

Sociodemographic and Clinical Profile of Cancer Patients Registered in the Home Visiting Program of a Public Hospital

doi: <https://doi.org/10.32635/2176-9745.RBC.2021v67n2.864>

Perfil Sociodemográfico e Clínico de Pacientes com Câncer Cadastrados no Programa de Visita Domiciliar de um Hospital da Rede Pública

Perfil Sociodemográfico y Clínico de los Pacientes Oncológicos Registrados en el Programa de Visitas Domiciliarias de un Hospital Público

Adrielly Elane Sousa Maia¹; Flávia Adrienne de Castro Grello²; Katiane da Costa Cunha³

ABSTRACT

Introduction: The sociodemographic profile is a vulnerability factor for the development of neoplasms in general, which can compromise preventive actions, hinder early diagnosis and/or access to an appropriate therapeutic, causing negative effects on the prognosis and quality of life of patients. Home care planning initiates in the hospital environment, when the family/caregiver receives guidance about coping with the disease and, above all, preventing complications related to the pathological condition. **Objective:** To characterize the sociodemographic and clinical profile of cancer patients registered in the home visit program of a public hospital. **Method:** Cross-sectional, quantitative, retrospective, and descriptive study whose data were extracted from the analysis of 274 charts of cancer patients registered in the hospital's home visit service from 2010 to 2017. **Results:** Most of the patients were females in the age range from 60 to 80 years old, mean of 4 to 7 years of formal education and living in the city of Belém. Stage IV genitourinary cancer was the most frequent. Finally, most patients had pain and were using wide-range potency analgesics. **Conclusion:** It is important to know the clinical and sociodemographic profile of the patients, in order to better planning and intervention together with the multidisciplinary team, since the population in the State of Pará has a scenario of high prevalence of types of cancer that can be diagnosed early.

Key words: Neoplasms/epidemiology; Home Care Services; Palliative Care; Cross-Sectional Studies.

RESUMO

Introdução: O perfil sociodemográfico constitui fator de vulnerabilidade para o desenvolvimento de neoplasias em geral, podendo comprometer as ações de prevenção, dificultar o diagnóstico precoce e/ou acesso à terapêutica adequada, ocasionando reflexos negativos no prognóstico e na qualidade de vida dos pacientes. O cuidado domiciliar tem seu planejamento iniciado no ambiente hospitalar, cuja família/cuidador recebe orientações acerca do enfrentamento da doença e, sobretudo, da prevenção de complicações relacionadas com o estado patológico. **Objetivo:** Caracterizar o perfil sociodemográfico e clínico de pacientes com câncer cadastrados do programa da visita domiciliar de um hospital da rede pública. **Método:** Estudo transversal, quantitativo, retrospectivo e descritivo, cujos dados foram extraídos da análise de 274 prontuários de pacientes oncológicos cadastrados no serviço de visita domiciliar do hospital, no período de 2010 a 2017. **Resultados:** A maioria dos pacientes era do sexo feminino na faixa etária de 60 a 80 anos, com média de estudo de quatro a sete anos e residentes na cidade de Belém. O câncer geniturinário foi o mais frequente e classificado no estágio IV. Por fim, a maior parte dos pacientes apresentava dor, fazendo o uso de analgésicos de ampla potência. **Conclusão:** Torna-se importante conhecer o perfil clínico e sociodemográfico dos pacientes, para melhor planejamento e intervenção junto à equipe multidisciplinar, uma vez que a população no Estado do Pará tem um cenário de alta prevalência dos tipos de câncer que podem ser diagnosticados precocemente.

Palavras-chave: Neoplasias/epidemiologia; Serviços de Assistência Domiciliar; Cuidados Paliativos; Estudos Transversais.

