Objective: to evaluate the quality of life of cancer patients under palliative care using a validated instrument. **Method:** this is a descriptive, quantitative study with patients admitted to an oncology unit of a large hospital in the Midwest region of Minas Gerais. **Result:** there was a significant loss in the participants' quality of life, especially in the domains “emotional well-being” and “functional well-being”. However, the domains “physical well-being” and “social-family well-being” were well evaluated by the participants. **Conclusion:** the health team, especially the nursing team, needs to be skilled to identify and timely solve issues that can harm the different dimensions of the person with cancer, with a view to maintaining symptom control, fostering the family participation in the care and providing the emotional and functional support appropriate to the individual demands of the person under palliative care.

Descriptors: Quality of life; Palliative care; Nursing; Oncology.

RESUMEN

Objetivo: Evaluar la calidad de vida de pacientes oncológicos en cuidados paliativos por medio de instrumento validado. **Método:** Se trata de un estudio descriptivo, cuantitativo con pacientes internados en una unidad de oncología de un hospital de gran porte del Centro-Oeste de Minas Gerais. **Resultado:** se observó una pérdida importante en la calidad de vida de los participantes, en particular en el ámbito del “bienestar emocional” y el “bienestar funcional”. Sin embargo, los ámbitos de “bienestar físico y bienestar social-familiar” fueron bien evaluados por los participantes. **Conclusión:** El equipo de salud, en especial la de enfermería, necesita instrumentalizarse para la identificación y resolución oportuna de cuestiones que pueden traer perjuicio a las diferentes dimensiones de la vida de la persona con cáncer, atentando para el mantenimiento del control de los síntomas, fomentando la participación de la familia en el cuidado y proporcionando el soporte emocional y funcional adecuado a las demandas individuales de la persona bajo cuidados paliativos.

Descriptorios: Calidad de vida; Cuidados paliativos; Enfermería; Oncológica.

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INTRODUCTION

Cancer is an important global public health problem and is the leading cause of death in developing countries, as it is the case of Brazil. In the national context, cancer ranks second in the ranking of deaths due to various causes among the general population, and for the biennium 2016-2017, it is estimated that around 600,000 new cases of this disease will be diagnosed⁽¹⁻²⁾.

Cancer diagnosis has important repercussions on the life of the person and his/her family, especially when the disease is advanced and with metastases, beyond the therapeutic possibility of cure. When this happens, the person is said to be in palliative care (PC), and from that point on, the emphasis is on measures that aim at the identification, evaluation and timely treatment of physical, psychosocial and spiritual symptoms and that affect the quality of life (QoL) of the person⁽³⁻⁴⁾.

Thus, PC can be understood as a therapeutic approach to the patient with no chance of cure through interventions aimed at symptom relief and the prevention of physical, psychosocial and spiritual suffering, aimed at the QoL⁽³⁾. To that end, different approaches are developed by the health teams of primary, secondary and tertiary care, composed of nurses, physicians, nutritionists, social workers, psychologists, occupational therapists, among others.

The aim of CP teams is the optimization of the person's QoL, for which there is no consensus on a universal definition. However, there is an agreement about its multidimensional, subjective and individual character encompassing health and also physical, functional, emotional and mental aspects, as well as important elements of the life of people, such as work, family, friends, and other everyday circumstances. The QoL is also influenced by people's perceptions of their position in life in relation to culture, value system, personal goals and expectations, not being just related to the presence or absence of illness⁽⁵⁾.

The evaluation of QoL results from the analysis of the individual's perception of their position in life, both in the context of the culture and of value systems in which they live, and in relation to their individual goals, expectations, standards and concerns regarding health, disease and what brings value and meaning to their lives⁽⁵⁾. Information on the QoL of specific groups can be useful in monitoring various therapeutic

interventions of different natures, thus favoring clinical decision-making and health care⁽⁵⁻⁶⁾.

