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Palliative Care in Breast Cancer: Patterns of Referral, Symptom Burden, Interventions, and Outcomes in a Developing System

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Abstract

Background: Breast cancer is the most commonly diagnosed malignancy among women worldwide and represents a substantial health burden in sub-Saharan Africa, where advanced stage presentation remains common. In Nigeria, patients with advanced breast cancer often have considerable supportive care needs, yet evidence describing their clinical characteristics, palliative care interventions, and outcomes remains limited.

Methods: A retrospective review was conducted among 122 patients with late-stage breast cancer referred to the Department of Hospice and Palliative Care, University College Hospital, Ibadan, Nigeria, between 2020 and 2024. Demographic and clinical characteristics, palliative care needs, documented interventions, and outcomes were extracted from programme registers. Patients were classified into four study-defined care patterns according to duration on programme (DOP) and follow-up status: Terminal Care (DOP ≤7 days), Intermediate Care (8–30 days), Supportive Care (>30 days), and Lost to Follow-up (LTF). Descriptive statistics were used.

Results: The mean age was 50.7 years (median 50 years). Stage III and IV disease accounted for 73.8% and 25.4% of cases, respectively. The surgical unit was the leading source of referral (52.5%). ECOG performance status was documented for 117 patients, of whom 84 (71.8%) had scores of 3 or 4 at referral. The most frequently documented palliative care needs were pain (46.7%), emotional and psychospiritual distress (41.0%), and financial difficulties (27.9%). Family conferences were the predominant documented intervention (73.0%), followed by financial support (28.7%) and pain management (12.3%). Among 74 patients (60.7%) with documented outcomes, the median DOP was 16.5 days (mean 49.4 days; range 1–425 days). Of the total cohort, 18.9% were classified as Terminal Care (median DOP 3 days), 21.3% as Intermediate Care (median DOP 16 days), and 20.5% as Supportive Care (median DOP 94 days). The remaining 39.3% were lost to follow-up.

Conclusion: Patients with late stage breast cancer referred for palliative care at this Nigerian tertiary institution frequently had substantial functional impairment and complex physical, psychosocial, and financial needs. The short duration of documented programme engagement among patients with known outcomes raises concerns about delayed palliative care involvement and highlights potential gaps in its integration into oncology services. These findings support the need for earlier, more systematic palliative care involvement alongside disease directed treatment. The proposed care pattern classification offers a practical descriptive approach to examining programme engagement in resource constrained settings, although further validation is needed.

Keywords: Breast cancer; Palliative care; Nigeria; Sub-Saharan Africa.

Introduction

Breast cancer is the most frequently diagnosed malignancy in women worldwide and the leading cause of female cancer mortality globally, accounting for an estimated 2.3 million new cases and 685,000 deaths in 2020 alone.[1] In high-income countries, population-based mammographic screening, targeted systemic therapies, and multidisciplinary oncological care have produced sustained reductions in breast cancer mortality over recent decades.[2] In sub-Saharan Africa, this progress remains largely unrealised. Incidence is rising, case fatality ratios are disproportionately elevated, and the majority of women present with locally advanced or metastatic disease, a pattern ingrained in the absence of organised screening, limited specialist infrastructure, and the financial and geographical barriers that delay access to tertiary care.[3,4] In Nigeria specifically, breast cancer accounts for approximately 50% of cancer cases in females and represents the leading cause of cancer-related death in women, with Stage III and Stage IV disease at presentation very common.[5,6]

Palliative care is the primary means of improving quality of life and alleviating suffering in those for whom curative treatment is no longer achievable. The World Health Organisation defines palliative care as an approach that addresses the physical, psychosocial, and spiritual problems associated with life-threatening illness through early identification, assessment, and treatment of pain and other sources of distress.[7] Evidence from prospective studies has demonstrated that early integration of palliative care alongside active oncological treatment improves symptom burden, mood, and quality of life, and, in some populations, confers a survival advantage, leading the American Society of Clinical Oncology to recommend early palliative care integration as a standard of practice in advanced solid tumours.[8]

In low and middle-income countries (LMICs), however, the infrastructure for palliative care remains significantly underdeveloped. Access to opioid analgesia is constrained by regulatory and supply chain barriers as well as cost, psychosocial and spiritual support structures are marginally available, and the palliative care workforce is unremarkable- predominantly physician-led, and concentrated in specified urban tertiary centers far removed from the communities carrying the greatest burden of advanced malignancy.[9] These structural realities mean that palliative care referral, when incorporated, definitely arrives late, when the disease is already advanced, and the range for meaningful intervention is limited. Financial toxicity, the direct economic burden of illness on patients and families in the absence of universal health coverage, further compounds the suffering of affected women and their households.[10]

Despite the enormity of this clinical dilemma, published data describing the palliative care experience of late-stage breast cancer patients in Nigeria are scanty. Existing literature captures staging and crude mortality data but does not systematically address the symptom burden at the

point of palliative care referral, the nature of interventions delivered, the duration of programme engagement, or the rates and drivers of attrition from follow-up. This study addresses this gap. It reports the demographic and clinical profile, palliative care issues, interventions, care trajectories, and outcomes of 122 consecutive patients with late stage breast cancer managed under a dedicated palliative care programme at the tertiary teaching hospital in Ibadan, Nigeria, between 2020 and 2024, and introduces a novel care pattern classification framework to support structured evaluation of palliative care delivery in resource constrained settings

The Global Burden of Breast Cancer and the Sub-Saharan African Context

Breast cancer is the most commonly diagnosed malignancy in women globally and the leading cause of female cancer mortality, according to successive GLOBOCAN estimates.[11] The 2020 estimates recorded 2.3 million incident cases and 685,000 deaths, representing 24.5% of all new cancers in women and 15.5% of female cancer deaths worldwide.[11] These figures, however, conceal a significant epidemiological inequity. In high-income countries, investment in mammographic screening and in increasingly effective systemic therapies, including HER2-targeted agents, CDK4/6 inhibitors, and PARP inhibitors, has produced measurable and ongoing reductions in age-standardized breast cancer mortality.[1] In sub-Saharan Africa, the trajectory is divergent. The region carries a disproportionately elevated case fatality ratio relative to its incidence burden, reflecting the structural determinants of late-stage presentation and inadequate access to treatment rather than tumour biology alone.[12]

The epidemiology of breast cancer in Nigeria has been characterised principally through the Ibadan Cancer Registry, one of the longest-established population-based registries in sub-Saharan Africa. Registry data consistently demonstrate that the majority of breast cancer cases in Nigeria present at Stage III or Stage IV, with over 70% of women reported to have locally advanced or metastatic disease at diagnosis in analyses of incidence trends across Nigerian registry sites.[13] Contributing factors include the absence of a national mammographic screening programme, low community awareness of early breast cancer signs, financial barriers to specialist referral, and the influence of traditional and faith-based healing practices that delay presentation to orthodox medical services.[13] The consequence is that palliative rather than curative intent must be imprinted into clinical planning for a substantial and growing proportion of affected women from the outset.

