Care pathway for women with breast cancer in the city of Rio de Janeiro

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Abstract: In Brazil, breast cancer is the second most common tumor in women. In 2020, the COVID-19 pandemic and social distancing restrictions impacted the monitoring and treatment of many health conditions by Primary Health Care (PHC) teams, which focused on treating flu-like symptoms. This study sought to understand the care provided to women with breast cancer during the pandemic. This was a qualitative and exploratory study, whose primary data collection was carried out through semi-structured interviews with two women diagnosed with breast cancer in 2021, registered at a family clinic in the city of Rio de Janeiro. Secondary data collection was carried out through documentary analysis of electronic medical records and the State and National Regulation systems. The results showed gaps in the comprehensive care of women with breast cancer as a result of the Covid-19 pandemic, both in primary care and in hospitals, with loss of follow-up by the primary care team. Strategies for maintaining continuity of care in times of crisis, especially in the monitoring and treatment of serious clinical and social situations, still need to be developed, but some clues could be identified.

➤ **Keywords:** Therapeutic pathway. Breast neoplasms. Comprehensive health care. Covid-19.

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Introduction

Breast cancer is the most common type of cancer among women in 158 of the 183 countries analyzed, accounting for about 12% of all cancer cases worldwide (WHO, 2023). In 2020, 2.3 million new cases were reported in women, making it the leading cause of cancer mortality in 107 countries (58%). When added to the countries where it ranks second in number of deaths, breast cancer is among the leading causes of death in 95% of the nations evaluated (WHO, 2023). In Brazil, it is the second most common type of cancer, with an estimated 74,000 new cases in the 2023-2025 triennium, corresponding to 10.5% of cancer diagnoses predicted for this period. In terms of mortality, it is the leading cause of cancer death among Brazilian women, except in the North Region, where it ranks second (INCA, 2021).

Breast cancer has a multifactorial etiology, with modifiable and non-modifiable risk factors. Among the modifiable factors are obesity, physical inactivity, alcohol consumption, exposure to ionizing radiation, nulliparity or first pregnancy after age 30, use of oral contraceptives, and hormone therapy during menopause. Non-modifiable factors include a family history of breast cancer (especially before age 50), ovarian cancer, breast cancer in men, mutations in the BRCA1 and BRCA2 genes, early menarche before age 12, and late menopause after age 55 (INCA, 2021).

Early detection of breast cancer comprises two main approaches: early diagnosis and screening (INCA, 2021). Early diagnosis is related both to educating the female population to recognize signs and symptoms suggestive of the disease and to the technical training of health professionals. With regard to screening, the World Health Organization (WHO) recommends that, ideally, at least 70% of eligible women undergo screening mammography. Although Brazil does not have a structured population screening program, such as those in the United Kingdom, Sweden, Finland, the Netherlands, and Canada (Jonsson *et al*., 2007; Giordano *et al*., 2012; Wadden; Doyle, 2006), the Ministry of Health adopts an opportunistic screening strategy, targeting women between 50 and 69 years of age, through biennial mammograms (Migowski; Corrêa, 2020). However, even before the Covid-19 pandemic, the country already had unsatisfactory coverage, with a mammography rate of around 24% during the 2018-2019 biennium (Vilas-Lobo *et al*., 2022).

The diagnostic investigation of breast cancer depends on the woman's age and symptoms. In women under 30, the initial exam is breast ultrasound. For those over 30

with a lump, it is recommended to start with mammography alone or in combination with ultrasound. In cases of nipple discharge, lymphadenopathy, thickening, or skin changes, the investigation should begin with both tests. Suspicious or highly suspicious findings should be supplemented with breast biopsy (INCA, 2022).

Recommendations for mammography screening as a method of breast cancer detection differ between the Ministry of Health, which recommends screening for women aged 50 to 69, and the Brazilian Society of Mastology, backed by Law No. 11,664/0843, which recommends starting screening at age 40 on an annual basis. This lack of uniformity has generated conflicts between Primary Health Care (PHC) and Specialized Care professionals, directly impacting users. Women treated in the private network or with health insurance generally start screening earlier than users of the Unified Health System (SUS) alone. However, this early start can result in overdiagnosis and overtreatment (Castro *et al*., 2022). It is important to note that Brazil still has a high rate of late diagnosis, representing about 60% of cases (Goldman *et al*., 2019), which may be associated with the ineffectiveness of the screening program, the difficulty in early detection of symptomatic cases, and failures in communication between levels of health care.

