SCREENING OF CERVICAL AND BREAST CANCER
RASTREAMENTO DO CÂNCER DE COLO DE ÚTERO E MAMA
MONITOREO DEL CÁNCER DEL CUELLO UTERINO Y MAMA

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ABSTRACT

Objective: to identify women who have been screened for cervical and breast cancer. **Method:** this is a quantitative, transversal, exploratory, and descriptive study. The sample consisted of 211 women, based on the population of 465 women aged 20 to 59 years old. The instrument used for data collection was a questionnaire. The data collected were typed in Excel spreadsheet and double checked, evaluating the consistency of the data and the correction, when necessary. The analysis was performed using SPSS® version 22.0. The results were expressed by means, percentile and standard deviation, presented in tables. **Results:** the majority of the 211 women distributed in the two ESF teams live in rural areas, mean age 53.1 years + 7.8 years old; 171 live with spouses or partner; 165 have incomplete basic education; 128 with income less than a minimum wage; 198 underwent cervical oncology cytology and 133 underwent mammography. **Conclusion:** there was a scope of coverage for cervical cancer screening and mammography deficit. However, they were inadequate at both intervals, identifying the need for organized screening. **Descriptors:** Primary Health Care; Mass Screening; Community Health Nursing.

RESUMO

Objetivo: identificar as mulheres que realizaram o rastreamento do câncer de colo de útero e mama. **Método:** estudo quantitativo, transversal, exploratório, descritivo. A amostra foi composta de 211 mulheres, baseada na população de 465 mulheres de 20 a 59 anos. O instrumento utilizado para a coleta de dados foi um questionário. Os dados coletados foram digitados em planilha eletrônica Excel e duplamente checados, avaliando a consistência dos dados e a correção, quando necessário. A análise foi realizada utilizando-se o SPSS® versão 22.0. Os resultados foram expressos por média, percentil e desvio padrão, apresentados em tabelas. **Resultados:** das 211 mulheres distribuídas nas duas equipes da ESF, a maioria moradoras da zona rural, idade média de 53,1 anos±7,8 anos; 171 convivem com cônjuges ou companheiro; 165 têm ensino básico incompleto; 128 com renda menor que um salário mínimo; 198 realizaram o exame de citologia oncológica cervical e 133 fizeram a mamografia. **Conclusão:** houve alcance de cobertura no rastreamento do câncer de colo de útero e deficit de mamografias, entretanto, em ambos os intervalos, foram inadequados, identificando a necessidade para um rastreamento organizado. **Descritores:** Atenção Primária à Saúde; Programas de Rastreamento; Enfermagem em Saúde Comunitária.

RESUMEN

Objetivo: identificar a las mujeres que realizaron el monitoreo del cáncer del cuello uterino y de mama. **Método:** estudio cuantitativo, transversal, exploratorio, descriptivo. La muestra fue compuesta de 211 mujeres, basada en la población de 465 mujeres de 20 a 59 años. El instrumento utilizado para la recolección de datos fue un cuestionario. Los datos recolectados fueron digitados en planilla electrónica Excel y duplamente checados, evaluando la consistencia de los datos y la corrección, cuando necesario. El análisis fue realizado utilizándose el SPSS® versión 22.0. Los resultados fueron expresados por media, porcentaje y desvío padrón, presentados en tablas. **Resultados:** de las 211 mujeres distribuidas en los dos equipos de la ESF, la mayoría vivían en la zona rural, edad media de 53,1 años±7,8 años; 171 conviven con cónyuges o compañero; 165 tienen enseñanza básica incompleta; 128 con renta menor que un salario mínimo; 198 realizaron el examen de citología oncológica cervical y 133 hicieron la mamografía. **Conclusión:** hubo alcance de cobertura en el monitoreo del cáncer del cuello uterino y déficit de mamografías, sin embargo, en intervalos, fueron inadecuados, identificando la necesidad para un monitoreo organizado. **Descriptor:** Atención Primaria de Salud; Tamizaje Masivo; Enfermería en Salud Comunitaria.

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INTRODUCTION

Cancer is considered a serious public health problem not only because of the number of diagnosed cases but also because of the financial investment in diagnosis, treatment, and rehabilitation. Also, it causes negative impact, causing inconvenience and suffering to the patient, family and society.¹

The gynecological consultation is an important working tool for the physician and the nurse of the Family Health Strategy (ESF) to perform cervical and breast cancer screening for women at risk age.²⁻³

In the rural area, one of the difficulties for the implantation of an effective screening in the ESF is the lack of a database of a specific population, with information on the cervical and breast cancer screening. The Ministry of Health suggests the registration of women with continuous updating of the schedules and active search for defaults to solve this problem.⁴ It is a recommendation that organized cancer screening be something that needs to be implemented to ensure the reduction of cost of the current and opportunistic model in force, as well as ensuring the improvement of its coverage above 70%.⁵

