ISSN 1695-6141
Revista electrónica trimestral de Enfermería
Nº58
Abril 2020
www.um.es/eglobal/

ORIGINALES

Profile of the patient with gastric cancer of the National Cancer Institute

Perfil do paciente com câncer gástrico do Instituto Nacional do Câncer

Perfil del paciente con cáncer gástrico del Instituto Nacional del Cáncer

Sonia Regina Aguiar Souza Springer[1]
Maria Teresa dos Santos Guedes[2]
Osnir Claudiano da Silva Junior[3]
Mônica de Almeida Carreiro[4]
Alexandre Souza da Silva[5]

[1] Nurse at the National Cancer Institute. Master's student, Graduate Program in Health and Technology in Hospital Space, Federal University of Rio de Janeiro State (UNIRIO) and Member of the Board of the Brazilian Society of Oncological Nursing (SBEO). Brazil. SSpringer@inca.gov.br.
[2] Nurse of the National Cancer Institute. Master in Nursing from UNIRIO. PhD student of the Graduate Program in Biosciences and Nursing at UNIRIO.Brazil.
[3] Nurse. Doctor of Nursing. Postdoctoral Internship at IMS / UERJ. Degree in History from the Bennett Methodist Institute / 2008 and Master in Education / UNIRIO / 2012. Full Professor at the Federal University of Rio de Janeiro State (UNIRIO). Brazil.
[4] PhD in Nursing from UFRJ / Anna Nery School of Nursing Professor of the Graduate Program in Health and Technology in Hospital Space - Professional Master - UNIRIO. Brazil.
[5] Professor at the Federal University of Rio de Janeiro State (UNIRIO). Brazil.

https://doi.org/10.6018/eglobal.373021

Received: 23/04/2019
Accepted: 9/08/2019

ABSTRACT:

Objective: Search and analyze the profile of patients with gastric cancer enrolled in the National Cancer Institute, José de Alencar Gomes da Silva (INCA), and the most prevalent nursing diagnoses.
Methodology: A sectional study developed at the Cancer Hospital I - INCA, approved by CEP-INCA, with a sample of secondary data from 649 patients admitted from October 1, 2015 to April 18, 2018. Data were analyzed by R® software - version 3.4 .4. In the Chi-square, Kruskal-Wallis and Wilcoxon tests. The level of significance of 5% was adopted.
Results: The average age was 62.74 years, ranging from 21 years to 96 years. 35.29% of patients had advanced disease. Low adenocarcinoma was the most prevalent (42.52%). Signal ring cells were present in 32.05% of the patients. The diffuse type was highlighted (17.72%). There was predominance of involvement of the middle third of the stomach (29.74%). Hypothesis tests have shown that the staging versus death and color versus death variables maintain a relationship of dependence. The variables age versus death and age versus the presence of the Sinete ring present a distinct distribution among them, which means that the first variable can influence the second. The most prevalent nursing diagnoses were present in 100% of the sample and were in congruence with the profile of the clientele identified.

Conclusion: The epidemiological profile of a population is of great value to guide the health policies of a country, to the internal institutional planning and to guide the assistance actions of the multiprofessional teams.

Key words: Gastric neoplasms; Nursing Oncology; Ambulatory care; Epidemiological studies; Nursing diagnosis; Nursing.

RESUMO:

Objetivo: Levantar e analisar o perfil dos pacientes com câncer gástrico matriculados no Instituto Nacional de Câncer José de Alencar Gomes da Silva (INCA), e os diagnósticos de Enfermagem mais prevalentes.
Metodologia: Estudo seccional desenvolvido no Hospital de Câncer I – INCA aprovado pelo CEP-INCA, com amostra de dados secundários de 649 pacientes admitidos entre 01 de outubro de 2015 à 18 de abril de 2018. Os dados foram analisados pelo software R® – versão 3.4.4. Nos testes Qui-quadrado, Kruskal-Wallis e Wilcoxon. Foi adotado o nível de significância de 5%.
Resultados: A média de idade foi de 62.74 anos, variando de 21 anos até 96 anos. 35.29% dos pacientes apresentavam doença avançada. O adenocarcinoma pouco diferenciado foi o mais prevalente (42.52%). Havia células em anel de sinete em 32.05% dos pacientes. Destacou-se o tipo difuso (17.72%). Houve predomínio do comprometimento do terço médio do estômago (29.74%). Os testes de hipóteses demostraram que as variáveis estadiamento *versus* óbito e cor *versus* óbito mantêm uma relação de dependência. As variáveis idade *versus* óbito e idade *versus* presença de anel de Sinete tem distribuição diferentes entre si, o que significa que a primeira variável pode influenciar a segunda. Os diagnósticos de enfermagem mais prevalentes estiveram presentes em 100% da amostra e encontravam-se em congruência com o perfil da clientela identificada.
Conclusão: O perfil epidemiológico de uma população é de grande valia para orientar as políticas de saúde de um país, para o planejamento interno institucional e para nortear as ações assistenciais das equipes multiprofissionais.

