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A study of socio-medical determinants affecting quality of life and perceived care among cancer patients

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OBJECTIVE **To explore the role of sociological factors in patients' quality of life and healthcare evaluation.** METHOD **A written survey was used as the research tool, consisting of 24 questions for patients and five questions on medical data completed by oncologists. The research was conducted in oncology departments in Split, Dubrovnik, and Zadar. The sample included 191 patients undergoing active treatment, most of whom were retired and from working-class backgrounds.** RESULTS **The majority of patients were diagnosed with breast, gastrointestinal and lung cancer (70.8%), often in advanced stages. Chemotherapy was the predominant treatment modality (56.0%). The most frequently reported feelings after diagnosis were surprise (53.4%), shock (50.3%), stress (46.0%) and fear (45.5%). Emotional support was mainly provided by spouses (35.1%) and children (24.1%). Notably, 71.2% of patients did not seek help from mental health professionals. Most patients reported spending their leisure time reading or watching television (80.1%) and walking (76.9%), while participation in other physical activities was limited. In terms of socio-economic indicators, the majority reported an average material status (84.7%) and perceived their quality of life as normal (82.2%). Most lived in their own home (81.7%), had children (83.8%) and reported a stable family structure (62.8%).** CONCLUSIONS **This study provided valuable insights into the broader context of cancer care, highlighting the significant influence of social and emotional factors on patient well-being. It underscored the need to strengthen support systems and develop more tailored interventions that address not only the medical but also the psychosocial and economic dimensions of living with cancer.**

Μια μελέτη των κοινωνικο-ιατρικών παραγόντων που επηρεάζουν την ποιότητα ζωής και την αντιληπτή φροντίδα μεταξύ των ασθενών με καρκίνο

Περίληψη στο τέλος του άρθρου

Key words

Cancer care
Healthcare perception
Oncology patients
Quality of life
Sociodemographic factors

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Cancer is a global health issue that causes approximately 10 million deaths annually.[1] Advances in diagnosis and therapy have enabled longer survival for many patients. However, there is growing awareness of the need for comprehensive care that addresses the physical, emotional, and social dimensions of patients' lives.[2] This disease not only represents a medical challenge but also has significant psychosocial and economic consequences for patients, their families, and society as a whole.[3] A cancer diagnosis profoundly impacts daily life, family relationships, and patients' social involvement.[4]

Sociological and demographic factors, such as age, education, employment, and marital status, significantly influence how patients experience and manage the disease. Research indicates that socioeconomic conditions and social support are crucial for adapting to a diagnosis and coping with long-term treatment.[5,6] Furthermore, the perception of quality of medical care is often linked to the level of communication between patients and healthcare professionals, as well as the availability of additional psychosocial resources.[7]

This study aimed to examine the impact of sociological and medical determinants on the perception of quality of life and the evaluation of medical care among oncology patients undergoing active treatment. The results will help identify areas where integrated care for cancer patients can be improved, with a particular focus on psychosocial and organizational interventions. Understanding these aspects can contribute to the development of targeted interventions and the enhancement of overall care for cancer patients.

MATERIAL AND METHOD

The research approach was socio-medical, socio-psychological, interdisciplinary and comparative. Both quantitative and qualitative methodological aspects were combined, both in the theoretical-methodological and analytical sense. The main research method was a survey consisting of a written questionnaire as the primary measuring instrument. The questionnaire contained 24 questions, which were completed by the patients surveyed, while the oncologists conducting the survey completed an additional five questions on the patients' medical data.

Research sample

The spatial scope of the study included oncology and radiotherapy departments in hospital centers in Split, Dubrovnik and Zadar. During the sampling procedure, a research sample was selected with the following characteristics regarding its type. It was constructed as a non-probability sample, since the probability of selecting patients as units of observation from the total population was variable and unknown to the researcher in advance; as a purposive sample, we selected only oncology patients who were undergoing active treatment; and as a random sample, since the respondents were patients who were attending their scheduled appointments at the oncology clinic during the field phase of the study. Among other characteristics of the patients interviewed, the primary medical dimensions of their selection were emphasized. These dimensions related to the research sample, for which the relevant criteria were active treatment and tumor type (in the baseline sample) and duration of treatment (primary, adjuvant; recurrence; metastatic disease) for the research subsamples. The basic characteristics of the sampling procedures were voluntariness, anonymity and cooperation of the patients with the oncologist-researcher. The size of the research sample depended on the availability and presence of patients who were actively undergoing treatment at the time of the field phase.

