









ORIGINAL RESEARCH

Frequency of unmet physical needs in patients with chronic oncological or cardiovascular diseases in Popayán, Colombia

Frecuencia de necesidades físicas no satisfechas identificadas en pacientes con enfermedades oncológicas o cardiovasculares crónicas en Popayán, Colombia

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Abstract

Introduction: Palliative care (PC) is essential for the management of patients with chronic and oncologic diseases. In turn, PC requires proper identification of physical needs and symptoms, which can be achieved through standardized instruments that allow for a comprehensive assessment of the patients' current condition.

Objective: To determine the frequency of unmet physical needs (UMPNS) in patients with chronic cardiovascular (CVD) or oncologic diseases treated in the inpatient wards of a university hospital in Popayán, Colombia.

Materials and methods: A descriptive cross-sectional study was conducted in 441 patients with chronic cardiovascular disease or cancer as their primary diagnosis admitted to the Hospital San José in Popayán between 2021 and 2022. The presence of UMPN was determined based on the responses to the 21 items of the Physical Symptoms domain of the validated Colombian version of the Sheffield Profile for Assessment and Referral for Care (SPARC-Sp) instrument.

Results. Of the 441 patients, 340 (77.10%) had chronic cardiovascular disease as their primary diagnosis. Pain was the most frequent UMPN (56.00%), followed by fatigue (41.95 %), and the feeling of being unable to control symptoms (38.09 %). The median UMPN was 4 (IQR: 2-7). The proportion of individuals with UMPN was higher in the cancer patient group in 18 of the 21 items. Consequently, cancer patients had more UMPNs (median UMPN: 7 [IQR: 4-9] vs. 3 [IQR: 1-7]; $p<0.001$).

Conclusion: Most patients experienced UMPNs, especially in the oncology group, with a significantly higher median and a higher proportion of individuals with UMPNs in 18 of the 21 items of the SPARC-Sp.

Resumen

Introducción. Los cuidados paliativos (CP) son esenciales en el manejo de pacientes con enfermedades oncológicas o cardiovasculares crónicas. A su vez, los CP requieren la identificación adecuada de las necesidades físicas y síntomas, lo cual se puede realizar a través de instrumentos estandarizados que permiten una valoración integral de la condición actual de los pacientes.

Objetivo. Determinar la frecuencia de necesidades físicas no satisfechas (NFNS) en pacientes con enfermedades oncológicas o cardiovasculares crónicas y atendidos en las salas de hospitalización de un hospital universitario de Popayán, Colombia.

Materiales y métodos. Estudio transversal descriptivo realizado en 441 pacientes con diagnóstico principal de cáncer o enfermedad cardiovascular hospitalizados en el Hospital San José de Popayán entre 2021 y 2022. La presencia de NFNS se determinó a partir de las respuestas en los 21 ítems del dominio Síntomas físicos de la versión validada en población colombiana del instrumento Sheffield Profile for Assessment and Referral for Care (SPARC-Sp).

Resultados. De los 441 pacientes, 340 (77.10%) tenían una enfermedad cardiovascular crónica como diagnóstico principal. Dolor fue la NFNS más frecuente (56.00%), seguido de sensación de cansancio (41.95 %) y sentir que los síntomas no están controlados (38.09 %). La mediana de NFNS fue 4 (RIQ: 2-7). La proporción de individuos en los que se determinó la presencia de una NFNS fue mayor en el grupo de pacientes con cáncer en 18 de los 21 ítems. De forma consecuente, los pacientes con cáncer tuvieron más NFNS (mediana de NFNS: 7 [RIQ: 4-9] vs. 3 [RIQ: 1-7]; $p<0.001$).

Conclusión. La mayoría de los pacientes presentaron NFNS, especialmente en el grupo oncológico, con una mediana significativamente más alta y una mayor proporción de individuos con una NFNS en 18 de los 21 ítems del SPARC-Sp.

Introduction

Palliative care (PC) refers to the active and comprehensive care of individuals who, regardless of age, are severely affected by chronic, progressive, or end-of-life illnesses.¹⁻³ Its aim is to improve the quality of life of patients, their families, and caregivers by preventing and alleviating suffering through early identification, comprehensive assessment, and treatment of physical, emotional, social, and spiritual symptoms.^{1,2} This definition acknowledges that PC should be provided based on the patient's needs rather than on the prognosis or stage of the disease, which means that PC is applicable in all hospital settings and levels of care, covering both general and specialized care.^{1,2,4}

Timely access to PC is an essential component of health care, as well as a key factor in universal health coverage.¹⁻⁵ However, there are still gaps in health care provision in most parts of the world due to various factors,¹ such as a lack of awareness of its availability, misinformation about the appropriate use of certain medications like opioids, and the focus that existing health outcome measures (which are major drivers of health policy and investment) have on extending life and productivity, downplaying health interventions aimed at relieving pain or avoiding negative impacts on people's dignity at the end of life.^{2,3}