On the other hand, in addition to the lack of an effective screening program, symptomatic cases are also a cause for concern, given the ineffectiveness of early detection. In the municipality of Rio de Janeiro, PHC is responsible for making referrals within the health network through existing regulatory systems, and secondary and tertiary levels do not have the autonomy to request a biopsy or consultation with oncology based on an abnormal imaging result (Gomes; Alves, 2023). While this organization tends to improve the coordination of care by the patient's referral clinic, any delay in the user's return to the unit or even a lack of care coverage by a health team can increase the waiting time for referral to other levels of care in the network, which is all the more worrying in the case of neoplasms—where the time between the appearance of the lump, the diagnosis, and the start of treatment impacts the outcome of the case.

Starting in March 2020, a global event would disrupt the Brazilian scenario: the identification of a coronavirus with high transmissibility and mortality, which quickly spread across continents and was named SARS-CoV-2. Thus, on March 11, the WHO declared a pandemic of the disease caused by this coronavirus, COVID-19. The following week, most countries would impose a lockdown on their inhabitants.

In March 2020, the Special Advisory Office of the municipality of Rio de Janeiro released a technical note (SMS-RJ, 2020) guiding the creation of a rapid response team in primary care units composed of doctors, nurses, nursing technicians, community health agents, and receptionists. The same document stated that the routine activities of these units—consultations, home visits, home care, and nursing procedures—should be maintained for pregnant women receiving prenatal care and people living with HIV/AIDS, tuberculosis, neoplasms, and other chronic conditions posing a high clinical risk.

As in Brazil, several countries, including Canada, the United States, France, Qatar, Taiwan, and Belgium, reported a significant impact of the COVID-19 pandemic on the demand for mammograms and MRIs for breast cancer screening and diagnosis (Allahqoli *et al*., 2022). In a systematic review, Muka *et al*. (2023) identified an overall reduction in the diagnosis of new cancer cases during the pandemic, varying according to region, the period analyzed, and the type of cancer. The review also pointed out that countries that adopted *lockdown* measures had the largest declines in the number of new diagnoses (Muka *et al*., 2023).

The following year, in January 2021, a contingency plan graded as moderate risk, high risk, and very high risk was implemented in the municipality of Rio de Janeiro, which determined a proposal for care in Primary Care Units with variations in full, partial, and suspended care that was reviewed weekly in order to address the heterogeneity of the municipality in the ten programmatic areas of health (SMS-RJ, 2021).

In the second half of January 2021, ANVISA approved two vaccines against the SARS-CoV-2 virus for emergency use. With this, the vaccination process began in the municipality of Rio de Janeiro for the elderly and health professionals who were working on the front lines of the fight against the virus. The vaccination strategy continued from February to September 2021 in descending order of age, associated with comorbidity and some priorities (pregnant women, people with permanent disabilities, health and education workers, urban cleaning services, municipal guards, bus drivers and conductors, as well as school transport).

Thus, the question that gave rise to this study was: how did the actions prioritized in the reorganization of PHC services in the face of the Covid-19 scenario experienced in 2021 interfere with the provision of care to women with suspected breast cancer in the municipality of Rio de Janeiro?

This study was derived from one of the authors' professional master's thesis in primary health care and sought to understand the care provided to women with breast cancer at a Family Clinic in the city of Rio de Janeiro in 2021, a scenario prioritized due to the COVID-19 pandemic.

Methodology

The study was qualitative and exploratory in nature (Minayo, 2014). Qualified listening to the experiences of these women can reveal inequalities, coping strategies, and rationalities that escape the institutionalized logic of care (Deslandes, 1997). Thus, in this study, the highlight of each care trajectory is unique, and this uniqueness becomes a powerful lens for understanding the social context (Minayo, 2010).

The research was conducted with women who were diagnosed with breast cancer in 2021 at a Family Clinic located in the central region of the municipality of Rio de Janeiro, with access to the main expressways of the city of Rio de Janeiro.

The inclusion criteria used for the selection of participants were:

1) women over 18 years of age;
2) diagnosed with breast cancer in 2021;
3) with active registration at the Family Clinic where the research was conducted, whether or not they had been referred to other services in the Rio de Janeiro network for breast biopsy, consultation with breast specialists, oncologists, or surgeons, chemotherapy, radiotherapy, among other specialized care.

