Rout and life expectation of the person under hemodialysis treatment

ABSTRACT

Objectives: understanding the process of acceptance and life expectancy of chronic renal patients under hemodialysis, and comparing the life expectancy of patients under treatment for less than 1 year with those for who are there for more than 1 year. Method: an exploratory descriptive study of a qualitative approach, which was carried out through interviews with 41 patients in June 2011. The data were analyzed following the precepts of Content Analysis. Results: two categories emerged regarding the discovery of the disease (State of compliance, Acceptance process); three related to treatment (Difficulty of routine acceptance, In the process of acceptance, Resistance to treatment) and three about life expectancy: Aware about the difficulties, Hope for improvement and Loss of hope. Conclusion: the patients are aware about the conditions they face and the difficulties to get a kidney transplant. Do not expect new treatments in the future but aims to better quality of life. Descriptors: Chronic Disease; Hemodialysis; Life Expectancy; Nursing Care.

RESUMO

Objetivos: compreender o processo de aceitação e a expectativa de vida do paciente renal crônico em hemodiálise, e comparar a expectativa de vida dos pacientes em tratamento há menos de 1 ano com os que estão por mais de 1 ano. Método: estudo exploratório-descritivo com abordagem qualitativa, realizado por meio de entrevistas com 41 pacientes em junho de 2011. As informações foram analisadas seguindo os preceitos da Análise de Conteúdo. Resultados: emergiram duas categorias referentes à descoberta da doença (Estado de conformidade, Processo de aceitação); três relativas ao tratamento (Dificuldade de aceitação à rotina, Em processo de aceitação, Resistência ao tratamento) e três sobre expectativa de vida: Cientes das dificuldades, Esperança de melhora e Perda da esperança. Conclusão: os pacientes estão cientes da condição que enfrentam e das dificuldades para conseguir um transplante renal. Não esperam novos tratamentos no futuro, mas almejam melhor qualidade de vida. Descriptores: Doença Crônica; Hemodiálise; Expectativa de Vida; Cuidados de Enfermagem.

RESUMEN

Objetivos: conocer el proceso de aceptación y esperanza de vida de los pacientes renales crónicos en hemodiálisis, y comparar la esperanza de vida de los pacientes en tratamiento por menos de 1 año con los con más de 1 año. Método: un estudio descriptivo exploratorio con enfoque cualitativo, llevado a cabo a través de entrevistas con 41 pacientes en junio de 2011. Los datos fueron analizados siguiendo los preceptos del Análisis de Contenido. Resultados: dos categorías surgieron con respecto al descubrimiento de la enfermedad (Estado de cumplimiento, Proceso de aceptación); tres relacionados al tratamiento (Dificultad en la aceptación rutinaria, El proceso de aceptación, Resistencia al tratamiento) y tres en la esperanza de vida: Consciente de las dificultades, La esperanza por la mejora y La pérdida de la esperanza. Conclusión: los pacientes están conscientes de las condiciones que enfrentan y las dificultades para conseguir un trasplante de riñón. No hay que esperar nuevos tratamientos en el futuro, pero apunta a una mejor calidad de vida. Descriptores: Enfermedades Crónicas; Hemodiálisis; Esperanza de Vida; Cuidados de Enfermería.
INTRODUCTION

The hope or expectation of life directly influences the behavior of individuals in relation to life. Their focus may be unique in the healing or desire to achieve more years of life, but also have various meanings depending on the context and the time of each person, especially if he is a carrier of a chronic disease (CD).¹

Among the CDs, we quote the Chronic Kidney Disease (CKD) as the progressive loss and generally irreversible kidney function. It is a rise in disease in Brazil and worldwide, and currently one of the major public health problems.² In Brazil there are about 91,314 people under dialysis, and 90.6% are on hemodialysis (HD) and 9.4% perform peritoneal dialysis.³

Such patients are assisted by a multidisciplinary team and are advised of the possibility of a kidney transplant. From that moment, we begin the examination for discovery of compatibility and there shall be an entry in the waiting list.⁴

At the beginning and during the treatment the patients may have mixed feelings. While they feel hopeful feel afraid to die, almost oscillatory manner.