Patients with chronic diseases, mainly cancer, cerebrovascular diseases, kidney problems, and Alzheimer's, often require PC due to the progressive deterioration of functional capacity resulting from these conditions.⁶⁻⁸ Thus, although PC was initially intended to alleviate suffering at the end of life, nowadays it is increasingly being used in the early stages of illness, with a focus on the needs of the patient and their family, rather than solely on numerical and objective tools. The aim is to take into account clinical factors, as well as psychological, health, and spiritual needs.⁷ The systematic and comprehensive assessment of symptoms and individual needs in each patient is key to establishing care and treatment goals and to promoting shared decision-making in both the short and long term.¹

In Colombia, Law 1733 of 2014 regulates health care provided to individuals with terminal, chronic, degenerative, and irreversible diseases.⁹ Nevertheless, there is no general consensus on the best way to assess and evaluate the holistic needs of patients with advanced chronic diseases, nor is there solid evidence on their use in the hospital setting. In view of the above, the Ministry of Health and Social Protection, through the Clinical Practice Guideline for Palliative Care, established that the Edmonton Symptom Assessment System (ESAS-r) and the Rotterdam Symptom Checklist can be used to assess symptoms in the context of studies evaluating the impact of palliative care.¹⁰

Similarly, although progress has been made in the implementation of PC programs in the country, according to the Colombian Palliative Care Observatory,¹¹ there is no information on the needs perceived by these patients, which makes it difficult to develop effective detection and intervention strategies. This gap is particularly evident in the systematic assessment of these needs using structured instruments in hospitalized patients with chronic diseases, especially cardiovascular diseases, despite the fact that they, together with cancer, are important contributors to the burden of disease, disability, and mortality in the region.^{12,13}

In clinical practice, there are several situations that contribute to the underreporting of intensity and occurrence of symptoms and patient needs, which differs from patients' self-perception, especially cancer patients.¹⁴ PC requires proper identification of physical needs and symptoms, which can be achieved using standardized instruments that permit conducting a comprehensive assessment of the patients' current condition, such as patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs).¹⁵⁻¹⁷

PROMs and PREMs are questionnaires used to collect information about patients' perceptions of their health. Their implementation in clinical practice allows modifying

treatment goals and supporting patients and their families in accordance with their individual values and preferences.^{16,17} In this regard, the Sheffield Profile for Assessment and Referral for Care (SPARC-Sp) questionnaire, validated for use in the Colombian population,^{18,19} is a PROM that comprehensively assesses the unmet holistic needs of patients on PC across the country in multiple domains.²⁰

In view of the above, the objective of this study was to determine the frequency of unmet physical needs (UMPNS) in patients with chronic cardiovascular (CVD) or oncologic diseases treated in the inpatient wards of a university hospital in Popayán, Colombia. It should be noted that this study specifically aimed to identify the presence of UMPNS in the 21 items of the “Physical Symptoms” domain of the SPARC-Sp, which includes symptoms such as pain, fatigue, dyspnea, and persistent discomfort, in order to focus the analysis on the most common and objectifiable manifestations of these patients while receiving hospital care.

These results are intended to further elaborate on the early and comprehensive identification of these patients’ needs to facilitate the implementation of PC-based interventions with a holistic approach.

Materials and methods

Study type

Descriptive cross-sectional study.

Study population and sample

The study population included patients with chronic oncologic or cardiovascular diseases as their primary diagnosis treated in the inpatient wards (medical or surgical) of the Hospital Universitario San José (tertiary care center) in Popayán between June 2021 and July 2022. To determine whether a patient had a chronic cardiovascular disease, we used the definitions provided by the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) (conditions lasting ≥ 1 year and requiring ongoing medical care and/or limiting activities of daily living).^{21,22}

It is worth pointing out that although the study population stems from the 507 patients who participated in the validation of the Spanish version of the SPARC instrument in the Colombian context,^{18,19} it does not include all of them (patients with a primary diagnosis of chronic disease, including cardiovascular, cerebrovascular, pulmonary, metabolic, and oncological diseases, among others). Since the present study only considered patients with oncologic diseases (at any stage) or chronic cardiovascular diseases as their primary diagnosis, data from 441 patients who met these eligibility criteria ($n=340$ and $n=101$, respectively) were analyzed.

It should also be noted that the study from which the data on these 441 patients was obtained did not include individuals with symptomatic brain metastases, uncontrolled psychological conditions, cognitive impairment, or those who were unable to communicate effectively with the researchers.

Procedures, data collection, and variables

A data collection form (Annex 1) was used to gather the information obtained from the review of the medical records and the information directly provided by the patients

during the administration of the SPARC -Sp. Data included biological sex, age, ethnicity (self-reported), place of residence (urban or rural area), educational level, primary diagnosis (chronic cardiovascular disease or cancer), years since diagnosis, presence of comorbidities, and functional status according to the Karnofsky Performance Scale.

The translated and validated version of the SPARC-Sp^{18,19} instrument for the Colombian population was administered individually and on paper during their hospital stay. Even though the SPARC-Sp instrument was designed to be completed by the patients themselves (self-report), if there were any difficulties reading or understanding one or more items, patients could ask for help from the person administering the instrument (duly trained research assistants).

Instruments

The Colombian Spanish version of the Sheffield Profile for Assessment and Referral for Care (SPARC-Sp) was used. This instrument was validated at the same health care center where the study was conducted,^{18,19} showing excellent overall internal reliability ($\alpha=0.91$) and domain coefficients between 0.73 and 0.89.¹⁸ These metrics support their suitability for the multidimensional assessment of palliative needs among inpatients with chronic diseases in the Colombian context.

