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Review Article

Transitional care for the aged person after Cerebrovascular Accident: a scoping review

Cuidado transicional da pessoa idosa após Acidente Vascular Cerebral: revisão de escopo

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ABSTRACT
Objective: to map the transition of care for the elderly after a stroke from hospital to home. **Methods:** a scoping review using the JBI methodology. The search was conducted in eight databases, an electronic library, and gray literature sources. Endnote and Rayyan were the tools used to select the studies, following the PRISMA-ScR guidelines. The selection of studies involved two reviewers, with a third for the final analysis. **Results:** of 1,378 studies, 30 were selected for full reading, resulting in 12 articles published between 2013 and 2023, three of which were qualitative, eight quantitative, and one mixed study. In addition, two book chapters were retrieved from the grey literature to make up the sample, giving a total of 14 studies on the subject. **Conclusion:** the proposals for a plan need to cover the general conditions of the elderly person in the transition process, but attention should be paid to the environmental context in which the person lives and the availability of resources. **Contributions to practice:** the evidence described can help build more effective measures to improve the care provided to this individual who needs to transition from hospital to home care.
Descriptors: Aged; Stroke; Patient Discharge; Transitional Care.

RESUMO
Objetivo: mapear a transição do cuidado da pessoa idosa após acidente vascular cerebral do hospital para o domicílio. **Métodos**: revisão de escopo, segundo a metodologia JBI. A busca foi conduzida em oito bases de dados, uma biblioteca eletrônica, além de fontes de literatura cinzenta. O Endnote e o Rayyan foram as ferramentas utilizadas para a seleção dos estudos, seguindo as diretrizes do PRISMA-ScR. A seleção dos estudos envolveu dois revisores, com um terceiro para análise final. **Resultados**: de 1.378 estudos, 30 foram selecionados para leitura na íntegra, resultando em 12 artigos publicados entre 2013 e 2023, sendo três qualitativos, oito quantitativos e um estudo misto. Além disso, da literatura cinzenta foram resgatados dois capítulos de livros para compor a amostra, totalizando 14 estudos abordando o tema. **Conclusão:** destaca-se que as propostas de plano necessitam abranger condições gerais da pessoa idosa no processo de transição, porém deve-se atentar para o contexto ambiental em que a pessoa vive e a disponibilização de recursos. **Contribuições para a prática:** as evidências descritas podem auxiliar a construção de medidas mais efetivas para o aprimoramento da assistência prestada a esse indivíduo que necessita transicionar seus cuidados do hospital para o domicílio.
Descritores: Idoso; Acidente Vascular Cerebral; Alta do Paciente; Cuidado Transicional.

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Introduction

Non-communicable diseases (NCDs) are a set of multifactorial illnesses characterized by long latency periods and prolonged duration[1]. These conditions represent a public health problem, especially in developing countries[2]. Brazil is going through a phase of demographic and epidemiological transition, reflected in the increase in life expectancy and the epidemiological transition to chronic diseases[3], with a notable increase in the number of cases, a reality that previously did not exist[3-4].

One of these conditions is Cerebral Vascular Accident (CVA), which occurs more frequently in the elderly because of the natural aging process that triggers adverse health conditions and increases susceptibility to the disease[5], considering that conditions such as atherosclerosis, hypertension, diabetes, and dyslipidemia contribute to this[6]. Post-CVA recovery represents a significant challenge for the elderly, given the physical and cognitive limitations that can hinder the effectiveness of rehabilitation[4-5]. Although there is an understanding of the elements that can trigger a CVA, global projections suggest a growing number of occurrences, particularly among the elderly and men. This increase is correlated with a greater demand for Brazilian public health services[7].

Thus, the transition from hospital to home care for the elderly after a CVA is extremely important due to the challenges that occur during the recovery process. This stage is defined as changes in patients between different contexts, locations, and health services. It involves the development of individualized discharge care plans and a variety of support services[8]. The safe and effective transition of this care is crucial to promoting a more agile and effective recovery, as well as reducing the risk of complications and hospital readmissions[9].

