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Research Article

Symptom Experiences before Medical Help-Seeking and Psychosocial Responses of Patients with Esophageal Cancer: A Qualitative Study

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Objective. The purpose of this study was to investigate patients with esophageal cancer symptom experiences before seeking medical help and psychosocial responses. *Methods*. Within one month of diagnosis, semistructured interviews were held with 14 adult patients with esophageal cancer. To fully comprehend the symptom experiences that patients with esophageal cancer had prior to seeking medical help and the psychosocial responses they had to these experiences, thematic analysis and interpretative phenomenological analysis were used. *Results*. Patients with esophageal cancer recounted their symptom experiences, and psychosocial responses were categorized into three main themes: physical, psychological, and social. Three subthemes were included in the physiological aspect: early symptoms (warning signs), specific symptoms (the catalyst for seeking medical help), and concurrent symptoms (masked side effects). Four subthemes were associated with psychological aspects: unfairness, regret, worry, and acceptance. Two subthemes were related to the social element, namely, dragging down one's family and societal self-isolation. *Conclusion*. Due to the self-remitting nature of early symptoms, the normalization of their interpretation, and concealment by other illnesses, patients with esophageal cancer may delay medical help-seeking. The findings could serve as a reference for healthcare professionals to implement tailored psychosocial interventions and help patients identify symptoms early in order to seek medical help.

1. Introduction

Esophageal cancer is one of the most aggressive malignancies of the digestive tract worldwide, yet its geographical distribution is extremely uneven. According to the latest Global Cancer Statistics Report (Globocan, 2020 edition) [1], 604,100 new cases of esophageal cancer and 544,076 deaths were reported, with China bearing more than half of the disease burden [2]. In 2020, the number of deaths from esophageal cancer in China reached 301,135, with a standardized mortality rate of 12.7/100,000, which is far higher than the global average (5.6/100,000) and means that China ranks first in the world in this regard [3]. Although the age-standardized 5-year survival rate of esophageal cancer in China has increased from 20.9% to 30.3% with the improvement of diagnosis and treatment technology, the overall level is still low [4, 5]. Early detection, diagnosis, and treatment are crucial to the survival outcomes of esophageal cancer, and the 5-year survival rate of early-stage patients can exceed 95% [6]. However, most patients with esophageal cancer are already in stage II to IV when they seek medical help, which brings challenges to treatment and recovery [7, 8].

2. Background

The insidiousness of early symptoms and patients' lack of awareness of esophageal cancer are two of the key causes of delayed medical help-seeking and poor prognosis in patients with esophageal cancer [9]. Due to the small size of

the tumor(s) and the inconspicuous stenosis of the esophageal lumen, the most prevalent symptoms that patients encounter in the early stages of esophageal cancer are swallowing obstruction and swallowing pain, among other things [10]. Advanced patients experience swallowing obstruction that escalates to dysphagia as the tumor continues to grow [11], in addition to typical symptoms such as starvation, weight loss, and exhaustion [12–14]. Esophageal cancer is a progressing condition; therefore, changes in the severity of symptoms may prompt patients to seek medical help.

Lacking knowledge about esophageal cancer can undoubtedly affect a patient's willingness to seek medical help. Lewis et al. [15] conducted qualitative interviews with patients with esophageal cancer within nine months of their diagnosis to understand factors influencing their symptom appraisal and subsequent adjustment to the disease. The findings demonstrated that patients had little understanding of esophageal cancer and had a propensity to normalize their symptoms (e.g., fatigue as a sign of old age) or misdiagnose these symptoms as other well-known disorders. Patients only contacted their general practitioner when their symptoms changed or interfered with their daily living. It is therefore challenging to accomplish early detection and diagnosis of esophageal cancer because a significant portion of patients are unaware of the symptomatic manifestation and disease-related knowledge and are prevented from knowing that it is cancer [16, 17].

Although previous studies have explored the interpretation of symptoms in patients with prediagnostic esophageal cancer, the description of symptom presentation is not thorough and detailed. Furthermore, squamous carcinoma is the most common pathogenic form of esophageal cancer in China [18]. Its growth rate and pathological changes are different from those of adenocarcinoma [19], so the patient may experience diverse symptoms and thus interpret them variously. Qualitative research is the process of observing, analyzing, and interpreting the ways and meanings of phenomena in a specific context, focusing on an in-depth understanding of the uniqueness, complexity, and rationality of different individuals [20]. Therefore, it is imperative to thoroughly explore the symptom experiences of patients with esophageal cancer before medical help-seeking using the approach of qualitative research.