The SPARC-SP has 45 items grouped into 8 domains: Communication and information issues (1 item), Physical symptoms (21 items on the presence of pain, nausea/vomiting, fatigue, dyspnea, among others), Psychological issues (9 items), Religious and spiritual issues (2 items), Independence and activity issues (3 questions), Family and social issues (4 questions), Treatment issues (2 questions), and Personal issues (3 questions).

Of the 45 items, 4 are dichotomous questions (yes/no; included in the domains “Communication and information issues” and “Personal issues”) and the remaining 41 are evaluated using a 3-point Likert scale (0: not at all, 1: a little bit, 2: quite a bit, and 3: very much) based on the patient’s perception.^{18,19} The presence of a UMPN is established based on the patient’s response to the 21 items of the “Physical Symptoms” domain as follows: none or a few: no physical need; considerable or many; presence of a need. Thus, a patient may score in the range from 0 to 21 UMPNs.

The Karnofsky Performance Scale assesses the functional status, ability to perform daily activities, and independence of a chronic patient.²³⁻²⁶ While originally designed to measure functional status and short-term survival in cancer patients undergoing chemotherapy,^{24,27} it is now widely used in patients with chronic diseases or other terminal illnesses.^{23-26,28} This scale has 11 items that vary depending on the patient’s functional status from 100 (normal functioning) to 0 (dead); in other words, the lower the score, the worse the individuals’ functional status.²³⁻²⁸

Statistical analysis

Data are described using absolute and relative frequencies for categorical variables, and means and standard deviations or medians and interquartile ranges (IQR) for continuous variables, depending on the normality of the data (Kolmogorov-Smirnov test and visual inspection of distributions using frequency histograms and Q-Q plots).²⁹

Of note, the distribution of participants’ response options (not at all, a little bit, quite a bit, very much) for the 21 items in the Physical Symptoms domain is presented using a barplot created with the Likert barplot 2.0 package of the R Version 4.4.2 software,³⁰

and the estimate of the frequency of patients who were found to have UMPNs for each item (quite a lot or very much) also included the corresponding 95% confidence intervals (95%CI). Furthermore, a lollipop plot was used to depict the estimated proportion of patients with UMPNs for each of the 21 items in the two groups defined based on diagnosis (oncologic diseases vs. cardiovascular diseases).

Concerning inferential analysis, bivariate analyses (chi-square test and Wilcoxon rank sum test) were performed to evaluate differences between groups (patients with cancer diagnoses vs. patients with cardiovascular disease diagnoses) regarding the presence of comorbidities, the number of UMPNs, and the Karnofsky Performance Scale score. All analyses were performed using the statistical software R (version 4.4.2),³⁰ and a statistical significance level of $p < 0.05$ was considered.

Ethical considerations

The study adhered to the ethical principles for biomedical research involving human subjects established in the Declaration of Helsinki³¹ and the scientific, technical, and administrative standards for health research set forth in Resolution 8430 of 1993 issued by the Colombian Ministry of Health;³² also, according to that resolution, this study is classified as a minimal risk research. Likewise, the study was approved by the Ethics Committee of the Hospital Universitario San José de Popayán as per minutes FO-ARH-01 dated May 21, 2021. All patients included confirmed their voluntary and informed participation by signing informed consent forms. Their personal details were anonymized.

Results

The mean age of patients was 68 years (SD=14.06), 58.50% were women, 77.56% self-identified as mixed-race, and 61.90% came from urban areas. The sociodemographic and clinical characteristics of patients are detailed in Table 1.

Table 1. Sociodemographic and clinical characteristics of patients (n=441).

Variable		n (%)
Age (mean±SD)		68±14.06
Sex	Female	258 (58.50)
	Male	183 (41.50)
Race	Mixed-race	342 (77.56)
	White	48 (10.88)
	Indigenous	26 (5.89)
	Afro-Colombian	25 (5.67)
Area of origin	Urban areas or urban centers	273 (61.90)
	Rural areas	168 (38.10)
Educational level	Elementary school	194 (43.99)
	High school	141 (31.98)
	Technical school	18 (4.08)
	University	21 (4.76)
	None	67 (15.19)
Primary diagnosis	Chronic cardiovascular disease	340 (77.10)
	Chronic cancer	101 (22.90)
Years since primary diagnosis (median (IQR))		10.78 (3.00-14.00)

With respect to the presence of comorbidities, 67.35% (n=297) had at least one, and 25.93% (n=77) of them had ≥ 2 . The proportion of patients with at least one comorbidity was higher in the cardiovascular disease group than in the cancer group, with this difference being statistically significant (71.18% vs. 54.46%; $p=0.002$). The median Karnofsky Performance Scale score was 80 (IQR: 60-90), with no significant differences between groups (80 [IQR: 60-90] vs. 80 [IQR: 70-90]; $p=0.8$).

Frequency of unmet physical needs

Pain was the item with the highest proportion of patients in whom a UMPN was identified (n=247, 56.00%; 95% CI: 51-60), followed by fatigue (n=185, 41.95%; 95% CI: 37-46), and sense of having uncontrolled symptoms (n=168, 38.09%; 95%CI: 33-42). Figure 1 shows the frequency of the four response options for each of the 21 items in the Physical Symptoms domain (the information is presented in ascending order based on the proportion of patients who responded “quite a lot” or “very much,” i.e., who presented UMPNs).

