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Research paper

Cardiovascular risk and communication among early stage breast cancer survivors

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ABSTRACT

Objective: African American (AA) women have disproportionately high rates of cardiovascular (CV) risk factors that, coupled with potentially cardiotoxic breast cancer (BC) therapies, place them at risk of adverse CV outcomes. The purpose of this study was to assess CV risk factors among white and AA BC survivors and perceptions of patient-provider CV-related communication and post-treatment information needs.

Methods: Early-stage, English-speaking BC survivors were recruited through community-based survivorship organizations/clinics in New Jersey. Qualitative, semi-structured interviews and a brief survey of socio-demographics and comorbidities were conducted.

Results: BC survivors reported high rates of CV risk factors. Most reported their health as good/excellent despite their cancer history and CV risk profile. Approximately half of overweight/obese BC survivors reported no weight-related conversation with their health care team and, among those who reported discussion, 36% indicated it was self-initiated and dismissed. More than half of BC survivors reported a desire for lifestyle-related information and guidance.

Conclusion: BC survivors may not understand how their separate, yet cumulative, health issues can impact their CV risk.

Practice implications: Patient-provider communication on behavioral risk factor modification and CV risk is needed, particularly among at-risk subgroups such as AA and obese BC survivors, to improve BC and CV outcomes.

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1. Introduction

Breast cancer (BC) is the most frequently diagnosed cancer among both African American (AA) and Caucasian women and is the second most common cause of cancer death among women in the United States (US) [1,2]. Overweight and obese post-menopausal women are three times more likely to develop breast cancer during their lifetime when compared to their normal

weight peers [3,4]. In developed countries like the US up to one-third of all cancer cases have been associated with key behaviors – obesity, physical inactivity, and poor nutrition – all of which are shared risk factors for cardiovascular disease (CVD) [5]. Moreover, evidence consistently demonstrates that obese BC survivors have poorer survival outcomes [6,7]. Improvements in early detection and innovations in cancer treatments have resulted in substantial survival gains among BC survivors; however, these survival benefits are not experienced equally by all populations [8–10]. Despite a six percent lower incidence rate for breast cancer among AA compared to Caucasian women, the mortality rates in AA women remain significantly higher [11]. Additionally, compared to women who are Caucasian and other racial/ethnic minorities, AA

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women have the highest rates of comorbidity (76%), like CVD and diabetes [12].

Due to shared behavioral (e.g., obesity) and/or clinical pathways (e.g. inflammation), CVD risk is an important potential health problem for BC survivors [13]. In fact, risk of cardiovascular (CV) death in cancer survivors is higher than the actual risk of cancer recurrence among older females [14,15]. Cancer treatments can cause or exacerbate existing CV health problems including increased risk of cardiac dysfunction, heart failure, arrhythmias, valvular heart disease, accelerated atherosclerosis and pericardial disease [16]. AA women have disproportionately high rates of CV risk factors that, coupled with potentially cardiotoxic breast cancer therapies, place AA BCS at substantial risk of adverse CV outcomes [8,17]. Despite the elevated CV risk posed and national guidelines recommending that traditional CV risk factors be assessed every 4–6 years in all people 20–79 years, reports indicate that AA BC survivors are not receiving CV risk assessment as part of routine follow-up care [18,19]. In fact, cancer survivors are less likely to receive CV preventive care as compared to the general population [18]. Cardiovascular disease and cancer risk both increase with age and, due to demographic shifts nationally, both the elderly and minority populations are projected to increase in coming decades suggesting that the prevalence of CVD among survivors will become a more pressing concern and may be a potential lever to address disparate outcomes among BC survivors [20].

Guidelines for behavioral risk factor management have been recently developed for healthcare providers delivering follow-up care to BCS and include maintaining a healthy weight, engaging in regular physical activity, adhering to a diet rich in fruits, vegetables and whole grains, reducing dietary fat consumption and limiting alcoholic intake [2,21–23]. Many BC survivors have characterized the post-primary treatment experience as lacking information and preparation for follow-up and providing inadequate support to address many of their care needs [24]. Although BC survivors may be aware of the relationship between lifestyle behaviors (e.g., smoking, risking drinking, weight management) and risk of BC recurrence, adherence to behavioral risk factor guidelines aimed at reducing recurrence are suboptimal [25,26].