The exclusion criteria were:

1) women registered with the principal investigator's reference team, who at the time worked at the unit where the research was conducted;
2) women who refused to participate in the research;
3) women with mental disorders and/or conditions that significantly reduce their decision-making capacity and ability to respond to the interview.

Nine women diagnosed with malignant breast neoplasia were identified in 2021 through a search of the e-SUS electronic medical records and the digital platforms used by PHC to refer patients to secondary and tertiary services, through the State Regulation System (SER) and the National Regulation System (SISREG), the latter used for outpatient exams and consultations by the municipality of Rio de Janeiro.

Of the nine women, three were excluded from the study because they belonged to the research team's staff and/or had changed their address. Two women died before the data collection period. One woman could not be located after several attempts by telephone and active search by the community health agent (ACS). Another woman was contacted and refused to participate in the study. Finally, two women agreed to participate in the study.

To produce the primary research data, the following were used: a) narratives from in-depth interviews with each of the participants, guided by a semi-structured interview script; and b) records of verbal and nonverbal aspects of the interviews in the researcher's field diary. The interview script was designed to help capture the subjectivity, distress, and anxiety surrounding the monitoring, diagnosis, and treatment of breast cancer, as well as to identify the formal and informal therapeutic pathway through the health network of the municipality of Rio de Janeiro.

Both interviews were conducted at the end of the first semester of 2023, on different days, in person, at the Family Clinic, specifically in the X-ray room, the most private area of the unit. The interviews were recorded with the consent of the participants and the signing of a Free and Informed Consent Form (FICF) and lasted approximately one hour each. The audio recordings were transcribed in full by the principal investigator. To ensure the anonymity of the participants and health professionals, as well as their families and places of care, all names and institutions were replaced with fictitious names.

For the production of secondary data, a documentary analysis of the records in the VitaCare electronic medical records, SER platform, and SISREG was used, searching for care and referrals made using the national health card (CNS).

For data interpretation, Bardin's content analysis method adapted by Minayo (Minayo, 2014) was used. The narratives and field diary entries were coded into thematic categories by similarity and cross-referenced to form the categories of analysis. Finally, these data were analyzed and correlated with the scientific reference found by the researcher in order to replicate the guiding question.

It should be noted that this article was the product of a master's thesis, there is no conflict of interest, and data collection began after authorization from the health institution and approval from the university research ethics committees EEAN/UFRJ CAAE 64091322.10000.5238 and municipal SMS/RJ CAAE 64091322.1.3001.5279.

