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A DESCRIPTIVE STUDY TO ASSESS THE KNOWLEDGE REGARDING MANAGEMENT AND PREVENTION OF BREAST CANCER AMONG WOMENRESIDING IN WAGHODIYA DISTRICT

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ABSTRACT

Background of the study: Breast cancer is a development of cancerous cells. The cancer spreads to other parts of the body if untreated. At age 40, the likelihood of developing breast cancer increases. Women over 50 have the highest incidence (almost 80% of invasive cases). Incidence and mortality rates and trends by age, race/ethnicity, stage, molecular subtype, and region based on incidence data through 2019 and mortality data through 2020; relative survival for patients diagnosed between 2012 and 2018 and followed through 2019 by stage at diagnosis and breast cancer subtype; and treatment patterns in 2018. **Material and method:** Total 153 females above 30 years of age were selected. The researcher used 25 knowledge questionnaires on management and prevention of breast cancer. Descriptive and inferential statistics were used. We use non probability convenient sampling technique. **Result:** For knowledge questions, out of 153 sample 0 (0%) had excellent knowledge, 10 (6.53%) had good knowledge and 143 (93.46%) had poor knowledge. **Discussionand Conclusion:** The next conclusion addresses the analysis and interpretation of data collected from 153 females above 30 years of age who undertook to assess the knowledge regarding management and prevention of breast cancer at waghodiya district, Vadodara.

Key words: Breast cancer, management, prevention

INTRODUCTION

Since 1980, breast cancer has been more common across all racial groups. With 32% of all female cancer cases being breast cancer, it is the most common type of cancer in women. It is second only to lung cancer as the major cause of cancer in women between the ages of 20 and 59 **[1]**.

Mammography in particular has improved in accuracy, allowing for earlier diagnosis, which explains for the huge rise in breast cancer incidence between 1982 and 1987 and is probably to blame for the present minor decline in death and incidence rates **[2]**.

Whites and African Americans had the greatest rates, while American Indians, Alaskan Natives, Asian and Pacific Islanders, and Hispanics have the lowest rates. Small, localized cancers are increasingly being diagnosed in white women. During the 1990s, the incidence rate for African American women stabilized, but many of these women will have larger tumors and more advanced disease when they are diagnosed. Corresponding to this, women of other racial and ethnic backgrounds are more likely to have a more severe illness diagnosed **[3]**. For things to change there needs to be more study done on chemoprevention, better systematic medicines, and better access to early detection and preventative healthcare for the socio economically disadvantaged. the disease's current death rates **[4]**.

In the last 40 years, the lifetime risk of breast cancer has climbed from 5.5% to 13% **[5]**. Possible reasons for these trends are that woman are living longer into the cancer prone years, statistical reporting is better and better screening methods are available. In addition, changes in dietary and socioeconomic habits and increasing exposure to carcinogens, may contribute to the higher incidence of breast cancer **[6, 7]**. The breast is made up of distinctive tissues, extending from exceptionally greasy tissue to exceptionally thick tissue. Inside this tissue could be an arrange of projections. Each flap is made up of little; tube-like structures called lobules that contain drain organs. Little channels interface the organs, lobules, and flaps, carrying drain from the projections to the areola. The areola is found within the centre of the areola, which is the darker region that encompasses the areola.

The incidence is rising in most countries and is projected to rise further over the next 20 years despite current efforts to prevent the disease **[8-11]**. The increased incidence is not surprising since there has been, in most countries, an increase in numbers of women with major breast cancer risk factors, including lower age of menarche, late age of

