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ORIGINAL ARTICLE

EXPERIENCE OF WOMEN DIAGNOSED WITH CERVICAL CANCER SUBMITTED TO SURGICAL TREATMENT

VIVÊNCIA DAS MULHERES DIAGNOSTICADAS COM CÂNCER DE COLO DE ÚTERO
SUBMETIDAS A TRATAMENTO CIRÚRGICO

VIVENCIA DE LAS MUJERES DIAGNOSTICADAS CON CÁNCER DE CUELLO UTERINO SOMETIDAS A
TRATAMIENTO QUIRÚRGICO

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ABSTRACT

Objective: to know how women diagnosed with Cervical Cancer (CC) experience diagnosis, surgical treatment and their return to daily activities. **Method:** a descriptive, qualitative approach developed in a semistructured interview. The recorded interviews were transcribed and submitted to the technique of Content Analysis, in the Thematic Analysis modality. **Results:** four categories emerged: << Feelings versus diagnosis >>; << Surgical Treatment >>; << Return to daily activities >> and << Nursing Assistance >>. Women experience fear, anxiety and distress before diagnosis, and family support, faith, and bonding with health professionals provide comfort in the treatment phase. There was a fear of returning to sexual activity. **Conclusion:** the accomplishment of this study increased the knowledge of the facets that permeate the experiences of the diagnosis, treatment and return to daily activities by women after surgical treatment of Cervical Cancer. **Descriptors:** Uterine Cervical Neoplasms; Surgical Procedures, Operative; Women's Health; Perioperative Nursing.

RESUMO

Objetivo: conhecer como as mulheres diagnosticadas com Câncer de Colo de Útero (CCU) vivenciam o diagnóstico, tratamento cirúrgico e seu retorno às atividades diárias. **Método:** estudo descritivo, de abordagem qualitativa, desenvolvido por meio de entrevista semiestruturada. As entrevistas gravadas foram transcritas e submetidas à técnica de Análise de Conteúdo, na modalidade Análise Temática. **Resultados:** emergiram quatro categorias: <<Sentimentos frente ao diagnóstico>>; <<Tratamento Cirúrgico>>; <<Retorno às atividades diárias>> e <<Assistência de Enfermagem>>. As mulheres apresentam medo, ansiedade e angústia perante o diagnóstico e o apoio familiar, a fé e o vínculo com os profissionais da saúde proporcionam conforto na fase de tratamento. Houve receio no retorno às atividades sexuais. **Conclusão:** a realização deste estudo ampliou o conhecimento das facetas que permeiam as vivências do diagnóstico, tratamento e retorno às atividades diárias por mulheres após tratamento cirúrgico de Câncer de Colo de Útero. **Descritores:** Neoplasias do colo do útero; Procedimentos Cirúrgicos Operatórios; Saúde da Mulher; Enfermagem Cirúrgica.

RESUMEN

Objetivo: conocer cómo las mujeres diagnosticadas con Cáncer de Cuello Uterino (CCU) experimentan el diagnóstico, tratamiento quirúrgico y su retorno a las actividades diarias. **Método:** estudio descriptivo, de abordaje cualitativo, desarrollado a través de entrevista semiestructurada. Las entrevistas grabadas fueron transcritas y sometidas a la técnica de Análisis de Contenido en la modalidad Análisis Temático. **Resultados:** surgieron cuatro categorías: << Sentimientos frente al diagnóstico >>; << Tratamiento quirúrgico >>; << Volver a las actividades diarias >> y << Asistencia de enfermería >>. Las mujeres presentan miedo, ansiedad y angustia ante el diagnóstico y, el apoyo familiar, la fe y el vínculo con los profesionales de la salud proporcionan bienestar en la fase de tratamiento. Se teme el retorno a las actividades sexuales. **Conclusión:** la realización de este estudio amplió el conocimiento de las facetas que permean las vivencias del diagnóstico, tratamiento y retorno a las actividades diarias por mujeres después del tratamiento quirúrgico de Cáncer de Cuello Uterino. **Descriptor:** Neoplasias del Cuello Uterino; Procedimientos Quirúrgicos Operativos; Salud de la Mujer; Enfermería Perioperatoria.