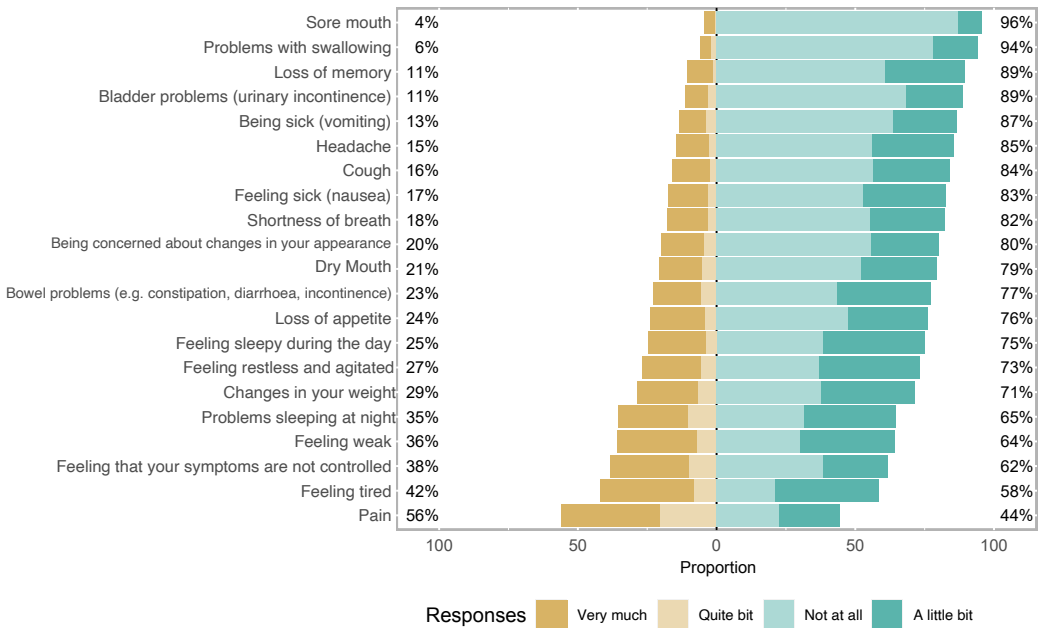


Figure 1. Distribution of patients by the 4 response options in each of the 21 items in the Physical Symptoms domain of the SPARC-Sp.

The median UMPN score was 4 (IQR: 2-7), and the proportion of individuals for whom a UMPN was found (responses “quite a lot” or “very much”) was higher in the cancer group for all items of the Physical Symptoms domain, except for urinary incontinence, shortness of breath, and memory loss (Figure 2). For example, in the pain category, 28.70% of cancer patients had a UMPN, while in the cardiovascular disease group, this number was 17.92% (Figure 2). Consequently, cancer patients had greater physical needs than those with cardiovascular disease, with a significant difference (median physical needs: 7 [IQR: 4-9] vs. 3 [IQR 1-7]; $p<0.001$).