Considering human beings as an open-minded whole, symptom experiences of patients with esophageal cancer led to multifaceted and complex psychosocial responses. Studies have shown that pretreatment patients may have a wide variety of psychological profiles that are closely linked to posttreatment physical recovery and quality of life [21–23]. However, research has also shown that postoperative patients' functional recovery is unaffected by their preoperative psychological status [24]. Psychosocial evaluation is rarely taken into consideration by healthcare professionals while performing the patient's initial assessment. As a result, we are also curious about the psychosocial responses exhibited by patients with esophageal cancer during the period from the diagnosis to receiving treatment.

Numerous qualitative studies of patients with esophageal cancer have focused on mental health, supportive care needs, and dietary management during the postoperative recovery period. However, it is important that a qualitative study be conducted to shed light on the symptoms that patients with esophageal cancer experience prior to seeking medical help and their psychosocial responses.

3. Methods

This study aims to explore the symptom experiences before seeking medical help and psychosocial responses with the description of patients with esophageal cancer. The symptom experience model combined with holistic nursing conception was used as a theoretical framework to construct the interview outline. The model includes three aspects: antecedents, symptom conception, and consequences, where antecedents include demographic, disease, and individual characteristics; symptom conception consists of symptom frequency, severity, distress, and meaning; consequences incorporate adjustment, mood, functional status, and disease progression. This study will understand patients' symptom perception and the impact of the disease on their lives based on three dimensions: physical, psychological, and social [25, 26] (see Figure 1 for details).

3.1. Design. We used a qualitative descriptive design. Data collection involved individual, in-depth, and semistructured interviews. Designing and reporting of this study strictly followed the COREQ checklist [27].

3.2. Recruitment Procedure. By using purposive sampling, we look for participants who have shared an experience but vary in characteristics such as sexes and time since diagnosis and in their individual experiences [28]. The first author (a nursing graduate student, HG) and the second author (a clinical nursing expert, LZ) recruited patients with esophageal cancer from the department of thoracic surgery of the comprehensive third-class hospital in Anhui Province from April to September 2021. Researchers informed eligible participants of the background and purpose of the study and obtained written informed consent on the day the patients participated in the interview.

3.3. Participants. Inclusion criteria are as follows:

(i) Patients who are pathologically diagnosed with esophageal cancer within one month.
(ii) Can speak Chinese and aged 18 years or over.
(iii) Without protective medical treatment.
(iv) Willing to undergo follow-up treatment (surgery/neoadjuvant chemo-radiotherapy).

The sample size was based on the criterion that no new themes emerged, at which point information reached saturation. When the number of participants reached 11, information came to light that overlapped with the previous information, after which 3 additional participants were

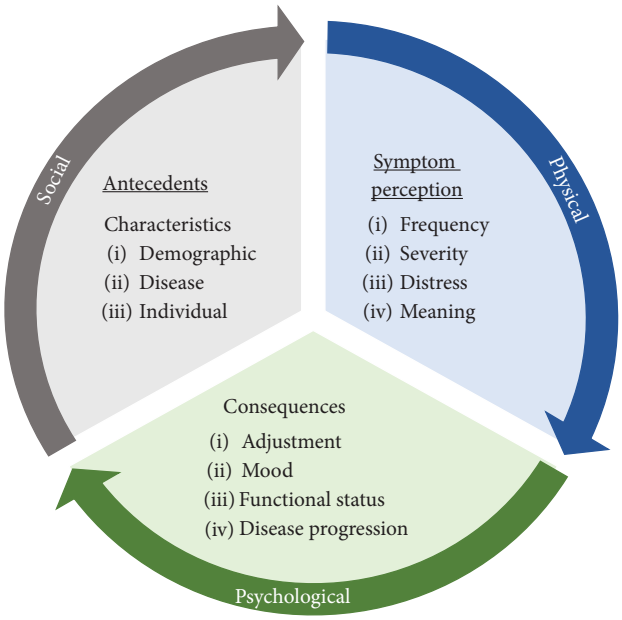

Figure 1: The theoretical framework.

interviewed to guarantee the power of the sample size. Finally, 14 participants diagnosed with esophageal cancer within one month were included, including 12 men and 2 women. An overview of participant characteristics is shown in Table 1.

