

Short Communication

Breast cancer screening with breast self examination

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Abstract

Background: The nurse care in breast cancer care focus is not only on the medical aspect but also on the emotional aspect of care. Strategies to help detect and prevent breast cancer include regular screening for all women and lifestyle changes.

Purpose: This study was done to screen the women population of Khanpur Kalan and surrounding villages of Haryana for breast cancer by implementing a screening programme among clinicians, nurses and paramedical workers.

Methods: Demographic and clinical data of breast cancer patients including mammography screening was tabulated in a proforma for evaluation. Breast self examination was taught with the help of nursing personnel.

Results: Breast-related complaints and/or benign/malignant breast, including fibroadenosis, adenocarcinoma, axillary lump, galactorrhoea, fibrocystic disease and mastitis were diagnosed in a sample survey of participants.

Conclusion: Breast screening in normal and/or asymptomatic women with significant clinical manifestations of disease is thus essential to reduce the burden of breast cancer. Nurses will be more successful in assisting women to obtain timely breast cancer screening and treatment when they better understand culturally appropriate education materials on breast cancer.

1. Introduction

Breast cancer is the most common cancer in women and the second leading cause of cancer deaths. According to the American Cancer Society (ACS), about one in eight women will be diagnosed with breast cancer during their life. Persons at high risk include those who carry or develop certain genetic mutations and those with a family history of breast cancer.

The treatment of primary breast cancer usually consists of surgery often followed by adjuvant therapy (radiotherapy, chemotherapy, hormonal treatment, etc.) to reduce the risk of recurrence. The breast cancer diagnosis and the treatments may have significant impact on the patients' quality of life. It may be viewed as a sudden, unexpected threat to life, may cause acute hospitalisation, usually involves surgery with the removal of a breast or part of a breast, creates a need for medical decisions, may necessitate additional treatments, and may give rise to symptoms and practical problems. These and many other factors may cause an acute and severe disruption of the patient's daily life.

Breast cancer surgery including conservative surgery followed by irradiation, and modified radical mastectomy or radical mastectomy followed by immediate reconstruction is associated with pain and fatigue and thus affecting quality of life in breast cancer patients. disrupted sexual functioning or unsatisfactory sexual life was related to poorer quality of life at younger age, Treatment with chemotherapy, total mastectomy, emotional distress further led to an unsatisfactory sexual life, and difficulties with partners because of sexual relationships.

In a health care context where specialised supportive care services (e.g. help from dietitians, psychologists, social workers) are often unavailable or difficult to access, supportive care remains largely a responsibility of medical and nursing professionals. According to the findings of the reviewed articles, oncology nurses promote the interests of their patients by analyzing patients' psychosocial and physical distress and care plans, particularly at the beginning of the illness trajectory. Oncology nurses also are instructed in the literature to educate patients about cancer management prior to the first treatment and during cancer.

The plastic surgeon must have close communication with the general surgeon, radiation and medical oncologists to ensure a

coordinated approach to caring for this complex patient population. It is important to understand the disease stage and the implications of that stage on adjuvant therapy. Immediate breast reconstruction is acceptable for ductal carcinoma in-situ (DCIS) and stage 1 or 2 disease. Reconstruction is usually delayed in women with inflammatory breast cancer.

Breast reconstruction using the latissimus dorsi myocutaneous flap generally provides patients with a high level of satisfaction, as well as a favorable outcome. Delay *et al.* found that approximately 90 out of 100 patients were satisfied with their reconstructed breasts, and reported sensation to fine touch in their reconstructed breasts as a factor contributing to satisfaction.

Moore in his study found that more than 90% of 170 patients who underwent breast reconstruction with the latissimus myocutaneous flap were satisfied with the outcome and recommended the procedure to others. It is also important for an obstetrical nurse and midwife to be able to educate the women on the need for primary prevention, so as the women to adopt a lifestyle by reducing the modifiable risk factors of breast cancer, e.g., smoking, alcohol consumption, unhealthy diet, anxiety, exposure to radiation, obesity, use of hormonal pills for a long period, positive family history and also delayed childbearing.

2. Discussion

Clinical Nurse Specialists play a major role in the delivery of specialist palliative care services to patients with breast cancer, in a hospital. A major component of their work focuses on the delivery of emotional care and support to patients and their families. Utilizing the tools of self-breast examination, yearly mammograms and clinical breast examinations, together with consistency, are the best protection in detecting early breast cancers.

Green *et al* found in a study of a total of 174 staff nurses working with such patients, the most common limiting factors were found to be unwillingness of a patients of the family to accept the prognosis and hospital, non-communicative status of the patients, belief of doctor's hesitance, nurse's discomfort and desire on part of nurses to maintain hope among patient and patient's families. This study

emphasizes improved skills on communication of prognosis will result in more referrals and a smooth transition to hospice.