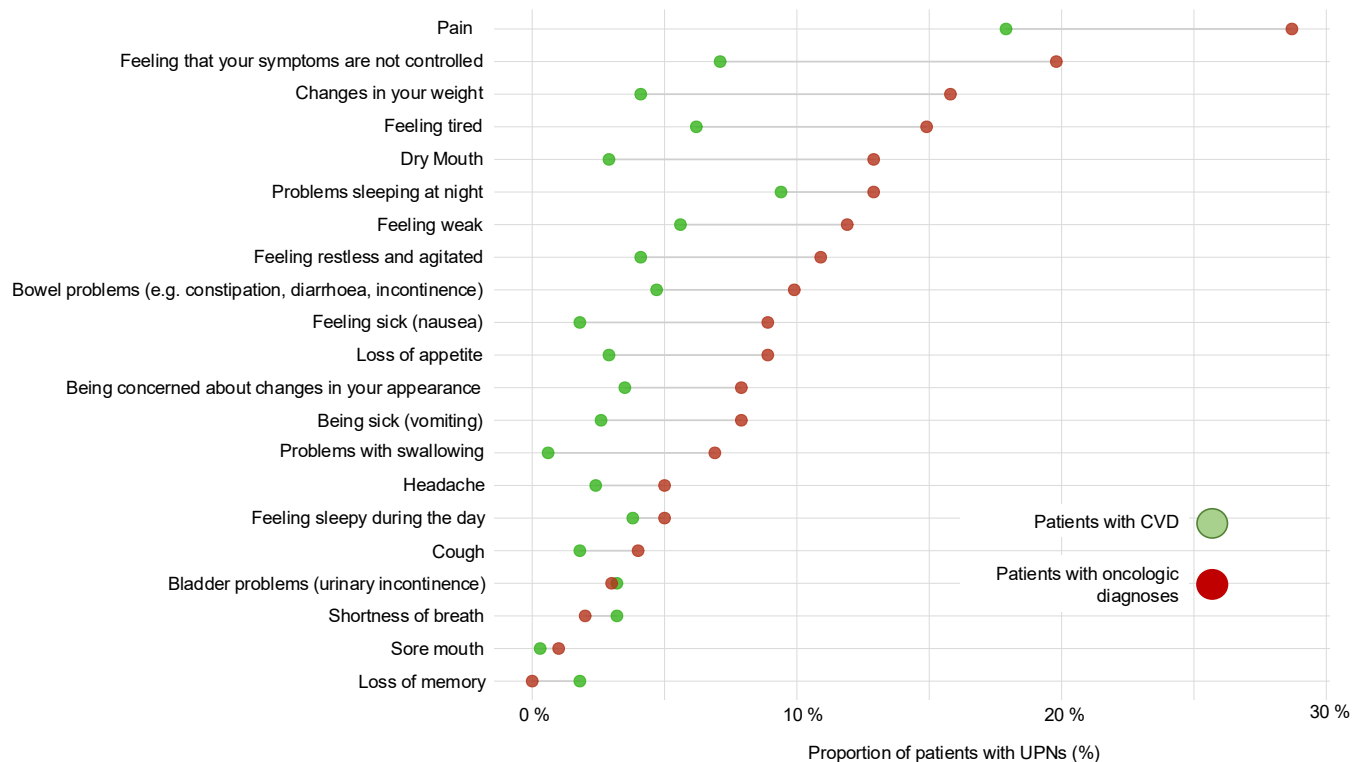


Figure 2. Proportion of patients for whom an unmet physical need was identified in each of the 21 items of the Physical Symptoms domain (patients with cancer vs. patients with cardiovascular disease).

Note: The vertical axis of the lollipop plot includes the 21 items or symptoms assessed with the instrument, while the horizontal axis represents the proportion of patients in each group in whom unmet physical needs were identified based on their responses (range 0-30%).

Discussion

The early incorporation of PC in the management of chronic diseases, both oncologic and non-oncologic, is a paradigm shift in the field of health care. This approach transforms the traditional model, which limited the use of PC to the terminal stages of the disease towards a broader and more proactive perspective, albeit it requires careful assessment of patients' needs.^{6,33-36}

In our study, at least half of the sample (patients hospitalized with chronic oncological or cardiovascular diseases) had a UMPN, with the most common symptoms being pain, fatigue, and feeling that symptoms were not under control. Furthermore, we found that, compared to patients with cardiovascular disease, patients with cancer as their primary diagnosis have more UMPNs. This difference could be explained by the greater symptom burden that cancer patients tend to experience, associated with the accelerated progression of certain types of cancer, as well as the adverse effects of treatments such as chemotherapy.³⁷⁻³⁹

As mentioned above, pain was the most frequent UMPN (56.00%), with the proportion of patients with a UMPN in this item being higher in the cancer group than in the cardiovascular disease group (28.70% vs. 17.92%). In this regard, it has been reported that pain is a common symptom in cancer patients, and that up to 40% suffer from chronic pain due to inadequate analgesic therapy.^{37,38,40}

Pain in cancer patients not only impacts their physical function but also contributes to a poor quality of life and leads to psychological distress.⁴¹ This suggests that, despite

existing guidelines for pain management in this population, there is still a significant gap in the implementation of effective strategies, reinforcing the need for early and personalized interventions. In this regard, the literature emphasizes that early integration of PC can significantly contribute to reducing pain and improving patient satisfaction and adherence to cancer treatments.^{42,43}

On the other hand, pain associated with cardiovascular diseases involves multiple mechanisms, including inflammatory, nociceptive, and neuropathic processes.⁴⁴ According to the literature, the prevalence of pain in patients with chronic heart failure (CHF) varies between 23.1% and 85% and increases as the patient's functional status worsens.⁴⁵

Fatigue was the second most common UMPN. This is consistent with the literature, which has established that chronic fatigue, defined as an overwhelming sense of tiredness that arises without provocation and cannot be relieved by rest,⁴⁶ is a common symptom of many chronic diseases.^{46,47} Fatigue is a common symptom in cancer patients,^{37,39} with a prevalence ranging from 32% to 90% depending on the stage of the disease in patients with advanced cancer.⁴² This condition is not monitored in clinical practice and, despite its profound impact on patients' quality of life, it is often underestimated.⁴⁸

Although some symptoms, such as fatigue and sleep disturbances, were common in both cancer patients and cardiovascular disease patients, underlying mechanisms and clinical manifestations may differ, reinforcing the idea of individualized detection.

Another noteworthy finding is that between 25% and 35% of patients had a UMPN score in the items feeling sleepy during the day, feeling restless and/or agitated, weight loss or gain, and sleep disturbances at night. This is consistent with what has been described in the literature, in which it has been established that chronic diseases often cause poor health outcomes that, in turn, are related to a poor quality of life.⁴⁹

Cancer and its treatment can cause changes in people's physical appearance, leading to a negative body image and psychosocial issues,³⁹ while sleep disorders are common in patients with cardiovascular disease.^{50,51} In our study, the symptoms "being concerned about changes in appearance" and "problems sleeping at night" were rarely reported, but in both cases they were more prevalent in the cancer group, which could be related to clinical underestimation, self-reporting, or normalization of discomfort, thus raising the need for future studies to further explore this difference.

