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COMFORT FROM THE PERSPECTIVE OFCANCER CLIENT SUNDER GOING OUT PATIENT CHEMOTHERAPY TREATMENT[1]

Lidiane da Fonseca Moura Louro*
Luiz Carlos Santiago**
Thiago Quinellato Louro***
Yonara Cristiane Ribeiro****
Roberto Carlos Lyra da Silva*****
Carlos Roberto Lyra da Silva******

ABSTRACT

The word comfort is present in the vocabulary of nursing professionals during their work process. Therefore, the objective of this study is to describe the factors that interfere in the perception of comfort by oncological clients in outpatient chemotherapy treatment. This descriptive and quantitative study was performed in a private oncology health care outpatient clinic located in the Lakes' Region in the State of Rio de Janeiro. A two-part instrument was used for the data collection: sociodemographic questions and the Patients' Comfort Evaluation Scale to those undergoing Chemotherapy. Out of the 30 interviewees, 70% were females, and 30% were males. The most prominent diagnosis was breast neoplasm. The socio-cultural context presented the highest mean among interviewees (M = 31.6, SD = 5.048), and the environmental context presented the lowest mean(M = 17.2, SD = 3.453). Cancer patients in out patient chemotherapy treatment face alterations related to their physical appearance and psychological and social aspects that affect patients and their families.

Keywords: Nursing care. Medical oncology.Patient Comfort.

INTRODUCTION

During the work process of nursing professionals, the word *comfort* is present in communicative situations, integrating expressions such as "*comfort* was provided," "the patient is comfortable," "was comforted," or "is comfortably installed"(1).

In the course of my professional experience providing nursing care to patients with cancer in the chemotherapy infusion room of a private institution located in Rio de Janeiro, I witnessed several situations in which the word comfort was constantly referred to by the nursing team during the care process. Thus, I realized that such a word was used in the most different contexts of the nursing practice.

The clientcan experience several uncomfortable situations during the pragmatic nursing care; however, it is necessary not to lose sight of the priority of nursing care considering its scientific base because it is the one that leads to the promotion of effective comfort(2).

Authors who have proposed to study the care that comforts, in the development of a humanistic theory in this area, affirm that the nursing care is a comforting response from one person to another in a moment of need in order to foster the development of well-being(3).

The literature reveals that comfort significantly constitutes the nursing care and is linked to its origin and development, assuming different meanings throughout history that relate to the historical, political, social, and religious evolution of humankind, besides establishing a relationship with the techno-scientific development(1).

Therefore, it is worth mentioning succinctly some theorists who set out to research the concept of comfort. Leininger and Watson consider comforting a component of caring, whereas Morse and Kolcaba agree that the nursing intervention is the act of comforting, and that *comfort* is the result of this intervention. For Morse, caring is a construct of *comfort*(1). The author focused his work on the *comfort* process, that is, on the actions of nurses, without referring to the evaluation of the results of these actions. Meanwhile, Kolcaba considers that the *comfort* process is only complete with the evaluation of results and, from this principle, created a medium-range theory in which the concept is operationalized(1).

Although the nursing work philosophy emphasizes customer satisfaction, and physical, emotional, spiritual,

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*RN.PhD student at the Graduate Program in Nursing and Biosciencesfrom the Federal University of the State of Rio de Janeiro – PPGENFBIO/UNIRIO. AssistantProfessorattheCenecistaCollegeofRio das Ostras – FACRO. Rio dasOstras, RJ, Brazil. E-mail: lidimoura@outlook.com.ORCID iD: https://orcid.org/0000-0003-3565-0567.

**RN. PhD in Nursing by the University of São Paulo – USP. Associate Professor in theDepartmentofFundamentalNursing/UNIRIO. Rio de Janeiro, RJ, Brazil. E-mail:luisolitrio@yahoo.com.br. ORCID iD: https://orcid.org/0000-0002-9725-4626.

***RN. Postdoctoral fellow at the Graduate Program in Nursing - PPGENF/UNIRIO.Adjunct Professor at the Nursing Department from the Fluminense Federal University– UFF. Rio das Ostras, RJ, Brazil. E-mail: thiagolouro@hotmail.com. ORCID iD: https://orcid.org/0000-0001-8371-628X.

