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Breast Cancer Treatment Options for Women Who Already have Serious Mental Disorders

Sohyun Obeid*

Department of Gynaecological, Institut National du Cancer 92513 002CBoulogne-Billancourt, France

Introduction

It is well known that people with severe mental illness die more often from cancer, and research suggests that care-related factors may play a role. Using a comprehensive population-based data-linkage study with a matched case-control design, our goal was to evaluate breast cancer care pathways for women in France. Women with incident breast cancer in and prior were the cases. They were matched with three controls without who shared similar demographics, the type of breast cancer they were diagnosed with, and the year of the incident. Using a consensus-based set of indicators covering diagnosis, treatment, follow-up, and mortality we compared cancer care pathways and their quality for cases and controls. Cases had lower odds of undergoing the primary diagnostic tests, a lumpectomy, chemotherapy, radiotherapy, and hormone therapy, as well as hormone therapy, after adjusting for but higher odds of undergoing a mastectomy. Both groups had cancer pathways of subpar quality, but cases had it worse because they didn't get treatment or care when they needed it after treatment. When considering the competing risks of death, women with had a significantly higher mortality rate from breast cancer. These findings highlight disparities in cancer care pathways for patients, as well as particular aspects of the care continuum that could benefit from targeted actions to achieve equity in outcomes.

Description

A wide range of chronic and disabling mental illnesses, such as bipolar and psychotic disorders, are considered to be severe mental illnesses. These disorders frequently manifest themselves in recurrent episodes that cause severe impairment, particularly in terms of limiting functional capacities and social skills. The excessive mortality of people with has been known for decades but they have not experienced the gradual increase in life expectancy seen in the general population As a result, their mortality has continued to increase over time or even worsened. Shared risk factors for mental and somatic disorders, drug-related parthenogenesis, differences in pain perception associated with and their treatment, economic difficulties and living conditions that are unfavorable to health and likely to limit individual healthcare-seeking, and factors linked to the health system are thought to be the causes of this health inequality. These factors can be organizational or behavioral [1,2].

Cardiovascular diseases and cancer are the most common causes of death in people with, just like in the general population group consistently has an excess mortality ratio of more than two In this population, risky health behaviors are frequently blamed for an increased risk of cancer development and death, but the scientific literature yields conflicting findings on the subject. While some studies have found a lower or similar incidence of cancer in people with compared to the general population others have found a higher overall risk Although there are age-related differences and variations depending on the type of cancer considered these findings suggest that intervening after the onset of the disease, such as at the time of access to the health system or care delivery, may play a significant role in the excess cancer mortality observed in the population. [3].

Prior research that focuses on specific phases of cancer care for this vulnerable group has consistently shown that they have lower care intensity and less access to cancer screening than the general population Because institutional and policy-level issues in care pathways are likely to be the source of many of the factors that contribute to the excessive mortality of people with this excessive mortality is a matter of human rights and equity. However, there is still a lack of research on this topic, despite the significance of documenting cancer care pathways in people with Only a handful of studies, to the best of our knowledge, have attempted to provide a global overview of cancer treatment pathways for patients [4].

Patients with schizophrenia and cancer were found to have a higher in-hospital mortality rate within a lower likelihood of receiving surgical or endoscopic treatment after adjusting for cancer stage, and a higher risk of advanced cancer upon admission in a national Japanese study focusing on gastrointestinal cancer Another Japanese study on breast cancer found that patients with schizophrenia were less likely than cancer patients without schizophrenia to receive chemotherapy or the recommended treatment On the other hand, a large Finnish study on the same kind of cancer found that women with had less access to radiotherapy. People with and cancer was less likely to receive adjutant radiation or chemotherapy and potentially curative surgical resection in Canada [5].

Conclusion

At a national level in France, our study has revealed disparities in the care pathways for breast cancer among women with SMI and controls without SMI. A crucial first step toward taking action is providing data on care disparities experienced by this vulnerable population, which has been overlooked in health-services research focusing on care inequities. With the knowledge that the complexity associated with SMI necessitates special consideration and that providing increased quality of care for this population group has the potential to make up for some of the structural health inequities they face throughout their life, additional research on causal mechanisms will help inform the development of system-level multifaceted interventions.

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***Address for Correspondence:** Sohyun Obeid, Department of Gynaecological, Institut National du Cancer 92513 002CBoulogne-Billancourt, France, E-mail: obeidsohyun@gmail.com*

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