According to current norms of the Unified Health System (SUS), attention in oncology should be organized in the Health Care Networks (RAS) model as a methodology to promote the health of the population.⁶

The Ministry of Health is prioritizing the construction of priority thematic networks to promote the intersectorality of different axes that can compose care for the citizen, among them the oncology care network, which can be complemented by services of the single social assistance system and women's care policies, hierarchically organized at different levels of complexity, founded on the Primary Health Care.⁷ For the qualified organization of the screening of cervical and breast cancer, the plan recommends improving the offer of exams to all women, especially those in vulnerable conditions, and to guarantee access to treatment in the initial stages.⁵

The screening and execution of specific diagnostic methods to apparently healthy individuals are intended to identify the disease in the early stages. The main goal of the survey and control of risk factors is to reduce the incidence of the disease, from cases of death, as well as to minimize the risks screened.⁸

Successful screening depends on its organization and it is directly related to the

execution of planned activities with the previously known population of women and predetermined test run intervals from an up-to-date database. However, it is verified the occurrence of consultations of women in the health units sporadically, which characterizes an opportunistic screening, being at this moment an occasion to execute the control. This strategy is inefficient and does not reduce morbidity and mortality due to cervical and breast cancer, which is characterized by low impact and repetitive screening of the same patients.⁹

In the city of Caxias/MA, the Oncology Care Network for the screening of cervical and breast cancer develops its actions in a decentralized manner in all ESF units in rural and urban areas.

OBJECTIVE

- To identify women who have been screened for cervical and breast cancer.

METHOD

This is a quantitative, transversal, exploratory, and descriptive study. The research was carried out in the municipality of Caxias, in the town of Caxirimbu, in the rural area of the municipality, located to the south, 20 km from the urban perimeter in the first district of the city.

The sample size was based on the population of 465 women between 20 and 64 years old enrolled in the ESF de Caxirimbu in 2014. The data collection was performed in a random manner and for convenience, according to the distribution of the residences in the sanitary districts of the researched rural location. The sample size was 211 participants for a 95% confidence interval and 5% margin of error.

Women with an age range greater or equal to 20 years old and 65 years old, having a registration with the ESF and living in the locality before January 1, 2012, were included. Women with temporary residency in the locality, household visitors during the collection period, and those with some functional difficulty (memory, cognitive, speech) to respond to the interview were excluded.

The surveys were carried out from June 10 to August 10, 2015. All visits were performed with the follow-up of a Community Health Agent (ACS), according to the convenience of the woman selected and prior appointment, at the participant's home.

The instrument used for data collection was a structured questionnaire, addressing

sociodemographic data, history of risk factors and screening exams for cervical and breast cancer; geo-referencing was also performed within the assigned area to identify the women who performed and did not perform the tests. Garmin nuvi series 3460lt was used to collect the location coordinates of each home, east latitude and west longitude. This reading and recording were done at the end of the interview. Participants who did not undergo the cervical oncology cytology examination were advised about the recommended interval and asked to go to the ESF to perform the procedure. Participants who had not yet a mammogram received the examination request shortly after the interview.

The data collected were typed in Excel spreadsheet and double checked, evaluating the consistency of the data and the

correction, when necessary. The analysis was performed by the SPSS® statistical software version 22.0. The results were expressed by means, percentile and standard deviation in tables.

The development of the study met the national and international norms of ethics in research involving human beings and was approved by the Research Ethics Committee of the Unisinos under number 1,011,293.

RESULTS

The sample consisted of 211 women living in the rural area of Caxirimbu/MA, distributed in two ESF teams. The sociodemographic characteristics of the participants are described in Table 1.

Table 1. Sociodemographic characteristics of women belonging to the Family Health Strategy teams, Locality of Caxirimbu, Rural Area of Caxias (MA), Brazil (2015)