RESUMEN

Introducción: El perfil sociodemográfico es un factor de vulnerabilidad para el desarrollo de neoplasias en general, que puede comprometer acciones preventivas, dificultar el diagnóstico precoz y/o el acceso a la terapia adecuada, provocando efectos negativos sobre el pronóstico y la calidad de vida de los pacientes. La atención domiciliar tiene su planificación iniciada en el ámbito hospitalario, en el que el familiar/cuidador recibe orientación sobre el afrontamiento de la enfermedad y, sobre todo, la prevención de complicaciones relacionadas con el estado patológico. **Objetivo:** Caracterizar el perfil sociodemográfico y clínico de los pacientes oncológicos registrados en el programa de visitas domiciliarias de un hospital público. **Método:** Estudio transversal, cuantitativo, retrospectivo y descriptivo, cuyos datos se extrajeron del análisis de 274 historias clínicas de pacientes oncológicos registrados en el servicio de visita domiciliar del hospital de 2010 a 2017. **Resultado:** La mayoría de los pacientes eran del sexo masculino mujer de 60 a 80 años, con un estudio promedio de cuatro a siete años y residente en la ciudad de Belém, siendo el cáncer genitourinario el más frecuente clasificado en estadio IV. Finalmente, la mayoría de los pacientes experimentaron dolor al usar analgésicos de gran potencia. **Conclusión:** Es importante conocer el perfil clínico y sociodemográfico de los pacientes, para poder planificación e intervención mejor con el equipo multidisciplinario, ya que la población del Estado de Pará tiene un escenario de alta prevalencia de tipos de cáncer que pueden ser diagnosticado temprano.

Palabras clave: Neoplasias/epidemiología; Servicios de Atención de Salud a Domicilio; Cuidados Paliativos; Estudios Transversales.

^{1,2}Hospital Ophir Loyola (HOL). Multi-professional Residency Program in Oncology – Palliative Care. Belém (PA), Brazil. E-mails: adriellymaiaa@gmail.com; flaviaadrienne@hotmail.com. Orcid iD: <http://orcid.org/0000-0002-6940-2417>; Orcid iD: <http://orcid.org/0000-0003-3031-6682>

³Federal University of Pará (UFPA). Belém (PA), Brazil. E-mail: katianefisio@yahoo.com.br. Orcid iD: <https://orcid.org/0000-0001-5361-5090>

Corresponding author: Adrielly Elane Sousa Maia. Ed. Torres Devant. Travessa Pirajá, 520, apto. 1202 - A - Leste - Pedreira. Belém (PA), Brazil. CEP 66083-513. E-mail: adriellymaiaa@gmail.com



INTRODUCTION

Cancer is defined as an abnormal growth of cells invading cells and organs classified as malignant, in addition to provoking the spread to different regions of the body away from the original tumor called metastasis¹.

Currently, cancer is considered a public health issue and is gaining more attention because of population ageing as age is related to several physiological changes and other factors pertinent to the modern world as inappropriate lifestyle. The best prognosis for the patient is generally associated with staging, early diagnosis, type of neoplasm and proper treatment¹⁻³.

However, when diagnosis occurs late, there are negative repercussions for the success of the therapeutic, being essential the choice of palliative care as complementary or exclusive measure whose aim is to mitigate signs and symptoms, promoting the well-being of the patient and caretaker or parent⁴.

Cancer is a chronic disease and a health marker in Brazil, it is utilized as indicator of the level of regional development because of the discussions about neoplasms and their demographic issues on life conditions and development of the population⁵.

The literature indicates that the sociodemographic profile can increase the vulnerability for the development of cancer due to the access to prevention procedures and initiatives, time to define the diagnosis, choice of the therapeutic modality and consequently the prognosis and survival of the patients^{6,7}.

Brazil's cancer control policies are based in the profile of morbidity and mortality of the several states and municipalities with wide variation from region to region. The estimates of cancer incidence cases can be utilized to offer epidemiologic information that are essential to plan actions of health promotion, early detection and oncologic attention in all levels⁵.

As a tool to provide care to the patient, mainly for those with advanced diseases and in terminal phase, palliative care is the multi-professional and interdisciplinary action which ensures the individual full and active attention. Regarding home support, there is a network whose goal is de-hospitalization, risks prevention and humanization of the care, offering the patient more control of the stressor symptoms and quality in its life end within an environment where as much as possible their preferences are prioritized^{8,9}.

Home care is a palliative care that patients and/or relatives frequently demand, typically for individuals in terminal phase. This action, it is worth noticing, is not definitive and requires several revaluations because of the unstable condition⁹.

Initially, the multi-professional team proposes home care in the hospital environment deliberating the conditions to receive this kind of follow up in concurrence with the family/caretaker, who is informed about the necessity and responsibilities, possible limitations and implementation. Overall, it occurs gradually, non-linear, followed up and reevaluated according to the clinical status with varied periodicity monthly, quarterly, weekly or even daily¹⁰.

For a better home care, the inclusion criteria should be clear and effective to maximize timing and avoid neglect in events that require caution during home visit. With the objective of organizing these procedures, chapter II of Ordinance number 825, April 25, 2016¹¹ brings indications for patients in clinical stability needing home care temporarily or definitely or for those who are somehow more vulnerable and the care provided should be more appropriate for treatment, rehabilitation, prevention of harms and palliative care.