In this sense, the nursing discharge plan for the elderly represents a systematized and standardized approach aimed at facilitating the safe and effective transition from the hospital environment to the home. The core of this strategy is to improve the patient's quality of life and mitigate the risk of complications and hospital readmissions, favoring a more expeditious and effective recovery, to ensure that the patient's specific needs and objectives are fully considered and met[10-11].

From this perspective, issues related to transitions of care for CVA patients have acquired a pre-eminent urgency in the context of health services, playing an essential role in the realization of comprehensive care. This study aimed to investigate the existing scientific literature on the transition of care for elderly patients after CVA, to consolidate existing knowledge in this area, and to identify gaps to guide clinical practice. Thus, this study aimed to map the transition of care for the elderly after a stroke from hospital to home.

Methods

We followed the scoping review methodology proposed by the JBI Collaboration[12], conducted by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR)[13].

The study question followed the acronym PCC. Population: post-stroke elderly; concept: the transition of care; and context: hospital to home. The guiding question was: "What are the recommendations described in the scientific literature on the transition of care from hospital to home for elderly people after a CVA?"

The inclusion criteria considered the results of primary and secondary studies of elderly people over 65, hospitalized due to stroke, with or without complications, and discharged from the hospital. Studies referring to partial results, technical notes, preliminary reports, approaches focused on pathophysiology, and the socio-economic impact related to diagnosis and treatment strategies were excluded.

The electronic databases were searched on February 23, 2023, including Medical Literature Analysis and Retrieval System Online (MEDLINE) via PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Library, SCOPUS, Web of Science, AgeLine, Latin American and Caribbean

Health Sciences Literature (LILACS), Scientific Electronic Library Online (Scielo). There was also a search for gray literature in Open Dissertations, Google Scholar, the Capes Thesis Portal, and textbooks.

To compose the guiding search strategy, controlled and synonymous terms and/or descriptors were used, combined using the Boolean operators AND, and OR, as follows. (("Aged"[Mesh] OR "Aged" OR "Elderly" OR "Aged, 80 and over"[Mesh] OR "Aged, 80 and over" OR "Oldest Old")) AND (("Stroke"[Mesh] OR "Stroke" OR "Strokes" OR "Cerebrovascular Accident" OR "Cerebrovascular Accidents" OR "CVA (Cerebrovascular Accident)" OR "Cerebrovascular Apoplexy" OR "Brain Vascular Accident" OR "Brain Vascular Accidents" OR "Cerebrovascular Stroke" OR "Cerebrovascular Strokes" OR "Cerebral Stroke" OR "Cerebral Strokes" OR "Acute Stroke" OR "Acute Strokes" OR "Acute Cerebrovascular Accident" OR "Acute Cerebrovascular Accidents"))) AND (("Hospital to Home Transition"[Mesh] OR "Hospital to Home Transition" OR "Hospital to Home" OR "Hospital to Homes" OR "Transitional Care"[Mesh] OR "Transitional Care" OR "Transitional Cares" OR "Transition Care" OR "Transition Cares" OR "Home Transition" OR "Home Transitions")).

The records identified in the databases were exported to the EndNote20 reference manager to remove duplicates, and then exported to Rayyan Software[14], where two reviewers were included to read the title and abstract, and then read the studies in full. At both stages, a third reviewer was consulted to resolve any conflicts. The information on the selected studies was organized into year of publication, language, country, objectives, design, main results, and transition results.

Results

A total of 1,378 records were initially identified, with 318 removed due to duplications. After reading the titles and abstracts, 1,060 records were excluded for not meeting the inclusion criteria, resulting in 30 studies considered eligible for full reading. During the full analysis, 18 articles were excluded due to the lack of complete data relating to the population and results. After this stage, we were left with 12 articles and two book chapters that addressed the subject and met all the pre-established inclusion criteria. The detailed process of searching for and selecting the studies in this review is described in the flowchart (Figure 1).