Variables	N (%)	Cytopathological Examination		Mammography	
		Yes	No	Yes	No
Age grupo (mean = 53.1 years old±7.8)					
31 to 40 years old	9 (4.3)	9 (4.3)	0 (0.0)	3 (33.3)	6 (66.7)
41 to 50 years old	76 (36.0)	69 (90.8)	7 (9.2)	39 (51.3)	37 (48.7)
51 to 60 years old	79 (37.4)	77 (97.5)	2 (2.5)	58 (73.4)	21 (26.6)
61 to 65 years old	47 (22.3)	43 (91.5)	4 (8.5)	33 (70.2)	14 (29.8)
Marital status					
Single	14 (6.6)	13 (92.9)	1 (7.1)	8 (57.1)	6 (42.9)
Married	144 (68.2)	136 (94.4)	8 (5.6)	95 (66.0)	49 (34.0)
Retracted/separated	9 (4.3)	9 (100)	0 (0.0)	8 (88.9)	1 (11.1)
Widow	17 (8.1)	15 (88.2)	2 (11.8)	11 (64.7)	6 (35.3)
Stable Communion	27 (12.8)	25 (92.6)	2 (7.4)	11 (40.7)	16 (59.3)
Education					
Incomplete elementary school	165 (78.2)	153 (92.7)	12 (7.3)	103 (62.4)	62 (37.6)
Complete elementary school	29 (13.7)	28 (96.5)	1 (3.5)	17 (58.6)	12 (41.4)
Incomplete High school	9 (4.3)	9 (100)	0 (0.0)	7 (77.8)	2 (22.2)
Complete High school	7 (3.3)	7 (100)	0 (0.0)	6 (85.7)	1 (14.3)
Graduated	1 (0.5)	1 (100)	0 (0.0)	0 (0.0)	1 (100)
Income (minimum wage)					
Without an own income	20 (9.5)	18 (90.0)	2 (10.0)	11 (55.0)	9 (45.0)
Less than 1	108 (51.2)	102 (94.4)	6 (5.6)	66 (61.1)	42 (38.9)
Between 1 and 2	76 (36.0)	71 (93.4)	5 (6.6)	51 (67.1)	25 (32.9)
Between 2 and 4	7 (3.3)	7 (100)	0 (0.0)	5 (71.4)	2 (28.6)
Self-referenced color					
White	25 (11.8)	24 (96.0)	1 (4.0)	18 (72.0)	7 (28.0)
Black	61 (28.9)	55 (90.2)	6 (9.8)	37 (60.7)	24 (39.3)
Brown	124 (58.8)	118 (95.2)	6 (4.8)	77 (62.1)	47 (37.9)
Yellow	1 (0.5)	1 (100)	0 (0.0)	1 (100)	0 (0.0)

Among the risk factors associated with cervical cancer, it is observed that the prevalence of HPV (Human Papilloma Virus) in this population is low (2.4%). However, 82.5%

of women do not use condoms in sexual relationships, despite the low incidence of sexually transmitted diseases (7.1%) (Table 2).

Table 2. Risk factors associated with uterine and breast cancer in women belonging to the Family Health Strategy teams, Locality of Caxirimbu, Rural Zone of Caxias (MA), Brazil (2015)

Variables	n	%
Risk Factors for Cervical Cancer		
History of Sexually Transmitted Diseases		
HPV	5	2.4
Gonorrhea	4	1.9
Syphilis	1 0,5	0.5
Soft câncer	2	0.9
Candidiasis	2	0.9
Gardnerella vaginalis	1	0.5
Do not use a condom	174	82.5
Onset of sexual activity (<15 years of age)	5	2.4
Previous history of cervical cancer	12	5.7
Risk Factors for Breast Cancer		
Age> 55 years old	164	77.7
Menarche before 12 years old	20	9.5
Do not breast-feed	14	6.6
Use of hormone replacement therapy for more than 5 years	3	1.4
Onset of menopause after 55 years old	9	4.3
Sedentary lifestyle	128	60.7
Risk Factors for Breast Cancer		
Daily alcohol intake	27	2712.8
Current smoking	102	48.3
Stature less than 170cm (average height)	209	99.1
Nulliparity	10	4.7
Obesity (BMI> 30)	47	22.3
Family history of breast cancer	15	7.1

Criteria used by Harvard report on cancer prevention

Figure 1. Geographic distribution of the visited households of the women who did and did not make the cytological examination, locality of Caxirambu, rural zone of Caxias (MA), Brazil (2015)

Figure 2. Geographic distribution of the visited households of the women who did and did not have the mammographic examination, Locality of Caxirumbu, rural area of Caxias (MA), Brazil (2015)

DISCUSSION

The sample investigated consists of 211 women, mostly married, with elementary education, low socioeconomic level and black and brown. The 13 women who did not perform the cervical oncology cytology were declared as Catholic and, of them, seven are in the age group of 41 to 50 years and six over 50 years. This fact can be attributed to the relationship of personal and regional order, such as age, level of education, social aspects, Afrodescendant ethnicity and marital status. It is also related to mortality from cervical cancer in the region under study.¹⁰ Also, in the locality of Caxirumbu, rural area of Caxias/MA, there is a strong influence of religious mysticism and syncretism of other Afro-descendant religions that offer preventive and curative inputs for diseases such as teas¹¹, blessings and miraculous portions.

The women in the researched area performed more cervical oncology cytology

than mammography, probably due to the fact that the local health unit was close to their home and the collection of the cervical examination was performed without bureaucracy and/or prior scheduling. Thus, besides to the active search, there is also the free demand on the day and time that the woman wishes, as well as without occurrence of annoyances due to clinical factors due to lack of information, sexual and physical hygiene. This aspect is not evidenced in other studies, in which it is reported that CP collections are performed by scheduling on a day of the week,¹²⁻³ while mammographic exams are performed in another municipality, by prior appointment, making access difficult.