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INTRODUCTION

In the past 30 years, there have been several achievements of women in various areas of society. In particular, in the area of health, women's health was rethought as a public health issue, so that they could be attended beyond the traditional attention to the pregnancy-puerperal cycle. Of particular note is the National Cancer Care Policy (NCCP), which established control of cervical cancer (CC) and breast cancer, and later, the National Program for the Control of Cervical Cancer (NPCCC), due to high Incidence of cervical cancer mortality in Brazil and the world.¹

In the regional analysis of the incidence of cervical cancer in Brazil, the North region stands out as the first most incident, with 23.97 cases per 100 thousand women. The Mid-West and Northeast regions occupy second place, with rates of 20.72 / 100 thousand and 19.49 / 100 thousand, respectively. In the Southeast, cervical cancer is the third most incident, with 11.3 / 100 thousand and the South occupies the fourth place, with 15.17 / 100 thousand. However, in relation to mortality, the North region presents the highest indices of the country, being the first cause of death by cancer in women, while the South and Southeast regions had the lowest cancer mortality rates in this population.²

CC, also called cervical-uterine, is a progressive condition, initiated with intraepithelial changes, corresponding to mild dysplastic lesions, mostly caused by the Human Papillomavirus (HPV) virus. These lesions progress to severe and carcinoma due to cell replication.² In the case of untreated cell changes due to intraepithelial lesions, it evolves into squamous invasive cervical cancer in a period of ten to twelve years.²

The therapeutic course for CC is based on the diagnosis, staging and prognosis of the disease. From the diagnosis, performed by means of biopsy, the treatment is indicated having as parameter the evaluation of the location, size and histological type of the tumor. When the neoplasm is in initial staging, the surgical procedure, called conization, allows the complete removal of the tumor and provides a greater chance of cure. The association of radiotherapy and / or chemotherapy with treatment depends on the staging of the disease and the tumor characteristics.³ In this sense, the question is: How do women diagnosed with cervical cancer experience surgical treatment and return to daily activities?

Despite the scientific advances for the prevention and control of CC, it still presents high rates of new cases and mortality, mainly in the population of socioeconomically disadvantaged women.⁴

OBJECTIVE

- To know how women diagnosed with cervical cancer experience diagnosis, surgical treatment and their return to daily activities.

METHOD

A descriptive, qualitative study,⁵ conducted through a semi-structured interview with seven women, in the postoperative period of cervical cancer, in the city of Chapecó-SC, Brazil.

The site of this investigation began in the Feminine Network for Cancer Combat (FNCC) of Chapecó, Santa Catarina, Brazil. The choice of this scenario occurred because this service was a reference in the outpatient diagnosis of epithelial alterations of the female reproductive tract, because it assisted a large number of women, which allowed access to the participants of the study proposed here.

The FNCC Chapecó is a philanthropic entity, with the objective of promoting the health of women through guidelines for self-care, as well as gynecological examinations for cervical and breast cancer. It was founded on August 28, 1982, an initiative that was given by Ligia Sperandio, which was inspired by the entity already existing in Florianópolis and also by the demand of the population affected by cancer in the region of Chapecó.⁶ The RFCC of Chapecó Collects almost 50% of the cytopathological exams of the uterine cervix of the municipality, surpassing seven thousand tests per year.⁶

Women enrolled in the FNCC of Chapecó / SC, aged 18 years or older, diagnosed with cervical cancer and submitted to surgical treatment in the year 2015 were eligible. Chapecó's FNCC provided a nominal list of ten women diagnosed and submitted to surgical treatment of cervical cancer in the year 2015, who were invited by telephone, to participate in the study, with a previous appointment for the home visit. Women not found after three attempts for the home or institutionalized visit during the period of data production were excluded from the study.

The data production was carried out through a semi-structured interview conducted by the researchers, during the home visit, previously scheduled and recorded with prior authorization of the participants. The option of approaching the woman at

home is that the home environment can make the interviewee more comfortable. In addition to the interview, a questionnaire was used to characterize the sample, containing socio-demographic data, gynecological-obstetric history and lifestyle, in the period of September 2016.