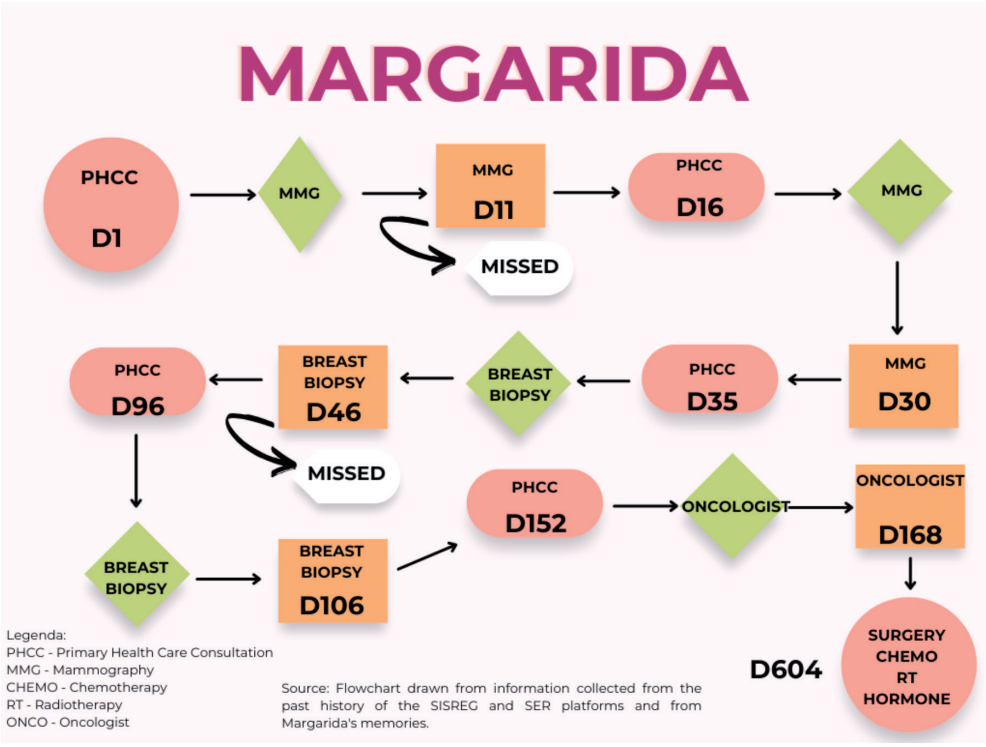
Results

Primary health care services must be able to give priority to people with signs or symptoms suggestive of cancer, in addition to consultations for screening purposes. When a suspected neoplasm is found, there must be prompt referral to other levels of care and additional tests, with a view to early diagnosis (Migowski; Corrêa, 2020).

Breast self-examination is no longer recommended by the scientific community and has even been abolished by the National Cancer Institute (INCA, 2017). However, although the recommendation for breast cancer screening is to be performed by mammography, it is advisable for women to know their own bodies and be able to notice small changes so that they can seek specialized help immediately (INCA, 2017).

Journey of two women with breast cancer during the pandemic

Flowchart 1. Margarida's therapeutic journey

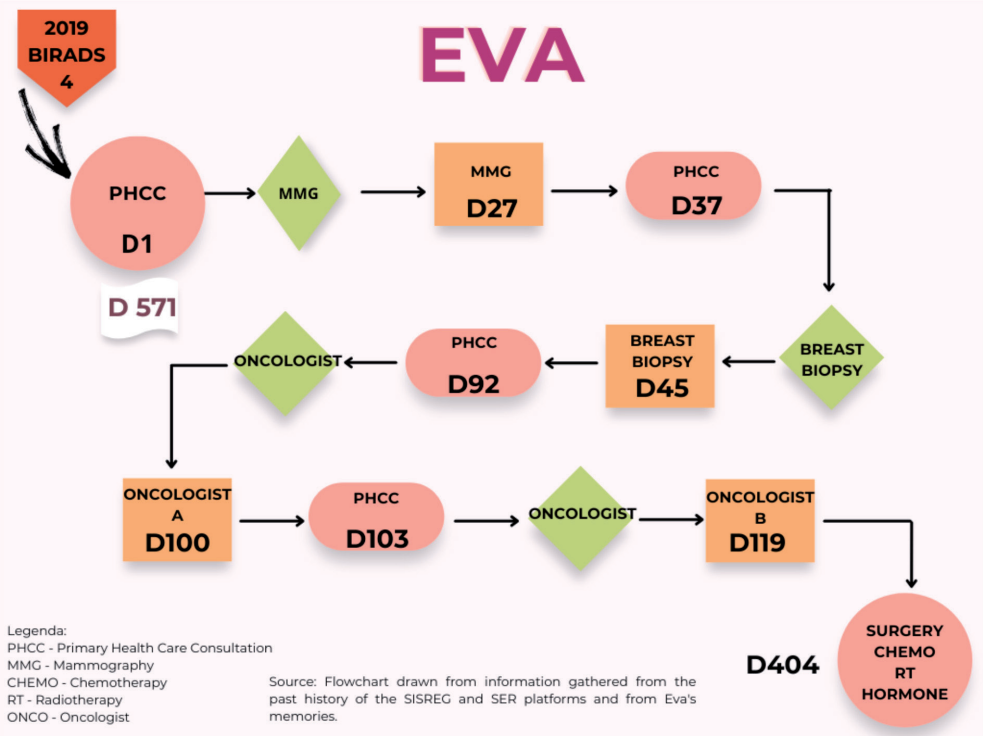


Source: the authors.

As shown in Flowchart 1, Margarida sought medical attention in February 2021 (D1) complaining of a lump in her right breast. The examination performed by the healthcare professional revealed the presence of a 1.5 cm nodule in her right breast, located in the upper inner quadrant[1] ([i]), with a regular surface. A diagnostic mammogram was then scheduled, but Margarida missed the exam (D11) and returned to the family clinic one month later to justify her absence. On the same day, Margarida was entered into the SISREG platform, and a mammogram was scheduled for 19 days later (D30). The results of this exam revealed: Right breast BIRADS 4 with irregular microcalcifications at the junction of the lateral quadrants (UQLAT), grouped by a metal marker in a palpable area in the right breast.[2] With this result in hand, the Family Clinic proceeded, in a new consultation (D35), to refer Margarida for a breast biopsy (D46), an appointment she did not attend.

