Original Article

Depressive Disorder: Subdiagnosis in Woman with Gynecological Neoplasms

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Abstract

Introduction: The cancer is one of the main causes of mortality in Brazil. In this ontext it has been noticed that the information about cancer diagnosis is a common medical practice which could imply in psychological, physical and interpersonal changes. Approximately 30% of the patients with cancer develop widespread apprehension, depression and mental disorder in the first year after the diagnosis. Therefore, it is important that the health professional has to be able to recognize these alterations and to conduct them better on the moment of diagnosis and the therapeutic options discuss. **Objective**: To evaluate female genital neoplasms diagnosis' impact in life of patients and their families. **Casuistic and methods:** Women with confirmed female genital neoplasms are submitted to a questionnaire to evaluate sociodemografics characters, impressions in the diagnosis' moment, health conditions, quality of life and depressive symptoms. **Results:** The serene feeling in the moment of diagnosis is requent in the major than 50 year old women (p=0002). The knowledge about their own illness is higher as higher is patient's school age (p=0013). A half of patients present depressive symptoms. There is no difference between the presence of symptoms and the time of diagnosis (p=0781), age (p=0711) and school age (p=0145). The more frequently doubts referred by patients are about disease's cure and its recurrence. **Conclusions:** The results suggest that women with female genital neoplasms are frequently committed by doubts and depressive symptoms that are rarely identified without appropriate instruments of evaluation. The health professional has to pay attention to the psychosocial aspect related directly with quality of life.

Keywords: Quality of Life, Depressive Disorder, Genital neoplasms, female.

Introduction

Cancer is among the principal causes of mortality in Brazil, currently representing the second cause of death in the country, surpassed only by cardiovascular disease. According to the Instituto Nacional de Câncer (INCA), 2008 estimates for the incidence of this disease in Brazil will be approximately 470,000 new cases per year, of which approximately 50,000 will correspond to new cases of breast cancer and 19,000 cases of uterine cervix cancer.[1] In the United States, these numbers are still greater. In 2004, estimates were for 1,368,000 new cases and 563,700 deaths. Estimates in the United States for 2008 are for 182,460 new cases of breast cancer and 40,100 new cases of uterine cancer with mortality of 40,480 and 7,470 deaths respectively.[2]

In the clinic of our institution, 65,520 women were attended during the period between 2000 and 2007. Within this universe, uterine cervix represented almost

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half of the sample (47%), followed by ovarian cancer (22%), endometrial cancer (14%) and other neoplasms as vulva and vagina that correspond to a total of 4% of the cases.

Thus, the revelation of the cancer diagnosis, although part of the medical routine and a complex and difficult situation, can be implicated in psychological, physical and interpersonal alterations, as well as affecting the symptoms, behavior, social relationships, prognostic and the self-perception of the patient and the attitudes of others.[3]

From the moment when the patient assumes that she can have cancer and makes the first contact with the doctor, a series of generally pessimistic reactions takes place with the patient and her family. These reactions are amplified and private while the cancer diagnosis is confirmed and the patient reaches an understanding in what is happening to make a necessary confrontation.[4]

The attitudes revealed by the patients are linked to the degree of instruction received, to the experiences lived and to the sociocultural context where they had grown. The personal experiences, the beliefs and the attitudes of the family interact among themselves, supplying a reference structure to make a decision during the process of the disease which includes adhesion to treatment.[5]

In accordance with the literature, around half the patients with cancer present some psychiatric disturbance. Depression is most frequent of these disturbances, present in about 25% of all the patients affected with some type of cancer.[6]

The adequate evaluation of the depressive symptoms in patients with associated clinical disease is made difficult by the overlapping of the same symptoms (fatigue, inappetence, pain, sleeplessness), as well as for the perception of the consequences of the condition. Intuitive criteria, as the disproportionate intensity of symptoms, await the clinical profile and the relation between the beginning of the depressive symptoms and the clinical pathology can induce errors, possibly delaying the diagnosis of depression.[7]

The difficulty in evaluating symptoms and defining the diagnosis of depression in these patients generate the necessity of defining criteria that define the question. The best approach for daily clinical practical is inclusive ,[7-8] where the depressive symptoms must be accounted for, independent if they are able to be explained by the base illness. This approach generates a greater number of diagnostic false-positives; however, it diminishes the risk of a slight symptomatic depressive condition going non-diagnosed.