Another care supportive tool is the registration in the chart which also helps the clinical and managerial decision, follow up and continuity of the process offered, in addition of being the connection among several professionals, source of the patients' clinical and current history and background; its implementation and content are criteria of evaluation of the quality of health care¹².

Therefore, the objective of this study was to analyze the clinical and sociodemographic profile of patients with cancer enrolled in the home visit program of Hospital Ophir Loyola from 2010 to 2017, presenting evidences that help to deepen the knowledge in this area since the approach to the reality the patient in home care lived may support the multi-professional team in its process of attention to health.

METHOD

Cross-sectional, quantitative, retrospective and descriptive study of analysis of the oncologic patients' charts treated through the Hospital Ophir Loyola home visit program from 2010 to 2017. The investigation occurred from December 2018 to April 2019.

This study complied with ethical regulations of research with human beings of the Declaration of Helsinki and the Nuremberg Code and with Resolution 466/12 of the National Health Council¹³. After the Institutional Review Board of Hospital Ophir Loyola approved the free access to the charts, (report 3.009.002), the study initiated; the hospital has a home visit program to follow up oncologic patients with regular visits and consultations held across several neighborhoods of the city of Belém.

Only charts of oncologic patients in palliative care of the Hospital's home program in the last eight years were included; incomplete charts, with scarce information to be included in the database were excluded.

Data were collected through the analysis of the patients' charts, completing a collection data card the investigators had created. The data collected were: patient's family income, number of persons living in the household, main caretaker, education level, survival in home care and composition of the multi-disciplinary team.

Clinical diagnosis, disease staging, pain, previous treatments (radiotherapy, chemotherapy, hormone therapy and surgery), drugs utilized and comorbidities as metastases, systemic arterial hypertension, *diabetes mellitus*, acute renal failure were analyzed as well.

The following databases were searched: Virtual Health Library (BVS), Scientific Electronic Library Online (SciELO) and Medical Literature Analysis and Retrieval System Online (MEDLINE) via PubMed. The terms utilized mainly were: cancer, analysis of charts, home visit, palliative care and sociodemographic profile.

The data were entered in software Excel 2010 used to prepare the tables. The statistical analysis was performed through software BioEstat 5.0 and EpiInfo 3.5.1. The categorical variables were presented as frequencies and the numerical through measures of central tendency and dispersion. Tests chi-square, chi-square (contingency) and G (adherence) were utilized to evaluate the significance of the data. All the results were considered statistically significant at significance level 5% ($p \leq 0.05$).

RESULTS

At Hospital Ophir Loyola, 440 charts of the patients in home consultation were collected, 166 of which were excluded due to incomplete data. The final sample consisted of 274 charts of the patients registered.

Of the 274 charts reviewed, great part were females (59.9%, $p=0.001^*$), in the age range from 60 to 80 years (50.0%, $p<0.0001^*$), married (45.3%, $p<0.0001^*$), mean years of education from four to seven years (37.6%, $p<0.0001^*$), their children were the main caretakers (53.6%, $p<0.0001^*$), specially females (86.5%, $p<0.0001^*$) as shown in Table 1.

Most of them were born in the city of Belém (93.4%, $p<0.0001^*$) in the state of Pará (95.6%, $p<0.0001^*$) with family income from one to three minimum wages (61.3%, $p<0.0001^*$) and four to six persons living in the same house (41.2%, $p<0.0001^*$) as shown in Table 2.

Several types of cancer were identified from the 274 charts reviewed and classified according to the system compromised. Most of them were in the genitourinary

Table 1. Overall data of patients with cancer treated through the home visit program of Hospital Ophir Loyola, Belém, Pará, 2010 to 2017 (n=274)