Previous research has shown that 20% of cancer survivors smoke, only 37% have a weight in the 'normal range' based on body mass index (BMI) values, and only 52% exercise at a moderate-vigorous intensity three or more times per week [27]. In another study, those with a history of cancer had similar smoking and alcohol consumption behaviors as reported by those without a cancer history [28]. In a convenience sample of the Sisters Network (n = 470), almost half (47%) of the AA BC survivors surveyed were found to be obese (47%) and the majority were not meeting guidelines for physical activity (53%), had hypertension (53%) and many had diabetes (21%) [29]. In a recent study, more than 90% of AA BC survivors reported that their physician did not mention diet or physical activity as ways to improve quality of life and health as a cancer survivor [30]. Further, research studies have shown that a substantial proportion of cancer survivors at risk for CVD (15–30%) do not discuss health promotion with their providers [14]; and AA BC survivors, in particular, have expressed the need for more information about co-morbid illnesses management and health promotion [31].

Evidence-based information and guidelines for follow-up care need to be provided to BC survivors, especially those with increased CV risk, to improve clinical outcomes. The current study evaluates CV risk factors among AA and white BC survivors. It also aims to explore BC survivors' perceptions of patient-provider CV-related communication and BC survivors' post-treatment information needs, overall and by race.

2. Methods

2.1. Setting

In November 2014–April 2015 we conducted an exploratory, qualitative research study that recruited BC survivors in New Jersey (NJ). This study was approved by the Institutional Review Board at Rutgers Biomedical and Health Sciences.

2.2. Sampling frame

We recruited a purposive sample of ambulatory, early stage (I or II), English-speaking BC survivors. Patients who were required, because of their disease, to see primarily oncologists for follow-up were excluded (i.e., those diagnosed with lymph node or distant metastasis [stage III or IV] or those within 1–2 years of their active treatment). Participants could be on hormonal therapy. Patients received a description of the study by phone, were screened for eligibility, and, if qualified, an interview date/time was scheduled. Patients who were evaluated to be overweight or obese during telephone screening, based upon self-reported height and weight, were asked if they would complete a moderately longer interview that contained weight-specific questions. If they were not interested (n = 3) they completed the general interview. The final sample included thirty-four breast cancer survivors – 12 healthy weight and 22 overweight/obese.

2.3. Data collection

In-depth, individual interviews were conducted. These intensive interviews with a small number of respondents are recommended as a qualitative research technique to explore perspectives on a particular idea, program, or situation. Survivors were recruited to the study through community-based survivorship organizations (Sisters Network of Central NJ, Susan G. Komen North Jersey, Young Survival Coalition, Breast Cancer Resource Center of the YWCA), local oncology (n = 1) and primary care (n = 1) practices, and the Rutgers Faculty and Staff online bulletin. We oversampled African-Americans by employing a purposeful sampling technique to achieve a similar number of White and AA BC survivors to allow for analysis of potential differences in their CV risk and communication. Study investigators worked with the directors of these organizations and individual clinicians at practices to identify eligible patients. At the time of the interview, each participant was asked to review and sign an informed consent form. Participants received a \$20 American Express gift card for completing the interview.

Interviews that ranged from 75 to 90 min were conducted in-person at Rutgers research offices by master's and doctoral-prepared interviewers with extensive qualitative interviewing experience. A semi-structured interview script was developed to elicit information about the needs and concerns of BC survivors out of active cancer treatment. Among overweight/obese BC survivors (n = 22), specific domains of interest were identified by the research team (i.e., body image, risk perception, weight management, physician-patient communication regarding weight, preferences for health information) and used to guide the qualitative interview. Responses to the following questions were used in the current analyses: 1) "Has anyone on your health care team discussed weight management with you," 2) "What do you think are the most important informational needs for people who have finished cancer treatment," and 3) "What would a health and wellness program for individuals who have been treated for cancer need to have to make you want to participate in it?"

Forty-five BC survivors were screened for study inclusion; 7 in total were excluded. Reasons for exclusion included having stage 0,

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