3.4. Ethical Considerations. This study protocol was approved by the University Ethics Committee with the consent and support of the relevant hospital departments. During the study, the information about participants remained confidential, and informed consent was signed after the patients agreed to participate in this study. The whole procedure strictly followed the principles of voluntariness, confidentiality, and nonharm. All participants were entitled to withdraw from the study at any time, and any medical treatment and rights were not to be affected.

3.5. Data Collection. One-on-one, face-to-face semi-structured interviews were collected by the first author (HG), who is a postgraduate nursing student trained in comprehensive, systematic qualitative research. The use of audio recorders, synchronized recording, and written records was employed. The researcher transcribed recordings into text within 24 h after the interview and returned it to the participants for verification. Based on the convenience of the participants, 10 of them chose the conference room, and 4 chose the treatment room, both of which were quiet and undisturbed places. The interview outline was formulated by combining relevant literature, the symptom experience model, and the holistic nursing concept. The interviewer began with an open-ended question by asking the patient what his or her main discomfort was now and having him or her recall what happened at the beginning of the disease; each patient was asked to provide details (see Figure 2 for the full interview outline). The interviews lasted an average of 36 min each (range: 28–51 min).

Table 1: Participant characteristics.

Number of participants $n = 14$ (%)	
Age mean (range)	65 (47–79)
Sex	
Female	2 (14)
Male	12 (86)
Marital status	
Married	12 (86)
Living alone	2 (14)
Residential status	
Rural	9 (64)
Urban	5 (36)
Education status	
Primary or none	6 (43)
Secondary	6 (43)
Tertiary	2 (14)
Smoking behavior	
Current smoker	7 (50)
Ex-smoker	3 (21)
Never smoked	4 (29)
Alcohol	
Overconsumption[a]	8 (57)
Time since diagnosis	
1-2 weeks	4 (29)
2-3 weeks	3 (21)
3-4 weeks	7 (50)
Type of pathology	
Adenocarcinoma	0 (0)
Squamous-cell carcinoma	14 (100)
Stage	
Stage I	2 (14)
Stage II/III	11 (79)
Stage IV	1 (7)
Treatment	
Neoadjuvant chemo-radiotherapy	3 (21)
Surgery	11 (79)

[a]Chinese dietary guideline limit on grams of alcohol for women (men) is 15 (25) grams/day.

3.6. Data Analysis. NVivo 11.0 software was used for data storage, coding, and theme development [29]. An in-depth understanding of the symptoms experienced by patients with esophageal cancer prior to seeking medical attention and their psychosocial reactions was achieved via the use of thematic analysis and interpretative phenomenological analysis [30, 31]. Initially, the researchers aimed to read the text repeatedly, become familiar with the content, and annotate the parts that might be meaningful to the study. Second, the text information was coded word by word and line by line in order to summarize and classify the code to obtain the primary theme. Third, after completing the extraction of primary themes for the last text file, links between the primary themes were established, and the final themes were determined. The process of analyzing a text was iterative and required frequent returns to the original text to maintain a close connection between the themes and the original text. The first author (HG) and the corresponding author (SWL) took the main

(i) Can you tell me what you are uncomfortable?

(ii) In addition to the above discomfort symptoms, are there any uncomfortable places?

(iii) Can you bring me back to the beginning of your illness and tell me what happened then?

Detail of symptoms: parts, frequency, severity, distress, etc.

(iv) How did esophageal cancer make you feel?

(v) Does being sick affect other aspects of your life?

(vi) Do you have any additional content you would like to share?

Figure 2: The interview outline.

roles in the data analysis process, and new themes were revised in consultation with the other authors (LZ, XXM, and WL). Each author contributed to the final themes that emerged from the data analysis.

4. Results

Patients with esophageal cancer described their own symptom experiences before seeking medical help, and their psychosocial responses fell into three main themes: physical, psychological, and social. Three subthemes were included in the physiological aspect: early symptoms, specific symptoms, and concurrent symptoms. Four subthemes were associated with psychological aspects: regret, worry, unfairness, and acceptance. Dragging down one's family and societal self-isolation were mentioned as two subthemes in the social aspect.