We understand the difficulties and complications of CKD and its treatment, they are broad and do not appear in isolation, being determined by multi-causal factors. To be discovered carrier of an incurable disease different feelings emerge and influence the way you see the world and treatment.

Thinking about the impact of this disease and its treatment options, not just to the patient, but also to those who live with him, we intend this study to understand the process of accepting and life expectancy of chronic renal patients under hemodialysis, and compare the expectations of life of patients on treatment for less than 1 year with those for more than 1 year.

METHOD

It consists of a descriptive and exploratory study of a qualitative approach, with HD patients of a philanthropic hospital in a city in the northwest of Parana, aged greater than or equal to 18 years old and of both genders.

The subjects were approached and invited to participate and, after exposure and clarification of possible doubts, opted to participate or not. Those who agreed were divided into two groups: those who started treatment for less than a year and those undergoing HD for longer than one year.

Data collection was performed individually during HD, by signing the informed consent form. We used an instrument divided into two parts: the first to obtain the data demographic partner and characterization of subjects by diagnosis and HD time and the second part was composed of the following guiding questions: How would you react when you discovered yourself with chronic renal failure? How is the hemodialysis period from the beginning to now? What is your life expectancy regarding the disease and to hemodialysis?

These questions were intended to get out and explore as much information about the subject investigated, without influencing or inducing story. The interviews were recorded, transcribed and coded. To preserve the identity of the subjects, after transcribed the speech received a code, and the G to identify which group the subject belongs (G1 or G2), followed by the interview number, guiding question number and the letter corresponding to speech of the subject.

The number of subjects was not predetermined, continuing with interviews seeking the depth and quality of information, until it obtained the data saturation and scope of the proposed objective. In total 42 subjects were addressed, of which only one refused to participate claiming illness. Of the 41 respondents, 19 are part of the group that is under treatment for less than a year, called G1, and 22 in the group that is in treatment for longer than one year, called G2.

Additional, the information was analyzed following the precepts of Content Analysis, which consists of: 1) Pre analysis: the process of organizing the raw data, which aims to systematize the initial ideas through fluctuating readings to establish contact with the documents. Its main rules completeness, representativeness, consistency and relevance; 2) Exploration of the material and training categorical: sorting the data by differentiation, and then reunification seconds semantic criteria to obtain the themes; 3) Treatment and interpretation of the obtained categories: selection of significant categories along with the implications and the opinion of other authors.⁵

The study was carried out with the authorization of the institution and approved by the Permanent Committee of Ethics in Human Researches (COPEP) of the State University of Maringa (UEM), in compliance with Resolution 466/12 - CNS, with CAAE: 117.0.093.000-11.
RESULTS AND DISCUSSION

G1 in the age group of respondents ranged from 21 to 71 years old, averaging 46, and in G2 showed the same variation of 22-78 years old, with an average of 50 years old. Family income ranged from 800-1800 Reals in G1 and 1200-6 thousand Reals in G2. The other characteristics related to socio-demographic data and TD then described in Table 1:

Table 1. Characterization of participants, Maringá (PR), Brazil.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Absolute value G1 G1 (%)</th>
<th>Absolute value G2 G2 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>15</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Marital status</td>
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<td></td>
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<tr>
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<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Divorced</td>
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<td>10</td>
</tr>
<tr>
<td>Single</td>
<td>02</td>
<td>01</td>
</tr>
<tr>
<td>Labor activity and occupation</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>37</td>
</tr>
<tr>
<td>Retired</td>
<td>08</td>
<td>42</td>
</tr>
<tr>
<td>Under professional activity</td>
<td>11</td>
<td>58</td>
</tr>
<tr>
<td>Perception about the cause of CKD</td>
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<td></td>
</tr>
<tr>
<td>Do not know</td>
<td>08</td>
<td>42</td>
</tr>
<tr>
<td>Hypertension and/or Diabetes Mellitus</td>
<td>05</td>
<td>26</td>
</tr>
<tr>
<td>Other causes</td>
<td>06</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>100</td>
</tr>
</tbody>
</table>

Analysis of the reports allowed identifying themes that revealed perceptions of patients to find out if patients with CRF and dependent on the therapeutic approach adopted, particularly life expectancy.