Parker *et al*[1] in his comparison of 258 women compared the short- and long-term effects of mastectomy with reconstruction, mastectomy without reconstruction, and breast conservation therapy on aspects of psychosocial adjustment and quality of life found the general patterns of psychosocial adjustment and quality of life were similar among the three surgery groups. The study results showed that during the long-term follow-up period (6 months to 2 years after surgery), women in all three groups experienced marked improvements in psychosocial adjustment (depressive symptoms, satisfaction with chest appearance, sexual functioning) and quality of life in physical and mental health domains.

A total of 72% of these women reported having talked with an oncologist about one or more supportive care issues; 78% with a surgeon; 73% with a family physician; and 45% with a nurse. Factors linked to seeking supportive care from physicians and/or nurses included: younger age, working status, higher education, additional health insurance beyond that provided by government, higher household income, and receiving chemotherapy. Results indicate that physicians and nurses were providing important supportive care to most women with breast cancer. Management to promote informed consent, but not to analyze patients' information or self-determination preferences for their patients by presenting and raising awareness of patients' needs and preferences in regard to the healthcare system.

Schmid buchi *et al* found in their study of breast cancer patients 56.2% suffered from distress, 24.1 % from anxiety and depression (12.1%). Physical and social impairment, impaired body image, distress, anxiety and depression, a lack of social support and conflicts in their day to day life were associated with emotional and supportive care needs.

Studies investigating the nurse patient interactions have shown that such interactions involve a complex process of knowing the patient (Skilbeck *et al*, 2003). Studies on the nurse experiences with breast cancer patients have shown the challenging nature of the cancer care highlighting the emotional nature of the care, with many nurses affected by patient situations. Many factors like communication, family, symptom management and the cost of caring strongly influence cancer care (Dunne *et al*, 2005). Active listening skills helps nurse to establish a relationship and giving hope helps coping of patient distress. Awareness about depression, the identification of symptoms like 'appropriate sadness' due to the patient's approach to death and initiation of treatment is essential for optimum breast cancer care.

Women in Jordan who knew about breast self-examination had positive attitudes toward breast cancer and practice breast self-examination on a regular schedule, and that nurses who taught about methods of early detection and breast self-examination were more aware about breast cancer screening and breast self-examination techniques than those who did not.

Schulman DG[2] found lack of rapport between clinicians and patients about prognosis and treatment could reduce the likelihood of referral to hospital services and there was a hindrance to access and benefit of these services. The most common obstacles in this study were unwillingness of a patient or the patient's family to accept the prognosis, sudden death or noncommunicative status of the patient.

Nurses had limited levels of knowledge about breast cancer risk factors and methods of early detection; few nurses practiced BSE monthly. Continuing education programs for nurses are urgently needed to improve nurses' knowledge about breast cancer and BSE. There is also very urgent need for updating the various curricular of these nurses to include courses in screening methods for early detection of breast cancer.

Denisson S[3] found in his study that patients affective concerns were missing in certain subjects where the nurse was only focused on physical care and treatment of patients.

Krujiver IP *et al*[4] stressed on the provision of continuing training programmes for nurses to learn effective means of communication in relation to patients' emotions and feelings, and to correlate and attach emotional care with practical and medical tasks.

Nurses can play an important role in promoting screening by teaching women about screening guidelines, the benefits and limitations of screening, and risk factors for breast cancer and helping women to reduce or eliminate barriers to screening. Continuing education programs for nurses are urgently needed to improve nurses' knowledge about breast cancer and early detection and change misconceptions about risk factors and attitude towards cancer screening even among the apparently normal woman.

Regular screening for breast cancer reduces mortality. Nurses working in tertiary hospitals as a part of their curriculum must educate women about normal breast anatomy, abnormalities, risk factors and benefits of reconstructive procedures.

References

- [1] Parker PA, Youssef A, Walker S, Basen-Engquist K, Cohen L, Gritz ER, Wei QX, Robb GL. Short-term and long-term psychosocial adjustment and quality of life in women undergoing different surgical procedures for breast cancer. *Ann Surg Oncol*. 2007; 14:3078-3089.
- [2] Schulman DG *et al*. Nurses communication of prognosis and implications for hospice referral: A study of nurses caring for terminally ill hospitalized patients. *Amer J of Crit Care* 2005 Jan, 14: 64-70.
- [3] Dennison S. An exploration of the communication that takes place between nurse and patients, whilst cancer chemotherapy is administered. *Journal of Advanced Nursing* .1995; 4(4): 227-33.
- [4] Kruijver IP, Kerkstra A, Bensing, Van de Wiel HB. Communication skills of nurse during interactions with simulated cancer patients. 2001; *Journal of Advanced Nursing*, 34(6); 772-9.
- [5] Irene J. Higginson *et al*. Communication in End-of-life Cancer care: A comparison of Team Assessments in three European countries. *Journal of Clinical Oncology*.2002; 20 (17):3674-82.
- [6] Schols M. Nurses role in breast cancer screening. *Plast Surg Nurs*. 2012 Oct-Dec; 32(4):143-5.
- [7] Alkhasawneh IM, Akhu-Zaheya LM, Suleiman SM. Jordanian nurses' knowledge and practice of breast self-examination. *Journal of Advanced Nursing*. 2009; 65(2):412-416.