The recorded interviews were transcribed and submitted to the Content Analysis technique, in the Thematic Analysis modality, following predefined steps, namely: pre-analysis; material exploration and treatment of results; inference and interpretation.⁵ Data for characterization of the sample underwent descriptive statistics analysis.

The data collected were depersonalized, using codenames in order of participation. For example, the first woman to participate in the research was identified by M1, the second, M2 and so on.

This study followed the guidelines of Resolution 466/2012, of the National Health Council,⁷ which determines the guidelines and regulatory norms of research involving human beings and was developed after approval of the Research Ethics Committee of the State University of Santa Catarina - UDESC, Under CAAE No. 55716416.4.0000.0118.

RESULTS AND DISCUSSION

The women were invited by telephone to participate in this study, with a previous appointment for the home visit. Of the ten women diagnosed with CC in the year 2015 and undergoing surgical treatment in the same year, two women did not agree to participate in the study and another justified that they were traveling during the period of data production, which resulted in seven women participating in this study.

The following, are the results of the study according to the sociodemographic profile, the gynecological-obstetric history and the women's lifestyle.

As for the sociodemographic profile, there was predominance in the age group between 36 and 45 years (44%), with elementary school (44%), with a fixed partner (72%), white (72%), 14% and satisfied with family income (86%).

In this study, there was no prevalence of a profession / occupation, presenting itself in a diversified manner, such as: construction worker (14.28%); teacher (14.28%); day laborer (14.28%); caregiver (14.28%); seamstress (14.28%); nanny (14.28%) and saleswoman (14.28%).

Regarding the Gyneco-Obstetric history of women who underwent surgical treatment for cervical cancer, they had a family history of

cancer (42%), had the first sexual intercourse before the age of eighteen (71%), had Children (86%) and reported more than one miscarriage (14.28%).

About lifestyle, they are not smokers (86%), do not consume alcohol (58%), sleep six to eight hours a day (100%), had no health problems in the last year (86%) and practice Exercise (42%).

From the analysis of the content of the interviews carried out with women with cervical cancer undergoing surgical treatment, four categories emerged: Feeling before diagnosis; Surgical Treatment; Return to daily activities; and, Nursing Assistance, which are presented below.

♦ Feelings about diagnosis

This category indicates the feelings faced with the diagnosis, the challenges faced, Family support and friends; and the importance of the multiprofessional team. Receiving the cancer diagnosis brings with it a number of feelings and vary from individual to individual. The way to perceive the health problem and face it can be influenced by social interpretations built throughout life. In an integrative review, which sought to analyze the main feelings brought about by the CC diagnosis, the predominance of the feeling of despair and fear, denial and shame was evident.⁸ In this study, there was a report of the feeling of despair and fear, such as:

Oh, it was not easy actually, right. We were very depressed for a few days, worried ... it took me by surprise. Because I was doing my tests right ... I had never given anything. [...]. (M4)

Scary, I panicked! (M5)

I was very worried [...] I could not even ask the doctor everything, you know? Because I was halfway ... [...] in the air. (M6)

The diagnosis of cancer leads a woman to develop coping strategies according to her personal conceptions and feelings related to the disease, in order to adapt to this reality, in the best way possible, and to build new paths in her life.⁹ Thus, to consider the social and cultural aspects of women, and to associate them with the modes of confrontation adopted, being able to emphasize that family or social support, religiosity or the link and communication with health team. These are the most observed means of emotional support.¹⁰

[...] I went alone and I heard that news, so I was sad. The second time, I asked my husband to come with me to accompany me, so I was more calm [...]. (M4)

[...] Wow, I was very nervous. I was with my sister-in-law, I cried a lot. But then it passes [...]. (M3)

[...] how I talked to other people. That already, too, they had this problem [...] Then I became more calm [...]. (M4)

[...] I have had enough faith [...] praying to God, I am delivered into the hands of the Lord God, our Father. (M4)