Margarida did not attend the unit for 50 days and then returned to report her absence from the breast biopsy exam. The health team requested a second appointment for a right breast biopsy (D96). This time, the exam was scheduled for 10 days later (D106). The breast biopsy report, released 30 days after the procedure, described a solid 31 x 16 mm nodule located in the lateral quadrant of the right breast (BIRADS 5) with a result of invasive breast carcinoma, non-special type, histological grade 2.[3] The breast biopsy report was ready on D136, but Margarida only returned to the Family Clinic on D152. Given the results, an oncology consultation was requested for Margarida through the SER Platform. This consultation took place 16 days later (D168).

Flowchart 2. Eva's therapeutic itinerary



Source: the authors.

Eva expresses satisfaction in her narrative at having her breast cancer detected quickly and undergoing surgery within a few months. However, medical records show that Eva had already had abnormal mammograms since 2019 (right breast Birads 3 and left breast Birads 4) and that, at that time, further investigation was already indicated. In addition, a breast biopsy performed in 2016, that is, at least five years before the official diagnosis of cancer, had already been documented in her medical records.

In 2020, during the Covid-19 pandemic, Eva's medical records show a consultation due to the presence of a lump in her left breast, which resulted in a request for a mammogram. However, there is no record of this result, and Eva makes no mention of this exam in her account.

As the lump grew, Eva decided, still in 2021, that she needed to return to the clinic for another consultation. She sees this day as ground zero in her fight

against cancer (D1), as shown in Flowchart 2. On that same day, a mammogram is requested and scheduled for 26 days later (D27). After 10 days, Eva returned to the family clinic with the test results, which revealed the presence of a nodule in the upper lateral quadrant of the left breast, measuring 21 x 50 mm, spiculated, poorly defined, with irregular microcalcifications grouped in the central region of the breast ( ), enlarged, dense, confluent axillary lymph nodes, BIRADS 5, and the right breast with irregular microcalcifications grouped in the inner quadrant of the breast, BIRADS 4.[4]

Based on the mammogram results, a breast biopsy was requested, which was performed 8 days after the PHC consultation (D45). After 47 days (D92), Eva returned for a consultation with the biopsy results, which confirmed bilateral breast cancer.

Eva was then referred to an oncologist for a consultation, which took place eight days later (D100). Eva says she was very upset by the way the specialist conducted the consultation and returned to her family clinic to inform them that she would not be returning to that hospital. A new referral was made to another hospital, and 19 days after the consultation with the first oncologist (D119), Eva was seen at another hospital.

Discussion

During the first year of the Covid-19 pandemic in Brazil, there was a significant reduction in breast cancer screening programs by mammography of about 40% compared to the period before the pandemic. Rio de Janeiro, in the same year, had a greater reduction in the availability of mammography than the national average, resulting in a total reduction of 47%. In 2021, 3,497,439 mammograms were performed on women in the SUS, of which 351,509 were screening mammograms and 3,145,930 were screening mammograms, corresponding to an 18% reduction compared to 2019, but a gradual increase compared to 2020 (INCA, 2022).

When searching for information on the SISREG transparency portal (SMS-RJ, 2024), it is possible to identify that the minimum waiting time for a breast biopsy in 2021 was 13 days and the maximum waiting time was 35 days. In Margarida's case, the results show that the delay in performing the exam and the consequent delay in starting treatment were not due to the time it took to schedule the breast biopsy (11 days and 10 days after the consultation, respectively), but rather to the user's absence.

In this sense, questions arise: was there really an active search for the patient? Did any professional from the team make a home visit? Was the patient made aware of the importance of the exam for diagnosis and eventual start of treatment?

Eva reported that between 2018 and 2021, she faced several complex issues, such as cases of cancer in family members, including the treatment of breast cancer in her daughter Sol, the birth of grandchildren, among other challenges. In healthcare, it is essential to recognize the uniqueness of each individual, understanding them in multiple contexts—social, cultural, family, work, and biological (Merhy *et al*., 2014). Therefore, healthcare practices must seek strategies that consider these multiplicities, focusing on the person and not just the disease.