first pregnancy, fewer pregnancies, shorter or no periods of breastfeeding, and a later menopause. Other risk factors which add to the burden of breast cancer are the increase in obesity, alcohol consumption, inactivity, and hormone replacement therapy (HRT) **[11]**. The impact of hereditary breast cancer has also increased. For example, it is estimated that the penetrance of the breast cancer 2 (BRCA2) founder mutations in Iceland increased fourfold over the last century, and the cumulative incidence of sporadic breast cancer by age 70 also increased fourfold, from 2.5% to 11% of the population, over the same period **[12]**. Birth cohort effects have also been seen for both BRCA1 and BRCA2 in other countries **[13], [14]**. These data suggest that both familial and non-familial risks have increased. The Collaborative Group on Hormonal Factors in Breast Cancer (2002) estimated that the cumulative incidence of breast cancer in developed countries would be reduced by more than half, from 6.3 to 2.7 per 100 women, by age 70 if women had on average more children and breastfed for longer periods as seen in some developing countries **[15]**. Given global increases in population growth and the strong evidence that a woman's ability to control her fertility may improve her social, economic, and overall health, it is not considered desirable to increase the birth rate per woman or to encourage pregnancies at a very young age. However, breastfeeding can and should be encouraged for many reasons, including possibly for the reduction of breast cancer risk. Many of the risks of reproductive factors are related to the effects of oestrogen as demonstrated by the reduction in breast cancer incidence after an early oophorectomy, by inhibition of the oestrogen receptor (ER) by using selective oestrogen receptor modulators (SERMs) such as a tamoxifen or raloxifene **[16]**, or by blocking oestrogen synthesis by using aromatase inhibitors (AIs) such as exemestane **[17]** and anastrozole **[18], [19]**.

A family history of breast cancer can increase your risk of developing the disease, but the vast majority of women diagnosed with breast cancer do not have a known family history of the disease. A disease is any condition which results in the malfunctioning of the body as a whole, or of any of its parts. A disease may be caused by external factors such as pathogens or by internal dysfunctions. The study of disease is called pathology. Diseases can be classified in a number of ways. One major classification is by cause: infectious diseases are caused by pathogens such as bacteria, viruses, fungi or parasites; while non-infectious diseases are caused by factors such as genetics, trauma, malnutrition or lifestyle

choices. Another way of classifying diseases is by their effect on the body: some diseases are acute, meaning they come on suddenly and last for a short time; while others are chronic, meaning they develop slowly and may last for many years. The history of disease is a long and complex one, spanning thousands of years and involving many different cultures. Early humans probably had little understanding of the causes of disease, and attributed them to supernatural forces **[20]**. Breast cancer is a devastating illness that affects tens of thousands of American women each year. Although it is impossible to predict who will develop breast cancer, clinicians can identify women who are at increased risk for breast cancer and provide them with options to reduce their risk. A number of validated, quantitative risk-assessment models incorporate features of a patient's medical and family history to help women more accurately estimate their individual risk and thus aid them in decision-making. Over the years, research has focused on the development of both surgical and medical methods for breast cancer risk reduction in high-risk women. This chapter will emphasize the importance of identifying and educating women at increased risk for breast cancer, and then providing them with a comprehensive breast cancer risk management plan. We will also discuss the surgical and medical options available and offer a management summary for breast cancer risk reduction **[21-28]**.

MATERIAL AND METHODS

Introduction:

The goal of this study was to evaluate the knowledge regarding management and prevention of breast cancer among women residing in waghodiya district. The assessment of the knowledge regarding management and prevention of breast cancer is the main emphasis of this study. It includes a description of the research approach, the research design, the variables being studied, the population, the setting, the sample size and sampling techniques, the sample, the development of the tool and procedure for data collection, the plan for data analysis, interpretation, and the study's ethical implications.

Research approach:

This study employs a Quantitative research approach to determine the knowledge regarding management and prevention of breast cancer among women residing in waghodiya district.

Research design:

Non-experimental descriptive research design was adapted in this study to determine the knowledge regarding management and prevention of breast cancer among women

residing in waghodiya district.

Place of study:

Piparia, Waghodiya district, Vadodara is the place of the study.

Source of data:

The data is collected from women residing in Piparia, Waghodiya district, Vadodara. The information for this study will come from that women residing in Piparia, Waghodiya district.