The first guiding question identified in both groups the same categories: State of compliance and Acceptance process. The second question three categories emerged in both groups: Acceptance of difficulty to the routine treatment; Acceptance method of treatment and Resistance to treatment. Finally, in the third guiding question, we noted two categories in both groups: Aware of the difficulty of improvement and Hope for improvement; and the category lost of hope for improvement only in G2.

In the category State in accordance realize that the majority of respondents reached a state in which appear to be resigned to their situation. They point out that, despite the initial impact brought by chronic illness and subsequent treatment today understand that HD is something necessary for their survival. Of the patients, 58% of G1 and 68% of G2 fell into place in this category, a fact which suggests that as time goes by, and the disease is less difficult to reckon with.

Oh I got very sad, because I was afraid of hemodialysis, I thought it was a very bad thing, but later I saw that it was so for the good of the people; I settled more. (G1-27 / 1a)

Some people want to kill themselves. I was one of them […] at first I was mad, because I know me and I know it’s hard, but as time went on we got used and adapting to reality […] (G2-32 / 1a)

Oh, it was horrible, it was very hard for me, I spent three months crying because I did not accept. But you have to do for it not to die. But I spent three months crying even. (G2-19/1a)

The reports suggest that the subjects, despite react only way to find out if patients with CRF have similar feelings. Since the initial shock of diagnosis to the time when it comes to shaping, patients go through several stages, from anger, denial, grief, loneliness, to accept their new condition.

The relationship between man and machine causes the appearance of many emotions such as anger, since the individual is subject to the same, while the gratitude that the machine keeps him alive. At other times he shows contempt, remaining good part of the four hours that is connected to the machine or sleeping eyes closed.5

The fact that both groups have issued similar reports leads to understand the impact caused by the disease leaves a mark when that begins to HD and endures throughout its length, making even after years, the painful feeling remains recluses for much of the compliance process to surface; however manifested with less intensity.

Often, the fact that the patient has a base of CD such as hypertension and diabetes mellitus, causes the HD become something...
expected, situation identified in 18% of G1 patients and 13% of G2.

Normal. It's a family heritage, I expected. (G1 - 34 / 1a)

I felt normal; quiet [...] did not shake me too not. I even hoped because we know that diabetes causes it all right there. In my consciousness I knew that one day could reach that point. (G1 - 9 / 1a)

[...] It was because of diabetes and when I saw I was in hospital. It was cool, not too scared not. (G2 - 8 / 1a)

Oh, it was hypertension that made me so. He began to shortness of breath in me, swell enough. I was sad, but it was not too difficult. (G2 - 6 / 1a)

Apparently, being a carrier of a pre-existing CD makes the HD patient gets used to the condition of dependency and all other restrictions and modifications that arise as the advancement of treatment. Realize the lines that they were not very slaughtered recalled the start of treatment and did not characterize this as an impactful event in their lives.

It is known that high blood pressure and diabetes are risk factors for the future development of kidney failure. As prevention, it is essential to develop all the guidelines regarding the controlled intake of salt and sugar, in addition to physical exercise for stabilization and no evolution of these pathologies. Unfortunately, most patients do not realize the self-care; making it increasingly they evolve and are HD causes in the future.

A study of patients participating in the HIPERDIA program, and therefore patients with hypertension and/or diabetes found that participants were unaware of any information regarding the DRC, including the progression of disease and risk factors, a fact that confirms that most patients do not perform self-care.6

Some respondents, 27% of G1 and 47% of G2, expressed accordingly no signs of trauma and without underlying pathology evidence, reporting only that the situation was perceived as normal, seeking support in faith and spirituality. However, the significant difference between the percentages of the two groups shows that over time the compliance status is consolidated. We note that the views of patients is not much different, assuming that the HD dwell time did not influence in a direct way their understanding of the disease and treatment.

Normal, do what [...] is now even spoiled [...] does not help to get too downcast [...] (G1 - 37 / 1a).

In the reports, respondents G1 expressed sadness and anger at having to adapt to this new stage and condition of life. One patient reported that he could not still emotionally stabilize the point of having an opinion about the situation, which can be attributed to small elapsed treatment period.

The person with CKD when starting HD goes through a breaking process with their lives; because the limitations caused by the disease along to the incorporation of treatment reverberate in all its dimensions, influencing the perception of their own body, bringing limitations in the way of perform their work and daily activities.6

In both groups, the subjects showed a lot of importance to the work and the fact that it can no longer perform their work activities the way they did earlier is something that
leaves them disheartened. This situation emerged in 9% of G1 patients and 14% of G2.