Palavras-chave: Neoplasias gástricas; Enfermagem Oncológica; Assistência ambulatorial; Estudos epidemiológicos; Diagnóstico de Enfermagem; Enfermagem.

RESUMEN:

Objetivo: Levantar y analizar el perfil de los pacientes con cáncer gástrico matriculados en el Instituto Nacional del Cáncer José de Alencar Gomes da Silva (INCA), y los diagnósticos de Enfermería más prevalentes.
Metodología: Estudio seccional desarrollado en el Hospital de Cáncer I - INCA aprobado por el CEP-INCA, con muestra de datos secundarios de 649 pacientes admitidos entre el 1 de octubre de 2015 al 18 de abril de 2018. Los datos fueron analizados por el software R® - versión 3.4.4. En las pruebas Chi-cuadrado, Kruskal-Wallis y Wilcoxon. Se adoptó el nivel de significancia del 5%.
Resultados: El promedio de edad fue de 62.74 años, variando de 21 años hasta 96 años. 35.29% de los pacientes presentaban enfermedad avanzada. El adenocarcinoma poco diferenciado fue el más prevalente (42.52%). Había células en anillo de sello en el 32.05% de los pacientes. Se destacó el tipo difuso (17.72%). Hubo predominio del compromiso del tercio medio del estómago (29.74%). Las pruebas de hipótesis demostraron que las variables de estadificación frente a la muerte y el color frente a la defunción mantienen una relación de dependencia. Las variables edad versus óbito y edad versus presencia de anillo de Sinete tienen distribución diferente entre sí, lo que significa que la primera variable puede influenciar la segunda. Los diagnósticos de enfermería más prevalentes estuvieron presentes en el 100% de la muestra y se encontraban en congruencia con el perfil de la clientela identificada.
Conclusión: El perfil epidemiológico de una población es de gran valor para orientar las políticas de salud de un país, para la planificación interna institucional y para orientar las acciones asistenciales de los equipos multiprofesionales.
Palabras clave: Neoplasias gástricas; Enfermería Oncológica; Asistencia ambulatoria; Estudios epidemiológicos; Diagnóstico de Enfermería; Enfermería.

INTRODUCTION

In Brazil, cancer is recognized as a public health problem - given its epidemiological, social and economic magnitude - being the second leading cause of death from the

disease in the country [1]. Brazil is undergoing demographic and epidemiological transition processes that have produced important changes in the profile of diseases that affect the population [2]. Infectious and parasitic diseases are no longer the leading cause of death, being replaced by diseases of the circulatory system and neoplasms [1].

The estimate for Brazil, in the 2018-2019 biennium, points to the possibility of about 600,000 new cases of cancer. This data reinforces the magnitude of the problem in the country, especially when it is estimated that by 2060 the Brazilian population will be 218.2 million. Worldwide, in 2012, the estimate indicated 14.1 million new cancer cases and 8.2 million deaths [2-4].

In most developed countries, the types of cancer associated with urbanization and development such as lung, prostate, female breast and rectum predominate. In the middle and low developing countries, cancer associated with infections such as cervix, stomach, liver is still high, which despite a lower incidence, mortality represents almost 80% of cancer deaths worldwide [4,5].

Gastric cancer, although incidence rates have declined in many countries, is still the second most common cause of cancer death worldwide and the fourth in incidence. This cancer in other countries such as the United States and England has declined, while in Latin American countries such as Chile, Costa Rica and Colombia, the incidence and mortality rates are higher. The largest number of cases is in Japan with an average of 780 patients per 100,000 inhabitants [2, 5-7].

The present study focuses on stomach cancer due to its high morbidity and mortality. The number of Brazilians diagnosed with gastric cancer is high, making it the fourth malignant tumor among men and the sixth among women. In Brazil, for each year of the 2018-2019 biennium, it is estimated that 13,540 new cases of this disease appear among men and 7,750 in women [4].

Gastric cancer has a very heterogeneous etiology, including consumption of foods rich in sodium, nitrate and nitrites that become nitrosamines with direct mutagenic properties, Helicobacter pylori bacterium infection involved in 60% of gastric adenocarcinomas, low fiber, vitamin and salt diet. minerals from fresh fruits and vegetables, alcohol consumption in large quantities, and tobacco. Also, high body mass index, increased abdominal fat and physical inactivity are associated with the development of gastric cancer [8].

Lower socioeconomic status, measured through education and income, has been strongly associated with twice the risk for developing gastric cancer in both high-risk and low-risk countries. The factors of this association are mainly attributed to the low socioeconomic condition, which increases the likelihood of H. pylori transmission and reinfection in households in large families with poor sanitation and less frequent use of antibiotic therapy. In addition, low socioeconomic status may indicate poor access to health services and reduced diet in fiber, vitamins and minerals [9,10].