****RN. PhD student at the PPGENFBIO/UNIRIO. Coordinator of the Undergraduate Nursing Course - UFF. Rio das Ostras, RJ, Brazil. E-mail: yonara.cristiane@hotmail.com. ORCID iD: https://orcid.org/0000-0002-6868-1629.

*****RN. PhD in Nursing by the Federal University ofRio de Janeiro - UFRJ.Coordinatorofthe PhD Program- PPGENFBIO/UNIRIO. Rio de Janeiro – RJ, Brazil. E-mail: proflyra@gmail.com.ORCID iD:https://orcid.org/0000-0001-9416-9525.

******RN. PhD in Nursing – UFRJ.Director of the Graduate School – UNIRIO. Rio de Janeiro, RJ, Brazil. E-mail: profunirio@gmail.com.ORCID iD: https://orcid.org/0000-0002-4327-6272.

and social well-being including that of the family and the appreciation fornursing professionals, we identified that the idea of *comfort*, in this case, goes far beyond the meaning of technical care.

Nursing care is made up of technical-scientific knowledge replete with rationality as well as actions of sensitivity, acceptance, compassion, and expressions of love for others. Hence, nursing care before the usual scientific basis may not always be sufficient to minimize the patient's sense of discomfort.

An environment of care configures a professional space where deep and meaningful relationships are established from one being to another. This environment emits an atmosphere rich in security, respect, zeal, knowledge, cherish, affection, understanding, tolerance, and love for people and the profession, resulting in confidence, security, and *comfort*.

Not to lose the focus of the essence of the nursing care in the aspect of assistance is fundamental because it is through care that the promotion of *comfort* is achieved, even if in many instances the patient may experience feelings of discomfort.

In an attempt to find a concept to accurately determine the idea of *comfort*, the nursing professional needs certain behavioral attributes to offer the comfort associated with technical-scientific knowledge, intuition, sensitivity, and emotion with excellence. Therefore, this professional must provide care based not only on the rational evaluation of the facts but also on the emotional perception of the context(4).

Consequently, we believe that the nursing care that values the client's subjectivity, considering himin hisindividuality, hisanguishes and concerns, obviously not disregarding the technical-procedural aspects, propitiates better-copingpossibilities forthe situation experienced and influences positively in the perception of *comfort*.

Thus, the present study was guided by the following question: Which factors associated with oncological clients under going an out patient chemotherapy treatment influence their perception of *comfort*?

The study is justified, considering the paucity of research that intends to evidence the perception of *comfort* by clients when submitted to cancer treatment, mainly in the process of infusion of anti neoplastic chemotherapeutics in an outpatient setting. Thus, this research stands out for showing how such a perception can help in coping with the disease and achieving good therapeutic results.

Fromthese findings, it is expected that the nursing team can better interpret the individual being cared for and, consequently, have the opportunity to plan the care to be implemented given the real needs of their clients, and to the detriment of the focus on mechanized procedures and routines.

Thus, it is worth ratifying that the objective of this study was to describe the factors observed inoncological clients in an outpatient chemotherapy treatment associated with the perception of *comfort*.

METHODOLOGY

In order to contemplate the proposed objectives, the methodological outline encompassed a descriptive study with a quantitative approach.

The scenario was one (01) outpatient unit of a private oncological health care clinic, located in the Lakes' Region of the State of Rio de Janeiro. The procedure was performed between February and July of 2015. This site was chosen based on the fact that it was the only institution in the municipality that had the service of anticancer chemotherapy.

The defined inclusion criteria were: clients who were under going chemotherapy in an out patient clinic, submitted or not to surgery, Portuguese speakers, literate, and with the cognitive ability to respond to the questionnaire. The sampling method used was the non-probabilistic or of convenience.

The instrument of data collection was composed of two parts: the first one with sociodemographic questions; and the second one with the application of the *Comfort* Evaluation Scale for Patients undergoing Chemotherapy (EACDQ)(5) based on the operational *comfort* model of Kolcaba.

The socio-demographic questionnaire was composed of 2 dichotomous questions, 2 of targeted choice, and 6 open questions.