Regarding cases of advanced cancer beyond the possibility of therapeutic cure, several factors can compromise QoL, from the diagnosis of the disease itself to the toxic effects of the therapies employed, the limitations imposed by the disease and the treatment and development of clinical conditions associated with anxiety and depression⁽⁴⁾. In this sense, the evaluation of the QoL of these patients through specific instruments is essential for the planning and implementation of care plans that enhance their well-being and satisfaction with life⁽⁴⁻⁶⁾.

The use of PC measurement instruments is essential for assessing the quality of care provided, increasing knowledge about the cancer patient's experience and the therapies employed, besides providing information about the efficiency of the proposed interventions, in order to improve people's symptoms and QoL. Among the possibilities of measuring PC results, the evaluation of QoL has become increasingly important in understanding the repercussion of the interventions proposed by the care teams in their lives⁽⁵⁻⁶⁾.

Different instruments of QoL measurement have been translated and validated for Brazil, with specific scales for the evaluation of quality of life of people undergoing palliative care⁽⁷⁻¹⁰⁾. However, such instruments have been little used as tools for the systematic evaluation of patients in clinical practice, and their use has been restricted to research⁽⁷⁾.

We believe that the application of validated scales for the measurement of QoL in different patient profiles and in different care settings may provide clues about the necessary adjustments to be made in the conformation of care plans in different health care contexts. In this sense, the present study aims to evaluate the quality of life of patients under palliative care admitted in an oncology unit of a large hospital in the Midwest region of Minas Gerais, through the application of a validated instrument.

METHOD

This is a descriptive, quantitative approach developed with PC patients hospitalized at an oncology unit of a large hospital affiliated of the High-Complexity Oncology Unit (UNACON in Portuguese). The assistance provided at that institution includes the integrated modalities of diagnosis, oncological surgery, radiotherapy,

chemotherapy, clinical oncology, hematology and supportive measures. The palliative care modality did not exist until the end of this research. The referred hospital is a reference for the treatment of patients with cancer in 86 cities in the Midwest region of Minas Gerais⁽¹¹⁾.

The oncological unit in which the study was conducted is intended for the clinical admission of people with cancer in different stages and with different prognoses, coming from both home, with acute problems arising from the disease and/or treatment, as well as from surgical treatment, chemotherapeutic and radiotherapeutic units of the institution.

In general, patients with an indication for PC admitted to this unit have advanced disease, are in a progressive state of decline and with limited functional capacity, making their participation in the research impossible. In addition, the turnover of these patients in the unit is relatively low, since many prefer to remain hospitalized due to the lack of home-level care and support services in the region.

Considering these specificities, the composition of the sample was non-probabilistic, by convenience, and was composed of patients with a medical indication of PC between April and June 2017. The inclusion criteria were being admitted to the oncology sector of the hospital; having a medical definition of PC expressed in the chart; being over 18 years of age; and being lucid and able to communicate verbally. Exclusion criteria were patients with functional capacity less than or equal to 30% (terminal stage) evaluated by the Palliative Performance Scale (PPS), version 2⁽¹²⁾.

The data were collected through individual interviews, and the eligible patients were individually approached in the room where they were hospitalized, in view of the physical limitations for bed displacement. To collect the data, two instruments were used, namely: the first containing sociodemographic and clinical variables and the second containing the variables related to QoL.

The QoL instrument chosen was the FACIT-Pal, developed by the Functional Assessment of Chronic Illness Therapy (FACIT), responsible for the construction and dissemination of QoL instruments for patients with non-communicable diseases. FACIT-Pal is widely used in North American health systems, with high internal consistency, reliability and validity, being an instrument aimed at measuring the quality of life

of people with advanced or life-limiting illness⁽¹³⁾, having been translated into Portuguese by the FACIT group and subsequently culturally validated⁽⁹⁾.

FACIT-Pal is composed of a general quality of life assessment scale (FACTG) combined with a specific subscale for the evaluation of people with diseases beyond the possibility of therapeutic cure and requiring palliative care. The instrument includes the evaluation of five domains, through 41 questions, namely: "physical well-being", "social/family well-being"; "emotional well-being"; "functional well-being" and "additional concerns". The answers are graded on a Likert scale with 5 options ranging from the answer "not at all" to "very much"⁽¹³⁾.