Participants

When selecting patients, the first and most important criterion for participation in the survey was exclusively membership of the group of oncology patients undergoing active treatment and receiving a specific therapy. Other criteria (e.g. gender, age, tumor type) were not decisive. When communicating with the patients, the researcher had to approach them personally. The best way of interviewing them was to give them the written questionnaire during their visit to the oncology clinic. The interviewing oncologist remained nearby to give explanations and answer questions, but without suggesting answers. It was important to "prepare" the respondents for the survey and explain to them what was expected of them and why they were being asked (about the benefits of their treatment, its improvement, etc.). Specifically, it was about their opinion on better organization within the oncology departments, more intensive care for oncology patients and the general improvement of their quality of life. All respondents had the opportunity to add comments on topics that were not included in the questionnaire.

Data collection

The research timeline included: (a) The field phase from March 2024 to June 2024; (b) the processing (coinciding with the field phase) and analysis of the research results (until the end of June 2024). Each questionnaire was coded (encrypted). The completion of the medical data logs for each subject was carried out by their oncologist, as the data were patient records and needed to be specific, accurate and unambiguous. This approach ensured the accuracy of the information (tumor type, year of diagnosis, type of therapy, start of therapy, etc.).

Statistical analysis

Two measurement instruments were used during the field phase of the research: a written questionnaire and a medical patient data protocol. The research results were processed with the Statistical Package for Social Sciences (SPSS), version 22.0, a powerful statistical package, which was used to analyze all available empirical data and to perform all primary and secondary analyses of the research results, as well as to cross-tabulate the data; (de) code, classify, typologize, etc. In addition to the quantitative and qualitative analyses of the research results, content analyses, the systematization of open-ended questions and similar techniques were also carried out.

Ethical considerations

This prospective study was conducted in accordance with the Declaration of Helsinki and was approved by the Ethics Committee of General Hospital Dubrovnik, General Hospital Zadar, and University Hospital Split, Croatia. All participants gave their written informed consent prior to enrollment in the study.

RESULTS

A total of 191 patients were interviewed, of whom 34.6% were male and 65.4% female. Of the respondents who reported their age (183 participants), the results were spread across several age categories, with the majority being between 65 and 74 years old. Analysis of the medical data showed that one-third of the patients in our sample had breast cancer (32.5%, 62 patients), followed by cancers of the digestive system and lung, which are generally among the most common cancers worldwide and in Europe. Most patients were at stage IV (115 patients, 60.0%), followed by stage III (49 patients), so that patients with metastatic or locally advanced disease predominated (85.8%), regardless of tumor type. Most patients were treated with chemotherapy alone or in combination with another treatment (56.0% of patients), with 42.0% receiving chemotherapy alone (81 patients) and 28 patients receiving chemotherapy in combination with immunotherapy or radiotherapy.

Approximately 13–16% of patients were treated with hormone therapy (31 patients) and immunotherapy (24 patients), a small number with targeted therapy (13 patients) and only 9 patients with radiotherapy (tab. 1). The majority were newly diagnosed patients (77.5%) whose disease had been detected within the last two years, i.e. between 2022 and 2024. In addition to malignant disease, 75.0% of patients had at least one concomitant disease, most commonly arterial hypertension (44.0%), followed by hyperlipidemia (18.0%) and heart disease (16.0%).

Most patients were of urban origin and were predominantly born in cities, while about 20.0% were born in villages, smaller towns or on islands. During the study, the

Table 1. Descriptive characteristics of respondents-patients (n=191).