Our results stem from a broad sample of inpatients predominantly diagnosed with cardiovascular diseases, offering a perspective closer to the reality of inpatient care and underscoring the need to integrate the systematic assessment of the most prevalent UMPNs into this level of care.

The detection of UMPNs must be supported by a response from PC services. Although evidence of its benefits has focused on cancer (with proven improvements in the control of symptoms such as pain, dyspnea, fatigue, and nausea, as well as in quality of life and patient satisfaction),^{37,38,42,43} the implementation of PC in patients with chronic non-oncologic diseases is also critical.⁵² On this point, in a systematic review and meta-analysis that included 28 randomized clinical trials (13 664 patients in total, mostly with non-cancer diseases), Quinn *et al.*³⁵ found that, compared with usual care, the implementation of PC was significantly associated with less emergency department use, less hospitalization, and a slightly lower symptom burden. In this sense, the results of our study, which report the frequency and nature of UMPNs, can help plan the implementation of PC for cancer and cardiovascular disease patients, especially the latter, because even though we included individuals with cancer, most (+70%) had cardiovascular diseases.

This study has several limitations that should be considered. First, convenience sampling of patients in a high-complexity hospital may reduce the validity of the results

by introducing potential selection biases toward cases with a higher symptom burden, although our objective was exploratory and aimed to demonstrate the existence of these UMPNs through systematic and standardized methods. Second, for participants with low levels of education or visual impairments, it was necessary to administer the instrument with assistance, which creates a risk of bias in the interviewer and a social desirability bias in the participants, especially on sensitive items such as perception of symptom control, memory, or mood; however, to minimize these risks, standardized training was provided to interviewers, neutral scripts were used, and privacy and continuous supervision were facilitated, although this does not rule out residual bias. Third, its cross-sectional and self-report design limits the ability of capturing the temporal variability of needs during hospitalization. Fourth, the length of the questionnaire may have caused respondent fatigue and, therefore, data may be missing. Finally, our analysis was based on a comparison between patients with two main diagnostic groups, so it is not possible to identify differences by specific diseases; in this regard, future research could explore specific differences by disease in greater depth using targeted or stratified designs.

Conclusions

Most patients admitted to a university hospital in Popayán due to cancer or chronic cardiovascular diseases presented with UMPNs, with cancer patients being the most affected, as the median of UMPNs was significantly higher in this group. Also, in 18 of the 21 items of the Physical Symptoms domain of the SPARC-Sp, the proportion of patients in whom the presence of UMPNs was identified was higher in this group compared to the cardiovascular diseases group. Pain was the most common UMPN. The high burden of UMPNs, especially in cancer patients, stresses the need to integrate systematic assessments into PC to optimize clinical response and reduce avoidable suffering.

Conflicts of interest

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Annex 1

Data collection form used in the study.

Fecha de realización: <input type="text" value="DIA"/> <input type="text" value="MES"/> <input type="text" value="AÑO"/>		Investigador: _____
Número de identificación: _____		
Sitio: HUSJ () HUSI () Otro: _____		

DATOS DEMOGRAFICOS	
Lugar de admisión: <input type="checkbox"/> Salas de hospitalización médica o quirúrgica <input type="checkbox"/> Atención ambulatoria del servicio de Dolor y Cuidados Paliativos <input type="checkbox"/> Atención ambulatoria de Oncología	
Etnia: <input type="checkbox"/> Mestizo <input type="checkbox"/> Afrocolombiano <input type="checkbox"/> Indígena <input type="checkbox"/> Blanco <input type="checkbox"/> Otro _____	
Género: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino <input type="checkbox"/> No especificado <input type="checkbox"/> Otro _____	
Edad: _____ años	
Estado civil: <input type="checkbox"/> Casado <input type="checkbox"/> Unión libre <input type="checkbox"/> Separado <input type="checkbox"/> Divorciado <input type="checkbox"/> Viudo <input type="checkbox"/> Soltero	
Religión: <input type="checkbox"/> Católico <input type="checkbox"/> Cristiano <input type="checkbox"/> Agnóstico <input type="checkbox"/> Ateo <input type="checkbox"/> Otro _____	
Religiosidad: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <div style="display: flex; justify-content: space-between; width: 100%;"> Muy poco Mucho </div>	
Nivel educativo finalizado: <input type="checkbox"/> Primaria <input type="checkbox"/> Bachillerato <input type="checkbox"/> Técnico <input type="checkbox"/> Universitario <input type="checkbox"/> Ninguno	
Ocupación actual: _____	
Procedencia (Municipio): _____ <input type="checkbox"/> Urbano <input type="checkbox"/> Rural	
Número de convivientes en su domicilio: _____	
Tiempo de transporte para consultar a la institución de salud más cercana: _____ horas	
¿Siente que cuenta con alguien cuando necesita sentirse querido, respetado o necesita un confidente para apoyarlo emocionalmente?	<input type="checkbox"/> Siempre <input type="checkbox"/> Algunas veces <input type="checkbox"/> Nunca
¿Siente que si tiene alguna enfermedad o se realiza alguna cirugía hay alguien que le puede ayudar con los asuntos de la vida diaria, como la comida o el aseo personal?	<input type="checkbox"/> Siempre <input type="checkbox"/> Algunas veces <input type="checkbox"/> Nunca
¿Siente que si necesita con urgencia dinero, hay alguien que se lo pueda prestar?	<input type="checkbox"/> Siempre <input type="checkbox"/> Algunas veces <input type="checkbox"/> Nunca