Biological and Demographic Characteristics of Breast Cancer in West Africa

The clinical profile of breast cancer in West African women differs from that described in high-income country literature in ways that have direct implications for palliative care planning. Age at diagnosis is consistently younger in this population, attributed to demographic structure, reproductive and hormonal factors, and a higher prevalence of biologically aggressive tumour subtypes.[14] A comprehensive review of breast cancer management across the African continent

found that triple-negative breast cancer (TNBC), characterised by the absence of oestrogen receptor, progesterone receptor, and HER2 expression, accounts for a markedly higher proportion of cases in West African women than in their European or North American counterparts, with estimates ranging from 27% to 82% in various sub-Saharan African series compared with approximately 10–15% in Western populations.[15] TNBC confers an aggressive clinical course, limited systemic treatment options beyond cytotoxic chemotherapy, and a shorter interval from diagnosis to palliative care transition. Its disproportionate prevalence in this population underscores the need for early palliative care provision.

The younger age at diagnosis also has significant social consequences that are not captured by standard oncological outcome measures. Women presenting with advanced breast cancer in Nigeria are frequently in the economically active phase of the life course, often serving simultaneously as breadwinners, mothers of dependent children, and primary domestic caregivers. Their illness and premature death generate economic and caregiving disruptions that extend across households and generations, and must inform the design of palliative care interventions.

Palliative Care: Definition, Principles, and the Evidence for Early Integration

Palliative care is defined by the World Health Organisation as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.[7] Two aspects of this definition are frequently overlooked in practice. First, the family is explicitly included as a subject of palliative care, not merely as caregivers but as individuals experiencing anticipatory grief, caregiver burden, and spiritual distress.

Second, palliative care is not confined to the terminal phase; it should be initiated at diagnosis and delivered concurrently, not sequentially, with active oncological treatment where appropriate.

The evidence base for early palliative care integration has been established principally through a landmark randomised controlled trial published in the New England Journal of Medicine in 2010. In this trial, patients with newly diagnosed metastatic non-small-cell lung cancer were randomised to early palliative care alongside standard oncological treatment versus standard care alone. The early palliative care group demonstrated significantly higher quality of life scores, lower rates of depression, and a median overall survival 2.7 months longer than the control group, despite receiving less aggressive end-of-life treatment.[8] The survival advantage was attributed to better symptom control, reduced psychological distress, and more appropriate goal setting. Subsequent meta-analyses of randomised controlled trials of early palliative integration across multiple advanced tumour types have corroborated the quality of life and symptom burden benefits. However, the survival advantage has not been consistently replicated.

These findings informed the American Society of Clinical Oncology guideline update of 2017, which recommended that patients with advanced solid tumours receive dedicated palliative care services early in the disease course, concurrent with active treatment. The World Health Assembly reinforced this in 2014 through Resolution 67.19, calling on member states to integrate palliative care into national health systems at all levels of care as a component of universal health coverage.[16] These frameworks establish the standard against which palliative care provision in Nigeria must be assessed.

Palliative Care in Sub-Saharan Africa: Infrastructure, Access, and Workforce

The gap between the evidence-based standard of palliative care practice and its delivery in sub-Saharan African settings is wide and well-documented. A landmark analysis published in The Lancet identified the near-universal unavailability of oral morphine, the absence of trained palliative care workforces, the non-integration of palliative care principles into undergraduate health professional education, and inadequate national palliative care policies as the principal structural barriers to equitable provision across the continent.[17] These barriers have remained recalcitrant to reform. Successive assessments have confirmed that access to strong opioid analgesics for cancer pain management remains severely restricted outside a small number of urban tertiary centres in Nigeria, with the majority of patients with moderate to severe cancer pain receiving inadequate analgesia as a consequence of regulatory constraints, supply chain failures, prescribing caution, and patient-level misconceptions about opioid dependence.[18]

Beyond the pharmacological care, the multidisciplinary team model of effective palliative care in high-income settings, integrating physicians, nurses, psychologists, social workers, physiotherapists, and community health workers, is evidently unavailable in most Nigerian palliative care units. The palliative care workforce in Nigeria is predominantly physician-led, small in absolute number, and concentrated in a handful of university teaching hospitals. This creates an inequity in which patients in rural communities, who carry the greatest burden of advanced malignancy, have the least access to palliative care. Community-based palliative care models, which have demonstrated feasibility and effectiveness in Uganda and Kenya, have not yet been systematically implemented at scale in Nigeria.[19]

Symptom Burden and Psychosocial Relations of Advanced Breast Cancer

The symptom burden of advanced breast cancer is multidimensional and has been characterised across a range of clinical populations. A systematic review of symptom prevalence in patients with incurable cancer identified pain, fatigue, weakness, anorexia, and dyspnoea as the most consistently reported physical symptoms, with psychological symptoms, particularly anxiety and depression, occurring in a substantial and frequently underrecognised proportion of patients.[20] Breast-specific symptoms, including fungating masses, lymphoedema, and chest wall pain, add to the burden in patients with locally advanced disease and impose workforce demands on nursing and wound care resources in LMICs.