Characteristic of respondents-patients	Number	%
Age (years)		
25–34	5	2.6
35–44	6	3.1
45–54	22	11.0
55–64	41	21.5
65–74	75	39.3
75–85	34	17.8
Gender		
Male	66	34.6
Female	125	65.4
Educational level		
Did not go to school	1	0.5
Incomplete primary school	6	3.1
Elementary school	24	12.6
Secondary school	110	57.6
College, university, academy	48	25.1
Acquired a scientific degree	1	0.5
Occupation		
Unemployed	20	10.4
Farmer	4	2.1
Worker	23	12
Officer	15	7.9
Manager	4	2.1
Expert	9	4.7
Housewife, pensioner	100	52.4
Military person	1	0.5
Private person	14	7.3
Someone else (caregiver)	1	0.5

Characteristic of respondents-patients	Number	%
Marital status		
Single	15	7.9
Married	120	62.8
Divorced	13	6.8
Common-law union	4	2.1
Widower	39	20.4
Primary site of tumor		
Breast	62	32.5
Digestive system	49	25.7
Lung	24	12.6
Female reproductive system	23	12.0
Urinary system	5	2.6
Skin	19	9.9
Head and neck	8	4.2
Knee (sarcoma)	1	0.5
Type of treatment		
Chemotherapy	81	43.5
Hormonal therapy	31	16.7
Targeted therapy	13	7.1
Radiotherapy	9	4.8
Immunotherapy	24	12.9
Chemoimmunotherapy	26	14.0
Chemoradiotherapy	2	1.1
Frequency of occurrence of comorbidities		
No comorbidities	47	24.6
One comorbidity	57	29.8
Two comorbidities	42	22.0
Three comorbidities	30	15.7
Four comorbidities	11	5.8
Five or more comorbidities	4	2.0

majority lived in larger Croatian cities such as Dubrovnik (16.8%), Split (16.2%) and Zadar (14.7%), with the remainder living in smaller towns or rural areas. Only 39.3% owned pets. Their main source of income was their own pension (61.3%), followed by self-employment or their own salaries (26.7%), and only a few were dependent on other people, social assistance or rental income. Most were well housed and lived in their own apartments or houses (81.7%). Most respondents were non-smokers (61.3%) and non-drinkers (77.5%). Most had children (83.8%) or were married (62.8%), while 20.4% were widowed, 6.8% were divorced and only 2.1% were cohabiting.

In the baseline sample, slightly more than half of the respondents (52.4%) were pensioners and housewives. Among the remaining respondents, workers and low-skilled occupations predominated (12.0%), as did those who were unemployed during the study period (10.4%). Only about one-fifth of the survey sample consisted of specialized occupations such as office workers and similar functions (tab. 1). These distributions did not differ significantly between hospitals or between the three subsamples (Split, Dubrovnik, and Zadar), with the exception that the Zadar region had a slightly higher proportion of unemployed and blue-collar workers. This suggests that these participants may belong to lower socioeconomic strata, which may make it more difficult for them to successfully manage their diagnosed illnesses and subsequent prescribed therapies.

At first glance, the educational structure of the patients surveyed appears to be somewhat more favorable. More than half (57.6 %) had completed secondary school, while a quarter (25.6%) had a higher educational qualification, an academic or scientific degree (tab. 1). However, these distributions also include retired patients, which at first glance gives a somewhat different "picture". Nevertheless, the educational dimension changes significantly when the situation in the three Croatian hospitals is analyzed: The proportion of highly educated patients and patients with secondary education is similar, while the proportion of patients with primary education increases slightly among respondents in Zadar. However, these territorial determinants are relative, considering that the selected hospitals serve patients from nearby municipalities and towns from other countries and even from abroad (e.g. Bosnia and Herzegovina, North Macedonia, Serbia or from other parts of the region).

When asked what bothered them most during treatment, 60.0% did not answer, while 25.0% mentioned waiting for various tests and doctor's appointments. The behavior of oncologists, general practitioners and nurses was rated as very professional, compassionate and respectful (97.0%, 82.7% and 88.0%, respectively), while the behavior of other doctors outside the oncology departments was rated less positively (52.0%). More than half of the patients received chemotherapy. 47.8% of them stated that they tolerated the chemotherapy very well, 17.8% moderately well and 19.4% did not want to give an answer.

The analysis of responses regarding emotional states after receiving a cancer diagnosis revealed that surprise, shock, stress and fear were the most common emotions (tab. 2). Sadness, disappointment, anger and confusion were reported by 18–38% of participants. Indifference or vague feelings were reported in 12.0% of cases.

The greatest support in coping with the disease came from spouses (35.1%), followed by their children (24.1%). Almost a quarter of participants said they were supported by "everyone a little", including friends, colleagues, other patients and relatives. However, 71.2% of respondents did not seek help or communicate with psychologists, psychiatrists, clergy or alternative practitioners and relied solely on medical care from oncologists and general practitioners.