The production of scientific knowledge about gastric cancer and nursing care for this patient profile is still scarce in Brazilian nursing. Thus, this study is timely and relevant. In view of the above, a study was carried out to survey and analyze the profile of patients with gastric cancer enrolled at the José Alencar Gomes da Silva National Cancer Institute (INCA), the most prevalent nursing diagnoses identified during the

consultation, at the Cancer Hospital I (HCI), outpatient abdomen, from October 1, 2015 to April 18, 2018.

METHOD

This is a cross-sectional study, which is characterized by the direct observation of a certain number of individuals at a single opportunity, obtaining various information in order to establish association or correlation relationships between the characteristics investigated. The study was developed at INCA / HC I, Abdominopelvic Surgery Section, where gastric cancer patients are enrolled and treated.

The study sample consisted of secondary data from medical records of 649 patients who are followed by the Gastric Cancer Study and Treatment Group - INCA.

Eligibility criteria were: patients with gastric cancer enrolled at INCA, aged over 18 years, with study variables recorded in physical or electronic medical records, from October 1, 2015 to April 18, 2018. The choice The temporal cutoff was due to the availability of information in the database of the Study Group and Treatment of Gastric Cancer - INCA, which optimized the time spent in collecting data from the cases to be studied.

The study variables were organized and entered into a Microsoft Excel® 2007 spreadsheet, namely: gender, color, age, histopathological type, smoking, alcoholism, tumor location, TNM 7th staging, presence of H. pylori, presence of cells. signet ring, Lauren classification, date of death, nursing diagnosis of the host consultation. The R® software - version 3.4.4 was used for statistical analysis of the data.

Descriptive and inferential statistical analysis was performed. The results were presented using descriptive measures of central tendency as mean and median and standard deviation, absolute and relative frequencies. For the normal or non-normal distribution test, the Shapiro-Wilk test was used, which directed the choice of nonparametric tests. For the hypothesis tests, the chi-square test ($\chi 2$), the Kruskal-Wallis test and the Wilcoxon test were used. In the application of statistical tests, it was adopted as a significance level of 5%, being considered significant the p-value of 0.05.

The research project was analyzed and approved by the INCA Ethics and Research Committee (CEP-INCA), under the number 11141412.0.0000.5274, and waiver of the consent form is allowed because it is collection and analysis of secondary data. In order not to allow the identification of individuals, confidentiality of the collected data was safeguarded, being anonymously analyzed and presented in aggregate form.

RESULTS

The study sample consisted of data from 649 patients with gastric cancer enrolled at INCA. The mean age of the group was 62.74 years, ranging from 21 to 96 years (median = 64; SD = 12.84), with 44.22% (n = 287) still in productive age.

Table 1. Frequency distribution related to the personal characteristics of patients with gastric cancer enrolled at INCA, from October 01, 2015 to April 18, 2018 (n = 649).

VARIABLE	N	%
Gender		
Female	257	39.60
Male	387	59.63
Not informed	5	0.77
Age		
21 to 65 y.o.	287	44,22
66 to 96 y.o.	362	55,78
Color		
White	185	28.51
Brunette or brown	342	52.70
Black	104	16.02
Not informed	18	2.77
Total	**649**	**100**

Source: Gastric Cancer Study and Treatment Group Database - INCA.

Regarding gender distribution, 59.63% of the patients were male and 39.60% female (Table 1). Most patients were brown (52.70%).

Table 2. Frequency distribution of clinical characteristics of gastric cancer patients enrolled at INCA, from October 1, 2015 to April 18, 2018 (n = 649).

VARIABLE N%	**N**	**%**
Smoking		
Yes	365	56.24
No	248	38.21
Not informed	36	5.55
Ethylism		
Yes	390	60.09
No	220	33.90
Not informed	39	6.01
H. pylori		
Yes	117	18.03
No	207	31.90
Not informed	325	50.08
Histopathological Type		
Poorly differentiated adenocarcinoma	276	42.52
Moderately differentiated adenocarcinoma	181	27.89
Well-differentiated adenocarcinoma	33	5.08
GIST	4	4.16
TNE	18	2.77
Lymphoma	29	4.47

Melanoma	1	0.15
Not informed	84	12.94
TNM Staging 7th Edition		
Tis	3	0.46
Ia	16	2.47
Ib	10	1,54
IIa	24	3.70
IIb	15	2.00
IIIa	18	2.77
IIIb	23	3.54
IIIc	35	5.39
IR	229	35.29
Not applicable	17	2.62
Not informed	261	40.22
Tumor Location		
1/3 Proximal	17	2.62
1/3 Average	193	29.74
1/3 Distal	147	22.65
1/3 Proximal + 1/3 Medium	18	2.77
1/3 Proximal + 1/3 Distal		
1/3 Medium + 1/3 Distal	113	17.41
3/3 of the Stomach	30	4.62
Not informed	130	20.03
Lauren's classification		
Fuzzy Type	115	17.72
Intestinal Type	89	13.71
Mixed Type	13	2.00
Not applicable	58	8.94
Not informed	374	57.63
Presence of Signet Ring Cells		
Yes	208	32.05
No	14	2.16
Not informed	427	65.79
Death		
Sí	296	45.61
No	353	54.39
Total	**649**	**100**

Source: Gastric Cancer Study and Treatment Group Database - INCA.