Oh it was very sad, it was difficult [...] I do not resign myself [...]. I could walk, I worked [...] today I do not give a can. (G1-28/1a)

Ah, it is a right shock. It's a shock because you stop working. (G2-3 / 1a)

Ah, after I lost the kidney I got a little discouraged [...] God! It was so good our work in the farm. I would prefer stay one hundred years without retire and stay working. (G2-18/1a)

Not being able to work and hence without contributing in household expenses is something that discourages and may cause patients to feel useless, lowering their self-esteem and contributing to non-acceptance to treatment.

Get away from work due to illness situation has several meanings, as the person ceases to be productive in a society in which the production process is highly valued by passing the provider of condition for a prisoner to the family environment.6

In some cases the patient is the main family provider, so there are needs to be an adaptation and a redefinition of the family budget to address the interference of the disease in industrial activities CRI carrier.7

In G2, 4% of patients showed the transition of difficulty of conservative treatment for DT.

As I was eight years in the conservative stage [...] So I have been putting off right here, not accepting [...] believing that I would not need it. Believing that no [...] I said 'no, I will not sit on that machine', but then came right time that there was no way, I got very disabled. (G2-5/1a)

Conservative treatment requires adequate lifestyle the necessary guidelines for the maintenance of health and slow the progression of chronic kidney disease. As the disease progresses, many doubts and fears appear, for the most part patients are not well informed about other treatment options.

To avoid a possible depressive or anxiety framework to start another treatment modality, the patient should receive all necessary information about the new routine of life, including the operating mode of the HD sessions, diet avoiding salt, fat and excess liquid, something that requires a care that was not previously performed by these patients, in addition to care with hygiene.8

The deficit of information about the disease and treatment, especially for those who still are in the conservative stage, negatively interferes with adherence to conservative treatment and the HD future.

Within the category, Difficulty adjusting to routine treatment, referring the second guiding question, 37% of G1 patients and 27% of G2 reported difficulties in adapting to the times, dependencies and constraints caused by HD.

It is a little difficult right because we work in and out of the service is bad [...] but we are taking right, do what [...] way of God for everything. (G1-35 / 2a)

 [...] It is bad it takes a long time, you may not have committed or anything these days from Monday, Wednesday and Friday, you have to be here, like it or not want to have to come here [...] so much that hinders. (G1-12 / second)

It is very difficult to know, I depend on others know; have to have someone to bring me, to seek me, not easy. (G2-20a)

It hinders a little the commitment of people; but nothing that cannot be interleaved at work but hinders roughly 30-40% of the income of people in the week. (G2-24/2a)

The DT poses difficult routines to follow as it brings with it the fact that it is permanent and necessary to the health of the patient. We realize that respondents G2 develop an adaptation process a little more worked than the G1, which are still at the beginning of treatment, and therefore failed to reconcile HD within their daily life routine. I assume that they do, but not the way we would like.

The incapacity for work and for various everyday activities influences the lives of HD-dependent, since it is very difficult to reconcile employment relationships and other activities to routine treatment. Added to this the complications and physical limitations caused by CKD, which besides causing feelings of depression, lower self-esteem of individuals, due to dependence on relatives or acquaintances.5

The limitations and dependencies imposed by HD causes the patient to lose more and more autonomy, because their life becomes dependent on the dialysis machine and prolonged treatment, painful and stressful, but necessary to their survival.5

In this category, we identified 4% of the respondents G2 that food and water restrictions are a negative point. Not being able to eat what they like and eat the amount of liquids that they were used can represent yet heartbeat.

 [...] The hardest part is actually to do the diet why we cannot eat some fruit, vegetables and I always had a very healthy, always drink plenty of water, for me it is difficult for me in that sense. (G2-30/2a)
While that food and water restriction assists in DT are a source of frustration, since they involve a drastic change in eating habits and impose many hardships.8

Also in this category, a fact that draws attention, 18% of G2 patients have established a positive relationship of dependency with HD, stating that if it were not for the machine, they would not be the way they are today.