The participants spent their free time mainly on passive activities such as reading the newspaper and watching TV (80.1%), going for a walk (76.9%), meeting friends (74.4%), resting (56.0%) and listening to music (54.9%). Around a third did sport, while only a fifth did manual activities such as embroidery or sewing. Overall, this was a physically inactive population, who tended to be more active at home and less likely to visit theaters, cinemas, museums or concerts (less than a third). Other activities that less than 25% of respondents engaged in included gardening, fishing, meditation, solving puzzles, raising chickens, spiritual

Table 2. Emotional states after finding out the diagnosis.

Emotional states after finding out the diagnosis	%
Surprised	53.4
Shocked	50.3
Stressed	46.0
Frightened	45.5
Sad	37.7
Confused	27.7
Disappointed	21.0
Furious, angry	17.8
Uncertained	12.0
Uninterested	12.0
Accept it as it is	0.5

education, Bible reading, cooking, tutoring, writing and crafting.

When assessing their material status, over 80.0% described it as average, with 58.1% stating that they had everything they needed, while 26.7% lacked some desired items. Around 10.0% considered themselves wealthy and only 3.0% described their situation as poor or barely survivable (tab. 3). The self-assessment of quality of life reflected the material status: 82.2% stated that they had a normal, average quality of life (tab. 4).

DISCUSSION

The present study provided valuable insights into the sociological and medical aspects of the lives of oncology patients undergoing active oncological treatment. By comparing the obtained results with relevant literature, it is possible to identify key trends and challenges faced by patients. The results clearly confirmed that cancer, especially in metastatic or locally advanced stages, has a profound impact on patients' quality of life. Among the sample of 191 respondents, breast, gastrointestinal, and lung cancer patients predominated, which aligns with global data on the incidence of these cancer types.[1] Most respondents were diagnosed with metastatic or locally advanced stages of the disease, indicating that this population bears a significant burden of illness. The predominance of chemotherapy as the main therapeutic option among 56.0% of respondents further underscores the importance of this treatment modality in oncology.

Table 3. Self assessment of the material status.

Self assessment of the material status	Number	%
No answer	3	1.6
Well off	20	10.5
Average, but I have everything I need	111	58.1
Average, I don't have everything I need	51	26.7
Poor	4	2.0
Barely surviving	2	1.0
Total	191	100.0

Table 4. Self assessment about quality of life.

Self assessment about quality of life	Number	%
No answer	6	3.1
Normal, average	157	82.2
Poor	15	7.9
Cannot estimate	11	5.8
Doesn't want to answer	2	1.0
Total	191	100.0

The emotional response of patients to a cancer diagnosis included shock, fear, and stress in the majority of respondents, while sadness and disappointment were also significantly present. This is consistent with the literature, which highlights that a cancer diagnosis evokes feelings of uncertainty and depression.[8–11] Studies have shown that one-third of cancer patients experience anxiety and severe depression during their lives.[12–14] Indifference and undefined emotions were reported by a smaller number of respondents, suggesting that coping with the disease is a highly individualized experience.

Social support plays a crucial role in dealing with the disease,[15] with respondents receiving the most support from family, particularly spouses (35.1%) and children (24.1%). Interestingly, 71.2% of respondents did not seek help from psychologists, psychiatrists, or other specialists, relying solely on medical care provided by oncologists and general practitioners. This finding suggests the need for better integration of psychosocial services into oncology care, as highlighted in previous studies that emphasize the importance of systematic support in reducing psychosocial stress among patients.[16,17] Various support strategies, such as counseling, support groups, and educational services, help patients cope with the emotional challenges of the disease.[18] These forms of support enable patients to manage anxiety, depression, and fear, thereby improving their quality of life and psychological well-being. Studies show that patients who receive emotional and psychological support report lower stress levels and greater life satisfaction.[18–20]

In the present study, one concerning aspect is the pronounced physical inactivity of patients and their tendency toward social isolation. Although the study did not include a representative sample, the results indicate a need for better strategies to engage patients in social and recreational activities. Studies show that social support can significantly impact mental health and quality of life, while isolation may exacerbate the challenges of the disease.[20,21] Physical activity can also significantly affect the quality of life of oncology patients.[22] Respondents primarily spend their leisure time in passive activities, such as reading or watching television, with no physical activity reported. This finding aligns with research that emphasizes the positive effects of physical activity on mental health and social interaction in oncology patients.[23] Promoting physical activity and social programs should be a priority in planning comprehensive care.