4.1. Physiological Aspects

4.1.1. Early Symptoms: Warning Signs. As it is a highly insidious disease, patients with esophageal cancer seek medical attention only when the disease begins to interfere with their daily activities or eating ability, so early detection is challenging. Early symptoms are frequently overlooked by patients or concealed by other chronic diseases.

Most self-remitting early symptoms, such as "chest tightness when lying down/activating," are easily overlooked. When lying down, the patient complained of feeling out of breath and having chest pressure; they also had chest tightness when doing a lot of activities. However, chest tightness is not continuous in its duration and disappears temporarily after changing position and resting to relieve it. Thus, patients ignore its severity after chest tightness has resolved and take a wait-and-see attitude.

> . . .Sleeping flat on my back, I feel like I can't breathe, and I feel something pressing on my chest. But I don't feel it when I sleep on my side. I think it's okay to sleep on my side (pt. 4).

> Sometimes when I walk a lot or do a lot of activities, I feel chest tightness and need to take a while. And I feel fine when I can get relief after a rest (pt. 5).

In addition, some patients recalled their early symptoms as a "painful swallow" at the beginning, but they attributed it to a "sore throat" brought on by talking too much. Patients tend to confuse the location of the esophagus and pharynx and thus normalize the early symptoms. Also, when patients experience painful swallowing, they do not even consider it as an esophageal disease because of lacking the knowledge of esophageal cancer.

> The first time I experienced pain when eating and swallowing, I assumed it was caused by talking too much, which made my throat painful. I did not even consider the possibility of esophageal disease at the time (pt. 13).

Both patients experienced the beginnings of the "hiccups," but they both believed hiccups were familiar and common and attributed their occurrence to "digestive issues."

> The first thing that happened to me was hiccups while eating. I thought it was normal to get hiccups, everyone gets hiccups; it should be caused by poor digestion (pt. 11).

On the other hand, patients with esophageal cancer who also had other chronic comorbid diseases could blame any atypical symptoms on their familiar disease presentation caused by the chronic disease. They might consider the early onset of "upper chest pain" as a "myocardial infarction" and "frequent coughing sputum" as "chronic bronchitis."

> I had high blood pressure before, so I thought I had a myocardial infarction to cause chest pain; then I went to check that my heart was normal, and I took nitroglycerin without relief. The doctor said that I should go for a gastroscopy to check, and the results were found to tumor (pt. 7).

> . . .I used to smoke so I already had chronic bronchitis, but it seems like I have been coughing up phlegm a lot since I have had problems eating. I think it's caused by chronic bronchitis (pt. 10).

4.1.2. Specific Symptoms: The Catalyst for Seeking Medical Help. Patients with esophageal cancer mostly choose to seek

medical help because of severe nutritional deficiencies due to swallowing and eating problems. In terms of swallowing, many patients felt a "foreign body in swallowing food," which gradually worsened to the point and in severe cases even when swallowing liquid or saliva.

> . . .I can feel something in my throat when I eat anything, and now I can feel it when I swallow saliva (pt. 1).
>
> I was drinking when I noticed that it was not smooth when I swallowed down, unlike normal people (pt. 9).

In terms of eating, the most common specific symptoms of patients are "pausing while eating" and "choking sensation," both of which coexist and affect each other. The specific symptoms mainly appear when the patient eats dry or hard food and then increasingly aggravates; they are also clear when the patient drinks semiliquids or liquids.

> Now it is obvious that I feel a little choked eating; I eat a bite and stop for a while because it is not as smooth as before (pt. 2).
>
> Before I would eat steamed buns and vegetables and feel unable to swallow; I would drink liquid food and also did not feel able to swallow. Now I eat porridge and still can't swallow (pt. 6).

Five patients reported feeling "increased mucus," especially when eating, and they would spit out a lot of mucus. We speculate that this is probably because of the esophageal lumen's significant narrowing or obstruction during eating, and the esophageal mucosa will secrete large amounts of mucus in response to tumor stimulation.

> I feel like I have been spitting saliva a lot lately, and it is not really saliva. It is just a little thicker than saliva, kind of like mucus, especially when I'm eating (pt. 8).

4.1.3. Concurrent Symptoms: Masked Side Effects. When the specific symptom such as dysphagia occurred, the patient might "vomit" as they struggle to swallow. Patients with esophageal cancer decreased the amount and frequency of food intake with the restriction of eating, leading to the occurrence of diet-related concurrent symptoms, such as "stomach pain," "constipation," and "weight loss."