DATOS DE HISTORIA CLÍNICA			
Diagnóstico principal: _____			
Diagnóstico secundario: _____			
Clasificación OMS del diagnóstico principal: _____			
<input type="checkbox"/> Enfermedad cardiovascular		<input type="checkbox"/> Enfermedad respiratoria crónica	
<input type="checkbox"/> Enfermedad neoplásica		<input type="checkbox"/> Diabetes mellitus	
Principal enfermedad crónica:		<input type="checkbox"/> Si	<input type="checkbox"/> No
Fecha (año) de diagnóstico estimada: _____			
Tratamiento de la enfermedad crónica: _____			
Enfermedad crónica oncológica		<input type="checkbox"/> Si	<input type="checkbox"/> No
Estadio del cáncer:			
<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> No aplica			
Metástasis: <input type="checkbox"/> Presente <input type="checkbox"/> Ausente <input type="checkbox"/> No aplica <input type="checkbox"/> Desconocido			
Tratamiento actual del cáncer (selección múltiple):			
<input type="checkbox"/> Quimioterapia		<input type="checkbox"/> Radioterapia	<input type="checkbox"/> Cuidados paliativos
<input type="checkbox"/> Cirugía		<input type="checkbox"/> Inmuno-hormono terapia	<input type="checkbox"/> Terapias alternativas <input type="checkbox"/> Ninguno
Escala de clasificación (valorar durante el diligenciamiento):			
Estado funcional del Eastern Cooperative Oncology Group (ECOG):			
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No aplica			
Escala de Karnofsky: _____ Puntos			
CUESTIONARIO SARC-F			
	0	1	2
¿Qué tanta dificultad tiene para llevar o cargar 4.5 Kg?	<input type="checkbox"/> Ninguna	<input type="checkbox"/> Alguna	<input type="checkbox"/> Mucha o incapaz
¿Qué tanta dificultad tiene para cruzar caminando por un cuarto?	<input type="checkbox"/> Ninguna	<input type="checkbox"/> Alguna	<input type="checkbox"/> Mucha, usando auxiliares o incapaz
¿Qué tanta dificultad tiene para levantarse de una silla o cama?	<input type="checkbox"/> Ninguna	<input type="checkbox"/> Alguna	<input type="checkbox"/> Mucha o incapaz, sin ayuda
¿Qué tanta dificultad tiene para subir 10 escalones?	<input type="checkbox"/> Ninguna	<input type="checkbox"/> Alguna	<input type="checkbox"/> Mucha o incapaz
¿Cuántas veces se ha caído en el último año?	<input type="checkbox"/> Ninguna	<input type="checkbox"/> 1 a 3 caídas	<input type="checkbox"/> 4 o más caídas

Annex 2

Spanish version of the Sheffield Profile for Assessment and Referral for Care (SPARC-Sp) questionnaire validated for use in the Colombian population.

Perfil de Sheffield para la evaluación y remisión al cuidado asistencial (SPARC)

Nos gustaría saber un poco más sobre usted y sus inquietudes o preocupaciones.

Por favor complete este cuestionario (si lo necesita, hágalo con la ayuda de un familiar o un cuidador) y entréguelo a alguien de nuestro equipo.

No hay respuestas "correctas" ni "incorrectas"

Si usted no sabe cómo contestar una pregunta, por favor deje la respuesta en blanco

GRACIAS

Sus iniciales:

TEMAS DE COMUNICACIÓN E INFORMACIÓN		
1. ¿Ha podido hablar con alguna de las siguientes personas sobre su situación o su enfermedad?	Si	No
a. Un médico o doctor que lo haya atendido	<input type="checkbox"/>	<input type="checkbox"/>
b. Enfermera (o) del puesto de salud	<input type="checkbox"/>	<input type="checkbox"/>
c. Enfermera (o) del hospital	<input type="checkbox"/>	<input type="checkbox"/>
d. Consejero u orientador religioso o espiritual (Padre, pastor, monja, Chamán, taita u otro)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trabajador(a) social	<input type="checkbox"/>	<input type="checkbox"/>
f. Familia	<input type="checkbox"/>	<input type="checkbox"/>
g. Otras personas (quienes): _____		