In the Nigerian and West African context, psycho-spiritual distress takes a form shaped by a distinctive cultural and religious landscape, diverging from the frameworks described in the

predominantly Western palliative literature. Distress is expressed through the lens of Christian and Islamic faith, through anger directed at God, through the existential weight of anticipated role loss, and through collusion, the practice, common across Nigerian families, of withholding a diagnosis or prognosis from a patient by family consensus to protect them from the perceived harm of full disclosure.[21] This places palliative care clinicians in sustained ethical tension, navigating between the patient's right to information and the family's protective authority, where both positions carry cultural legitimacy. Addressing these dimensions of distress requires cultural and spiritual competencies that are absent from standard palliative care training curricula.

Financial Toxicity and Economic Dimensions of Advanced Cancer in LMICs

The concept of financial toxicity was introduced in the oncological literature to describe both the objective financial burden (the out-of-pocket costs of cancer treatment) and the subjective financial distress experienced by patients and families navigating cancer care without adequate financial protection.[22,23] In high-income countries with universal or near-universal health coverage, financial toxicity represents a significant but manageable burden for many patients. In Nigeria, where out-of-pocket expenditure accounts for a substantial proportion of total health spending and where no functioning national health insurance scheme covers the majority of the population, financial toxicity represents a frequently insurmountable barrier to care.[10]

For patients with advanced breast cancer, the financial consequences of illness are compounded by the high cost of palliative care medications, wound care supplies, nutritional support, hospital transportation, and informal caregiving arrangements, all of which fall directly on the patient and her family. The progressive depletion of household assets, withdrawal of children from education, and assumption of caregiving roles by elderly relatives have been documented in qualitative studies of advanced cancer households in Nigeria.[10] Financial constraint thus functions not merely as a social determinant of health but as a direct mediator of physical suffering, determining whether a patient can afford the analgesics, dressings, and nutritional supplements her condition requires.

Gaps in the Evidence and Rationale for the Present Study

The literature reviewed above documents the scale of advanced breast cancer burden in Nigeria, the structural inadequacy of palliative care infrastructure, the multidimensional nature of patient suffering, and the evidence base for early palliative care integration. What is absent from the published literature is a systematic description of what palliative care for late stage breast cancer patients in Nigeria looks like in practice: who is referred, at what stage, with what symptom profile, receiving what interventions, for how long, and with what outcome?

In the absence of data describing the current reality of palliative care delivery for this population, health systems, clinicians, and policymakers lack the empirical foundation needed to identify points of failure, design targeted interventions, advocate for resources, and evaluate service quality. This study addresses this gap directly, providing the first comprehensive descriptive analysis of a five year palliative care programme for late stage breast cancer patients at the University College Hospital, Nigeria, and introducing a novel care pattern classification

framework, distinguishing terminal, Intermediate, Supportive, and lost to follow-up trajectories, as a replicable tool for structured service evaluation in resource constrained settings.

Methods

A retrospective review of 122 patients with late-stage breast cancer referred to the Department of Hospice and Palliative Care, University College Hospital, Ibadan, Nigeria, between January 2020 and December 2024 was conducted. Demographic and clinical characteristics, palliative care needs, documented interventions, and clinical outcomes were extracted from programme registers.

Patients were categorized into four mutually exclusive groups according to their duration on programme (DOP) and follow-up status: Terminal Care (DOP ≤7 days), Intermediate Care (DOP 8–30 days), Supportive Care (DOP >30 days), and Lost to Follow up (LTF). Descriptive statistics were used to summarize the study variables.

Results

A total of 122 patients with late stage breast cancer were included in the study. The mean age was 50.7 years, with a median of 50 years (Figure 1). Most patients were self employed. Stage III and Stage IV disease accounted for 73.8% and 25.4% of cases, respectively (Figures 2 and 3). Histological documentation was incomplete; however, invasive ductal carcinoma was the most frequently recorded histological subtype among cases with available data (Figure 4).

At referral, 71.8% of patients had an Eastern Cooperative Oncology Group (ECOG) performance status of 3 or 4, indicating substantial functional impairment (Figure 5). The surgical unit was the predominant source of referral, accounting for 52.5% of cases (Figure 6). The most frequently documented palliative care needs were pain (46.7%), emotional and psychosocial or spiritual distress (41.0%), and financial difficulties (27.9%) (Figure 7).

Family conferences were the most frequently documented intervention (73.0%), followed by financial support (28.7%) and pain management interventions (12.3%) (Figure 8).

Outcomes were documented for 74 patients (60.7%), among whom the median duration on programme (DOP) was 16.5 days (mean 49.4 days; range 1–425 days). Based on the study defined care pattern classification, 18.9% of the total cohort were categorised as Terminal Care (median DOP 3 days), 21.3% as Intermediate Care (median DOP 16 days), and 20.5% as Supportive Care (median DOP 94 days). The remaining 39.3% were lost to follow-up (Figure 9). The distribution of care patterns across disease stages is illustrated in Figure 10.

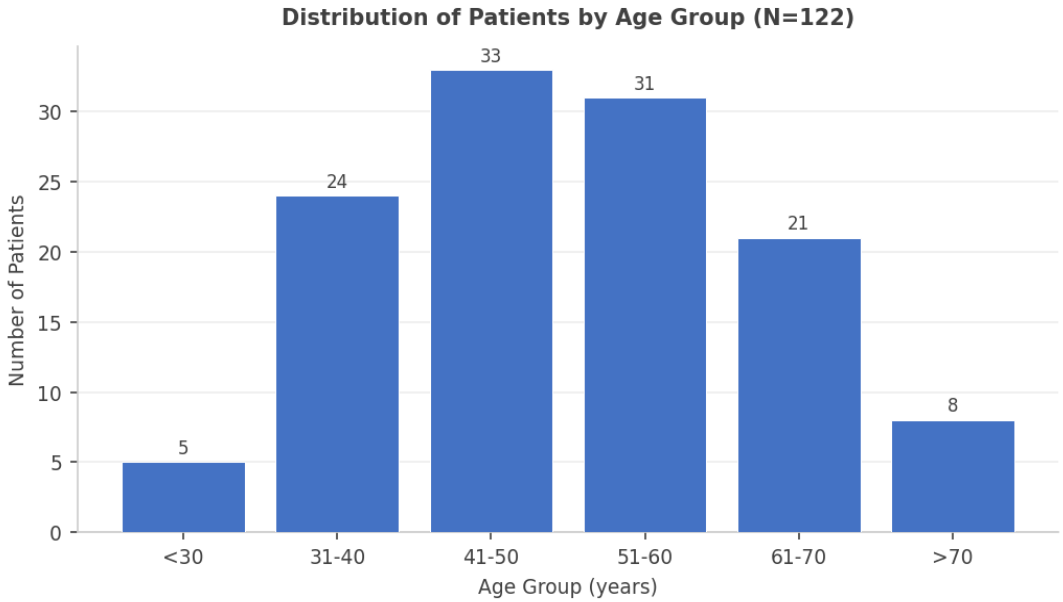

Figure 1. Distribution of Patients by Age Group (N=122)