Population:

The population residing in Piparia, Waghodiya district, Vadodara. Only women residing in waghodiya district will be included in this population. The age range of the population will be from 30 years old minimum and above 60 years old maximum age in year, and all types of patients will be considered without any preference of any religion or sex.

Sampling technique:

The process of choosing a sample from the research study's target population is referred to as sampling technique. Utilizing a non-probability convenient sampling technique, the study's sample was chosen. Sampling technique of the research is non-probability convenient sampling technique.

Sample size:

Sample the group of study subjects that were chosen. 153 women residing in Piparia, Waghodiya district, made up the study's sample.

Ethical consideration:

Ethical clearance was obtained from the ethical committee, Sumandeep Vidyapeeth. Informal consent was obtained from the subjects before the data collection.

Sample selection criteria:

1. Inclusion criteria:-

1. Females including in the study.
2. Females who are present during the time of study data collection.
3. Females who are willing to participate.

2. Exclusive criteria

1. Females who are deaf and dumb.
2. Females who are less than 30 years of age.

Description of tool

Section A: Demographic variable

This section includes demographic variables such as Age, Education, Family type, Family history and previous knowledge regarding breast cancer.

Section B: Knowledge questionnaires

This section includes 25 question of knowledge; treatment and nutrition related to breast cancerand scoring interpretation of the data are poor, average and good.

Good: 17-25

Average: 9-16

Poor: 1-8

Section C: Association between Socio-demographic variables with knowledge score.

Section A:

Table 1: Frequency and percentage distribution of socio-demographic variables (N=153)

Sr. No.	Factors	Frequency	Percentage
1.	Age (in years)		
	30-40	57	37%
	40-50	49	32%
	50-60	16	10%
	Above 60	32	21%
2.	Educational qualification		
	Higher Secondary	32	21%
	Graduate	29	19%
	Post Graduate	35	23%
	Any other, specify	58	38%
3.	Family type		
	Joint	94	61%
	Nuclear	59	39%
4.	Family history of patient with breast cancer		
	Yes	21	14%
	No	131	85%
	If yes, whom	1	1%
5	Previous knowledge regarding breast cancer		
	Yes	20	13%
	No	133	87%
	If yes, from where	00	00%

Section B:

Table 2: Frequency and percentage of structured knowledge questionnaires (N=153)

Sr. no.	Knowledge Level	Frequency	Percentage
1	Poor	143	93.46%
2	Average	10	6.54%
3	Good	00	00%

Section C:

Table 3: Association between socio-demographic variables with knowledge score (N=153)

Variables		Falls at 6 and above	Falls below 6	Total	DF	X^2	T Value	Level off Significance
Age (inyears)	30-40	30	26	56	6	0.02	12.59	NS
	41-50	28	21	49				
	51-60	11	5	16				
	60 above	15	17	32				
Educational qualification	Higher secondary	17	15	32	6	0.02	12.59	NS
	Graduate	16	13	29				
	Post graduate	22	13	35				
	Any other, specify	29	28	57				

Variables		Falls at 6 and above	Falls below 6	Total	DF	X^2	T Value	Level off Significance	
Family type	Joint	52	44	96	1	0.04	3.81	NS	
	Nuclear	32	25	57					
Family history of patient with breast cancer	Yes	10	11	21	2	0.18	5.91	NS	
	No	72	58	130					
	If yes,Whom	1	1	2					
Previous knowledge	Yes	11	9	20	2	0.07	3.81	NS	
	No	73	60	133					

DISCUSSION:

Frequency and percentage distribution of socio-demographic variables.