As shown in table 2, most were smokers (56.24%) and alcoholics (60.09%). H. pylori was not reported in 325 cases (50.08%). Poorly differentiated adenocarcinoma was the most prevalent histological type (n = 276; 42.52%). There were signet ring cells in 208 cases (32.05%), but in 427 cases (65.79%) there was no record. Regarding Lauren's classification for histological aspects, we highlight the diffuse type (n = 115; 17.72%), the intestinal type (n = 89; 13.71%) and not informed (n = 374; 57.63%). Regarding TNM staging of the disease, 305 patients had advanced disease (stages III

to IV). Regarding the region affected by the stomach tumor, there was a predominance of the middle third of the stomach in 193 patients (29.74%), followed by the distal third in 147 patients (22.75%). Regarding death, 296 patients (45.61%) died during this period.

Table 3. Statement of chi-square test results (χ2) applied (p-value <0.05).

X^2Test (p-value)						
	Gender	**Color**	**Death**	**LHP**	**Smoking**	**Ethylism**
Gender	*	*	*	0.08031	*	*
Color	*	*	0,002494	0,528	*	*
Tumor Site	0,7919	0,06769	0,2094	*	0,3765	0,9618
Death	0,05605	*	*	*	*	*
Staging	0,175	0,1962	p< 0,01	*	0,5263	0,4384

*Not relevant or duplicate

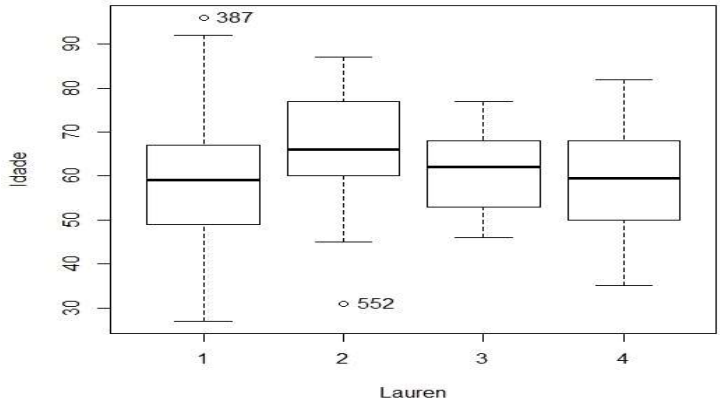
As shown in table 3, the χ2 test was performed, and it was observed that tumor staging is independent of gender, color, alcoholism and smoking and has a dependence relationship with death. It was also found that the tumor site is independent of gender, color, alcoholism and smoking. Death, however, is independent of gender, but dependent on color. And histopathological diagnosis is independent of color and gender.

Table 4. Statement of Wilcoxon test results applied (p-value <0.05).

Wilcoxon test (p-value)			
	Death	***H. pylori***	**Signet Ring**
Age	0,0001447	0,9228	0,0384

Through the Wilcoxon test, it is verified that there is a different distribution between the age variable and the death variable (p-value = 0.0001447), thus, the first influence on the second one; Between the variable age and the variable H. Pylori infection the distribution is equal (p-value = 0.9228), so there is no influence of one in relation to the other. Between the age variable and the presence of Signet Ring variable, the distribution is different (p-value = 0.0384), thus, the first influence on the second.

Graph 2. Boxplot of variable age X Lauren classification



The reading of graph 2 allows us to affirm that age directly influences the type of tumor according to the Lauren Classification, being the median age located between 60 and 65 years, approximately.

Table 5. Statement of Kruskal-Wallis Test results applied (p-value <0.05).

	Kruskal-Wallis test (p-value)			
	TU Site	Staging	Lauren	Histopathological
Age	0,4889	0,00335	0,00000639	0,000006922

When performing the Kruskal-Walllis test shown in Table 2, it appears that the age variable has equal distribution only as the local tumor variable, thus, it is noted that the first variable has no influence on the second. In addition, the age variable has a different distribution in relation to the other variables, such as TNM staging, Lauren's classification and the histopathological type, thus, the age variable directly influences the mentioned variables.

A total of 22 different nursing diagnoses (ND) were detected according to NANDA taxonomy (2015-2017), identified through physical examination and interview at the first nursing consultation. Chart 1 describes the 12 ND that were present in all patients in the sample studied.

Chart 1. Most prevalent nursing diagnoses in gastric cancer patients raised at the first nursing consultation, from October 1, 2015 to April 18, 2018 (n = 649).

Nursing Diagnosis	**Defining characteristics found in the sample**
1.Imbalanced nutrition: less than body needs related to gastric injury.	Food intake lower than the recommended daily portion due to lack of appetite and early gastric fullness.
2. Nausea related to gastric injury, rapid infusion of enteral diet or retention of food in the stomach for long periods.	Weight loss even with adequate food intake due to extensive gastric injury.