The *Comfort* Evaluation Scale for Patients undergoing Chemotherapy (CESPC) was derived from the general *comfort* questionnaire validated by Gameiro and Apóstolo, consisting of 33 statements(4). The statements were presented as positive and negative (inverted items, questions 2; 5; 7; 8; 11; 15; 16; 17; 21; 22; 23; 24; 27; and 29). Each statement evaluated the *comfort* in a specific state and a specific context in order to consider all their domains and according to the taxonomic structure of *comfort* of Kolcaba.

The scale used was the Likert type in which participants assigned scores from 1 to 5 to the level of *comfort*/discomfort in each of the statements, varying as follows: 1 –It does not correspond to what happens to me/it is totally false; 2 - It corresponds a little to what happens to me; 3 - It corresponds fairly to what happens to me; 4 –It corresponds to a lot of what happens to me; 5 - It totally corresponds to what happens to me/it is totally true.

The maximum and minimum values of the scores for the 33 questions of the questionnaire were determined by the authors who developed the CESPC in order to measure total and partial *comfort* levels according to contexts and states and to facilitate data treatment and the correlation analys is between the characterization variables. The results were: a) Total *Comfort* = total *score*, sum of the 33 questions scores, varying between 33 and 165 (33 questions); b) Physical context, Psycho-spiritual context, and Social-cultural context = partial *score* varying between 9 and 45 (9 questions); c) Environmental context = in this context the *score* varied between 6 and 35 (6 questions); d) State of relief and State of tranquility = thes e*scores* varied between 12 and 60 (12 questions); and e) State of transcendence = the partial *score* for the physical context varied between 9 and 45 (9 questions).

Data were analyzed through descriptive statistics using central tendency and variability measurements, which were: mean(M), mode(Md), and standard deviation (SD).

The obtained data were compiled and analyzed with the help of the Microsoft Excel program.

The sample consisted of 30 clients assisted at the mentioned health unit, who authorized their participation by signing the Term of Free and Informed Consent - TCLE and according to Resolution 510/2016 of Directives and Norms Regulating Research Involving Humans of the National Health Council (CNS)(5). Thus, the ethical and legal precepts that circumscribe research involving human beings were met. It should be noted that this research was registered in the Brazil Platform after being duly approved by the Research Ethics Committee of the Federal University of the State of Rio de Janeiro under protocol CAAE: 38846514.9.0000.5285.

RESULTS

The sociodemographic analysis showed that out of 30 subjects, 70% (n = 21) corresponded to females and 30% (n = 9) to males. The group showed the mean age of 49.5 years with a standard deviation of 14.87;the minimum age was26 years, and the maximum age was79 years.

The most prominent diagnosis was Breast Neoplasia with 14 subjects, followed by Colon Neoplasia and Non-Hodgkin's Lymphoma with 3subjects each. Pancreas and Ovarian Neoplasia and Hodgkin's Lymphoma were present in 2 participants. One subject was identified in each of the following neoplasms: testicle, lung, uterus, and Ewing's sarcoma.

The time since disease diagnosis showed a mean of 21 months with a standard deviation of 31.61 and minimum of 2 and a maximum of 118 months.The time in chemotherapy treatment showed a mean of 17 months with a standard deviation of 27.70 and minimum of 1 month and a maximum of 118 months.

Table 1 shows the analysis of the total *comfort* level () through the types of context; we sought to verify in which contexts *comfort* levels were elevated.

The social-cultural context presented the highest mean among respondents (X=31.6, S=5.04), and the environmental context represented the lowest mean (X=17.2, S=3.45).

Tabela 1. Distribuição do *Conforto* Total estratificado por contexto. Rio de Janeiro, RJ, Brasil, 2018.

CONTEXT	MINIMUM	MAXIMUM	X	S
Physical	17	36	27,36	5,33
Psycho-spiritual	18	40	28,43	4,43
Environmental	10	25	17,26	3,45
Sociocultural	19	43	31,6	5,04

Source: the authors.

The maximum and minimum values, respectively 5 and 1, were observed in the descriptive analysis of the level of *comfort* for each of the 33 questions in the scale.

The results are presented as follows in relation to *comfort* contexts in which the analysis to ok into account that each of these contexts were presented through positive and negative questions, inversely proportional. Thus, it was consideredthat this wayit was possible to identify the *comfort* needs expressed by the subjects.

