

A voice in the discussion concerning causes for late diagnostics of cancer of the reproductive organ in women, based on the example of the Lublin Region

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Cancerous diseases are the second cause of deaths in Poland, which results primarily from the fact of their late detection and low effectiveness of treatment, despite a constant improvement in the situation [1]. The number of cases of cancer in Poland is still alarming. At present, approximately 120,000 cases are noted annually, and for many years this number has been growing more rapidly than the number of the population. Cancerous diseases are the cause of approximately 40% of deaths among females and 30% of deaths among males aged 45–64, i.e. at reproductive age [2].

Since 2007, the number of the reported cases of malignant cancer in females has been systematically increasing. In 2010, 70,024 new cases were reported among the population of males, and 70,540 in females. In 2010, standard morbidity rates were 254/10⁵ in males, and 205/10⁵ in females. Per 100,000 cases of diseases, 365 are due to malignant cancer [3, 4].

For many years, epidemiologists have been interested in the geographic distribution of the values of standardized morbidity and mortality rates due to cancer in Poland. The presently observed distribution fluctuates around the standard which has been in effect for over three decades. The Gdańsk and Poznań Regions are at the top of the list of regions according to the values of standardized morbidity rates due to malignant cancer (ICD-10 C00-D-09). The Lublin Region is placed in the middle of this list, preceding, among others, the Regions of Białystok, Warsaw, and Opole [4]. Analysis of the health situation of the inhabitants of the Lublin Region in recent years confirms the all-Polish problem in the control of cancerous diseases.

The Lublin region, located in the south-eastern part of Poland, occupies an area of 25,155 km², and is poorly populated and urbanized. It is a typically agricultural region with centres of food, engineering and chemical industries, and is a coal mining area. In 2010, the population of the Region was 2,151,895 inhabitants – 1,042,109 males and 1,109,786 females [3].

During the same period, i.e. in 2010, in the Lublin Region more than 8,000 new cases of malignant cancer were registered – 3,888 among females. Compared to the previous decades, this number increased and came close to the number noted during the same period among males. Deaths due to cancer more frequently occurred in males; however, among the population aged 40–44, approximately 60% of deaths concerned females [3, 4, 5].

According to the incidence of cancer among females in 2010, as well as in previous years, in the Lublin Region there dominated breast, gastrointestinal, genital organs and lung cancers. Among cancers of the female reproductive system, endometrial cancer occupied the first position – 7.2% of cases (n=278), followed by ovarian cancer – 5.7% (n=222), and cervical cancer – 5.0% (n=184) [3, 4].

An increase was observed in standardized morbidity rates due to endometrial cancer from about 9/100,000 in 1990 to over 14/10,000 in 2010, which is a growth of more than 80%. A lower intensity of the growth trend was observed for ovarian cancer (from 10/100,000 in 1989 to nearly 13/100,000 in 2010 – a growth of more than 25%). In 2010, a decrease was noted in standardized morbidity rates due to cervical cancer (from 13.2/100,000 in 1989 and 13.0/100,000 in 2008, down to 8.2/100,000 in 2010). However, this may be a misleading phenomenon in the evaluation of the exposure to this type of cancer occurring among the population of women in the Lublin Region, because this growth was accompanied by an increase in the number of registered cases of this cancer *in situ* (D06) (66 cases in 2010; standardized morbidity rate 5.2/100,000 women). While analyzing the total number of invasive (C53) and non-invasive (D06) cases of uterine cancer, this location would be placed in the sixth position among the most frequent cancers in females [3].

Generally, in Poland, a slow downward tendency in morbidity due to this type of cancer has been observed; nevertheless, according to the data by the National Cancer Register, among Polish women, mortality due to cervical cancer still remains one of the main oncologic problems, despite the possibility of diagnosing the disease at its early stage [2, 3].