Among the methods of depression evaluation, the Beck Depression Inventory (BDI) stands out. It is a questionnaire that consists of 21 items, whose intensity varies from 0 to 3, with the intention to detect and measure symptoms and attitudes that can be related to a profile of depression, including sexual interest.[9]

The BDI is probably the most widely used measure of self-report of depression in research as well as clinical practice,[10] having been translated in various languages and validated in different countries.

When compared with other clinical evaluations of depression, such as the Hamilton Rating Scale for Depression [11] and the Zung Self-Rating Depression Scale,[12] a high validity for psychiatric patients is realized, which represents a good method of tracking depressive symptoms. The Brazilian version was validated by Cunha et al.[13] in 1996, which demonstrated its psychometric properties of trustworthiness and internal consistency.

A controversial point would be what the BDI would really be measuring in samples without a previous diagnosis of depression. According to Gotlib,[14] in such samples, the BDI would be only one measure of general psychopathology. In accordance with Hill et al.[15] it would be evaluating specific aspects of depression.

Gorestein and Andrade[16] conducted two discriminating analyzes considering specific and non-specific items of depression, defined in accordance with Salamero et al.[17] a high index of correct classification for depressed subjects was observed on the basis of specific items and not depressed on the basis of non-specific items. These data, when compared with a larger index of incorrect classification on the basis of the non-specific items of depression, suggest that beyond general psychopathology, the BDI would also be measuring specific aspects of depression in this sample.

The effectiveness proven in the tracking of the depression is allied to its ease of application and understanding on the part of the interviewed subjects, making the Beck Depression Inventory an excellent option to investigate this illness in patients with cancer .[14-15,17]

These psychological disorders normally harm the quality of life of the patients concordant to the corporal modifications caused by the disease, symtomatology, alterations in social interaction and the family relationship.

Currently the involved psychosocial aspects in the context of gynecological cancer assumes great importance due to the greater diagnostic capacity and treatment success, resulting in increasing numbers of women who live with the disease[18-19] Thus, it is important that the health professional be able to recognize these alterations, as well as the defense mechanisms of the patients and their relatives, and be able to guide the patient the best way possible from the therapeutic options at the moment of diagnosis.[20]

The evaluation of the feelings that these patients

and relatives live with at the moment of diagnosis, as well as the impact they have in lifestyle, autonomy and perspectives, constitute an important material of study for health professionals, allowing a greater understanding of the universe in which the patient is encountered at the moment of the discovery of the disease and supplying important information that will result in basic benefit to the patient with gynecological cancer.

The primary objective of this work was to study the profile of patients with gynecological cancer in accompaniment in our oncology unit, with the intention to recognize the population in study and to plan an adequate approach for these patients.

The secondary objective was to evaluate the impact of the diagnosis of gynecological cancer and its repercussions in the life of these patients in respect to the frequency of the diagnosis of depression, through the Beck Depression Inventory.

Casuistry

The study, transverse in nature, was made through the application of a questionnaire to patients with a confirmed previous diagnosis of gynecological cancer. The work was previously approved by the Research Ethics Committee of the Institution and carried out between the months of August and September of 2008, in our ambulatory unit. Fifty-one women were interviewed, whose participation was voluntary after signing the terms of free and informed consent.

The sample was composed of 51 patients with gynecological cancer in diverse stages, with 17% of them (n=9) stage IV (with metastasis). The patients were divided into two groups, with group 1 consisting of patients submitted to chemotherapy or radiotherapy (n=33) and group 2 consisting of patients who had never submitted to any one of these therapeutic modalities (n= 18). Within group 1, the patients had been further subdivided into patients submitted to chemotherapy (n=19) and patients submitted to radiotherapy (n=25), with 11 patients submitted to both the configured treatments, in this second division, in the two subgroups.

Patient eligibility criteria included patient bearers of gynecological cancer, previous knowledge of the diagnosis and age superior to 18 years. Established exclusion criteria included period of cancer diagnostic investigation, previous diagnosis of psychiatric illness, previous or current use of antidepressants, pregnancy, breast feeding, bedridden, bearer of physical deficiency, bearer of other chronic non-transmissible illnesses and patients in menopause with the use of hormone replacement therapy.

No patient was in a period of chemotherapeutic or radiotherapeutic treatment at the time of the interview.