Living networks are dynamic connections that occur in parallel to the formal healthcare network and can arise at any time and without a pre-established logical order. These networks are built in the territories and individualized, reflecting the uniqueness of each case. It is important to note that the user may be receiving care from other services, including outside the field of health, which requires coordination with institutions over which neither the health professional nor the user has control (Merhy *et al*., 2014).

In the cases of Eva, Margarida, and possibly other patients monitored in PHC, it is clear that the team lost track of them. It is the responsibility of the PHC health team to monitor patients and share responsibility for their follow-up and treatment, guaranteeing their right to health and access to information about the risks and benefits related to their clinical conditions. Among the possible failures in surveillance, the Covid-19 pandemic stands out, which distanced part of the populati ly from health services. During this period, professionals were mainly involved in treating flu-like syndromes, and in-person home visits were temporarily suspended. However, other measures could have been taken to ensure that information about the continuity of care for suspected and confirmed cancer cases was being provided, such as telephone contact, guidance to the population through the media, and a waiting room at the unit for those awaiting care, among others.

It is important to note that often, in the daily routine of PHC and the rush of consultations, records are compromised even when there is communication with the user, and it is possible that with the exchange of electronic medical records, some important information, such as test results and crucial information related to health surveillance, may have been lost. In this sense, we reaffirm the need to

record all forms of communication with the user and all guidance provided during consultations or in the field in the medical records for the purposes of effective and continuous care, in addition to reinforcing the importance of discussing these cases in weekly team meetings and documenting the most critical cases, establishing a defined referral flow so that care does not depend on the professional who is providing care at the time.

Although Law No. 12,732/2012 exists to guarantee all patients with malignant neoplasms the right to undergo their first treatment in the Unified Health System (SUS) within 60 (sixty) days from the date of diagnosis in the pathological report, in practice, what we see in the records of the SUS Outpatient Information System (SIA-SUS) for the period 2015-2019 was an average time of 113 days, despite the 60 days, and only 43% of women started treatment within the time frame provided for by law. In this case, the time between diagnosis and first treatment was 100 days for Eva and 168 days for Margarida.

Another point of utmost relevance in this study was the barrier to access imposed by the healthcare professional representing a hospital specializing in breast cancer treatment in the city of Rio de Janeiro, who calls himself an oncologist and who, by acting unethically and immorally, delayed the start of Eva's treatment. She was clearly not welcomed and her rights as a user of the SUS were not guaranteed, even though she was in a public service. When it comes to providing care and communicating clinically with cancer patients, especially in a specialized environment such as a large hospital, it is essential that healthcare professionals and other employees in the sector exercise caution and awareness because they are dealing with people who are emotionally vulnerable in the face of a cancer diagnosis and fear about treatment. From this perspective, it is necessary that the first encounter with the patient be more welcoming and involve qualified listening to their anxieties, fears, and suffering. The bond and confidence in successful treatment depend on this.

A meta-analysis study published in the *British Medical Journal* (BMJ), which included more than 1.2 million cancer patients in Canada and the United Kingdom between January and April 2020, found a strong correlation between delays in cancer treatment and an increased risk of mortality (95% confidence interval). On average, in relation to delays in surgical treatment for breast cancer, the increased risk of death was respectively: 8% for a four-week delay, 17% for an eight-week delay, and approximately 26% for a 12-week delay (Hanna *et al*., 2020).

According to Helman (2009), mutilating surgeries such as mastectomies, alopecia, changes in skin color and appearance, and other bodily changes caused by radiotherapy and chemotherapy can make women feel that they are suffering losses, interfering with their feminine identity. Since ancient times, breasts have been idealized as symbols of femininity , fertility, motherhood, self-esteem, sexuality, among others (Helman, 2009).

Law No. 12,802/2013 provides for breast reconstruction in cases of mutilation resulting from cancer treatment, through reconstructive breast surgery by the SUS network of units at the same time as surgery, when technical conditions exist; and in the event of impossibility of immediate reconstruction, the guarantee of performing the surgery immediately after reaching the required clinical conditions. In the case of cancer patients who have private health insurance coverage, mandatory coverage is provided for in Federal Law No. 9,656/1998.