Analysis of the relevant literature allows the presumption that for many years, there have contributed to the present epidemiological situation, among other things, the unsolved problem of late oncologic diagnostics and insufficient involvement of women in preventive actions. This situation still maintains itself and, to some extent, is independent on actions undertaken within the National Health Programme, which has been functioning from 1996 until today – on one its strategic goals focused on malignant cancer control, as well as of the National Cancer Control Programme [1, 2, 3].

For many years, in many countries (Australia, USA and the countries of the so-called 'old' European Union) this problem has been systematically limited by mass prophylactic actions carried out at all levels of prevention, as well as studies of personal patterns of behaviours in the area of health [6, 7, 8, 9], and the results of these studies were used while developing promotion and prophylactic actions.

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In order to achieve an effect in the form of the improvement of the effectiveness of cancer prevention, it is necessary to initiate and consistently conduct studies concerning the justification, methodology, and validity of preventive actions addressed to individual groups of addressees functioning in various local communities. This paper is an attempt to initiate discussion concerning the causes of late diagnostics of cancerous diseases, and the conditioning of insufficient health awareness, as well as health threatening behaviour patterns of the population to whom preventive actions are directed.

The paper contains extracts from studies of complex causes for late diagnostics of cancer among inhabitants of the Lublin Region. Among the detailed goals of the study undertaken was recognition of the subjective assessment by oncologically ill women of the reasons for their late diagnosis of cancer of the reproductive system. An attempt was also made to display the problem of late oncologic diagnostics from the perspective of a patient, and also to indicate the conditioning of the problem, which is important from the point of view of organizers of health care – mainly in the area of cancer prevention and its early diagnostics by means of screening tests.

The study group consisted of 130 women living in the Lublin Region who were receiving oncologic care, with the diagnosis of malignant cancer of the reproductive organ (cervical or endometrial cancer) in the late stage of the disease. The study was conducted by the method of a diagnostic survey, using a standardised questionnaire form designed for the purpose of the study. The study was of an environmental character and was an element of nursing diagnosis performed by primary health care nurses employed in the regions of the patients' residence. The place of permanent residence was the key variable considered in the analysis of the causes of late cancer diagnostics in the light of the opinions collected.

In the relevant literature, such an approach to the problem has not been found. Despite this, the results may be compiled with the reports by researchers dealing with the causes of low rate of participation of women in prophylactic examinations, and those who study inequalities in the access to health care in rural and urban areas.

The results obtained allowed identification of the conditioning of the causes of late oncologic diagnostics among women living in rural areas, which may help in indicating the directions of actions on behalf of the improvement of effectiveness of cancer prevention.

Clear differences were observed in the perception of the reasons for late diagnosis of the cancerous process between women from the urban and rural environments. Such differences were also indirectly indicated by other researchers dealing with the analysis of the causes for low participation rates of women in prophylactic examinations [10, 11, 12, 13]. Irrespective of the confirmation of the importance of the environment of residence for the differences in the perception of the causes of late cancer diagnostics, the low level of oncologic awareness of the women examined is alarming. In a group of the four most frequently reported causes, three were related with the health awareness of the women (deficit or low level of knowledge concerning the prevention of cancer and alarming symptoms, lack of awareness of the risk of a cancerous disease and late reporting to a gynaecologist). These causes were mentioned despite the fact that 43.1% (n=56) of respondents admitted that in their close family environment there was an oncologically ill person, most often

due to cancer of the reproductive system. The results obtained fully confirm the studies by other researchers from Poland and worldwide [7, 10, 14, 15]. It seems that the presence in the closest environment of a person ill with cancer does not result in an increase in knowledge, and may even contribute to resignation from preventive actions because of fear of unfavourable diagnosis.

In own studies, fear of diagnosis constituted an important cause of late cancer diagnostics among the women examined – who unfortunately were already ill. The results obtained indicate that it is necessary to place an emphasis on health education from the aspect of an individual and society, with consideration of the conditionings of the life environment.

Among the causes of late diagnosis of cancer, both rural and urban women frequently mentioned late detection of cancer by a physician '*despite regular visits*', and – more rarely – lack of interest of other physicians in the health of a woman. However, only rural women selected the survey item '*lack of trust in physicians*'.