> I could not swallow my food, and when I tried to swallow it, again and again, I would vomit it all up (pt. 6).
>
> . . .Sometimes I feel stomach pain because I cannot eat and my stomach is empty. There is no food to digest, so it hurts (pt. 7).
>
> There is no way to avoid constipation. I cannot eat, so there is no food in my stomach, so I cannot go to the bathroom to relieve the constipation (pt. 10).
>
> It is not at all possible to eat a meal without keeping up with nutrition. As the saying goes, people are iron, and rice is steel, and by now I have lost a lot of pounds (pt. 12).

4.2. Psychological Aspects

4.2.1. Unfairness. Both female patients believed they had healthy lifestyles and expressed confusion and sadness that they would get esophageal cancer, believing that God was unfair. Particularly for women who lead relatively regular lives and have no bad addictions, receiving an esophageal cancer diagnosis might make them more easily complain of unfair destiny.

> When I first found out about it, I was slightly confused that I could get cancer too. I do not smoke or drink, so how could I get this disease? I felt that the whole world had gone gray, and God was truly unfair (pt. 2).
>
> In fact, I am in good health; it is very inexplicable to have esophageal cancer. I live a very regular life. I do not eat too hot, spicy, stimulating food, smoke, or drink. How can I get this disease? It is truly unfair (pt. 12).

4.2.2. Regret. Almost all patients have experienced the psychological experience of regret when they learned of the diagnosis of esophageal cancer. Relatively young patients "regret that they did not value their bodies," while older patients "regret that they were late in seeking medical help."

> I truly regret that I did not take care of my body before. When I get home from the hospital, I will exercise every day and quit smoking and drinking. I did not pay attention to my body before, and only after I got sick, did I feel regret; nothing is more important than my health (pt. 8).
>
> Ah, I should have seen a doctor when I had painful swallowing, I regret it so much. Now it is getting worse, and it does not feel very smooth drinking milk anymore (pt. 6).

The psychological state of regret does not persist. Patients will worry about prognosis and adaptation to new dietary patterns as their treatment advances, but after being guided by a healthcare professional, they will accept having cancer more swiftly.

4.2.3. Worry. Some patients reported that they were "worried" about the outcome and prognosis of their treatment, which made it "impossible to concentrate" on their work or life.

> I'm just worried that the surgery will not be successful and that it will not work well. I do not know how I will eat following the surgery; will I always be hungry? (pt. 13).

4.2.4. Acceptance. After experiencing psychological distress, most patients indicated that they had accepted the fact of cancer and divided it into two attitudes: embrace and resignation.

Some patients initially experience discomfort and resistance to follow-up treatment but gradually change their mindset and accept the fact of cancer. There are also those patients who maintain a positive attitude in the face of their esophageal cancer diagnosis without going through mindset shift. But the result is the same; patients embrace the disease by being more open, tolerant, and optimistic in the face of the illness.

> Happiness is the most important thing. Being sick requires optimism rather than crying (pt. 1).
>
> At that time, I felt that I was miserable and didn't want to undergo surgery. However, people live for a mouthful of food, so if you're sick, treat it well (pt. 6).

There are also several patients who expressed an indifferent and resigned attitude toward the disease, believing that it is destiny that they got sick and that they should just accept reality.

> I do not think there is a need for extreme emotions, just accept it openly and listen to God's plan. Therefore, I am not afraid of this illness; it is all God's will (pt. 10).
>
> It does not matter; cancer is nothing to be afraid of. I reassured my children that they do not have to worry; it's no big deal, it's destiny (pt. 13).

4.3. Social Aspects

4.3.1. Dragging Down Family. Some patients believe that their illness will drag down their families and place a heavy financial burden on them. Meanwhile, they also expressed worry that "being sick will delay work," and they would not be able to earn money to support their family, particularly middle-aged patients with esophageal cancer who are working.

> My family has two children in junior high school and is waiting for me to earn money. The sudden illness has added to the family's woes. I have had everything but the locusts (pt. 6).
>
> I can't work anymore and can't earn money, but my family still depends on me to support them (pt. 14).

4.3.2. Societal Self-Isolation. Patients with specific symptoms often respond to socialization by self-isolating, such as avoiding or reducing diet-related social activities.