Oh, okay saw. If it had not been that machine I’ve gone. (G2-1 / 2a)

It is not difficult not got a good doctor, it was quiet, I do dialysis without any problem [...] (G2-22 / 2a)

It is not difficult not. I come and go away, I never was two minutes more for to feel sick in two years to this day I never needed. It's quiet [...] (G2-23/2a)

From the moment in which patients accept their new condition and understand that HD is something necessary and that unfortunately must be made for life, a way of seeing the disease and treatment changes. What was once seen as a suffering is seen as something just routine.

We observed that this occurred only in the group of patients who are under treatment for over a year, which suggests that although each individual has a long single reaction, adaptation does not happen from one moment to another, taking a few years to be implemented without causing anguish and resentment by the situation experienced. Perhaps this reflects an unconscious defense mechanism, of accommodation, of coping.

Some patients in the face of drastic change and adaptation process that happens, they tend to consider themselves normal from the moment you can include in your routine hemodialysis in a positive way, and when they realize social and leisure activities.5

The category of Treatment acceptance process also emerged when patients were asked about how being the HD period. According to reports, it was revealed that although each individual has a long single reaction, adaptation does not happen from one moment to another, taking a few years to be implemented without causing anguish and resentment by the situation experienced. Perhaps this reflects an unconscious defense mechanism, of accommodation, of coping.

For me it's not hard not to. It's peaceful, you know? [...] because I'm retired right then we have enough time and I just feel like the day I do not come, because then I feel isolated at home. I got used already, know? [...] I feel good here. (G1-9 / 2a)

 [...] the human being gets used to everything. I got used [...] if you think about it so here ends up being your family, nurses, patients, we will interact with each other and will survive and this time passes [...] (G2-32/2a)

Thinking that HD is part of an intense and lasting process in which the patient is required to appear at the place of reference for the treatment three times a week lasting about four hours a day, it is expected that proper create link among themselves and with the team in order to optimize the time you spend connected to the dialysis machine and share experiences with other patients.8 However, professionals should be aware of this relationship ceases to be affective and pass to be dependent.

Still in the second guiding question, the category Treatment resistance encompasses negative sentiments expressed in both groups, including presenting the same percentage, 10%. Although not a high number, the lines when you're all well, there are days when you do not accept, you are there imagining things on your mind [...] have hours you arrive thinking “have we not spent my time and I'm doing overtime here?” Keeps thinking right? Only you have to do [...] there's no way. (G2-3/2b)

We did not observe discrepancy in the reports of both groups of respondents. Surfaced in both the difficulties and benefits of doing HD, although a G2 patient, question if the HD is not the finish line, just an extension of life and that maybe his time is coming.

HD is a treatment that causes in patients ambiguity of feelings, because at the same time ensuring the life causes the person to become dependent on a machine and technology to survive. The CRI carrier that does HD is aware of the importance of treatment, but this patient partnership / machine generates mixed feelings and in some cases causes anger, to recognize the dependence and gratitude for the machine that keeps him alive.

Another point raised in this category was the fact the HD be seen by patients as an environment in which they make friends, chat, create bond with the team and miss the days when you are not signed. Patients in both groups raised this issue, 5% in G1 and 4% in G2.
are striking and HD appears as a serious problem in their lives.

For me it is terrible. It's something I cannot accept [...] if I had made arrangements at the time, made control, weight loss, not abused [...] eating meat, having a beer [...] I drank, but not much drank [...] So all this hurt, it all worked. So for me it is a sacrifice [...] this here for me, I call it Nazi concentration camp know? [...] it is horrible here, one thing you may not want to anyone [...] it is terrible [...] it is very difficult to go through it here. At first I thought until I talked to kill myself "oh no use be doing a section there that knows how long". Then, has my wife who is very religious [...] there has passed. (G1-2 / 2a)

It is a problem, there are times that I raging right [...] We have day nervous [...] But now I came to the point of understanding what I need. We do not even be wanting life, we be wanting to improve. (G1-28 / 3a)

That's it you are seeing. Comes here takes two needles, it is not wrong if it takes more wrong, since I was six needles hanging from the arm. It's horrible, not good not. (G2-19/2a)

The reports reveal that the treatment causes anger and suffering. Although one of them already have a considerably long period of treatment, we believe that HD is extremely painful and exhausting as it came to a point where you do not want to live well, if you just keep on condition that it is and caring forever not worse.