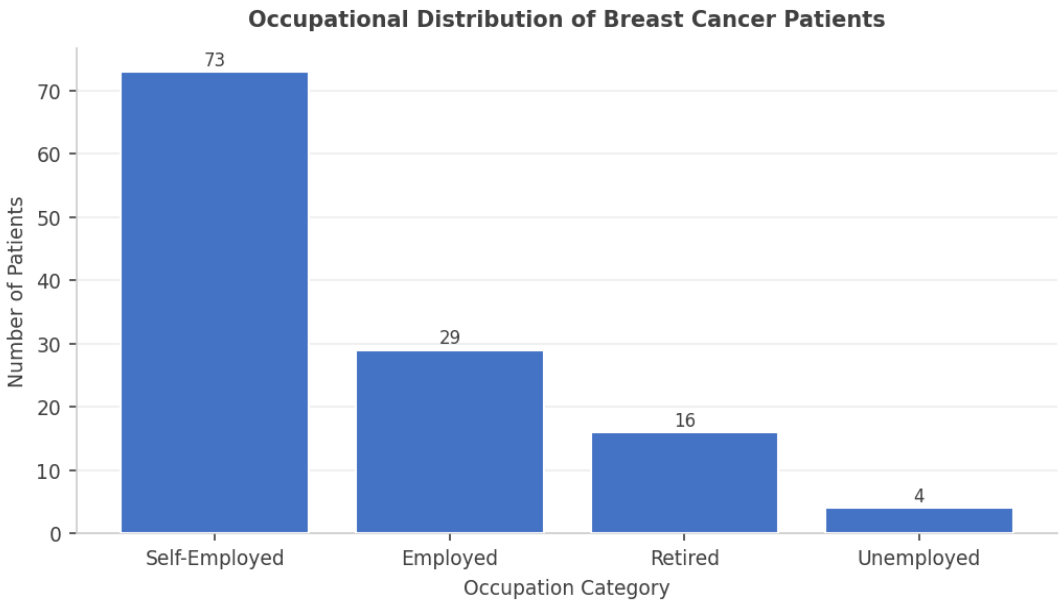

Figure 2. Occupational Distribution of Breast Cancer Patients

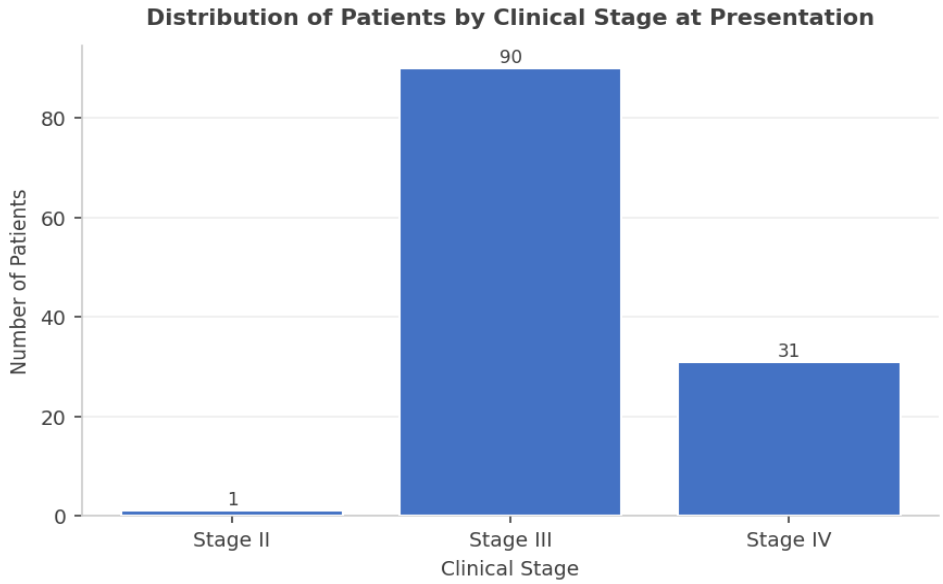

Figure 3. Distribution of Patients by Clinical Stage at Presentation

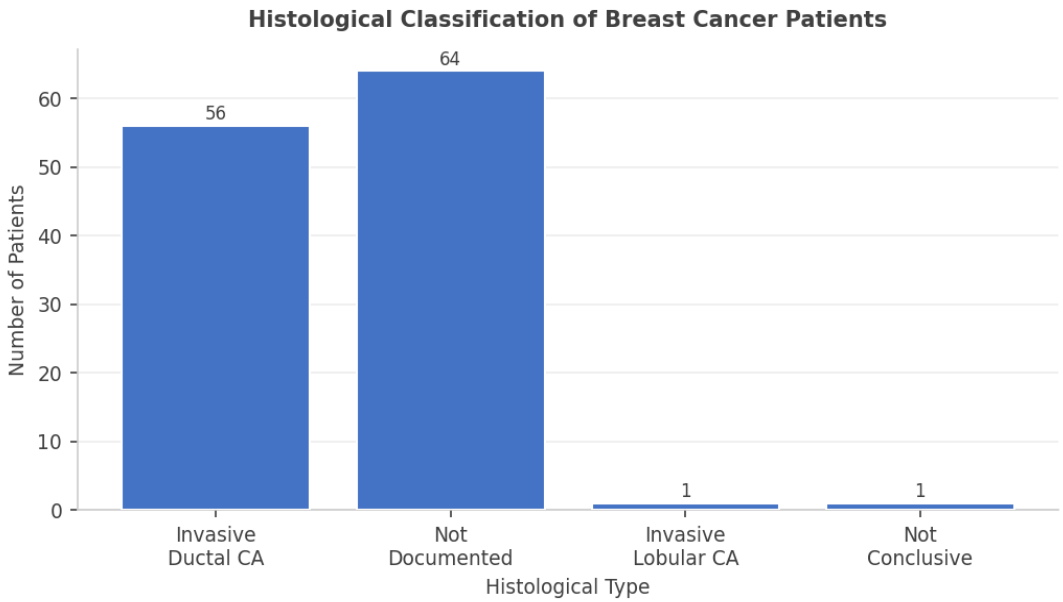