SÍNTOMAS FÍSICOS	Por favor, marque UNA respuesta por cada línea			
En el último mes, se ha sentido angustiado o molesto por:	Nada	Un poco	Bastante	Mucho
2. ¿Dolor?	0	1	2	3
3. ¿Pérdida de memoria?	0	1	2	3
4. ¿Dolor de cabeza?	0	1	2	3
5. ¿Boca seca?	0	1	2	3
6. ¿Dolor de la boca?	0	1	2	3
7. ¿Falta de ire?	0	1	2	3
8. ¿Tos?	0	1	2	3
9. ¿Sentirse enfermo (con náuseas)?	0	1	2	3
10. ¿Sentirse enfermo (con vómitos)?	0	1	2	3
11. ¿Alteraciones intestinales (por ejemplo: estreñimiento, diarrea, incontinencia)?	0	1	2	3
12. ¿Alteraciones de vejiga (incontinencia urinaria)?	0	1	2	3
13. ¿Sentirse con debilidad?	0	1	2	3
14. ¿Sensación de cansancio?	0	1	2	3
15. ¿Alteraciones para dormir por la noche?	0	1	2	3
16. ¿Sentirse con sueño durante el día?	0	1	2	3
17. ¿Pérdida del apetito?	0	1	2	3
18. ¿Pérdida o ganancia de peso?	0	1	2	3
19. ¿Dificultad para tragar o deglutir?	0	1	2	3
20. ¿Estar preocupado por cambios en su apariencia?	0	1	2	3
21. ¿Sentirse inquieto (a) y/o agitado (a)?	0	1	2	3
22. ¿Sentir que sus síntomas no están controlados?	0	1	2	3

TEMAS PSICOLÓGICOS		Por favor, marque UNA respuesta por cada línea			
En el último mes, se ha sentido angustiado o molesto por:	Nada	Un poco	Bastante	Mucho	
23. ¿Sentirse ansioso(a)?	0	1	2	3	
24. ¿Sentirse triste?	0	1	2	3	
25. ¿Sentirse confundido (a)?	0	1	2	3	
26. ¿Sentir dificultad para concentrarse?	0	1	2	3	
27. ¿Sentirse solo (a)?	0	1	2	3	
28. ¿Sentir que todo es un esfuerzo?	0	1	2	3	
29. ¿Sentir que la vida no vale la pena?	0	1	2	3	
30. ¿Pensamientos acerca de terminar con todo?	0	1	2	3	
31. ¿Su situación ha afectado su vida sexual?	0	1	2	3	

TEMAS RELIGIOSOS Y ESPIRITUALES		Por favor, marque UNA respuesta por cada línea			
En el último mes, se ha sentido angustiado o molesto por:	Nada	Un poco	Bastante	Mucho	
32. ¿Pensamientos o preocupaciones sobre la muerte, el morir o el fallecimiento?	0	1	2	3	
33. ¿Necesidades religiosas o espirituales no satisfechas?	0	1	2	3	

INDEPENDENCIA Y ACTIVIDAD		Por favor, marque UNA respuesta por cada línea			
En el último mes, se ha sentido angustiado o molesto por:	Nada	Un poco	Bastante	Mucho	
34. ¿Perder su independencia?	0	1	2	3	
35. ¿Cambios en su capacidad para llevar a cabo sus actividades diarias como aseo, bañarse o ir al baño?	0	1	2	3	
36. ¿Cambios en su capacidad para realizar las tareas domésticas como cocinar o hacer aseo de la casa?	0	1	2	3	

TEMAS RELACIONADOS CON LA FAMILIA Y VIDA SOCIAL		Por favor, marque UNA respuesta por cada línea			
En el último mes, se ha sentido angustiado o molesto por:	Nada	Un poco	Bastante	Mucho	
37. ¿Siente que los demás no entienden lo que usted quiere?	0	1	2	3	
38. ¿Le preocupa el efecto que su enfermedad tiene en su familia y otras personas?	0	1	2	3	
39. ¿Falta de apoyo de su familia o de otras personas?	0	1	2	3	
40. ¿Necesitas más ayuda de la que su familia u otras personas le pueden brindar?	0	1	2	3	

TEMAS RELACIONADOS CON EL TRATAMIENTO		Por favor, marque UNA respuesta por cada línea			
En el último mes, se ha sentido angustiado o molesto por:	Nada	Un poco	Bastante	Mucho	
41. ¿Efectos secundarios de su tratamiento?	0	1	2	3	
42. ¿Preocupación por los efectos a largo plazo de su tratamiento?	0	1	2	3	

ASUNTOS PERSONALES			
		Si	No
43. ¿Necesita ayuda con sus asuntos personales?		<input type="checkbox"/>	<input type="checkbox"/>
44. ¿Le gustaría hablar con otros profesionales sobre su enfermedad o tratamiento?		<input type="checkbox"/>	<input type="checkbox"/>

45. ¿Le gustaría tener más información sobre los siguientes temas?	Si	No
a. Su enfermedad	<input type="checkbox"/>	<input type="checkbox"/>
b. Su cuidado	<input type="checkbox"/>	<input type="checkbox"/>
c. Su tratamiento	<input type="checkbox"/>	<input type="checkbox"/>
d. Otros tipos de apoyo o soporte	<input type="checkbox"/>	<input type="checkbox"/>
e. Asuntos financieros	<input type="checkbox"/>	<input type="checkbox"/>
f. Otras personas (quienes): _____		

¿Tiene otras preocupaciones que le gustaría que nosotros conociéramos?

Continúe con la página si es necesario

Usted puede utilizar esta sección para escribir cualquier pregunta que tenga para sus médicos u otros profesionales encargados de sus tratamientos y cuidados

Pregunta 1

Pregunta 2

Pregunta 3

Para terminar, marque un número entre 0 y 10 que mejor describe que tanta angustia ha vivido durante la última semana (Incluido el día de hoy)

Sin angustia

Máxima
angustia

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----