VARIABLES	N	%	p-value
Gender			
Male	110	40.1%	$^a 0.001^*$
Female	164	59.9%	
Age			
18 to 38 years	16	5.8%	$^b <0.0001^*$
39 to 59 years	71	25.9%	
60 to 80 years	137	50.0%	
81 to 101 years	49	17.9%	
102 to 122 years	1	0.4%	
Marital Status			
Single	46	16.8%	$^b <0.0001^*$
Married	124	45.3%	
Divorced	22	8.0%	
Widow/widower	58	21.2%	
Not informed	24	8.8%	
Education			
None	25	9.1%	$^b <0.0001^*$
4 to 7 years	103	37.6%	
8 to 10 years	55	20.1%	
11 to 14 years	35	12.8%	
15 or more years	12	4.4%	
Not informed	44	16.1%	
Main Caretaker			
Male	34	12.4%	$^b <0.0001^*$
Female	237	86.5%	
Not informed	3	1.1%	
Kinship of the Caretaker			
Spouse	47	17.2%	$^b <0.0001^*$
Mother	4	1.5%	
Father	2	0.7%	
Son/daughter	147	53.6%	
Extended family	67	24.5%	
Friend	2	0.7%	
Professional Caretaker	2	0.7%	

Captions: a = Chi-square test; b = Test G (adherence). * Result statistically significant, $p \leq 0.05$.

system (44.2%, $p<0.0001^*$), which was predominant at admission in 2012 (23.6%, $p<0.0001^*$), with last visit in 2012 (27.4%, $p<0.0001^*$), cancer staging IV (59.9%, $p<0.0001^*$) and a substantial percentage with pain (76.3%, $p<0.0001^*$) (Table 3).

Table 2. Sociodemographic data of patients with cancer treated through the home visit program of Hospital Ophir Loyola, Belém, Pará, 2010 to 2017 (n=274)

VARIABLES	N	%	p-value
Origin			
Pará	262	95.6%	
Other State	11	4.0%	^a <0.0001*
Other Country	1	0.4%	
City			
Belém	256	93.4%	^b <0.0001*
Ananindeua	18	6.6%	
Family Income			
None	2	0.7%	
< 1 minimum wage	6	2.2%	
1 to 3 minimum wages	168	61.3%	
3 to 6 minimum wages	18	6.6%	
6 to 9 minimum wages	1	0.4%	^a <0.0001*
9 to 12 minimum wages	1	0.4%	
> 12 minimum wages	1	0.4%	
Not informed	77	28.1%	
Persons living in the same house			
1 to 3 persons	96	35.0%	
4 to 7 persons	113	41.2%	
8 to 10 persons	11	4.0%	^a <0.0001*
> 10 persons	3	1.1%	
Not informed	51	18.6%	

Captions: a = Test G (adherence); b = Chi-square test. * Result statistically significant, $p \leq 0.05$.

The majority of the patients (56.9%, $p < 0.0001^*$) did not present any of the comorbidities analyzed. But for those with comorbidities, 22.3% had systemic arterial hypertension, 9.1%, *diabetes mellitus* and 4%, acute renal insufficiency. Of the individuals with metastasis, great part was in the bone system (30.3%) and submitted to radiotherapy (46.0%). It was possible to notice that among the professionals in the only multi-disciplinary team, social worker was the most significant (96.0%), if compared with rehabilitation professionals as physiotherapist and occupational therapist who joined the visits only once a month (Table 4).

Regarding clinical outcome, 62.0% died ($p < 0.0001^*$) both at home and hospital. The outcome for most of them (26.6%) occurred in 2012, with mean survival of 115.43 ± 199.15 days for those who died.

Table 3. Clinical characterization of patients with cancer treated through the home visit program of Hospital Ophir Loyola, Belém, Pará, 2010 to 2017 (n=274)

VARIABLES	N	%	p-value
Clinical Diagnosis			
Cancer of digestive system	90	32.8%	
Cancer of cardiovascular system	12	4.4%	
Cancer of respiratory system	20	7.3%	
Cancer of the genitourinary system	121	44.2%	
Cancer of the nervous system	8	2.9%	
Cancer of the integumentary system	4	1.5%	<0.0001*
Cancer of the lymphatic system	3	1.1%	
Cancer of the endocrine system	2	0.7%	
Cancer of the bone system	7	2.6%	
Cancer of soft parts	1	0.4%	
Occult primary tumor	4	1.5%	
Not informed	2	0.7%	
Year of hospital admission			
2010	4	1.5%	
2011	38	13.9%	
2012	72	26.3%	
2013	37	13.5%	
2014	27	9.9%	<0.0001*
2015	25	9.1%	
2016	33	12.0%	
2017	35	12.8%	
Not informed	3	1.1%	
Last visit			
In treatment	7	2.6%	
2010	5	1.8%	
2011	19	6.9%	
2012	75	27.4%	<0.0001*
2013	43	15.7%	
2014	32	11.7%	
2015	25	9.1%	
2016	35	12.8%	
2017	33	12.0%	
Cancer staging			
III	18	6.6%	
IV	164	59.9%	<0.0001*
Not informed	92	33.6%	
Presence of pain			
Yes	209	76.3%	
No	24	8.8%	<0.0001*
Not informed	41	15.0%	

Captions: Test G (Adherence). * Result statistically significant, $p \leq 0.05$.