It is important to consider that socioeconomic factors play a significant role in access to and quality of care, particularly among lower socioeconomic groups.[5] Our research also revealed the socioeconomic characteristics of the respondents, most of whom come from urban areas, with the majority living in their own apartments or houses (81.7%). The material status of most respondents was described as average, with only 3.0% reporting financial hardship and 10.0% rating their status as relatively wealthy. Such circumstances may somewhat ease the financial burden of oncology treatment.

This research underscores the importance of a holistic approach to treating oncology patients. Based on these findings, it is recommended to focus on integrating psychosocial support, better involving patients in social activities, and promoting physical activity. Additionally, strengthening collaboration with other professionals (psychologists, social workers) and raising awareness about the importance of collective support programs in the treatment process is essential. The literature clearly shows that such interventions not only improve patients' quality of life but also contribute to more successful therapeutic outcomes.[24–27] Although the socioeconomic status of respondents appeared relatively stable, existing literature points out that lower socioeconomic status is often associated with limited access to healthcare services and therapeutic options.[28] This research offers important insights into the social, emotional, and medical challenges experienced by oncology patients undergoing active treatment. The findings confirm the profound impact of a cancer diagnosis on patients' quality of life, both personally and socially. The majority of respondents were patients with metastatic or locally advanced breast, gastrointestinal, or lung cancer, aligning with global incidence patterns.

A cancer diagnosis commonly elicits intense emotional reactions such as shock, fear, and anxiety. Yet, despite this psychological burden, the vast majority of patients reported not seeking psychological or spiritual support. This underscores the urgent need to integrate psychosocial care into standard oncology treatment protocols.[6,8] While spouses and children were identified as the primary sources of emotional support, patients often exhibited a tendency toward social withdrawal and reliance solely on oncologists and general practitioners for care. These findings highlight the importance of fostering community-based and social activities aimed at enhancing emotional resilience.[7,21,23] Leisure time was predominantly spent on passive pursuits, with minimal engagement in physical activity. This finding supports the promotion of structured programs that encourage physical exercise and social interaction, both essential components for improving quality of life.[23]

Taken together, these findings reinforce the necessity of a multidisciplinary approach that incorporates medical, psychological, and social support systems to optimize patient care and overall well-being. Future interventions should prioritize the integration of psychosocial services, the promotion of healthy lifestyle habits, and the removal of socioeconomic barriers to treatment access.

ΠΕΡΙΛΗΨΗ

Μια μελέτη των κοινωνικο-ιατρικών παραγόντων που επηρεάζουν την ποιότητα ζωής και την αντιληπτή φροντίδα μεταξύ των ασθενών με καρκίνο

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ΣΚΟΠΟΣ Εξερεύνηση του ρόλου των κοινωνιολογικών παραγόντων στην ποιότητα ζωής των ασθενών και στην αξιολόγηση της ιατρικής περίθαλψης. **ΥΛΙΚΟ-ΜΕΘΟΔΟΣ** Χρησιμοποιήθηκε η γραπτή έρευνα ως εργαλείο της μελέτης, αποτελούμενη από 24 ερωτήσεις για τους ασθενείς και 5 ερωτήσεις σχετικά με ιατρικά δεδομένα που συμπληρώθηκαν από ογκολόγους. Η έρευνα διεξήχθη σε ογκολογικά τμήματα στις πόλεις Split, Dubrovnik και Zadar. Το δείγμα περιλάμβανε 191 ασθενείς που υποβάλλονταν σε ενεργή θεραπεία, οι περισσότεροι από τους οποίους ήταν συνταξιούχοι και προερχόμενοι από εργατική τάξη. **ΑΠΟΤΕΛΕΣΜΑΤΑ** Η πλειοψηφία των ασθενών διαγνώστηκε με καρκίνο του μαστού, του γαστρεντερικού και του πνεύμονα (70,8%), συχνά σε προχωρημένα στάδια. Η χημειοθεραπεία ήταν η κυρίαρχη μέθοδος θεραπείας (56%). Τα πλέον συχνά αναφερόμενα συναισθήματα μετά τη διάγνωση ήταν