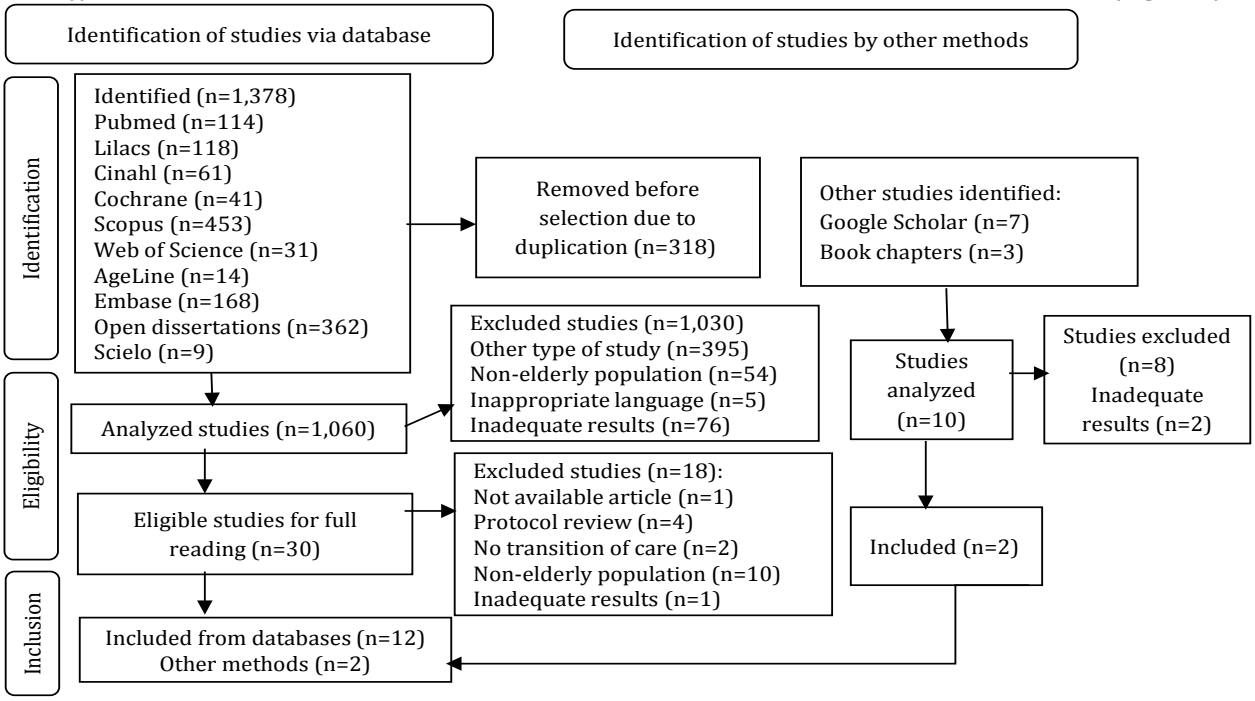

Figure 1 – PRISMA-ScR flowchart used to identify and select studies. Barra do Garças, MT, Brazil, 2023

About the studies selected, the publications covered the years 2013 to 2023, distributed as follows: one in 2013 (8.3%)[15], one in 2016 (8.3%)[16], two in 2019 (16.6%)[17-18], three in 2020 (25%)[19-21], two in 2021 (16.6%)[22-23], one in 2023 (8.3%)[8]. Of the 12 studies, four used a qualitative methodology[15-17-18-22] (33.3), seven were quantitative[8,16-19-20-21,23-24] (58.3%) and one was a mixed study[25] (8.3%). The total sample size was 11,139 participants.

Concerning language, ten studies were conducted in English[8,16-18,20-25] (83.3%), while two were conducted in Portuguese[15,19] (16.6%). As for the origin of the studies, four were from the United States[17-18,20-21] (33.3%), two from Australia[24-25] (16.6%), two from Brazil[15,19] (16.6%), two from Canada[8,16] (16.6%), one from South Africa[22] (8.3%) and one from Sweden[23] (8.3%) (Figure 2).