Methods

The analysis instrument consisted of a structured questionnaire of multiple choice questions, applied by a previously qualified interviewer, composed of the topics of sociodemografic information, time of diagnosis and state of health. Sociodemografic information consisted of age, marital status, profession and education. For the time of diagnosis topic, the patients were questioned as to the time of diagnosis, the way the cancer diagnosis had been disclosed to them, how they had felt when being informed, what was the biggest concern at that moment, with whom they understood better of the disease and if they would like to receive more information in respect to questions they would like to make to their doctor. The topic of state of health incorporated the name of the disease, the gravity of the disease, the considered state of health, if the patient had submitted to chemotherapy and/or radiotherapy, if the disease presented metastasis and what the expectation was in relation to treatment.

For the diagnosis of depressive symptoms, the Beck Depression Inventory (BDI) was used. The scale consists of 21 items that assess symptoms and attitudes. The items refer to sadness, pessimism, sense of failure, lack of satisfaction, sense of guilt, sensation of punishment, self-debasement, self-accusation, suicidal ideas, crises of crying, irritability, social withdrawal, indecision, distortion of the corporal image, inhibition for work, sleeplessness, fatigue, inappetence, weight loss, somatic worries and reduction of libido and sexual interest. All the questions were scored from 0 to 3, with the score grouped in accordance to the following division: 0 to 9 equal an absence of depressive symptoms, 10 to 15 equal light depressive symptoms, 16 to 23 equal moderate depressive symptoms and >23 equal serious depressive symptoms.

The collected data were tabulated in Excel spreadsheet software for Windows and confirmed by a second data entry keyer.

The analysis made was primarily descriptive, following the correlation between the sociodemografic data, time of diagnosis, state of health, lifestyle changes and depressive symptoms through the program Epi Info 6.04 with calculation of chi-square, Fisher´s exact test and chi-square with Yates´ correction for continuity when necessary, while the level of accepted statistical significance was $p<0.005$.

Results

General Information on the Participants

The study was composed of 51 women. The average age was 54.31 ± 14.77 years (varying from 26 to 80). The clinical and sociodemografic characteristics are presented in Table 1.

Time of Diagnosis

The time of diagnosis of the studied patients varied from 1 to 240 months with an average of 28.41 ± 44.33 months.

When being questioned on who had disclosed to them their cancer diagnosis, a near-unanimity (92%) affirmed to have been communicated to by their doctor. The predominant sensation at the moment of diagnosis disclosure was sadness (41%), 25% said to have had fear and 10% affirmed not to have believed at the first moment. Twenty-four percent of the patients considered themselves calm when receiving the diagnosis.

The feeling of "calm" was more prevalent in the patients with lower education, among the illiterate/low education group, 30% had felt calm, while only 17% of the patients of moderate/high education group had related this behavior. No patient below 50 years of age related to have felt calm at the moment of diagnosis disclosure, different than the patients above 50 years of age, in which this fact occurred in 39% of the cases. (Fisher <0.004)

The predominant concern at the moment of the diagnosis disclosure was with the husband and/or children (39%), followed by fear of dying (29%) while 27% related not to have worried.

Approximately two-thirds of the sample had related the necessity to receive more information in respect to the disease, while one-third (27%) related they had already possessed enough information, while 7.84%, even though were not considered informed, had related not to have interest in knowing greater details.

Almost half of the women (45%) related not to have doubts of the disease or its treatment. Of those who expressed doubt (55%), it was possible to group the questions in accordance with Table 2.

State of Health Related by the Patients

Of the total of 51 patients in the study, 37% did not know how to correctly inform the name of their disease, of these, 42% were considered well-informed or

Table 1 - Clinical and Sociodemografic Characteristics of the Women Studied

		N	%
Age			
	≤ 50 years	18	35.29
	>50 Years	33	64.71
Marital Status			
	Single	18	35.29
	Married	23	45.10
	Divorce/separeted	3	5.88
	Widowed	7	13.72
Education			
	Literatate/low	33	64.71
	moderate/High	18	35.29
Profession			
	In Home	27	53.00
	Activity outside of domicile	24	47.00
Time of Diagnosis			
	Up to 12 mnths	27	52.94
	More Than 12 months	24	47.06
Classification of disease			
	Simple	12	23.53
	Moderate	19	37.25
	Serious	20	39.22
Considered State of health			
	Good	27	52.94
	Moderate	20	39.22
	Bad	4	7.84
Help in daily activies			
	Yes	23	45.10
	No	28	54.90
Expectation in relation to treatment			
	Cure	38	74.51
	improvement	10	19.61
	Indifference	2	3.92
	Not Known	1	1.96
Future Perspectives			
	Hopelessness		
	Anger	1	1.96
	Fear of dying	3	5.88
	Hopeful	47	92.16
Scoring in BDI questionnaire			
	0-9 points	25	59.02
	10-15 points	13	25.50
	16-23 points	7	13.72
	24 or more points	6	11.76