έκπληξη (53,4%), shock (50,3%), άγχος (46%) και φόβος (45,5%). Η συναισθηματική υποστήριξη παρεχόταν κυρίως από τους συζύγους (35,1%) και τα παιδιά (24,1%). Σημαντικό είναι ότι το 71,2% των ασθενών δεν αναζήτησαν βοήθεια από επαγγελματίες ψυχικής υγείας. Οι περισσότερες ασθενείς ανέφεραν ότι περνούσαν τον ελεύθερο χρόνο τους διαβάζοντας ή παρακολουθώντας τηλεόραση (80,1%) και περπατώντας (76,9%), ενώ συμμετείχαν σε άλλες φυσικές δραστηριότητες σε περιορισμένο βαθμό. Όσον αφορά στους κοινωνικοοικονομικούς δείκτες, η πλειονότητα ανέφερε ότι είχε μέσο υλικοτεχνικό επίπεδο (84,7%) και αντιλαμβανόταν την ποιότητα ζωής τους ως κανονική (82,2%). Οι περισσότεροι διέμεναν στο δικό τους σπίτι (81,7%), είχαν παιδιά (83,8%) και είχαν σταθερή οικογενειακή δομή (62,8%).
ΣΥΜΠΕΡΑΣΜΑΤΑ Η μελέτη παρέχει πολύτιμες πληροφορίες σχετικά με το ευρύτερο πλαίσιο φροντίδας του καρκίνου, επισημαίνοντας τη σημαντική επιρροή των κοινωνικών και των συναισθηματικών παραγόντων στην ευημερία των ασθενών. Υπογραμμίζει την ανάγκη ενίσχυσης των συστημάτων υποστήριξης και ανάπτυξης πιο στοχευμένων παρεμβάσεων που να αντιμετωπίζουν όχι μόνο τα ιατρικά θέματα αλλά και τις ψυχοκοινωνικές και τις οικονομικές διαστάσεις της ζωής με καρκίνο.

Λέξεις ευρετηρίου: Αντίληψη της υγειονομικής περίθαλψης, Ασθενείς Ογκολογίας, Κοινωνικοδημογραφικοί παράγοντες, Ποιότητα ζωής, Φροντίδα καρκίνου