Reference	Type of study and sample	Main results	Main results
A[8]	Qualitative and descriptive. Sample: 90 participants.	Thirty-nine participants received the Transitional Care Stroke Intervention (TCSI) and 40 were controls. There were no significant differences in the initial risks of readmission at six months. The TCSI group had improvements in physical functionality, CVA self-management, and patient experience, with no differences in total healthcare costs.	Although participation in the TCSI transitional care intervention did not affect readmissions, older people with CVA (stroke) and multimorbidity experienced improvements in physical functionality, CVA self-management, and patient experience, with no increase in total healthcare costs.
A[15]	Ethnographic case study. Sample: 20 participants, 10 caregivers, and 10 elderly people.	Most caregivers had little knowledge about the disease and post-discharge care. Caregivers face physical and emotional challenges adapting to changes at home. Communication between the healthcare team and caregivers is crucial, but was often poor, making the transition of care difficult.	The study revealed that caregiver burden was a significant factor in the transition of care, with many caregivers reporting a lack of time and emotional support to cope with the demands of home care.
A[16]	Descriptive exploratory, with analysis of secondary data on the transition of care in CVA. Sample: 20 participants	The results indicated three models for the transition from intensive care, which address essential items for a successful transition, such as patient and caregiver involvement, complex medication management, patient and caregiver education, continuity of care, and care team responsibility.	It was highlighted that the transition from care to home after a CVA can be a difficult and complex process for survivors and caregivers. The importance of the active involvement of caregivers in the transition of care was emphasized, and the need for greater attention was highlighted since a lack of support can have negative consequences for the survivor's recovery.
A[17]	Cross-sectional. Sample: 169 CVA patients cared for.	The results revealed that many participants perceived the transition of care to be of high quality. However, several areas for improvement were identified. People with more severe CVA reported lower transition quality compared to those with mild CVA. There was a weak association between patient or clinical characteristics and perceived quality.	Improvement in preparation for discharge and in post-discharge support for self-management in the transition of care were identified. Attention is needed for people with severe CVA. Few clinical characteristics were associated with perceived quality. The importance of contextual factors such as discharge routines and individualized care plans was highlighted.
A[18]	Qualitative. Sample: 8 participants were discharged from hospital after CVA.	The results revealed that many participants perceived the transition of care as being of high quality. However, several areas for improvement were identified. People with more severe strokes reported a lower quality of transition compared to people with mild strokes. There was a weak association between clinical or patient characteristics and perceived quality.	The transition was complex, with challenges in returning to daily life, and problems with mobility, communication, and daily activities. Difficulties in accessing health services and social support were identified. The importance of a person-centered approach is highlighted, with an emphasis on understanding the experience and personalized solutions.

(the Figure 2 continue in the next page...)