Table 4. Clinical characterization of patients with cancer treated through the home visit program of Hospital Ophir Loyola, Belém, Pará, 2010 to 2017 (n=274)

VARIABLES	Yes		No		p-value
	N	%	N	%	
Comorbidities					
Absent	156	56.9%	118	43.1%	
Systemic arterial hypertension	61	22.3%	213	77.7%	
Diabetes mellitus	25	9.1%	249	90.9%	<0.0001*
Acute renal insufficiency	11	4.0%	263	96.0%	
Not informed	38	13.9%	236	86.1%	
Metastasis					
Digestive System	53	19.3%	221	80.7%	
Cardiovascular System	0	0.0%	274	100.0%	
Respiratory System	37	13.5%	237	86.5%	
Genitourinary System	13	4.7%	261	95.3%	
Nervous System	13	4.7%	261	95.3%	
Integumentary System	4	1.5%	270	98.5%	<0.0001*
Lymphatic System	11	4.0%	263	96.0%	
Endocrine System	0	0.0%	274	100.0%	
Bone System	83	30.3%	191	69.7%	
Absent	2	0.7%	272	99.3%	
Not informed	37	13.5%	237	86.5%	
Treatment accomplished					
No	25	9.1%	249	90.9%	
Surgery	62	22.6%	212	77.4%	
Chemotherapy	106	38.7%	168	61.3%	
Radiotherapy	126	46.0%	148	54.0%	<0.0001*
Brachytherapy	9	3.3%	265	96.7%	
Hormone therapy	3	1.1%	271	98.9%	
Not informed	77	28.1%	197	71.9%	
Multi-disciplinary Team					
Social Worker	263	96.0%	11	4.0%	
Psychologist	251	91.6%	23	8.4%	
Nurse	254	92.7%	20	7.3%	
Physiotherapist	26	9.5%	248	90.5%	
Nutritionist	2	0.7%	272	99.3%	0.43
Physician	260	94.9%	14	5.1%	
Phono audiologist	12	4.4%	262	95.6%	
Occupational Therapist	43	15.7%	231	84.3%	
Odontologist	2	0.7%	272	99.3%	

Captions: Chi-square test (contingency). * Result statistically significant, $p \leq 0.05$.

In relation to drug therapy, 54.0% used high potency analgesics (Table 5).

Table 5. Use of medications in patients with cancer treated through the home visit program of Hospital Ophir Loyola, Belém, Pará, 2010 to 2017 (n=274)

MEDICATIONS	Yes		No	
	N	%	N	%
High potency analgesic	148	54.0%	126	46.0%
Low potency analgesic	42	15.3%	232	84.7%
Antiacid and antiulcerative	93	33.9%	181	66.1%
Antiemetic	93	33.9%	181	66.1%
Antipsychotic	82	29.9%	192	70.1%
Diuretic	8	2.9%	266	97.1%
Antidepressant	53	19.3%	221	80.7%
Antimicrobial	17	6.2%	257	93.8%
Corticosteroid	25	9.1%	249	90.9%
Anticonvulsant	15	5.4%	256	93.4%
Laxative	78	28.4%	196	71.5%
Antihypertensive	17	6.2%	257	93.8%
Benzodiazepines	26	9.4%	248	90.5%
Analgesic and antipyretic	34	12.4%	240	87.6%
Antifibrinolytic	3	1.0%	271	98.9%
Antidiabetic	2	0.7%	272	99.3%
Nonsteroidal anti-inflammatory	6	2.1%	268	97.8%
Anticonvulsant	3	1.0%	271	98.9%
Antiphysetic	4	1.5%	270	98.5%
Anti-hemorrhagic	8	2.9%	266	97.1%
Anti-histaminic	1	0.3%	273	99.6%
Anticholinergic	1	0.3%	273	99.6%
Expectorant	2	0.7%	272	99.3%
Antiflatulent	2	0.7%	272	99.3%
Antiarrhythmic	1	0.3%	273	99.6%

DISCUSSION

It was verified in the present study that the profile of oncologic patients consulted within the home care program of Hospital Ophir Loyola were women, similar to the literature¹⁴. There are high levels of detection of neoplasms in women as cervical and breast cancers, which stand out among the tumors that most affect this

gender worldwide, mainly in underdeveloped regions. In developed countries, however, the incidence of cancer of men and women is similar because of investments in prevention¹⁵.