3. Poor fluid volume or risk of poor fluid volume related to deviations that affect fluid intake such as gastric obstruction or nausea / vomiting.	Aversion to food; bitter taste in the mouth; sialorrhea; and craving for vomiting or feeling faint.
4. Constipation and / or risk of constipation related to low fiber and fluid intake.	Anorexia, bloating, effort to evacuate, hard and dry stools, complaint of indigestion, reduced frequency and volume of stools.
5. Impaired skin integrity related to low fluid intake and poor nutrition.	Alteration of skin hydration, manifested by decreased turgor and dry, peeling skin.
6. Body image disorder related to change in body structure (weight loss), fear of others' reaction and focus on previous appearance.	Disease (gastric cancer), impaired psychosocial function and treatment regimen
7. Risk of bleeding, related to advanced gastric injury.	Gastrointestinal disorders.
8. Fatigue related to physiological condition, malnutrition, negative life event and sleep deprivation.	Tiredness, drowsiness, apathy, insufficient energy and impaired ability to maintain the usual level of physical activity.
9. Pain related to gastric injury.	Change in sleep pattern, self-reported pain intensity using visual analog scale (VAS) and pain report by family member.
10. Fear related to illness and treatment.	Stimulus understood as threat (gastric cancer) and report of increased tension.
11. Insomnia related to grief due to cancer diagnosis, anxiety and fear of treatment and control of the disease.	Impaired health status, mood swings, changes in sleep patterns and reduced quality of life.
12. Poor knowledge related to institutional resources for disease treatment and location of services in the physical space of the hospital.	Inappropriate behaviors (apathetic), inadequate follow-up of instructions and lack of adherence to treatment.

Source: Gastric Cancer Study and Treatment Group Database - INCA.

DISCUSSION

The data analyzed in this research allowed us to delineate the profile of patients diagnosed with gastric cancer, enrolled at INCA, from October 01, 2015 to April 18, 2018. The study of the epidemiological profile of a population is very useful to guide the health policies of a country, for institutional internal planning and to guide the care actions of multiprofessional teams.

The distribution of gastric cancer cases according to gender and age, nationwide, followed the incidence rate observed in the rest of the world. It is almost twice higher in males than in females, with incidence peaks between 50 and 70 years old, being an uncommon condition at younger ages. The greater involvement of men can be

explained by the participation of factors such as lifestyle, where males are usually more exposed to alcohol and tobacco consumption [11,12].

Different studies cite, in common, interactions between personal lifestyle such as smoking and alcoholism, personal genetic factors and external agents such as ionizing radiation, chemical and biological carcinogens as the causes for the development of most cancers, including gastric câncer [13]. In this study, the participants had exposure to risk factors, smoking and alcoholism, mostly.

The age of the patients in this research ranged from 21 years to 90 years. However, 16.64% of them were under 50 years of age, which requires more careful evaluation due to the suspicion of hereditary cancer syndrome. Refer to Genetic Counseling and advise the family on signs and symptoms of stomach tumors so that they seek primary care. Germline mutation in the e-cadherin gene is responsible for the familial autosomal dominant gastric cancer syndrome that leads to the development of gastric cancer at an early age. Criteria for suspicion of the syndrome include an individual diagnosed with gastric cancer before age 50, or two or more successive generations of affected families [1,14,15].

The brown population was the most prevalent (52.51%), followed by white (28.51%), unlike that found in the literature where there is a predominance of white color. The mechanism responsible for this predominance cannot be attributed only to socioeconomic conditions or lifestyle, assuming that genetic factors may have relevance, since they determine different susceptibility among ethnic groups [16,17].

Unfortunately, only 34.2% of the cases analyzed (n = 222) had a record of the presence or absence of signet ring cells. Of these, 208 were positive cases, representing 93.7% of those with information. The presence of signet ring cells is strongly associated with poor prognosis and recurrence of the gastric tumor [18,19].

As shown in one study [20], the presence of signet ring cells is the largest and strongest indicator of poor prognosis in patients with gastric adenocarcinoma and, among other recommendations, indicate an accurate investigation of the family history of cancer in these patients, because they are often caused by mutations in the CDH1 gene. Our analysis was not performed satisfactorily due to the high number of cases without information (n = 427, 65.79%).

Some authors [21], point out the usefulness of databases with complete records for the excellence studies, which was not observed in this study for the presence of signet ring cells, Lauren microscopic classification, H. pylori infection and TNM stage (table 2). In one assessment [22], the completeness of the records ranged from poor to very poor. These authors recommend a score based on the concept of data completeness, which is classified into the following degrees of evaluation: excellent, when the variable has less than 5% of incomplete filling; good (5% to 10%); regular (10% to 20%); poor (20% to 50%); very bad (50% or more).

Regarding H. pylori infection, we found no record in 325 cases (50.08%). Of the 324 cases in which this information was present, infection was found in 117 patients, or 18.03%. By associating age with H. pylori infection, it was observed that there is no influence of one on the other. Scholars explore the importance of H. Pylori's research, showing that most cases of gastric cancer are related to sporadic somatic cell mutations, resulting from a long exposure of the gastric mucosa to the inflammatory

process caused by the bacteria, making the need for alert evident. for risk factor for gastric cancer[23,24].