- The age groups of the participants were as follows, the highest percentage is 37% of age group is 30 to 40 year, high percentage is 32% of age group is 40-50 year, medium percentage is 10% of age group is 50-60 year and rest of 21% age group above 60 year.
- Regarding educational qualification of the women indicates highest percentages are (38%) of any other, specify, average percentage are (23%) of post-graduate, lower percentage are (21%) of higher secondary and rest of percentage are (19%) graduate.
- Regarding family type of women, 61% are of joint family and 37% are of nuclear family.
- Regarding family history of women with breast cancer 14% are having history of breast cancer, 85% are not having any history of breast cancer and if yes, whom are 1%.
- Previous knowledge regarding breast cancer was as follows, 95% are of without familyhistory and rest of 5% is having with family history.

Frequency and percentage of structured knowledge questionnaires

- 93.46 % of poor knowledge, 6.54% of average knowledge and 00% of good knowledge knowledge regarding management and prevention of breast cancer among women residing in waghodiya district.

Association between socio demographic variable with knowledge score

- **Age in years:** Association of selected demographic variable with the knowledge score. The calculated value of chi square is 1.56 is less than tabulated value 12.59, the table value of chi square at the 6 degree of freedom and 0.02 level of significance.
- **Educational qualification:** Association of selected demographic variable with the knowledge score. The calculated value of chi square is 0.06 is less than tabulated value12.59, the table value of chi square at the 6 degree of freedom and 0.02 level of significance.
- **Family type:** Association of selected demographic variable with the knowledge score. The calculated value of chi square is 0.06 is less than tabulated value 3.81, the table value of chi square at the 1 degree of freedom and 0.04 level of significance.
- **Family history of patient with breast cancer:** Association of selected demographic variable with the knowledge score. The calculated value of chi square is 0.17 is less than tabulated value 5.99, the table value of chi square at the 2 degree of freedom and 0.18 levelof significance.

- **Previous knowledge regarding breast cancer:** Association of selected demographic variable with the knowledge score. The calculated value of chi square is 0.07 is less than tabulated value 3.81, the table value of chi square at the 2 degree of freedom and 0.07 level of significance.
- **Association between knowledge score with the selected demographic variables:** Here to test the hypothesis, chi square test has been used. Data have been analysed by the researcher manually and the outputs are depicted in the above table. The table reveals there is no

Significant association between knowledge score with selected demographic variables. Therefore Research Hypothesis (H1) is rejected and null hypothesis (H0) is accepted.

SUMMARY

Statement of study

"A Descriptive study to assess the Knowledge Regarding Management and Prevention of Breast Cancer among Women Residing in Waghodiya District."

Objectives of the study:

1. To assess the knowledge regarding management and prevention of breast cancer among women residing in waghodiya district.
2. To find out the association between knowledge score with selected socio-demographic variables regarding management and prevention of breast cancer among women residing in waghodiya district.

Hypothesis

H1: There will be significant association between levels of knowledge on management of breast cancer among women residing in waghodiya district.

H0: There will be no significant association between levels of knowledge on management and prevention of breast cancer among women residing in waghodiya district.

Delimitation:

The study is delimitation for:

1. Women residing in waghodiya district.
2. Period of 4-6 weeks.
3. 3.Sample size is limited to 153.

Description of t

The research tools were developed by a systematic process and tools in three sections were identified. Section:

Section: 1

Demographic Variables: -

it consists of age, education, family type, family history and previous knowledge regarding breast cancer. Section:

Section 2:

Structured Knowledge Questionnaires: - it consists of knowledge, treatment and nutrition,

Section: 3

Associations between Demographic Data & Knowledge Questionnaires

To assess the feasibility of study and assessing the reliability of tools, a pilot study was organized by researcher and its result stated that the study tools were reliable and feasible. Before that the validity of tool were assessed by experts from nursing experts. Process of study scheduled to gather all relevant information in one go. The gathered data were arranged in master sheet and calculated under Microsoft excel.

CONCLUSION

After the detailed analysis, this study leads to the following conclusions: 93.46 % of poor knowledge, 6.54% of average knowledge and 00% of good knowledge regarding management and prevention of breast cancer.

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