The predominant age range of the sample was from 60 to 80 years, a finding consistent with a study where 859 patients' charts were reviewed, most of them with mean age of 72 and median of 78 years¹⁶. Other two studies explained this fact because of the increase of life expectancy, that is, populational ageing and its close relation with non-communicable diseases (NCD) in addition to exposure to environmental risk factors as cancer, which can create more demand for palliative care^{17,18}.

Regarding education, the mean was from four to seven years and family income from one to three minimum wages with four to seven persons living in the same house. Lampert et al.¹⁹ revealed this same information in a study where the results showed that the majority had until four years of education, a reality that hampers the understanding of health-related guidance, difficulty of access of preventive programs, support for early diagnosis and proper and immediate treatment. NCD affect strongly more vulnerable groups as those with low income and education levels²⁰.

Based in the investigation of the population in study, the predominance is genitourinary system, because of the high rates of prostate and cervical cancers in the Northern region²¹. Similar data was found in the study of Atty and Tomazelli²², where the main recurrent neoplasms requiring palliative home care for men was prostate and for women, breast cancer. These authors emphasize that it is worrying the frequency of cases of cervical cancer in palliative care because it is a neoplasm of difficult early diagnosis and prevention in the health basic attention of the country.

To meet the necessities of persons in palliative care with regional or remote metastasis, in addition to the symptomatic treatment, palliative finality treatments as surgery, chemotherapy, radiotherapy and hormone therapy can be used²³. The most frequent antineoplastic treatments the patients of this study were submitted previously were radiotherapy, followed by chemotherapy and surgery. However, in a study²⁴ with patients in advanced stage in a reference hospital of Curitiba, from previous antineoplastic treatments, it was verified that 78 patients underwent chemotherapy, 57, some sort of surgery and 42, radiotherapy, 13, another type of treatment as hormone therapy or brachytherapy and 30 did not receive palliative treatment.

As the results of the present study show, patients were at advanced stage of the disease and in the literature²⁵ it is also common that most of the patients at admission were at advanced stages (more than 90% with metastasis).

With this, the importance of palliative care together with the necessity of its expansion is reinforced to ensure the universality and integrality of the studies for neoplastic diseases, which currently are the second cause of death in the country²⁵, further to the necessity of investment in primary level to prevent neoplasms, early diagnosis and immediate proper treatment.

For cases of metastatic cancer, bone metastasis is a frequent occurrence, is the third most common site of remote metastasis, followed by liver and lung. There are cases where bone metastases are painless, but in many cases, they cause significant and debilitating pain²⁶. In addition to bone pain, bone metastases can cause other comorbidities as pathological fractures and of the spinal cord compression²⁶, a data similar to this article where bone system is the highest incidence site of metastases.

Bone tumor invasion is the most common cause of lung, breast, prostate neoplasms and myeloma, being a nociceptive somatic type of pain where the mechanism helps when the tumor activates nociceptors by pressure leading to ischemia and secretion of painful substances as prostaglandins and factor of activation of osteoclasts²⁷.

Pain was the main symptom in the population investigated corroborating the article of Rangel and Telles²⁷, where it was identified that pain affects from 60% to 80% of patients with cancer; of these, 25% to 30% at diagnosis and from 70% to 90% of the patients with advanced staging who classify pain as moderate to severe.

In relation to drug approach for pain relief, primarily, the choice of the correct opioid should be matched to the pain intensity. In this perspective, a study of Fripp²⁵ about the clinical profile of 213 patients of the Interdisciplinary Home Admission Program noticed that 65% of the patients reported pain, of these 90% reported moderate to intense pain. 78% of all the patients needed analgesic opioids, being morphine (43%) and codeine (26%) the most utilized. Among the available opioids, morphine stands out and is considered the golden standard for the treatment of moderate and intense pain, being indicated in other studies of the literature^{28,29}.

CONCLUSION

This study analyzed the clinical and sociodemographic characterization of patients in palliative home care. The data found in this article were similar to the literature with predominance of females, mean age ranging from 60 to 80 years, low socioeconomic level and four to seven years of education, most of them from Pará and living in the capital, Belém.

Genitourinary cancer was the most frequent with advanced clinical staging and great occurrence of

metastasis mainly in the bone system, considering the clinical profile. Pain was the symptom found in the majority of the population and among the medications used more frequently, the most common were high potency analgesics.