Spirituality is considered a "foundation" for coping with the disease process. For the patients, spirituality comprises the search for meaning and significance for the process of illness. Study points out that, that spirituality provides strength for overcoming; courage; relief in suffering; helping to adhere to and adapt to treatment.¹¹

Faith assists in coping with cancer, as well as in coping with the challenges posed by treatments, or even the fear of death. For this reason, faith is pointed out as an important instrument for the patient and their family in confronting the diagnosis and treatment, for their tendency to promote comfort and hope in overcoming the disease.¹²

Positive thinking is very important [...] it is very important to have faith. (M2)

Everything has its time, everything has to have faith in God [...]. (M3)

From the beginning, the human being worries about understanding life and death, which gives meaning to his presence in the world, especially, to face adversities. In this sense, spirituality and religiosity become increasingly present in moments of fragility, as in the case of illness, in which individuals tend to feel the need of spiritual and religious support.¹³ And, from the perspective of spirituality, Nursing must appropriate elements such as loving care and listening, allowing the patient to express their own needs. Professionals who work at home must be prepared for spiritual palliative care, giving priority to technical, ethical and spiritual care.¹⁴

Anxiety or tension are normal feelings of having the stressor stimulus, which, in this case, is the diagnosis of cancer and surgical treatment. However, already feeling worried involves from the family context, religiosity and the orientations promoted in the preoperative period. The trust that will be all right, must be a responsibility of the multiprofessional team, in order to minimize negative feelings in order to overcome the repercussions of the disease to the patient's well-being,¹⁵ as observed in the speech:

[...] poston there from the North, who had advice there and all about diseases. [...] I went there to see them about these exams, right? And get more information about the

disease and everything. There, they guided me [...]. (M4)

It is emphasized, here, the importance of the role of the Family Health Strategy (FHS), as it represents a care model focused on prevention, promotion, protection and recovery of health with the objective of creating a link between the health team and the user.¹⁶ In this way, There is greater ease of access, communication and exchange of information with the population, raising doubts, fear and yearnings and providing adequate knowledge about the disease.

The waiting time between the diagnosis and the beginning of the treatment, appeared in the interviews as a challenge faced, because it generated some type of anxiety and doubts about its clinical condition. Observed in the speeches:

I was anxious, but I questioned [...] if you can not get the surgery right away, there is a danger that within a year, I have other commitments [...] in two months, he managed to score. [...] This wait is the greatest anguish. (M2)

From then until I came to the biopsy, you are imagining a thousand and thousand things right. (M3)

A study that sought to identify the main difficulties faced for the access route and therapeutic itinerary of cancer patients, verified that the distance covered by the patient reflects in the late diagnosis of the disease. And, socioeconomically disadvantaged individuals are more exposed to inequalities in access to health and the level of concern increases with regard to diagnosis and treatment.¹⁷

The biopsy is the apex of the path taken in the direction of diagnosis, that is, it is at that moment that the woman centralizes her forces in the positive thoughts that she will not be a malignant disease, and after her accomplishment she enters a stage of distress, since Nothing can be done before the result of the biopsy, that takes a few days. During this time, the woman experiences moments of hope and hopelessness, marked mainly, by anxiety.¹⁸ According to the narratives:

[...] you go there to take an exam and think you're going to die ... - M3.

I already imagined a thousand things, that could be scattered throughout my entire body and that I was going to die. (M7)

I was sent to a conization, there came the result of the biopsy that had already invaded and turned into a cancer. Then he went to surgery again, so they decided to do another procedure [...]. (M5)

◆ Surgical treatment

This category there are some points about the therapeutic choice; The fear of the return of the disease after the treatment and the doubts that arose in the pre- and postoperative period. Treatment is indicated to the woman based on tumor staging, histological type, age and available resources; all agreed between the patient and the average. This may be indicated by radical or conservative surgeries, chemotherapies, radiotherapies and their association.³⁻⁴

This study does not intend to judge the therapeutic treatments of cancer treatment and the services offered, but it was verified that the therapeutic choice was given exclusively by the doctor, according to the words:

They explained what they were going to take. And even for me, I would take it all right? But he did not want to. (M3)