Regarding gastric cancer, regarding the histopathological type, 490 patients with adenocarcinoma were found, corresponding to 75.49% of the total patients analyzed. Among the histological types of gastric cancer, adenocarcinoma corresponds to 95% of cases, followed by lymphoma, which represents about 3% of cases [4,25].

Staging of the tumors revealed that the most frequent tumors were in stage IV (n = 222, 35.29%), which indicates advanced disease with metastasis and palliative treatment. It is worth pointing out that the high percentage of uninformed staging (n = 261, 40.22%) becomes a limiting factor for study analysis.

Tumor localization, as described in the literature, is more prevalent in the distal third of the stomach, in the gastric antrum near the notch angularis. It is associated with nitrate (nitrosamine) ingestion or H. pylori infection. Some studies have shown a change in the presentation pattern of adenocarcinoma, from distal to proximal regions and with distinct histological characteristics. In our study, there was a predominance of the middle third (n = 193, 29.74%), followed by the distal third, unlike the literature [26,27].

Regarding the Lauren classification, the findings indicated a higher prevalence of diffuse type (Table 2), followed by intestinal, and the tests performed suggest that age directly influenced the histological types of the Lauren Classification. Lauren's classification divides gastric neoplasms according to their microscopic configuration and growth pattern into two histological types: Intestinal type - the most common type in males and usually affects the distal region of the stomach (small curvature in the gastric antrum). It is of better prognosis when compared to the diffuse type. Diffuse has a family history (hereditary), is more common in women, affects younger individuals compared to intestinal type, and tumor localization is frequent in the proximal region of the stomach (closest to the esophagus)[27,28].

Regarding mortality, the frequency of death in the study period was 296 cases (45.61%), almost half of the cases, which coincides with the high mortality reported in epidemiological studies of the disease[18]. We note that most patients enrolled at INCA already arrive with advanced disease, which practically makes curative treatment unfeasible and justifies the high percentage of death.

Regarding nursing, specifically, knowing the patient profile of the unit in which they work is fundamental both for the development of prevention and health promotion actions, as well as for care actions in the hospital space, especially when it is intended to work with the Systematization. Nursing Care (SAE) and the Nursing Process (PE).

The Systematization of Nursing Care (SAE) allows the involvement of nurses in the planning, execution and evaluation of nursing actions that are implemented, enabling the global view of care [29]. It is a method of operationalizing the Nursing Process (PE), being the EP a methodological instrument that guides nursing care to the patient and allows the documentation of professional practice [30].

In resolution [30], the EP is organized into five interrelated, interdependent and recurrent stages: Data Collection (Nursing History), Nursing Diagnosis, Nursing Planning, Nursing Implementation and Evaluation.

Systematized nursing practice allows the identification of care needs expressed and / or reported by patients and family members, and provides dialogue with other members of the health team to direct care, composing a tactic appropriate to a person-centered practice and not only on tasks or illness.

Therefore, knowing the profile of this patient is of great value to the Nursing Professional, as it allows directing a deeper look at the signs and symptoms presented, verbalized or not, arising from the disease process and / or treatment imposed by the disease, to provide humanized nursing care and promote better quality of life for this patient and / or family member.

It is noteworthy that for the implementation of the EP, in its first stage - initial evaluation - it is essential to know the profile of the clientele served in order to link this profile to a nursing theory that will provide the support for the construction of the data collection instrument. Data that meets this patient profile, so that the apt and critical processing of inferences and judgments can be developed and thus the precise determination of the nursing diagnosis, the second step of the EP, and, consequently, for the advancement of the other stages of the process. PE [31].

Regarding the identified nursing diagnoses (ND), in the first nursing consultation of the patients in this study, there was a predominance of 12 ND in 100% of the sample, these diagnoses being in full congruence with the profile of the researched clientele.

Nursing diagnoses underlie the prescription of care to address the affected needs of patients. It opens up new possibilities for care, as it enables the sick The first is to apply scientific knowledge to identify problems and prescribe care according to their professional competence, using standard medical record language, based on signs and symptoms presented by patients, enabling clear communication among health team members [32].

It is also interesting to highlight the importance of this research to equip health professionals to develop actions aimed at health promotion and disease prevention in family health strategies.

FINAL CONSIDERATIONS

We conclude that the objectives of this study were achieved, that the knowledge of the clinical and epidemiological profile of gastric cancer patients is mostly compatible with the national and international literature and that the identified nursing diagnoses are aligned with this profile of patient.

One of the weaknesses of this study, as it is secondary database research, was the low degree of completeness observed for the presence of signet ring cells, Lauren microscopic classification, H. pylori infection and TNM stage. Therefore, due care is recommended and the development of a broader prospective study.