The specific subscale for the evaluation of people with diseases that are beyond the therapeutic possibility of cure contains 19 items with information regarding the most prevalent symptoms in PC (eg, shortness of breath, constipation, xerostomia), the relationship with family and friends (perception of social support), issues related to the end of life (eg, "having made peace with others", "feeling hopeful", "making each day important"), decision-making, communication and skills (eg, ability to make decisions, to think clearly, and to openly discuss concerns)⁽¹³⁾.

In order to measure the quality of life, the scores of each domain were calculated. The scores for "physical well-being", "social/family well-being" and "functional well-being" ranges from 0 to 28 points, and the "emotional well-being" domain score ranges from 0 to 24 points and the "additional concerns" domain score ranges from 0 to 76 points. The higher the score obtained, the better the assessment of quality of life for that domain⁽¹³⁾.

The authors of FACIT-Pal present three indices that must be calculated, namely: (1) the Trial Outcome Index (TOI), obtained by the sum of the domains "physical well-being", "functional well-being" and "additional concerns", with scores ranging from 0 to 132, (2) the General Living Quality Index (FACTG), obtained by the sum of the domains "physical well-being", "social well-being" and "functional well-being", with scores ranging from 0 to 108, and (3) the Total Index of the Quality of Life in Persons under Palliative Care (FACIT-Pal), obtained by the sum of all domains of the scale ("physical well-being", "social well-being", "emotional well-being", "functional well-being" and "additional concerns", ranging from 0

to 184 points. The higher the scores, the better the person's perception of their quality of life⁽¹³⁾.

We used the Statistical Package for the Social Sciences (SPSS), version 22.0 for the treatment and analysis of the data. Descriptive analysis of the data were presented through the measures of central tendency (median), absolute frequency, dispersion measures (maximum and minimum) and percentiles.

Participation in the research was voluntary, through the signing of the Informed Consent Term. The study protocol was approved by the Research Ethics Committee of the Federal University of São João del-Rei, Approval Certificate No. 0043.0.410.20310 and by the Ethics Committee of the Institution, Approval Certificate No. 0043.0.410.203-10A, according to Resolution 466/12 of the National Health Council.

RESULTS AND DISCUSSION

The sample consisted mainly of females (n = 5, 55.6%), married people (n = 5, 55.6%), with children (n = 7, 77.8%), and with children

indicated as one of the main caregivers by the participants. Most of them had a low level of schooling, with a predominance of incomplete elementary school (n = 3, 33.3%) and complete elementary school (n = 2, 22.2%). Similar data were found in a study⁽¹⁴⁾ with 124 patients in PC, in which the majority of the participants were female, married and with low level of education. These data may show that, even with several campaigns and public policies aimed at the female audience, the number of people of this sex continues to be high. One of the factors that can contribute to this is the low level of education, which is pointed out in the literature as a variable that delays the identification of cancer and the beginning of treatment, as it makes it difficult to access and assimilate information on prevention, diagnosis, control and treatment of the disease.

Table 1 shows the frequencies and percentages on the other sociodemographic data of the study sample.

Table 1 – Characterization of the sociodemographic profile of cancer patients in palliative care. Divinópolis, MG, Mar-June, 2017 (n=9)

Variable	Distribution in categories	N	%
Self-declared race	Brown	2	22.2
	Light-brown	3	33.3
	Black	2	22.2
	White	0	0.0
	Undeclared	2	22.2
Salary range	Up to a minimum wage	5	55.6
	1 to 3 wages	3	33.3
	≥ 4 wages	0	0.0
	Undeclared	1	11.1
Family income	Up to a minimum wage	0	0.0
	1 to 3 wages	6	66.7
	4 to 10 wages	2	22.2
	≥ 10 wages	0	0.0
	Undeclared	1	11.1
Religious	Yes	8	88.9
	No	1	11.1
CNCD*	No	8	88.9
	Yes	1	11.1

Source: elaborated by the authors based on research data.

* Chronic Non-communicable diseases.