The decision to undergo delayed breast reconstruction may be made for two reasons: after radiotherapy (RT), tissues not belonging to the breast bed, such as muscle flaps, skin, and prostheses, would be irradiated unnecessarily, and immediate breast reconstruction (IBR) performed before RT may lead to inadequate planning, due to excessive irradiation of adjacent organs, insufficient irradiation of the surgical bed, and/or lymph node drainage. Another consequence of IRR before RT would be fibrosis and scarring, as radiation compromises skin quality (Marta *et al.*, 2011).

When analyzing Eva's statement about the three-year interval between mastectomy and breast reconstruction—both in her case and in that of her daughter Sol—without obvious clinical justifications, it is inevitable to question the establishment of this time frame as protocol. Would it be a coincidence that two women from the same family simultaneously presented contraindications to immediate reconstruction, or were there non-transparent institutional practices that systematically determined this interval? This question becomes even more pertinent in light of Law No. 12,802/2013, which guarantees the right to immediate breast reconstruction when clinical conditions allow.

Eva's account shows that the suffering and complexity of the illness go beyond the individual experience, echoing in the family nucleus and directly affecting her own health care. According to Eva, her daughter Sol did not have access to breast reconstruction immediately after her mastectomy, and this absence contributed to the development of depression and weight gain while she waited for the procedure. At

the time of the interview, Sol was undergoing treatment for weight loss, a condition imposed to make the reconstructive procedure feasible. This context generated significant emotional overload for Eva, who began to prioritize her daughter's care over her own treatment process, which contributed to delays in consultations that could have made her early cancer treatment feasible.

Although this was not the main objective of this research, the contradictions observed raise the need for specific investigations into the effectiveness of the application of this legislation and the protocols adopted in public health services, especially in the municipality of Rio de Janeiro. The lack of published data on this topic to date reinforces the urgency of studies that analyze the practices and barriers that contribute to the recurring postponement of breast reconstruction, contrary to both legal frameworks and established clinical guidelines.

Chemotherapy-induced alopecia has an overall incidence of 65% and is one of the most commonly reported adverse events by patients undergoing chemotherapy, due to the cytotoxic effects of these drugs. Clinically, alopecia is most noticeable on the scalp and appears within days to weeks after the start of treatment. After chemotherapy ends, new growth usually begins within 1-3 months; however, there may be changes in texture, color, and/or thickness. The impact of hair loss is due to its sudden and visible occurrence, exposing the disease and altering women's self-esteem (Silva, 2020; Almeida *et al.*, 2015).

As side effects of breast cancer treatment, women may experience decreased libido and arousal, reduced sexual interest, and inhibition of orgasm due to changes in sex hormone production, which can also make sexual intercourse painful (Silva, 2008).

Radiodermatitis is a skin reaction that occurs due to exposure to ionizing radiation and can begin within hours or weeks after the start of radiation therapy. Unfortunately, in Brazil, there are not many studies on the incidence of radiodermatitis that can be applied on a large scale. A study was conducted at the Radiotherapy Outpatient Clinic of the High Complexity Oncology Unit (UNACON) of the University Hospital of Brasília (HUB), linked to the University of Brasília (UnB), involving 112 patients who underwent radiotherapy between March 15, 2016, and May 4, 2017, of whom 50 had breast cancer. The incidence of radiodermatitis was 98% in patients with breast cancer, a value similar to that found in the international literature, which ranged from 95 to 100%. The main changes found were: erythema or hyperpigmentation, edema, epilation, dry and wet desquamation (Bontempo *et al.*, 2021).

Radiotherapy causes acute and late toxicities in addition to radiodermatitis. One of the most common acute toxicities is mucositis (due to irradiation of the mucosa), and a late toxicity is xerostomia. In the latter, there is a considerable decrease in saliva, which leads to persistent dry mouth, oral discomfort, sore throat, tooth decay, difficulty speaking, taste alteration, and impaired chewing and swallowing functions, which can lead to nutritional depletion and weight loss (Turk *et al*., 2020).

One of the essential attributes of Primary Care described by Starfield (2002) is the coordination of care. This attribute, as its name suggests, brings the concept of integrating Health Care Networks into the care of SUS users, avoiding delays in patient information, misunderstandings about diagnoses or treatments, providing essential and necessary care, and promoting quaternary prevention (Starfield, 2002).