A[19]	The methodological study was conducted in three stages. Sample: 10 specialists.	The results included a care protocol with educational interventions divided into four categories: guidance on CVA, care of the elderly, medication, and prevention of complications. The protocol was structured into domains: guidance on the disease; emotional support; and use of the Healthcare Network, among others related to care.	The results indicate that the construction of the care protocol can help with the transition from hospital to home care, promoting the training of family caregivers of elderly people after CVA.
A[20]	Single-blind, prospective, randomized pilot study; Sample: 40 participants.	The Transitions Of Care Coordinator (TOCC) program for hospitalized patients with acute ischemic CVA, conducted by nurses, demonstrated feasibility. There was no significant difference in the length of hospital stay between the TOCC and usual care groups. However, there was a trend towards greater patient satisfaction in the TOCC group, assessed 30 days after discharge.	A care transition program for hospitalized CVA patients is feasible and may be associated with greater patient satisfaction. Hospitals designated as comprehensive stroke centers are often equipped with stroke nurse navigators, allowing for easy implementation of nurse-driven quality improvement studies.
A[21]	Observational cohort. Sample: records of 7,812 patients.	The study analyzed 7,812 eligible records from the Australian Stroke Clinical Registry, a nationwide clinical quality registry that collects prospective data. Forty-seven percent of eligible patients received a discharge care plan.	Discharge planning is recommended to optimize the transition from intensive care to home for hospitalized CVA patients. The study identifies factors associated with receiving a discharge care plan: higher socioeconomic status, diagnosis of ischemic CVA, greater severity or discharge with antihypertensive medication.
A[22]	Qualitative. Sample: 20 CVA caregivers.	The main results showed that caregivers had concerns about the transition from care to home after CVA, which included: uncertainty about the ability to cope with care, anticipation of future challenges, and cues to action, such as warning signs of possible patient health problems.	The study showed that caregivers face significant challenges when preparing for care at home. These concerns can negatively affect the transition of care and its quality. Therefore, it is essential to address these concerns and provide adequate resources during this period.
A[23]	Randomized clinical trial. Sample: 2,904 patients.	The results included a reduction in hospital readmissions with the care program. This involved a transition plan, telephone assessments, and home visits. Patients in the program had fewer readmissions within 30 days of discharge compared to the conventional care group.	The team of specialized nurses was essential in the transition of care, reducing readmissions. Follow-up phone calls were crucial to improving post-discharge care.
A[24]	Prospective observational. Sample: Intervention group: 81 patients, and control group: 740 patients.	*Neurocare,* Australia's community neurological nursing service, generated total hospital cost savings of A$101,639 per year and A$275/patient/year. There was no significant difference in length of hospital stay, but older age was associated with longer length of hospital stay and a predictor of non-neurological readmissions.	The nurse-led transitional care model for neurological patients generated savings and a positive return on investment. There was a functional improvement, a reduction in the need for equipment/services, and a better quality of life. Patients felt involved in self-managing their condition with post-discharge care.
A[25]	Prospective mixed method with pre-test/post-test; Sample: 25 elderly participants.	The participants had various risk factors for CVA. The integrated transitional care intervention for CVA had an acceptability rate of 89%, with an average of 4.73 home visits over 6 months, mainly led by occupational therapists, with other professionals also involved: social worker, physiotherapist, speech therapist, and nurse.	The intervention was feasible and acceptable to both the elderly and the providers. From the start to six months, there was no statistically significant difference in health outcomes (self-efficacy, depression, anxiety disorder, and quality of life scales). However, there was a significant reduction in total use per person and in health service costs.

Figure 2 – Characterization of the studies included by the author, type of study/sample, main results, and transition results (n=12). Barra do Garças, MT, Brazil, 2023

In 12 articles obtained from periodicals and two book chapters selected, the search was directed at the discharge plan for the elderly in the transitional period from hospital to home, from which it emerges that the proposals used in practice still need greater monitoring of this population group, with records of people's conditions, the environment they live in and the resources of health services. Figure 4 shows two chapters from selected books, translated into Portuguese, which are references in nursing. Both books offer perspectives on the management of CVA, from the critical phase to the transition to home care (Figure 3).

Reference	Information about the work	Main data on the transition of care
A[26]	This is an American nursing textbook focused on medical-surgical nursing practice. Chapter 62 covers cerebral vascular disorders, including incidence, risk factors, preventive measures, and impact. The classification of CVA (cerebrovascular accident) into ischemic and hemorrhagic is discussed, along with its causes, clinical manifestations, and management. The principles of nursing management for patients in the critical stage of ischemic CVA are also covered. Care strategies and guidelines for patients and their families are also detailed. Finally, it addresses the promotion of home, community, and transitional care for CVA.	Care Transition for Ischemic CVA: guidance on self-care and restrictions needed during the critical phase; additional guidance on self-care strategies and the rehabilitation process; use of assistive devices and modifications to the home environment to live with the disability. Transition of Care for Hemorrhagic CVA: guidance on preventing another stroke and keeping follow-up appointments; referral to home, community or transitional care to assess home environment and patient capacity; monitoring of patient's physical and psychological state and family capacity to cope with changes.
A[27]	This is an American nursing textbook, focusing on nursing practices in various healthcare settings. Chapter 15 deals with CVA cases. The text focuses on important information for nurses and healthcare professionals on the assessment, care, and interventions related to CVA. It provides information on the associated risk factors and describes the common signs and symptoms, including weakness, numbness, difficulty speaking, changes in consciousness, and severe headache. It addresses the importance of rapid assessment of the patient with suspected CVA, including the performance of neurological examinations, imaging tests, and assessment of the patient's general condition, and the immediate interventions required. It also emphasizes the provision of appropriate nursing care, the importance of patient and family education about the disease, its treatment, prevention of recurrences, and lifestyle changes.	Transitional care: is the concept that ensures coordination and continuity of care when a patient moves from one care setting to another. Post-stroke care: nurses play a key role in providing ongoing care, rehabilitation, and patient and family education on the prevention of recurrent CVA and appropriate care. Interdisciplinary communication: collaboration with other healthcare professionals is essential to ensure the provision of comprehensive and effective care. Home care considerations emphasize passive range-of-motion exercises, prevention of deformities with stretching and strengthening, monitoring for signs of depression, and supporting the patient's family. Patient education and health maintenance: educate patient and family about adaptations, rest, quiet environment, assistive devices, aphasia management, lifestyle modification, and support.