Most participants had low salary range (up to a minimum wage/month), as well as low family income (1 to 3 minimum wages/month), considering the number of residents in the family home (from 2 to 3 residents). Regarding these findings, the existence of a sick person imposes the need for transportation, purchase of medication and other demands, and such expenses end up compromising the already precarious purchasing power of the family,

especially when the sick person and/or their caregiver are family providers⁽¹⁴⁾. In this sense, information about the social and economic situation of the family of people with cancer needs to be included in the discussions of the health team in order to consider the possibilities of support and/or refer specific demands for available support services.

Most of the participants in this study reported having a religion, being divided between

Catholic (55.5%) and Evangelical (33.3%) religion. On this point, the belief in a higher being, faith, spirituality and religious practices are important coping strategies, providing to the person under PC and to his/her family comfort and meaning to life, to the dependence and to the provision of care⁽¹⁵⁾. A study suggests that even if there is no established religious belief, spirituality is expressed by patients under PC, especially those close to the end of life. Thus, neglecting spirituality means to neglect an essential component for people under PC⁽¹⁶⁾.

Spirituality gives hope, purpose and meaning to the end-of-life process of the person,

enabling the creation of mechanisms to deal with illness, loss, loneliness and death. A study showed that the spiritual support provided by the care team is associated with better QoL, greater use of PC and less aggressive medical interventions at the end of life. However, this type of support is little frequent among professionals due to multiple factors, such as insufficient human resources, lack of training and lack of time⁽¹⁷⁾.

Regarding the characterization of the clinical profile, the primary site of cancer among the participants was breast (n = 3; 33.3%), as can be seen in Table 2 below.

Table 2 – Characterization of the clinical profile of patients in palliative care admitted to the oncology sector. Divinópolis, MG, Mar-June, 2017 (n=9).

Variable	Distribution in categories	n	%
Primary cancer	Breast	3	33.3
	Head/Neck	1	11.1
	Stomach	1	11.1
	Colon/Rectum	1	11.1
	Lung	1	11.1
	Womb	1	11.1
	Prostate	1	11.1
	Primary metastasis	Bones	4
Liver		2	22.2
CNS		1	11.1
Undeclared		1	11.1
Does not have		1	11.1
Have you undergone any surgical treatment at any time during the course of the disease?	Yes	5	55.6
	No	4	44.4
Have you undergone radiation therapy at any time during the course of the disease?	Yes	6	66.7
	No	3	33.3
Have you undergone chemotherapy at any time during the course of the disease?	No	7	77.8
	Yes	2	22.2
Have you undergone hormone therapy at any time during the course of the disease?	No	6	66.6
	Yes	3	33.4

Source: elaborated by the authors based on research data.

Because breast cancer is the type that most affects women in the national context, it is essential that the nursing team be prepared to meet the needs of these patients in their totality, in a humanized way. A study with women with breast cancer under in palliative care pointed out that the good relations established between the woman and the nurse favor the process of communication and care, impacting the woman's quality of life⁽¹⁸⁾.

The majority of participants in the present study had metastasis, with the most affected sites being the bones (n = 4, 44.4%) and the liver (n = 2, 22.2%). Bone metastases are, admittedly, the most frequent distant metastases related to breast cancer. In addition, bone metastases are common in advanced cancers, occurring in

approximately 50% of patients with metastatic cancer. This type of metastasis causes high morbidity due to pain, impaired mobility, hypercalcemia, pathological fractures, among others, with a significant repercussion on the patient's QoL due to the pain and physical limitations they impose⁽¹⁹⁻²⁰⁾. On the other hand, the liver is the main organ affected by hematogenous metastases arising from the portal circulation of systemic circulation. This fact can be attributed to the fact that the liver is the largest solid viscera of the organism, receiving great arterial and venous blood flow⁽¹⁹⁾.

The participants of this study had a history of different treatments throughout the course of the disease, and most of them had undergone surgical (n = 5, 55.6) and radiotherapy (n = 6

66.7%) at some point. This finding may be related to the early search for health services and the timely diagnosis of the disease⁽¹⁴⁾.

The quality of life of the study participants was measured according to the recommendation of the authors of FACIT-PAL, and the data analysis by domain is presented in Table 3.