Figure 4. Histological Classification of Breast Cancer Patients

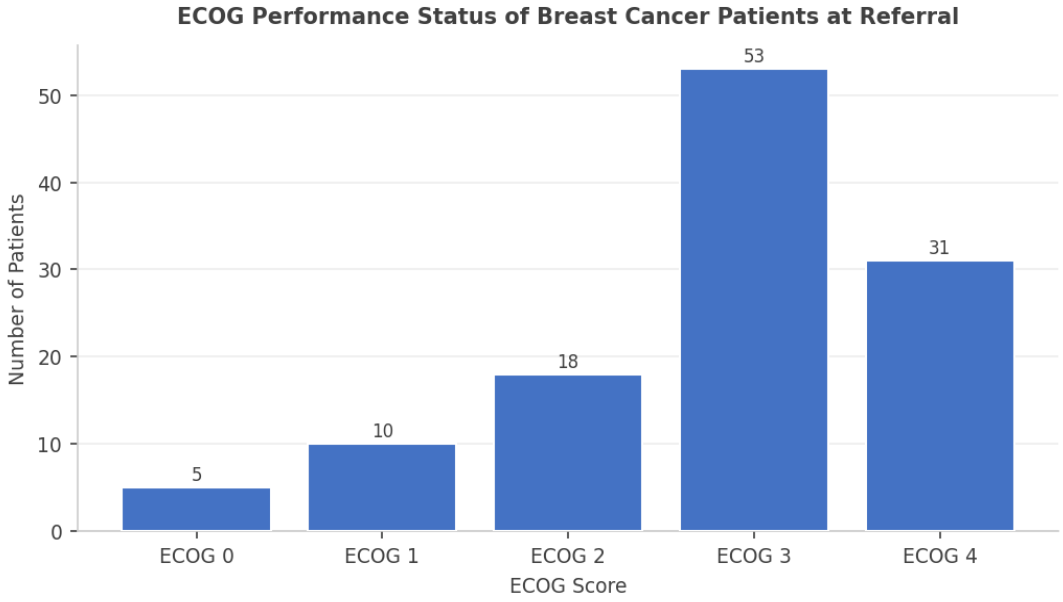

Figure 5. ECOG Performance Status of Breast Cancer Patients at Referral

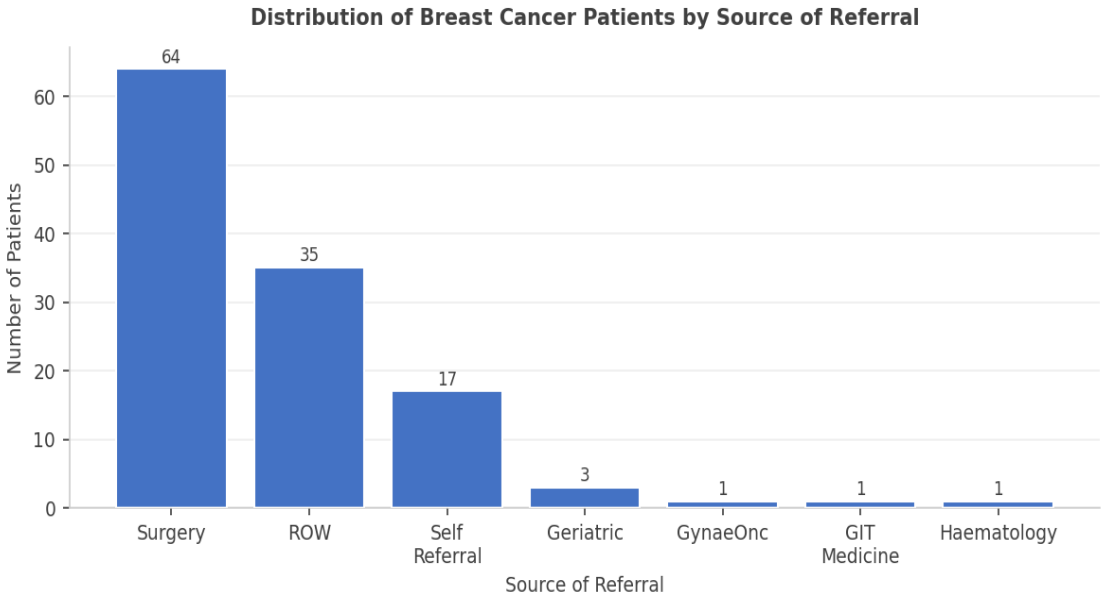

Figure 6. Distribution of Patients by Source of Referral