[...] one doctor spoke one thing, another doctor spoke another. Some wanted to take others did not want to take the uterus. This doubt of them, which made me more insecure and even more doubtful. (M5)

It was also observed that, the treatment approach was nonspecific, not clarifying what would be done with clarity, that is, not specifying what would be done, how long it would take, the desired and undesired effects, observing, in the reports, that the acceptance of the conduits Prescribed by the women:

[...] he explained to me, but I did not quite understand. [...] Then, when I came back in the consultation, he explained that only one piece was removed there like that. (M4)

I was sent to a conization, there came the result of the biopsy that had already invaded and turned into a cancer. Then he went to surgery again, so they decided to do another procedure. (M5)

It is common for the patient to be ashamed of his or her ignorance about matters which he thinks are obvious to the physician. In this way, patients often stop asking their doubts with doctors because they feel ashamed or do not feel comfortable asking them. Or, because they did not want to know at the time.¹⁹

[...] I talked to the doctor and he said that I would get better, right? But I did not want to ask too much, so [...]. (M4)

[...] I could not even ask the doctor everything, you know? Because I was halfway through [...]. (M6)

The therapeutic relationship between health professional and patient should establish a permeability between knowledge and information needs, so that the patient's participation in the resolution of their care

needs can be achieved, through the acquisition of knowledge. And that consequently, it increases autonomy to the patient, encouraging the search of its limits, helping it, to establish its opinions on the meaning of the process health and disease.²⁰

Therapeutic procedures, behaviors, and routines, while existing to restore and promote patient well-being, are perceived as threatening, aggressive, and invasive, increasing feelings of helplessness, vulnerability, and fragility. In addition to triggering fear of recurrence of the disease or of death itself.²¹ Corroborating with the following statements:

[...] my main doubt and fear was that if I was not going to be able to have children anymore and if I would not enjoy the sexual relationship anymore. (M7)

Several doubts [...] if you only have one piece of the uterus, you can have children. (M3)

[...] the fear of returning, of returning. How I did not remove the entire uterus right? [...] I was afraid I would come back. (M5)

The feeling of fear, uncertainty about the efficacy of treatment and the fear of cancer recurrence will always be feelings surrounding people exposed to such a diagnosis, provoking reflections about the human vulnerabilities expressed in doubts and their desires.²²

◆ Return to daily activities

In this subcategory, questions about sexuality after treatment are addressed; The lifestyle and what services followed the patient after the surgical treatment. Gynecological cancer affects different dimensions of the female's life, both on a physical, sociocultural and psychological level. The effect of the disease on the woman is highly significant, since her feminine constitution is compromised after the diagnosis.²³

Although the treatment brings benefits, the acute or late adverse effects seem to interfere in a negative way in the quality of life of the patients, mainly, related to the sexual function.²⁴ In this way, we perceive that the sexuality, in the mentioned study, was experienced in a negative way by the participants, perceiving that feelings of fear, dissatisfaction and uncertainty, are associated with the practice of sexual activity, as shown in the following reports:

So, actually, I'm not very satisfied. Because, well, sometimes I do not know how to concentrate? I get scared. Because sometimes I had a relationship and I do not know if it was the position, it hurt me well on

one side. Not every time, but some, I suspect that was the position. (M4)

I was worried, uncomfortable, thinking that I could hurt myself, my cervix; or that he was not giving his partner pleasure. But it was only a phase, a difficult period. But now, nowadays, I'm fine [...] only in the first few months did I feel uncomfortable, then everything went back to normal as if nothing had happened. (M7)

Not by the partner, but because I am in the process of recovery and entering the menopause. Then there's that discomfort sometimes, right? (M5)

[...] I anticipated the process of early menopause right? From then on I entered the menopause, I had all the symptoms of menopause; Because of withdrawal of the cervix. According to the doctor it was one of the consequences that could happen. (M5)

Sexuality is inherent to the human being, which is in force the way we are. The woman with CC shows feelings of fragility, tension, doubts and, above all, the fear of the new, which, in a way, emotionally debilitates the woman.²⁵