Table 2 presents the level of comfort in the physical context in which it can be verified that the highest means of negative questions were: Q2 "Nausea is difficult to bear" (X=2; Mo=2; S=1.17); Q8 "I avoid leaving the house due to changes in my physical appearance"

(X=2.2;Mo=1; S=1.51), and Q21 "I have a bad physical disposition that prevents me from resting" (X=2.4; Mo=1; S=1.52).

The lowest means were observed in the positive questions as: Q31 "I feel my body relaxed" (X=3.3; Mo=4; S=1.53); Q32 "At this moment I already feel with physical energy and vigor" (X=3.3; Mo=3; S=1.34); Q33 "I feel physically well" (X=3.4; Mo=5; S=1.5).

Table 2. Distribution of *Comfort* in the Physical Context segmented by questions in the EACDQ form. Rio de Janeiro, RJ, Brazil, 2018.

QUESTION	X	Mo	S
EACDQ 2	2	2	1,17
EACDQ 4	3,6	5	1,49
EACDQ 8	2,2	1	1,51
EACDQ 13	3,6	5	1,37
EACDQ 14	4,1	5	1,08
EACDQ 21	2,4	1	1,52
EACDQ 31	3,3	4	1,53
EACDQ 32	3,3	3	1,34
EACDQ 33	3,4	5	1,5

Source: the authors.

Table 3 presents the questions concerning the psycho-spiritual context in which we can highlight that the negative questions obtained the highest means: Q15 "The changes I have experienced make me afraid" (X=2.6; Mo=2; S=1.39) and Q29 "I am afraid of what might happen next" (X=2.6, Mo=2, S=1.54). Conversely, one positive question deserves to be highlighted: Q1 "I know that my discomfort is fleeting" in which a lower mean was observed(X=3.8, Mo=5, S=1.48).

Table 3. Distribution of comfort in the psycho-spiritual context segmented by questionsinthe EACDQ form. Rio de Janeiro, RJ, Brazil, 2018.

QUESTION	X	Mo	S
EACDQ 1	3,8	5	1,48
EACDQ 5	2,5	2	1,47
EACDQ 9	4,6	5	0,97
EACDQ 11	2,1	1	1,33
EACDQ 15	2,6	2	1,39
EACDQ 16	2,1	1	1,47
EACDQ 18	4,6	5	0,96
EACDQ 25	4,2	5	1,22
EACDQ 29	2,6	2	1,54

Source: the authors.

Table 4 shows that the comfort level for the environmental context presented a higher mean in the following negative question: Q7 "The noises disturb me" (X=2.3; Mo=1; S=1.62). In relation to the positive question, we highlight: Q20 "The smells no longer bother me" as the positive question that presented the lowest mean in this context (X=3.2; Mo=5, S=1.61).

Table 4. Distribution of comfort in the environmental context segmented by questions in the EACDQ form. Rio de Janeiro, RJ, Brazil, 2018.

QUESTION	X	Mo	S
EACDQ 7	2,3	1	1,62
EACDQ 17	1,6	1	1,37
EACDQ 20	3,2	5	1,61
EACDQ 27	1,6	1	1,28
EACDQ 28	4,3	5	1,15
EACDQ 30	4,7	5	0,84

Source: the authors.

Table 5 presents the comfort level in relation to the Sociocultural Context, whose means were above score 4 in all positive items. Q26 "The state of mind of the people around me gives me encouragement" (X=4.2, Mo=5; S=1.27) was the one with the lowest mean and with the greatest variance. However, the negative item Q24 "I feel dependent on others" (X=2.1; Mo=1; S=1.45)presented the highest mean.

Table 5. Distribution of *comfort* in the social-cultural context segmented by questions in the EACDQ form. Rio de Janeiro, RJ, Brazil, 2018.

QUESTION	X	Mo	S
EACDQ 3	4,3	5	1,18
EACDQ 6	4,3	5	1,24
EACDQ 10	4,7	5	0,84
EACDQ 12	4,6	5	0,73
EACDQ 19	4,8	5	0,73
EACDQ 22	1,7	1	1,3
EACDQ 23	1,9	1	1,59
EACDQ 24	2,1	1	1,45
EACDQ 26	4,2	5	1,27

Source: the authors.

DISCUSSION

In relation to the Physical Context, some authors point out that weight loss, associated with fatigue and weakness, frequently affects cancer patients(6-8).