References

1. SUNG H, FERLAY J, SIEGEL RL, LAVERSANNE M, SOERJOMATARAM I, JEMAL A ET AL. Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin* 2021, 71:209–249
2. MONTAZERI A, MILROY R, HOLE D, McEWEN J, GILLIS CR. Quality of life in lung cancer patients: As an important prognostic factor. *Lung Cancer* 2001, 31:233–240
3. KERR A, ROSS E, JACQUES G, CUNNINGHAM-BURLEY S. The sociology of cancer: A decade of research. *Sociol Health Illn* 2018, 40:552–576
4. LI TC, LI CI, TSENG CH, LIN KS, YANG SY, CHEN CY ET AL. Quality of life predicts survival in patients with non-small cell lung cancer. *BMC Public Health* 2012, 12:790
5. BOTTARO R, FARACI P. The influence of socio-demographics and clinical characteristics on coping strategies in cancer patients: A systematic review. *Support Care Cancer* 2022, 30:8785–8803
6. CHIU CJ, HSU YC, TSENG SP. Psychological prognosis after newly diagnosed chronic conditions: Socio-demographic and clinical correlations. *Int Psychogeriatr* 2017, 29:281–292
7. LAUNONEN M, VEHVILÄINEN-JULKUNEN K, MIKKONEN S, KVIST T. Care quality and satisfaction at the cancer hospital – a questionnaire study of older patients with cancer and their family members. *BMC Health Serv Res* 2024, 24:190
8. STANTON AL. Psychosocial concerns and interventions for cancer survivors. *J Clin Oncol* 2006, 24:5132–5137
9. KRISHNASAMY M, HASSAN H, JEWELL C, MORAVSKI I, LEWIN T. Perspectives on emotional care: A qualitative study with cancer patients, carers, and health professionals. *Healthcare (Basel)* 2023, 11:452
10. BAGHJARI F, SAADATI H, ESMAEILINASAB M. The relationship between cognitive emotion-regulation strategies and resiliency in advanced patients with cancer. *Int J Cancer Manag* 2017, 10:e7443
11. FERNANDES T, AARTHI R, BOHRA S. Cognitive emotional regulation: In the context of breast cancer. *Int J Indian Psychol* 2015, 2:14–25
12. RADHAKRISHNAN R, SELVARAJ H, CHIDAMBARAM K, KV A, JAMES A, THANGAVEL S. Prevalence of depression and anxiety disorders among cancer patients: An insight from a single institute. *Cureus* 2023, 15:e42831
13. BOYES AW, GIRGIS A, D'ESTE C, ZUCCA AC. Flourishing or floundering? Prevalence and correlates of anxiety and depression among a population-based sample of adult cancer survivors 6 months after diagnosis. *J Affect Disord* 2011, 135:184–192
14. HONG JF, ZHANG W, SONG YX, XIE LF, WANG WL. Psychological distress in elderly cancer patients. *Int J Nurs Sci* 2015, 2:23–27
15. JOSHY G, THANDRAYEN J, KOCZWARA B, BUTOW P, LAIDSAAR-POWELL R, RANKIN N ET AL. Disability, psychological distress and quality of life in relation to cancer diagnosis and cancer type: Population-based Australian study of 22,505 cancer survivors and 244,000 people without cancer. *BMC Med* 2020, 18:372
16. CULL A, STEWART M, ALTMAN DG. Assessment of and intervention for psychosocial problems in routine oncology practice. *Br J Cancer* 1995, 72:229–235
17. DING Y, WANG X, ZHANG F, YAN H, LIU Y, ZHAN L. The relationship between perceived social support, coping style, and the quality of life and psychological state of lung cancer patients. *BMC Psychol* 2024, 12:439
18. HYLAND KA, SMALL BJ, GRAY JE, CHIAPPORI A, CREELAN BC, TANVETYANON T ET AL. Loneliness as a mediator of the relationship of social cognitive variables with depressive symptoms and quality of life in lung cancer patients beginning treatment. *Psychooncology* 2019, 28:1234–1242
19. KOSUGI K, NISHIGUCHI Y, MIURA T, FUJISAWA D, KAWAGUCHI T, IZUMI K ET AL. Association between loneliness and the frequency of using online peer support groups among cancer patients with minor children: A cross-sectional web-based study. *J Pain Symptom Manage* 2021, 61:955–962
20. WANG C, QIU X, YANG X, MAO J, LI Q. Factors influencing social isolation among cancer patients: A systematic review. *Healthcare (Basel)* 2024, 12:1042
21. GANGANE N, KHAIRKAR P, HURTIG AK, SAN SEBASTIÁN M. Quality of life determinants in breast cancer patients in Central Rural In-

dia. *Asian Pac J Cancer Prev* 2017, 18:3325–3332

22. MISIĄG W, PISZCZYK A, SZYMAŃSKA-CHABOWSKA A, CHABOWSKI M. Physical activity and cancer care – a review. *Cancers (Basel)* 2022, 14:4154
23. WARNER EL, KENT EE, TREVINO KM, PARSONS HM, ZEBRACK BJ, KIRCHHOFF AC. Social well-being among adolescents and young adults with cancer: A systematic review. *Cancer* 2016, 122:1029–1037
24. DOGAN N, TAN M. Quality of life and social support in patients with lung cancer. *Int J Caring Sci* 2019, 12:263–269
25. PINQUART M, DUBERSTEIN PR. Associations of social networks with cancer mortality: A meta-analysis. *Crit Rev Oncol Hematol* 2010, 75:122–137
26. PINQUART M, HÖFFKEN K, SILBEREISEN RK, WEDDING U. Social support and survival in patients with acute myeloid leukaemia. *Support Care Cancer* 2007, 15:81–87
27. KROENKE CH, KUBZANSKY LD, SCHERNHAMMER ES, HOLMES MD, KAWACHI I. Social networks, social support, and survival after breast cancer diagnosis. *J Clin Oncol* 2006, 24:1105–1111
28. GUADAMUZ JS, WANG X, RYALS CA, MIKSAD RA, SNIDER J, WALTERS J ET AL. Socioeconomic status and inequities in treatment initiation and survival among patients with cancer, 2011–2022. *JNCI Cancer Spectr* 2023, 7:pkad058

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