A study found that dyspareunia is the main contributory factor for the development of sexual dysfunction in women with CC after surgical treatment. And, although they feel the desire to maintain sexual activity, the woman is afraid of the sexual act and, consequently, avoids the same, which can negatively influence the conjugal life of the relationship of populations to this reality.²⁶

Lack of communication about sexual issues can lead to disagreement and possibly a sense of rejection.²⁷ And what affected sexual activity can influence the intimacy of the relationship due to reduced physical contact, intimate communication of feelings and actions. Therefore, the surgical treatment of CC is capable of causing sexual dysfunction and compromising the quality of life of these women.²⁸

Health professionals should be aware of this type of event to try to develop strategies to stimulate the couple's interaction and acceptance with the changes caused by cancer through a sexual approach and counseling about the disease.²⁹ Understanding the role of the partner as an emotional, affective, physical and social support and that can preserve the quality of life of the patient.³⁰

The processes that encompass the experience of a disease such as cancer promote different changes, both in women's lives, and in the family and social context. The changes that originate after the antineoplastic treatments are due to a new

meaning attributed to life, evidenced by the insertion of habits previously practiced and / or valued in their daily life, and also by the re-evaluation of some pre-existing concepts. Some of these modifications occur immediately upon the woman discovering the diagnosis of cancer; others, when initiating treatments, and still others occur as a consequence of this whole process.¹²

It is noticed that the most present changes in the daily life of the women interviewed in the respective study were the change in the healthy habits of life and giving new meaning the importance of the prevention, associating the accomplishment of the preventive examination, verified in the lines:

Then I started to balance more emotionally and start caring more about food. (M2)

[...] certainly changes, you know? Because we begin to rethink our lives, our health, that we leave our own body a bit aside ... and that when you have a life-threatening illness, you think about improving ever. In doing that, we become healthier, do not let this come back. (M7)

[...] Which is not to forget to do the preventive, no year! (M6)

Ah, changed! It changed in the matter in relation to [...] that every six months have to always follow up for two years. (M4)

Developing healthy habits significantly improves the quality of life of the person, providing less chance of the return of cancer.³¹ Study indicates that women after the diagnosis and treatment of cancer, it is common to experience changes in some behaviors, resulting from the desire to have a better quality of life And for this, people develop healthier life habits, especially those related to eating and practicing physical activities.³²

Regarding post-surgical follow-up services, all participants reported attending only the FNCC, and this service is composed of a team of doctors, nurses and Nursing technicians.³³

No, I was only there at the Women's Network. (M6)

No, I only had follow-up even by the female network. (M7)

Assistance to women with CC provides care in a comprehensive and humanized way.³⁴ Aim aiming at the insertion of the same into the health care networks (HCN), drawing a line of care for uterine cervical neoplasia based on their needs.³⁵ BHU plays an important role in the performance of the unique therapeutic project, since it will coordinate care, monitor and organize the flow of users between the points of attention of the HCN, acting as a communication center between the various

Silva JRT da, Ascari TM, Klein ML et al.

Experience of women diagnosed with cervical...

points of attention and taking responsibility for the care through a horizontal, continuous and integrated relationship, aiming at the shared management of integral care.³⁵

In the reports, it was observed that the choice to opt for the FNCC service alone was due to the best reception, agility and organization, according to reports:

I felt better there on the Net. In the post is less agility, less interest, that I felt ... but it is understood that there are so many people [...] in the Network, the course of things is organized. You're taken care of soon, you do not have so much waiting time. If you have doubts, they can answer you. If they do not know, they combine with you and respond to you [...] is very good. (M2)

[...] falling into the hands of the female network was very good! They treat us very well. (M3)

◆ Nursing care

In primary care, it is the nurse's responsibility to focus on prevention, promotion, protection and recovery of health, in order to establish a link with the patient belonging to the risk group, when related to cervical cancer. In secondary and tertiary care the nurse offers support in the hospital and in diagnostic and therapeutic services; consultations and specialized examinations. Nursing care is of paramount importance for the proper functioning of the units, whether in the care of equipment, monitoring, procedures, guidelines, clarification of doubts or even hearing the patient and her relative.³⁶