Studies have linked fatigue to disease consequences that depend on treatment and timing of treatment. Some somatic mechanisms have been associated with fatigue such as malnutrition caused by anorexia, alterations in the metabolism, vomiting, diarrhea, and anemia, which can lead to fatigue during the day(7). Nausea and vomiting may occur hours after the chemotherapy session even with the use of anti-emetic medication because the cells of the gastrointestinal tract are affected. The severity of vomiting may vary depending on the medication and chemotherapy dose; in addition, its frequency can cause the patient to become anorexic and dehydrated(6), and to lose weight.

Fatigue is perhaps the most common and debilitating response to treatment in people affected by cancer because it interferes directly in the performance of day-to-day activities. When discussing the etiology of fatigue, the possibility of the influence of psychological factors is present, such as depression arising from daily concern with the fatality of the disease. Therefore, depression and fatigue can occur concomitantly(8).

The disease and the treatment are responsible for the pathological alterations in patients with malignant neoplasia because they reach the central nervous system at the center of hunger and satiety, which can stimulate food intake or inhibit hunger, and consequently, result in weight loss and weakness(6).

Positive body image was also highlighted by the research subjects as a necessity because cancer patients deal with changes in their appearance throughout the course of the disease and treatment. Surgery, hair loss, weight loss, and skin changes are some of the effects that may arise, threatening the self-esteem of these patients(9).

The human being, in planning his or her life, envisions a happy and promising future aiming for health and dynamism. However, when he finds himself inserted in a different reality that interferes with his vanity, autonomy, will to live, self-confidence, and above all, that causes significant changes in his body image, he feels defeated before the world(10).

Chemotherapy enhances the patients' ability to get on with life; however, the adverse effects are responsible for changes in bodies that result in changes in body image and self-esteem. Therefore, chemotherapeutic treatment can bring greater vulnerability to clients followed by conflicting feelings of pain, suffering, fear, frustration, anguish, and despair(9).

The cancer patient, when experiencing a disease that brings with it the concrete probability of death, has two paths open: to escape to oblivion, that is, to surrender to the disease and lose himself in daily banality; or imprint his power of transcendence upon the world and upon himself, assuming his authentic being in the world(7,11). Thus, to exist in the world with cancer is to walk a path that begins with the disease diagnosis and continues throughout life. Extending beyond the constraints of treatment time and space, it is a come and go process insearch of the hope of healing(11).

Suffering from cancer provides meanings of strength and weakness, vulnerability and determination, resignation and courage. In this condition, people turn to God for the first time, or more often than before, because they believe that He always helps(12).

The meaning that patients attribute for having experienced cancer, which brings them closer to God, also seems to suggest an increasing need or willingness to approach others, already meaning a form of coping(12). Therefore, the search for help and *comfort* by the patient in faith, if existing, should be encouraged because religion brings strength and courage to continue with the treatment and to follow on daily activities(12).

Living with cancer continues to be a significant social fact because it has evil connotations generating important changes in the patient's social relations and family dynamics(13). The patient and his family seek the support they need in their potentialities to move on with life and overcome the obstacles imposed by the disease.

The family is the main social institution in which the individual initiates his affective relationships, creates bonds, and internalizes values. This family relationship presents itself in an interconnected way as if it were an extension of one another(12). The emergence of a serious illness, responsible for changes in people's way of thinking, feeling, and acting makes the family support to intensify and be essential to the obstacles that may arise. Therefore, the constant presence and affection of family and friends make the patient with cancer feel not only their proximity but also their support. This narrowing of family ties encourages the patient, reducing the feeling of vulnerability and incapacity caused by the disease(12). Finally, the family's embracement of the individual with cancer is a fundamental element in the process of coping with the disease because it provides security to the patient, contributing to his self-esteem, self-confidence, physical recovery, and return to social activities(14).

Hence, the findings of the present study may allow nursing professionals working in the respective sector to rethink their behavior, and consequently, assist them in developing a more accurate look at the psycho-emotional changes in oncology patients. Definitely, these behaviors allow more efficiency in the care and favor the offer of care that provides comfort(15).

Faced with this perspective, the need for training and specialization of health professionals, especially nurses working in the area, is indisputable because the complexity of the chemotherapy treatment and consequences of adverse events require a more qualified practice in the oncological nursing care(16).