> I used to love to get together and meet my friends for dinner once a week. After I was diagnosed, I did not eat with other people anymore (pt. 1).
>
> I am not willing to go outside and eat with my friends; I eat the least and put a damper on them (pt. 14).

5. Discussion

To our knowledge, this study is the first to employ a qualitative approach to explore symptom experiences before seeking medical help and psychosocial responses of patients with esophageal cancer. In terms of physiology, it includes three subthemes, the first of which is early symptoms, i.e., warning signs, including those often overlooked by patients or concealed by other chronic diseases.

Chest tightness and painful swallowing are early symptoms that are commonly ignored due to two main factors. One is the self-remitting nature, such as chest tightness changing with one's position and active-rest rhythm. In the Andersen behavioral model of health service utilization, predisposing factors, enabling factors, and need factors directly affect individual medical help-seeking behavior. Among them, need factors play a vital role in influencing individual healthcare utilization, including patients' perception of illness or pain, self-appraisal severity of illness, symptom presentation, and symptom duration [32, 33]. However, these symptoms do not necessarily appear in every meal, and the degree may vary from time to time, which may be one of the reasons why it is difficult for cases to be detected early. In addition, patients often normalize early symptoms, so they miss the opportunity for the best time for treatment. For example, patients think that early painful swallowing is a sore throat due to Shanghuo (this is a concept in traditional Chinese medicine) and hiccups are thought to be caused by indigestion. In this study, the average age of the patients was 65 years and 64% were from rural areas. They were prone to overlook and normalize the early symptoms due to the vulnerable vigilance of the elderly rural population and low cancer symptom awareness. This highlights that healthcare personnel should pay more attention to the elderly population in rural areas while continuously educating and raising awareness of diseases and early symptoms of esophageal cancer.

Upper chest pain, coughing sputum, and hiccups were the early symptoms concealed by other chronic diseases in this study. Patients with esophageal cancer who also have other chronic comorbid ailments may interpret these symptoms as signs of their preexisting conditions. In this study, patients with concomitant hypertension may mistake upper chest pain for the beginning of a myocardial infarction and seek medical attention when self-administering nitroglycerin fails to provide relief. This finding seems counterintuitive since one might assume that chest pain would lead a patient to seek medical attention immediately. After reviewing the patient's description, this may be because of the patient's confidence in their self-perception and self-management of their chronic diseases, choosing to dispose of the changes in common/familiar symptoms with a coping style they understand [34, 35], which is inconsistent with Lewis' findings [15]. Accordingly, patients with chronic diseases should increase their disease sensitivity and seek prompt medical help, especially if they experience upper chest pain, frequent coughing sputum, or hiccups.

In addition to the insidious nature of early symptoms, patients may also actively delay seeking medical help. Especially, middle-aged patients who are working as the primary breadwinner of the family think that being sick delays their work and increases the burden on the family. Unsar et al. [36] showed that esophageal cancer not only imposes physical and psychological burdens on patients but also gradually increases family caregivers' anxiety and depression as the caregiving burden increases. Moreover, income levels are considered a crucial influencing factor for patients to actively seek medical care [37–39]. In the case of esophageal cancer as a chronic disease, expensive follow-up treatment can place a heavy financial burden on families, leading to delays in seeking medical help or poor treatment adherence [40, 41].

The catalyst for patients seeking medical help is the appearance and progression of specific symptoms. Over time, symptoms progressively worsen with dysphagia and significantly restricted feeding, which affect patients' normal dietary and nutritional needs. The result clearly suggests that whether patients choose to seek medical help depends on their own judgment of the severity of the disease. Several studies have shown that cancer patients tend to ignore the above symptoms and delay medical help-seeking when they only have common nonspecific symptoms, such as fatigue, appetite loss, and painless lumps [42–45]. The presence of specific symptoms is accompanied by masked side effects, that is, concurrent symptoms, such as vomiting due to dysphagia, stomach pain, and constipation. The prominence of specific symptoms may mask the severity of concurrent symptoms, and the impact of specific symptoms on daily life is more severe. Patients pay more attention to resolving the problems brought about by the specific symptoms as soon as possible, resulting in a lag in the patients' perception of the concurrent symptoms. Therefore, in the initial evaluation of patients with esophageal cancer, healthcare professionals should focus on the specific symptoms while also obtaining as detailed and comprehensive picture of the concurrent symptoms if possible.