When we analyze the category Aware of the difficulty for improvement on the third guiding question, we understand that patients have hope of significant improvement, although understand the difficulty of the stabilisation and good quality of life. This category emerged in both groups, 37% in G1 and G2 at 32%, suggesting that many believe the treatment and bet.

I hope one day have better conditions. I know that full recovery is unlikely to happen until a function of age. Each day gets older will more advancing the trend is the disease we sacrifice more. But I hope ordinary days as I live today. (G1-9 / 3a)

I still do not know. Because I know that will not heal but I sometimes I think so it will be good because there are people who's doing 15 years ago, 16 years ago, have children [...] so I get better. (G1-27 / 3a)

Healing will not have. I'll do 82 this December. I know I have not, but I will not live in so much pain right [...] that not before. I think for me it's just right, the end. (G1-28 / 3a)

Oh I hope that God will help me and I live at least ten years. There are people who's doing twenty years ago and has not died yet, so at least some ten years are already okay [...] (G2-18/3a)

While the reports show some hope, also appear some conformity, because of the age of respondents, time of treatment and the difficulty in getting appropriate treatment, such great complications caused by chronic kidney disease.

The HD is necessary and vital in combating the CKD, transplantation is inevitable and the success of the procedure is unpredictable. The only thing patients should make sure is that courage and strength are required to live on, forever seeking a better quality of life, either by making TD, waiting for a transplant or even post transplanted.

Another situation found in this category is that the patient's point out some restrictions on the kidney transplant, accepting only donor bodies for fear of harming someone for personal gain. This emerged in 5% of respondents in G1 and in 4% of G2.

I think if it is well done and care, it is able to last about [...] eight, ten years. After that it is difficult, the body is weakened. Oh I'm trying here a little longer, I do not know ... by the next year thinking about a transplant. Now will depend largely on who will get the kidney from a relative [...] if not I will continue here. Because you get a kidney from a normal person, a healthy person [...] my son wants to donate, but he's thirty years old [...] I'm going to get the kidney from a guy who is thirty-five years old! I will not [...] (G1-2 / 3a)

I hope a corpse kidney, because kidney living person I do not want from anyone; but to accept corpse I do. I do not want to mess with who is good to fix me. (G2-23/3a)

The fear of making someone go through the difficulties faced causes some respondents abdicating their own welfare and reneging transplant from a living donor.

In the category of Better Hope, we noticed that patients express more courage, and more willingness to improve than the previous category, since 45% of G2 patients and 58% of G1 want a kidney transplant and a better quality of life.

I hope to get good. God forbid, operate my kidney, my recover because it's not easy [...] (G1-15/3a)

Transplant. I think that is what everybody wants right, transplanting. (G1-41/3a) For now we do hemodialysis, but we're in the queue of the transplantation [...] So I hope to one day get. (G2-4/3a)

I hope a transplant. To me looking out for a transplant, not normal, but at least almost. (G2-24/3a)

Patients seem quite interested in performing a kidney transplant and change
life regarding the disease and treatment. We understand that the impact of the lived situation is so intense that even after years of HD the disease is still remembered as something that generates suffering.

In both groups, we realized that most respondents appeared to be stable emotionally, so do not seek other for forms of treatment and do not dream about it in the future. There are well aware of their condition and the therapy used today where the best chance of survival remains with the kidney transplant, a technique that still imposes various physical limitations, such as the rejection of the transplanted organ, and moral in which the recipient has to harmonize their internal conflicts in an attempt to better cope with the situation.

You need the commitment of other support networks in order to provide psychological and clinical support in the different stages of the disease, and propose conditions that will help to alleviate feelings of insecurity and suffering, encouraging the patient to invest in a better quality of life.10

We understand that there are still many feelings and implications to be explored and that further research is needed so that health professionals working in this area have a closer look at these patients often suffer silently. We believe that from the moment you know the feeling and expectation of another can plan the care with better quality and guided the needs that it presents, making the humanized and holistic care.

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Corresponding Address
Roberta Tognollo Borotta
Rua Antonio Valdir Zanuto, 53
Bairro Jardim Novo Horizonte
CEP 87010-100 – Maringá (PR), Brazil