In this study, there were more associations of Nursing care to the hospital scope than to basic care, according to the following reports, of the guidelines received from Nursing:

They told me that I should be careful [...] that it was not for me to lift weight, to lie down a little, things like that. (M1)

[...] normal procedures, no matter of clothing, no matter of metal, the question of the organization of my body, right? From hygiene and such, things that already come routine. (M2)

Ah, the care that should be taken right? Not lifting too much weight, not having intercourse. (M3)

It's the nurses helping me out on some things I needed right? They stayed there [...]. (M4)

It was doctor's advice. They also commented when they came to do, as I say, before I do the surgery right? They also commented that it had to be guarded. (M6)

It is during the preoperative period that the nurse must provide information about the surgical procedure, adverse reactions, specific care, guidelines regarding the preparation for

surgery, clarification of the routines of the surgical center, clarification on anesthesia and questioning that cover the period From postoperative to hospital discharge.³⁷ Noticing, in the reports, that there were some negligence on the part of the Nursing professionals who did not stop to provide more information to the patient, however, the patients reported satisfaction with the care provided by the Nursing professionals, as if notes in the following lines:

They attended me well there. I liked. [...] in fact, they did not say much. It was only the doctor who told me that he could not have intercourse for so many days, not to lift weight [...] but the nursing did not say much. Only when I got up that I went into the bathroom did they help me [...]. (M4)

From the nurses [...] there the nurses were very attentive, they were very helpful, they helped me when I woke up. Then I started crying a lot for no reason. They gave me encouragement, they took me to the bathroom, they explained to me [...] they said that I might have bleeding but that this bleeding was normal. And they made me quieter. (M7)

Thus, the perception regarding the quality of care of Nursing professionals is related to empathic communication, to the reception of doubts and concerns and to the provision of information to patients, leaving them more calm and secure. In another study that sought to understand the disease health process of women with cervical-uterine cancer and it was found that patients feel safe with Nursing professionals.³⁸

CONCLUSION

Experiencing the surgical treatment for cervical cancer causes different dimensions of feelings that precede the surgical act itself, until the return to daily activities. From this perspective, the presence of feelings such as fear, anxiety and anguish was observed in the experience of the diagnosis of CC. And with, the support of family, friends, health professionals and religion, the patients have been able to cope with these negative feelings, accepting illness and treatment in a less drastic and painful way.

The therapeutic choice was not made jointly, patient and doctor. It was unclear and understandable, causing doubts, about the efficacy of the treatment, anxiety and fear of the adverse effects that it could generate, such as the fear of not being able to have more children, the return of the disease and sexual issues.

The surgical-gynecological treatment directly affects the psychosocial dimensions of

the individual submitted to the procedure. It was realized that sexuality issues were intimately affected, evidencing feelings of tension, fragility and fear, as well as dyspareunia and discomfort in the sexual act, being these negative factors can influence the marital life of these women. However, the postoperative provided positive changes in the lifestyle of these women, the search for a healthier life and establishment of a bond with the health service were evidenced in the experience of the postoperative period.

The profile of women after CC surgical treatment was found among women aged 36-45 years; With schooling up to elementary school; with a fixed partner; white color; catholic; not presenting a specific occupation to characterize this sample; presenting satisfaction regarding family income; with family history of cancer; age of first intercourse between 16-18 years; perform the cytopathological exam yearly; presenting three to more pregnancies and no abortion; are not smokers or drink alcohol; they sleep more than eight hours a day; have not had any health problems in the last year and do not exercise. Such a profile can serve as a wake-up call for health teams to track the most vulnerable and exposed populations.

Regarding the perception of women diagnosed with CC about Nursing care, it was associated with Nursing, more in the hospital setting, linking good care with a host, a simple help getting out of bed, empathic communication and providing information. They considered that the nurse is perceived as a point of reference, establishing a condition of trust and complicity.

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Silva JRT da, Ascari TM, Klein ML et al.

Experience of women diagnosed with cervical...

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