According to the interviewees, 12 of them (5.7%) had relatives with cervical cancer. Although it is not a direct risk factor for this type of cancer, it may be considered a further incentive for the woman to seek the health service.¹⁴

The sexually transmitted HPV virus is the leading cause of the onset of cervical cancer.¹⁵ Other risk factors may also stimulate the onset of uterine cancer, such as smoking, oral contraceptives, sexually transmitted diseases, nutritional deficiencies¹⁵, low socioeconomic conditions, early sexual activity (under 15 years old),¹⁴ multiparity and multiple partners.¹⁶ What is most noticeable in the women surveyed is that 82.5% do not use condoms, while other factors are not very prevalent. In a study conducted in the city of São Luiz - Maranhão, with 465 women aged 25 to 49 years, adherence to condom use during sexual intercourse was 82.4% (n = 383), followed by 17.6% (n = 82) that did not use it¹⁷, which does not corroborate with the findings of this research, pointing out the cultural specificities of rural and urban environments.

In the popular culture of the countryside of aranhão, it is common for girls to initiate sexual activity early and marry before 15. In general, they have low adherence to the use of condoms and get pregnant early. In this context, marrying in the adolescence, generating children and family is something well seen in the cultural daily life of the researched locality. Thus, it can be verified that this woman may develop greater susceptibility to cervical cancer risk factors due to early sexual activity and

from March 2008 to November 2015, in the Caxirimbu locality, 16 HPV cases were identified through cervical oncocyctic cytology reports, relating them to CIN I, II and III. These women need to be in a condition of continuous monitoring, with periodic examinations every 6 months, to see if there is virus elimination, regression and/or evolution of the lesion, and the ESF "has an important role in the expansion of the population tracking and monitoring as an active search of these women, to positively impact the reduction of morbidity and mortality due to this disease."^{16: 173}

In a study¹⁸ with a universe of 21,592 women over 15 years old and living in the city of Rio do Sul, in Santa Catarina, it was verified that the lower level of education, the lower adherence to the screening test for cervical cancer. However, in the Caxirimbu locality, rural Caxias/MA, although they are in contexts that differ by geographical and historical-cultural aspects, there was a high adherence (94%) of women of the low educational level to the examination.

Compared with other studies conducted in Brazil, the low adherence to cervical cancer screening is related to socio-demographic

factors, color, and age, corroborating the findings of this study.¹⁹⁻²¹

Among the risk factors for breast cancer, the most noteworthy in this sample were age over 55 (77.7%), sedentary lifestyle (60.7%), history of smoking (48.3%) and the height less than 1,70m (99,1%). Background of breast cancer in first-degree relatives was not the most prevalent, despite being a factor found. This finding corroborates other studies by Silva and Riul²² and the recommendations of the Ministry of Health.¹⁶

In this study, 27% (n = 21) of women aged 50 years old and older did not perform mammography, despite the strategies performed by the local team (screening, monitoring, and flexibility of the agenda), highlighting that rural women still face difficulties access, interfering with adherence. Being that the age over 50 is the most relevant risk factor for breast cancer and is often identified in isolation among women. It is in this age group that the highest morbidity and mortality rates due to the lack of early diagnosis are verified, and the disease is detected in later stages.¹⁶

Unfortunately, the care model used in the Family Health Unit of Caxirimbu does not favor the coverage of breast cancer screening coverage. In this context, although it has demonstrated the scope in this study for cervical cancer screening, the mammography screening indicator was out of the standardized by the Ministry of Health. In addition, the sample has several risk factors for breast cancer, such as age 55 and over, sedentary lifestyle, smoking, obesity, mean height of 1.53 cm and short breastfeeding time.¹⁶

Besides the difficult access to transportation, women living in the rural area of Caxirimbu find other difficulties, such as scheduling the exam in the urban area, scheduling of the exam and the execution of the exam, which requires more efforts related to the detachment and financial investment.

CONCLUSION

This research showed a high coverage of cervical cancer screening and the screening of breast cancer did not reach the parameter recommended by the Ministry of Health, and they were inadequate in both intervals.

As a limitation of this study, we can mention the scarce national studies, mainly in rural areas, in the last five years.

It should be pointed out that the contribution of this research highlights the invisibility of the health conditions of these

rural women in the Brazilian context. Other research is recommended to subsidize actions aimed at the health promotion of these women.

Even the findings of this study are better than in other rural and even urban communities, it is necessary to elaborate and implement tools for an organized screening as recommended by the Ministry of Health, replacing the opportunistic model. The nurse stands out as the main manager of these actions.

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