Figure 3 – Characterization of the records included in the grey literature. Barra do Garças, MT, Brazil, 2023

Discussion

Exploring the knowledge produced in the literature on the transition of care for elderly people after CVA from hospital to home is a painstaking process, given the overall complexity of this issue.

The literature shows that the transition of care for older people after CVA faces significant challenges. Up to 60% of elderly people hospitalized for CVA are discharged directly home, requiring ongoing rehabilitation in the community[8]. Another study reveals that the transition of care is often inadequate, with a readmission rate of 17.4% within 30 days in this population[28]. They face challenges such as limited access to post-acute services, ineffective CVA education, and disorganization of community services[29]. Despite the availability of post-discharge care services in many developed countries, these services often lack standardization and are fragmented, hindering the recovery and reintegration of CVA survivors and their caregivers[30].

In daily professional practice, it is observed that, after being cared for in the health service, the elderly person is discharged from the hospital. Although post-hospital care is generally conducted by medical professionals, the lack of access to health education in their care environment is a common reality. This makes it difficult to understand the disease, and its complications in the daily routine, and to learn about self-care or the need for assistance from others.

In this context, the transition from the hospital environment to the home emerges as a critical period. The lack of adequate support at this time can result in complex challenges, overburdening caregivers and increasing the risk of readmissions[23,27]. One study analyzed the causes of readmission in patients discharged after CVA from specialist units in the south--west of England and highlighted the fundamental importance of the discharge plan in minimizing these readmissions[9]. In addition, receiving a discharge care plan was associated with a greater likelihood of attending post-discharge follow-up appointments[21]. A reduction in complications and hospital readmissions is a positive outcome of a well-managed transition of care, which can lead to a better allocation of resources and a reduction in the economic impact on the healthcare system.

To develop an effective discharge plan, nurses begin the process by assessing the needs and risks of the post-CVA patient, especially in the home setting[19]. The discharge plan must contain information that elucidates the specific repercussions of the CVA. In addition, the nurse must address crucial issues such as the risk of infections, falls and pressure injuries, and complications intrinsic to the post-CVA condition. This approach aims to ensure a safer transition to the home environment[18].

Nurses are responsible for teaching patients and caregivers how to use the Healthcare Network so that they continue to receive care from a healthcare team. The lack of clear and consistent communication between the healthcare team and the elderly person's caregiver is an obstacle to an adequate transition of care[15]. From this perspective, the importance of communication and access to care is highlighted for a more comprehensive and integrated approach between health teams, caregivers, and the elderly person, to ensure a successful transition of care[16,18,27], seeking comprehensive care in health services, forming a care network[15].

CVA survivors face difficulties reintegrating into the community after hospital discharge, due to a lack of support and resources, difficulties with mobility and access to health services, financial constraints, and a lack of understanding and support from family and community(18). Based on this, the nurse's discharge plan includes providing information about community health services and support groups.

One of the essential elements of optimal discharge planning involves the active participation of the patient and caregivers as integral partners in the educational process. Everyone involved needs to be ready for the adaptations and changes that can occur through the implementation of coping, learning, and

support strategies[31]. This highlights the importance of support and training programs for caregivers to prepare them for the challenges of the care transition and to avoid caregiver overload. Some authors state that to educate patients and caregivers, their health knowledge, skills, and preferences should be considered. It is necessary to use resources such as simple language, interpreters, demonstrations, or written materials, based on an assessment of their abilities[13,32]. The educational process involves providing clear and coherent information about the health condition, physical, emotional, and social limitations, as well as challenges in the care process[18,22].