The high prevalence of cases with advanced disease reflects the difficulty of access of the Unified Health System users to early diagnosis. This finding leads us to identify what efforts should be made, universally and equitably, to identify groups and risk factors for the development of gastric cancer through the training of health

professionals so that they can act in the planning and implementation. of gastric cancer prevention and control programs.

We think the study can help prepare nurses and students for the development and application of control, prevention and care strategies in primary, secondary and tertiary care. For the specialist nurse in cancer care, can collaborate in the development of skills to assist this clientele in all its dimensions and for comprehensive and humanized care in meeting the basic human needs of this patient profile, so assaulted by the disease and the treatment imposed. Knowing the profile of the gastric cancer patient and the most prevalent nursing diagnoses indicates the effectiveness of the Nursing Care Systematization with the operationalization of the Nursing Process, in order to offer quality, safe and humanized nursing care to the patient, family and community in INCA.

Emphasizing that nursing consultation to patients in an outpatient clinic is a mediator instrument of humanization of care during the work process of nurses, in order to establish an effective relationship through dialogue, sensitive listening and conversation, capable of transforming insecurity and fear of the patient in a work process with more collaborative attitude and adherence to treatment and care offered, although other studies should be conducted to evaluate the effects of nursing consultation on the clinical response or quality of life of patients.

REFERENCES

1- Instituto Nacional de Câncer (Brasil). ABC do câncer: abordagens básicas para o controle do câncer / Instituto Nacional de Câncer. – Rio de Janeiro: Inca, 2011.128 p.: il. http://bvsms.saude.gov.br/bvs/publicacoes/abc_do_cancer.pdf.

2- Ferlay J, Soerjomataram I, Dikshit R, Eser S, Mathers C, Rebelo M, et al. Cancer incidence and mortality worldwide: Sources, methods and major patterns in GLOBOCAN 2012. Int J Cancer. [Internet]. 2015 [Access May 30, 2016]; 36(5):E359-86. https://doi.org/10.1002/ijc.29210.

3- Fundação Instituto Brasileiro de Geografia e Estatística (IBGE). Diretoria de Pesquisas. Coordenação de População e Indicadores Sociais. Gerência de Estudos e Análises da Dinâmica Demográfica. (Oliveira J C, Albuquerque FRPC, Lins IB), 2004. [Internet]. [Acesso 22 mar 2018]. Projeção da população do Brasil por sexo e idade para o período de 1980-2050 – revisão 2004. www.ibge.gov.br/home/estatistica/populacao/estimastiva2004/metodologia.pdf.

4- Instituto Nacional do Câncer - INCA. [Internet]. [Acesso 02 maio 2018]. Estimativa 2018: Incidência do Câncer no Brasil. http://www.inca.gov.br/estimativa/2018/.

5- World Health Organization (WHO). Cancer. Fact sheet N°297. February 2012. [Internet]. [Acesso 24 mar 2018]. http://www.who.int/mediacentre/factsheets/fs297/en/.

6- Siegel RL, Miller KD, Jemal A. Cancer statistics, 2016. CA Cancer J Clin. 2016 Jan-Feb;66(1):7-30. doi: 10.3322/caac.21332. Epub 2016 Jan 7.

7- Piazuelo MB, Epplein M, Correa P. Gastric cancer: An infectious disease. Infect Dis Clin North Am. 2010; 24(4): 853–869.

8- Karimi P, Islami F, Anandasabapathy S, Freedman ND, Kamangar F. Gastric Cancer: Descriptive Epidemiology, Risk Factors, Screening, and Prevention. Cancer Epidemiol Biomarkers Prev. 2014; 23(5): 700–713.

9- Rezaeian S, Khazaei S, Khazaei S, Mansori K, Moghaddam AS, Ayubi E. Human Development Inequality Index and Cancer Pattern: a Global Distributive Study. Asian Pac J Cancer Prev, 17, Cancer Control in Western Asia Special Issue, 201-204. 2016.