This article is concluded, therefore, emphasizing the importance of knowing the patients' clinical and sociodemographic profile for better planning and intervention together with the multi-disciplinary team with instructive materials (spreadsheets) and epidemiological investigations since the population of the study has high prevalence of cancer types that can be diagnosed early. It is necessary to encourage this population with measures of promotion, early diagnosis and treatment the local public power provides, which can contribute to reverse palliative cases, consequently.

The paucity of studies and scientific researches about this theme, further to other studies addressing the clinical and sociodemographic profile of patients in home palliative care are limitations of this study in this region.

CONTRIBUTIONS

All the authors contributed for the study conception and/or design, collection, analysis and interpretation of the data, wording and critical review and approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

FUNDING SOURCES

None

REFERENCES

1. Santos M, Matsudo VKR. Atividade física e uso de medicamentos. *Diagn Tratamento*. 2018;23(4):152-159.
2. Macêdo GD, Lucena NMG, Soares LMMM, et al. Influência do estilo de vida na qualidade de vida de mulheres com câncer de mama. *Rev Bras Cienc Saude*. 2011;14(4):13-18.
3. Batista DRR, Mattos M, Silva SF. Convivendo com o câncer: do diagnóstico ao tratamento. *Rev Enferm UFSM* 2015;5(3):499-510. doi: <http://doi.org/10.5902/2179769215709>
4. Carvalho RT, Parsons HA, organizadores. *Manual de cuidados paliativos ANCP*. 2. ed. São Paulo: Academia Nacional de Cuidados Paliativos; 2012.
5. Menezes MFB, Camargo TC, Guedes MTS, et al. Câncer, pobreza e desenvolvimento humano: desafios