The main questions asked by caregivers and patients diagnosed with CVA were diet, medication administration, possible clinical complications after discharge, health conditions, and body care. Based on this, it is essential to teach caregivers how to: measure and record vital signs; identify warning symptoms, such as sudden changes in speech, weakness, or paralysis on one side of the body; know details about prescribed medications; offer guidance on skin care to prevent pressure injuries and proper hygiene[9,20,31,33]. The improvements in self-management and physical functionality indicate that the transition of care can lead to a better quality of life for CVA patients and their caregivers.

In addition to the challenges of physical care, the lack of support can harm survivors and caregivers. Care after a CVA represents a delicate period for those involved[15], leading to feelings of uncertainty and anxiety[13] due to the abrupt changes in daily routine and the need to adapt to the new reality, resulting in cases of emotional exhaustion and care overload[33]. This highlights the need for adequate attention to the emotional dimension of post-CVA patients and caregivers[9,15,18-19].

It should be noted that a protocol qualifies the transition of care after hospital discharge, helping nurses in their care practice. However, several studies carried out with CVA survivors, and their caregivers have highlighted the need for more personalized, patient-centered approaches[15,22,23]. The emphasis on patient-centered approaches and personalized solutions indicates that a quality transition of care requires a thorough understanding of the patient's individual needs and experiences. Thus, discharge from the hospital after a CVA represents a significant milestone, requiring special attention to ensure a safe and effective transition[21-24]. In this respect, nurses play a necessary role in discharge planning, providing health education to both patients and families[8-9,21]. This suggests that investing in resources and training to improve the quality and implementation of discharge plans is key to an effective transition of care.

CVA referral hospitals are often equipped with nurse navigator services, allowing for an improvement in the quality of care in post-acute CVA care, as well as providing greater patient satisfaction[22]. However, there was no significant difference in the length of hospital stay between the groups receiving care from a nurse navigator service and usual care[20]. Several studies have attempted to address these concerns of post-acute CVA care by testing a variety of interventions, including the use of nurse navigators or social workers. However, these efforts have mixed results. The wide range of interventions tested also reflects one of the many challenges of transitional care research[29]. This suggests that more studies be conducted on nurse navigator-led care transitions for CVA survivors.

A well-planned and managed transition of care can lead to positive outcomes for CVA patients, improving functionality, self-management, and quality of life while reducing costs, and complications for the healthcare system.

Study limitations

Considering the prevalence of CVA in the elderly population and the urgent need for effective care transition programs for continuity of care at home, one of the limitations of the studies is that the authors identified in the scoping review did not detail the programs so that they could be replicated in other health

services. The heterogeneity of the studies made it difficult to synthesize the results. In addition, the scoping review may not have provided detailed analyses of each study, and the variety of sample sizes may have affected the generalizability of the results. Another limitation was the exclusion of articles in unspecified languages.

Contributions to practice

The study sheds light on gaps in the literature about the transition of care after CVA. In this sense, the evidence described can help build more effective measures to improve the care provided to individuals who need to make the transition from hospital to home care.

Conclusion

It was found that the literature provides little detail on the planning and implementation of discharge plans for elderly people affected by stroke. The studies highlighted the need to consider the general condition of the elderly person, the environmental context, and the resources available in the healthcare network. The need for protocols and individualized care to reduce or remedy possible post-stroke sequelae was also elucidated; however, most of the studies that promote these practices are from developed countries, highlighting the gap to be filled in Brazil with post-hospital follow-up.

Authors' contribution

Conception and design or analysis and interpretation of data; writing of the manuscript or relevant critical review of the intellectual content; final approval of the version to be published; responsibility for all aspects of the text in ensuring the accuracy and integrity of any part of the manuscript: Coêlho WG, Matiello FB, Bento DYK, Mendes KDS, Fernandes DS, Rodrigues RAP. Conception and design or analysis and interpretation of data; Final approval of the version to be published; Responsibility for all aspects of the text in ensuring the accuracy and completeness of any part of the manuscript: Braga PG.

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