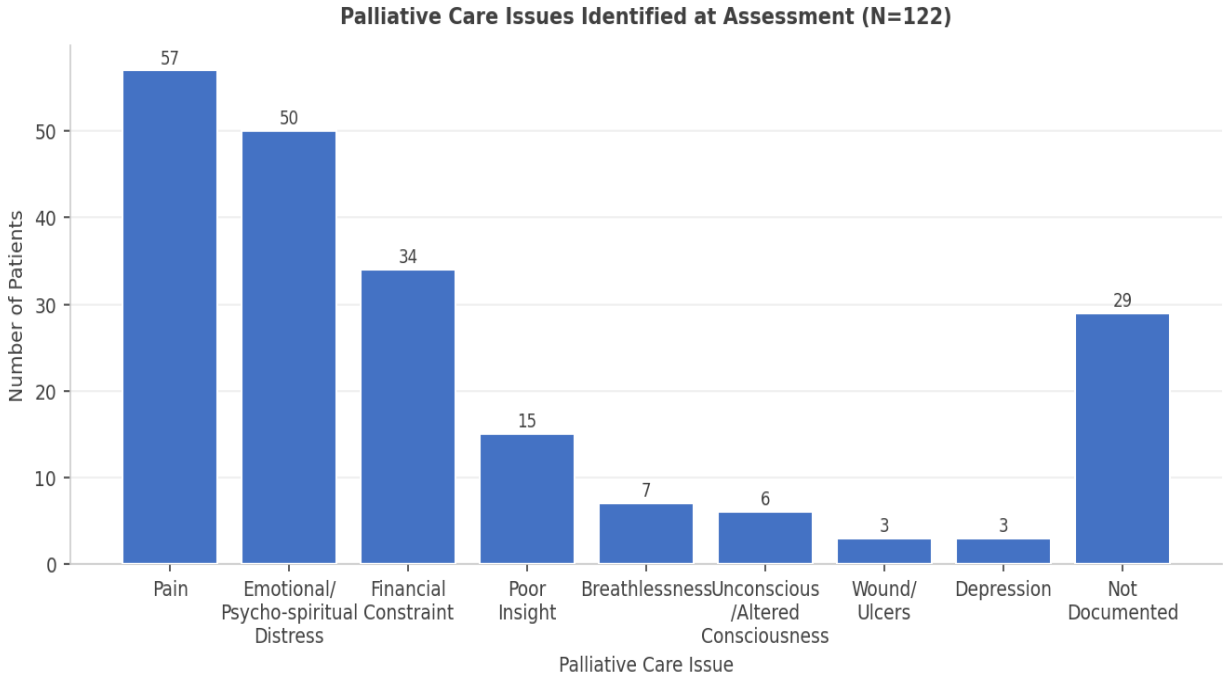

Figure 7. Palliative Care Issues Identified at Assessment (N=122)

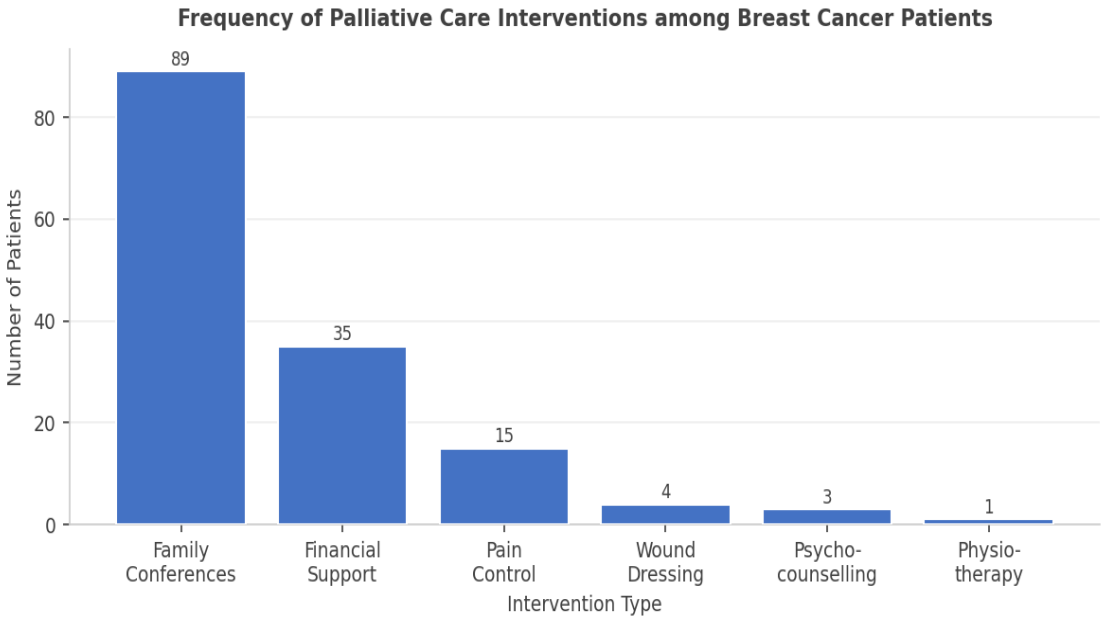

Figure 8. Frequency of Palliative Care Interventions among Breast Cancer Patients