In terms of psychological responses, patients show four common emotions: unfairness, regret, worry, and acceptance. Psychological responses manifest themselves in different forms, and they are not in an adversarial relationship but in a dynamic and changing process. After experiencing different degrees of psychological distress, patients choose to accept the fact of having cancer, including the acts of embracing the diagnoses and resigning themselves to it. A study has shown that patients who experience presurgery psychological distress can influence postoperative functional recovery and prognosis [46]. Ohkura et al. longitudinally tracked changes in the psychological status of patients undergoing esophagectomy at five time points and showed that changes in patients' psychological status were significantly associated with changes in symptom experience and quality of life brought about by esophagectomy [47, 48]. At different stages of the illness, patients' experiences of bodily sensations and symptoms vary [43], thus affecting their psychological responses. Healthcare providers should complete psychological screening, dynamically assess psychological status, and provide tailored proactive psychosocial interventions for patients with esophageal cancer in a timely manner.

The social aspect included only two subthemes, probably because untreated patients have not yet suffered from the image disorders and social distress associated with esophageal cancer (e.g., indwelling nutrition tubes and hoarseness) [49]. However, many patients adopt societal self-isolation after illness and reduce their frequency of social interactions, especially social activities related to eating. Huang et al. [50] conducted a comprehensive meta-analysis to identify the correlates of cancer stigma, which included 31 studies involving 7,114 cancer patients. The results showed that cancer stigma was positively associated with self-blame, self-perceived burden, and social constraint, leading patients to intentionally reduce their disease-related social activities and subsequently develop societal self-isolation. Societal self-isolation is the individualized and concentrated manifestation of perceived self-stigma. In the development of Chinese society and culture, the internalization of patient stereotypes, direct rejection by others, and discrimination in the social system have contributed to the creation of societal self-isolation [51, 52]. It is the common goal of healthcare professionals and social media to correct patients' misconceptions of esophageal cancer and enhance science to eliminate the public's prejudice against cancer.

5.1. Limitations. An important limitation of this study relates to its transferability. Participants were recruited from a single tertiary cancer center, all Chinese-speaking with squamous-cell carcinoma, so the results should be carefully transferred to other patients with esophageal cancer of cultural backgrounds and pathological types. Additionally, we used the purposive sampling to look for specific kinds of people holding different and important views about the ideas at question; however, the socioeconomic status was not considered into the selection standard. Patients with good socioeconomic status are more likely to seek prompt medical help at the onset of early symptoms.

6. Conclusions

Our findings indicate that the self-remitting nature of early symptoms, the normalization of their interpretation, and their concealment by other diseases before seeking medical help may cause patients with esophageal cancer to put off seeking medical attention. The presence of specific symptoms, on the other hand, is the catalyst for seeking medical help while also masking some of the concurrent symptoms. Furthermore, the psychological responses of patients with esophageal cancer undergo a dynamic change and are expressed via four emotions: unfairness, regret, worry, and acceptance. Dragging down one's family and societal self-isolation reflect the social aspect of patients' experiences. The findings of this study could serve as a reference for healthcare professionals to implement tailored interventions and help patients with esophageal cancer identify symptoms early in order to seek medical help.

7. Relevance to Clinical Practice

Our findings have three implications for clinical care and medical professionals. First, a qualitative approach allows for an in-depth exploration and description of the symptom experiences undergone before seeking medical help and the psychosocial responses of patients with esophageal cancer. Research findings show that the early symptoms of patients are easily ignored and concealed. Healthcare professionals need to focus on the sensitivity of high-risk groups of esophageal cancer to early symptoms and publicize the knowledge of esophageal cancer to facilitate early detection, early diagnosis, and early treatment. Second, the psychological response of patients with esophageal cancer is undergoing a dynamic change. Researchers should complete psychological screening in a timely manner, dynamically assess psychological status, and provide tailored proactive psychosocial interventions for patients with esophageal cancer. Third, medical personnel should correct patients' misconceptions about the disease and eliminate public prejudice against cancer to reduce patients' societal self-isolation and self-stigma.

Data Availability

The qualitative data used to support the findings of this study are available from the corresponding author upon request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

HG was responsible for conceptualization, methodology, software, formal analysis, data curation, original draft preparation, and review and editing. LZ, XXM, and WL were responsible for methodology and review and editing. SWL was responsible for conceptualization, formal analysis, review and editing, and supervision.

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