Table 3 – Scores of quality of life domains of cancer patients under palliative care. Divinópolis, MG, Mar-June, 2017.

Descriptive statistics	Physical well-being 0 – 28	Social and family well-being 0 – 28	Emotional well-Being 0 – 24	Functional well-being 0 – 28	Additional Concerns 0 – 76
Median	16.0	15.0	11.0	12.0	34.0
Minimum	5.0	4.0	2.0	5.0	29.0
Maximum	23.0	20.0	20.0	16.0	47.0
Percentile 25	12.5	13.5	7.0	8.5	31.0
Percentile 75	22.0	18.0	14.5	14.0	41.5

Source: elaborated by the authors based on research data.

In the present study, the domains of the QoL assessment instrument have behaved independently and autonomously, in the same way as in a study that also used this instrument⁽²¹⁾.

According to the guidelines of the FACIT group⁽¹²⁾, the higher the score in the different domains of the scale, the better the QoL. The domains that obtained the highest scores were "physical well-being" (median = 16, minimum = 5, maximum = 23 points) and "social-family well-being" (median = 15, minimum = 4, maximum = 20 points). A similar result was identified in a study that used FACIT-Pal in patients undergoing palliative care, in which the physical domain maintained the highest scores in a 18-month follow-up⁽²¹⁾. Thus, the participants' perception of their physical condition and their social relationships, as well as the social roles adopted in life were less affected by their current condition, illness and/or treatment. However, in the same study mentioned earlier, participants reported that symptoms not included in the QoL assessment instrument, such as vertigo, instability, numbness and confusion, associated with their physical conditions and treatment compromised their ability to perform simple daily routine tasks⁽²¹⁾.

Contrary to what was identified in the present study, the domain "physical well-being" obtained low scores in the first four evaluations involving patients with advanced cancer under palliative therapy. However, better scores in this area were identified from the fifth evaluation, in a total of six evaluations. Thus, the authors inferred that there was a better perception of physical well-being with the progress and continuity of the palliative approach⁽¹⁰⁾.

In view of this, despite the advancement of the disease and the treatment physically compromising the patient, their perception of their physical condition can be positively influenced by the use of appropriate drug therapy to control the symptoms, as well as by the support provided by the health team.

Despite the challenges in the patients' ability to perform daily life activities due to their physical limitations imposed by the disease and treatment, a study showed that the acceptance of their health condition and the search for aids to complement the daily tasks helped the patients to overcome the limitations⁽²¹⁾. Thus, the participation of the support network of the patients in their care, as well as of the health professionals, is crucial so that patients face this stage of their life with quality.

The scores of the "social-family well-being" domain were also high in another study, and the participants of this study pointed out that frequent social interactions with family members, friends and health professionals were essential for receiving the necessary support. Experiencing the disease with the help of partners was pointed out by these same participants as a reinforcement of the relationship, and the time spent with the care provided by the partners was seen as an opportunity to strengthen and improve the relationships⁽²¹⁾.

Another study showed that "social-familial well-being" was well evaluated by patients under palliative care in the first evaluations performed, with declines in those that occurred in the last months of the research. Therefore, the authors infer that this domain becomes more present and significant with the evolution of the disease, which indicates the need for specific

interventions to maintain adequate social support to patients throughout the course of the disease⁽¹⁰⁾.

Symptom control still remains an important challenge for the health team working with patients with advanced cancer, considering its direct impact on the QoL and its difficult management⁽²⁰⁾.

The dimensions with the highest perceived impairment among the participants in this study were "emotional well-being" (median = 11, minimum = 2, maximum = 20 points) and "functional well-being" (median = 12, minimum = 5, maximum = 16 points). A study using the same QoL assessment instrument also obtained the worst scores in the emotional domain, which was justified by the patients' perception of important changes in their daily life due to their health conditions⁽⁷⁾.