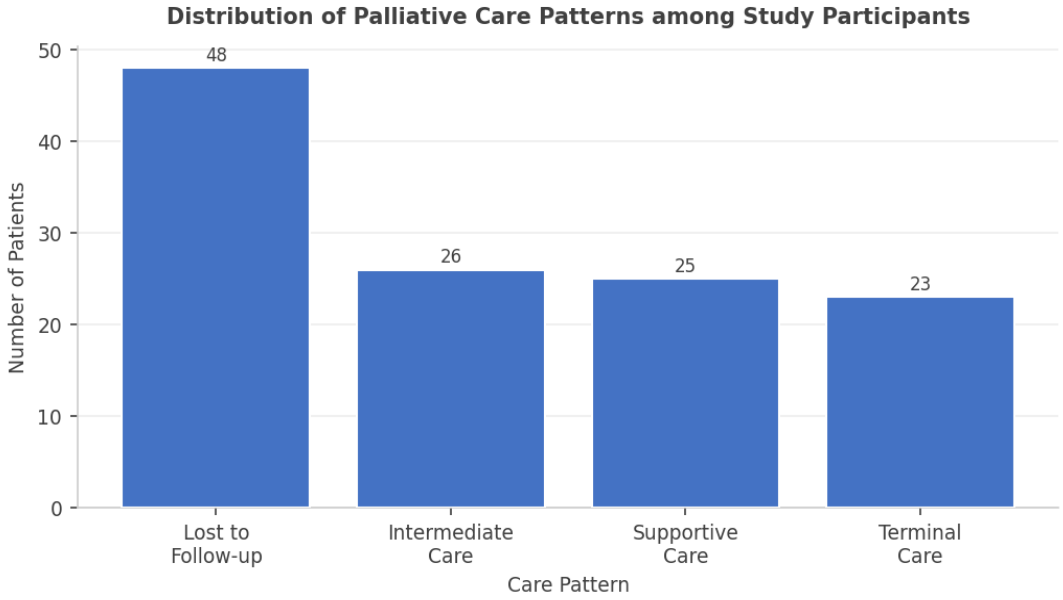

Figure 9. Distribution of Palliative Care Patterns among Study Participants

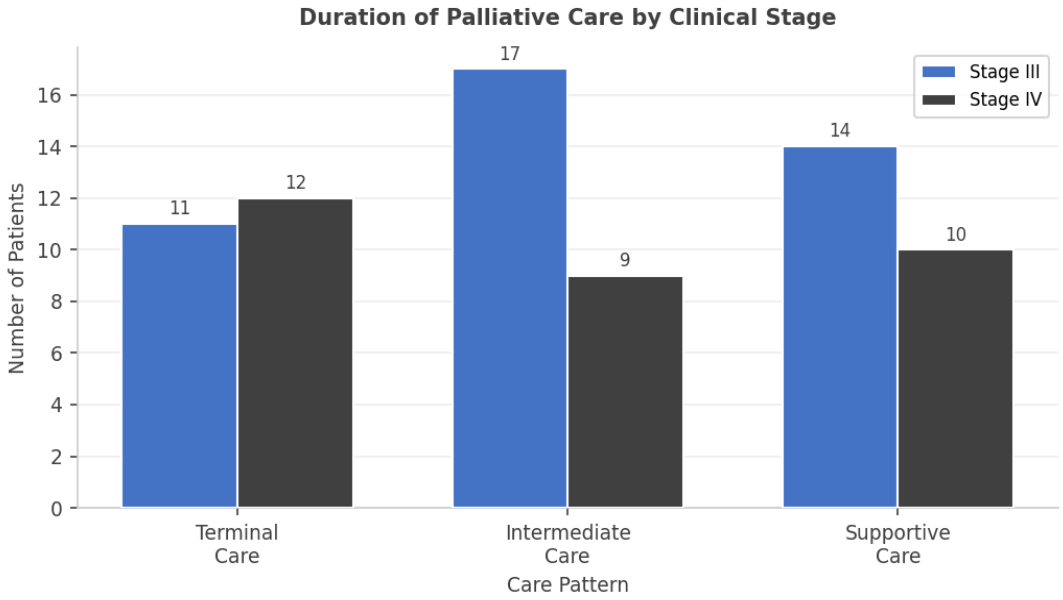

Figure 10. Distribution of Care Patterns by Clinical Stage (Stage III vs. Stage IV) among Patients

DISCUSSION

This study described the characteristics, palliative care issues, interventions, and outcomes of 122 patients with late stage breast cancer managed under the palliative care programme at the University College Hospital (UCH), Ibadan, over five years. The mean age of 50.7 years, with the modal group in the 41 to 50 year bracket (27.0%), is consistent with the younger age at breast cancer diagnosis consistently reported in West African series. Age specific analysis of breast cancer in Nigerian women has documented a peak incidence in the fifth decade of life, a full decade earlier than the 60 to 65-year peak typically reported in European populations. The predominance of Stage III disease (73.8%) and Stage IV disease (25.4%) confirms that the majority of patients in this cohort carried a disease burden that warranted palliative care involvement from the point of diagnosis. That the palliative care programme received them instead at a median of 16.5 days before death is not a reflection of the programme's capacity but of where palliative care sits in the care pathway: downstream, and contingent on referral, rather than embedded from the outset.

Pain, fatigue, breathlessness, and emotional distress were the dominant palliative care issues in this cohort. This multidimensional burden is well characterized in advanced breast cancer. It encompasses pain from bone and soft tissue metastases, dyspnoea from pleural and pulmonary involvement, lymphoedema, wound-related complications, and pervasive psychosocial distress. Emotional pain was the most frequently recorded issue across all care trajectory categories, consistent with qualitative evidence from Nigerian women with advanced breast cancer documenting profound existential suffering, including anger at God, hopelessness, and fear of anticipated role abandonment.

Financial constraint was documented in 28.7% of patients and was frequently co-recorded with poor treatment adherence and absent analgesic access. None of these needs were new at the point of palliative care referral. They are intrinsic to the experience of late-stage breast cancer from diagnosis. They would have been present, but not weighted in the scheme of care, till when almost all the available options of care had been exhausted, throughout whatever period of active oncological treatment preceded palliative care. Their concentration at the point of referral reflects prolonged neglect on the care pathway, deferring their management to a terminal phase.

The high proportion of patients presenting with ECOG performance status 3 or 4, together accounting for 71.8% of the cohort, is a direct indicator of how late in the disease course palliative care was first established. ECOG 3 denotes limited self care capacity, and ECOG 4 denotes complete functional dependence; functional decline of this degree does not occur overnight. It accumulates over weeks and months of unmanaged symptom burden, undertreated pain, and unaddressed psychosocial distress.

The 10 patients (11.6%) who arrived unconscious or near unconscious at the first palliative care contact represent the endpoint of this trajectory: a patient who had moved from diagnosis through active treatment to terminal decline without palliative care ever being made part of her care. This is consistent with documented patterns of late interunit referral in Nigerian tertiary centres, where palliative care has remained structurally peripheral to oncological care rather than concurrent with it.

The median duration of palliative programme engagement among patients who died was 16.5 days, notably longer than the average of six days of palliative care team involvement reported from a comparable case notes review in Malawi. However, both figures reflect the same structural absence of early integration.

The most striking finding in this cohort is that 18.9% of patients who died, nearly one in five, survived seven days or fewer after first palliative care contact, constituting the Terminal Care trajectory. While the retrospective design of this study precludes formal causal attribution, the temporal pattern strongly supports the conclusion that these patients reached the palliative care service only when active oncological management had been exhausted. Death was imminent, rather than at a point when the full scope of palliative care intervention was still achievable. Patients in this group presented with the highest ECOG scores, the most advanced disease, and, in several cases, loss of consciousness at first contact, leaving no clinical window for pain titration, psychosocial intervention, or advance care planning.