The Family Health team must work in harmony with the SUS user, accompanying them from the onset of illness, through the identification of the stages of grief upon discovery of the disease, to diagnosis and treatment, in coordination with secondary and tertiary care specialists. This exchange of information, known as counter-referral, not only helps users better understand their condition and actively participate in decisions about their care, but also strengthens the bond between professional and patient, favoring more positive health outcomes.

Conclusion

This study identified gaps in the comprehensive care of women with breast cancer, both in PHC and in hospitals. Among the main challenges are the lack of vigilance on the part of health professionals, failures in actively seeking to ensure that patients return for follow-up appointments, and the teams' inability to demonstrate empathy, ethics, and affection in some interactions with these women. It should be noted that these issues are not restricted to the context of the Covid-19 pandemic, but represent structural problems that can be mitigated with practical changes in the day-to-day running of health services.

This study had some limitations. First, regarding the number of interviews conducted, two in total, since some women refused to participate in the research and others who could participate could not be found, due to change of territory and death. In any case, this limitation does not invalidate the applicability of the results

in other studies, since the objective was not to exhaust the participants' statements, but rather to reflect on improvements in the comprehensive care of breast cancer patients. The second limitation is information bias, since there was a change in electronic medical records at two points during the interval of four municipal terms, with possible data loss during data migration.

We conclude by emphasizing the fundamental role of PHC in the care of women with breast cancer, especially through the use of light technologies and the strengthening of the bond with SUS users. However, it is still necessary to develop strategies that ensure continuity of care in times of crisis, especially in the monitoring and treatment of serious clinical and social conditions. This study pointed to some possible directions for addressing these challenges: in the face of technological innovations, digital health presents itself as an ally, allowing the dissemination of reliable and timely information to support evidence-based decisions.[5]

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Notes

[1] QID - stands for lower lateral quadrant, meaning it is only the location of the change in the breast.

[2] The breast is basically made up of fatty tissue, connective tissue, and glandular tissue, as well as blood vessels, lymphatic vessels, and nerve fibers. In some cases, calcium deposits (calcifications) are also associated with various types of lesions, whether tumorous or not. Malignant microcalcifications vary greatly in shape, size, density, and number.

[3] Non-special invasive carcinoma accounts for about 75% of breast cancer cases. When treatment is done correctly, the chances of cure are over 95%.

[4] Spiculated nodules have irregular contours, which leads to the name spicules, or projections on their peripheries, giving them the appearance of sun rays and raising strong suspicion of breast cancer.

[5] L. G. De Brito: study design and execution, fieldwork, data analysis, approval of the final version of the article. T. B. do Espírito Santo: co-supervision of the study, research design, critical review of the manuscript. J. G. Golçalves and K. S. C. Coelho: research development, writing and revision, approval of the final version of the article. C. T. Seixas: research design, data analysis, formulation and critical review of the manuscript, approval of the final version of the article.

Resumo

Itinerário de cuidado de mulheres com câncer de mama no município do Rio de Janeiro

No Brasil, o câncer de mama é o segundo tumor mais incidente em mulheres. Em 2020, a pandemia de Covid-19 e as restrições de isolamento social impactaram o acompanhamento e tratamento de muitas condições de saúde pelas equipes da Atenção Primária à Saúde (APS), focadas no atendimento à síndrome gripal. Este estudo buscou compreender a produção do cuidado de mulheres com câncer de mama durante o período pandêmico. Estudo de abordagem qualitativa e exploratória, cuja coleta de dados primários foi realizada por meio de entrevista semiestruturada com duas mulheres diagnosticadas com câncer de mama em 2021, cadastradas em clínica da família do município do Rio de Janeiro. A coleta dos dados secundários foi realizada por meio de análise documental dos registros de prontuário eletrônico e dos sistemas Estadual e Nacional de Regulação. Os resultados evidenciaram lacunas no cuidado integral de mulheres com câncer de mama em decorrência da pandemia de Covid-19, tanto no âmbito da APS quanto no hospitalar, com perda de seguimento pela equipe de APS. Estratégias para manutenção da continuidade do cuidado em período de crise, sobretudo no acompanhamento e tratamento de situações clínicas e sociais graves ainda precisam ser construídas, mas algumas pistas puderam ser apontadas.

➤ **Palavras-chave:** Itinerário terapêutico. Neoplasias da Mama. Atenção Integral à Saúde. Covid-19.