CONCLUSION

Cancer patients in outpatient chemotherapy treatment face alterations related to their physical appearance and psychosocial factors that affect their family as well.

Cancer, when diagnosed, is usually accompanied by physical symptoms and bodily and mental alterations that lead to a loss of autonomy, thus, generating dependence on someone on the part of the affected individual. This problem is very particular and requires care that meets the needs of patients.

In addition to the technical-scientific activities that permeate the professional nursing practice, the team must adopt aid measures to relieve anxiety, tension, fear, and anguish both for patients and their families. These factors directly influence the care process since they constitute important obstacles in the development of the nurse/client relationship.

Hence, we believe that nursing must provide holistic care using therapeutic tools to promote *comfort* and well-being. For this, care should include interventions in the context of physical alterations or symptoms in the management of emotions and preparation for routine changes and possible modifications in family and social roles, allowing the patient to adapt to a new condition of health and life.

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O CONFORTO SOB A PERSPECTIVA DOS CLIENTES ONCOLÓGICOS EM TRATAMENTO QUIMIOTERÁPICO AMBULATORIAL

RESUMO

A palavra *conforto* se faz presente no vocabulário dos profissionais de enfermagem durante seu processo de trabalho. Diante disso, objetiva-se, nesta pesquisa, descrever os fatores que interferem na percepção de conforto por parte de clientes oncológicos em tratamento quimioterápico ambulatorial. Esse estudo descritivo e quantitativo foi realizado em um ambulatório de assistência oncológica privada em saúde, situada na Região dos Lagos, no Estado do Rio de Janeiro. Para a coleta de dados, utilizou-se um instrumento composto por duas partes: questões sociodemográficas e a Escala de Avaliação de *Conforto* em Doentes a realizar Quimioterapia. Dos 30 entrevistados, 70% corresponde ao sexo feminino e 30% ao sexo masculino. O diagnóstico mais destacado foi a Neoplasia de mama. O contexto sociocultural apresentou a maior média entre os entrevistados (M=31,6; DP=5,048), e o contexto ambiental representou a média mais baixa (M=17,2; DP=3,453). Os pacientes oncológicos em tratamento quimioterápico ambulatorial enfrentam alterações relacionadas ao seu aspecto físico e a fatores psicológicos e sociais que afetam a pessoa doente e sua família.

Palavras-chave: Cuidados de enfermagem. Oncologia. Conforto do Paciente.

CONFORT DESDE LA PERSPECTIVA DE LOS CLIENTES CON CÁNCER SOMETIDOS A QUIMIOTERAPIA AMBULATORIA

RESUMEN

La palabra *confort* se hace presente en el vocabulario de los profesionales de enfermería durante su proceso de trabajo. Frente a esto, el objetivo de esta investigación fue describir los factores que interfieren en la percepción de confort por parte de clientes oncológicos en tratamiento quimioterapéutico ambulatorio. Este estudio descriptivo y cuantitativo fue realizado en un ambulatorio de atención oncológica privada en salud, ubicado en la *Região dos Lagos*, en el Estado de Rio de Janeiro-Brasil. Para la recolección de datos, se utilizó un instrumento compuesto por dos partes: cuestiones sociodemográficas y la Escala de Evaluación de *Confort* en Enfermos sometidos a Quimioterapia. De los 30 entrevistados, 70% corresponde al sexo femenino y 30% al sexo masculino. El diagnóstico más destacado fue la Neoplasia de mama. El contexto sociocultural presentó el mayor promedio entre los entrevistados (M=31,6; DP=5,048), y el contexto ambiental representó el promedio más bajo (M=17,2; DP=3,453). Los pacientes oncológicos en tratamiento quimioterapéutico ambulatorio enfrentan alteraciones relacionadas a su aspecto físico y a factores psicológicos y sociales que afectan a la persona enferma y a su familia.

Palabras clave: Atención de enfermería. Oncología. Confort del Paciente.

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Correspondig author: Thiago Quinellato Louro. Endereço: Rua Recife, Lotes 1-7 - Jardim Bela Vista, Rio das Ostras - RJ, CEP: 28895-532. Telefone: (22) 2764-9604. E-mail: thiagolouro@hotmail.com.

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