Table 2 - Most Frequent Doubts in Women with Gynecological Cancer (n=28)

Question	%
Will the disease come back?	28.5
Will I be cured?	25.0
Can the disease spread?	10.7
What will the treatment be?	7.1
What are the consequences of the surgery?	7.1
What is the gravity of the disease?	7.1
How did this happen?	3.5
How will I follow?	3.5
Am I healthy?	3.5
How long will the treatment be?	3.5
Patients with doubts (n=28)	55.0
Patients who related they did not have doubts on the disease (n=23)	45.0

they would not like to know more on the subject.

The time of diagnosis and education was related to a greater knowledge of the disease, demonstrated in women diagnosed for more than 12 months (p=0.15) and with moderate/high education (p=0.0059).

The majority of the women (39%) classified their disease as serious, 36.5% considered it moderate and 24% as light. In spite of this, 53% considered their state of health as good, 39.2% as moderate and 7.8% as bad. Among the women who considered their disease serious, a greater frequency was verified of those with time of diagnosis above 12 months.

While questioned on metastasis, it was noted that 37% had not known how to give this information. Of all the women, 17% related to have metastasis, although 55% of them classified their disease as simple or moderate in the previous question.

The expectation in relation to treatment cure was 74.5%, while 19.6% related to only expect improvement in the quality of life and the remainder had no expectation or did not know how to relate.

Diagnosis of Depressive Symptoms

In accordance with the BDI, 49% (n=25) of the patients did not present depressive symptoms (0-9 points), 25.5% presented light depressive symptoms (10-15 points), 13.8% moderate depressive symptoms (16-23 points) and 11.7% serious depressive symptoms (more than 24 points).

Age and education did not influence the presence of depressive symptoms. The same can be observed in relation to the time of diagnosis and profession, even though these last ones can represent a factor of gravity when there is depression, a fact evidenced for greater frequency of serious depressive symptoms in these women when the same have manifested depression.

Among the symptoms most frequent cited by the 51 interviewed were: sleep alterations (53%), fatigue (65%) and weight loss (26%). These symptoms were more frequent in the patients who had presented metastasis or who previously had been submitted to chemotherapy or radiotherapy. Of the patients without metastatic disease and who had never submitted to these two therapeutic modalities, 28% related they had sleep alterations, 14% had complained of fatigue and none related weight loss. About 17% of the total of women related to present metastasis, with 78% of this group having presented some symptom of depression. When comparing the incidence of depression in patients with or without metastasis, a statistically significant difference was evidenced, revealing that symptoms of depression had been more frequent in patients with metastasis. (p=0.04) However, in spite of being more frequent in this group of women, the degree of depression did not manifest itself more serious than that in the group of women without metastasis.

With the intention to correlate depressive symptoms to an aggressive treatment, the patients were divided into two groups: group 1 consisted of patients who submitted to chemotherapy or radiotherapy (n=33) and group 2 included patients who never submitted to any one of these therapeutic modalities (n= 18).

Among the women who had submitted to chemotherapy, 73.68% (n=14) had presented signs of depression against 26.32% (n=5) who had not presented any symptoms. Among those who had never submitted to chemotherapy treatment, 62.5% (n=20) had presented no signs of depression, against 37.5% (n=12), that had manifested some sign. The greatest incidence of depressive symptoms in women submitted to chemotherapy revealed statistical significance (p= 0.02).

Among the women submitted to radiotherapy, 72% (n=18) had shown evidence of depression against 28% (n=7) in which depressive symptoms had not been evidenced. Among the women who had not made radiotherapy, 30.77% (n=8) related signs of depression while 69.23% (n=18) had denied any related symtomatology. In this subgroup, significant statistical difference was also observed in relation to depressive symptoms between the women submitted to radiotherapy and those who never had submitted to this treatment

(p= 0.05).