These results show the necessity for thorough observance of the standards of oncologic prophylaxis by gynaecologists and physicians of other specialties, as well as the necessity for improvement in the accessibility to physicians among rural women. Many researchers also highlight this problem in their reports [10, 14, 16].

The assumptions of the National Cancer Control Programme assign to the occupational group of physicians a task which is difficult to handle independently – improvement of the health situation in the area of cancerous diseases. It seems that without professional support by other occupational groups which contribute to this area of health of the Polish population, the performance of this task will encounter many difficulties. American studies carried out in a group of Latin women, inhabitants of the frontier areas of the USA and Mexico, present measurable benefits from the introduction into prophylactic actions of parties providing educational services in the area of oncologic practice other than physicians [17]. Therefore, this confirms the need for the division of tasks in the domains of prophylaxis, diagnostics and oncologic treatment, in accordance with the competences of health care system professionals [14, 18].

The fact of occurrence, mainly in the group of rural inhabitants, of the cause of late cancer diagnostics defined as '*lack of partner's consent for visits to a gynaecologist*' is noteworthy. The cause formulated in this way may indirectly indicate a profound deficit of knowledge concerning cancer prophylaxis among the partners of the women in the study [19, 20], but also on the disturbed process of interpersonal communication and cultural stereotypes deeply rooted in the environment of a respondent's life, which requires further analyses.

More than 30% of rural women indicated the male gender of the physician and lack of choice of a doctor close to their place of residence as important causes for late cancer diagnostics. The male gender of a gynaecologist – however, more rarely than in rural women – contributed to postponing the decision to visit a gynaecologist by women living in urban areas. This fact may have been due to easier access to a wider circle of specialists of both genders in the urban than rural areas. Also, other researchers highlight the fact that male gender of a gynaecologist hinders women in the systematic participation in gynaecological prophylactic examinations [21].



Self-examination of the breast once a month was admitted by 33.1% (n=43) of respondents, more than a half of whom were urban inhabitants. According to most of the reports analyzed dealing with the presented problem, urban inhabitants are more engaged in actions on behalf of own health, compared to rural women. This fact, comprehensively confirmed in the relevant literature, should constitute a basis for the differentiation of actions planned in the area of oncologic diagnostics for recipients from the rural and urban areas [18, 22].

Analysis of the subjective opinions expressed by women concerning the cause for late oncologic diagnostics is a valuable source of information concerning the social, individual, environmental and organizational reasons for the unsatisfactory effects of oncologic prophylaxis and early diagnostics.

Analysis of the relevant literature shows that it is effective to conduct population studies in order to detect oncologic problems, provided, among other things, that they are performed with an adequate frequency, which would allow diagnosis of the disease at an early stage, and with the informed participation of the recipients. In other cases, individual screening tests will not achieve the intended goals, because their success is combined with the conscious participation of the women in oncologic prevention. In Poland, insufficient emphasis is still placed on shaping the health promoting behaviours of society, which is translated into low health awareness [10, 18, 23].

CONCLUSIONS

Place of residence diversified opinions concerning the causes for late cancer diagnostics, and should be considered at the stage of developing educational programmes.

Oncologic awareness of women already ill with cancerous diseases – irrespective of the local environment in which they lived – did not constitute a basis of adequate behaviours accompanying an early cancer diagnostics. This confirms the necessity for studies of effective instruments for increasing the level of this awareness, especially in the population of the healthy.

The collected opinions indirectly indicate the poor organization and effectiveness of actions within the programmes of prevention of cancerous diseases in the rural than in the urban areas.

The data obtained confirm the necessity for further studies concerning late diagnostics of cancerous diseases, with the consideration of the specificity of the place of residence, and availability of oncologic care in this environment, health awareness of its inhabitants, and use of professional educators who would reinforce the intellectual potential of the members of local environments and, therefore, increase the effectiveness of preventive actions.

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