Another study showed a high score in the area of emotional well-being, and in this study, there was a decline in the evaluation of this domain only in the evaluation performed in the three months preceding the patient's death. Emotions such as sadness, frustration, anger and loneliness were expressed by the participants of this study, and the maintenance of the positive perspective and search for distraction activities are indicated as a way to overcome negative emotions⁽²¹⁾. The provision of emotional support by the patient's social network and by health professionals, especially in the months before his/her death, may favor patient coping. Therefore, it is essential that the professionals of the care team be qualified and develop the aptitude and sensitivity necessary to identify non-verbal signals of emotional needs that extrapolate needs verbally informed by the patient.

Regarding the perceived impairment in "functional well-being", we consider that the limitations for the development of life activities had a repercussion on these patients' perception of well-being. The decline in functionality associated with disease progression, treatments and co-morbidities of patients with advanced cancer is common, and authors have indicated that impairments in the ability to participate in normal activities with significant people have an important impact on the quality of life⁽²²⁾.

A similar result was found in a study with the same instrument, in which the worst results were obtained in the "functional well-being" domain. Although participants had tried to use

positive coping mechanisms before their health status, seeking to accept their limitations, they stated that the constant need for help to carry out activities of daily living negatively impacted their perception of functional capacity⁽²¹⁾. In this sense, we believe that nursing interventions that favor self-care, respecting the limitations and individual conditions of patients under PC, could contribute to the improvement of their perception about their functional capacity, allowing improvement in their perception regarding QoL.

In the evaluation of the overall indices of the instrument, results evidenced impairment in the participants' quality of life. In the Trial Outcome Index, a median of 62 points (minimum = 52, maximum = 80) was obtained out of 132; in the general quality of life index (FACT - G) a median of 53 points (minimum = 38, maximum = 63) was obtained out of 108; in the total index of palliative quality of life (FACIT-Pal), we obtained a median of 84 points (minimum = 76, maximum = 110) out of 184. The fact that there is no PC service in the institution where the study participants were hospitalized and that the health professionals working in this context still have a rather shallow approach to this theme may have had repercussions on late definitions of the need for this type of care and on the delay in the implementation of care measures focused on QoL. The study pointed out that, as PC is relatively recent in Brazil, a large contingent of health professionals is still unaware of this modality of care. This situation was related by the authors to the shortage of disciplines focused on the teaching of contents pertinent to the subject in curricula of undergraduate and postgraduate courses in the national context⁽²³⁾.

In addition, since PC is still being consolidated within the scope of the national health system, in the municipality where the present study was conducted there are no structured services to provide this type of assistance at different levels of care, which may have contributed to the late reception of care for comfort, discontinuity of care and worsening of patients' perception of well-being. A recent study that evaluated QoL of patients in CP identified that the systematic follow-up of the care team through regular visits and promotion of earlier palliative practices have positively impacted the perception of QoL of the participants⁽²¹⁾.

The present study presents limitations, mainly related to the size of the sample and its

descriptive design, which makes it impossible to establish a causal relationship. In addition, the results found may not be generalized to the general population as it is a convenience sample. However, the findings can subsidize the construction and conduction of future studies that deepen the evaluation of the quality of life of patients under palliative care, correlating it with other variables of interest to this population.

CONCLUSION

The QoL of the patients admitted to an oncology unit, as measured by a validated instrument for this purpose, presented scores with discrepancies in the evaluation by the participants, who perceived better well-being in the domains related to physical and social/family dimensions and worse well-being in the domains related to emotional and functional dimensions. This information evidences the need for investments by the health and nursing team in strategies for identifying and solving issues that bring impairments both in the capacity of the person under PC to carry out their daily life activities and in their way of dealing with and expressing the emotions that come to the surface and interfere in their perception about QoL.

However, although the scores in the domains related to the physical and social/family dimensions have been better evaluated, it is crucial that the care team be skilled to identify early physical signs and include, in the care plan, interventions directed to the maintenance of control of existing symptoms and identification and control of new symptoms. In addition, it is essential that the nurse assess and monitor the social and family support provided to the patient and provide means for the people who are part of the patient's social network to participate actively in their care.

In addition, there is a need for greater dissemination of knowledge about PC among health professionals working at different levels of care, so that palliative practices can be part of comprehensive care for patients with advanced diseases and out of therapeutic possibility of cure.

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