10- Campelo JCL, Lima LC. Perfil Clínico epidemiológico do câncer gástrico precoce em um hospital de referência em Teresina, Piauí. Rev Bras Cancerol [Internet] 2012; 58(1):15-20. [Acesso 23 abr 2019]. http://www1.inca.gov.br/rbc/n_58/v01/pdf/04. Acesso em 30/04/18.
11- Siegel RL, Ma J, Zou Z, Jemal A. Cancer Statistics – 2014. CA Cancer J Clin, 2014; 64(1):9-29.
12- Kim Y, Ejaz A, Spolverato G, Squires MH, Poultsides G, Fields RC, et al. Conditional survival after surgical resection of gastric cancer: a multi-institutional analysis of the us gastric cancer collaborative. Ann Surg Oncol. 2015 Feb;22(2):557-64.
13- Instituto Nacional do Câncer – INCA. Ações de enfermagem para o controle do câncer: uma proposta de integração ensino serviço. Rio de Janeiro, 3ª Ed. 2008. Rev. Atual. Ampl. [Internet]. [Acesso em 06 jun 2018]. http://www1.inca.gov.br/enfermagem/index.asp.
14- Figueiredo T, Guedes MTS, Souza LPS, Rosa AAS, et al. Prevalence of Family History of Cancer among Gastric Cancer Patients at Brazilian National Cancer Institute. Health, 09:01(2017), Article ID:73245,13 pages, 10.4236/health.2017.91003. DOI: 10.4236 / health.2017.91003.
15- Boland CR, Yurgelun MB. Historical Perspective on Familial Gastric Cancer. Cellular and Molecular Gastroenterology and Hepatology, 2017, 3 (2): 192-200. DOI: https://doi.org/10.1016/j.jcmgh.2016.12.003.
16- Guedes MTS, Jesus JP, Filho OS, Fontenele RM. Clinical and epidemiological profile of cases of deaths from stomach cancer in the National Cancer Institute, Brazil. Ecancermedicalscience. 2014 Jul 17; 8:445. Doi: 10.3332 / ecancer.2014.445.
17- Braga-Neto MB, Carneiro JG, de Castro Barbosa AM, et al. Clinical characteristics of distal gastric cancer in young adults from Northeastern Brazil. BMC Cancer. 2018 Feb 5; 18(1):131. Epub 2018 Feb 5.
18- Bamboat ZM, Tang LH, Vinuela E, Kuk D, et al.Stage-stratified prognosis of signet ring cell histology in patients undergoing curative resection for gastric adenocarcinoma. Ann Surg Oncol. 2014 May;21(5):1678-85. DOI: 10.1245 / s10434-013-3466-8.
19- Kim BS, Oh ST, Yook JH. Signet ring cell type and other histologic types: differing clinical course and prognosis in T1 gastric cancer. Surgery. 2014;155(6):1030–35.
20- Piessen G, Messager M, Lefevre JH, Goéré D, Mabrut JY. *et al*. Eur J Surg Oncol. 2014 Dec;40(12):1746-55. doi: 10.1016/j.ejso.2014.04.019.
21- Lagergren J, Andersson G, Talbäck M, Drefahl S, et al.Marital status, education, and income in relation to the risk of esophageal and gastric cancer by histological type and site. Cancer, v. 122, n. 2, p. 207-12, 2016. doi: 10.1002 / cncr.29731.
22- Romero DE, Cunha AB. Avaliação da qualidade das variáveis epidemiológicas e demográficas do Sistema de Informações sobre Nascidos Vivos, 2002. Cad Saúde Pública, v. [Acesso 11 ago 2017]. http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2007000300028.
23- Ishaq S, Nunn L. Helicobacter pylori and gastric cancer: a state of the art review. Gastroenterol Hepatol Bed Bench 2015;8(Suppl.1): S6-S14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495426/
24- Doorakkers E et al. Helicobacter pylori eradication treatment and the risk of gastric adenocarcinoma in a Western population. Gut 2018 Jan 30; [e-pub]. https://doi.org/10.1136/gutjnl-2017-315363.
25- Cutsem EV, Sagaert X, Topal B, Haustermans K, Prenen H. Gastric cancer. The Lancet, v. 388, 2016, p. 2654-64. DOI: https://doi.org/10.1016/S0140-6736(16)30354-3.

26- Lucchese IC, Ferreira DK, Copetti FVS, Carvalho FG, Tonento MG. Câncer Gástrico precoce: uma doença curável no Brasil. Rev AMRIGS [Internet]. [Acesso 23 abr 2019]. 2008;52(4):309-14. http://www.amrigs.com.br/revista/52-04/14-288-c%E2ncer_g%E1strico_precoce.pdf
27- Campelo JCL, Lima LC. Perfil Clínico epidemiológico do câncer gástrico precoce em um hospital de referência em Teresina, Piauí. Rev Bras Cancerol [Internet] 2012; 58(1):15-20. [Acesso 23 abr 2019]. http://www1.inca.gov.br/rbc/n_58/v01/pdf/04. Acesso em 30/04/18.
28- American Cancer Society - ACS. What is stomach cancer? 2017. https://www.cancer.org/cancer/stomach-cancer/about/what-is-stomach-cancer.html.
29- Tannure MC, Gonçalves AMP. SAE, Sistematização da Assistência de Enfermagem: guia prático. Rio de Janeiro: Guanabara Koogan; 2.ed. 2013.
30- Conselho Federal de Enfermagem (COFEN). Resolução n.358 de 15 out 2009. [Acesso 19 mar 2018]. http://www.coren.rj.org/resolução.
31- NANDA Internacional. Diagnósticos de enfermagem da NANDA, definições e classificação 2015-2017. Porto Alegre. 10ª Ed. 2015. Artmed.
32- Guedes MTS, Valente LM, Porto MA, Lanes M, et al. Diagnoses and Nursing Care for Patients with Gastric Tumors Treated at the Outpatient Clinic of the Group for Research and Treatment of Gastric Cancer. IOSR Journal of Nursing and Health Science, 6(1), Ver. I, 2017, p. 86-93.

ISSN 1695-6141