

Psychosocial Distress Affecting Patients With Ductal Carcinoma in Situ Compared to Patients With Early Invasive Breast Cancer

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Psychological distress in patients with a diagnosis of ductal carcinoma in situ (DCIS) or early invasive breast cancer (EIBC) can emanate from perceived risk of recurrence and is accompanied by perceived risk of death from the diseases. These factors can impart a lower quality of life that can result in poorer health outcomes. In addition, inaccurate risk perceptions can have an effect on decision making, psychosocial outcomes, and subsequent health behaviors. The purpose of this study is to assess patients with DCIS and EIBC and their perceived risk of recurrence and perceived risk of dying, and evaluate their outlook for the future, the degree of social support from spouses and significant others of patients who have been diagnosed with DCIS and EIBC, and the relationship to the patient's perceived risk perception of recurrence and dying from the diseases.

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All nurses who care for patients with cancer should recognize the importance of the differences between ductal carcinoma in situ (DCIS) and early invasive breast cancer (EIBC). Most female patients with cancer hear only one word after being given a diagnosis: cancer. The nurses who care for these patients are the ones who help them understand their diagnosis. Whether the diagnosis is DCIS or EIBC, the severity and the perceived risk of recurrence or dying from the diseases needs to be addressed.

Prior to 1980, before the widespread use of screening mammography, DCIS was a rare diagnosis. DCIS accounted for 2%–5% of all newly diagnosed breast cancers (Cady & Chung, 2011). With the increased use of screening mammography, 40% of all breast cancers diagnosed by mammography are DCIS. DCIS is the fourth most common cancer diagnosed in women, and almost 60,000 new cases are diagnosed annually in the United States (Cady & Chung, 2011).

DCIS accounts for 20% of all newly diagnosed breast cancers (Cady & Chung, 2011). It often appears without warning

in asymptomatic women, having been detected on routine screening mammography. The treatment of DCIS is basically the same as stage I EIBC, which includes a segmental mastectomy followed by radiation therapy (with or without tamoxifen if patients are sensitive to estrogen or progesterone) and, in the case of multifocal DCIS, with a mastectomy (Liu et al., 2010).

The general consensus is that pure DCIS has no metastatic potential. In addition, the cause-specific survival of DCIS, regardless of the type of therapy, is 96%–98%. It has been suggested that calling neoplastic cells that do not invade or metastasize *carcinoma* is an anomaly. Instead, it has been suggested that the term *DCIS* be replaced with *ductal intraepithelial neoplasia* (Veronesi, Zurrida, Goldhirsch, Rotmensz, & Viale, 2009).

EIBC is cancer that has spread from where it began, usually from the lobules (milk glands) or milk ducts. This occurs when cancer evolves from inside of the ducts or lobules and spreads into surrounding breast tissue. A difference between DCIS and EIBC is that, with DCIS, the cancer will grow inside the ducts; with EIBC, the cancer will have invaded surrounding breast tissue.