In COVID-19 admissions at this same institution, hospitalizations lasting less than 24 hours resulted in death in all cases, with late presentation identified as a likely contributor; the same mechanism is the most plausible explanation for the terminal trajectory documented here.

Family conferences were the most frequently delivered intervention, provided to 73.0% of all patients. Formal pain control was documented in only 12.3%, psychocounselling in 2.5%, and physiotherapy in less than 1%. This interventional profile is not incidental. It is the portrait of a palliative care service operating without upstream integration: when patients arrive at ECOG 3 or 4 and survive for a median of 16.5 days, the only intervention the clinical encounter has time for is preparing the family for death. The structured, iterative work of palliative care in advanced breast cancer, titrating analgesia, managing lymphoedema, addressing spiritual distress, supporting advance care planning, requires weeks and months of engagement, not days.

The dominance of family conferences in this cohort is therefore a direct consequence of palliative care being positioned as a terminal destination rather than a concurrent component of care from the point of advanced diagnosis.

The evidence that embedding palliative care within the oncological care pathway from diagnosis produces materially better outcomes than late or crisis-driven referral is well established.

A randomised controlled trial in The Lancet Oncology found that early and systematic palliative integration significantly improved quality of life compared with on demand palliative consultation, independent of the psychosocial support already provided by the oncology team. A cluster-randomised trial in The Lancet further demonstrated that concurrent palliative care significantly improved satisfaction with care and quality of end-of-life outcomes for both patients and family caregivers at four months. The patients in the present cohort had the same disease, symptom burden, and psychosocial needs as those in the trials. What they did not have was a care system that included palliative care from the beginning. The median engagement of 16.5 days and the 18.9% terminal trajectory rate are the measurable costs of that absence.

Lost to follow-up accounted for 39.3% of the total cohort, the largest single outcome category. This proportion reflects the compound effect of financial toxicity, distance from the tertiary

facility, disease progression outpacing appointment intervals, and the absence of proactive outreach systems. Financial constraint was documented as a palliative care issue in 28.7% of the cohort, and out-of-pocket costs in Nigerian breast cancer care have been identified as a primary driver of treatment discontinuation and non-attendance. Critically, the lost-to-follow-up group represents patients who were already known to the programme but for whom the care structure could not sustain engagement. Had palliative care been embedded within the oncological care pathway from the point of diagnosis, the therapeutic relationship and the logistical infrastructure supporting it would have been established before the financial and physical barriers that precipitate dropout became acute. The outcomes of these 48 patients are unknown, and their inclusion as a distinct trajectory category rather than as missing data reflects a deliberate methodological choice to acknowledge rather than erase this uncertainty.

The Supportive Care trajectory, comprising patients who survived more than 90 days under palliative care follow-up, constituted 20.5% of the cohort and represents the subset of patients in whom the programme had sufficient time to function as designed. Their prolonged engagement, relative to the Terminal and Intermediate Care groups, demonstrates that continuity of palliative care is achievable in this setting when engagement duration is adequate. This group offers a glimpse of what the full cohort's care trajectory could have resembled had palliative care involvement been established at the point of advanced diagnosis rather than at the point of treatment failure. The contrast between this group and the Terminal Care trajectory does not reflect differences in disease or patient characteristics so much as in when the care continuum began.

Limitations

This study has several limitations. First, its retrospective design and reliance on routinely collected clinical records limited the availability and completeness of relevant data. In particular, the timing of palliative care referral relative to the initial cancer diagnosis could not be reliably established. Consequently, delayed referral was inferred from patients' functional status at first contact and the short interval between palliative care consultation and death, rather than directly measured.

Second, incomplete documentation, particularly of Edmonton Symptom Assessment System (ESAS) scores, Eastern Cooperative Oncology Group (ECOG) performance status, and histological findings, limited the completeness of clinical characterization and the assessment of symptom burden. The substantial proportion of patients lost to follow-up (39.3%) further introduces uncertainty regarding patient outcomes and the potential for ascertainment bias, as their subsequent clinical course could not be determined.

Finally, the single centre design may limit the generalizability of the findings to other healthcare settings in Nigeria. Nevertheless, as a major tertiary referral institution, University College Hospital, Ibadan, serves a diverse patient population, and the observed clinical characteristics are broadly consistent with patterns reported in Nigerian breast cancer literature. The findings

therefore provide useful insight into the delivery of palliative care for patients with advanced breast cancer in a tertiary healthcare setting.

CONCLUSION

This five year retrospective study at University College Hospital, Ibadan, highlights a significant gap in the timely integration of palliative care into the management of advanced breast cancer. Patients frequently accessed palliative care at a stage of substantial functional impairment, with a median interval of only 16.5 days between their first palliative care consultation and death. The finding that 18.9% of patients were already on a terminal trajectory, alongside the predominance of family conferences among documented interventions, further suggests that palliative care was largely introduced during the final stages of illness.

Evidence from randomized trials and clinical guidelines supports the early introduction of palliative care alongside disease directed treatment, particularly for improving symptom control and quality of life. The findings of this study underscore the need for more proactive referral pathways, routine assessment of palliative care needs, and closer collaboration between oncology and palliative care teams.

In this setting, meaningful improvement will require moving beyond a model in which palliative care is primarily associated with the end of life towards one in which it is recognized as an essential component of comprehensive cancer care from the diagnosis of advanced disease.

DECLARATIONS

Abbreviations

Nil

Ethics approval and consent to participate

Granted by the University of Ibadan University College Hospital ethical committee (UI/UCH EC) College of Medicine, University of Ibadan with IRB Number UI/EC/26/0392.

The participants gave informed consent. This work was carried out according to the declaration of Helsinki

Consent for publication

N/A

Availability of data and material

Available on demand, all the participants gave informed consent.

The dataset used and /or analysed during the current study are available from the corresponding author on reasonable request

Competing interests

The Authors declare they have no conflict of interests

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Authors' contributions

O.A- Conceptualized, writing, editing, review

O.K- Editing

O.E- Editing, Review

O.O- Data extraction, editing

Y- Data extraction

I- writing, review

O.O- Review

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