- para a assistência de enfermagem em oncologia. *Rev Latino Am Enfermagem*. 2007;15(n. spe):780-85. doi: <https://doi.org/10.1590/S0104-11692007000700011>
6. Paiva CJK. Câncer de mama no hospital de câncer de Pernambuco: perfil sociodemográfico e aspectos relacionados ao atraso no diagnóstico e tratamento [dissertação]. Recife: Departamento de Saúde Coletiva, Instituto Aggeu Magalhães, Fundação Oswaldo Cruz; 2013.
 7. Kolankiewicz ACB, Souza MM, Magnago TSBS, et al. Apoio social percebido por pacientes oncológicos e sua relação com as características sociodemográficas. *Rev Gaúcha Enferm*. 2014;35(1):31-38. doi: <http://doi.org/10.1590/1983-1447.2014.01.42491>
 8. Saunders CM. Cicely Saunders: selected writings 1958-2004. Oxford: Oxford University Press; 2006. Chapter 42, The evolution of palliative care; p. 263-8.
 9. Floriani CA, Schramm FR. Desafios morais e operacionais da inclusão dos cuidados paliativos na rede de atenção básica. *Cad Saúde Pública*. 2007;23(9):2072-80. doi: <https://doi.org/10.1590/S0102-311X2007000900015>
 10. Santos LR, Ponce de Leon CGRM, Funghetto SS. Princípios éticos como norteadores no cuidado domiciliar. *Ciênc Saúde Colet*. 2011;16(Suppl 1):855-63. doi: <https://doi.org/10.1590/S1413-81232011000700017>
 11. Ministério da Saúde (BR). Portaria nº 825, de 25 de abril de 2016. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS) e atualiza as equipes habilitadas. *Diário Oficial da União*. Brasília, DF; 2016 abr 26. Seção 1, p.33.
 12. Vasconcellos MM, Gribel EB, Moraes IHS. Registros em saúde: avaliação da qualidade do prontuário do paciente na atenção básica. *Cad Saúde Pública*. 2008;4(Suppl 1):s173-s182. doi: <http://doi.org/10.1590/S0102-311X2008001300021>
 13. Conselho Nacional de Saúde (BR). Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. *Diário Oficial da União*, Brasília, DF; 2013 jun. 13. Seção I, p. 59.
 14. Bastos BR, Pereira AKS, Castro CC, et al. Perfil sociodemográfico dos pacientes em cuidados paliativos em um hospital de referência em oncologia do estado do Pará, Brasil. *Rev Pan-Amaz Saúde*. 2018;9(2):31-6. doi: <http://doi.org/10.5123/s2176-62232018000200004>
 15. Souza RS, Simão DAS, Lima EDRP. Perfil sociodemográfico e clínico de pacientes atendidos em um serviço ambulatorial de quimioterapia paliativa em Belo Horizonte. *Rev Min Enferm*. 2012;16(1):38-47.
 16. Carnaúba CMD, Silva TDA, Viana JF, et al. Caracterização clínica e epidemiológica dos pacientes em atendimento domiciliar na cidade de Maceió, AL, Brasil. *Rev Bras Geriatr Gerontol* 2017;20(3):353-63. doi: <https://doi.org/10.1590/1981-22562017020.160163>
 17. Ciałkowska-Rysz A, Kowalczyk M, Gottwald L, et al. The comparison of common cancer types and the coincidence of concomitant chronic diseases between palliative home care patients in Lodz Voivodeship and the general Polish population. *Arch Med Sci*. 2012;8(3):496-503. doi: <https://doi.org/10.5114/aoms.2012.29406>
 18. Silva JVF, Silva EC, Rodrigues APRA, et al. A relação entre o envelhecimento populacional e as doenças crônicas não transmissíveis: sério desafio de saúde pública. *Ciênc Biol Saúde*. 2015;2(3):91-100.
 19. Lampert MA, Brondani CM, Donati L, et al. Perfil de doentes crônicos de um serviço de internação domiciliar da Região Sul do Brasil. *J Nurs Health*. 2013;3(2):147-56. doi: <https://doi.org/10.15210/JONAH.V3I2.3554>
 20. Malta DC, Andrade SSCA, Oliveira TP, et al. Probabilidade de morte prematura por doenças crônicas não transmissíveis, Brasil e Regiões, projeções para 2025. *Rev Bras Epidemiol*. 2019;22: e190030. doi: <https://doi.org/10.1590/1980-549720190030>
 21. Instituto Nacional de Câncer José Alencar Gomes da Silva. Estimativa 2020: incidência de câncer no Brasil [Internet]. Rio de Janeiro: INCA; 2019 [acesso 2019 dez 11]. Available from: <https://www.inca.gov.br/sites/ufu.sti.inca.local/files/media/document/estimativa-2020-incidencia-de-cancer-no-brasil.pdf>
 22. Atty ATM, Tomazelli JG. Cuidados paliativos na atenção domiciliar para pacientes oncológicos no Brasil. *Saúde Debate*. 2018;42(116):225-36. doi: <http://doi.org/10.1590/0103-1104201811618>
 23. Carvalho MWA, Araújo AA, Nóbrega MML. Diagnóstico de enfermagem para pacientes com toxicidade hematológica pós-quimioterapia antineoplásica com base na CIPE. *Rev Enferm UFPE*. 2009;3(4):12-19. doi: <http://doi.org/10.5205/reuol.581-3802-1-RV.0304200902>
 24. Visentin A. Avaliação da qualidade de vida e sobrevida de pacientes com câncer avançado na terapêutica paliativa [tese]. Curitiba: Universidade Federal do Paraná; 2016.
 25. Fripp JC. Internação domiciliar e cuidados paliativos para pacientes oncológicos no município de Pelotas/RS [dissertação]. Rio Grande do Sul: Universidade Federal de Pelotas; 2009.
 26. Sze WM, Shelley M, Held I, et al. Palliation of metastatic bone pain: single fraction versus multifraction radiotherapy. *Cochrane Database Syst Rev*. 2002(2):CD004721. doi: <http://doi.org/10.1002/14651858.CD004721>
 27. Rangel O, Telles C. Tratamento da dor oncológica em cuidados paliativos. *Rev Hosp Univ Pedro Ernesto*. 2012;11(2):32-7.
 28. Fripp JC, Facchini LA, Silva SM. Caracterização de um programa de internação domiciliar e cuidados paliativos no município de Pelotas, Estado do Rio Grande do Sul, Brasil: uma contribuição à atenção integral aos usuários com câncer no Sistema Único de Saúde, SUS. *Epidemiol*

Serv Saúde. 2012;21(1):1679-4974. doi: <http://doi.org/10.5123/S1679-49742012000100007>

29. Nogueira FL, Sakata RK. Palliative sedation of terminally ill patients. Rev Bras Anesthesiol. 2012;62(4):580-92. doi: [http://doi.org/10.1016/S0034-7094\(12\)70157-5](http://doi.org/10.1016/S0034-7094(12)70157-5)

Recebido em 1/6/2020
Aprovado em 10/11/2020