When we compare group 1 (patients submitted to chemotherapy or radiotherapy, n=33) with group 2 (patients never submitted to any one of these therapeutic modalities, n= 18), we observe that group 1 presented greater incidence of depression than group 2, with statistically significant difference. (p=0.00038). In group 1.69.7% (n=23) of patients presented signs of depression against 30.7% (n=10) who had not. In group 2, 83.33% (n=15) denied any suggestive symptom of depression against only 16.66% (n=3) that had related some sign. Still, as to group 2, all the cases where depressive symptoms had been related, the depression was classified as light, not having any case of moderate or serious depression.

Discussion

The diagnosis of cancer and the entire process of the disease are lived by the patient and their family as a moment of intense anguish, suffering and anxiety. Beyond the label of a painful and mortal disease, the patient commonly lives in the treatment, generally long, adverse losses and symptoms, causing loss in functional and vocational abilities and uncertainty as to the future .[21-22] In this context, gynecological cancer is presented in a unique way, in the measure where, associated to the stigmas of the disease and the aggressiveness of the treatment, attacking of reproductive organs that represents femininity and fertility. The concurrence of these factors has deep psychological implications in respect to corporal image, self-esteem and confidence in satisfying social relations in these patients.[23]

Currently, more than a definitive cure, patients with cancer are in search of guarantees of well-being and quality of life. In this situation, the disease and its treatment are great determinants of this well-being. It is known that the emotional repercussions for malignant disease can even exceed physical suffering.[24]

The adaptation of the patient to cancer is a continuous process of personal adjustments to a variety of factors associates to the disease. The disclosure of the diagnosis consists of an important event, and its approach, as well as the care taken at this moment, can reflect in the way as the woman faces her condition and determines the changes and the impact of the same in the life of this patient, enabling to still influence the effectiveness of the treatment. In our unit, 92% of the women received the diagnosis through the doctor, to whom this delicate roll falls.

In our study it was observed that the only variables that influenced the reaction at the moment of diagnosis had been age and education. As anticipated, the feelings most cited at this moment had been sadness and fear. The sensation of calm was more frequent in patients with more advanced age and those with lower education, allowing the inference that younger patients with a greater degree of instruction recognize cancer as a serious disease. With regard to age, the proximity with death must constitute a main determinative factor, which added to the other conditions associated to aging, such as greater physical debility, loss of loved ones and memories of an entire live lived, could lead to a better acceptance of the symptoms and the risk of death.

In what is referred to as the degree of education, it is possible that more educated women present a greater capacity to understand and to elaborate their proper emotions than women less educated, beyond possessing a greater capacity of understanding the process of the disease.

The family is constantly cited as a source of concern, mainly, the children. This point matches with data found in the literature, demonstrating that the reference of a woman is centered in the people near to whom she devotes herself almost entirely.[25]

Approximately two-thirds of the sample related the necessity and interest in receiving more information regarding the disease. However, about 8% of the patients revealed a preference in not receiving such information. Since the moment of the diagnosis disclosure, doctors must question their patients as to the more in-depth information they want to receive, taking care to ensure if this opinion if kept throughout the course of the disease.

The questions mentioned by the patients reflect the nature of the doubts of these women and in this study the most questioned point was to the real possibility of cure, also referred to as the greatest expectation in relation to the treatment for 75% of the patients interviewed.

When questioned as to the occurrence of metastasis, almost 40% had not known how to inform. Among the patients who had related metastasis, 55% had classified their disease as simple or moderate. Such a fact refers to the importance of the doctor´s role in supplying sufficient and relevant information to their patients, thus becoming capable to significantly participate in the decisions as to the conduction of the disease, in the measure which they desire.[5]

The majority of international studies reveal a prevalence of psychological morbidities associated to cancer that varies from 4.5% to 50%.[26-30] Authors as Ritterband and Spielberger [31] affirm that this prevalence

can reach 85% of oncologic patients. The psychiatric disorder that is more frequently associated with cancer is depression. The rates of depression can affect from 9 to 58% of the people with cancer diagnosis.[32-33]

In the present study it was noted that more than 50% of the women studied related depressive symptoms; the evaluated sample presenting a frequency equivalent to that related to in the literature. A majority of the patients did not consider their state of health as bad or relate it as a negative impact on their lives; however, after the application of the BDI, symptoms of depression had been diagnosed in many of them. Such a fact returns to a crucial question in the attendance of patients with this profile; the superficial approach of the repercussions of the diagnosis does not reflect the real psychological state of the woman. With the high prevalence of depression in patients with clinical disease of base, depression is still under-diagnosed and the treatment is not instituted correctly. Only 35% of the patients are adequately diagnosed and treated.[34]

Depression in this group of women when evaluated under the socioeconomic approach can be considered variable-independent; therefore, the majority of the comparisons among the variables (education, age, profession) did not obtain statistical relevance. According to Souza et al.,[35] the simple diagnosis of cancer is associated to the idea of sadness, less value, pessimism and death independently of the degree of education of the patient, quantity or quality of information received or time of diagnosis.

Searching for other variables that could have influence on the manifestation of depressive symptoms, we analyzed the frequency of these symptoms in patients with metastasis and patients submitted previously to chemotherapy or radiotherapy. The results disclosed a significant increase of the diagnosis of depression in patients with metastasis when compared with women with disease in initial stages, with $p=0.04$.

A still more significant difference, with $p=0.00038$, was observed in patients submitted to chemotherapy and/or radiotherapy in relation to those never submitted to any of these therapeutic modalities.

The resulting symptoms of advanced disease or aggressive treatment, as chemotherapy and radiotherapy, can provoke diagnostic confusion at the moment in searching for depressive symptoms. In this situation, it becomes difficult to determine if the symptoms mentioned by the patient are provoked by the base disease, for the treatment, or only for the depressive symptoms.

However, with the objective of tracking the occurrence of depression, the option for an inclusive approach (accounting for depressive symptoms independent of the cause of the same) appears more prudent while reducing the risk of not diagnosing a depressive condition slightly symptomatic. In this context, our results allow to infer that metastasis, chemotherapy and radiotherapy constitute important factors of risk for the development of depressive symptoms.

The present study was not proposed to evaluate alterations regarding the quality of life of patients with cancer, but to know that the perception of the patients regarding their proper quality of life is not determined only by the sequel of the disease and/or the treatment, but mainly for its personal history, familiar context, as well as social relations and professional profile[36-38]. here are indications that the patients that receive orientations from the moment of diagnosis disclosure, being alerted regarding the possible limitations in the long-term, possess greater possibilities of success when dealing with the sequel of the disease.[39-40] Moreover, psychosocial interventions, based in the preparation of the patients so they can manage their emotions and stress, as well as solving personal and sexual problems, demonstrate the improvement in the quality of life of patients with cancer.[41-42]

The importance of the association between depression and cancer justifies the necessity of constant monitoring for its detection. The present study corroborates evidence that the superficial analysis of the patient is not enough to evaluate their real psychological profile; the ways that routine medical consultations are currently conducted are probably not capable to identify such disturbances. To be possible to prevent psychosocial disturbances, as well as early detection and supplying necessary support, it is fundamental that the health professional does not lose of sight of the importance and high incidence of these manifestations, taking care to evaluate their patient overall, conferring adequate attention not only to the technical aspects but to all aspects of the disease process. In this context, the application of specific questionnaires for the detection of depressive symptoms must constitute a good method of tracking, serving as an important instrument in the complete approach of the patient with cancer.

Depression acts as a worsening factor in patients with other clinical illnesses. Studies have described greater mortality in elderly patients with chronic illness associated with depressive symptoms.[43-44] Patients

with clinical illnesses and depression present greater risk not to adhere to medical recommendations[45] and demonstrate a greater perception of inexplicable physical symptoms.[46] The presence of concomitant depression with cancer makes these two entities feed unto themselves, interacting to create a deteriorating situation, in a way that harms potential consequences, the efficient treatment of the depression are praised, as well as are the orientation in depressive symptoms without comorbidities.[8]

Nevertheless, the results of this work present the limitation of having been obtained in a sample from our unit, and it is possible that these coincide with other populations, constituting important information for all health professionals.

Conclusion

The present study related with the impact of the diagnosis of gynecological cancer made it possible for us to arrive at some conclusions:

First, when analyzing the profile of our study population, the importance was evidenced to question the patients as to the information they wish to receive, and, despite the choice made, the same must receive orientations and psychological preparation so that they can better deal with its condition and minimize the negative impact of the disease on their lives.

Moreover, observed in the analyzed sample was the occurrence of a subdiagnosis of depression that occurs daily in medical practice. Among the patients with depression, the presence of metastasis and the treatment with chemotherapy and radiotherapy constituted risk factors for the occurrence of depressive symptoms. The simple and efficient suggestion for resolution of this point is the application of specific questionnaires for depressive symptoms, such as the Beck Depression Inventory, with the objective of if tracking depression and identifying patients who need specialized aid.

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